Senator Ron Wyden
Ranking Member
Senate Finance Committee

Health Coverage That Works For Everyone

July 30, 2026

At a time when the American people are more dissatisfied with their health insurance than they have been in 20 years,[1] Democrats have an obligation to take bold, meaningful action to fix America's broken for-profit private health insurance system.

To kickstart this important work, I released a Dear Colleague letter in March along with eleven of my colleagues.[2] We outlined a commitment to reverse harmful cuts and cost increases enacted by Republicans over the past year, and go beyond that by reimagining what a health coverage system that truly works for all Americans should look like. This includes ensuring that everyone can easily afford coverage that meets their needs without facing financial barriers to care such as unaffordable premiums, deductibles, or cost-sharing. It also includes making sure that private insurance companies are no longer able to put profits over patients by abusing practices such as prior authorization to delay and deny essential care, and ensuring that taxpayer dollars are being spent on lowering costs for the American people rather than executive compensation and stock buybacks.

Since the release of the Dear Colleague letter, Senate Finance Committee Democratic staff have held over 80 meetings with nearly 250 advocates and experts to gather perspectives on the path forward. The co-signers of the letter, along with Senators that have since joined our effort, have made their staff available to participate in these meetings as well.

In 2008, the Finance Committee released a paper outlining many of the challenges with America's health care system, along with options for needed reforms.[3] Two years later the Affordable Care Act was signed into law, representing the largest health reforms in America since the establishment of Medicare and Medicaid. Senate Democrats are taking on this challenge once again in order to build the foundation for the next generation of meaningful, consensus-driven reforms and swift legislative action at the next opportunity.

The release of this request for information marks the next step in this work. It is not intended to be an exhaustive summary of the challenges before us and the ways they could be addressed, but the responses we receive will inform our ongoing work to build consensus around meaningful reforms that the American people believe are long overdue. We encourage written feedback and input in the coming weeks and months.

Sincerely,

Ron Wyden

Ron Wyden
United States Senator
Ranking Member, Committee on Finance

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[1]Lydia Saad and Megan Brenan. "Cost Leads Americans' Top-of-Mind Healthcare Concerns." *Gallup*, December 15, 2025. https://news.gallup.com/poll/699770/cost-leads-americans-top-mind-healthcare-concerns.aspx.

[2]"Health Coverage That Works for Everyone," United States Senate Finance Committee, March 19, 2026, https://www.finance.senate.gov/imo/media/doc/031926_dear_colleague_insurance.pdf.

[3]"Call to Action: Health Reform 2009," United States Senate Finance Committee, November 12, 2008, https://www.finance.senate.gov/imo/media/doc/finalwhitepaper1.pdf.

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INTRODUCTION & EXECUTIVE SUMMARY

Democrats have always been the party that moves American health care forward. In 1945, President Truman proposed a system of universal health care. In 1965, President Johnson signed Medicare and Medicaid into law, providing high-quality coverage for seniors and people with disabilities. In 1997, President Clinton signed the Children's Health Insurance Program (CHIP) into law, ensuring that children and pregnant women have access to low-cost care. In 2010, President Obama signed the Affordable Care Act (ACA) into law, expanding access to coverage, creating a new path for people to buy insurance, and establishing consumer protections to reform a broken private insurance market and rein in wasteful spending.

Despite that progress, significant challenges remain. The United States is the only developed nation that does not guarantee health coverage to all its citizens, and Americans spend more on health care yet experience worse health outcomes than people in other high-income countries.[4] Annual health care spending in the United States is projected to eclipse $6 trillion in 2026,[5] greatly exceeding per-capita spending in other wealthy nations. Costs continue to increase faster than inflation, and are projected to grow faster than average gross domestic product (GDP) over the next decade.[6] These challenges cannot be fully addressed without system-wide reforms and cost-containment policies that require *every industry in the health care sector* to provide constructive solutions. This Request for Information (RFI) is the second in a series of long-term projects led by Senate Democrats to develop those reforms, following a June 2026 RFI focused on lowering prescription drug prices and reducing costs for patients.[7]

The hard-won gains made since the ACA was signed into law are under constant attack: the number of uninsured Americans declined from over 46 million in 2010 to fewer than 27 million in 2024,[8] but that number is on the rise once again after Republican cuts to Medicaid and the ACA that will kick 15 million people off their coverage, according to the non-partisan Congressional Budget Office (CBO).[9] The Trump administration continues to pursue policies that will lead to higher premiums, unreachable deductibles, smaller networks, fewer benefits, and endless red tape placed between the American people and their health care, causing millions more to lose coverage.[10]

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[4]Munira Z. Gunja et al., "U.S. Health Care from a Global Perspective, 2026." The Commonwealth Fund, May 28, 2026. https://www.commonwealthfund.org/publications/issue-briefs/2026/may/us-health-care-global-perspective-2026; Shameek Rakshit et al., "How Does U.S. Life Expectancy Compare to Other Countries?" Peterson-KFF Health System Tracker, March 31, 2026. https://www.healthsystemtracker.org/chart-collection/u-s-life-expectancy-compare-countries/.

[5]"NHE Fact Sheet," Centers for Medicare & Medicaid Services, June 24, 2026, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet.

[6]Centers for Medicare & Medicaid Services, "NHE Fact Sheet."

[7]"Wyden Seeks Input on New Policies to Lower Drug Prices," United States Senate Finance Committee, June 16, 2026, https://www.finance.senate.gov/ranking-members-news/wyden-seeks-input-on-new-policies-to-lower-drug-prices.

[8]Jennifer Tolbert et al., "Key Facts about the Uninsured Population," KFF, June 16, 2026. https://www.kff.org/uninsured/key-facts-about-the-uninsured-population/.

[9]Phillip L. Swagel et al, "Federal Subsidies for Health Insurance, 2026-2035," Congressional Budget Office, July 23, 2026, https://www.cbo.gov/system/files/2026-07/62539-Health-Insurance.pdf; Phillip L. Swagel to Ranking Members Ron Wyden, Frank Pallone, Jr., and Richard E. Neal, "Estimated Effects on the Number of Uninsured People in 2034 Resulting From Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act," Congressional Budget Office, June 4, 2025, https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf

[10]Sabrina Corlette et al., "Fact Sheet: The Proposed Marketplace Rule Would Make Health Care Less Affordable and Add Red Tape," Georgetown University Center on Health Insurance Reforms , March 20, 2026,

As Senate Democrats continue to hold Republicans accountable for making insurance harder to get, more expensive to keep, and more difficult to use, we are also doing the work to build a health care system that works for everyone. Democrats are in strong agreement that coverage should be universal, comprehensive, easy to get, and easy to use for all Americans, regardless of where they live, where they work, and what they are able to afford. On March 19, 2026, Ranking Member Wyden, along with Senators Warner, Ossoff, Warnock, Blunt Rochester, Baldwin, Whitehouse, Merkley, Slotkin, Warren, Smith and Welch, released a Dear Colleague letter making the case for needed private insurance reforms.[11] Additional Democratic Senators have since joined these discussions, including Senators Hassan, Hirono, Cantwell, Blumenthal and Bennet.

In the months since the release of the Dear Colleague letter, Finance Committee Democratic staff have been joined by staff from participating Senate offices in over 80 listening sessions with nearly 250 patient advocates, consumer groups, researchers, hospitals, doctors, and health plans. This RFI is the next step in this work, and reflects conversations, proposals and feedback received during these initial listening sessions related to private insurance reforms in the individual, small group and large group markets. This RFI is not intended to presuppose policy outcomes or reflect an exhaustive list of policy options that could be considered, but is a call for specific feedback, analysis and proposals to address the topics and issues highlighted throughout.

Ranking Member Wyden, along with the Senators participating in this effort, invite detailed comments, feedback, data, and specific policy proposals that are responsive to some or all of the topics contained within this RFI. This Executive Summary includes a brief overview of each section of this RFI, please note in your response which section or sections you are responding to. These responses will be used to inform future policymaking efforts and legislative drafting.

Please submit written comments to insurance@finance.senate.gov **no later than October 2, 2026.**

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https://chir.georgetown.edu/fact-sheet-the-proposed-marketplace-rule-would-make-health-care-less-affordable-and-add-red-tape/; Matt McGough et al., "What We Know So Far About 2026 ACA Marketplace Enrollment, Premiums, and Deductibles," KFF, May 19, 2026, https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/; Sabrina Corlette et al., "Final Notice of Benefit & Payment Parameters: Implications for State Based Marketplaces and Insurance Regulators," State Health and Value Strategies, Princeton University School of Public and International Affairs, May 2026, https://shvs.org/wp-content/uploads/2026/05/SHVS_2027-NBPP-FINAL.pdf

[11] "Health Coverage That Works for Everyone," United States Senate Finance Committee, March 19, 2026, https://www.finance.senate.gov/imo/media/doc/031926_dear_colleague_insurance.pdf.

Section 1: Reversing Republican Cuts and Reimagining a Better Path

Senate Democrats intend to reverse a Republican health care agenda that has made coverage less affordable and less accessible. This is a first step in our work to meaningfully reform a fundamentally broken coverage system.

Within Section 1 of this RFI Senate Democrats request feedback and recommendations on the following topics related to enrollment, coverage and costs:

- Approaches to expanding the availability of impartial enrollment assistance and support tools, and limiting deceptive or profit-driven marketing tactics;
- The establishment of a 'unified Exchange' framework that would allow consumers to use a centralized source to enroll in coverage they are eligible for, regardless of income or employment status and no matter where they get their coverage;
- Modernizing eligibility verification and enrollment processes to eliminate enrollment red tape and streamline access to financial support and coverage;
- Ensuring that consumers receive comprehensive coverage that provides broad access to providers and includes affordable caps on total spending, inclusive of premiums, deductibles and cost-sharing;
- Expanding rate review authorities and increasing support for states to ensure that insurance companies fully justify their cost increases each year and subject their filings to more rigorous public review;
- Establishing a uniform affordability standard that takes into account a consumer's total cost of care and their ability to pay for such care;
- Reforming deductibles and cost-sharing requirements to ensure that health plan design does not create barriers to essential care, including non-shoppable services;
- Evaluating whether coinsurance is limiting access to high-value care, driving medical debt and creating barriers to necessary care, including primary care;
- Establishing a uniform approach to capping cost-sharing based on affordability;
- Reimagining a coverage system that provides all Americans with a Medicare-type choice regardless of income, job status or ability to afford premiums;
- Expanding minimum coverage requirements and consumer protections, including for people with pre-existing conditions, by strengthening benefit design and eliminating junk insurance from the market;
- Ensuring that reforms to strengthen consumer protections and improve affordability are extended across private insurance markets to provide parity and predictability for consumers regardless of where they get their coverage; and
- Establishing safeguards to ensure that people who churn through different health coverage programs throughout the year due to changes in income or eligibility maintain seamless coverage and are not subject to financial penalties.

Section 2: Making Health Care Simpler For Families

Senate Democrats are interested in proposals and reforms that will make health coverage easy to get, easy to understand, and easy to use for all Americans, regardless of what coverage they are eligible for.

Within Section 2 of this RFI Senate Democrats request feedback and recommendations on the following topics related to benefits, barriers to care and administrative burdens:

- Establishing and codifying standardized benefits and plan designs that ensure affordability, address disparities, drive competition based on value and quality, and help consumers choose coverage that best meets their needs;
- Ensuring access to broad networks of high-quality providers for all consumers, regardless of where they get their coverage, and eliminating misleading forms of coverage that do not provide financial protection or broad access to high-quality providers;
- Ensuring that practices such as prior authorization and claims denials cannot be abused by for-profit insurance companies to generate profits and limit access to care;
- Protecting consumers from unexpected mid-year cost increases or coverage changes caused by their insurance company or due to an unforeseen need to switch coverage;
- Guaranteeing that patients and families have access to and can easily navigate an appeals process that puts them on a level playing field with their insurance plan;
- Quantifying the wasteful administrative burden imposed on consumers, hospitals and providers by insurance companies, and eliminating unnecessary costs and hurdles;
- Holding insurance companies accountable when they improperly delay or deny care; and
- Protecting consumers from Republican efforts to use misleading and unsubstantiated claims of fraud as an excuse to kick people off their coverage or keep them uninsured.

Section 3: Taking on Corporate Greed

Senate Democrats are interested in proposals that will address insurance company profiteering and put an end to the shell games that are used to maximize revenue and impose undue administrative barriers and requirements on providers, employers and patients.

Within Section 3 of this RFI Senate Democrats request feedback and recommendations on the following topics related to profits, gaming and vertical integration:

- Ensuring that taxpayer dollars and premiums paid by consumers and employers are being spent on patient care rather than corporate profits, including proposals to limit the practice of using health care dollars for stock buybacks, non-health care investments and executive compensation;
- Establishing safeguards to ensure that private equity-backed entities cannot raise costs, worsen care, or extract profit margin at the expense of employers, families and patients;
- Eliminating financial incentives that encourage vertical integration and the use of intercompany transfers and eliminations to move revenue and profits, including reforms to end gaming of Medical Loss Ratio (MLR) reporting and rebate obligations;
- Reforming MLR to improve oversight, transparency and accountability for insurance companies, including proposals to expand reporting requirements and refine definitions of expenses such as quality improvement activities;
- Addressing anticompetitive practices and gaming that third-party administrators and other middlemen owned by or affiliated with insurance companies use to extract profit using practices similar to those used by pharmacy benefit managers (PBMs); and
- Expanding transparency and reporting requirements across private markets to create a truly level playing field where employers and consumers have access to prices, claims and other cost data.

THE URGENT NEED FOR REFORM

The American health care system has undergone significant changes since the Affordable Care Act (ACA) was signed into law by President Obama in 2010. The ACA's coverage expansions reduced the uninsured rate in America to the lowest it has ever been.[12] Private market reforms established consumer protections that were long overdue, and created a viable individual market that now provides coverage for over 20 million working people. The ACA strengthened our fragmented health care system and ended many of the egregious practices that insurance companies used to drive profits at the expense of patients, including denying, rescinding or excluding coverage for people with pre-existing conditions and charging higher premiums that made coverage unattainable for people who needed it most.

The ACA also ended the insurance company practice of imposing arbitrary annual or lifetime limits on the amount of coverage they would provide, and created caps on annual out-of-pocket costs. People with private insurance are now able to receive no-cost preventive care,[13] and many insurance plans are required to cover essential health benefits such as emergency services, hospital stays, behavioral health services, maternity care, prescription drugs, and pediatric services. None of this was guaranteed prior to the ACA. These reforms have saved lives and improved the health and well-being of millions of American families.

While the ACA represented significant progress, it was not intended to be the final step in our work to achieve universal high-quality coverage for all Americans. We were reminded in 2016 by President Obama that, "for all the good that the Affordable Care Act is doing right now–for as big a step forward as it was–it's still just a first step."[14]

Rather than work with Democrats to take additional steps to expand coverage, improve affordability, and strengthen consumer protections, Republicans have spent the past 16 years focused on doing the opposite, and in 2026 the United States remains the only developed nation that does not guarantee health coverage for all its citizens. Republicans have tried to repeal the ACA over seventy times, failing on each occasion because the law continues to have broad support from the American people.[15] Realizing that full repeal efforts would continue to fail, Republicans used their current majorities in Congress to raise costs, erode coverage and benefits, impose red tape on consumers, destabilize insurance markets, and kick millions of Americans off of Medicaid and ACA Marketplace plans.[16]

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[12]"National Uninsured Rate Reaches an All-Time Low in Early 2023 After the Close of the ACA Open Enrollment Period," ASPE Office of Health Policy, August 3, 2023, https://aspe.hhs.gov/sites/default/files/documents/e06a66dfc6f62afc8bb809038dfaebe4/Uninsured-Record-Low-Q12023.pdf

[13]Sara Rosenbaum et al., "Affordable Care Act Recommended Preventive Health Services Without Cost-Sharing Yields Health Benefits and Savings for Families," Geiger Gibson / RCHN Community Health Foundation, April 2026, https://geigergibson.publichealth.gwu.edu/sites/g/files/zaxdzs4421/files/2026-04/Preventive%20Services%20Health%20Benefits%20and%20Savings.pdf

[14]Barack Obama, "Remarks by the President on the Affordable Care Act," Miami Dade College, Miami, Florida, October 20, 2016, https://obamawhitehouse.archives.gov/the-press-office/2016/10/20/remarks-president-affordable-care-act/

[15]Yasmeen Abutaleb and David Ovatelle, "Why Republicans' attempts to kill Obamacare keep backfiring," *The Washington Post*, October 12, 2025, https://www.washingtonpost.com/politics/2025/10/12/obamacare-shutdown-republicans-repeal/; "Tracking the Public's Views on the ACA," KFF, January 26, 2026, https://www.kff.org/affordable-care-act/the-publics-views-on-the-aca-tracker/

[16]McGough et al., "What We Know So Far."

Taken together, the 2025 Republican reconciliation bill, Trump administration rulemaking,[17] and Republicans' refusal to extend tax credits that made coverage more affordable for working people amounted to the largest health care cuts in American history.[18] This sustained 'repeal by one thousand cuts' strategy has been carried out to quietly achieve the longstanding Republican goal of repealing the ACA, while avoiding accountability to the American people for policies that will continue to undermine their access to coverage and care over time.

The results of this Republican health care agenda are already clear, across private insurance markets. Working people who buy their own insurance have seen their monthly premiums increase by an average of 58 percent in 2026, and millions of Americans have already lost coverage.[19] Premiums will continue to increase dramatically in 2027,[20] and the uninsured rate is projected to rise further in the coming years,[21] reversing over a decade of progress driven by the coverage expansions in the ACA. Employers are increasingly struggling to afford health care for their employees, with total premiums for a family of four increasing by 53 percent since 2015, reaching an average cost of $37,840 in 2026.[22] Employees have seen their premium contributions skyrocket at a time when they are also struggling to afford essentials such as housing, food and utility costs. A recent survey found that over 80 percent of people with employer coverage believe it is unaffordable,[23] reflecting broad dissatisfaction in a private insurance market that provides coverage for over 160 million people and has not seen meaningful reforms in decades.[24]

Health care has become unaffordable for millions of Americans even when they have insurance. For-profit insurance companies continue to engage in practices that delay and deny coverage, drive significant consumer dissatisfaction, and fail to deliver what the American people should expect from companies that receive hundreds of billions of dollars from taxpayers, employers and working people each year.[25]

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[17]Phillip L. Swagel "The Estimated Effects of Enacting Selected Health Coverage Policies on the Federal Budget and on the Number of People With Health Insurance," September 18, 2025, https://www.cbo.gov/system/files/2025-09/61734-Health.pdf; Sabrina Corlette, "The Dismantling of Obamacare Starts August 25 – Unless Litigation Can Stop It," Georgetown University Center on Health Insurance Reforms, August 12, 2025, https://chir.georgetown.edu/the-dismantling-of-obamacare-starts-august-25-unless-litigation-can-stop-it/

[18]Swagel, "Estimated Effects on the Number of Uninsured People."

[19]McGough et al., "What We Know So Far."

[20]Matt McGough et al., "How much and why ACA Marketplace premiums are going up in 2027," Peterson-KFF Health System Tracker, July 8, 2026, https://www.healthsystemtracker.org/brief/how-much-and-why-aca-marketplace-premiums-are-going-up-in-2027/

[21]Swagel et al, "Federal Subsidies for Health Insurance."; Tolbert et al., "Key Facts."

[22]Deana Bell et al., "2026 Milliman Medical Index," Milliman, May 20, 2026, https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2026-Articles/2026_Milliman-Medical-Index.pdf

[23]"The Health Care Affordability Gap: When Employer Coverage Isn't Enough," United States of Care, June 1, 2026, https://unitedstatesofcare.org/public-opinion-poll-affordability-june-2026-esi/;"2025 Employer Health Benefits Survey," KFF, October 22, 2025, https://www.kff.org/health-costs/2025-employer-health-benefits-survey/

[24]Gary Claxton et al., "Employer-Sponsored Health Insurance 101," KFF, April 15, 2026, https://www.kff.org/health-costs/health-policy-101-employer-sponsored-health-insurance/

[25]Karen Pollitz et al., "KFF Survey of Consumer Experiences with Health Insurance," KFF, June 15, 2023, https://www.kff.org/affordable-care-act/kff-survey-of-consumer-experiences-with-health-insurance/; Katie Keith, "Insurer Accountability in the Next Generation of Health Reform," *Saint Louis University Journal of Health Law and Policy* 15, no. 2 (2022), https://scholarship.law.slu.edu/cgi/viewcontent.cgi?article=1289&context=jhlp

These companies have found ways to exploit gaps and loopholes in existing laws that allow them to generate revenue through administrative waste and increase profits by placing barriers between patients and their care. They are increasingly saddling consumers and families with unreachable out-of-pocket costs for basic services and essential care: average deductibles in the individual market are the highest they have ever been,[26] increasing by 37 percent this year, over $1,000 per enrollee on average.[27] Deductibles in the employer market have increased by over 40 percent in the past ten years,[28] and the average family of four must now pay over $4,000 in costs beyond their monthly premiums before their insurance company will provide meaningful financial help.[29]

These rising costs are leaving families with impossible choices: nearly half of people with insurance report receiving a bill for a service they expected would be covered by their insurance company,[30] and nearly 40 percent of people with insurance have delayed or skipped care altogether because they cannot afford it.[31] Over 100 million Americans report having medical debt,[32] including more than 4 in 10 people with health insurance.[33]

In addition to being increasingly unaffordable to use, health insurance is becoming harder to get and uninsured adults increasingly report that they do not want coverage at all.[34] People between ages 19 and 34 account for the highest percentage of uninsured adults,[35] which suggests that affordability challenges and dissatisfaction with insurance are keeping this relatively healthy, low-cost population from buying health insurance altogether. This trend raises overall costs and has a destabilizing effect on markets, hospitals and risk pools over time.

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[26]McGough et al., "What We Know So Far."
[27]"The Average Marketplace Deductible Grew by About $1,000 Per Person in 2026, With More Enrollees Shifting to Higher-Deductible Plans as Enhanced Tax Credits Expired," KFF, May 19, 2026, https://www.kff.org/affordable-care-act/the-average-marketplace-deductible-grew-by-about-1000-per-person-in-2026-with-more-enrollees-shifting-to-higher-deductible-plans-as-enhanced-tax-credits-expired/
[28]KFF, "2025 Employer Health Benefits"
[29]"Average Annual Deductible per Enrolled Employee in Employer-Based Health Insurance for Single and Family Coverage," KFF, 2024, https://www.kff.org/private-insurance/state-indicator/average-annual-deductible-per-enrolled-employee-in-employer-based-health-insurance-for-single-and-family-coverage/
[30]Avni Gupta et al., "Unforeseen Health Care Bills and Coverage Denials by Health Insurers in the U.S.," The Commonwealth Fund, August 1, 2024, https://www.commonwealthfund.org/publications/issue-briefs/2024/aug/unforeseen-health-care-bills-coverage-denials-by-insurers.
[31]Grace Sparks et al., "Americans' Challenges with Health Care Costs," KFF, April 30, 2026, https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/
[32]Noam N. Levey, KFF Health News, "100 Million People in America Are Saddled With Health Care Debt," June 16, 2022, https://kffhealthnews.org/health-care-costs/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/
[33]Tolbert et al., "Key Facts."
[34]Robin A. Cohen and Abhigya Giri, "Trends in Selected Reasons for Being Uninsured Among Adults Ages 18–64: United States, 2019–2024," CDC National Center for Health Statistics, March 2026, https://www.cdc.gov/nchs/data/hestat/hestat114.htm; Gary Claxton et al., "How employers support lower-waged workers' access to health insurance options," Peterson-KFF Health System Tracker, April 20, 2026, https://www.healthsystemtracker.org/chart-collection/how-employers-support-lower-waged-workers-access-to-health-insurance-options/
[35]Tolbert et al., "Key Facts."

It should come as no surprise that Americans report being more dissatisfied with health insurance than they have been at any point in over twenty years,[36] and this sharp frustration with the status quo comes at a time when the largest for-profit health insurance conglomerates in America are generating tens of billions of dollars in annual profits across private insurance markets and spending billions on stock buybacks and executive compensation.[37]

The Trump administration and congressional Republicans have capitalized on this environment of dissatisfaction and distrust by pursuing unprecedented cuts to the ACA,[38] often with public support from many for-profit health insurance companies that receive billions in taxpayer funding to provide coverage for working people.[39] Republicans work hard to frame their cuts as so-called anti-fraud measures,[40] but their policies have eroded consumer protections and driven increased profits for insurance conglomerates and their shareholders at the expense of coverage and patient care.[41]

A health care system that provides affordable, high-quality coverage and meets the needs of the American people would be durable enough to withstand Republicans' false narratives and repeal by one thousand cuts strategy. A universal system of coverage that supports patients when they need care and protects families from financial ruin would not be vulnerable to Republican cuts that raise costs, eliminate provider and hospital networks, promote junk insurance, and enrich for-profit health care conglomerates while leaving patients unable to afford the care they need,

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[36]Saad and Brenan, "Cost Leads Americans'"

[37]Wendell Potter, "The majority of big insurers' health plan revenues are subsidized by American taxpayers," *Healthcare Uncovered*, September 7, 2022, https://healthcareuncovered.substack.com/p/the-majority-of-big-insurers-health; Wendell Potter, "As Americans Struggled, Health Insurers Made a Record-Breaking $71.3 Billion in Profits," *Healthcare Uncovered,* August 6, 2025, https://healthcareuncovered.substack.com/p/as-americans-struggled-health-insurers; Adrienne M. Gilligan et al., "Death or Debt? National Estimates of Financial Toxicity in Persons with Newly-Diagnosed Cancer," *American Journal of Medicine* 131, no. 10 (2018), October 2018, https://www.amjmed.com/article/S0002-9343(18)30509-6/abstract; Wendell Potter, "The Margin Myth: Why One of the Insurance Industry's Favorite Talking Points is Designed to Mislead You," *Healthcare Uncovered*, June 10, 2026, https://healthcareuncovered.substack.com/p/the-margin-myth-why-one-of-the-insurance; Wendell Potter, "2025: Big Insurance's $1.7 Trillion Year," *Healthcare Uncovered*, February 23, 2026, https://healthcareuncovered.substack.com/p/2025-big-insurances-17-trillion-year; "UnitedHealth Group Reports 2025 Results and Issues 2026 Outlook," United Health Group, January 27, 2026, https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2025/unh-reports-2025-results-and-issues-2026-outlook.pdf; "The Cigna Group Reports Strong Fourth Quarter and Full Year 2025 Results, Establishes 2026 Outlook and Increases Dividend," The Cigna Group, February 5, 2026, https://newsroom.thecignagroup.com/2026-02-05-The-Cigna-Group-Reports-Strong-Fourth-Quarter-and-Full-Year-2025-Results,-Establishes-2026-Outlook-and-Increases-Dividend; "CVS Health Corporation Reports Fourth Quarter and Full-Year 2025 Results," CVS Health, 2025, https://s206.q4cdn.com/752775519/files/doc_financials/2025/q4/Q4-2025-Earnings-Release.pdf

[38]Swagel, "The Estimated Effects of Enacting"

[39]Sabrina Corlette, "Stakeholder Perspectives on CMS' Proposed 'Marketplace Integrity' Rule: Health Insurers and Brokers,"Georgetown University Center on Health Insurance Reforms, May 5, 2025, https://chir.georgetown.edu/stakeholder-perspectives-on-cms-proposed-marketplace-integrity-rule-health-insurers-and-brokers/; Sabrina Corlette, "Stakeholder Perspectives on CMS' Proposed 2027 Notice of Benefit and Payment Parameters: Health Insurers and Brokers," Georgetown University Center on Health Insurance Reforms, April 7, 2026, https://chir.georgetown.edu/stakeholder-perspectives-on-cms-proposed-2027-notice-of-benefit-and-payment-parameters-health-insurers-and-brokers/

[40]"HHS Notice of Benefit and Payment Parameters for 2027 Final Rule," The Centers for Medicare & Medicaid Services, May 15, 2026, https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-payment-parameters-2027-final-rule; "Debunking Myths About Enhanced ACA Tax Credits," American Cancer Society, February 11, 2025, https://www.fightcancer.org/sites/default/files/debunking_myths_about_aca_enhanced_tax_credits_and_fraud_final_02112025.pdf

[41]Wendell Potter, "Big Insurance Q1 2026 Earnings Round Up," *Healthcare Uncovered*, May 12, 2026, https://healthcareuncovered.substack.com/p/big-insurance-q1-2026-earnings-round

and exposed to crushing medical debt.[42] Democrats can and will enact comprehensive, structural reforms that build such a system. Senate Democrats are beginning this work now in order to be prepared to swiftly deliver the type of meaningful change the American people deserve at the next opportunity.

