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October 2, 2026

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

**RE: Request for Information; Health Coverage
that Works for Everyone**

Dear Senator Wyden:

Thank you for the opportunity to provide comments on the Senate Finance Committee's Request for Information (RFI) on "Health Coverage that Works for Everyone." For over 57 years, the National Health Law Program (NHeLP) has protected and advanced the health rights of low-income and underserved populations. Our advocacy efforts are guided by the core belief that every person (irrespective of their characteristics and circumstances) has a right to their highest attainable standard of health and that, to make this possible, any health reform initiative must first recognize access to health care services as a fundamental human right.

To that end, below we provide comments on various topics that we believe Congress should consider moving forward. Some of these comments focus on general principles that any overarching health reform proposal should take into account. Other comments focus on incremental approaches that should be implemented in the more immediate term to address gaps in coverage that have remained since the enactment of the Affordable Care Act (ACA), some of which have been exacerbated by recent federal actions.

While we do not discuss it at length, we first acknowledge the need to undo the policies enacted and implemented over the past two years that are harming access to health care, particularly for low-income families and populations traditionally neglected by our health care system, such as Black, Indigenous, and Other People of Color (BIPOC), LGBTQIA+ individuals, and people with disabilities. In particular, we call attention to the significant disruptions the Medicaid program has suffered since the passage of H.R. 1 or so-called “One Big Beautiful Bill” (OBBA). Medicaid is a lifeline for millions of low-income families that would otherwise be unable to afford necessary health care services. Having that coverage not only guarantees access to essential health care, but also allows individuals to more fully participate in work and community activities, making Medicaid an important piece of the U.S.’s economy.¹

Unfortunately, Medicaid and its many societal benefits are now at risk through the imposition of work requirements, reduced redetermination periods, increased cost-sharing, and limits on coverage for immigrant populations.² H.R. 1 also severely limits states’ ability to finance their Medicaid programs through prohibitions on new provider taxes and restrictions on state-directed payments and other initiatives that seek to make it harder for states to ensure comprehensive levels of coverage for all low-income individuals.³ These policies will not only hurt the Medicaid program, but will also disrupt

¹ Robert Wood Johnson Found., *Medicaid’s Impact on Health Care Access, Outcomes and State Economies* (Feb. 1, 2019), <https://www.rwjf.org/en/insights/our-research/2019/02/medicaid-s-impact-on-health-care-access-outcomes-and-state-economies.html>; Elena Andreyeva, Hannah I. Rochford, & Daniel J. Marthey, *Examining the Impact of ACA Medicaid Expansion on Insurances Coverage, Access to Care and Health of Low-Income Parents*, 18 HEALTH SERV RES. e14625 (Apr. 2025), <https://pmc.ncbi.nlm.nih.gov/articles/PMC12461110/>; Marko Mijic, *Medicaid Is One of America’s Strongest Economic Engines. Why Don’t We Treat It That Way?*, Cal. Health Care Found. (May 6, 2025), <https://www.chcf.org/blog/2025/05/06/medicaid-one-americas-strongest-economic-engines-why-dont-we-treat-way/>; HHS, Assistant Sec’y for Planning & Evaluation, *Medicaid: The Health and Economic Benefits of Expanding Eligibility* (Sep. 26, 2024), <https://aspe.hhs.gov/reports/benefits-expanding-medicaid-eligibility>; Kaiser Permanente Inst. for Health Pol’y, *Medicaid’s Impact: healthier people, communities, and local economies* (2025), https://www.kpihp.org/wp-content/uploads/2025/04/1618489482_Value-of-Coverage-IHP-Issue-Brief_033125_ADA.pdf.

² Jennifer M. Haley et al., *Up to 2.3 Million Young Adults Ages 19 to 24 Could Lose Medicaid Under OBBA’s Work Requirements and More-Frequent Redeterminations*, Urban Inst. (Sep. 14, 2026), <https://www.urban.org/research/publication/23-million-young-adults-ages-19-24-could-lose-medicaid-under-obbbas-work>; Preethi Rao et al., *State-Level Impacts of Key Medicaid Provisions in the One Big Beautiful Bill Act*, RAND (June 18, 2026), https://www.rand.org/pubs/research_reports/RRA4098-1-v2.html; Amina Khaliq & Natasha Murphy, *On the First Anniversary of the OBBA, Millions of Americans Have Been Left behind*, Ctr. for Am. Progress (June 25, 2026), <https://www.americanprogress.org/article/on-the-first-anniversary-of-the-obbba-millions-of-americans-have-been-left-behind/>.

³ Geraldine Doetzer, *Medicaid Financing after OBBA: state Directed Payments and Provider Taxes*, Nat’l Health Law Prog. (Sep. 17, 2025), <https://healthlaw.org/resource/medicaid-financing-after-obbba-state-directed-payments-and-provider-taxes/>; Eileen Appelbaum, *States Face Massive Medicaid Issues Thanks*

the health care system in general. They will lead to more uninsured individuals, more uncompensated care, and increased costs for providers and plans that will then get passed on to individuals buying insurance through the private market.

Additional policies taken at the administrative level in the past two years are also severely hampering access to health care and should be reversed. For instance, HHS has systematically gutted the vaccine recommendation system, introducing partisanship and sowing doubt in a system that had traditionally relied on the best available scientific evidence.⁴ The agency has also repeatedly attacked access to gender-affirming care services by finalizing rules restricting access to certain services and procedures for minors in Medicaid and individual and small-group plans, proposing a rule that would limit Medicaid and Medicare providers' ability to render gender-affirming care to minors, and otherwise amplifying misinformation about these evidence-based medically necessary services.⁵ HHS has also, once again, introduced a rule that would make it harder for immigrant communities to access health care services through public programs by expanding the traditional understanding of public charge.⁶ These are only three examples of the many administrative actions that should be reevaluated in the immediate term and such reversals should form a starting point for any future reforms.

to the *One Big Beautiful Bill Act*, Ctr. for Econ. & Pol'y Rsch. (June 16, 2026), <https://cepr.net/publications/states-face-massive-medicaid-issues-thanks-to-the-one-big-beautiful-bill-act/>; Chani Seals, Eric Levine, & Drew Wood Palmer *OBBA Provider Tax Provisions Impact on Medicaid Stakeholders*, Avalere Health (July 22, 2025), <https://advisory.avalerehealth.com/insights/obbba-provider-tax-provisions-impact-on-medicaid-stakeholders>.