[42]Corlette, "Stakeholder Perspectives on CMS' Proposed 2027 Notice"; "Health Tax Accounts: The big Republican giveaway to banks and big insurance, A Senate Finance Committee Minority Staff Report," United States Senate Finance Committee, November 2025, https://www.finance.senate.gov/imo/media/doc/111825_hsa_report_final2.pdf;
Reed Abelson, "Can't Pay Medical Bills? Trump Officials Suggest Getting a Loan." *The New York Times*, June 11, 2026, https://www.nytimes.com/2026/06/11/business/aca-health-care-costs-medical-debt.html; "More Costs, Less Care: The Republican 'Plans' for Health Care," United States Senate Health, Education, Labor and Pensions (HELP) Committee Minority Staff Report, December 9, 2025, https://www.sanders.senate.gov/wp-content/uploads/12.9.25-Republican-Health-Plans-HELP-Minority-Report-1.pdf

SECTION 1: Reversing Republican Cuts and Reimagining a Better Path

The Trump administration and Republicans in Congress have spent the past two years enacting the largest health care cuts in history, and dismantling the ACA has been a central part of that agenda. Over 15 million Americans will lose Medicaid and ACA Marketplace coverage as a result of these cuts,[43] and in the coming years it will become harder to enroll in coverage, increasingly impossible to afford premiums and deductibles, and more difficult to maintain coverage as provisions of the Republican health care agenda continue to take effect.[44] Republicans also ended tax credits that working people use to buy their own insurance, which caused premiums to skyrocket for over 20 million Americans this year and injected instability and uncertainty into state insurance markets across the country.[45]

We are already seeing the damaging effects of these policies, and in the coming months we will continue to learn more about the coverage loss and rising costs faced by working people across the country. These cuts must be reversed, but beyond simply reversing cuts, Democrats are committed to reimagining what a coverage system must look like moving forward and enacting new reforms so that every American is not only covered, but can access, afford and receive care when they need it.

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

To ensure that working people and families can enroll in the health coverage they are eligible for, the enrollment process needs to be easy to understand and quick to complete. Over the past year, Republicans have executed a regulatory and legislative agenda that does the opposite.[46] When the enrollment process gets more difficult and fewer non-biased resources are available to help consumers understand their options, working people and families are more likely to unknowingly enroll in a health plan that does not meet their needs, or miss out on coverage they are eligible for altogether.[47]

Consumers who might be eligible for Medicaid, or those with complex enrollment circumstances, often rely on the Navigator program to understand their options because they are less likely to receive enrollment assistance from brokers and agents.[48] The Navigator program provides impartial outreach, education and enrollment assistance to consumers, and Navigators are funded through federal grants rather than insurance company commissions. One of the Trump administration's first actions upon taking office in 2025 was to cut funding for the

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[43]Swagel, “Estimated Effects on the Number of Uninsured People."
[44]“By the Numbers: Harmful Republican Megabill Will Take Health Coverage Away From Millions of People and Raise Families’ Costs," Center on Budget and Policy Priorities, August 27, 2025, https://www.cbpp.org/research/health/by-the-numbers-harmful-republican-megabill-will-take-health-coverage-away-from
[45]McGough et al., “What We Know So Far”; McGough et al., "How Much and Why."
[46]Stacy Pogue and Sabrina Corlette, “Emerging State Data Paint a Bleak Picture of 2026 Marketplace Enrollment," The Commonwealth Fund, June 8, 2026, https://www.commonwealthfund.org/blog/2026/emerging-state-data-paint-bleak-picture-2026-marketplace-enrollment
[47]Dave Kendall et al., “Cost Caps and Coverage for All: How to Make Health Care Universally Affordable," Third Way, February 19, 2019, https://www.thirdway.org/report/cost-caps-and-coverage-for-all-how-to-make-health-care-universally-affordable
[48]Karen Pollitz et al., “2022 Survey of ACA Marketplace Assister Programs and Brokers," KFF, October 17, 2022, https://www.kff.org/affordable-care-act/2022-survey-of-aca-marketplace-assister-programs-and-brokers/

Navigator program by 90 percent,[49] severely limiting access to this impartial resource that assists with enrollment and provides non-biased information. This significant cut took place at a time when Republicans also made it more difficult to enroll in coverage by eliminating presumptive eligibility for federal assistance, ending annual automatic re-enrollment in the ACA Marketplace, and pursuing rulemaking designed to place hurdles and barriers between eligible people and their coverage.[50] Democratic reforms must include policies that build a simple, streamlined enrollment and coverage system that will meet the needs of the American people.

Consumer-Friendly Enrollment

Working people and families should be able to quickly determine what coverage they are eligible for, and enroll without having to navigate multiple websites or make complex decisions because the information they need is missing or unclear. This year, the Trump administration proposed to double down on the confusion their policies have caused by allowing third-party enrollment entities administered by brokers and health insurance companies to more broadly promote and sell coverage outside of centralized, regulated ACA Marketplaces. These enrollment entities can mislead consumers by promoting plans that are more profitable for insurance companies because they do not comply with ACA consumer protections, and giving preferential marketing and placement to insurance companies that pay for such treatment.[51]

Third-party assistance. The individual and small-group markets can be vulnerable to misleading third-party marketing efforts and deceptive practices that harm consumers by obscuring key details about their coverage and omitting information about eligibility for financial assistance. This is particularly true when consumers are encouraged to shop for "off-Exchange" coverage that is not subject to ACA requirements and protections. In an environment where the Navigator program has been drastically limited, consumers may rely more heavily on misleading marketing and outreach from bad actors that seek to generate commissions and maximize profits at the expense of ensuring that people are enrolling in the best possible coverage and receiving the financial assistance available to them.[52]

Every consumer who receives enrollment assistance should be provided with complete information about their eligibility for financial assistance or other affordable coverage options. Third-party entities participating in these markets should be required to provide non-biased guidance, and should be held accountable for deceptive practices that can mislead consumers. **Senate Democrats invite proposals and feedback on approaches to ensure that consumers**

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[49]"CMS Announcement on Federal Navigator Program Funding," CMS, February 15, 2025, https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding; Kaye Pestaina, "A 90% Cut to the ACA Navigator Program," KFF, February 14, 2025, https://www.kff.org/quick-insights/a-90-cut-to-the-aca-navigator-program/

[50]Corlette, "The Dismantling of Obamacare."

[51]Stacey Pogue, "Stakeholder Perspectives on CMS's 2027 Notice of Benefit and Payment Parameters: State Insurance Departments and Marketplaces," Georgetown University Center on Health Insurance Reforms, April 17, 2026, https://chir.georgetown.edu/stakeholder-perspectives-on-cmss-2027-notice-of-benefit-and-payment-parameters-state-insurance-departments-and-marketplaces/

[52]"What Consumers Need to Know About Health Coverage That Doesn't Comply with the Affordable Care Act," The Commonwealth Fund, February 19, 2026, https://www.commonwealthfund.org/publications/explainer/2026/feb/what-consumers-need-know-health-coverage-doesnt-comply-aca; Pogue, "Stakeholder Perspectives on CMS's"

seeking to enroll in high-quality coverage are protected from misleading marketing and substandard coverage.

Centralized enrollment platforms. Restoring funding for the Navigator program and eliminating the red tape Republican policies added to the enrollment process will be an important first step in future reforms. During listening sessions, patient and consumer organizations expressed support for reforms that go beyond restoring previous policies in order to improve and simplify the enrollment process for consumers, regardless of what coverage they are eligible for. People can become eligible for many types of coverage and financial assistance over their lifetime based on changes in age, income, employment status, and other factors.

Enrolling in coverage at different times and across markets could be made easier for consumers through a more standardized or centralized platform that creates a consistent enrollment experience across coverage programs. **Senate Democrats invite comments on the benefits of this approach 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.**

Employers play a significant role in purchasing health care for American families. Some organizations representing consumers and employees suggested during listening sessions that existing enrollment processes in the employer market can be burdensome for workers to navigate and for employers to administer. **We are interested in feedback on the specific challenges or inefficiencies that employers experience and request comments on whether access to a more standardized enrollment platform could potentially help reduce burden and costs for employers and people with employer coverage.**

State-Based Marketplaces (SBMs) operate in more than 20 states and have been established by governors and legislatures of both political parties. SBMs consistently demonstrate a non-partisan commitment to serving residents who want to shop for coverage and receive the financial assistance they are eligible for, and they offer a strong model for what centralized non-biased consumer engagement and enrollment support can look like. SBMs have developed effective approaches and best practices that could be more broadly adopted to support efficient enrollment for everyone who needs coverage. **We request feedback on ways the operations and authorities of SBMs could potentially be expanded to strengthen insurance markets and streamline enrollment processes across private markets and public programs, and invite proposed reforms that would better support the ongoing work of SBMs and encourage broader adoption across states.**

Coverage Value and Costs

American taxpayers support the cost of health insurance across private markets by providing for-profit insurance companies with hundreds of billions of dollars in annual subsidies, tax breaks and tax exclusions each year.[53] In return for such significant taxpayer assistance, for-profit

[53]Swagel et al, "Federal Subsidies for Health Insurance."; Juliette Cubanski et al., "What Does the Federal Government Spend on Health Care?," KFF, February 24, 2025, https://www.kff.org/medicaid/what-does-the-federal-government-spend-on-health-care/

insurance companies should be required to provide high-quality coverage and basic protections to people who purchase coverage with federal support. This is increasingly not the case after Republican cuts to the ACA that are driving consumers to enroll in subsidized coverage that offers comparatively lower premiums, but less protective coverage that exposes them to higher overall costs during the year.[54] This trend will likely continue in the coming years as premiums continue to increase rapidly and the Trump administration continues to erode the quality of coverage on the individual market by expanding the availability of substandard insurance options that offer little financial protection.[55]

Republicans continue to promote high-deductible health plans and catastrophic coverage, options that allow insurance companies to generate larger profits by passing additional costs and risk onto consumers through higher out-of-pocket expenses and a lower actuarial value for coverage.[56] Recent Trump administration rulemaking will erode financial protection for consumers even further by introducing plan options with no networks and increasing potential annual maximum out-of-pocket costs on the ACA Marketplace to over $15,000 for individuals, and $31,000 for families.[57]

Republicans have proposed to address rising costs by providing consumers with health savings accounts (HSAs) that are funded with as little as $80 per month and would leave American families to negotiate the costs of care on their own while relying on a nominal monthly contribution to pay their medical bills.[58] This approach would be a continuation of a Republican health care agenda that allows large for-profit insurance conglomerates to generate billions in annual revenue and profits by accepting taxpayer dollars and providing the minimum coverage that the law allows.[59]

Essential health benefits. The ACA requires that insurance companies in the individual and small-group market provide a minimum level of coverage to enrollees by covering ten essential health benefits.[60] Some states have expanded this requirement to include coverage for additional services. In order to ensure that consumers receive truly comprehensive coverage, some patient and consumer advocates propose expansions of the ACA essential health benefits requirements, including by establishing additional evidence-based coverage requirements or better enabling states to expand their own coverage requirements. Recent Trump administration rulemaking

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[54]United States Senate HELP Committee Minority Staff Report, "More Costs, Less Care." https://www.sanders.senate.gov/wp-content/uploads/12.9.25-Republican-Health-Plans-HELP-Minority-Report-1.pdf; Pogue, "Emerging State Data Paint."

[55]McGough et al., "How Much and Why"; Stacey Pogue, Abigail Knapp, "Early Signals Suggest a Second Year of Double-Digit Marketplace Premium Increases," Georgetown University Center on Health Insurance Reforms, June 18, 2026, https://chir.georgetown.edu/early-signals-suggest-a-second-year-of-double-digit-marketplace-premium-increases/; Katie Keith, "HHS Finalizes Sweeping Marketplace Changes, Part 1: Higher Bronze Deductibles And Expansion Of Catastrophic Plans," *Health Affairs Forefront,* May 18, 2026, https://doi.org/10.1377/forefront.20260518.133412.

[56]United States Senate HELP Committee Minority Staff Report, "More Costs, Less Care."

[57]Nicole Rapfogel, Jennifer Sullivan, "New Final Rule Pushes Marketplace Enrollees Toward Lower-Quality, More Expensive Coverage," Center on Budget and Policy Priorities, May 26, 2026, https://www.cbpp.org/blog/new-final-rule-pushes-marketplace-enrollees-toward-lower-quality-more-expensive-coverage

[58]United States Senate HELP Committee Minority Staff Report, "More Costs, Less Care."

[59]"HHS Notice of Benefit and Payment Parameters for 2027 Proposed Rule," CMS, February 9, 2026, https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-payment-parameters-2027-proposed-rule

[60]"What Marketplace health insurance plans cover," HealthCare, https://www.healthcare.gov/coverage/what-marketplace-plans-cover/

limits state flexibility by requiring states to assume significant additional costs if they expand coverage, and eliminating state authority to provide coverage for certain benefits.[61] **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.**

Affordability determinations. A wide range of groups, including patient and consumer organizations, providers and hospitals, have expressed concerns with Republican policies and support for reforms that provide meaningful protection and assistance, including for people who can afford to buy insurance but increasingly cannot afford to use it. Affordability could be addressed broadly through statutory adjustments to the methodology used to determine eligibility for premium tax credit amounts. Affordability percentages currently apply only to premiums, but could be reformed to take into account total exposure to costs over the course of the plan year, inclusive of premiums and cost-sharing obligations. This change could eliminate unreasonable financial exposure to health care costs, particularly for lower-income people who purchase insurance only to face insurmountable deductibles and out-of-pocket costs that create barriers to care and increase medical debt.

Eligibility determinations for coverage and federal assistance that incorporate an evaluation of affordability beyond premiums could also encourage consumers to enroll in coverage that provides true value and financial protection rather than shopping for coverage based primarily on monthly premium costs. **Senate Democrats request feedback on these reforms and other approaches that would expand protections and assistance for people who cannot afford to use their health insurance.** Additional policy options could include adjusting the benchmark plan calculation, actuarial value requirements, or eligibility for ACA coverage, and reforms to improve inefficient shopping and enrollment processes that cause consumers to forgo savings from cost-sharing reductions they are eligible for because they unknowingly select an ineligible plan.

High-value care without cost-sharing. The success of the ACA's elimination of cost-sharing for high quality, evidence-based preventive care serves as a model to improve affordability and incentivize people to seek out high-value care that improves long-term health outcomes.[62] Providers, consumer organizations and patient advocacy organizations have expressed strong support for building on this model in future reforms by eliminating cost-sharing for additional high-value services. Primary care visits and associated services, or a certain number of urgent care or behavioral health visits per year, are examples of services that could drive value and consumer satisfaction if they are available before the deductible with limited or no cost-sharing.

Some researchers and consumer groups assert that access to certain high-value services and elimination of cost-sharing barriers has a positive effect on long-term health outcomes, spending

[61]Katie Keith, "HHS Finalizes Sweeping Marketplace Changes (Part 3): Essential Health Benefits, Non-Network Plans, And More," *Health Affairs Forefront*, May 27, 2026, https://doi.org/10.1377/forefront.20260527.665516; Sabrina Corlette, "New Federal Rules Affecting Coverage of Treatment for Gender Dysphoria: Considerations for States," State Health & Value Strategies, Princeton University, August 1, 2025, https://shvs.org/new-federal-rules-affecting-coverage-of-treatment-for-gender-dysphoria-considerations-for-states/

[62]Rosenbaum et al., "Affordable Care Act Recommended."

and consumer satisfaction with coverage. **Senate Democrats invite analysis, data and evidence-based feedback on the types of outcomes and measures that should inform consideration of these types of expanded coverage requirements.** Considerations could include improved health outcomes, reductions in long-term health care costs and spending, improved care delivery, improved value, and increased consumer satisfaction. We ask that comments include analysis of premiums, workforce considerations, and other short and long-term costs.

Rate Review

Costs across private insurance markets are growing significantly faster than in public programs,[63] and Americans with private insurance are being forced to absorb higher premiums and out-of-pocket costs each year that increase significantly faster than their wages. The ACA requires annual review of proposed private market rate increases, and provides the public with an opportunity to comment on proposed rates.[64] Rate increases above a certain threshold are subject to independent review,[65] though existing review authorities have not been fully leveraged to maximize plan accountability and exercise control over annual rate increases. Health insurance companies often cite rising medical costs when they propose significant annual rate hikes,[66] but are rarely required by state or federal regulators to meaningfully demonstrate that the cost increases they are imposing on consumers are justified or supported by data.

State authorities. Annual rate review is a tool that could be used more effectively to control costs over time, and there is broad agreement among researchers and advocates that unreasonable rate increases should be subjected to additional scrutiny, review, and denial if they are not justified. Some states have taken steps to enhance their rate review processes to improve oversight and control costs. For example:

- Oregon evaluates the appropriateness of rate increases and subjects the process to public review and an evaluation of actuarial soundness.[67]
- Maine hosts forums that are open to the public and available online where rates are evaluated and residents have the opportunity to ask questions about the information and assumptions underlying proposed rates.[68]

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[63] Jamie Godwin, Zachary Levinson, "Hospital Prices Have Risen Much Faster for Private Insurance Than Medicare Since 2019," KFF, May 18, 2026, https://www.kff.org/health-costs/hospital-prices-have-risen-much-faster-for-private-insurance-than-medicare-since-2019/

[64] Keith, "Insurer Accountability."

[65] "State Effective Rate Review Programs," CMS, September 10, 2024, https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/rate_review_fact_sheet

[66] Tammie Smith, "In Preliminary Rate Filings, ACA Marketplace Insurers Largely Propose Double-Digit Premium Increase For 2027, Following a Steep Climb This Year," July 8, 2026, https://www.kff.org/affordable-care-act/in-preliminary-rate-filings-aca-marketplace-insurers-largely-propose-double-digit-premium-increase-for-2027-following-a-steep-climb-this-year/

[67] "Oregon health rates, 2027 Annual Rate Review First Public Hearing," Oregon Division of Financial Regulation, July 13, 2026, https://dfr.oregon.gov/healthrates/pages/index.aspx; "Understanding health insurance rate review," Oregon Division of Financial Regulation, https://dfr.oregon.gov/healthrates/Pages/understanding-rate-review.aspx

[68] "Maine Merged Market Health Insurance Rate Filings," Maine Bureau of Insurance, https://www.maine.gov/pfr/insurance/legal/upcoming-hearings/public-access-to-aca-filings

- Rhode Island's approach to rate review includes coverage and cost requirements to facilitate expanded access to higher quality care, and has demonstrated downward effects on premiums.[69]

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.

A lack of resources combined with the absence of stronger minimum federal requirements may lead some states to rely on less rigorous review standards and forgo the use of authorities or opportunities to adjust or reject rates, even when there is good reason to consider doing so. We invite feedback on ways to better support state agencies and insurance commissioners, including with additional authorities, guidance, technical assistance, or other resources.

Automatic review. Consumer and patient advocacy organizations suggested during listening sessions that reforms should expand the scope of proposed rate increases that are subject to automatic review. One proposal would build on existing ACA rate review authorities by evaluating annual increases in administrative costs and the use of utilization management practices that delay care and drive up consumer spending without demonstrating an improvement in patient safety or reduced costs.[70] This would require expanding the types of data and analysis that plans are required to submit to states during the rate review process to support their spending and justify potential increases.

Another option for strengthening automatic review would be to establish a federal floor or backstop that would subject premium or administrative cost increases above a defined benchmark to an automatic review and justification process, ensuring that rates are thoroughly reviewed and justified even when states are unable to conduct these reviews directly. **We seek feedback on the types of additional criteria that should subject proposed rates to automatic review.**

Enhanced review. Consumer organizations expressed support during listening sessions for enhanced review processes that include stronger authorities to address excessive rate increases. This could be accomplished by establishing an independent federal review process that would evaluate proposed rates that exceed defined growth rate or affordability benchmarks, and include authorities to revise or reject rates that are deemed excessive. For example:

- The Choose Medicare Act (S.2032), led by Senator Merkley, includes reforms that would give the Department of Health and Human Services (HHS) new authority to review and reject excessive rate increases in the private market.[71]

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[69]Sabrina Corlette, "Health Care Costs for Small Employers: Analysis of Market Challenges and Policy Solutions," Georgetown University Center on Health Insurance Reforms, February 2026, https://georgetown.app.box.com/s/o3w9z5l6jw14m0evsbqnqkzgeyin849s.

[70]Sabrina Corlette and Vrudhi Raimugia, "Looking Under the Hood: 'Enhanced' Health Insurance Rate Review to Improve Affordability," Georgetown University Center on Health Insurance Reforms, September 2023, https://georgetown.app.box.com/v/looking-under-the-hood

[71]Choose Medicare Act, S.2032, 119th Congress. (2025), https://www.congress.gov/bill/119th-congress/senate-bill/2032

- One recent proposal would deem rate increases that exceed a defined benchmark based on medical trend presumptively excessive and subject to review and potential rejection.[72]

Capped Rates. Consumer advocates also expressed support during listening sessions for approaches to capping annual rate increases.[73] Allowable annual rates could be capped at a flat percentage growth rate, or benchmarked to medical trend, in order to eliminate premium spikes and create additional incentives to control costs.

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. We invite comments on approaches to establishing stronger national standards, including feedback on what factors should be incorporated into a federal rate review standard and whether federal officials should have the express authority to cap, reduce or reject proposed rates that are not justified.[74]

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

The Republican health care agenda has driven deductibles and cost-sharing to historic highs,[75] and this trend will continue in the coming years as additional Republican policies go into effect. Much of the focus on rising private insurance costs has been on premium affordability, though premiums are only one of the financial challenges driving consumer dissatisfaction with their health insurance.[76]

Across private insurance markets, consumers are increasingly enrolling in the lowest-premium option available to them, even if it may leave them with higher overall costs during the plan year.[77] Many consumers face unreachable deductibles and maximum out-of-pocket costs that have spiked drastically over the past decade and will likely increase further next year as a result of Republican policies.[78] Health insurance companies are also subjecting patients to coinsurance for necessary care, including emergency services and hospitalizations, requiring patients to pay a percentage of the cost of their care that can amount to thousands of dollars. In the employer market, coverage offerings are becoming less protective of employees and families not because employers believe this is a good option for their workforce, but because lower-quality coverage is becoming the only type of coverage that many can afford.[79]

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[72]Topher Spiro et al., "A Patients' Bill of Rights To Lower Health Care Costs," Center for American Progress, April 7, 2026, https://www.americanprogress.org/article/a-patients-bill-of-rights-to-lower-health-care-costs/.
[73]Spiro et al., "A Patients' Bill of Rights."
[74]Pinar Karaca-Mandic et al., "States With Stronger Health Insurance Rate Review Authority Experienced Lower Premiums In The Individual Market In 2010–13," *Health Affairs* 34, no. 8 (2015), https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1463
[75]McGough et al., "What We Know So Far."
[76]Sparks, "Americans' Challenges."
[77]Sparks, "Americans' Challenges"; McGough et al., "What We Know So Far."
[78]"Deductibles in ACA Marketplace Plans, 2014-2026," KFF, November 6, 2025, https://www.kff.org/affordable-care-act/deductibles-in-aca-marketplace-plans/ ; McGough et al., "What We Know So Far"; Keith, "HHS Finalizes Sweeping Marketplace Changes, Part 1."
[79]Claxton, "How employers support lower-waged."

The Republican solution to these skyrocketing costs has been to pursue incremental reforms that they claim would allow consumers to shop for health care. Democrats strongly support meaningful improvements that increase competition and empower consumers and employers, but do not support a health care system that relies on families to shop for and negotiate the cost of care such as chemotherapy while in the midst of cancer treatment.

Years of discussion about making prices more available to consumers has not meaningfully improved access or affordability for services that might be theoretically shoppable,[80] and it remains nearly impossible for working people and families to shop for essential health care services and negotiate on a level playing field with providers and hospitals. Patients do not have leverage to negotiate prices, and most do not have the time, energy or medical knowledge to participate in negotiations over the cost of their complex medical care. Many services, such as emergency care, are not shoppable at all. Transparency on its own is not a comprehensive solution to addressing affordability challenges in private insurance markets, and must be paired with meaningful reforms that require insurance companies that collect thousands of dollars in premiums from consumers to provide quality coverage and financial protection in return.[81]

The rising affordability challenges faced by people with health insurance are not limited to the individual and small-group markets. Employers are struggling with the cost of health care, and in 2026 people with employer coverage experienced their highest premium increase in a decade.[82] Any reforms to address affordability and improve financial protections should provide relief for consumers and promote consistency and predictability across private insurance markets.

Senate Democrats invite detailed proposals and reforms that strengthen benefit design and cost-sharing requirements within existing coverage options. Along with specific feedback on modernized approaches to evaluating and improving affordability for consumers in an environment where out-of-pocket costs continue to skyrocket, we invite analysis and feedback on reforms that account for the unique differences in coverage, financing and purchasing across the individual, small group and large group markets while also ensuring consistency and continuity in coverage and protections for consumers who move between markets during a plan year.

Deductibles

About half of people with insurance do not have the financial resources they would need to meet their annual deductible,[83] and unreachable deductibles cause many people with health insurance to forgo necessary health appointments, medications and care. As a result, many consumers question the value of the product they are paying monthly premiums for.

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[80] United States Senate HELP Committee Minority Staff Report, “More Costs, Less Care.”
[81] Sparks, “Americans’ Challenges."
[82] KFF, “2025 Employer Health Benefits”
[83] Gregory Young et al., “How many people have enough money to afford private insurance cost sharing?," Peterson-KFF Health Tracker, March 10, 2022, https://www.healthsystemtracker.org/brief/many-households-do-not-have-enough-money-to-pay-cost-sharing-in-typical-private-health-plans/

Non-shoppable services. Health insurance companies assert that deductibles are an essential tool for managing utilization and controlling costs, though the majority of health care services are not shoppable, and a significant portion of high-cost surgeries are not elective.[84] Imposing cost barriers for services that may be considered elective but in practice constitute essential medical care may also shift future spending onto other health care programs, including Medicare. A recent article profiled several patients who were delaying care such as CT scans or colonoscopies until they were eligible for Medicare to avoid the high costs of their private health plan.[85]

Deductibles applied to emergency and inpatient care shifts costs from insurance companies to patients and families, and does not promote access to high-value care or improvements to patient safety. Patient and consumer advocates, along with some researchers and providers, propose eliminating deductibles, or limiting the application of deductibles to non-shoppable services, in recognition of the reality that higher cost-sharing in these circumstances cannot influence patient behavior, but does result in higher out-of-pocket spending, delayed care, or uncompensated care. **Senate Democrats request feedback on the application of deductibles to non-shoppable services, and welcome proposals that prioritize consumer access and affordability while appropriately taking into account patient safety, care quality, and evidence-based utilization management.**

Income-based deductibles. Patient and consumer organizations consistently raised concerns during listening sessions on behalf of people with insurance who choose not to receive needed care because of cost-sharing requirements that they are not able to meet. Reasonable caps on deductibles could eliminate barriers to essential care and provide protection against medical debt, particularly for lower income people.

One approach to addressing this challenge would apply a version of federal affordability percentages currently used to determine eligibility for premium assistance to the total cost of care, inclusive of deductibles.[86] This would be similar to an approach taken by Covered California based on their findings that applying affordability metrics only to premiums was not adequately protecting consumers from unreachable health care costs.[87] Other proposals would establish hard-dollar or affordability percentage-based limits or caps on deductibles to address growing concerns about the value of coverage and ensure that everyone can afford to use their coverage regardless of their financial circumstances. The application of a reasonable growth rate could be applied to account for costs over time in a way that does not increase financial pressure on consumers.

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[84]Michael Chernew et al., "Are Health Care Services Shoppable? Evidence from the Consumption of Lower-Limb MRI Scans," Yale Institution for Social and Policy Studies, July 30, 2018, https://isps.yale.edu/resource/are-health-care-services-shoppable-evidence-from-the-consumption-of-lower-limb-mri-scans; David A Magno-Padron et al., "Elective surgery resource utilization," *Langenbeck's Archives of Surgery,* 407, (2021): 829-833. https://pmc.ncbi.nlm.nih.gov/articles/PMC8542497/

[85]Sam Whitehead, "Rising Health Costs Push Some Middle-Aged Adults To Skip the Doc Until Medicare," KFF Health News, March 23, 2026, https://kffhealthnews.org/health-care-costs/health-costs-middle-aged-adults-delay-affordable-care-act-obamacare-medicare/

[86]Kendall et al., "Cost Caps and Coverage."