⁴ George Washington Univ., *Legal and Public Health Experts Say HHS Vaccine Downgrades Violate Federal Law and Endanger Public Health* (Feb. 10, 2026), <https://www.newswise.com/articles/legal-and-public-health-experts-say-hhs-vaccine-downgrades-violate-federal-law-and-endanger-public-health>; Josh Michaud & Jennifer Kates, *The White House Takes Another Shot at Changing U.S. Childhood Vaccine Recommendations*, KFF (Aug. 11, 2026), <https://www.kff.org/other-health/the-white-house-takes-another-shot-at-changing-u-s-childhood-vaccine-recommendations/>.

⁵ Lindsey Dawson, *New Regulation Prohibits Federal Medicaid Funds From Covering Gender-Affirming Care for Young People*, KFF (Aug. 13, 2026), <https://www.kff.org/quick-insights/new-regulation-prohibits-federal-medicaid-funds-from-covering-gender-affirming-medical-care-for-young-people/>; Sabrina Corlette, *New Federal Rules Affecting Coverage of Treatment for Gender Dysphoria: Considerations for States*, State Health & Value Strategies (Aug. 1, 2025), <https://shvs.org/resources/new-federal-rules-affecting-coverage-of-treatment-for-gender-dysphoria-considerations-for-states/>; Katie Keith, *Proposed Federal Rules Target Health Care For Transgender Youth (Part 2)*, HEALTH AFF (Dec. 23, 2025), <https://www.healthaffairs.org/content/forefront/proposed-federal-rules-target-health-care-transgender-youth-part-2>.

⁶ Leighton Ku, *Public Charge Restrictions For Immigrants And Their Families: No Rules, No Accountability*, HEALTH AFF (Sep. 3, 2026), <https://www.healthaffairs.org/content/forefront/public-charge-restrictions-immigrants-and-their-families-no-rules-no-accountability>.

I. Coverage of services under any future system must match or exceed Medicaid's comprehensive level of coverage.

An important achievement of the ACA was ensuring that insured individuals had access to a minimum level of comprehensive coverage, understanding that benefit packages must meet all the health care needs of covered individuals. The ACA significantly improved access to benefits that we now take for granted, such as contraceptive services, mental health and substance use disorder (SUD) services, and rehabilitative and habilitative services.⁷ Access to these services has significantly reduced disparities in health care, particularly among Medicaid expansion populations and those covered through individual and small-group plans, which are required to cover a set of essential health benefits (EHB).⁸ Still, many gaps in access to services remain within the 10 EHB categories, and a number of important services, like adult dental, are not described under the 10 categories.

Importantly, filling those gaps should not come at the expense of weakening current levels of coverage for low-income individuals. Medicaid coverage should set the floor for any future health reforms. No Medicaid beneficiary should experience any cuts, reductions, or limits on the amount and scope of services they currently have access to. Medicaid coverage has been carefully crafted to address the particular needs of low-income individuals and those with complex health conditions. Low-income populations and those traditionally covered by Medicaid often experience higher rates of chronic and behavioral health conditions, as well as significant social needs that negatively impact their health, such as food insecurity, housing instability, and lack of transportation to and from medical appointments.⁹ As such, the minimum coverage requirements

⁷ Jamie R. Daw & Benjamin D. Sommers, *The Affordable Care Act and Access to care for Reproductive-Aged and Pregnant Women in the United States, 2010-2016*, 109 AM J PUBLIC HEALTH 565 (Apr. 2019), <https://pmc.ncbi.nlm.nih.gov/articles/PMC6417599/>; Jesse C. Baumgartner, Gabriella N. Aboulafia, & Audrey McIntosh, *The ACA at 10: How Has It Impacted Mental Health Care?*, The Commonwealth Fund (Apr. 3, 2020), <https://www.commonwealthfund.org/blog/2020/aca-10-how-has-it-impacted-mental-health-care>; Mark Olfson et al., *Effects of the ACA on health care Coverage for Adults with Substance Use Disorders*, 72 PSYCHIATR SERV. 905 (May 2021), <https://pmc.ncbi.nlm.nih.gov/articles/PMC8328862/>; Steven Shapiro, *Understanding the Rehabilitative and Habilitative Services Essential Health Benefit*, HEALTHCARE INSIDER (July 31, 2019), <https://healthcareinsider.com/rehabilitative-habilitative-services-ehb>.

⁸ Katie Keith, *How Insurers Can Advance Health Equity Under the Affordable Care Act*, The Commonwealth Fund (Aug. 10, 2021), <https://www.commonwealthfund.org/blog/2021/how-insurers-can-advance-health-equity-under-affordable-care-act>; L.J. Blumberg & J. Banthin, *The Implications of Eliminating Essential Health Benefits*, Robert Wood Johnson Found. (Nov. 1, 2020), <https://www.rwjf.org/en/insights/our-research/2020/11/the-implications-of-eliminating-essential-health-benefits--an-update.html>.

⁹ Nat'l Ass'n of Medicaid Dir., *What We Know About Medicaid and Who it Serves* (Apr. 24, 2023), <https://medicaiddirectors.org/resource/what-we-know-about-medicaid-and-who-it-serves/>; Isabella Backman, *New Study Reveals High Disease Burden Among At-Risk Medicaid Beneficiaries*, Yale Sch. Of

established in the Medicaid Act acting as a floor, combined with the flexibility states have to incorporate additional services depending on the needs of their populations, are critical to protecting the health of low-income beneficiaries and should be preserved in any future health reform proposal.

We encourage lawmakers to address gaps in access to key services in private insurance by extending many of the required Medicaid benefits to other programs and populations. Some of those benefits include:

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Reforms should include periodic screenings for minors under 21 and coverage of any service when necessary to correct or ameliorate the individual's condition. Children and families should also be also informed of these services and insurers should assist individuals with obtaining screening and arrange for needed treatment.

Prescription drugs. Health reform proposals should ensure access to outpatient prescription drugs while curbing skyrocketing prices. These goals are not mutually exclusive. For example, even though coverage of prescription drugs is optional for states under Medicaid, all states have elected to cover them. Under federal law, once a state Medicaid program elects to cover prescription drugs, it must provide comprehensive coverage of most FDA-approved medications while keeping costs down through required rebates. Similarly, Medicare Part D includes six protected classes of drugs used in treatment for certain conditions, like HIV, that are not subject to prior authorization or step therapy. Reform should build upon these successes, rather than undermining existing coverage standards and protections.

Mental health and SUD services. Individuals should have access to comprehensive community-based mental health and SUD services provided through an integrated system and in coordination with other services. In addition, mental health and SUD services must be provided in parity with medical and surgical services; that is, any financial requirements or treatment limitations imposed on these services must not be more restrictive than limits imposed on medical and surgical benefits.

Med. (Nov. 11, 2025), <https://medicine.yale.edu/news-article/high-disease-burden-among-at-risk-medicaid-beneficiaries/>; Nathan D. Shippee & Katherine D. Vickery, *The Complex Needs of Medicaid Expansion Enrollees with Very Low Incomes*, The Commonwealth Fund (May 31, 2018), <https://www.commonwealthfund.org/publications/issue-briefs/2018/may/complex-needs-medicaid-expansion-enrollees-very-low-incomes>.

Vision, hearing, and dental services. Vision, dental care, and hearing services are essential to the health and well-being of all individuals, and all plans should include these benefits for both adults and children.

Long term supports and services (LTSS). Long term supports and services should be included in any universal health care proposal. Reform requires a recognition that it is unacceptable that Medicaid is virtually the only program that provides for LTSS. Individuals should not have to sacrifice employment opportunities, economic self-sufficiency, or their entire life savings to access crucial LTSS.

Sexual and Reproductive Health (SRH) Services. Everyone deserves equitable access to affordable, comprehensive sexual and reproductive health (SRH) care. Yet the U.S.'s fragmented health coverage system leaves far too many people without meaningful access to this care, contributing to unacceptable disparities in both access and health outcomes. Despite longstanding stigmatization and the siloing of SRH services from other forms of health care, SRH care is essential health care that supports the health and well-being of people throughout their lives.

Access to high-quality SRH care prevents pregnancy-associated morbidity and mortality, improves birth outcomes, and has been associated with educational and workforce advancement and poverty reduction.¹⁰ Accordingly, any meaningful health reform must ensure access to comprehensive SRH care at every stage of life.

To achieve this equitable SRH coverage at every stage of life, all health programs and plans should be held to the same high standards for comprehensive, high-quality SRH care and meaningful access. Thus, we recommend that all health programs and plans be required to provide comprehensive coverage of the full range of SRH services, including abortion, contraception and related services, pregnancy-related care (including full-spectrum doula services and midwife care), assisted reproductive care, care for chronic SRH health conditions, and STI prevention, testing, and treatment. These services should be covered without financial or administrative barriers that impede access, including cost-sharing, prior authorization, or other utilization-

¹⁰ Sarah E. Romer et al., *Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs (Revised 2024)*, 67 AM. J. PREV. MED. S41–S86 (2024), <https://societyfp.org/wp-content/uploads/2025/02/Providing-Quality-Family-Planning-Services-in-the-United-States-Recommendations-of-the-US-Office-of-Population-Affairs-Revised-2024.pdf>; Inst. for Women's Policy Research., *Contraception Access Increases Women's Educational Attainment and Earnings* (Sep. 26, 2019), <https://iwpr.org/press/contraception-access-increases-womens-educational-attainment-and-earnings/>; Stephanie P. Browne et al., *The Effects of Contraception on Female Poverty*, 33 J. POL. ANAL. & MGMT. 602 (2014), <https://onlinelibrary.wiley.com/doi/10.1002/pam.21761>.

management requirements. Coverage must also ensure that patients can access SRH services through the modality that best meets their needs, including in-person care and synchronous and asynchronous telehealth, with access to both audio-only and audio-video services. And to ensure that abortion coverage translates into meaningful access, in addition to requiring coverage without restrictions, provider reimbursement rates must be adequate and sustainable.

Additionally, as lawmakers consider proposals to expand Medicare or use Medicare as the foundation for a federal public option, it is critical to recognize that Medicare's existing benefit structure falls far short of providing comprehensive SRH coverage. In addition to longstanding restrictions on abortion coverage under the Hyde Amendment, Medicare does not require comprehensive contraceptive coverage. Contraception is generally excluded from coverage under Parts A and B, while coverage under Part D and Medicare Advantage is limited and may be subject to cost-sharing.

Moreover, many of the coverage requirements and consumer protections that help guarantee access to STI screening, pregnancy-related care, contraception, and other preventive and reproductive health services in private plans regulated by the ACA do not apply to Medicare. Therefore, any proposal that builds upon Medicare must greatly improve upon this SRH coverage while preserving and strengthening the protections already available under Medicaid and the ACA.

Since the 1970s, Medicaid has required coverage of family planning services and supplies without cost-sharing, with additional protections to ensure that enrollees can access the methods and providers of their choice without coercion or interference. Similarly, the ACA requires most private insurance plans to cover the full range of contraceptive services and methods without cost-sharing. Despite these longstanding federal protections, coverage of contraception and related services is inconsistent, incomplete, and inadequately enforced.¹¹ As the lawmakers consider options to improve health coverage in the U.S., it should protect and improve contraceptive coverage for everyone including by requiring coverage for the full range of contraceptive services and products, without cost-sharing.

¹¹ Committee on Oversight & Reform U.S. House of Representatives, *Barriers to Birth Control: An Analysis of Contraceptive Coverage and Costs for Patients with Private Insurance* (Oct. 2025), <https://oversightdemocrats.house.gov/imo/media/doc/2022-10-25.COR%20PBM-Insurer%20Report.pdf>.

II. Health reform should always be guided by an equity lens and should incorporate the need to address social determinants of health.

Our country is marked by sustained imbalances in the allocation of power and resources that are rooted in systems of oppression such as racism, gender-based discrimination, ableism, and xenophobia. These imbalances create stark health inequities. Any federal health care reform proposals, including public options, must center health equity in policy design, implementation, and beyond. It is not enough for the health care system to produce results “on average;” it must produce results across populations and sub-populations. This means it must also track results across populations and sub-populations. The system must account for and actively work to dismantle inequities through actions such as:

- **Providing robust protections against discrimination in health care.**

Discrimination within and beyond the U.S. health care system contributes to the nation’s vast health inequities. Section 1557 of the ACA prohibits discrimination in health care across race, color, national origin (including language and immigration status), age, sex (including sexual orientation, gender identity, and sex stereotypes), and disability.¹² Any future health reform should ensure that coverage is subject to Section 1557 so that enrollees can receive its critical protections.