[87]Emily Kohn et al., "Total cost of coverage for members in California's marketplace," *Health Affairs Scholar*, July 9, 2025, https://pmc.ncbi.nlm.nih.gov/articles/PMC12322486/pdf/qxaf135.pdf; Jessica Altman, "Executive Director's Report," Covered California, January 16, 2025, https://board.coveredca.com/meetings/2025/January%2016,%202025/2025.01.16_ED_Report.pdf

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.

Some insurance companies have expressed concerns that any reduction in cost-sharing could increase utilization of unnecessary health care and increase premiums. In an environment of significant affordability challenges, we are interested in detailed feedback and analysis of the relationship between reduced cost-sharing and behavioral changes, particularly among lower-income consumers who historically utilize comparatively less health care due to cost and other constraints.

Coinsurance

The imposition of coinsurance, which requires that enrollees pay a defined percentage of the total cost of their care including after reaching their deductible, is often a source of financial stress for people with health insurance. The application of coinsurance to necessary health care services generates significant and often unpredictable expenses for consumers in an environment where more than one in four American households report struggling with medical debt.[88] Patient groups and researchers raised questions during listening sessions about whether coinsurance has any role in a health coverage system that is truly protective of patients, and whether it creates barriers to necessary care without any corresponding benefit.[89] Some health insurance companies assert that coinsurance can be used to direct patients to lower-cost and higher-quality care, though this potential benefit as a utilization management tool does not exist when a patient is receiving non-shoppable services or emergency care that can cost tens of thousands of dollars.

The expanding and unpredictable nature of the types and costs of care subject to coinsurance across private insurance markets, and the application of coinsurance to care that consumers cannot shop for, suggests that coinsurance is being used for reasons other than to influence decision-making or encourage the use of higher-quality care, even as it exposes patients to unaffordable medical bills. There are several approaches that could address this concern, including:

- Prohibiting the use of coinsurance as a utilization management tool;
- Limiting the application of coinsurance to items and services that are truly shoppable while also ensuring that consumers are able to effectively shop for such services before subjecting them to coinsurance; and
- Requiring insurers to provide data and analysis demonstrating that coinsurance is an evidence-based tool to encourage the use of higher-value, lower-cost care.

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.

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[88]Lunna Lopes et al., "Health Care Debt In The U.S.: The Broad Consequences Of Medical And Dental Bills," KFF, June 16, 2022, https://www.kff.org/health-costs/kff-health-care-debt-survey/

[89]Rosenbaum et al., "Affordable Care Act Recommended."

Maximum Out-of-Pocket Caps

The ACA established annual maximum out-of-pocket caps that limit the total spending enrollees can be expected to incur during a plan year. While these caps are an important consumer protection, they are set at levels that do not provide meaningful financial protection for a growing number of people with insurance. Maximum out-of-pocket caps for plan year 2026 exceed $10,000 for an individual and $20,000 for a family,[90] and the Trump administration will allow them to reach as high as $15,600 and $31,200, respectively, for some plans in 2027.[91] For-profit insurance companies collect premiums from working people and receive billions of dollars in taxpayer support for coverage that includes out-of-pocket maximums that are de facto unreachable for millions of Americans based on their income and assets, which leaves them underinsured and exposed to significant financial burden and medical debt.

Many organizations representing patients, consumers, hospitals and providers support reforms to unreachable out-of-pocket caps, and some advocate for no cost-sharing whatsoever. Policy options could include establishing a reduced annual out-of-pocket maximum in statute along with a reasonable growth rate, or establishing a formula that would apply income-based caps to maximum out-of-pocket costs. **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.**

As premiums rise drastically, consumers in the ACA market are increasingly switching from higher-value coverage to lower-value options that provide less financial protection and can cause people to unknowingly forgo federal cost-sharing assistance they are eligible for.[92] Proposals to address these challenges could include:

- Increasing the actuarial value requirements across metal tiers in the ACA Marketplace;
- Ensuring that consumers who are eligible for cost-sharing reductions receive the full amount of federal assistance they are eligible for, regardless of their plan selection; and
- Revisiting the application of premium tax credit eligibility to the second-lowest cost silver benchmark plan.

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

[90]Michelle Long et al., “Policy Changes Bring Renewed Focus on High-Deductible Health Plans," KFF, January 5, 2026, https://www.kff.org/patient-consumer-protections/policy-changes-bring-renewed-focus-on-high-deductible-health-plans/
[91]Keith, “HHS Finalizes Sweeping Marketplace Changes, Part 1.”
[92]McGough et al., “What We Know So Far."

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

Democratic health reform efforts have led to significant coverage gains over time, though the uninsured rate is on the rise due to Republican cuts.[93] Gaps in coverage continue to leave millions without affordable coverage and care, including in states that have not expanded Medicaid and for the significant number of full-time workers who do not have access to affordable coverage for themselves and their families.[94]

Ensuring that every American gets the medical care they need will require reforms that *go beyond* reversing Republican cuts and restoring ACA protections, and must also include reforms that support the over 160 million people who access coverage through an employer.[95]

A number of approaches to establishing and financing a universal coverage system have been proposed over time, including expanding eligibility for existing programs, establishing new optional forms of coverage, and moving to a single payer model. Within each approach there are important questions and policy options to consider, including how to finance coverage, how to ensure that providers and hospitals receive adequate payment, how any new program would interact with or replace existing health coverage and markets, and whether enrollment would be automatic, required or optional.

Important shared goals and values have emerged within this debate: Democrats are in strong agreement that successful reforms must make coverage universal, comprehensive, easy to get, and easy to use for all Americans, regardless of where they live, where they work, and what they are able to afford. **Senate Democrats seek detailed analysis, data, and feedback on specific proposals that will inform and advance these policy discussions.**

The discussion below does not presuppose a preferred policy outcome or assign value to any particular approach, and we encourage analysis and feedback on existing proposals as well as new approaches to achieve the shared goal of universal coverage that meets the needs of the American people.

Every type of private insurance coverage in our health care system is heavily subsidized, in different ways, so the expansion of or transition from existing approaches to federal financing across private markets raises important questions. Stakeholders across the health care sector are in broad agreement that coverage expansion should be accomplished in a way that preserves access to doctors, hospitals, and other health care providers, and does not cause disruption to care, including in rural and underserved communities and in areas of the country where there is limited competition or significant market concentration.

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[93]Swagel et al, “Federal Subsidies for Health Insurance.”; Tolbert et al., "Key Facts."; Alice Burns et al., “How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State?,” KFF, August 20, 2025, https://www.kff.org/uninsured/how-will-the-2025-reconciliation-law-affect-the-uninsured-rate-in-each-state/

[94]Tolbert et al., "Key Facts."

[95]Claxton et al., “Employer-Sponsored Health."

Researchers and advocates suggested during listening sessions that international efforts to design universal coverage systems and reform diverse health care markets may offer insights into the challenges and opportunities associated with different approaches to expanding coverage in the United States.[96] **We invite analysis and feedback that takes these systems and learnings into account.** Approaches to financing universal coverage must be evaluated within the context of the significant cuts made to Medicaid and the ACA that will continue to go into effect in the coming years.

Some researchers also highlight the potential benefits for employers and employees of a system in which affordable health coverage is not so closely tied to employment, and raise questions about whether there are changes that would reverse the trend of higher health care costs leading to stagnant or reduced wages for workers.[97] **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.**

In particular, we encourage comments from employers and plan sponsors of all sizes, including those that wish to continue playing a role in providing comprehensive coverage to their workers and those that are increasingly unable to do so due to increasing costs and complexity.[98]

Strengthening the Existing Coverage Framework

Health care has become increasingly unaffordable, including for people with insurance, and there are persistent gaps in coverage caused by affordability challenges, consumer dissatisfaction, and Republican failures to expand Medicaid and promote coverage. Consumers are facing higher costs and coverage loss caused by Republican cuts to Medicaid and ACA Marketplace coverage in their 2025 reconciliation bill and Trump administration rulemaking,[99] and increasingly lack access to high-quality choices as markets become more consolidated.[100]

Organizations representing patients, consumers and hospitals voiced strong support during listening sessions for efforts led by Democrats to reverse these cuts, while acknowledging that addressing persistent coverage gaps and affordability challenges will require reforms that go beyond simply reversing recent cuts. Some challenges could potentially be addressed by expanding and strengthening existing ACA programs and authorities.

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[96]Gunja et al., "U.S. Health Care";"International Health Care System Profiles," The Commonwealth Fund, May 2026, https://www.commonwealthfund.org/sites/default/files/2026-05/2026_Country-Profiles_UnitedStates.pdf; Imani Telesford et al., "How does health spending in the U.S. compare to other countries?," Peterson-KFF Health System Tracker, March 11, 2026, https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/

[97]Zack Cooper, "$27,000 a Year for Health Insurance. How Can We Afford That?," *New York Times*, December 10, 2025, https://www.nytimes.com/2025/12/10/opinion/health-care-aca-cost-insurance.html

[98]KFF, "2025 Employer Health Benefits"

[99]McGough et al., "What We Know So Far"; Pogue, "Emerging State Data Paint."

[100]Jared Ortaliza et al., "Tracking Insurer Participation Changes in the ACA Marketplaces in 2027," KFF, June 26, 2026, https://www.kff.org/affordable-care-act/tracking-insurer-participation-changes-in-the-aca-marketplaces-in-2027/

Patient and consumer organizations support various approaches to reforming existing authorities in order to expand coverage and improve affordability. **Senate Democrats invite specific feedback on these approaches, including:**

- Codifying policies that reverse Trump administration rulemaking and establish new protections in statute that would provide comprehensive coverage and true financial protection for enrollees and families across all metal tiers;[101]
- Expanding or creating coverage options to address coverage gaps that persist in states that have not expanded Medicaid;[102] and
- Reversing recent ACA cuts and making permanent improvements to the eligibility, enrollment and financing of Marketplace coverage by restoring enhanced tax credits, simplifying eligibility and enrollment determinations, and improving affordability determinations.

Some advocacy organizations emphasized during listening sessions that proposals to leverage the existing system must be paired with reforms that meaningfully address abusive practices in the private insurance market. This is particularly true in an environment where some large for-profit insurance companies have expressed public support for many of the Republican policies that Senate Democrats seek to reverse,[103] and others are choosing to exit the ACA market altogether as it becomes less profitable.[104] **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**.[105]

Expanding choice and competition. Insurance company consolidation limits the ability of consumers in highly-concentrated markets to benefit from competition that could drive improved affordability and better coverage in the private market. Distinct from many of their large for-profit competitors, community-affiliated plans have voiced opposition to many of the harmful cuts and policies pursued by the Trump administration through rulemaking.[106] In many communities, the departure of community-affiliated plans from existing markets would leave consumers with no choice but to seek coverage from a large for-profit insurance conglomerate. Reforms to address coverage and affordability challenges in existing ACA markets should take

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[101]"Average Monthly Marketplace Premiums by Metal Tier," KFF, 2026, https://www.kff.org/affordable-care-act/state-indicator/average-marketplace-premiums-by-metal-tier/

[102]Sammy Cervantes et al., "How Many Uninsured Are in the Coverage Gap and How Many Could be Eligible if All States Adopted the Medicaid Expansion?," KFF, February 25, 2025, https://www.kff.org/medicaid/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/

[103]Corlette, "Stakeholder Perspectives on CMS' Proposed 'Marketplace'"; Corlette, "Stakeholder Perspectives on CMS' Proposed 2027 Notice"

[104]Jared Ortaliza et al., "How Has Insurer Participation in the ACA Marketplaces Changed in 2026?," KFF, June 11, 2026, https://www.kff.org/affordable-care-act/how-has-insurer-participation-in-the-aca-marketplaces-changed-in-2026/; Ortaliza, "Tracking Insurer Participation."

[105]Ellyn Maese, "U.S. Adults' Ability to Afford Healthcare at a Five-Year Low," *Gallup*, June 17, 2026, https://news.gallup.com/poll/710942/adults-ability-afford-healthcare-five-year-low.aspx

[106]Corlette, "Stakeholder Perspectives on CMS' Proposed 'Marketplace'"; Corlette, "Stakeholder Perspectives on CMS' Proposed 2027 Notice"

this into account, and also protect against the possibility of "bare counties" with no insurance options.

Several approaches to addressing limited competition in the existing ACA market were raised during listening sessions, including:

- Aligning plan participation requirements across Medicaid Managed Care Organizations (MCOs) and qualified health plans sold on the ACA Marketplace;
- Allowing state employee health plans to offer individual market coverage on the ACA Marketplace;
- Encouraging expansion of consumer operated and oriented plans; and
- Requiring Federal Employee Health Benefits (FEHB) Program plans to offer individual market coverage in bare counties and areas with limited competition or access.

Senate Democrats invite specific comments and feedback on these approaches, as well as other proposals that would strengthen and expand existing markets to improve competition in the individual market to address coverage gaps and affordability challenges.

ACA firewall. The so-called ACA firewall prevents people from receiving financial support to purchase ACA coverage if they have access to other coverage that meets minimum value requirements and is deemed affordable. Many employees have access to employer coverage that is considered affordable under existing law, but is not affordable in practice for themselves or their families. This leaves working people and families uninsured or underinsured because they cannot afford their employer coverage and are ineligible to receive financial assistance if they shop on the ACA Marketplace.

Absent reforms to address the ACA firewall, an improved ACA market would not benefit people who have access to theoretically affordable coverage through their employer. **We seek feedback and analysis on the effects of eliminating the ACA firewall, as well as additional proposals that would allow employees and their families to enroll in high-quality affordable coverage in the individual market with at least as much financial support to purchase coverage as they would otherwise be eligible to receive in the employer market.** For example, some consumer groups express support for allowing employees to use the value of their employer provided coverage to purchase their own coverage on the ACA Marketplace.

Improving oversight of existing private insurance markets. Limited transparency and oversight in the private insurance market, along with inconsistent rules and requirements across markets, creates incentives for insurance companies to exploit loopholes in existing laws in order to limit access to care and generate revenue. Improving transparency and oversight across markets could promote alignment and predictability of rules, coverage, and consumer protections. One recent proposal to increase accountability across private insurance markets would establish an entity similar to the Medicare Payment Advisory Commission (MedPAC) and the Medicaid and Children's Health Insurance Program Payment and Access Commission (MACPAC) that would evaluate behaviors and trends in the commercial market and recommend reforms on an ongoing

basis in response to those findings.[107] A similar proposal would establish an independent entity that would evaluate coverage and affordability across private insurance markets to ensure that taxpayer dollars are being spent on coverage that provides value and financial protection to consumers.

We seek comments on these proposals, and other approaches that would strengthen oversight of these heavily-subsidized markets. We are particularly interested in feedback on how to structure an oversight and reporting entity to maximize its authority to review and analyze cost and other data to improve coverage and promote consistency across private markets.

State Authorities and 1332 Waivers

Section 1332 of the ACA provides states with flexibility through State Innovation Waivers to expand access to affordable coverage for their residents using federal dollars, including by establishing state public options. Several states have established public options in recent years and these efforts provide insight into how policy choices affect uptake, affordability, and savings.[108] For example:

- Nevada introduced a state public option for plan year 2026 that seeks to reduce individual market premiums by leveraging existing Medicaid infrastructure and requiring MCOs to submit bids to administer a plan. More than 10,000 people have enrolled in the Nevada public option for plan year 2026.[109] The state projects that their public option will achieve savings.

- Colorado required private insurers to offer the "Colorado Option" plan to compete alongside private plans beginning in 2023.[110] The Colorado Option does not set rates, but does require negotiations to take place with doctors and hospitals, with state payment floors established as a fallback if negotiations are unsuccessful. Annual enrollment in the Colorado Option has increased steadily as the number of available Colorado Option plans has increased, though the plan has not met its established premium reduction targets.[111]

- Washington established "Cascade Select" plans in 2019,[112] which are administered by private insurers but include payment rates to doctors and hospitals that are established by

[107]Jeanne Lambrew, "Let States Lead on Lowering the Cost of Employer-Sponsored Insurance," The Century Foundation, March 18, 2026, https://tcf.org/content/commentary/let-states-lead-on-lowering-the-cost-of-employer-sponsored-insurance/
[108]Lanhee J Chen, "Early Lessons From State-Based Public Option Plans," *JAMA Health Forum*, March 28, 2024, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2817158
[109]Tabitha Mueller, "Nevada health insurance marketplace enrollment dips nearly 6% but 'remained fairly steady'," *The Nevada Independent,* January 27, 2026, https://thenevadaindependent.com/article/nevada-health-insurance-marketplace-enrollment-dips-nearly-6-but-remained-fairly-steady
[110]"Colorado Option," Colorado Department of Regulatory Activities, https://doi.colorado.gov/colorado-option
[111]Christine Monahan, "Colorado Option: Increasing Transparency and Driving Down Costs Through Enhanced Rate Review," Georgetown University Center on Health Insurance Reforms, September 11, 2023, https://chir.georgetown.edu/colorado-option-increasing-transparency-and-driving-down-costs-through-enhanced-rate-review/; Andrew Shermeyer, "Affordability trade-offs following a public option: learning from the Colorado Option," *Health Affairs Scholar* 3, no. 8, (2025), https://doi.org/10.1093/haschl/qxaf160
[112]"Cascade Select (public option)," Washington State Health Care Authority, https://www.hca.wa.gov/about-hca/programs-and-initiatives/cascade-select-public-option

the state legislature and capped at 160 percent of Medicare, with the legislature able to make additional downward adjustments to payment rates.[113] Hospitals are required to contract with at least one Cascade Select plan, though the plan has experienced challenges establishing broad networks. Like Colorado, Washington identified initial premium reduction targets that have not been met.[114]

- Several states have leveraged the Basic Health Program (BHP) established by Section 1331 of the ACA to pursue coverage expansions for their lower income residents. The BHP can be established in combination with Section 1332 waiver authorities to allow states to provide an affordable coverage option to people earning up to 200 percent of the federal poverty level. Oregon, Minnesota and New York currently operate BHPs, though uptake of this approach has been somewhat limited as states continue to evaluate how a BHP fits within state markets alongside Medicaid and the ACA Marketplace.[115]

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. Adoption of state public options and BHPs has been limited to date, so we seek specific feedback on ways to encourage broader adoption by states and promote plan designs that address persistent coverage gaps.

State-based single payer authority. Some advocates also support establishing new state-based coverage expansions that would build on existing waiver authorities and allow states to pursue transitions to state-level single-payer models.

The State-Based Universal Health Care Act of 2025 (S.2286), led by Senator Markey, would allow states to pursue a new waiver option to establish a state-based single payer plan that would achieve universal or near-universal coverage by leveraging federal dollars, including Medicare and Medicaid funds.[116] These newly-established 1335 waivers would adopt the model established by Section 1332 waiver authority but broadly expand state access to federal funds that would be used to establish universal coverage programs. This so-called 'super waiver' would require that coverage be at least as generous as existing options, and would also allow states to pursue regional waivers to establish multi-state plan options.

Senate Democrats invite comments on this state-based approach, including how lessons learned from Section 1332 waiver authority would inform the establishment and administration of this 'super waiver' authority.

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[113]Chen, "Early Lessons."
[114]Christine Monahan, "A Progress Report on Washington's Public Option Plans," Georgetown University Center on Health Insurance Reforms, March 6, 2023, https://chir.georgetown.edu/progress-report-washingtons-public-option-plans/
[115]Naomi Zewde et al., "Basic Health Programs: An Alternative to Public Options?," The Commonwealth Fund, March 27, 2024, https://www.commonwealthfund.org/publications/issue-briefs/2024/mar/basic-health-programs-alternative-to-public-options
[116]State-Based Universal Health Care Act of 2025, S.2286, 119th Congress. (2025), https://www.congress.gov/bill/119th-congress/senate-bill/2286

Establishing a Federal Option

Federal public option frameworks have been proposed by Democrats for decades, including in early versions of the ACA that would have established a public option intended to reduce costs and drive competition in the ACA Marketplace.[117] Proposals have included key differences, though each would establish a coverage option administered directly or indirectly by the federal government. The public option would be made available in either some or all markets to compete with private insurance plans, rather than replace them.[118]

There are a number of important policy questions that need to be considered within public option proposals. Many of these questions have been analyzed and modeled in the past,[119] though there is limited analysis that accounts for current health care markets and recent Republican health care cuts. The experience of state public options has made clear that decisions about plan administration, provider participation, and reimbursement rates are central to the success of such frameworks in attracting enrollment, making premiums affordable, and reducing costs.

Important considerations within any public option framework include how the plan is administered and by whom; who bears the risk associated with the plan; what services are covered; how premiums and cost-sharing are determined; how networks and payment rates are established and maintained over time; what markets the plan would be available in; and who is eligible to enroll. Existing public option proposals have looked to Medicare, Medicaid, and the commercial market to develop answers to these questions, and there are additional lessons to be learned from the states that have established their own public options, just as state action in Massachusetts informed the development of the ACA Marketplace.[120]

Instability in the individual and small group markets caused by Republican health care cuts has introduced new challenges that also need to be considered when proposing or evaluating public option frameworks and policies. We ask that proposals, feedback and analysis take these considerations into account. Discussion in this RFI is limited to proposals that have been introduced by Senate Democrats in the 119th Congress, though we welcome specific feedback and comments on other public option frameworks.

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[117]Helen Halpin and Peter Harbage, "The Origins And Demise Of The Public Option," *Health Affairs*, June 2010, https://www.healthaffairs.org/doi/10.1377/hlthaff.2010.0363

[118]Linda J. Blumberg, "Comparing Public Option and Capped Provider Payment Rate Proposals," Urban Institute, March 2021, https://www.urban.org/sites/default/files/publication/103815/comparing-public-option-and-capped-provider-payment-rate-proposals_3.pdf

[119]"A Public Option for Health Insurance in the Nongroup Marketplaces: Key Design Considerations and Implications," Congressional Budget Office, April 2021, https://www.cbo.gov/system/files/2021-04/57020-Public-Option.pdf; Matthew Fiedler, "Designing a public option that would reduce health care provider prices," Brookings, May 5, 2021, https://www.brookings.edu/articles/designing-a-public-option-that-would-reduce-health-care-provider-prices/; John Holohan, Michael Simpson, "Introducing a Public Option or Capped Provider Payment Rates into Private Insurance Markets," Urban Insitute, March 2021, https://www.urban.org/sites/default/files/publication/103817/introducing-a-public-option-or-capped-provider-payment-rates-into-private-insurance-markets.pdf

[120] Marin Wolf,"Leaders celebrate 20 years of Romneycare against backdrop of federal uncertainty," *Boston Globe*, April 13, 2026, https://www.bostonglobe.com/2026/04/13/business/romneycare-health-care-massachusetts-mitt-romney/

Recent examples of federal public option proposals include:

> The Medicare-X Choice Act of 2025 (S.3369), led by Senators Bennet and Kaine, would authorize the HHS Secretary to establish a Medicare Exchange plan available on the Federally-Facilitated Marketplace (FFM) and through SBMs, leveraging existing Medicare infrastructure or contracting with new entities to administer the plan.[121] The plan would cover primary care services without cost-sharing, and provide plan options in the bronze, silver and gold metal tier levels. Coverage would be financed through permanent enhanced premium tax credits that are calculated using the methodology in place from 2021 through 2025. Providers that participate in Medicare or Medicaid would be required to accept Medicare Exchange coverage. The bill seeks to address high-cost care by funding a national reinsurance program, and would include expanded drug price negotiation authority to establish prices for prescription medications.
>
> The Affordable CHOICE Act (S.3599), led by Senators Whitehouse and Slotkin, would create a public option that would compete with private plans offered on the ACA Marketplace, subject to existing plan requirements and financed using ACA premium tax credits.[122] It would allow the HHS Secretary to enter into contracts to perform plan administration, though HHS would retain the risk associated with the plan similar to the risk assumed by an employer in a self insured plan. The HHS Secretary would be responsible for establishing geographically-appropriate premiums and negotiating rates with providers each plan year.

Coverage. A federal public option that seeks to address affordability challenges and close existing gaps in coverage could be designed in many different ways, and advocacy organizations, researchers and policymakers have proposed and supported many different approaches over time. **Senate Democrats are interested in specific feedback and comments on approaches to establishing a federal public option that would address persistent affordability challenges and achieve universal coverage**. We welcome detailed analysis responsive to the following topics:

- How a federal public option could be designed and financed to achieve universal coverage, including the role of proactive outreach or automatic enrollment for low-income and other populations;
- How a federal public option could be designed and financed to meaningfully address affordability and close the coverage gap in non-Medicaid expansion states;
- How to ensure that a federal public option provides continuity of coverage for individuals who churn in and out of other types of coverage over the course of a plan year;
- Whether uptake of a federal public option should be optional for states; and
- Whether a federal public option would be an attractive alternative for employers and workers struggling to afford rising health care costs.

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[121] Medicare-X Choice Act of 2025, S.3269, 119th Congress. (2025), https://www.congress.gov/bill/119th-congress/senate-bill/3369

[122] Affordable CHOICE Act, S.3599, 119th Congress. (2026), https://www.congress.gov/bill/119th-congress/senate-bill/3599

A federal public option would need to provide comprehensive coverage that is affordable for everyone to access and use. **We are specifically interested in feedback on gaps in existing data and research that would need to be addressed in order to fully evaluate the effects that a federal public option could have on cost and coverage in the current environment of increased affordability challenges and ongoing Republican health care cuts set to take effect in the coming years. We also invite feedback on the limitations of this approach.**

Premiums. Establishing premiums for a federal public option that could achieve universal coverage requires a complex evaluation of affordability and effects on existing markets. For example, a federal public option introduced into existing markets as the lowest or second-lowest cost silver plan would likely reduce the amount of premium assistance families would be eligible for, potentially increasing net premiums for those who choose to purchase private coverage. Changes to existing eligibility for financial assistance or benchmark plan calculations that impact net premiums would need to be considered when developing plan design and establishing pricing.

Research has shown that public option plan design could also affect competition and drive changes to private plan pricing and benefit design, particularly in highly-concentrated markets and in markets with limited insurer participation.[123] The entry of a federal public option into the market could have different impacts on coverage and costs depending on whether it is offered at a single actuarial value or across all metal tiers, phased into markets, and priced in a way that affects the benchmark plan.[124] Additional policy considerations include whether to align age rating of premiums with existing state laws or apply federal requirements, and whether the plan would have a separate risk pool or participate in risk adjustment with other plans offered in the market, particularly since a higher-quality offering would be likely to attract a sicker risk pool and incur higher costs. **Senate Democrats request analysis and feedback on how public option plan design and pricing would, or should, impact the existing market.**

Payment. Evidence suggests that competitive private markets generally have benchmark plans with payment rates similar to Medicare,[125] though recent analysis also demonstrates that private plans are less successful than government programs at controlling costs over time.[126] For-profit insurance companies have increasingly called for government-imposed price caps that would replace their negotiated rates, a form of government intervention that goes beyond reforms in states like Colorado and Washington that have tried to control costs by establishing benchmarks and negotiation frameworks. Previous research also considered the practical limitations and complexity associated with requiring a federal public option to negotiate rates across the country.[127]

[123]"A Public Option for Health."; Blumberg, "Comparing Public Option."
[124]"A Public Option for Health,"; Blumberg, "Comparing Public Option."
[125]Blumberg, "Comparing Public Option."
[126]Godwin and Levinson, "Hospital Prices Have Risen."
[127]Fiedler, "Designing a public option"; Scott Heiser et al., "The Costs Are Too Damn High: Responding To Affordability Pressures In ACA Markets," *Health Affairs Forefront*, December 18, 2025, https://doi.org/10.1377/forefront.20251212.744779.

Senate Democrats welcome comments on establishing payment rates in a federal public option, including but not limited to feedback on the following approaches:

- Providing the HHS Secretary with negotiation authority;
- Establishing boundaries, references or benchmarks for payments, including use of Medicare payment rates as a benchmark or starting point; and
- The creation of a public option fee schedule that would require the Centers for Medicare & Medicaid Services (CMS) to establish annual payment rates, including use of the Traditional Medicare program as a model.

Research has shown that payment rates in a federal public option could provide administrative savings to doctors and hospitals, which could help ensure adequate reimbursement and long-term participation in the market.[128] A federally-administered public option could leverage existing CMS infrastructure and eliminate profit-driven insurance company practices such as prior authorization and improper claims denials, which could generate significant administrative savings not only for doctors and hospitals, but also for consumers. Per-enrollee administrative expenses incurred by the Medicare program are significantly lower than in private insurance markets, so a federal public option could present opportunities to generate efficiencies that bring savings to providers and consumers through reductions in burden and expense.[129] Ensuring adequate payment is especially important in rural and underserved areas where enhanced payment rates may be necessary.