- **Not excluding people from health coverage based on immigration status.**

Immigrants comprise the largest group of uninsured people in the U.S.¹³ Past efforts to advance universal access to affordable health coverage have largely left noncitizen immigrants living in the U.S. behind.¹⁴ The categorical exclusion of immigrants from health coverage (e.g., the 2025 reconciliation law that eliminates eligibility for many lawfully present immigrants for federally-funded health programs; and the ACA’s complete ban on Marketplace coverage for undocumented people) is xenophobic and perpetuates uninsurance and health inequities for immigrants and their families, especially BIPOC.¹⁵ Congress must ensure that any

¹² 42 U.S.C. § 18116.

¹³ See, Health Coverage of Immigrants, Kaiser Family Foundation (June 12, 2026), <https://www.kff.org/racial-equity-and-health-policy/key-facts-on-health-coverage-of-immigrants/>.

¹⁴ See, e.g., Randy Capps & Michael Fix, *Immigration Reform: A Long Road to Citizenship and Insurance Coverage*, 32 HEALTH AFF. 639 (2013) (noting that “unauthorized immigrants will still be frozen out” of the ACA’s health coverage gains).

¹⁵ See, Akash Pillai et al., *Implementation of Medicaid Immigrant Eligibility Restrictions Under the 2025 Reconciliation Law: Issues to Consider*, KFF (Sep. 22, 2026), <https://www.kff.org/immigrant-health/implementation-of-medicaid-immigrant-eligibility-restrictions-under-the-2025-reconciliation-law-issues-to-consider/>.

reform truly achieves universal coverage — inclusive of people regardless of immigration status. Otherwise, Congress will undermine potential gains in access to affordable coverage for all and health equity.

- **Meeting the health coverage needs of potential enrollees in the U.S. Territories.** Congress should address the disparate treatment of residents of U.S. territories when it comes to the different health care programs that involve federal funding. As with Medicaid and Medicare funding, private insurance in the individual market remains unaffordable for most people living in the territories. Lawmakers should ensure that health reforms protect and improve coverage in the territories and consider the need to expand affordability and coverage protections for people in the territories in order to reduce inequities among these mostly-BIPOC populations. In the immediate future, Congress should ensure equal treatment for the territories when it comes to federal Medicaid funds. In particular, as Puerto Rico faces a looming Medicaid fiscal cliff in 2027, Congress must act expeditiously to guarantee continued availability of services.¹⁶
- **Health care systems should address social determinants of health.** Health is more than health care. Societal, political, and economic conditions have a profound impact on health. Health care, including Medicaid, the Marketplace, and any public option approach should appropriately address these determinants. It must embrace case management, which can help enrollees access needed health care, social, and other services, as an essential health care service. In addition, connected and coordinated health care and health-related social services are necessary to reduce preventable morbidity and mortality, promote a healthy population, and alleviate health inequities. Any health reform should ensure coverage of screening for unmet physical, behavioral, and health-related social needs, such as food security and housing stability.
- **Health care must incorporate effective, culturally and linguistically competent, and accessible communication services.** Individuals must have access to free and funded language services to ensure effective communication with their providers. In addition, the system must ensure that all individuals receive effective, accessible, understandable, and respectful care provided in a manner compatible with their cultural beliefs, practices, preferred language, with any other

¹⁶ See League of United Latin Am. Citizens, *The Medicaid Funding Cliff in Puerto Rico* (Sep. 30, 2026); Angélica V. Marrero Sánchez, *The Cost of Uncertainty: Medicaid in Puerto Rico and the Gaps in Federal Funding*, Espacios Abiertos (Sep. 2026), https://espaciosabiertos.org/wp-content/uploads/The_Cost_of_Uncertainty_Medicaid_PR_EN_09.14.2026_1200-1.pdf.

necessary communication services or auxiliary aids and services. As part of these efforts, proposals must adopt strategies to recruit, retain, and promote a diverse staff representative of the service area and must ensure that providers and other relevant staff receive ongoing training in the delivery of culturally and linguistically appropriate services and accommodations for individuals with disabilities.

- **Health care must incorporate reproductive justice principles.** The reproductive justice framework, developed by Black women, recognizes that reproductive autonomy depends on more than just reproductive rights. It encompasses the human rights to bodily autonomy and to have children, not have children, and to parent in safe and healthy communities with dignity and support. It recognizes that exercising these rights requires the economic, social, and political resources necessary to make meaningful decisions about one's body, health, family, and future. Aligning health care with reproductive justice necessitates unimpeded access to truly comprehensive and full-spectrum sexual and reproductive care.¹⁷

III. Cost-sharing protections must mirror or include pre-OBBBA Medicaid.

Health care must be affordable for everyone. Cost-sharing, deductibles, and premiums create burdens that can cause low-income individuals and families to delay or forego care.¹⁸ Cost-sharing must also provide protections for people with disabilities, those with chronic conditions, and others who may have heightened health care needs. If cost-sharing and premiums are imposed, they should be limited to higher income populations and must be reasonable and predictable for both individuals and families. Burdens such as these should be non-existent or nominal for low-income people.

Under Medicaid rules, out-of-pocket costs are generally restricted to nominal amounts for people under the poverty line. States may impose slightly higher cost-sharing on individuals with income above the poverty line, with a maximum out-of-pocket expense limit at 5% of monthly or quarterly income. Under OBBBA, states now face an unprecedented mandate to apply cost-sharing to expansion enrollees with incomes

¹⁷ We recommend the following reproductive justice resources as additional resources to utilize during the course of your ongoing health reform efforts: [Reproductive Justice Principles for Universal Health Reform](#); [NHeLP Principles on Assisted Reproduction](#); [Data Privacy & Reproductive Freedom](#).

¹⁸ Eve Roberts et al., *Consequences of Health Insurance Cost Sharing Among Low-Income Medicare Beneficiaries: Evidence from benefit Cliffs in Medicaid and Medicare's Prescription Drug Subsidy Program*, 55 HEALTH SERV RES. 98 (Aug. 2020), <https://pmc.ncbi.nlm.nih.gov/articles/PMC7440584/>. See also Dave Macheldt & Jane Perkins, *Medicaid Premiums and Cost Sharing*, Nat'l Health Law Prog. (Mar. 25, 2014), <https://healthlaw.org/resource/medicaid-premiums-and-cost-sharing/>.

above the poverty line. Expansion enrollees and expansion enrollees who are older and have more chronic conditions than younger, healthy enrollees in this income bracket, will likely have higher out-of-pocket costs under the new rules.¹⁹ Congress should at least restore states' flexibility to not impose cost-sharing, if not mandate lower cost-sharing for people at lower income levels.

Many Medicaid cost-sharing protections should remain or be expanded under any health reform. For example, Medicaid caps household out-of-pocket costs (cost-sharing + premiums) at 5% of aggregate quarterly or monthly income. This aligns health care costs with an individual's real ability to pay and protects people from financial ruin if they ever need a major health care intervention.²⁰ By legally preventing out-of-pocket expenses from rising past this relative threshold, Medicaid rules effectively eliminated the threat of extreme medical debt and bankruptcy for vulnerable households while ensuring that nominal fees never became insurmountable barriers to care. This kind of cap could be extended to other programs or incorporated into a universal health care proposal. States should retain the flexibility to completely waive cost-sharing. Transitioning these specific consumer protections into a universal system would improve equitable access, protect low-income families from disproportionate financial strain, and maintain a compassionate, health-first approach to national coverage.

IV. Prior authorization should be eliminated or severely restricted and regulated in future health reforms.

Prior authorization consistently reduces access to care, denies and delays medically necessary services, and creates costly administrative burdens on patients and providers.²¹ While intended to control costs and promote "appropriate" care, prior authorization represents one of the biggest barriers to timely treatment and one of the largest administrative hurdles in health care. For managed care organizations (MCOs) and other payers, creating barriers and denying care is an effective business model

¹⁹ Priya Chidambaram & Jennifer Tolbert, *Utilization of Health Care Services by Medicaid Expansion Status*, KFF (May 28, 2025), <https://www.kff.org/medicaid/utilization-of-health-care-services-by-medicaid-expansion-status/>.

See also, Jennifer Tolbert & Priya Chidambaram, *Cost Sharing Requirements Could Have Implications for Medicaid Expansion Enrollees With Higher Health Care Needs*, KFF (June 27, 2025), <https://www.kff.org/medicaid/cost-sharing-requirements-could-have-implications-for-medicaid-expansion-enrollees-with-higher-health-care-needs/>.

²⁰ KFF, *Health Provisions in the 2025 Federal Budget Reconciliation Law* (Aug. 22, 2025), <https://www.kff.org/medicaid/health-provisions-in-the-2025-federal-budget-reconciliation-law/>.

²¹ Medicaid & CHIP Payment & Access Comm'n (MACPAC), *Prior Authorization in Medicaid* (Aug. 1, 2024), <https://www.macpac.gov/publication/prior-authorization-in-medicaid-2/>.

designed to cut costs and maximize revenue, where patients and providers get worn down amid seemingly endless reviews and documentation requests.

Enrollees often wait weeks for decisions, including approvals, even if urgent care is needed, or they receive denials that are confusing and hard to appeal.²² The burden of prior authorization processes disproportionately affects Medicaid beneficiaries, low-income BIPOC, underserved communities, and people with disabilities.²³ The harm from these delays cannot be overstated; for many patients, they are deadly.²⁴

In January 2024, the Centers for Medicare & Medicaid Services (CMS) published the “Interoperability and Prior Authorization Final Rule” and recently filed a Notice of Proposed Rulemaking to expand the requirement to prescription drugs.²⁵ The 2024 rule represents a significant first step toward reforming prior authorization but key protections like meaningful, disaggregated public reporting, defined and protected appeals processes, active audits, and continuity of care protections are still needed.²⁶

Voluntary industry regulation has not proven successful. In 2025, America’s Health Insurance Plans (AHIP), the national trade association representing the health insurance industry, and the Blue Cross Blue Shield Association announced a set of “voluntary commitments” to “streamline” prior authorization and “improve patient outcomes.”²⁷ Most of these commitments were not new — the 2024 rule already required payers to take most of these actions. They were also duplicative of the failed promises that many of these corporations made in 2018 and again in 2023.²⁸ At the

²² *Id.* at 1–3.

²³ Brit Vanneman, *Prior Authorization in Medicaid Issue Brief #1: Prior Authorization and the Critical Need for Reform*, Nat’l Health Law Prog. (Nov. 2025), https://healthlaw.org/wp-content/uploads/2025/11/Vanneman_Prior-Auth-Issue-Brief-1_11242025.pdf; Ass’n of Black Cardiologists, *Identifying How Prior Authorization Impacts Treatment of Underserved and Minority Patients* (Feb. 2019); T. Christian Miller, Patrick Rucker, & David Armstrong, *Not Medically Necessary: Inside the Company Helping America’s Biggest Health Insurers Deny Coverage for Care*, PROPUBLICA (Oct. 23, 2024), <https://www.propublica.org/article/evicore-health-insurance-denials-cigna-unitedhealthcare-aetna-prior-authorizations/>.

²⁴ Vanneman, *supra* note 23; Miller, Rucker, & Armstrong, *supra* note 23.

²⁵ Medicare & Medicaid Programs: Patient Protection and Affordable Care Act; Advancing Interoperability and Improving Prior Authorization Processes, 89 Fed. Reg. 8,534 (Feb. 8, 2024).

²⁶ Brit Vanneman, *Prior Authorization in Medicaid Issue Brief #2: Federal Oversight of Prior Authorization*, Nat’l Health Law Prog. (Nov. 2025), https://healthlaw.org/wp-content/uploads/2025/12/Vanneman_NHeLP_Prior-Auth-Issue-Brief-2_12.10.2025-1.pdf.

²⁷ Am. Health Ins. Plans, *Health Plans Take Action to Simplify Prior Authorization* (June 23, 2025), <https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization>.

²⁸ See Am. Med. Ass’n et. al., *Consensus Statement on Improving the Prior Authorization Process* (Jan. 18, 2018), <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf>; Berkeley Lovelace Jr., *Health Insurers Promise*

time, they vowed to reduce prior authorization and increase transparency. But without any enforcement, those promises went nowhere and the volume of prior authorization increased.²⁹ An industry that stands to profit from less oversight and more denials should not be left to regulate itself.