A federal public option would require adequate funding and access to reserves to reliably and promptly pay claims, such as through the establishment of a trust fund.[130] A plan that competes on quality rather than risk would likely incur higher costs, but could provide significant opportunities to improve health outcomes by incentivizing access to preventive services, primary care, and other high-value services rather than imposing financial barriers that cause people to forgo these and other types of care.

A federal option with significantly improved coverage and benefit design would likely initially attract disproportionately high-cost enrollees. These costs could be fully-funded by premiums, or incorporate elements of reinsurance or federally-administered stop-loss coverage to account for high-cost enrollees. Options to finance a federally-administered public option could include an enhanced version of existing premium tax credits, and premium contributions made by employers that choose to offer this coverage as an option for their employees to purchase. **Senate Democrats request feedback on approaches to financing a federal public option.**

Networks. A federal public option could establish and administer networks in a number of different ways. One approach would model a federal option after state public options that contract with existing entities to perform administrative tasks such as establishing networks and paying claims. Alternatively, a federal option could require that CMS leverage its existing

[128]Fiedler, "Designing a public option."
[129]"Private Health Insurance Premiums and Federal Policy," Congressional Budget Office, February 2016, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf; Fiedler, "Designing a public option."
[130]"A Public Option for Health."

infrastructure to ensure adequate networks, establish payment rates, administer benefits and pay claims in a manner similar to Medicare.[131]

The establishment of a federal public option could present a unique opportunity to rethink network design and consider new approaches to paying for out-of-network care.[132] A federal public option would need to consider whether to align with state standards and coverage requirements, or establish a federal standardized benefit offering that could potentially differ or be more generous than existing coverage in certain markets. A federal public option could also rethink the concept of network requirements altogether and consider approaches similar to Traditional Medicare. **We request feedback on these topics and concepts.**

Medicare or Medicaid Buy-In

In addition to the creation of a new federal option for coverage, some advocates, researchers and policymakers propose to address persistent coverage gaps by expanding eligibility for a Medicare plan option or expanding options to buy into the Medicaid program.[133] Distinct from previous proposals to lower the Medicare eligibility age,[134] Medicare buy-in proposals would seek to expand coverage and reduce overall Medicare costs by covering any additional costs through premiums and improving the health of pre-Medicare age workers and retirees so they are healthier when they reach Medicare age. Proposals to expand access to Medicare through buy-in eligibility would generally allow people who have not reached Medicare eligibility to purchase Medicare coverage with federal assistance such as premium tax credits, and require income-based premium payments until age 65.[135] A Medicaid buy-in option would seek to achieve similar goals by leveraging an existing federal program that has national reach but can differ widely across states.

Discussion in this RFI is limited to recent legislation introduced in the Senate, though we also invite comments on other approaches. Examples of Medicare and Medicaid buy-in proposals introduced in the Senate during the current Congress include:

> The Choose Medicare Act (S.2032) led by Senator Merkley, which would establish the option for individuals and employers to purchase coverage through a newly-created Medicare "Part E" plan.[136] Coverage would be available across the individual, small group and large group markets, and the plan offering would be actuarially equivalent to existing gold metal tier plans offered in the ACA Marketplace. Premiums could be paid using an enhanced version of existing premium tax credits. The legislation also includes

[131]"A Public Option for Health."
[132]"A Public Option for Health."
[133]CAP, "Medicare Extra for All A Plan to Guarantee Universal Health Coverage in the United States," Center for American Progress, February 22, 2018, https://www.americanprogress.org/article/medicare-extra-for-all/; Michael Sparer, "Buying Into Medicaid," The Century Foundation, January 10, 2018, https://tcf.org/content/report/buying-into-medicaid/
[134]"How Lowering the Medicare Eligibility Age Might Affect Employer-Sponsored Insurance Costs," KFF, April 27, 2021, https://www.kff.org/affordable-care-act/how-lowering-the-medicare-eligibility-age-might-affect-employer-sponsored-insurance-costs/
[135]Paul Starr, "A New Strategy for Health Care," *The American Prospect*, January 4, 2018, https://prospect.org/2018/01/04/new-strategy-health-care/
[136]Choose Medicare Act, S.2032, 119th Congress. (2025).

an out-of-pocket cap and surprise billing protections, and would seek to offer a competitively priced, high-quality coverage option across the country with a particular emphasis on markets where there is limited competition due to consolidation.

The State Public Option Act (S.2073) led by Senator Schatz, which would create a state option to establish a Medicaid buy-in option for all residents, regardless of their income.[137] This approach would leverage existing federal financing, including premium tax credit dollars, to support this expanded coverage.

Advocacy and provider organizations have raised questions about how expanding access to Medicare or Medicaid could affect existing financing and coverage. Some Medicare and Medicaid buy-in proposals would modify existing financing altogether, relying on tax withholdings to collect premiums for guaranteed coverage rather than providing these dollars as tax credits.[138] For individuals and families that are not close to Medicare age and do not qualify for Medicaid, buy-in options could potentially leverage the existing ACA tax credit framework to allow the purchase of coverage through Medicaid MCOs that would be required to offer coverage on Exchanges as a condition of participation in the Medicaid program. This approach could improve competition in markets where there are limited plan options available on the ACA Marketplace. **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.**

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. Feedback on Medicaid buy-in approaches should take into account the significant Medicaid cuts in the 2025 Republican reconciliation bill.[139]

Single Payer

Many advocates, researchers and health care workers voice support for a single payer system that would leverage the resources of the federal government to provide a single source of coverage for all Americans, replacing existing health insurance with a system of universal coverage that would be available without cost and would reduce or eliminate out-of-pocket expenses for enrollees relative to current law.[140] Supporters of this approach cite America's lack of universal coverage, persistent health disparities, continuously rising costs and inability of people to access and afford care as evidence that this reform is needed. Analysis from researchers and CBO suggests that this approach would reduce mortality rates and improve health outcomes.[141]

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[137]State Public Option Act, S.2073, 119th Congress. (2025), https://www.congress.gov/bill/119th-congress/senate-bill/2073
[138]CAP, "Medicare Extra for All."
[139]Nathaniel Weixel, "Senate megabill marks biggest Medicaid cuts in history," *The Hill*, July 1, 2025, https://thehill.com/policy/healthcare/5378970-medicaid-cuts-senate-republicans/
[140]"How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program," Congressional Budget Office, December 2020, https://www.cbo.gov/system/files/2020-12/56811-Single-Payer.pdf
[141]Alison P Galvani et al., "Improving the prognosis of health care in the USA," Lancet 395, no. 10223, (2020):524-533. https://pubmed.ncbi.nlm.nih.gov/32061298/; Jaeger Nelson, "Economic Effects of Five Illustrative Single-Payer Health Care

A single payer system would seek to generate significant administrative savings, estimated at over $500 billion annually, by eliminating barriers and bureaucracy imposed by insurance companies on providers and hospitals and leveraging the efficiencies of the Medicare program, which is administered at a significantly lower cost than private insurance.[142] CBO has projected potentially significant reductions in health care costs and spending in a single payer system, including a reduction in wasteful administrative spending.[143] A single payer system would also take advantage of the Medicare program's demonstrated ability to control costs more effectively than the private insurance market over time, and capitalize on what economists generally agree would be reduced employer spending on health care and increased wages for working people.[144] Proposals generally seek to reduce overall costs for consumers by replacing the existing financing of coverage that relies on a patchwork of taxes, subsidies, and cost-sharing, with more uniform payroll and income taxes.[145]

Researchers, advocates and experts have conducted significant analysis of single payer proposals over time.[146] **We invite updates to that analysis and additional feedback that accounts for an environment of increasing affordability challenges, strong consumer dissatisfaction with existing coverage options, and historic cuts to health care programs.**

While the details about coverage and benefits offered within a federal single payer system could vary, we limit the scope of discussion within this RFI to the federal single payer proposal in the Senate:

> The Medicare for All Act (S.1506), led by Senator Sanders, has served as the prevailing single payer proposal since being introduced in 2017.[147] This legislation would separate health insurance from employment and allow working people to access coverage without relying on for-profit insurance companies. The Medicare for All Act would provide universal coverage without premiums, deductibles, or cost-sharing, and remove barriers to care by eliminating networks and prior authorization. It would require provider participation, and establish a payment methodology for doctors and hospitals.

The Medicare for All Act would also eliminate cost-sharing that keeps people from accessing care. Eliminating barriers imposed by cost-sharing and ending practices such as prior authorization could have significant positive impacts on overall health outcomes, productivity, wages and spending within a single payer system.[148] **Senate Democrats invite analysis and feedback on these potential effects.**

Systems," Congressional Budget Office, February 2022, https://www.cbo.gov/system/files/2022-02/57637-Single-Payer-Systems.pdf

[142]Nelson, "Economic Effects of Five."; "The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services," Congressional Budget Office, January 2022, https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf

[143]"Private Health Insurance Premiums."

[144]Nelson, "Economic Effects of Five."; Holohan, "Introducing a Public Option."

[145]"How CBO Analyzes."

[146]Galvani et al., "Improving the prognosis of."; Nelson, "Economic Effects of Five."

[147]Medicare for All Act, S.1506, 119th Congress. (2025), https://www.congress.gov/bill/119th-congress/senate-bill/1506

[148]Nelson, "Economic Effects of Five."

Transition plan. The transition to the Medicare for All Act's single payer system would occur over time, first by offering coverage to children and progressively lowering the Medicare age over a four-year period. During that four-year period, a temporary federal option administered by CMS would be created to ensure that there are no gaps in coverage. This transition plan would be made available to individuals and employers through the FFM and SBMs, and would require all Medicare providers to participate.

The plan would reimburse providers at rates similar to Traditional Medicare, and would determine appropriate reimbursement for providers that do not typically participate in the Medicare program, such as pediatricians. Premiums would be established using an enhanced version of the affordability percentages used to determine premium tax credit eligibility, with individuals and families paying as little as 2 percent and no more than than 5 percent of their income for coverage.

The transition plan would include an out-of-pocket maximum and coverage for dental, vision and hearing services. The actuarial value of this transition plan coverage would be 90 percent, equivalent to platinum metal tier coverage currently sold on the ACA Marketplace.[149] **Senate Democrats invite feedback on the establishment of and transition to a single payer system, including updated detailed analysis of changes in health outcomes and economic impacts of this approach.**

Federal Independence

An unfortunate challenge that must be considered when developing any version of a Medicare-type choice administered by the federal government is how to guarantee fact and science-based decision making and access to coverage for essential services. This need has taken on significant urgency in the past two years. For instance, prior to the tenure of Robert Kennedy Jr. as HHS Secretary it was reasonable to assume that an evidence-based plan design would include, for example, coverage of vaccines recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices and preventive services receiving strong recommendations from the U.S. Preventive Services Task Force. With experts on these panels increasingly sidelined or removed, and replaced with individuals with extreme ideological views who are not qualified or willing to conduct impartial reviews and make decisions based on science and data,[150] it is less certain that an expanded federal coverage framework can rely on what had previously been highly objective, science-based institutions. Similar concerns exist for other types of care where federal officials have recently attempted to call into question long-standing medical consensus or otherwise undermine existing standards of care.

Senate Democrats invite feedback on approaches to ensure that any Medicare-type choice is administered independently, decisions are made based on facts and science, and access to a wide range of essential care is protected and guaranteed. Feedback and proposals to rebuild our nation's public health infrastructure are outside the scope of this RFI, though the current

[149]S.1506, 119th Congress. (2025)"
[150]Rosenbaum et al., "Affordable Care Act Recommended."

landscape will need to be considered and addressed within the context of any new federal coverage framework.

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

Republicans are actively advancing policies to promote and expand substandard coverage in private insurance markets. Republican policies have allowed for-profit health insurance companies to increase premiums, raise deductibles, shrink networks, offer worse coverage, and shift more costs to consumers, under the guise of improved choice.[151]

A more recent Republican proposal paints a particularly dark picture for the American people:

- Consumers and patients would pay a for-profit insurance conglomerate thousands of dollars in premiums each year for low-quality coverage;
- They would receive a health savings account containing just over $80 per month and likely administered by a for-profit bank owned by the same for-profit insurance conglomerate;[152]
- And they would rely yet again on that same for-profit insurance conglomerate to issue them an interest-bearing loan if they cannot afford to pay for care that the plan they pay premiums for will not cover.[153]

In addition to driving consumers into debt, such an approach would eliminate incentives that for-profit insurance companies might currently have to control costs for consumers. It could also create incentives for insurance companies to increase cost-sharing obligations for consumers in order to drive new sources of revenue for their affiliated banks.

Ending Junk Coverage Across Markets

Rulemaking from the Trump administration has effectively locked junk insurance into the individual market, and they continue to pursue policies designed to degrade the quality of private insurance even further.[154] Taxpayer dollars are increasingly subsidizing high-deductible health plans and other types of coverage that do not adequately protect people when they need care, exacerbating medical debt, uncompensated care, and worse health outcomes. The proliferation of junk insurance creates confusion and the deceptive and misleading marketing practices associated with the sale of junk insurance causes many consumers to unknowingly enroll in

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[151]Rapfogel and Sullivan, “New Final Rule Pushes Marketplace."
[152]Natalie Murphy et al., “Senate Republicans’ HSA Plan Can’t Replace the Enhanced Premium Tax Credits," Center for American Progress, December 9, 2025, https://www.americanprogress.org/article/senate-republicans-hsa-plan-cant-replace-the-enhanced-premium-tax-credits/; “Wyden Report Shows How GOP Health Tax Scheme Funnels Money to Big Banks and Insurance Companies While Sticking Families with High Costs," Senate Finance Committee, November 19, 2025, https://www.finance.senate.gov/ranking-members-news/wyden-report-shows-how-gop-health-tax-scheme-funnels-money-to-big-banks-and-insurance-companies-while-sticking-families-with-high-costs
[153]Abelson, “Can’t Pay Medical Bills?”
[154] Katie Keith, “HHS Finalizes Sweeping Marketplace Changes (Part 3)"; Keith, “HHS Finalizes Sweeping Marketplace Changes, Part 1”

coverage that does not provide basic financial protection.[155] The ability of these plans to attract healthier consumers and draw them from plans that offer more comprehensive coverage can destabilize risk pools and lead to higher costs for people with pre-existing conditions. And these efforts are just the starting point: the Trump administration intends to issue new rules to expand other forms of junk coverage, including short-term limited duration insurance which does not have to comply with the ACA's consumer protections so can deny coverage to people with pre-existing conditions, refuse to cover essential health benefits, and more.[156]

Many patient and consumer organizations assert that minimum standards for coverage and benefits should apply to all plans. Policy options could include expansions of ACA consumer protections and market reforms, codifying policies that ensure existing and future versions of junk coverage cannot be considered compliant with ACA requirements, or enacting legislation that would prohibit junk coverage from the market entirely, similar to the reforms in the No Junk Plans Act (S.942), led by Senator Baldwin.[157]

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.

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

Before the ACA it was nearly impossible for working people without access to employer coverage to purchase the health coverage they needed.[158] The ACA created a regulated individual market to address that gap, and improved affordability by providing assistance with monthly premiums using tax credits that are calculated and received in advance based on estimated annual income. Enrollees estimate their income at the time of enrollment, often during the Open Enrollment period prior to the start of the plan year. Their premium tax credit eligibility is determined based on that estimate and reconciled during tax filing season after the conclusion of the plan year.

While these estimates are often correct, unanticipated factors such as a job change, more or fewer shifts or hours than expected, a raise, or in the case of a small business owner an unexpectedly successful year, can change the amount of premium tax credit an individual is in fact eligible for. Many working people who purchase insurance on the ACA Marketplace, including hourly and seasonal workers, gig economy workers, and self-employed people, are

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[155]Amy Killelea and JoAnn Volk, "The Peddling Of 'Junk Plans' To Consumers Facing Higher Insurance Premiums," Georgetown University Center on Health Insurance Reforms, February 27, 2026, https://chir.georgetown.edu/the-peddling-of-junk-plans-to-consumers-facing-higher-insurance-premiums/

[156]See: Office of Information and Regulatory Affairs, Pending EO 12866 Regulatory Review, "Short-term Limited Duration Insurance (CMS-9881)," https://www.reginfo.gov/public/do/eoDetails?rrid=1404663

[157]No Junk Plans Act, S.942, 117th Congress. (2021), https://www.congress.gov/bill/117th-congress/senate-bill/942

[158]"Nearly 54 Million Americans Have Pre-Existing Conditions That Would Make Them Uninsurable in the Individual Market without the ACA," KFF, October 4, 2019, https://www.kff.org/affordable-care-act/nearly-54-million-americans-have-pre-existing-conditions-that-would-make-them-uninsurable-in-the-individual-market-without-the-aca/

likely to experience income fluctuations over the course of a year relative to their best estimate at the time of enrollment.[159]

Policymakers considered this possibility when establishing the advanced premium tax credit, and understood that good-faith prospective estimates of annual income would not always be accurate when reconciled fifteen months later, particularly for people with less predictable, more variable incomes. To protect working people from significant tax penalties and ensure that unexpected tax liabilities did not serve as a deterrent to enroll in health coverage moving forward, income-based safe harbors were established to cap the amount of premium tax credit recapture that could occur at tax filing season.[160]

Republicans eliminated these income-based caps on premium tax credit recapture in their 2025 reconciliation bill, effective for plan year 2026. As a result, millions of working people could face significant unexpected tax liability as soon as next year if they pick up extra shifts, receive a promotion or a raise, or secure a new higher paying job.

We invite feedback on proposals that protect working people from being penalized with surprise tax bills and debt they cannot afford. Policy options could include:

- The restoration of premium recapture caps at the levels previously included in the ACA, similar to provisions included in the Restoring Patient Protections and Affordability Act (S.3368) introduced by Senator Blunt Rochester;[161] and
- Enhancements to previous recapture caps including expanded safe harbors for lower-income working people.

The elimination of premium tax credit recapture caps will be particularly devastating for people who experience a change in their income that makes them ineligible for premium tax credits altogether. For example, an individual who estimated in December 2025 that they would make $63,000 this year (just under 400 percent of the Federal Poverty Level for 2026) is eligible for premium tax credits under current law, but if during the 2027 tax filing season they report an income of $64,000 or are determined to have unknowingly been eligible for other coverage, they will be required to pay back the full amount of premium tax credit they received during the 2026 plan year, a tax penalty that could exceed ten thousand dollars for some.

Organizations representing patients, consumers, providers, hospitals, and some health plans broadly agree that consumers should receive the assistance they are eligible for and not be penalized for making good-faith estimates that unexpectedly change over time due to eligibility for other coverage or other changes in circumstance. Some consumer organizations and health

[159]Justin Lo et al., "Marketplace Enrollees with Unpredictable Incomes Could Face Bigger Penalties Under House Reconciliation Bill Provision," KFF, May 19, 2025, https://www.kff.org/affordable-care-act/marketplace-enrollees-with-unpredictable-incomes-could-face-bigger-penalties-under-house-reconciliation-bill-provision/

[160]Tara Straw, "Threat of Tax Credit Repayment Would Reduce Coverage, Put Many Families at Financial Risk," Center on Budget and Policy Priorities, November 14, 2017, https://www.cbpp.org/research/threat-of-tax-credit-repayment-would-reduce-coverage-put-many-families-at-financial-risk

[161]Restoring Patient Protections and Affordability Act of 2025, S.3368, 119th Congress. (2025), https://www.congress.gov/bill/119th-congress/senate-bill/3368/all-info

plans suggested during listening sessions that minimum eligibility determinations could be made based on the previous year's income or tax data to establish prospective tax credit eligibility amounts, which could address certain barriers to enrollment and financial assistance. Other advocacy and research organizations raised concerns that this could make it difficult for people to receive the full amount of assistance they are eligible for in circumstances where they were eligible for less assistance in the previous year based on that year's income. **Senate Democrats request feedback on these proposals and others that would ensure that working people who experience changes in their employment receive the financial support they need and are not penalized for good-faith mistakes.**

SECTION 2: Making Health Care Simpler for Families

Health insurance should be easy to shop for, easy to understand, and easy to use. Unfortunately, that is often not the case, across all types of private coverage. Despite annual premiums increasing in the ACA Marketplace by an average of 58 percent this year and averaging nearly $27,000 in the employer market, for-profit insurance companies increasingly impose coverage and payment rules that generate revenue and profits by making it harder for consumers to realize value and receive protection from the health insurance they are paying for.[162]

Nowhere has this been more evident than in the ACA Marketplace. In 2025, the Trump administration undertook rulemaking that will cause nearly 2 million people to lose coverage by adding red tape to the enrollment process designed to be so burdensome that it will cause eligible people to stop trying to buy coverage altogether.[163] This rule proposed to add new fees for people renewing coverage, shorten the annual Open Enrollment period, and add millions of hours in new paperwork burdens for consumers, according to CMS' own estimates.[164] Senate Democrats forced a vote on the floor to overturn this rule,[165] and many of its policies were so inconsistent with statutory authority that they were struck down by a federal court.[166]

The 2025 Republican reconciliation bill added additional bureaucratic red tape to the enrollment process and eliminated annual automatic re-enrollment, which CBO estimates will cause over 3 million people to lose coverage.[167] The Trump administration continued their efforts this year by finalizing additional cuts in the 2027 Notice of Benefit and Payment Parameters (NBPP),[168] including policies that will eliminate standardized plan options that make it easier for consumers to shop for coverage that meets their needs. Senate Democrats are forcing a vote to overturn these harmful policies as well,[169] which will cause up to 2 million more people to lose coverage.[170]

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[162]McGough et al., "What We Know So Far"; KFF, "2025 Employer Health Benefits"; Anjalee Khemlani,'We Are All To Blame' For Failure Of US Health System, Forbes, March 02, 2026, https://www.forbes.com/sites/anjaleekhemlani/2026/03/02/insurance-exec-we-are-all-to-blame-for-failure-of-us-health-system/

[163]Sabrina Corlette, "Final Federal Marketplace Integrity Rule: Implications for States," State Health and Value Strategies, Princeton University School of Public and International Affairs, June 2025, https://shvs.org/wp-content/uploads/2025/06/SHVS_2025-Final-Marketplace-Integrity-Rule.pdf ; Gideon Lukens, Elizabeth Zhang, "Administration's ACA Marketplace Rule Will Raise Health Care Costs for Millions of Families," Center on Budget and Policy Priorities, August 1, 2025, https://www.cbpp.org/research/health/administrations-aca-marketplace-rule-will-raise-health-care-costs-for-millions-of

[164]"Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," Federal Register, March 19, 2025, https://www.federalregister.gov/documents/2025/03/19/2025-04083/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability

[165]A joint resolution providing for congressional disapproval under chapter 8 of title 5, United States Code, of the rule submitted by the Centers for Medicare & Medicaid Services relating to "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, S.J.Res.84, 119th Congress. (2025), https://www.congress.gov/bill/119th-congress/senate-joint-resolution/84

[166]"Court Blocks Unlawful Trump."

[167]Swagel, "Estimated Effects on the Number of Uninsured People."

[168]"HHS Notice of Benefit."

[169] A joint resolution providing for congressional disapproval under chapter 8 of title 5, United States Code, of the rule submitted by the Centers for Medicare & Medicaid Services of the Department of Health and Human Services relating to "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program, S.J.Res.197, 119th Congress. (2026), https://www.congress.gov/bill/119th-congress/senate-joint-resolution/197?s=3&r=6

[170]Corlette, "Final Notice of Benefit."

The Trump administration has carried out many of these cuts with the support of several large for-profit insurance companies, reflected in the public comments they submitted to CMS during the rulemaking comment periods in 2025 and 2026.[171] Notably, community plans generally voiced opposition to many of the policies and cuts that large for-profit insurance conglomerates chose to support, pointing out that these policies will make it more difficult for smaller plans to provide comprehensive affordable coverage and remain competitive in markets against a backdrop of significant coverage loss and an increasingly less stable risk pool.[172]

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

Consumers often struggle to efficiently select health insurance that best meets their needs, and this process is made worse when markets are overwhelmed with plan choices that make it more difficult to evaluate meaningful differences in coverage.[173] It is well documented that so-called choice overload leads to lower-quality decisions. This is especially true with health insurance, where choice overload has been shown to lead consumers to choose insurance that does not meet their needs, or to not enroll in coverage at all.[174] Flooding markets with plan options is also used by insurers to generate profits by competing on risk selection rather than on quality.[175] The result is often a race to the bottom, where plans with low premiums are marketed in ways that can mask shortcomings in plan design such as narrow networks, high deductibles, and less coverage, and evaluating meaningful differences in plan options generates additional administrative costs.[176]

Standardized Benefits

Standardized plan designs feature uniform benefits and cost-sharing that make it easier for consumers to evaluate benefits and shop for coverage. Beyond making shopping quicker and less confusing, there is significant evidence that standardized plans reduce disparities and improve value for consumers. Eliminating confusing and often meaningless differences across plans allows consumers to evaluate and compare coverage based on quality and cost, which improves value and drives true competition by forcing plans to compete on quality, customer service, and networks. Seniors benefit from standardization across Medigap policies, and some states have applied a similar approach in their ACA Marketplace. For example, California's SBM uses a patient-centered benefit design that standardizes cost-sharing and deductibles across plans within

[171]Corlette, "Stakeholder Perspectives on CMS' Proposed 'Marketplace'"; Corlette, "Stakeholder Perspectives on CMS' Proposed 2027 Notice"
[172]Corlette, "Stakeholder Perspectives on CMS' Proposed 'Marketplace'"; Corlette, "Stakeholder Perspectives on CMS' Proposed 2027 Notice"
[173]Kaye Pestaina et al., "Signing Up for Marketplace Coverage Remains a Challenge for Many Consumers," KFF, October 30, 2023, https://www.kff.org/affordable-care-act/signing-up-for-marketplace-coverage-remains-a-challenge-for-many-consumers/
[174] Rose C. Chu et al, Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces (Assistant Secretary for Planning and Evaluation Office of Health Policy, HP-2021-29, 2021) http://resource.nlm.nih.gov/9918538381606676; Erin Audrey Taylor et al, Consumer Decisionmaking in the Health Care Marketplace, Rand (2016), https://www.rand.org/pubs/research reports/RR1567.html
[175]Jeanne M. Lambrew, Christen Linke Young, "Lessons from the ACA: Simplifying Choices to Optimize Health Coverage," The Commonwealth Fund, December 2, 2025, https://www.commonwealthfund.org/publications/issue-briefs/2025/dec/lessons-aca-simplifying-choices-optimize-health-coverage
[176]Lambrew, Young, "Lessons from the ACA."

each metal tier.[177] Consumers shop for coverage that has the same deductibles, annual out-of-pocket maximums, and copayment levels, which prevents insurance companies from hiding costs and allows consumers to more directly compare plans based on factors such as price and provider networks.[178] Standardizing benefits and costs across plans also protects consumers who need to switch coverage during the plan year from confusing changes and unexpected cost increases designed to limit their access to care.

In May 2026, the Trump administration finalized a rule that allows insurance companies to discontinue standardized plan offerings,[179] making it harder for people to compare plans based on quality. This policy change was opposed by patient and consumer organizations as well as community plans because it will make it more difficult for consumers to shop for coverage based on quality.[180] For-profit insurers largely supported the proposal,[181] and the association representing large insurance companies advocated for both the elimination of standardized plan requirements, and the elimination of caps on the number of non-standardized plans that can be offered,[182] despite studies demonstrating that standardizing plan options improves health outcomes and limits discriminatory and complex plan design that insurance companies can use to deter people with pre-existing conditions from enrolling in their plan options.[183]

Eliminating standardized plans from the market will increase confusion and potentially increase profits for third-party agents and brokers, who will generate more business and additional commissions. These costs will ultimately be paid by taxpayers as more people need help navigating an increasingly confusing enrollment process.