A. Banning Prior Authorization

We remain skeptical of prior authorization's value as a utilization management and care coordination tool. One recent study estimated a near total ban on prior authorization could save more than \$32 billion per year in provider administrative costs and would reduce poor outcomes due to delayed care.³⁰ It notes that 9 out of 10 surveyed physicians reported that prior authorization leads to increased, not decreased, utilization.³¹ Another study of prescription drugs argues for a "deescalation of utilization management" after calculating that the burden of establishing, processing, navigating, and contesting utilization management structures increased total costs on payers, manufacturers, providers, and patients by \$93.3 billion annually.³²

An alternative approach is to ban the use of prior authorization for certain services and medications. Several states have already taken steps down this path. Minnesota prohibits the use of prior authorization for certain categories of services:

- Emergency services;
- Outpatient mental health treatment or outpatient SUD treatment, except medication used (though we would recommend all medication, including for medications for opioid use disorders);
- Services with an A or B rating from the United States Preventive Task Force;
- Immunizations recommended by the Centers for Disease Control and Prevention;

Changes to Prior Authorization Process — What to Know, NBC NEWS (June 23, 2025), <https://www.nbcnews.com/health/health-news/kennedy-says-health-insurers-promise-changeprior-authorization-proces-rcna214515/>; Brit Vanneman, *Voluntary Industry Prior Authorization Commitments: Empty Promises, Little Accountability*, Nat'l Health Law Prog. (July 8, 2025), <https://healthlaw.org/voluntary-industry-prior-authorization-commitments-empty-promises-little-accountability/>.

²⁹ See Andis Robeznieks, *In 2018 Payers Agreed to Rein in Prior Auth. The Clock is Ticking*, Am. Med. Ass'n (June 10, 2022), <https://www.ama-assn.org/practice-management/prior-authorization/2018-payers-agreed-rein-prior-auth-clock-ticking>; Am. Med. Ass'n, 2024 AMA Prior Authorization Physician Survey (2024), <https://fixpriorauth.org/2024-ama-prior-authorization-physician-survey>.

³⁰ Hannah Garden-Moheit & Emma Freer, *Ban Prior Authorization: Ending Big Medicine's Strategy to Boost Profits by Denying Medically Necessary Care*, Economic Liberties Project (Aug. 2026), <https://www.economicliberties.us/our-work/ban-prior-auth/>.

³¹ *Id.* at 6.

³² Scott Howell et al., *Quantifying the Economic Burden of Drug Utilization Management on Payers, Manufacturers, Physicians, and Patients*, 40 HEALTH AFF. 1206 (2021).

- Preventive services and screening provided to women;
- Antineoplastic cancer treatment; and
- Pediatric hospice services (among others).³³

In addition to these services, we support restrictions on prior authorization for:

- treatment recommended by a primary care physician;
- mobile response and stabilization services;
- HIV medications;
- treatment and medications for chronic conditions and cancers;
- screening services (among others).

It is not enough to simply look at the services and medications where prior authorization is usually granted — regulators must identify services where people need urgent access to care, where consistent care is needed over a long period of time, and where the most unnecessary delays and denials occur.

No matter the approach, Medicaid’s standard protections for beneficiaries must be maintained and, ideally, expanded to all beneficiaries of insurance. For example, Medicaid EPSDT benefit for youth helps prevent unnecessary prior authorization delays and denials by requiring states to cover any medically necessary service that could be covered under the Medicaid state plan, using a standard for medical necessity appropriate for this age group.³⁴ A state or MCO may allow prior authorization to determine medical necessity, but it cannot deny or delay the services for youth. Federal oversight could — in theory — follow the same approach. Of note, prior authorization may not be used to deny EPSDT screening services for children and youth.

B. Other Policy Solutions and Transparency Measures

The RFI requests information on policies to resolve issues with prior authorization — including gold carding, shifting burdens to insurers, standardizing requirements to increase transparency, and time restrictions. We remain skeptical of some of these policies as long-term policy solutions, particularly gold carding. In general, they may work best when combined with categorical bans and strict transparency requirements. For example, exemptions for providers with a history of high approval rates (“gold carding”), can lead to inequitable access to services by favoring certain providers, while leaving the larger issues with prior authorization in place.

³³ Minn. Stat. § 62M.07, Subd. 2. (2025), <https://www.revisor.mn.gov/statutes/cite/62M.07>.

³⁴ 42 U.S.C. § 1396d(r)(5).

When prior authorization is used, the process should be as transparent, efficient, and simple as possible to ensure it does not cause unnecessary delay or wrongful denials. Federal requirements that payers post their clinical guidelines and clearly state what supporting documentation is required for an approval must be enforced.³⁵ As required by federal law, notice of decisions must clearly describe the process, the timing, and most importantly, the specific justifications for any decisions and the steps beneficiaries need to take if they would like to appeal an adverse decision. Beneficiaries have clear rights when it comes to appealing denials and delays.

Federal regulations require, or will soon require plans to post information including: the services that are subject to prior authorization; criteria used for prior authorization decisions; and data on approvals, denials, appeals, and reversal rates. This information should be available to enrollees and potential enrollees at the time of plan selection. Unfortunately, data on approval and denial rates is currently reported in the aggregate, which can mask prior authorization abuses for less common services. Instead, prior authorization outcomes should be reported by service type as well.

Clinical coverage criteria for determining medical necessity and how that criteria is applied must be transparent and consistent with generally accepted standards of care. To prevent improper denials, or at least make them easier to remedy, all payers should be clear about what their clinical criteria are and how they are applied. Regulators (the federal government) should regularly audit samples of prior authorization decisions and conduct reliability tests to ensure reviewers' decisions are consistent with clinical guidelines and consistent over time.

Moreover, transparency in the age of artificial intelligence (AI) requires reliability tests to ensure that reviewers' decisions are consistent with clinical guidelines and consistent over time. AI cannot replace the crucial function of an individualized clinical review. Even where human reviewers nominally make decisions about denials, many payers still exploit loopholes or ambiguities to rely on AI. They may use reviewers who are not in the same field/specialty of practice as the requesting clinician. The human decision maker may not have an active license to practice medicine. Most AI systems select, summarize, or prioritize information, so human reviewers may only see what the system surfaces. In these circumstances, human decision makers are also more likely to defer

³⁵ 42 C.F.R. § 431.80(b).

to AI-generated recommendations, a phenomenon known as automation bias.³⁶ Compounded by time pressure to process requests in mere seconds to a couple minutes, human review can become a rubber stamp and not a meaningful safeguard.³⁷

C. Medicaid's Due Process Protections and Medicare's Third-Party Review

One of the most important features of the Medicaid program is the right to due process. The Medicaid Act guarantees applicants and beneficiaries the opportunity for a hearing when a claim is not denied or not acted on with reasonable promptness.³⁸ In addition, the Supreme Court has long recognized that the Due Process Clause of the U.S. Constitution entitles individuals to prior notice as well as a hearing when an individual is in jeopardy of losing publicly-funded medical care.³⁹ The Supreme Court's decision in *Goldberg v. Kelly* places a number of requirements on the Medicaid termination process, including the right to timely notice from the agency stating the basis for the proposed termination.⁴⁰ To this end, HHS has required that Medicaid notices be in writing and contain "a statement of action the State" intends to take, a "clear statement" of the specific reasons supporting the intended action, and the regulations supporting the decision.⁴¹ The same is true for any delay or denial of treatment caused by prior authorization, as regulations make clear, and must be protected.