Patient and consumer organizations, as well as researchers and some health plans asserted during listening sessions that standardized plan offerings play a critical role in improving consumers' ability to shop for and enroll in coverage that works best for them when they need to use it. In addition to reversing recent Trump administration actions to eliminate standardized plan options, proposed reforms have included:

- Codifying or building on previous requirements to standardize plans and limit or eliminate non-standardized plans on the ACA Marketplace;
- Establishing a uniform approach to displaying standardized plans on Exchange platforms to ensure that consumers can efficiently evaluate and compare their coverage options;

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[177]"2026 Patient-Centered Benefit Designs and Medical Cost Shares," Covered California, https://www.coveredca.com/pdfs/Health-Benefits-Table.pdf

[178]"Coverage Levels: The Metal Tiers," Covered California, https://www.coveredca.com/support/before-you-buy/metal-tiers/

[179]Katie Keith and Matthew Fiedler, "HHS Finalizes Sweeping Marketplace Changes (Part 4): Standardized Plans, Risk Adjustment, And More," *Health Affairs Forefront*, May 29, 2026, https://www.healthaffairs.org/content/forefront/hhs-finalizes-sweeping-marketplace-changes-part-4-standardized-plans-risk-adjustment

[180]Leah Sullivan, "Stakeholder Perspectives on CMS' Proposed 2027 Notice of Benefit and Payment Parameters: Consumer and Patient Advocate Organizations," Georgetown University Center on Health Insurance Reform, April 27, 2026, https://chir.georgetown.edu/stakeholder-perspectives-on-cms-proposed-2027-notice-of-benefit-and-payment-parameters-consumer-and-patient-advocate-organizations/

[181]Corlette, "Stakeholder Perspectives on CMS' Proposed 2027 Notice"

[182]AHIP, "Comment on CMS-2026-0496-0002," Regulations, March 16, 2026, https://www.regulations.gov/comment/CMS-2026-0496-0791

[183]Douglas Jacobs, "CMS' Standardized Plan Option Could Reduce Discrimination," *Health Affairs Forefront*, January 6, 2016, https://www.healthaffairs.org/content/forefront/cms-standardized-plan-option-could-reduce-discrimination

- Expanding standardization beyond actuarial value, copayments, deductibles and cost-sharing to include additional coverage and services that would drive value and improve consumer experience; and
- Incorporating approaches to establishing uniform copays and deductibles that have been implemented in states like California and have proven to provide value and protection to consumers.[184]

Plan options should be designed and presented to consumers in a manner that limits consumer confusion and drives the type of quality, value and competition that taxpayers should expect from companies that receive billions in taxpayer funding each year. **We request feedback on approaches to establish minimum requirements for standardized plans.** We also invite specific feedback on the types of differences in plan designs that drive meaningful value and choice for consumers, and analysis of the potential reduction in administrative costs if consumers are able to rely less on third-party brokers and agents for enrollment assistance because they are experiencing a more efficient, less confusing shopping experience.

Network Adequacy

Consumers should be able to quickly and easily understand whether a doctor or hospital is in their network at the time they select coverage, and should be able to rely on their health plan network being accurate for the entirety of their plan year. Federal policies should incentivize broad networks of high-quality providers, particularly in rural and underserved areas where access to care is often challenging.

In the 2027 NBPP, the Trump administration proposed eliminating the federal floor and oversight of network adequacy requirements that require plans to contract with a sufficient number of providers to guarantee access to care.[185] This change was adopted over strong opposition from providers and consumer groups, though some large for-profit insurance companies expressed support for the proposal during the public comment period.[186] The policy was recently blocked by a federal court after the Trump administration failed to respond to concerns that the rule could lead to longer wait times and narrower networks, as well as reduced access to specialists, mental health care and treatment for substance use disorder.[187]

The 2027 NBPP also attempted to reduce the minimum number of essential community providers and federally-qualified health centers (FQHCs) that health plans would be required to contract with, a proposal that would have further eroded access to care in areas of the country

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[184]"Covered California's Standard Benefit Plan Designs," Covered California, January 2022, https://hbex.coveredca.com/pdfs/Covered_CA_Standard_Benefit_Plan_Designs_2022-01-27.pdf
[185]Michael Cohen et al., "Summary of Provisions in HHS's Proposed 2027 Notice of Benefit and Payment Parameters and Other Key Regulations," Wakely, February 2026, https://www.wakely.com/wp-content/uploads/2026/02/Provisions-of-HHSs-Proposed-2027-Notice.pdf
[186]Karen Davenport, "Stakeholder Perspectives on CMS' Proposed 2027 Notice of Benefit and Payment Parameters: Health Care Providers," May 4, 2026, https://chir.georgetown.edu/stakeholder-perspectives-on-cms-proposed-2027-notice-of-benefit-and-payment-parameters-health-care-providers/; Sullivan, "Stakeholder Perspectives on CMS""
[187]Katie Keith, "Court Stays Major 2027 Marketplace Changes,"*Health Affairs Forefront* July 24, 2026, https://www.healthaffairs.org/content/forefront/court-stays-major-2027-marketplace-changes

where access can already pose significant challenges.[188] The association representing large insurance companies expressed support for reducing the minimum number of essential community providers and FQHCs that plans must contract with.[189]

In addition to creating increasingly narrowing networks, insurance companies also employ tactics that make it difficult to rely on those networks at all. Some health plans use so-called ghost networks, which are provider directories that include providers that are not actually in the network.[190] These inaccurate provider directories mislead consumers when they are selecting coverage or seeking care, prevent people from getting timely medical care, and create undue financial stress. The No Surprises Act, passed as part of the Consolidated Appropriations Act of 2021, holds consumers harmless for costs associated with relying on such networks, though patients and families can still be left navigating coverage with a misleading network that does not meet their needs.[191]

Consumer and patient organizations suggested during listening sessions that stronger penalties for ghost networks should be considered to hold insurance companies accountable to the patients who rely on them, including stronger civil monetary penalties, stronger protections for consumers against unexpected out-of-network costs, and removal of repeat offenders from certain markets. Congress has taken action to address ghost networks in Medicare Advantage, though the problem may persist across other private markets. **We request feedback on these proposals and additional reforms to ensure that consumers are not being misled by inaccurate provider directories.**

Some patient and consumer advocates proposed additional reforms during listening sessions that would address challenges consumers face due to narrow networks, including codifying stronger requirements to contract with a minimum number of providers with a focus on essential community providers and FQHCs, and requiring MCOs and other plan types such as state employee plans to offer coverage in markets with limited competition. These approaches could strengthen networks and improve payment and stability for essential community providers and community health centers. **Senate Democrats seek feedback on these and other proposals to strengthen networks and ensure broad access to high-quality providers.**

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

At a time when people with insurance are increasingly struggling to afford the cost of their premiums, they are also finding that the coverage they are paying for is not there for them when they need it most.[192] Practices such as prior authorization and claims denials are characterized by

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[188]Sullivan, "Stakeholder Perspectives on CMS'"
[189]"Comment on CMS-2026"
[190]"Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks," United States Senate Committee on Finance, May 03, 2023, https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf
[191]Consolidated Appropriations Act, 2021, H.R.133, 116th Congress. (2020), https://www.congress.gov/bill/116th-congress/house-bill/133/text
[192]Ashley Kirzinger et al., "KFF Health Tracking Poll: Prior Authorizations Rank as Public's Biggest Burden When Getting Health Care," KFF, febuary 2, 2026,

insurance companies as essential utilization management tools that manage costs and ensure patient safety, but there is evidence that for-profit insurance companies abuse utilization management tools to retain premium dollars and generate profit by stepping between doctors and patients to delay or deny payment for care.[193]

These practices also require doctors and hospitals to spend significant time and resources engaging with health plans to resolve improper denials and fight for approvals. These bureaucratic hurdles generate administrative expense that is passed onto patients and taxpayers in the form of higher health care costs. Insurance companies are able to impose burdensome utilization management policies on patients and providers knowing that their ability to hold them accountable is limited.[194] Despite the significant dissatisfaction with these practices reported by consumers, for-profit health plans are doubling down on these approaches by subjecting consumers to decisions made by artificial intelligence and chat bots rather than experienced professionals providing meaningful assistance.[195]

Prior Authorization

The use of prior authorization has grown exponentially in the decades since the passage of the Health Maintenance Organization Act of 1973.[196] Prior authorization practices were initially applied narrowly in specific circumstances, but have been increasingly turned against consumers over time and applied broadly across areas of care, including inpatient, outpatient, imaging, procedures and prescription drugs.[197] Critics of prior authorization point to excessive and harmful practices that drive up administrative burden and costs for patients, doctors and hospitals, and result in delayed care that worsens patient outcomes.[198] Physicians and their staff spend an average of 14 hours completing 45 prior authorizations per week, time that could be spent on patient care.[199] The administrative costs of prior authorization account for tens of billions of dollars in health care spending annually.[200]

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https://www.kff.org/public-opinion/kff-health-tracking-poll-prior-authorizations-rank-as-publics-biggest-burden-when-getting-health-care/

[193]Potter, "The Margin Myth."

[194]Spiro et al., "A Patients' Bill of Rights."

[195]"Earnings call transcript: UnitedHealth Q1 2026 beats expectations, stock rises," *Investing.com*, April 26, 2026, https://www.investing.com/news/transcripts/earnings-call-transcript-unitedhealth-q1-2026-beats-expectations-stock-rises-93CH-4637516.

[196]Health Maintenance Organization Act of 1973, S.14, 93rd Congress. (1973), https://www.congress.gov/bill/93rd-congress/senate-bill/14?hl=health+maintenance+organization+act&s=3&r=1

[197]Karen Pollitz et al., "Consumer Problems with Prior Authorization: Evidence from KFF Survey," KFF, September 29, 2023, https://www.kff.org/affordable-care-act/consumer-problems-with-prior-authorization-evidence-from-kff-survey/

[198]Ani Turner et al., "High U.S. Health Care Spending: Where Is It All Going?," The Commonwealth Fund, October 4, 2023, https://www.commonwealthfund.org/publications/issue-briefs/2023/oct/high-us-health-care-spending-where-is-it-all-going; Spiro et al., "A Patients' Bill of Rights."

[199]"2025 AMA prior authorization physician survey," AMA, 2025, https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

[200]Nikhil R. Sahni et al., "Administrative Simplification and the Potential for Saving a Quarter-Trillion Dollars in Health Care," *JAMA* 326, no. 17 (2021) , https://jamanetwork.com/journals/jama/fullarticle/2785480; David Cutler, Nikhil R. Sahni, "How to save a quarter-trillion dollars in health-care spending every year," *Washington Post*, November 11, 2021, https://www.washingtonpost.com/outlook/2021/11/11/health-care-costs-administrative-spending/

Delays and denials by health insurance companies are cited as a major problem by 73 percent of the public.[201] Half of adult patients report having needed to obtain a prior authorization in the past two years, and 30 percent reported that they have experienced delays and denials in care.[202] A recent poll found that 7 in 10 adults believe prior authorization is a burden, including a third who deem it "a major burden."[203]

There is clear evidence that the imposition of prior authorization is leading to delayed and abandoned care,[204] and is associated with worsening disease, preventable hospitalizations, longer hospital stays and lower rates of survival.[205] A significant majority of physicians report that prior authorization has caused their patients to delay or abandon necessary care, more than 1 in 4 report experiencing a prior authorization hurdle leading to an adverse health event for their patient, and 1 in 5 report having experienced this bureaucratic hurdle resulting in a patient being hospitalized.[206] Some health insurance companies acknowledge that the industry has gone too far in imposing prior authorization on providers and patients, with one health plan CEO testifying before Congress earlier this year noting that the prior authorization process "sucks."[207]

Many health plans argue that prior authorization plays an important role in helping insurers and employers control costs and curtail inappropriate care, encouraging providers to seek alternatives and adhere to the latest evidence-based standards, and reducing out-of-pocket costs for patients by ensuring coverage before treatment is administered. Insurance companies maintain that prior authorization allows them to ensure patient safety and guard against improper spending, though there is evidence that some health plans use prior authorization to restrict patient access to care rather than achieving these asserted goals.[208] Its use has even proliferated into areas of health care where there is no evidence of patient safety concerns or overprescribing.[209]

More than 40 states have passed laws to streamline prior authorization while reining in abusive prior authorization practices. These bills are slowly starting to take effect and span from restricting prior authorization altogether to refining the ways it is conducted. Notably, states are

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[201]Grace Sparks et al., "KFF Health Tracking Poll: Public Finds Prior Authorization Process Difficult to Manage," KFF, July 25, 2025, https://www.kff.org/patient-consumer-protections/kff-health-tracking-poll-public-finds-prior-authorization-process-difficult-to-manage/

[202]Sparks et al., "KFF Health Tracking"

[203]Sparks et al., "KFF Health Tracking"

[204]Jay S. Pickern, "Prior Authorizations and the Adverse Impact on Continuity of Care," *American Journal of Managed Care* 31, no. 4 (2025), 163-165, https://www.ajmc.com/view/prior-authorizations-and-the-adverse-impact-on-continuity-of-care

[205]Jacob Murphy et al., "Adverse effects of health plan prior authorization on clinical effectiveness and patient outcomes: A systematic review," *American Journal of Medicine* 139, no. 1 (2026): 24-32, https://pubmed.ncbi.nlm.nih.gov/40912445/

[206]Ryan Crowley et al., "Principles of Managed Care: A Position Paper From the American College of Physicians," *Annals of Internal Medicine* 179, no. 1 (2026):107-109. https://pubmed.ncbi.nlm.nih.gov/41285009/

[207]"Written Testimony of Paul Markovich CEO and President of Ascendiun (parent company of Blue Shield of California)," United States House of Representatives, Committee on Ways & Means, January 22, 2026, https://waysandmeans.house.gov/wp-content/uploads/2026/01/Paul-Markovich-Testimony_Ways-and-Means_FINAL.pdf

[208]Daniel Schwarcz and Amy B. Monahan, "Preserving Meaningful External Review Despite Insurers' Rulification of Medical Necessity," The Petrie-Flom Center, May 7, 2021, https://petrieflom.law.harvard.edu/2021/05/07/medical-necessity-rules-external-review/

[209]Amy Killelea and Christine H. Monahan,"Continuous Glucose Monitor Coverage Criteria And The Need For Prior Authorization Reform," *Health Affairs Forefront*, May 7, 2026, https://www.healthaffairs.org/content/forefront/continuous-glucose-monitor-coverage-criteria-and-need-prior-authorization-reform

limited in their ability to apply reforms across private insurance markets, so the establishment of a uniform standard would require congressional action. Over a dozen pieces of legislation have been introduced in the current Congress, with a focus on specific markets and practices rather than a comprehensive approach to setting a uniform standard across markets.

Patient organizations, consumer groups, providers and researchers have proposed a broad range of reforms to address prior authorization abuses and eliminate barriers to care. **Senate Democrats request comments and analysis on the following approaches and concepts, including feedback on how they could be applied across private markets and how they would meaningfully change consumer experience:**

Gold carding. Over a dozen states have implemented "gold carding" systems to create prior authorization exemptions for providers who meet certain performance standards. Gold carding exempts a provider from prior authorization when they have a sufficiently high historical approval rate. A similar version of this policy would prohibit prior authorization for services that are broadly approved at a sufficiently high historical rate across providers. During listening sessions, some patient and consumer advocates suggested expanding the gold card system to all in-network providers, since they have presumably gained the confidence of an insurer in order to be brought in-network for coverage. Others raised questions about evaluating lower-volume services in such a system, and whether a sufficient number of providers would be able to qualify.[210]

Limitations or bans. Limitations or bans on prior authorization could apply in specific circumstances such as for chronic conditions, time-sensitive treatments where a delay would likely worsen a patient's prognosis (such as treatment for cancer), certain preventive screenings, or specific classes of drugs or treatments, similar to actions taken in Oregon and other states.[211]

Neutral third-party evaluators. Some advocacy organizations, provider groups and researchers advocate for banning the use of prior authorization altogether and replacing the existing system with independent clinical review criteria or neutral third-party evaluators to review prior authorization and claims denials,[212] a concept discussed in more detail below. Others proposed an approach to replace prior authorization with a third-party auditing framework that would conduct ongoing evaluations to identify outlier trends, patient safety issues, or abuses such as over-prescribing that could trigger targeted applications of utilization management.

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[210]Alisa Pierce, "Shielding the Gold Card Law: TMA Fights to Guarantee Gold Card is Implemented as Intended," Texas Medical Association, December 2023, https://www.texmed.org/ShieldGoldCard/

[211]Oregon State Legislature, "SB 463- 2023 Regular Session: Relating to proton beam therapy," https://olis.oregonlegislature.gov/liz/2023r1/Measures/Overview/SB463; Oregon State Legislature, "HB2292- 2025 Regular Session: Relating to treatment of human immunodeficiency virus," https://olis.oregonlegislature.gov/liz/2025r1/Measures/Overview/HB2292; Oregon State Legislature, "SB598- 2025 Regular Session: Relating to step therapy for nonopioids," https://olis.oregonlegislature.gov/liz/2025r1/Measures/Overview/SB598; Governor Maura Healey and Lt. Governor Kim Driscoll, "Governor Healey Takes Nation-Leading Action to Make It Easier, More Affordable for People to Get Health Care," Massachusetts Executive Office of Health and Human Services, January 14, 2026, https://www.mass.gov/news/governor-healey-takes-nation-leading-action-to-make-it-easier-more-affordable-for-people-to-get-health-care

[212] Keith, "Insurer Accountability"; Spiro et al., "A Patients' Bill of Rights."

Reviewer requirements. Providers increasingly report experiencing peer-to-peer review of prior authorization decisions with clinicians that lack experience in the field or type of care being discussed. Only 16 percent of physicians participating in a peer-to-peer medical necessity review report having met with a clinician who is appropriately qualified and credentialed.[213] Some health plans even use incentive-based internal review processes that reward denials. During listening sessions with provider organizations, many expressed strong support for transparency reforms that would require reviewing physicians to disclose information about themselves, such as their name and specialty. The American Medical Association (AMA) has publicly called for these reforms alongside licensing requirements and accountability for consequences of clinical decisions.[214] Additional reforms could include requiring true peer-to-peer evaluation of prior authorization decisions that involve engagement with a board certified clinician with direct experience and expertise related to the type of care being subjected to administrative review.

Shared risk. A shared risk model could include the application of prior authorization policies similar to those used in Traditional Medicare,[215] where only a small number of services are subject to prior authorization requirements, in exchange for adjustments to provider rates that are offset by significantly reduced administrative burden for providers.

Shifting the burden to insurers. Under this proposed framework,[216] rather than requiring a doctor to justify their clinical decision-making to an artificial intelligence chat bot,[217] or a human reviewer who has no experience in their practice area, in-network care would be presumptively deemed medically appropriate unless a health plan's clinical review team can demonstrate a patient safety issue or lack of medical necessity. Since health plans are initiating prior authorizations, they would presumably be able to quickly and easily determine what information would be needed to initiate and complete this process in real time.

This shift could eliminate disruptions and delays in care and allow plans to retrospectively audit outlier behaviors and subject outlier providers to additional prior authorization requirements. It could also allow health insurers to assess on an ongoing basis whether certain providers are in fact pursuing clinically inappropriate care and evaluate whether they should contract with them moving forward. If providers know they are being evaluated against such measures, it could serve as a check on over-utilization in a manner that does not harm patient access or safety.

Standardizing prior authorization. Standardizing prior authorization could involve the creation and enforcement of uniform prior authorization forms, codes, processes, and practices across insurers, which would increase transparency for providers and patients. A recent report showed

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[213]"2025 AMA prior authorization"
[214]Tanya Albert Henry, "AMA adds more to its game plan to fix prior authorization," AMA, June 9, 2026, https://www.ama-assn.org/practice-management/prior-authorization/ama-adds-more-its-game-plan-fix-prior-authorization
[215]"Medicare Prior Authorization," Center for Medicare Advocacy, https://medicareadvocacy.org/prior-authorization/; "Prior Authorization and Pre-Claim Review Initiatives," CMS, September 15, 2025, https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives.
[216]Keith, "Insurer Accountability."
[217]Crowley et al., "Principles of Managed Care"

that only 35 percent of medical plans use fully electronic prior authorization processes,[218] even though it is more efficient and less costly to administer.[219] Some health plans have expressed concerns about adoption of necessary electronic prior authorization tools, especially in rural settings, and some provider organizations recommended requiring health plans to contribute financially in support of their adoption since they have become necessary to navigate a process insurers created.[220] Prior authorization could be particularly prone to automation, and health insurers and providers are increasingly incorporating artificial intelligence into their systems.[221] During listening sessions, some patient and consumer advocates raised concerns about this trend, which may be leading to an increase in improper denials.[222]

Time restrictions. Explicit time requirements for prior authorization determinations could apply in specific circumstances or for specific types of care. For example, Oregon recently enacted a bill requiring that prior authorization decisions be made within 72 hours of any request for complex rehabilitation technology.[223] Safeguards could be considered to account for reports of insurers gaming systems to circumvent prior authorization time requirements by manufacturing artificial pauses or resets of the decision clock. Potential solutions could include creating fees or other escalating penalties for insurers that do not meet these requirements, or deeming any prior authorizations presumptively approved if they are not resolved within reasonable time frames.

Voluntary Commitments. In 2025, large for-profit health insurers pledged six reforms to improve their prior authorization processes, including standardizing electronic prior authorization submissions; reducing the volume of medical services subject to prior authorization; honoring existing authorizations during insurance transitions to ensure continuity of care; enhancing transparency and communication around decisions and appeals; expanding real-time responses to minimize delays in care with real-time approvals for most requests by 2027; and ensuring medical professionals review all clinical denials.[224] Earlier this year, these companies announced that these voluntary changes led to an 11 percent reduction in the use of prior authorization.[225] However, a recent survey indicates that the majority of physicians do not believe these changes will make a meaningful difference for patients.[226]

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[218]"2024 CAQH Index Report From Transactions to Trust: Building Better Care Through Healthcare Automation," CAQH, 2024, https://www.caqh.org/hubfs/Index/2024%20Index%20Report/CAQH_IndexReport_2024_FINAL.pdf

[219]"2023 CAQH Index Report A New Normal: How Trends From the Pandemic are Impacting the Future of Healthcare Administration," CAQH Insights, 2023, https://www.caqh.org/hubfs/43908627/drupal/2024-01/2023_CAQH_Index_Report.pdf

[220]Anjalee Khemlani, "Insurance Exec: 'We Are All To Blame' For Failure Of US Health System," Forbes, March 2, 2026, https://www.forbes.com/sites/anjaleekhemlani/2026/03/02/insurance-exec-we-are-all-to-blame-for-failure-of-us-health-system/

[221]Derek C. Angus et al., "AI, Health, and Health Care Today and Tomorrow: The JAMA Summit Report on Artificial Intelligence," *JAMA*, October 13, 2025, https://jamanetwork.com/journals/jama/fullarticle/2840175

[222]Michelle M. Mello et al., "The AI Arms Race In Health Insurance Utilization Review: Promises Of Efficiency And Risks Of Supercharged Flaws," *Health Affairs*, January 6, 2026, https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00897

[223]Oregon State Legislature, "SB549- 2025 Regular Session: Relating to complex rehabilitation technology," https://olis.oregonlegislature.gov/liz/2025r1/Measures/Overview/SB549

[224]"HHS Secretary Kennedy, CMS Administrator Oz Secure Industry Pledge to Fix Broken Prior Authorization System," U.S. Department of Health and Human Services, June 23, 2025, https://www.hhs.gov/press-room/kennedy-oz-cms-secure-healthcare-industry-pledge-to-fix-prior-authorization-system.html.

[225]"Health Plans Reduce Prior Authorization, Support Continuity of Care and Enhanced Consumer Communications," *AHIP*, April 7, 2026, https://www.ahip.org/news/articles/health-plans-reduce-prior-authorization-support-continuity-of-care-and-enhanced-consumer-communications.

[226]"2025 AMA prior authorization"

Senate Democrats invite insurance companies to provide additional information about these reductions in prior authorization. We are particularly interested in understanding who is being affected by these changes, whether they have resulted in measurable changes to consumer experience or satisfaction, and whether the changes have addressed specific concerns raised by patients and providers, including concerns related to the use of automated review or artificial intelligence.

Absent additional information, we are not able to evaluate the significance or effect of these voluntary changes. However, this voluntary action appears to be an acknowledgement that reforms are needed, and these reforms have not had an effect on premiums, which suggests that changes may have addressed certain arbitrary barriers to care that caused delays but were often overturned.

We also request specific feedback from providers, hospitals, health plans and other affected stakeholders about the real-world effectiveness and impact of these voluntary reforms. We are interested in feedback on whether these consensus reforms should be codified, and whether insurance companies are well-positioned to develop reasonable unbiased utilization management policies that do not create undue barriers to patient care.

Claims Denials

Patients and providers commonly report dissatisfaction caused by claims being delayed or denied,[227] which can lead to unexpected costs, inappropriate billing, and delays in care. Artificial intelligence is increasingly being used to deny claims and issue justifications, and determinations of eligibility for external appeals are often adjudicated by entities that contract with the health plan itself. Reporting has uncovered examples of large insurance companies denying claims without even reviewing them, and insurance companies have reportedly penalized their claims reviewers when they are not denying claims quickly enough.[228]

Claims denials can drive increased revenue for health insurance companies by allowing them to improperly retain premium dollars that should be used to pay for patient care. Denials can also cause irreparable harm to patients who delay or abandon medically necessary care, and drive up costs for the health care system as a whole if a patient needs emergency care after their initial care was denied. Patients and providers are often denied visibility into the factors or circumstances that led to a denial, which causes undue stress for patients and increases burden for providers.

The ACA requires plans to report data each year related to claims denials, including the reasons for denials, and qualified health plans sold on the federal ACA Marketplace currently make this information available. However, insurance companies are able to severely limit the amount of

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[227]Michelle Long et al., "Claims Denials and Appeals in ACA Marketplace Plans in 2024," KFF, March 24, 2026, https://www.kff.org/patient-consumer-protections/claims-denials-and-appeals-in-aca-marketplace-plans-in-2024/.

[228]Patrick Rucker et al., "How Cigna Saves Millions by Having Its Doctors Reject Claims Without Reading Them," *ProPublica*, March 25, 2023, https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims.; Patrick Rucker and David Armstrong, "A Doctor at Cigna Said Her Bosses Pressured Her to Review Patients' Cases Too Quickly. Cigna Threatened to Fire Her," *ProPublica*, April 29, 2024, https://www.propublica.org/article/cigna-medical-director-doctor-patient-preapproval-denials-insurance.

useful information they are reporting. For example, the most common reason for coverage denials cited by plans subject to reporting requirements in 2024 was "other."[229]

Existing reporting requirements could be strengthened and fully enforced, including across other private markets where similar data is not collected or reported for the over 160 million people with employer sponsored coverage.[230] **Senate Democrats are interested in feedback on approaches to expanding existing authorities to ensure that data collection and reporting takes place across private insurance markets, and that the data collected is sufficiently detailed to be useful for researchers and policymakers.**

Despite its limited reach, the 2024 data set revealed that 19 percent of all in-network claims were denied, amounting to 85 million total claims that year.[231] This volume of claims denials, regardless of whether they are ultimately upheld or overturned, injects significant administrative expense into the health care system and imposes stress, barriers to access, and additional costs on patients seeking care.[232] The structural barriers faced by patients who wish to challenge claims denials may create additional incentives for plans to deny and delay claims as a revenue driver, particularly in the employer market where transparency requirements and many ACA protections do not apply.

Communication and transparency. Patient and provider organizations express frustration with the lack of visibility into claims denials, and voice support for policies that increase transparency, such as requiring insurers to provide patients with plain language reasons for denied claims, information about their internal process, justification for each denial, and any other relevant information that would provide insight for patients and providers. **We invite comments on this concept as well as feedback on the specific types of information that insurance companies should be required to send to providers and patients when a claim is denied, and how to establish a standardized plain language format for communications.**

Independent Review. The claims denial and internal review process can be heavily weighted against the interests of consumers and patients, because the arbiters of this process are health plans that can generate revenue by denying claims.[233] The ability to understand and potentially appeal denied claims can be heavily influenced by the scope of information, or lack thereof, a health plan provides to the patient.

Organizations representing patients, consumers and providers suggest the establishment of a federal framework that would correct this imbalance across private insurance markets, similar to proposed approaches to addressing abuses of prior authorization. One such proposal would

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[229]Long et al., "Claims Denials and Appeals."
[230]Long et al., "Claims Denials and Appeals"; Claxton et al., "Employer-Sponsored Health Insurance 101."
[231]Long et al., "Claims Denials and Appeals."
[232]K.R. Prabha et al., "How health plans can tackle rising administrative costs," Advisory Board, August 27, 2025, https://www.advisory.com/topics/cost-control/health-plans-tackle-rising-admin-costs; Miranda Yaver, "Rationing by Inconvenience: How Insurance Denials Induce Administrative Burdens," *Journal of Health Politics, Policy and Law* 49, no. 4 (2024): 539-565, https://doi.org/10.1215/03616878-11186111; Ayesha Rahim et al., "Overturned Health Insurance Claim Denials," *JAMA Internal Medicine* 186, no. 6 (2026): 779-781, https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2847657.
[233]Potter, "The Margin Myth."

remove plans from claims adjudication altogether due to their inherent conflict of interest, replacing the existing system with an independent claims adjudication entity that would evaluate medical necessity and establish claims adjudication frameworks. Insurers would continue to establish contracts and evaluate claims, but would be removed from determinations of medical necessity. **We seek feedback on how such a system could be designed to ensure the application of uniform, clinically appropriate, objective standards that incorporate appropriate utilization management safeguards across private insurance markets while also achieving administrative savings and adding clarity and efficiency into the existing system.**

Mid-Year Plan Changes

Patients report facing disruptions to care caused by mid-year coverage and network changes that are imposed upon them by their health plan without notice or consent.[234] Mid-year changes to networks can leave patients exposed to significant unexpected out-of-pocket costs, and changes to coding and payment policy imposed on providers can create unanticipated access issues, including for patients that are in the middle of receiving care. Health plans are required to update provider directories every 90 days and hold consumers harmless for unexpected financial costs resulting from relying on inaccurate network information.[235] However, this still leaves many patients and families scrambling to ensure that they can continue to receive essential care for the remainder of their plan year when unexpected plan changes occur.[236]

Organizations representing patients and consumers expressed concerns during listening sessions that many health plans are violating the 90-day requirement, particularly in the employer market. Insurers do this by denying coverage in violation of existing continuity of coverage requirements, or imposing significant paperwork requirements on providers and patients before they will continue providing coverage and paying claims at the appropriate rate.

Several reforms have been proposed to address these issues, including:

- The Consumer Health Insurance Protection Act (S.1213), led by Senator Warren,[237] which would hold patients harmless for cost and access issues caused by certain mid-year plan changes;
- Ensuring stronger oversight and accountability for plans by imposing civil monetary penalties on plans that violate continuity of care requirements, and removing repeat offenders from certain markets; and
- Proposals to extend existing 90-day continuity of care requirements, including requiring coverage for at least 180 days or through the end of active treatment, or the greater of 90

[234]"Mid-Year Plan Changes," Arthritis Foundation, accessed July 2026, https://www.arthritis.org/advocate/issue-briefs/mid-year-plan-changes; Bram Sable-Smith, "So Your Insurance Dropped Your Doctor. Now What?," *KFF Health News*, October 29, 2025, https://kffhealthnews.org/health-care-costs/health-care-helpline-hospital-insurance-network-contract-disputes-what-to-do/.
[235]Keith, "Insurer Accountability."
[236]Keith, "Insurer Accountability."
[237]Consumer Health Insurance Protection Act of 2019, S.1213, 116th Congress. (2019), https://www.congress.gov/bill/116th-congress/senate-bill/1213/all-info.

days or the end of the plan year, in order to limit the stress and disruptions to care imposed on patients by mid-year plan changes.[238]

Senate Democrats invite detailed comments on these approaches and others that would hold plans accountable for costs and delays imposed by mid-year changes to networks and coverage, and eliminate the use of mid-year changes as a tool to generate profit and deny care.

Consumer Appeals

The ACA established the right to access internal and external appeals processes when claims denials occur, but patients often do not take advantage of their rights to pursue appeals.[239] Research shows that denied claims are appealed by patients at a rate of approximately 0.2 percent, and fewer than 1 in 20,000 claims ever reach the external appeals process.[240] Patients may struggle to understand what care was denied and why, what their appeal options are, and how to pursue them. Many patients may not know that they can appeal a denied claim, and information about rights to appeal is often buried in fine print or otherwise not conveyed in plain language. Some do not appeal denied claims because they do not believe they will be able to take on their insurance company and win.[241] Others choose not to pursue appeals because the process is time consuming and unclear, perhaps intentionally so,[242] as one doctor noted while reflecting on insurance companies incentivized to protect their bottom line, "death is cheaper than chemotherapy."[243]

When patients do manage to navigate the appeals process, a significant percentage of claims denials are overturned on appeal. The relatively limited use of appeals processes, combined with the high rate of denials that are overturned on appeal, suggests that patients would likely have additional success appealing coverage denials beyond that which is currently taking place if the appeals process was more accessible and understandable.[244] The high rate of overturned appeals also suggests that plans may be improperly denying medically necessary care.

Appeals processes, protections and transparency can also vary widely across private insurance markets. For example, the Employee Retirement Income Security Act (ERISA), signed into law in 1974 and primarily intended to regulate pension and retirement plans, includes requirements that health plans provide consumers with information related to the decision making process they

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[238]Consumer Health Insurance Protection Act of 2019, S.1213, 116th Congress. (2019)
[239]Karen Pollitz, "Consumer Appeal Rights in Private Health Coverage," KFF, December 10, 2021, https://www.kff.org/private-insurance/consumer-appeal-rights-in-private-health-coverage/ ; Keith, "Insurer Accountability."
[240]Yaver, "Rationing by Inconvenience"; Pollitz, "Consumer Appeal Rights."
[241]Yaver, "Rationing by Inconvenience"; Long et al., "Claims Denials and Appeals."
[242]Miranda Yaver, *Coverage Denied: How Health Insurers Drive Inequality in the United States* (Cambridge University Press, 2026).
[243]Cheryl Clark, "I Set Out to Create a Simple Map for How to Appeal Your Insurance Denial. Instead, I Found a Mind-Boggling Labyrinth," *ProPublica*, August 31, 2023, https://www.propublica.org/article/how-to-appeal-insurance-denials-too-complicated.
[244]Corrie Mook et al., "Understanding Prior Authorization: Current Landscape, Practices, and Challenges," Brown University Center for Advancing Health Policy Through Research, February 2026, https://doi.org/10.26300/psqz-1b42; Suzanne Murrin, "Some Medicare Part D Beneficiaries Face Avoidable Extra Steps That Can Delay or Prevent Access to Prescribed Drugs," U.S. Department of Health and Human Services, Office of Inspector General, https://oig.hhs.gov/documents/evaluation/3141/OEI-09-16-00411-Complete%20Report.pdf.

used to deny a claim.[245] However, some patient advocates reported during listening sessions that plans do not always fully produce these records upon request, and expressed concerns that the Department of Labor (DOL) is not adequately enforcing this and other provisions of the ERISA statute.[246] Failure to adequately enforce existing law means patients are not being protected in times of need, and also creates an incentive for insurance companies to ignore existing federal requirements, knowing there is a relatively low likelihood that they will be held meaningfully accountable under the existing regulatory and oversight framework.

Given the harm that can be caused to patients as a result of improper denials, and the need for a consumer-friendly appeals process to protect against undue medical debt or harmful delays in receiving essential care, organizations and researchers representing patients and consumers recommend several proposals to improve internal and external appeals processes for consumers. **We invite detailed comments and feedback on these approaches as well as additional reforms.**

Appeals oversight. Organizations representing patients and providers voiced support during listening sessions for improved oversight, reporting and data collection to protect consumers from frivolous claims denials and incentivize more consistent processes and outcomes. Insurers could be required to annually publish sufficiently-detailed data on appeals, denials and overturns across private insurance markets. This reporting could be used to audit outliers and issue corrective action or civil monetary penalties for repeat offenders that report high rates of denials, reversals, or overturned appeals over time.

Automatic external review. A small percentage of denials and adverse determinations are eligible for external review under existing law, and patients are often required to navigate complicated internal processes and overcome hurdles imposed upon them by their health plan before they are eligible for external options.[247] Several patient and consumer advocates suggest implementing an automatic independent appeal and review process where a consumer would no longer need to initiate these steps on their own. This could incentivize insurers to improve their internal claims review processes.

Consumer communication. Some states have taken steps to develop and improve consumer support tools designed to assist patients with appeals. For example, Oregon and Washington provide residents with appeals templates along with detailed guidance on pursuing appeals.[248] Health plans could be required to send this type of useful plain language information to patients when a claim is denied, along with the reasons and justification for the denial, and clear instructions on how to appeal. **While comprehensive reforms to electronic health records systems fall outside the scope of private insurance reforms, we request comments and**

[245]"Is ERISA Up For The Job? Improving Employer-Sponsored Health Insurance Affordability," Georgetown University Center on Health Insurance Reforms, June 2026, https://georgetown.app.box.com/v/ERISA-Issue-Brief.
[246]Center on Health Insurance Reforms, "Is ERISA Up For The Job?"
[247]Pollitz, "Consumer Appeal Rights"; Schwarcz and Monahan, "Preserving Meaningful External Review"
[248]"Oregon Health Plan Appeal and Hearing Request Form," Oregon Health Authority, July 2021, https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/he3302.pdf; "How to appeal a health insurance denial," Washington State Office of the Insurance Commissioner, https://www.insurance.wa.gov/insurance-resources/health-insurance/appealing-health-insurance-denial/how-appeal-health-insurance-denial.

feedback on the role of insurance companies in ensuring that their consumers have access to their billing records, correspondence, and information about claims denials and appeals in a centralized easy to access location that is available to them electronically at any time.

Reforms to existing consumer protection frameworks. The existing ACA appeals framework could be expanded to incorporate additional consumer rights and protections that would improve internal and external appeals processes and make them more accessible to patients. Policy options could include expanding or clarifying the scope or types of claims eligible for external review, establishing a more protective review standard, imposing time requirements for internal review, and ensuring that patients are not barred from accessing external appeals rights simply because they have failed to fully navigate their plan's internal review process.[249] **Reforms could be designed to apply a consistent standard across private markets and establish a federal floor in states that offer more limited protections.**

Unified appeals framework. In order to provide clarity and consistency for consumers, some consumer advocates proposed during listening sessions the establishment of a unified appeals framework with standardized timelines, processes and required documentation that could apply across private markets and include expedited timelines and processes for urgent appeals. Consumer protections could be incorporated, including requirements that reviews be conducted by independent clinicians specializing in the type of care being reviewed. Another approach would create a Medicare-style third-party claims adjudication entity that would level the playing field between patients and health plans and apply consistent decision-making across markets.

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

When for-profit insurance companies use administrative practices such as prior authorization and claims denials to create barriers to care, they are also generating revenue and profit by retaining control over premium dollars that are not being used to pay medical claims, even if only temporarily.[250] This creates an incentive for profit-driven insurance companies to impose administrative barriers on patients and providers - including when they might jeopardize patient care and lead to worse health outcomes - in order to retain premium dollars as long as possible. When this occurs, doctors and hospitals are delaying care they believe is medically necessary and are forced to spend time and resources navigating administrative processes. Eliminating this administrative waste and addressing these misaligned incentives has the potential to improve health outcomes and reduce health care spending and consumer costs.

Administrative Waste as a Profit Generator

Over $370 billion is spent each year on administrative costs associated with health care in the United States, accounting for nearly ten percent of total spending, and research suggests that over

[249]Amy Monahan and Daniel Schwarcz, "Rules of Medical Necessity," *Iowa Law Review* 107 (2022), https://doi.org/10.2139/ssrn.3777505.
[250]Potter, "The Margin Myth."

half of that spending is wasteful.[251] Administrative costs have more than tripled since 2020, and over 9 billion health care claims are processed each year at an average administrative cost of $12 to $19 per claim.[252] Hospitals report spending over $25 billion in claims adjudication in 2025, and estimate that at least $18 billion was spent on avoidable administrative work to overturn improper claims denials.[253] Addressing basic administrative inefficiencies across the health care system could generate estimated savings of up to $60 billion per year.[254]

These significant administrative costs and inefficiencies are unique to the American health care system. So too are the incentives that drive for-profit insurance companies to use bureaucratic hurdles and complex administrative delays as revenue generators. Many of the processes that providers and hospitals are required to undertake in order to navigate prior authorizations and receive payment for claims are established by insurance companies. Hospitals and providers report having to navigate insurance company practices that intentionally delay payment for weeks or months by making one single claims determination at a time, with each new request for information, denial justification, or medical necessity review restarting the process and the timeline for review and payment. This process can be particularly burdensome for less resourced providers, such as rural hospitals and solo practitioners.

Senate Democrats welcome analysis and research that provides additional detail on the revenue and profits being generated by for-profit insurance companies when they impose delays and denials that are ultimately overturned, and we seek feedback on whether and how the excessive revenue generated through these administrative abuses could be returned to providers, hospitals and consumers.

Delayed payments. Organizations representing hospitals and providers also express concerns that a significant driver of administrative expense is the time it takes to resolve payment disputes. Many hospitals report having delayed and unpaid claims that can exceed $100 million at a given time.[255] Our health care system expects doctors and hospitals to provide care, which relies at least in part on cash flow, while insurance companies serve as administrative entities responsible for establishing networks and paying claims. **We invite proposals that would streamline the responsibilities that doctors and hospitals are required to take on.**

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[251]Jason D. Buxbaum et al., "Substantial Variation In Administrative Spending And Profit Across State Insurance Markets, 2023," *Health Affairs*, March 2, 2026, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00779 ; "The Role Of Administrative Waste In Excess US Health Spending," *Health Affairs Brief*, October 6, 2022, https://www.healthaffairs.org/content/briefs/role-administrative-waste-excess-us-health-spending.

[252]Linda J. Blumberg et al., "The Complex Web of Health Care Financial Interests and Their Implications for Ever Higher Spending: An Expert Perspective," Georgetown University Center on Health Insurance Reforms, October 2025, https://georgetown.app.box.com/s/rtmi4pbcyz2wav084pphsmvof9085ibp; Nikhil R. Sahni et al., "Active steps to reduce administrative spending associated with financial transactions in US health care," *Health Affairs Scholar* 1, no. 5 (2023), https://doi.org/10.1093/haschl/qxad053.

[253]Michael J. Alkire et al., "Claims Adjudication Costs Providers $25.7 Billion - $18 Billion is Potentially Unnecessary Expense," *Premier*, February 24, 2025, https://premierinc.com/newsroom/policy/claims-adjudication-costs-providers-257-billion-18-billion-is-potentially-unnecessary-expense.

[254]Sahni et al., "Active steps."

[255]"Skyrocketing Hospital Administrative Costs, Burdensome Commercial Insurer Policies Impacting Patient Care," American Hospital Association, https://www.aha.org/guidesreports/2024-09-10-skyrocketing-hospital-administrative-costs-burdensome-commercial-insurer-policies-are-impacting.

One approach proposed by several hospital and provider groups during listening sessions would address administrative waste by requiring large health plans to make prompt payments to providers and collect applicable copays and cost-sharing directly from patients. This would ensure that patients receive one clear, unified invoice, from a health plan they have a relationship with and an insurance card from, rather than potentially receiving several invoices from different providers, some of whom they may not recall having interacted with. Organizations representing hospitals assert that this approach could improve consumer experience, increase plan accountability to consumers, improve efficiency and generate savings. **We request specific feedback on this approach and its impact on costs and premiums, as well as other proposals to address administrative hurdles and payment burdens for providers, including proposed reforms to leveling the playing field for smaller providers in highly concentrated markets.**

Direct contracting. Increasingly burdensome administrative requirements created by health insurance companies also contribute to the emerging trend of practices transitioning to direct primary care, direct contracting or cash payment arrangements with employers, unions and states.[256] Large employers, states and purchasers have expressed support for emerging options to enter into direct contracting arrangements with hospitals and providers that increase transparency, reduce spending and reduce employee costs for services such as primary care.

These models have the potential to improve administrative efficiency for providers and yield savings in the self insured market without limiting access to care. However, these approaches are less feasible in the individual and small group markets. Depending on their design, arrangements such as direct primary care subscription models may create new unintended barriers to care for people who are unable to participate in a health care system that requires non-trivial cash payments or HSA contributions. **We invite comments and analysis of the administrative savings being realized from these approaches, as well as specific feedback on the benefits of these approaches relative to contracting for the same services through a health plan or third-party administrator (TPA).** We also invite feedback from small and mid-size employers on the types of factors and considerations that limit their ability to consider these options.

Independent clearinghouse. In order to align incentives, eliminate profit-seeking middlemen and ensure that insurance companies cannot generate revenue through administrative waste, some advocates and researchers proposed during listening sessions the establishment of an independent entity responsible for standardizing coding and billing processes into a single clearinghouse that would allow providers and hospitals to interact with one predictable system rather than the processes imposed upon them by multiple insurance companies. **We invite comments and feedback on this approach and request specific proposals on the type of entity that should own and operate such a clearinghouse.**

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[256]Pickern, "Prior Authorizations," 163-165; Martha Hostetter and Sarah Klein, "In Focus: How Unions Act as a Force for Change in Health Care Delivery and Payment," Commonwealth Fund, March 21, 2019, https://www.commonwealthfund.org/publications/2019/mar/focus-how-unions-act-force-change-health-care-delivery-and-payment; Alan Condon, "'Hospitals are stepping up': Direct contracting gains traction in Indiana," *Becker's Hospital Review*, April 23, 2026, https://www.beckershospitalreview.com/finance/hospitals-are-stepping-up-direct-contracting-gains-traction-in-indiana/.

Consistency Across Markets

States are primarily responsible for regulating their insurance markets and often lead on developing reforms that address costs and improve consumer protections. The majority of people with insurance are insured through their employers, and the majority of that majority are enrolled in self insured plans.[257] Patient and consumer advocacy organizations expressed support during listening sessions for including employer market reforms as part of broader private insurance reform efforts. In an environment where employers and employees are increasingly struggling with costs, the employer market may benefit from certain policies and protections that exist in the individual and small group markets.

ERISA preemption limits the ability of states to enact reforms and establish consumer protections in the employer market. When ERISA became law, approximately 6 percent of Americans received health insurance through self insured employer plans,[258] so the consequences of bifurcated markets and inconsistent consumer protections were relatively limited. The subsequent decades have seen that number grow to over 60 percent, leaving tens of millions of workers subject to these more limited consumer protections.[259]

According to some employers, researchers and advocacy organizations, existing protections have become inadequate when taking into consideration the size and sophistication of the for-profit insurance companies they regulate. Consumers in self-funded plans do not have guaranteed access to external appeals rights, which leaves them subject to an internal review process in which the health plan is evaluating its own decision. This may create a financial incentive for TPAs that administer self-funded plans to deny claims, and leads to disparities in coverage across self insured and fully insured markets, even in cases involving the same insurance company, the same doctor, and the same care. Insurance companies are able to leverage the differences in oversight and regulation in the self insured market to generate revenue and increase spending relative to the same care provided in the fully insured market.[260]

Oversight and enforcement. Plan sponsors often contract with large for-profit insurance companies that act as TPAs,[261] which are largely shielded from state regulation and consumer protections in the self insured market in addition to being subject to more limited federal

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[257]Gary Claxton et al., "What are the recent trends in employer-based health coverage?," Peterson-KFF Health System Tracker, April 17, 2026, https://www.healthsystemtracker.org/chart-collection/trends-in-employer-based-health-coverage/.
[258]Center on Health Insurance Reforms, "Is ERISA Up For The Job?";
Marjorie Smith Mueller and Paula A. Piro, "Private Health Insurance in 1974: A Review of Coverage, Enrollment, and Financial Experience," Social Security Administration, March 1976, https://www.ssa.gov/policy/docs/ssb/v39n3/v39n3p3.pdf.
[259]"2024 Employer Health Benefits Survey," KFF, October 9, 2024, https://www.kff.org/health-costs/2024-employer-health-benefits-survey/#a78224c2-7660-405c-9e60-f72e76c7aa7e ; Christine Monahan, "ERISA 101: The United States' Hands-Off Approach to Regulating Employer Health Plans," Georgetown University Center on Health Insurance Reforms, January 24, 2023, https://chir.georgetown.edu/erisa-101-united-states-hands-off-approach-regulating-employer-health-plans/ ; Miranda Yaver, "This nightmare delay and denial shows why patients need a bill of rights," *The Hill*, January 13, 2025, https://thehill.com/opinion/healthcare/5079894-erisa-health-insurance-barriers/.
[260]Keith, "Insurer Accountability."; Blumberg et al., "Complex Web."; Lambrew, "Let States Lead."
[261]Jean M. Abraham, Amanda C. Cook, and E. Tice Sirmans, "Prevalence And Profits Of Insurers In The Administrative Services Only Market Serving Self-Insured Employers, 2010–22," *Health Affairs,* 43, no. 12 (2024): 1655–1663, https://www.healthaffairs.org/doi/epdf/10.1377%2Fhlthaff.2024.00359

oversight. Some patient and consumer advocates suggested during listening sessions that ERISA preemption combined with lax oversight from the Department of Labor (DOL) could create incentives for TPAs to employ abusive practices and impose administrative hurdles on employers, clinicians and patients in the self insured market that they cannot pursue in other private markets. Regulation and oversight of self insured plans is the responsibility of the Employee Benefits Security Administration (EBSA) within DOL. EBSA oversees nearly 3 million health plans across the country,[262] and lost an estimated 25 percent of its workforce due to cuts initiated by the Trump Administration in 2025.[263]

Some patient and consumer advocates assert that EBSA enforcement takes place too infrequently and may not serve as a deterrent. Oversight over sophisticated multi-billion dollar insurance conglomerates and their operations in the self insured market is considered by some organizations representing patients and consumers to be so lax that some referred to the self insured market as the 'unregulated market' when raising concerns during listening sessions. Several advocates raised examples of patients and providers experiencing significantly different behavior from insurance companies related to coverage, denials and appeals depending on whether they were operating in the self insured or fully insured market. This potentially leaves the majority of workers with employer coverage with fewer protections than consumers in other private markets.[264] **Senate Democrats invite comments and feedback on approaches to bolstering federal oversight and enforcement authorities in order to address these concerns.**

State authority. In order to provide stronger consumer protections and consistency across private markets, some advocates and researchers propose the establishment of a waiver authority that would grant states the ability to regulate their self insured market in certain circumstances, similar to existing authorities that allow states to pursue innovative approaches to coverage in their Medicaid and ACA markets. **We invite comments and feedback on this proposal, as well as other approaches that would allow states to regulate additional parts of their private insurance markets and apply consistent policies and protections across markets.[265]**

Putting Consumers on a Level Playing Field

Health plans collect and generate a significant amount of information about their customers and use this information to make decisions on their behalf, including initiating prior authorizations and claims denials.[266] Consumers and patients pay thousands of dollars in monthly premiums for health insurance but have very limited access to the information plans use to make their coverage decisions, even when requesting it. Insurers mostly exclude consumers from the coverage determination process and task providers with the administrative burden to navigate their

[262]"About EBSA," U.S. Department of Labor, accessed July 2026, https://www.dol.gov/agencies/ebsa/about-ebsa.
[263]Paul Mulholland, "EBSA Loses Over 20% of Staff from Resignations," *Plan Sponsor Council of America*, April 24, 2025, https://www.psca.org/news/psca-news/2025/4/ebsa-loses-over-20-of-staff-from-resignations/.
[264]Center on Health Insurance Reforms, "Is ERISA Up For The Job?"; KFF, "2025 Employer Health Benefits"
[265]Lambrew, "Let States Lead"
[266]Anne Neubert et al., "Understanding the use of patient-reported data by health care insurers: A scoping review," *PLOS One*15, no. 12 (2020): e0244546, https://doi.org/10.1371/journal.pone.0244546; Kris DeFrain et al., "Health Insurance Artificial Intelligence/Machine Learning Survey Results," National Association of Insurance Commissioners, 2025, https://content.naic.org/sites/default/files/inline-files/NAIC%20AI%20Health%20Survey%20Report%20.pdf.

increasingly complex systems.[267] The information about claims denials and internal adjudication processes that insurers provide to their customers is often difficult to interpret or otherwise buried within a high volume of paperwork, and does not empower patients to advocate on their own behalf when a denial or delay occurs.

Explanations of benefits. The ACA required that health plans provide standardized explanations of benefits, which was an important step in improving consumer communication. Congress also intended for patients to receive advanced explanations of benefits,[268] though this has not been fully implemented. Patient and consumer organizations expressed support during listening sessions for its implementation, and for additional standardized plan communication requirements across private markets so consumers can effectively navigate the bureaucracy imposed upon them by large for-profit health insurance companies, particularly during health challenges. **Beyond enforcement and implementation of existing law, Senate Democrats invite feedback on ways to increase consumer transparency and ensure that consumers receive plain language information about their costs from their insurance plan.**

Clear and timely billing. Patient advocacy organizations also express frustration about the confusion caused when patients receive a bill for health care services that may have occurred months ago and does not include enough information for the patient to determine what they are being billed for. One proposal raised during listening sessions to address that frustration would require that providers and health plans subject themselves to the same billing deadlines they impose upon patients to remit payment. Such an approach would either ensure that bills are sent in a timely manner, or minimize the undue pressure that patients feel to quickly remit payment for items and services when they do not feel they have sufficient information to understand what they are being billed for. **We invite comments on the benefits and challenges associated with this proposal and request feedback on additional proposals to simplify billing for patients.**

Accountability for Plans

Patients have very limited protection from abusive insurance practices that generate delays and denials, and limited recourse when they are harmed by those practices. Organizations representing patients, consumers, providers and hospitals voice support for reforms that would increase accountability and establish penalties for improper delays and denials, arguing that this could empower consumers and deter insurance companies from generating profits and revenue by delaying and denying care. Consumers who buy coverage on the individual market have limited recourse if their insurance company improperly denies coverage or benefits,[269] and ERISA imposes limitations on remedies available to consumers with employer coverage.[270]

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[267]Jihad Abdelgadir and Gabriela Plasencia, "The Health Care System Is Broken—and Prior Authorization Is a Big Part of the Problem," RAND, July 31, 2025, https://www.rand.org/pubs/commentary/2025/07/the-health-care-system-is-broken-and-prior-authorization.html.
[268]Consolidated Appropriations Act, 2021 (Public Law 116-260)
[269]Kaye Pestaina, Rayna Wallace and Michelle Long, "The Regulation of Private Health Insurance," KFF, October 8, 2025, https://www.kff.org/patient-consumer-protections/health-policy-101-the-regulation-of-private-health-insurance/; Stephanie Lewis, "A Guide to the Federal Patients' Bill of Rights Debate," KFF, August 2001, https://files.kff.org/attachment/report-guide-to-federal-patients-bill-of-rights.
[270]Pestaina, et al, "The Regulation of Private Health."; Gary Claxton, "Comparison Of The Liability Provisions Of House And Senate Patients' Rights Bills," KFF, October 2002,

Financial recovery for improper denials is generally limited to the cost of the claim or benefit that was denied.[271] This limited recovery likely creates a disincentive for consumers to pursue recovery, and a corresponding incentive for profit-seeking health insurance companies to deny care.

If an insurance company causes harm to a patient by improperly denying coverage for a service that causes the patient to delay or skip that care, that patient can generally only recover the costs of the denied claim minus their cost-sharing. This is true even in instances where insurance company decision-making led to worse health outcomes or irreversible harm.[272] Patients generally cannot recover costs for any subsequent treatment, or even recoup medical expenses that were caused by the improper denial or delay. When a patient pursues legal recourse, attorney fees are left to the discretion of the judge, which creates a financial barrier for most people, particularly in the midst of a health crisis.[273] Self insured plans have historically supported this existing framework and resisted reforms, arguing that an external review process should be sufficient in order to avoid higher health care costs driven by abuses of the judicial system by unscrupulous parties.[274] **We invite feedback on how to protect the interests of employers engaging in good faith to design coverage and benefits while also ensuring that health plans and TPAs are held accountable for improper utilization management decisions that harm patients.**

Existing limitations on oversight and accountability may create incentives for health plans to delay and deny care based on the assumption that consumers and regulators will be unwilling or unable to hold them accountable. Several reforms have been proposed to address these concerns, including:

- A longstanding bipartisan proposal that would hold insurance companies accountable to their enrollees through the establishment of a tailored private right of action for consumers against their private insurance plans across private markets;[275]
- Establishment of a stronger federal accountability framework of fiduciary duties and standards of review that would apply to insurance companies and TPAs making determinations of medical necessity or denying claims to hold them accountable to employers and consumers across private insurance markets;
- Establishment of penalties for repeat offenders that could include civil monetary penalties or a ban from markets where violations have repeatedly taken place; and
- Proposals previously considered by Congress that would limit insurance company practices that block patients from receiving care and eliminate incentives to use so-called cost control strategies as a way to generate profits at the expense of providing care.[276]

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https://www.kff.org/wp-content/uploads/2002/09/report-comparisons-of-the-liability-provisions-of-the-house-and-senate-patients-rights-bills.pdf.