Medicaid law also guarantees beneficiaries timely and adequate notice, clear and specific reasons for adverse actions, meaningful opportunities to appeal, and an opportunity to receive continued benefits as an appeal is reviewed. Any adjudicated authorization decision should specify the reason, which must be based on ascertainable standards that include sufficient supporting documentation to understand the basis for reaching that decision.⁴²

³⁶ See, e.g., Kate Goddard, Abdul Roudsari, & Jeremy C. Wyatt, *Automation Bias: A Systematic Review of Frequency, Effect Mediators, and Mitigators*, 19 J. AM. MED. INFORM. ASS'N 121 (2012), <https://pmc.ncbi.nlm.nih.gov/articles/PMC3240751/>.

³⁷ Patrick Rucker, *A Doctor at Cigna Said Her Bosses Pressured Her to Review Patients' Cases Too Quickly. Cigna Threatened to Fire Her*, PROPUBLICA (Apr. 29, 2024), <https://www.propublica.org/article/cigna-medical-director-doctor-patient-preapproval-denials-insurance>.

³⁸ 42 U.S.C. § 1396a(a)(3).

³⁹ *Goldberg v. Kelly*, 397 U.S. 254 (1970); U.S. Const. amend. XIV, § 1.

⁴⁰ 397 U.S. at 269–71.

⁴¹ 42 C.F.R. §§ 431.206(b), 431.210(a)-(c). See also *Strouchler v. Shah*, 891 F. Supp. 2d 504 (S.D.N.Y. 2012); *Ortiz v. Eichler*, 616 F. Supp. 1046, 1062 (D. Del. 1985) ("Fundamental due process requires that a person be informed in advance of the issues to be addressed at a hearing, so that he or she can be prepared to present evidence and arguments that address those issues.").

⁴² Jane Perkins, *Demanding Ascertainable Standards: Medicaid as a Case Study*, Nat'l Health Law Prog. (2016), <https://healthlaw.org/resource/demanding-ascertainable-standards-medicare-as-a-case-study/>.

These protections are crucial for ensuring individuals understand the role of prior authorization and the necessary steps to appeal wrongful denials or delays. In addition to these due process requirements, we recommend that oversight include independent external medical review when an appeal is denied to the greatest extent possible. This is done automatically for Medicare enrollees and serves to protect Medicare beneficiaries from biased decisionmakers.⁴³ All of these protections and rights should attach to prior authorization decisions, regardless of payer.

In conclusion, we believe that reforms should rein in prior authorization as it exists today and we question whether it even has a place in a fair and equitable health care system. The abuses often overshadow the benefits, and the costs are far too high.

V. Any effort to move toward a universal coverage model should consider the key role of quality improvement and oversight.

At its base, accountability is about how we make sure that a MCO (or another payer) is doing what it has agreed to do under its contract or by law. Capitated managed care — where insurers receive a fixed per member, per month fee for each enrollee regardless of which or how many services that individual might use — can create financial incentives where insurers make more money if they provide fewer services. This financial structure increases the importance of robust accountability systems in managed care. Without effective accountability measures, the financial incentive might lead to wrongful denials of care, inadequate networks, and other access issues. Through enforcement or incentives, states can use accountability tools to compel plans to do better.

Performance measures and signed assurances are the predominant approaches to oversight in Medicaid today. But alone these tools will never be enough to hold plans accountable to program standards. Desk reviews also fall short. Quality measures and other performance metrics have their place, but the most consistent way to reveal problems or see how well systems actually work, is to look behind the words on a paper. In rulemaking, CMS has referred to this kind of approach as “direct testing.”

Secret shopper surveys are among the best-known direct testing methods and CMS has recognized their value by implementing required reporting of secret shopper surveys to validate federal wait time standards for different provider groups in both Medicaid and the Marketplace. This approach tracks with the actual experience beneficiaries have

⁴³ *Id.*

when trying to access care. We have written on the importance of transparency and the need to standardize the methodology for conducting the surveys in Medicaid managed care.⁴⁴ This kind of approach can effectively complement time and distance standards for oversight of plan network adequacy. Moreover, secret shopper methodologies can easily expand to test equity in health care access, such as by using call scripts testing access for people with disabilities or people with limited English proficiency.⁴⁵

Research continues to uncover the value of direct testing of provider networks to expose errors in provider directories. They have also produced evidence of “ghost” providers that see few or no Medicaid patients or show up in plans’ submitted networks but not at all in their provider directories.⁴⁶ Efforts to design effective oversight of managed care in both public and private insurance should include similar approaches. Required secret shopper surveys rolled out in Marketplace plans in 2025. Medicaid will follow suit in 2028. However, recent regulatory changes have started to undermine these requirements. The results from 2025 Marketplace secret shopper surveys have never been posted, and the recently finalized federal rules scaled back the requirement for some states to conduct these annual oversight activities.⁴⁷

Efforts to expand health care coverage and access should lean into this kind of network adequacy analysis. The key elements will be to maintain reporting transparency, find mechanisms to tie oversight to effective enforcement, and adapt these methodologies to identify and reduce disparities in access to care geographically and demographically.

Direct testing can also strengthen oversight in other areas related to accessing timely health services. Recent investigations on Medicaid and Medicare Advantage from the

⁴⁴ David Machledt & Michelle Yiu, *Best Practices for Medicaid Secret Shopper Survey Implementation*, Nat’l Health Law Prog. (Jan. 2025), <https://healthlaw.org/resource/best-practices-for-medicaid-secret-shopper-survey-implementation/>.

⁴⁵ Esmeralda Melgoza et al., *A Qualitative Mystery Shopper Study That De(Codes) the Experiences of English and Spanish-Speaking Patients Who Call to Schedule a First-Time Primary Care Appointment in the Los Angeles, Houston, and New York Metropolitan Statistical Areas*, 7 QUALITATIVE RESEARCH IN HEALTH 100525 (2025), <https://pubmed.ncbi.nlm.nih.gov/42137884/>.