[271]Pestaina, et al, "The Regulation of Private Health."; Lewis, "A Guide"; Claxton, "Comparison Of The Liability Provisions."

[272]Yaver, "This nightmare delay."

[273]Yaver, "This nightmare delay."

[274]Lewis, "A Guide."

[275]Lewis, "A Guide" ; Yaver, "This nightmare delay."

[276]Angie A. Welborn, "Federal and State Causes of Action Against Health Plans Under S. 1052 and S. 889," Congressional Research Service, June 19, 2001, https://www.everycrsreport.com/files/20010619_RS20937_4025c5690d9b064b19bb62739c157bc958a8ed56.pdf.; "Real Patients'

These proposals have sought to establish protections for employers in instances where a health plan or TPA action initiated an improper denial or delay of care.[277] **Senate Democrats invite proposals and feedback to improve consumer protections and plan accountability across private insurance markets, along with proposals that would ensure accountability when plans or TPAs improperly delay or deny care.**

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

People should be able to quickly and easily enroll in the coverage they are eligible for, regardless of what program or insurance company provides that coverage. In our fragmented health care system it is not uncommon for individuals to cycle through several types of coverage over the course of their life, going from employer coverage to an ACA plan, churning into and out of Medicaid, and ultimately ending up on Medicare. Each of these coverage options comes with different eligibility requirements, different enrollment processes and timelines, and different coverage rules and plan information. The burden of these variations is placed on the American people, because each variation makes it more confusing to enroll in and maintain coverage, and increases the likelihood that consumers will not receive the most optimal version of the coverage and financial assistance they are eligible for.

Addressing ACA Fraud Where it Actually Occurs

Republicans have used misleading claims of fraud to justify historic cuts to the ACA through reconciliation and rulemaking that make it more difficult for people to enroll in coverage they are eligible for, but have not produced credible evidence of fraud being committed by people enrolling in coverage. Senate Democrats support fighting fraud where it actually exists. There has been extensive research and reporting on ACA fraud that has actually occurred, and it is perpetuated by bad-actor brokers and agents seeking to generate undue commissions.[278] Republicans have ignored this research and instead rely on analysis from a partisan think tank with a long-standing reputation for producing incorrect analysis using flawed data. For example, as an increasing number of consumers with insurance are choosing to forgo care due to cost,[279] many Republicans claim that enrollees who generate zero claims are fraudsters in order to justify making further cuts to the ACA and other federal programs. However, rates of zero-claims enrollment in the ACA Marketplace are comparable to rates in the employer market, where there have been no similar claims of fraud.[280]

In order to protect federal programs and the people who rely on them from additional Republican cuts, **Senate Democrats invite feedback on policies that would address fraud in the private insurance market where it may actually exist, without harming access to coverage and care.**

Bill of Rights and Patient's Rights Tour 2000," National Archives, September 14, 2000, https://clintonwhitehouse4.archives.gov/WH/New/html/Wed_Oct_4_114418_2000.html; Lewis, "A Guide."

[277]Claxton, "Comparison Of The Liability Provisions."

[278]Pogue et al., "Federal Efforts Ostensibly Aimed."

[279]Sparks, "Americans' Challenges."

[280]Barbara Rubino and Emory Wolf, "Covered California's Data Tells A Fuller Story About ACA Marketplace Utilization," *Health Affairs Forefront*, September 22, 2025, https://doi.org/10.1377/forefront.20250919.339396.

We request specific feedback on the benefits of permanently increasing mandatory funding for the Health Care Fraud and Abuse Control (HCFAC) Program to conduct oversight and investigations in the private insurance market without creating coverage barriers for eligible people.

We also request feedback on ways to ensure that HHS, CMS, DOL and the Department of Justice (DOJ) have the authority and resources to investigate and prosecute fraud in the private market where it actually occurs, including cracking down on bad-actor brokers, agents and marketers who capitalize on a commission-based structure to commit fraud that undermines the availability of coverage for people who rely on it.[281]

Streamlining Eligibility

Republicans included cuts in their 2025 reconciliation bill that make enrolling in coverage more difficult by eliminating special enrollment periods that allow low-income people to enroll in coverage throughout the year.[282] The reconciliation bill also added bureaucratic work reporting requirements and arbitrary additional eligibility determinations in Medicaid, and eliminated annual automatic re-enrollment for over 20 million working people and families who buy their own insurance.[283] With fewer opportunities to enroll, more bureaucratic red tape to navigate during the enrollment process, and less assistance to do so, coverage loss will escalate in the coming years.[284]

One way to ensure that people receive the coverage they are eligible for is to establish an efficient, predictable enrollment process that can be used across programs and markets. Several reforms have been proposed to advance these goals, including:

- Establishing a federal minimum requirement for annual Open Enrollment across markets and coverage types, so people understand their options and deadlines regardless of whether their coverage status has changed;
- Establishing a uniform annual Open Enrollment period across private markets;
- Providing federal support similar to Maryland's Easy Enrollment program, which allows consumers to receive direct outreach from their Exchange and be eligible for a special enrollment period if they check a box on their tax returns indicating their interest;[285]
- Providing presumptive eligibility for a minimum level of federal assistance using prior year income data;
- Restoring annual automatic re-enrollment to provide consistency across private insurance markets; and
- Restoring provisional eligibility for premium tax credits.

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[281]Insurance Fraud Accountability Act, S.976, 119th Congress. (2025), https://www.congress.gov/bill/119th-congress/senate-bill/976/text.

[282]H.R. 1- An act to provide for reconciliation pursuant to title II of H. Con. Res. 14,H.R.1, 119th Congress. (2025), https://www.congress.gov/bill/119th-congress/house-bill/1/text ; Louise Norris, "What happened to ACA's low-income special enrollment period?," healthinsurance.org, May 26, 2026, https://www.healthinsurance.org/special-enrollment-guide/what-happened-to-acas-low-income-special-enrollment-period/.

[283]H.R.1, 119th Congress.

[284]Swagel, "Estimated Effects on the Number of Uninsured People."; Swagel, "The Estimated Effects of Enacting."

[285]"Easy Enrollment Program," Maryland Health Connection, https://www.marylandhealthconnection.gov/easyenrollment/

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.

Some patient and consumer advocates also expressed concerns during listening sessions with the different rules and restrictions that can limit coverage for family members in different ways across private markets. For example, some employers prohibit employees from enrolling their spouse in their family coverage if their spouse has another available coverage option. This approach eliminates a benefit that is central to employer coverage, and exposes families to higher costs and multiple affordability calculations. It also forces families to choose between paying multiple monthly premiums and facing multiple deductibles and out-of-pocket maximums each plan year, or choosing a lesser plan that provides their family with worse coverage. **We invite feedback on ways to align enrollment and eligibility rules so consumers are not subject to barriers that keep them from purchasing coverage for their family in certain markets.**

Modernizing Eligibility Verification and Enrollment

The ACA established a centralized enrollment process through a federal platform, and in just over a decade health insurance marketplaces have become a reliable source of information and coverage for over 20 million people. The eligibility verification framework established by the ACA relies on the Internal Revenue Service (IRS) to verify income data, and the Social Security Administration (SSA) to verify citizenship status. Republicans have sought to undermine this framework by promoting false claims of so-called fraud that they use to justify delaying or denying enrollment to eligible individuals.

Leveraging SBMs. SBMs have been at the forefront of ensuring that consumers in their respective states are aware of their options and can easily enroll in the ACA or Medicaid coverage they are eligible for.[286] SBMs in states across the political spectrum have demonstrated success in maximizing enrollment, improving access to coverage, and designing outreach and enrollment systems that take into account the unique needs of their states.[287] SBMs have also modeled an approach to successfully implementing eligibility and enrollment systems that protect against broker fraud while providing a high-quality enrollment experience for enrollees.[288] This track record has continued in the face of hurdles and challenges created by Trump administration rulemaking and the 2025 Republican reconciliation bill.

[286]"Supporting coverage through state health insurance exchanges," State Marketplace Network, https://statemarketplacenetwork.org/.

[287]Julie L. Hudson and Asako S. Moriya, "Association Between Marketplace Policy and Public Coverage Among Medicaid or Children's Health Insurance Program–Eligible Children and Parents," *JAMA Pediatrics* 172, no. 9 (2018): 881-882, https://jamanetwork.com/journals/jamapediatrics/fullarticle/2687008.

[288]Sabrina Tarrizzi et al., "State versus federal health insurance marketplaces: A bigger deal for Medicaid and a smaller deal for the individual mandate," *Health Policy OPEN* 3, (2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC10297752/

Some advocates and researchers express support for bolstering and expanding the work of SBMs as part of a comprehensive strategy to improve and streamline eligibility and enrollment processes, and we invite comments on the following policies and concepts:

- Eliminating bureaucratic requirements and reducing costs by reversing Republican enrollment and eligibility verification policies;
- Promoting consistent and streamlined enrollment processes by expanding the scope of coverage and services that can be offered by SBMs across markets;
- Providing financial incentives for states to establish SBMs; and
- Providing support for SBMs to expand, modernize and streamline enrollment processes.

Leveraging technology. There have been significant advances in technology, changes in consumer behavior, and improvements to consumer-facing online shopping tools since the passage of the ACA, along with an improved understanding of how those technologies drive consumer behavior. There are also new state data systems that could potentially be leveraged, as well as national databases administered by entities such as credit reporting agencies that were not considered during the drafting of ACA eligibility verification policy. There has been over a decade of consumer experience with the FFM, and innovation taking place across SBMs that could inform future policymaking and best practices.

We request feedback on ways to leverage and promote advances and best practices to expand efficient enrollment platforms across private markets and protect consumers against false accusations of fraud.[289]

[289]Pestaina et al., "Fraud in Marketplace Enrollment and Eligibility: Five Things to Know," KFF, June 30, 2025, https://www.kff.org/patient-consumer-protections/fraud-in-marketplace-enrollment-and-eligibility-five-things-to-know/.; Stacey Pogue et al., "Federal Efforts Ostensibly Aimed at Marketplace "Fraud" Ignore Obvious Strategies to Counter Broker Misconduct," Georgetown University Center on Health Insurance Reforms, June 10, 2025, https://chir.georgetown.edu/federal-efforts-ostensibly-aimed-at-marketplace-fraud-ignore-obvious-strategies-to-counter-broker-misconduct/.

SECTION 3: Taking on Corporate Greed

The seven largest for-profit health insurance companies in America take in a trillions of dollars in revenue,[290] and generated over $54 billion in profits last year,[291] at a time when millions of people cannot afford coverage and millions more cannot afford to use the coverage they have. The success of these for-profit companies appears to be judged not by how well they cover people or improve health, but by how efficiently they can turn taxpayer subsidies and premium dollars paid by employers and workers into shareholder returns. In an industry that often prioritizes profit margins over patients, policies that delay or deny coverage for medically necessary care are often driven by balance sheets and shareholder demands rather than the needs of American families.[292]

For-profit insurance companies characterize their business as low-margin, citing net profits in the low single digits as a percentage of total revenue.[293] However, this misleading framing sidesteps discussion of the scale of insurance industry profits in real dollar terms,[294] and avoids a serious assessment of the opportunity cost imposed on the health care system when billions of dollars in taxpayer support and spending from employers and workers are permitted to be used in ways that neither benefit consumers nor improve patient care. This framing also overlooks the for-profit health insurance industry's ongoing efforts to limit care and reduce payments to providers in order to extract even more margin from the American health care system by retaining premium dollars instead of investing in patient care.[295]

Despite receiving billions in taxpayer funding each year, the interests of large insurance conglomerates have become increasingly misaligned with the interests of working people who purchase coverage from them, leading some researchers to conclude that these companies cannot be trusted to act in the best interests of the consumers who rely on them for access to care.[296] Some of the nation's largest for-profit insurance companies have expressed public support for many of the Republican cuts to the ACA that have taken place over the past year,[297] including policies that have been overturned in federal court because they undermined ACA coverage and affordability protections.[298] For example, the association representing large insurance companies expressed support in public comments for eliminating special enrollment periods and establishing bureaucratic verification requirements in the ACA Marketplace,[299] policies that CBO

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[290]Victor Roy et al., "Shareholder Payouts Among Large Publicly Traded Health Care Companies," *JAMA Internal Medicine* 85, no. 4 (2025): 466-468, https://doi.org/10.1001/jamainternmed.2024.7687.
[291]Potter, "2025: Big Insurance's $1.7 Trillion Year."
[292]Roy et al., "Shareholder Payouts."; "Earnings call transcript."
[293]Larry Levitt, "Are Health Insurance Companies the Reason for Our Health System's Ills?," *JAMA Forum* 7, no. 4 (2026): e261755, https://doi.org/10.1001/jamahealthforum.2026.1755; Ryan Crowley, "Financial Profit in Medicine: A Position Paper From the American College of Physicians," *Annals of Internal Medicine,* 174, 10, (2021):1447-1449. https://pubmed.ncbi.nlm.nih.gov/34487452/
[294]Potter, "The Margin Myth."
[295]"Earnings call transcript."
[296]Blumberg et al., "Complex Web."
[297]Corlette, "Stakeholder Perspectives on CMS' Proposed 'Marketplace'"; Corlette, "Stakeholder Perspectives on CMS' Proposed 2027 Notice"
[298]"Court Blocks Unlawful Trump."
[299]AHIP comments to Administrator Mehmet Oz, "RE: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Proposed Rule," AHIP, April 11, 2025, https://www.regulations.gov/comment/CMS-2025-0020-24078.

estimated would cause nearly 2 million people to lose coverage.[300] As Republican health care cuts continue to take effect, leaving millions of working Americans uninsured or paying more for less coverage, these same companies have already reported better-than-expected profits for their shareholders in 2026.[301]

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

Taxpayer subsidies and preferential tax treatment for private insurance companies account for more than one-third of all federal health care subsidies for people under 65. The total cost of this taxpayer support is projected to exceed $500 billion annually in the coming year, with continued growth expected.[302] Despite claims that large insurance conglomerates use their market share and negotiating power to reduce costs and improve efficiency, research shows that they capture nearly $1,000 per enrollee annually in overhead and profit, dollars that are not spent on providing care and financial protection for patients.[303] And it is not clear that for-profit insurance companies are effectively negotiating on behalf of taxpayers, employers and consumers, since prices across the private insurance market are substantially higher than prices paid by public programs, and have increased faster over time.[304]

Maximizing the retention of taxpayer and premium dollars by spending less on patient care is a key revenue driver for these large insurance conglomerates.[305] UnitedHealth Group, for example, cited reduced payment of medical claims as a reason for recent profits that significantly exceeded expectations, and plans to initiate stock buybacks earlier in 2026 than anticipated.[306] Cigna reported better-than-expected profits and shareholder value for the first quarter of 2026 due to lower-than-expected spending on medical care,[307] which likely means that enrollees are receiving less care and absorbing higher out-of-pocket costs. Large for-profit health insurance companies are increasingly using these profits generated with American taxpayer dollars for investments outside of health care, and in some cases outside of the United States entirely.[308]

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[300]Swagel, "Estimated Effects on the Number of Uninsured People."
[301]"Earnings call transcript."; John Tozzi, "Cigna beats estimates, raises outlook on lower medical costs," *Modern Healthcare*, April 30, 2026, https://www.modernhealthcare.com/insurance/mh-cigna-earnings-outlook-evernorth-health/.
[302]"Federal Subsidies for Health Insurance Coverage for People Under 65: 2020 to 2030," Congressional Budget Office, September 2020, https://www.cbo.gov/publication/56650.
[303]Levitt, "Our Health System's Ills."
[304]Whaley, Christopher M., Rose Kerber, Daniel Wang, Aaron Kofner, and Brian Briscombe, "Prices Paid to Hospitals by Private Health Plans: Findings from Round 5.1 of an Employer-Led Transparency Initiative." RAND Corporation, 2024, https://www.rand.org/pubs/research_reports/RRA1144-2-v2.html; Godwin et al., "Hospital Prices Have Risen
[305]Potter, "The Margin Myth."
[306]"Earnings call transcript."
[307]Tozzi, "Cigna beats estimates."
[308] Jennifer Johnson et al., "Double-Digit Decrease in US Insurers' Foreign Investments at Year-End 2024," NAIC Capital Markets Bureau, May 2025, https://content.naic.org/sites/default/files/capital-markets-special-reports-foreign-investments-ye2024.pdf.

Stock Buybacks and Executive Compensation

The seven largest for-profit insurance companies spend tens of billions of dollars on stock buybacks, and these buybacks have increased over time.[309] The CEOs of these companies collectively received nearly $150 million in total compensation in 2024.[310] In 2025, Cigna spent over $5 billion on stock buybacks and dividends, and gave its CEO a compensation package worth over $51 million.[311] CVS spent over $3 billion on stock buybacks and paid its CEO over $23 million in compensation.[312]

Policymakers have restricted the ways some for-profit companies can use or invest taxpayer dollars, such as by taxing or restricting stock buybacks,[313] and researchers expressed support during listening sessions for similar limitations on health insurance companies, including limiting executive compensation, or limiting investment of taxpayer funds to domestic health care activities that provide a demonstrated public benefit. **Senate Democrats request feedback on these proposals.**

Private Equity-Backed Profiteering

Profiteering in health care is not limited to insurance markets. The encroachment of private equity into all areas of health care leads to higher costs and worse care for consumers.[314] Private equity-backed firms are purchasing health care facilities and middlemen to maximize profits at the expense of patient care. Researchers and stakeholders across the health care sector express significant concerns with the expanding presence of private equity in health care. Several reforms have been proposed to address these concerns, including:

- Establishing restrictions on the types of investments that private equity-backed health care entities can make using profits generated from the American health care system;
- Limiting corporate and private equity entry into health care that disrupts clinical decision-making and patient care, similar to steps taken in Oregon;[315]

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[309]Roy et al., "Shareholder Payouts."
[310]"UnitedHealth Group Reports."; Paige Minemyer, "UnitedHealth shareholders sign off on CEO Hemsley's compensation," *Fierce Healthcare*, June 2, 2025, https://www.fiercehealthcare.com/payers/unitedhealth-ceo-hemsley-earn-1m-base-salary-60m-equity-award; "The Cigna Group Reports."; "CVS Health Corporation Reports."; Potter, "As Americans Struggled."
[311]"The Cigna Group Reports."
[312]"CVS Health Corporation Reports."; "2025 Notice of Annual Meeting of Stockholders and Proxy Statement," CVS Health Corporation, April 4, 2025, https://s206.q4cdn.com/752775519/files/doc_financials/2024/ar/CVS-Health-2025-Proxy.pdf.
[313]Similar conditions have been applied previously by Congress to taxpayer funding to banks (see Emergency Economic Stabilization Act of 2008) and airlines (see Coronavirus Aid, Relief and Economic Security (CARES) Act of 2020.
[314]Eileen O'Grady, Mary Bugbee, and Michael Fenne, "Private Equity in U.S. Healthcare: Trends in 2023 Deal Activity," Private Equity Stakeholder Project, March 6. 2024, https://pestakeholder.org/reports/private-equity-in-u-s-healthcare-trends-in-2023-deal-activity/; Blumberg et al., "Complex Web."
[315]"Oregon Passes First-in-the-Nation Bill to Block Corporate Takeovers of Medical Practices," Oregon State Legislature, May 28, 2025, https://www.oregonlegislature.gov/housedemocrats/Documents/Oregon%20Passes%20First-in-the-Nation%20Bill%20to%20Block%20Corporate%20Takeovers%20of%20Medical%20Practices.pdf.;
Julia Burleson, "State Spotlight: Oregon's Multi-Pronged Approach to Corporate Influence in Physician Practices," Georgetown University Center on Health Insurance Reforms, April 27, 2026, https://chir.georgetown.edu/state-spotlight-oregons-multi-pronged-approach-to-corporate-influence-in-physician-practices/.

- Requiring full transparency and reporting of ownership and corporate structures;[316]
- Requiring that any health care investments made by private equity be reported to a centralized, publicly-available database along with information about the ownership and structure of the companies undertaking these investments;[317] and
- Requiring that investments made by private equity-backed health care entities be limited to domestic health care investments that benefit American taxpayers.

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.

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

Large for-profit insurance conglomerates can exploit loopholes and game existing rules to maximize profits and eliminate competition by acquiring doctors, pharmacies, PBMs, and other health care entities.[318] For example, UnitedHealth Group owns nearly 2,700 subsidiaries and employs over 90,000 doctors, which allows the company to generate significant revenue by paying itself, often at higher rates than they pay practices they do not own.[319] This corporate structure also allows large for-profit insurance conglomerates to control which doctor a patient sees and where they fill their prescription, while generating revenue and profit at each step along the way.

The structure of these vertically-integrated insurance conglomerates and the lack of visibility that federal policymakers have into their organization limits accountability and drives up costs for patients and taxpayers as insurers seek to maximize profits.[320] These behaviors are becoming more prevalent.[321]

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[316]Yashaswini Singh and Erin C. Fuse Brown, "The Missing Piece In Health Care Transparency: Ownership Transparency," *Health Affairs Forefront*, https://doi.org/10.1377/forefront.20230921.886842.

[317]Crowley et al., "Financial Profit in Medicine."

[318]Michelle Robb and Jason Karcher, "Medical loss ratio requirements: Challenges posed by vertical integration," Milliman, February 2026, https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2026-Articles/2-9-26_PhRMA-MLR-Paper.pdf.

[319]"UnitedHealth Group," Sunlight Report, effective 2025, https://www.sunlightreportinsurance.com/; Bob Herman, "UnitedHealth Group now employs or is affiliated with 10% of all physicians in the U.S.," *STAT News,* November 29, 2023, https://www.statnews.com/2023/11/29/unitedhealth-doctors-workforce/; Daniel R. Arnold and Brent D. Fulton, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2025.00155; Randolph W. Pate, "The Unintended Consequences Of The ACA's Medical Loss Ratio Requirement," *Health Affairs Forefront*, https://doi.org/10.1377/forefront.20251014.467242; Blumberg et al., "Complex Web."; Tara Bannow, "UnitedHealth pays its own physician groups 17% more than outside ones, study shows," *STAT News*, November 3, 2025, https://www.statnews.com/2025/11/03/unitedhealth-pays-its-optum-physicians-17-percent-more/; Pragya Kakani et al., "Profit Regulation and Strategic Transfer Pricing by Vertically Integrated Firms: Evidence from Health Care," *National Bureau of Economic Research*, no. 35043, April 2026, https://doi.org/10.3386/w35043; Arnold and Fulton, "UnitedHealthcare Pays Optum Providers."

[320]Blumberg et al., "Complex Web."

[321]Sara Sirota and Krista Brown, "UnitedHealth's self-dealing is accelerating," Health Care Un-covered, January 12, 2024, https://healthcareuncovered.substack.com/p/unitedhealths-self-dealing-is-accelerating.

Vertical Integration

Integrated health systems have been established over time in an effort to improve the delivery of care. However, consolidation and vertical integration accelerated in the late 2010s as large for-profit insurers acquired providers, pharmacies, and PBMs. UnitedHealth Group's Optum is now the nation's largest physician employer.[322] CVS Health acquired Aetna in a deal valued at roughly $69 billion in 2018 and now operates nearly 10,000 retail pharmacies, including about 1,100 in-store MinuteClinics.[323] Cigna acquired Express Scripts for approximately $67 billion in 2018.[324]

Vertical integration is typically touted by large insurance conglomerates as a way to increase efficiency and reduce costs, though this consolidation enables creative accounting to maximize profits. There is evidence that vertical integration is increasing costs and harming access to care, particularly when large for-profit health insurance companies purchase doctors and begin to influence the cost and delivery of care.[325] A review of six major insurers found that their combined revenue rose from approximately $245 billion in 2010 to $1.1 trillion by 2021–2022, more than a fourfold increase over that period.[326]

Researchers and policymakers lack visibility into the structure of vertically-integrated insurance conglomerates, which makes it difficult to identify problematic behaviors and pursue targeted reforms. Financial flows within insurance conglomerates often remain opaque even when ownership is disclosed, because operational and financial relationships are treated as proprietary or sensitive and are therefore not fully transparent to the public.

Senate Democrats are interested in proposals and reforms that would strengthen oversight of vertically integrated insurance companies. We welcome feedback on the following topics and concepts:

- Eliminating incentives driving vertical integration by identifying and prohibiting anticompetitive practices;

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[322]Arnold and Fulton, "UnitedHealthcare Pays Optum Providers."
[323]"United States v. CVS and Aetna: Questions and Answers for the General Public," U.S. Department of Justice, October 18, 2018, https://www.justice.gov/d9/press-releases/attachments/2018/10/10/cvs-aetna_-_public_qa_final_0.pdf; Susan Morse, "CVS Health and Aetna merger closes," *Healthcare Finance News*, November 28, 2018, https://www.healthcarefinancenews.com/news/cvs-health-and-aetna-merger-closes.
[324]Richard G. Frank and Conrad Milhaupt, "Related businesses and preservation of Medicare's Medical Loss Ratio rules," Brookings, June 29, 2023, https://www.brookings.edu/articles/related-businesses-and-preservation-of-medicares-medical-loss-ratio-rules/.
[325]Hayden Rooke-Ley et al., "Health Care Conglomerates: Policy and Legal Options for Addressing Vertical Integration," Brown University Center for Advancing Health Policy Through Research, May 2026, https://doi.org/10.26300/3asf-mq68; Zack Cooper et al., "Review of Expert and Academic Literature Assessing Vertical Integration in Health Care," Health Care Affordability Lab at Yale, June 9, 2026, https://cdn.prod.website-files.com/682cf1c625625bb1fcf9efa1/6a282ed7091dec7b1685a522_JTF_Vertical%20Integration.pdf; Jeffrey Marr et al., "From Payer to Provider: Impacts of Insurer Vertical Expansion into Physician Services," Brown University Center for Advancing Health Policy Through Research, April 14, 2026, https://doi.org/10.26300/9xte-nh94;
[326]Wendell Potter, "A decade-long look at how Big Insurance profiteers American taxpayers and the sick," Healthcare Uncovered, April 4, 2022, https://healthcareuncovered.substack.com/p/a-decade-long-look-at-how-big-insurance

- Enhancing data collection and public reporting on health plan and provider ownership structures, mergers, acquisitions, affiliates and financial relationships;[327]
- Ensuring that federal oversight entities have the resources and expertise needed to effectively collect and review data and reporting and act on problematic findings;
- Increasing transparency into corporate structures and the effects they have on costs, competition, and access;[328]
- Protecting independent providers from practices used by for-profit insurance companies to force them to relinquish independence in order to receive adequate payment rates; and
- Protecting unaffiliated providers by benchmarking rates paid to insurance company subsidiaries and affiliated entities.

Democratic Senators have also proposed policies to address the harmful effects of vertical integration by breaking up insurance conglomerates. Recent proposals include:

> The Break Up Big Medicine Act (S.3822) introduced by Senator Warren,[329] which includes a prohibition against insurance companies owning providers and PBMs; and
>
> The Patients over Profits Act (S.2836) introduced by Senator Merkley,[330] which would prevent insurance companies from owning Medicare Part B or C providers.

Senate Democrats invite feedback on these proposals. We are interested in analysis of the effects on different types of vertically-integrated entities that each have unique incentives to control costs and revenue, such as large for-profit health insurance conglomerates, provider-sponsored plans, and integrated closed-network systems.

Intercompany Transfers and Eliminations

One significant consequence of vertical integration by large for-profit health insurance companies has been the strategic use of intercompany transfers and eliminations to raise costs and increase profits. This practice allows vertically-integrated insurance companies to steer patients to their own subsidiaries in order to generate additional revenue while also evading federal rules that require excessive insurance profits to be rebated to consumers.[331]

Intercompany eliminations accounted for approximately one third of UnitedHealth Group's total revenue in 2025.[332] This practice allows for-profit insurance companies to artificially inflate their spending on medical care, which in turn inflates the amount of revenue the insurance company

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[327]Andrés Argüello and Natasha Murphy, "Medical Loss Ratio Reform Can Help Curb Corporate Power and Lower Health Care Costs," Center for American Progress, October 6, 2025, https://www.americanprogress.org/article/medical-loss-ratio-reform-can-help-curb-corporate-power-and-lower-health-care-costs/.
[328]Jim Jusko et al., "Transparency Reveals Health Care Prices—And A Billing And Payments System In Need Of Overhaul," *Health Affairs Forefront*, October 16, 2025, https://doi.org/10.1377/forefront.20251015.235112.
[329]Break Up Big Medicine Act, S.3822, 119th Congress. (2026), https://www.congress.gov/bill/119th-congress/senate-bill/3822.
[330]POP Act, S.2836, 119th Congress. (2025), https://www.congress.gov/bill/119th-congress/senate-bill/2836.
[331]Seth Glickman, "Gaming the System: Medical Loss Ratios and How Insurers Manipulate Them," Health Care Un-covered, February 26, 2025, https://healthcareuncovered.substack.com/p/gaming-the-system-medical-loss-ratios.
[332]"UnitedHealth Group Reports."

can retain as profits under existing law, while capturing the excess dollars as profit in another affiliated non-insurance subsidiary of the same company.

We request feedback on proposals that could address this gaming, including:

- Imposing restrictions on all-or-nothing or steering and tiering tactics that large insurers use to keep patients within their vertically integrated systems to maximize revenue;
- Limiting the share of transfers and eliminations that can be reported as medical spending; and
- Restoring parity with unaffiliated providers by capping intercompany transfers at benchmark rates tied to median prices or a percentage of Medicare rates.

Existing research and securities filings provide some insight into these practices, including evidence of an increase in their prevalence over time, though policymakers lack full visibility into how vertically-integrated conglomerates are structured and how dollars move among and between subsidiaries and affiliates.

Transparency and reporting requirements alone will not be sufficient to stop gaming within increasingly sophisticated, profit-driven corporations, but researchers and advocacy organizations agree there is a concerning lack of visibility into these corporate structures, practices and finances. **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.**

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

The ACA established Medical Loss Ratio (MLR) requirements to ensure that insurance companies spend at least a minimum percentage of premium dollars they receive on medical care and quality improvement activities (QIA). MLR requires insurance companies in the individual and small group markets to spend at least 80 percent of premium dollars on medical claims and QIA, and large group plans to spend at least 85 percent of premium dollars on the same.[333] Insurance companies that do not meet these thresholds must rebate the difference to enrollees.

Under the existing MLR structure, for-profit insurance companies can retain up to 20 percent of revenue. In contrast, CMS administers Medicare at an annual cost of less than 2 percent of total spending.[334] This disparity makes it clear that there is significant opportunity to reduce administrative waste and profiteering in the private insurance market.

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[333] "Medical Loss Ratio," CMS, last modified March 13, 2026, https://www.cms.gov/marketplace/private-health-insurance/medical-loss-ratio.

[334] Juliette Cubanski and Tricia Neuman, "What to Know about Medicare Spending and Financing," KFF, January 19, 2023, https://www.kff.org/medicare/what-to-know-about-medicare-spending-and-financing/.

Insurance companies have paid over $12 billion in rebates to enrollees since the establishment of MLR, making it an important consumer protection and cost containment tool.[335] In 2024, rebates totaled $1.1 billion, or approximately $200 per enrollee.[336] However, limiting profits based on a percentage of revenue and spending may have the effect of increasing incentives for insurance companies to raise their own costs.[337] In the sixteen years since the passage of the ACA, large for-profit insurers have identified loopholes in MLR that they increasingly exploit to avoid paying rebates.[338] A vertically-integrated for-profit insurance conglomerate is both a buyer through its insurance subsidiary, and a seller through its provider subsidiary, enabling profit shifting through strategic transfer pricing. MLR applies only to the insurance entity rather than the parent company,[339] which has created unintended incentives for insurers to expand into provider, PBM, and pharmacy markets to maximize profits and avoid rebate obligations.

MLR Oversight and Reporting

MLR rules rely on plans to self-report data used to determine compliance and rebate obligations. There is limited oversight or verification of this self-reporting,[340] and growing evidence that relying on insurance companies to determine their own MLR rebates creates opportunities for inaccurate reporting[341] Regulators have little visibility into internal pricing flows within large vertically-integrated companies, and there is limited public data on internal pricing and affiliate markups.

Some insurance companies suggested during listening sessions that they would support reforms to MLR that strengthen transparency and close existing loopholes in reporting and oversight, noting that much of the gaming is driven by large national vertically-integrated health insurance companies in ways that create competitive disadvantages for other plans. **Senate Democrats invite feedback on proposals that would strengthen MLR reporting, including:**

- Routine audit authority to verify the accuracy of self-reported data along with penalties for non-compliance;
- Standardized MLR reporting including line-item disclosures for payments to affiliate versus non-affiliate providers, QIA spending, and administrative overhead; and
- Stronger transparency and reporting requirements related to ownership, corporate structure and spending that would allow regulators to identify intercompany transfers and eliminations that are used to manipulate MLR calculations.

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[335]"Total Medical Loss Ratio (MLR) Rebates in All Markets for Consumers and Families," KFF, 2025, https://www.kff.org/affordable-care-act/state-indicator/mlr-rebates-total/
[336]Frank and Milhaupt, "Medicare's Medical Loss Ratio rules."
[337]Blumberg et al., "Complex Web."
[338]Kakani et al., "Profit Regulation and Strategic Transfer Pricing."
[339]Pate, "The Unintended Consequences."; Argüello and Murphy, "Medical Loss Ratio Reform."; Erin C. Fuse Brown, Hayden Rooke-Ley, and Christopher Whaley to Administrator Jeff Wu, January 27, 2025, https://cahpr.sph.brown.edu/sites/default/files/documents/CMS_MLR_Vertical%20Integration.pdf.
[340]Keith, "Insurer Accountability."
[341]Keith, "Insurer Accountability."; Elizabeth Plummer and WIlliam F. Wempe, "Do Health Insurers Manage Their Medical Loss Ratios? At What Cost?", National Association of Insurance Commissioners Journal of Insurance Regulation, Vol 40, No.1, https://content.naic.org/sites/default/files/JIR-ZA-40-01-EL_0.pdf

Quality Improvement Activities

QIAs are intended to be evidence-based activities carried out by health plans to improve health outcomes. Large for-profit insurance companies have identified loopholes in existing rules that define permissible QIAs, which they are now exploiting.[342] One such loophole allows plans to classify a broad scope of expenses as QIAs in order to meet applicable MLR percentage thresholds.

Under federal MLR rules, QIAs must meet a four-part test: they must aim to improve health quality, produce objectively measurable and verifiable results, be directed at enrollees or defined populations and be based on evidence-based medicine or widely accepted clinical guidelines.[343] Existing rules allow for-profit insurance companies to report QIAs using vague classifications, such as promoting wellness activities,[344] and avoid fully reporting administrative expenses. These vague classifications amount to hundreds of millions of dollars each year.[345] Under existing QIA rules, plans have been able to classify items and activities such as untargeted provider bonuses, general marketing, overhead and lobbying as QIA, shifting premium dollars away from patients while still meeting MLR requirements.[346]

Researchers are in broad agreement that QIA classification rules and reporting requirements need to be strengthened to eliminate known loopholes in MLR reporting. **Senate Democrats invite feedback and comments on proposed reforms and improvements to QIA data collection and reporting requirements, including:**

- Eliminating the ability of plans to invest heavily in QIAs late in the plan year, in response to concerns that these 'investments' only occur when plans need to game MLR thresholds;
- Establishing an independent, outcomes-based review process to appropriately classify QIAs;
- Prohibiting the classification of utilization management activities as QIA given concerns related to the use of utilization management as a barrier that generates profit;
- Requiring more detailed data collection and standardized reporting on specific activities, amounts being spent on each activity, and evidence of each QIAs effectiveness in reducing costs and improving health outcomes to substantiate ongoing classification as QIA for purposes of calculating MLR rebate obligations; and
- Strengthening QIA classification rules to appropriately limit the types of services that should count as QIAs and identify the types of services and activities that should not count as QIAs.

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[342]Glickman, "Gaming the System"; Argüello and Murphy, "Medical Loss Ratio Reform."; 45 CFR Part 158 (2026).
[343]45 CFR Part 158 (2026), https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-158.
[344]45 CFR Part 158 (2026); Robb and Karcher, "Medical loss ratio requirements."
[345]45 CFR Part 158 (2026); Robb and Karcher, "Medical loss ratio requirements."; Glickman, "Gaming the System."
[346]Karen Davenport, "Questionable Quality Improvement Expenses Drive Proposed Changes to Medical Loss Ratio Reporting," Georgetown University Center on Health Insurance Reforms, February 22, 2022, https://chir.georgetown.edu/questionable-quality-improvement-expenses-drive-proposed-changes-medical-loss-ratio-reporting/.

MLR Modernization

There is limited visibility into exactly what type of plan self-reporting is taking place, and there is also evidence that plans use strategies to overstate their medical spending or inflate payments to affiliated subsidiaries for items and services to avoid rebate obligations by shifting funds to affiliated non-health insurance subsidiaries.[347] These practices have allowed insurance companies to avoid rebating an estimated hundreds of millions of dollars to consumers.[348] While MLR has resulted in billions of dollars in rebates being paid to consumers, the current policy may be limited in its ability to meaningfully control costs and incentivize quality care absent reforms that would modernize requirements to account for current insurance company abuses.

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, as well as feedback on following concepts:

- Capping profits and administrative spending using a fee-based metric tied to a growth rate rather than as a percentage of total spend;[349]
- Capping profits at a flat percentage of revenue regardless of how such revenue is spent;[350]
- Disallowing internal price markups from MLR calculations, and capping or benchmarking related party transactions to prices paid to unaffiliated entities for the same services;[351]
- Establishing escalating penalties for health plans that are abusing or consistently failing to meet their MLR obligations over time, including increased civil monetary penalties, or the inability to receive federal subsidies or participate in certain markets; and
- Extending MLR protections to employers and consumers enrolled in self insured plans, in light of research suggesting that avoiding rebate obligations may be a driver of decision-making related to offering self insured or fully insured coverage.[352]

Patient and consumer organizations have also voiced support for reformulating or increasing existing MLR thresholds. **We invite feedback on this approach, along with detailed proposals for specific adjustments that appropriately limit insurance company profiteering and gaming.** Proposals and analysis should take into consideration that an estimated MLR calculation applied to traditional Medicare would be above 97 percent,[353] and FEHB operates with gross margins that are 40 percent lower than commercial averages.[354]

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[347]Keith, "Insurer Accountability."; Argüello and Murphy, "Medical Loss Ratio Reform."; Plummer and Wempe, "Do Health Insurers Manage."
[348]Keith, "Insurer Accountability."; Plummer and Wempe, "Do Health Insurers Manage."
[349]Spiro et al., "A Patients' Bill of Rights."
[350]Blue Shield of California self-imposing a 2 percent profit cap is an example of this.
[351]Argüello and Murphy, "Medical Loss Ratio Reform."; Kakani et al., "Profit Regulation and Strategic Transfer Pricing."
[352]Pate, "The Unintended Consequences."
[353]Argüello and Murphy, "Medical Loss Ratio Reform."
[354]Barbara S. Cooper and Karen Davis, "The Federal Employee Health Benefits Program: A Model for Workers, Not Medicare," The Commonwealth Fund, November 1, 2003, https://www.commonwealthfund.org/publications/fund-reports/2003/nov/federal-employee-health-benefits-program-model-workers-not.

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

Large for-profit insurance conglomerates are increasingly engaging in versions of the same profit-seeking behavior that has been identified in other areas of health care, including relying on the use of middlemen to increase complexity, drive up costs and extract profit from the health care system while providing limited value in return.[355] Middlemen in the private insurance market are often owned by or affiliated with large for-profit insurance companies, and they generate profit by managing costs and complexities across claims and billing processes, many of which are likely created by their health plan affiliates.[356]

Practices used by insurance company middlemen–including spread pricing, hidden rebates, and patient steering–have drawn comparisons to the strategies used by PBMs, some of which are owned by these same large insurance companies. There has been bipartisan support for cracking down on abusive PBM practices,[357] and many consumer advocates support a similar crackdown on middlemen in the private insurance market.

Third-Party Administrators (TPAs)

TPAs generate revenue in the self insured market by entering into administrative services only (ASO) contracts with self insured employers to establish networks and administer benefits on their behalf. ASOs are provided by the same national for-profit insurance conglomerates that operate elsewhere in the private market. UnitedHealth, Elevance, Cigna, and CVS provide the majority of TPA services in the self insured market, and their ASO profits are nearly five times higher than their profits in fully insured markets.[358]

Some unions, employers, and researchers express significant concern about the opaque pricing and contracting strategies used by TPAs and ASOs in the self insured market, and the likelihood that these practices are driving up costs for self-funded employers and employees. Most employers rely on TPAs or brokers to assist with their annual purchasing of health care for employees, often without knowing that those TPAs and brokers are owned by or affiliated with for-profit insurance conglomerates that also own PBMs, physicians, revenue cycle managers, repricers, and other middlemen that benefit from higher prices charged to employers that generate larger fees and commissions.[359]

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[355]"Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies," U.S. Federal Trade Commission, July 2024, https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf.
[356]Linda J. Blumberg and Kenneth Watts, "The Incursion Of Profit-Enhancing Middlemen In US Health Care," *Health Affairs Forefront*, October 22, 2024, https://doi.org/10.1377/forefront.20241016.522706.
[357]Karen Handorf et al., "Third-Party Administrators – The Middlemen Of Self-Funded Health Insurance," Georgetown University Center on Health Insurance Reforms, May 28, 2025, https://chir.georgetown.edu/third-party-administrators-the-middlemen-of-self-funded-health-insurance/; "Pharmacy Benefit Managers," NAIC, June 2, 2025, https://content.naic.org/insurance-topics/pharmacy-benefit-managers.
[358]Julia Burleson, "Vertical Integration in Health Care: Implications for Consumers, Employers, and Clinicians," Georgetown University Center on Health Insurance Reforms, May 12, 2026, https://chir.georgetown.edu/vertical-integration-in-health-care-implications-for-consumers-employers-and-clinicians/; Jean M. Abraham, "Prevalence And Profits Of Insurers In The Administrative Services Only Market Serving Self-Insured Employers, 2010–22," *HealthAffairs* 43, no. 12 (2024): 1655-1663, https://doi.org/10.1377/hlthaff.2024.0035.
[359]Blumberg et al., "Complex Web."

Many self insured employers work with brokers and agents to evaluate and select TPAs and ASOs, but these brokers and agents may also have undisclosed financial relationships with those same TPAs and ASOs. Similar financial relationships within the Medicare Advantage program have led to higher costs and worse coverage.[360]

Lack of transparency makes it challenging for even the largest and most well-resourced employers to efficiently shop for health care on behalf of their employees. There is emerging evidence that for-profit insurance companies providing TPA services in the self insured market are taking advantage of this imbalance and failing to act in the best interests of their clients by improperly retaining employer dollars and avoiding meaningful efforts to reduce costs.[361]

Researchers identify a number of concerns with the role of TPAs and middlemen in the self insured market, the lack of protections offered by existing laws and regulations, and the effect that profit-seeking behavior and gaming by middlemen owned by large for-profit insurance companies is having on costs for employers and employees. **Senate Democrats request detailed comments and analysis on the following topics and concepts:**

Oversight and regulation. Despite their outsized presence and profit-making, TPAs operate under relatively limited regulation and oversight, which weakens requirements to share comprehensive claims and spending data with regulators or with the employers they serve. It is nearly impossible for plan sponsors to determine the price they are being charged by a TPA relative to the actual cost of the service, or to intervene if they believe improper practices are being used to drive profit maximization.[362] Plan sponsors, including employers, have a fiduciary duty to manage health care costs on behalf of their employees, yet they often lack meaningful visibility into those costs because TPA contracts frequently include non-disclosure and similar clauses that restrict data sharing and bar the use of independent auditors to review plan spending.[363] Efforts by plan sponsors to review their own claims and payment data are often obstructed by the TPAs they retain to administer self-funded plans, even as emerging evidence indicates that many TPAs deploy PBM-style tactics, relying on hidden fees and overpayments to inflate costs and extract profit without delivering commensurate value.[364]

Policy options to address these challenges could include establishing and clarifying TPA fiduciary duties to plan sponsors and employees to protect against profiteering and improper determinations of medical necessity, and ensuring that existing laws and regulations that should be protecting employers and employees from unfair practices are being adequately enforced.[365]

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[360]"Wyden Investigation Finds Rapid Growth in Spending on Marketing Middlemen Among Medicare Advantage Plans," United States Senate Finance Committee, March 25, 2025, https://www.finance.senate.gov/ranking-members-news/wyden-investigation-finds-rapid-growth-in-spending-on-marketing-middlemen-among-medicare-advantage-plans.

[361]Christine Monahan, "Questionable Conduct: Allegations Against Insurers Acting as Third-Party Administrators," Georgetown University Center on Health Insurance Reforms, March 24, 2023, https://chir.georgetown.edu/questionable-conduct-allegations-insurers-acting-third-party-administrators/; Blumberg et al., "Complex Web."

[362]Elizabeth Y. McCuskey, "State Cost-Control Reforms and ERISA Preemption," The Commonwealth Fund, May 16, 2022, https://www.commonwealthfund.org/publications/issue-briefs/2022/may/state-cost-control-reforms-erisa-preemption.

[363]Blumberg et al., "Complex Web."

[364]Blumberg et al., "Complex Web."; Georgetown University Center on Health Insurance Reforms, "Is ERISA Up For The Job?"

[365]Georgetown University Center on Health Insurance Reforms, "Is ERISA Up For The Job?"

Transparency for plan sponsors. Researchers and advocates raise concerns that TPAs do not consistently act in the best interests of the clients that hire them, including one recent example where Kansas filed a lawsuit against the TPA of their state employee plan alleging diversion of state funds to subsidize losses incurred in a different plan, an act known as cross-plan offsetting.[366] TPAs bill their self-funded clients for health care costs while offering limited visibility into actual spending on care or the terms of their contracts with providers and other third parties, including affiliated entities. ASO fees vary widely, ranging from $165 at the 25th percentile to $345 at the 75th percentile per enrollee,[367] and employers often lack the necessary information to assess whether these fees are appropriate. TPA contracts with employers that self-fund frequently include terms that shield their financial relationships and conflicts of interest from disclosure.[368] Some employers, advocates and researchers express support for transparency and reporting requirements applied to TPAs and ASOs that require stronger disclosures and guarantee employers access to their cost and claims data.[369]

Payment rates. Some researchers and advocates cite instances in which TPAs and ASOs manipulate payment structures to generate additional profit at the expense of self insured employers. TPAs often require plan sponsors to accept anticompetitive contracting terms, such as anti-tiering and anti-steering provisions and restrictions on using lower-cost, higher-value providers, to capture revenue across their vertically-integrated enterprises even when these arrangements increase costs for employers and workers. TPAs may also push all-or-nothing contracts that limit patient access to non-affiliated providers, or pay their affiliated physicians more than they pay independent physicians for the same services.[370] In the self insured market, those additional costs are paid by plan sponsors. Policy options to deter TPAs from using affiliated entities to inflate costs could include benchmarking fees and payments to those entities against fair-market rates or arrangements between unaffiliated parties.

Profits. TPAs generate significant profits in the self insured market through the use of hidden fees, spread pricing and other tactics. Proposed reforms to limit the ability of TPAs and other middlemen to capture excessive profits from employers include:

- Extending MLR rebate obligations to apply to TPAs and ASO contracts in the self insured market, with rebates for excessive non-health care spending going to plan sponsors and/or enrollees;
- Limiting TPA and ASO contracts to a defined per-member-per-month fee-based structure that eliminates incentives to work with profit-extracting middlemen and affiliates, and forecloses opportunities to generate revenue using tactics such as spread pricing;[371] and

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[366]*State of Kansas, ex rel. Kris W. Kobach v. Aetna Health Inc., Aetna Health Insurance Company, and Aetna Life Insurance Company*, No. SN-2026-CV-000599 (Shawnee County Dist. Ct. June 24, 2026), complaint, https://www.scribd.com/document/1056434789/Kansas-Aetna-complaint.; Elizabeth Casolo, "Kansas sues Aetna over alleged diversion of state employee health plan funds," Becker's Payer Issues, June 29, 2026, https://www.beckerspayer.com/legal/kansas-sues-aetna-over-alleged-diversion-of-state-employee-health-plan-funds/.
[367]Frank and Milhaupt, "Medicare's Medical Loss Ratio rules."
[368]Blumberg et al., "Complex Web."
[369]"Finally: Healthcare Data That Works for Employers," Peterson Health Analytics, https://petersonanalytics.com/.
[370]Burleson, "Vertical Integration in Health Care: Implications."
[371]Blumberg et al., "Complex Web."

- Requiring TPAs to pass savings onto plan sponsors similar to the requirements applied to PBMs, inclusive of rebates, discounts and revenue from shared savings arrangements.[372]

Unbiased administrative services. Some employer groups, unions, advocates and researchers express concerns that employers are increasingly struggling to negotiate benefits on a level playing field due to the complex systems and opaque corporate structures created by for-profit insurance conglomerates. In addition to access to costs and claims data, some plan sponsors would benefit from technical assistance related to TPA and ASO contracting and negotiations. Policies that promote access to unbiased third-party support for plan sponsors, or independent TPAs and ASOs that are free from potential conflicts of interest and profit motives because they are not entangled with vertically-integrated for-profit health insurance companies, could drive improved value and outcomes for self insured employers and their employees.

Benefit to plan sponsors. Several researchers and advocates raised concerns during listening sessions with TPA and ASO profiteering. Some proposed to address these concerns through the development of independent fee-based TPAs that provide ASO services to self-funded plans. Others suggested leveraging existing resources, such as Medicare administrative contractors or health insurance marketplaces, to provide broader access to impartial services that are free from conflicts of interest. **We are interested in comments on these proposals, and feedback from self insured employers on whether TPAs and ASOs are providing true value or have instead become unavoidable middlemen given the complexities of health care purchasing.**

Other Health Insurance Middlemen

The increasing complexity of corporate structures and lack of modernized reporting and disclosure requirements makes it nearly impossible for researchers and policymakers to have full visibility into the ownership, affiliations and profits that health insurance middlemen are extracting from employers, consumers and taxpayers.[373] It is difficult to evaluate whether the services these middlemen provide are generating value, or generating revenue by inflating costs to increase spending for employers and employees, though available research suggests the need for reforms.[374] The administrative complexity created by large for-profit health insurance companies has led to the emergence of an entire industry of affiliated subsidiaries that perform tasks related to payment and claims management. For example:

- Claims repricers generate revenue by entering into shared savings agreements and working to establish lower out-of-network reimbursement, with reductions being shared between the repricer and their client. Repricers often work with or are affiliated with TPAs that have an incentive to artificially increase prices in order to inflate the size of the savings their repricers are able to generate, including by keeping certain providers out of

[372]Spiro et al., "A Patients' Bill of Rights."
[373]Blumberg and Watts, "Incursion Of Profit-Enhancing Middlemen."
[374]Blumberg et al., "Complex Web."

network so they can charge higher rates.[375] Repricers generate profits through the savings they negotiate, while patients are exposed to higher out-of-pocket costs.[376]

- Revenue cycle management companies provide billing and collection services, and maximize profits when there are administrative hurdles in the health care system that they can be contracted with to navigate.[377] They are often affiliated with the same insurance company that provides TPA services, so may generate additional revenue for themselves and their affiliated TPA by increasing costs and complexity to maximize billing.[378]

Recent efforts to inject transparency into employer contracting seek to address anticompetitive practices used by TPAs, including self-dealing with affiliated entities.[379] However, without additional reforms to curb anticompetitive contracting and strengthen transparency more broadly, it will be difficult to level the playing field, especially for employers that lack the resources and bargaining power to challenge TPAs owned by large for-profit insurers, given those companies' relative size and resources.[380] Self- insured employers are increasingly pursuing direct contracting arrangements with hospitals and other providers in order to gain greater control over their costs and claims data and bypass TPAs and other intermediaries owned by or affiliated with large for-profit insurers. Meanwhile, smaller employers that lack the ability to pursue such arrangements are increasingly deciding they cannot provide employee coverage altogether.[381]

A number of reforms to address abuses and profiteering by middlemen affiliated with large for-profit insurance conglomerates were proposed during listening sessions. **We request detailed proposals and feedback on the following topics and concepts:**

- Applying a fee-based payment structure to services provided by middlemen to eliminate incentives that drive profits and increase costs;
- Applying policies similar to bipartisan PBM reforms to TPAs and affiliated entities;[382]
- Establishing additional transparency and reporting requirements to provide employers and regulators with meaningful visibility into the profits generated by middlemen affiliated with for-profit health insurance companies;
- Requiring that profits generated by repricers or through spread pricing be passed to plan sponsors; and
- Using pricing benchmarks to eliminate undue profits generated through affiliated entities.

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[375]Blumberg et al., "Complex Web."
[376]Blumberg et al., "Complex Web."; Chris Hamby, "Insurers Reap Hidden Fees by Slashing Payments. You May Get the Bill," *The New York Times*, April 9, 2024, https://www.nytimes.com/2024/04/07/us/health-insurance-medical-bills.html.
[377]"U.S. Revenue Cycle Management Market (2025 - 2030)," Grand View Research, February 2025, https://www.grandviewresearch.com/industry-analysis/us-revenue-cycle-management-rcm-market.
[378]Blumberg et al., "Complex Web."
[379]Consolidated Appropriations Act, 2021 (Public Law 116-260) ; Marissa Plescia, "Will Mark Cuban's Cost Plus Wellness Appeal to Employers?," *MedCity News*, May 21, 2026, https://medcitynews.com/2026/05/will-mark-cubans-cost-plus-wellness-appeal-to-employers/.
[380]Corlette, "Health Care Costs for Small Employers."
[381]Corlette, "Health Care Costs for Small Employers."
[382] Consolidated Appropriations Act, 2026, H.R.7148, 119th Congress. (2026), https://www.congress.gov/bill/119th-congress/house-bill/7148.

System-Wide Transparency and Reporting

A consistent theme across all examples of corporate profiteering in health care raised by stakeholders during listening sessions is a lack of oversight and transparency that prevents researchers and policymakers from achieving a full understanding of the scope of the problems and potential solutions. Establishing strong transparency and reporting requirements is an important part of comprehensive health care reform, though transparency alone will not address affordability or immediately resolve the profiteering and gaming carried out by for-profit insurance companies across private insurance markets.[383]

Meaningfully modernizing transparency and reporting will inform new policy solutions, and may act as a deterrent while providing data and information that allows policymakers to effectively limit new forms of gaming in the future. Regulators across agencies should be able to effectively collaborate, evaluate data and information, and take meaningful action against increasingly complex corporate entities to protect consumers across private markets.

Inter-agency efforts to begin this type of data collection and evaluation appeared to be underway in 2024,[384] but there has not been meaningful progress on those efforts to date and it is unclear whether the existing federal oversight structure is sufficient to evaluate and act on increasingly complex matters that implicate several agencies at a given time. For example, the increasing complexity of the corporate structure of large national for-profit insurance companies might raise questions about whether HHS or state insurance regulators are adequately resourced and staffed to evaluate ownership arrangements and their effect on health care markets and costs. Similarly, imposing additional transparency requirements on the self insured employer market may yield data and information that DOL lacks the resources and expertise to review and act on in ways that would hold bad actors accountable and deter future gaming.

Senate Democrats invite feedback on these concepts, and proposals to improve federal oversight across private insurance markets. Reforms should ensure that state and federal regulators across agencies are able to:

- Effectively collaborate;
- Evaluate relevant data and information; and
- Take meaningful action against increasingly complex vertically-integrated entities to protect employers and consumers from unfair costs and abusive practices across private insurance markets.

Proposals should also ensure that data collection is occurring consistently across private markets and is centralized, standardized and publicly available for use by employers, researchers, and

[383]Cooper et al., "Literature Assessing Vertical Integration."
[384]"Federal Trade Commission, the Department of Justice and the Department of Health and Human Services Launch Cross-Government Inquiry on Impact of Corporate Greed in Health Care," Federal Trade Commission, March 5, 2024, https://www.ftc.gov/news-events/news/press-releases/2024/03/federal-trade-commission-department-justice-department-health-human-services-launch-cross-government.

state and federal policymakers, including through all-payer claims databases or similar clearinghouses.[385]

Feedback on system-wide transparency should take into account questions posed throughout this RFI related to achieving a stronger understanding of for-profit health care ownership and corporate structure, and practices across markets such as MLR gaming, TPA abuses, and intercompany transfers and eliminations within vertically-integrated insurance conglomerates.

[385]Stacey Pogue and Abigail Knapp, "Leveraging Data to Control Health Care Costs," Georgetown University Center on Health Insurance Reforms, April 30, 2026, https://chir.georgetown.edu/leveraging-data-to-control-health-care-costs/.; Matthew Fiedler and Christen Linke Young, "Federal policy options to realize the potential of APCDs," Brookings, October 23, 2020, https://www.brookings.edu/articles/federal-policy-options-to-realize-the-potential-of-apcds/