⁴⁶ HHS Off. Inspector Gen. (HHS OIG), *Inaccurate Medicaid Managed Care Network Lists May Compromise State Oversight of Access to Maternal Health Care* (June 2026), <https://oig.hhs.gov/reports/all/2026/inaccurate-medicaid-managed-care-network-lists-may-compromise-state-oversight-of-access-to-maternal-health-care/>; Jane M. Zhu et al., ‘Ghost’ Physicians: More Than One-Quarter Of Physicians Enrolled In Medicaid Delivered No Care To Beneficiaries In 2021, 45 HEALTH AFF. 129; Abigail Burman, *Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories*, 40 YALE LAW & POL’Y REV. 78 (2021).

⁴⁷ Nat’l Health Law Prog., *NHeLP Comments on 2027 Notice of Benefit & Payment Parameter NPRM*, 32-34 (Mar. 12, 2026) [hereinafter “NHeLP 2027 NBPP Comments”] <https://healthlaw.org/resource/nhelp-comments-on-2027-notice-of-benefit-payment-parameter-nprm/>.

HHS' Office of Inspector General (OIG) have demonstrated the efficacy of another form of direct testing: auditing plan prior authorization decisions.⁴⁸ This methodology, which OIG recommends all states integrate into their accountability systems, has uncovered the misapplication of clinical criteria for medical necessity as well as evidence of systemic denials in both Medicaid and Medicare.⁴⁹ Such audits represent an important component to a multi-method accountability framework that can support patient access.

Publicly reported core measure sets certainly should continue to play a role in any health care accountability framework, but not to the exclusion of other approaches. Measure selection should prioritize improving health outcomes but also focus on items that produce actionable data and center patient experience of care. One drawback of current core measures is the often-long lag time between data collection and data reporting. Designing systems to reduce that reporting lag makes data more relevant and actionable. Consistently tracking measures over time is also important. One of the undersung elements of Medicaid External Quality Review (EQR) requires each annual report to provide recommendations for improvement for each plan, and to report on how plans have addressed prior recommendations and performance improvement projects. If taken seriously, these components can be very revealing of how plans perform over time. Finally, health care quality measures should track health disparities and statutory language should prioritize reducing disparities over time as a goal of quality improvement. During the last administration, CMS finalized regulations to require stratified reporting of core measures over time, but those efforts have been seriously undermined. Health care access is often most challenging for underserved populations, and effective oversight needs to be able to identify those gaps.⁵⁰

Alongside recurring reporting on things like core quality measures, we need other systems that more effectively address short-term, real-time changes to fix systemic issues. One example could be having a beneficiary support system that aggregates recurring individual problems and reports them up the chain. We have described such a system that did so effectively in North Carolina.⁵¹ Other types of qualitative approaches,

⁴⁸ Christi A. Grimm, *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care*, HHS OIG (July 2023), <https://oig.hhs.gov/reports/all/2023/high-rates-of-prior-authorization-denials-by-some-plans-and-limited-state-oversight-raise-concerns-about-access-to-care-in-medicaid-managed-care/>.

⁴⁹ *Id.*; HHS OIG, *Keystone First Should Improve Its Procedures for Reviewing Service Requests That Require Prior Authorization* (Dec. 20, 2022), <https://www.oversight.gov/sites/default/files/documents/reports/2023-01/32000201.pdf>.

⁵⁰ David Machledt, *Addressing Health Equity in Medicaid Managed Care*, Nat'l Health Law Prog., (May 2021), <https://healthlaw.org/resource/addressing-health-equity-in-medicaid-managed-care/>.

⁵¹ Miriam Delaney Heard, Elizabeth Edwards, & David Machledt, *The NC Medicaid Managed Care Ombudsman: A Robust and Effective Beneficiary Support System*, Nat'l Health Law Prog. (Mar. 31, 2026),

such as site visits, can complement audits and quality metrics to provide context for how health care is delivered in real time.

Transparency and public reporting are foundational to effective oversight, but public posting of findings is just step one. There are hundreds of Medicaid EQR reports posted annually that barely get cracked open, and using the data there to tell a meaningful story about compliance can be really challenging. CMS has acknowledged this and is working to reformat EQR reports to make them easier to read. Ideally, transparently reported quality and oversight data could also become an effective tool individuals and families can use to guide their choice of MCO. However, this goal requires not only timely, transparent reporting but also clear, plain language explanations of what quality data shows about patient care and access.

The last and perhaps most important step in an effective accountability system is enforcement. Various reports of managed care oversight in Medicaid and other health programs suggest that simply identifying examples of non-compliance is not enough.⁵² Monetary sanctions have often been too small to incentivize behavior change, though some states have levied larger fines in recent years.⁵³ California recently issued temporary funding withholds for 10 behavioral health plans that failed to meet the state's network adequacy standards.⁵⁴ Identifying enforcement mechanisms that can drive quality improvement will be a key component of successful health reform efforts.

VI. In the more immediate term, health reforms should focus on strengthening access to services in the private Marketplace.

Any plan for health reform should immediately take action to mitigate and reverse the damage that recent administrative actions have done to the ACA Marketplace. The current administration has "engaged in numerous legislative and regulatory efforts that have made health care coverage "more expensive" and "less comprehensive," and

<https://healthlaw.org/resource/the-nc-medicaid-managed-care-ombudsman-a-robust-and-effective-beneficiary-support-system/>.

⁵² Max Blau, *State Regulators Know Health Insurance Directories Are Full of Wrong Information. They're Doing Little to Fix It.*, PROPUBLICA (Nov. 14, 2024), <https://www.propublica.org/article/ghost-networks-health-insurance-regulators>.

⁵³ Dan Young, *Lessons Learned from North Carolina's MCPAR Reports*, Nat'l Health Law Prog. (Mar. 26, 2026), <https://healthlaw.org/resource/lessons-learned-from-north-carolinas-mcpar-reports/>; Daniel Young, *Revisiting Managed Care Sanctions*, Nat'l Health Law Prog. (July 30, 2025), <https://healthlaw.org/resource/revisiting-managed-care-sanctions/>.

⁵⁴ Dep't of Health Care Servs., *California Takes Action to Improve Timely Access to Behavioral Health Care* (Aug. 12, 2026), <https://www.dhcs.ca.gov/news/california-takes-action-to-improve-timely-access-to-behavioral-health-care/>.

which “seriously undermine and destabilize the health insurance market.”⁵⁵ Enrollment is down, costs are up, and the spiral shows no signs of stopping under current conditions.⁵⁶ However, strengthening EHB standards, heavily regulating “junk insurance” products, and promoting plan standardization are all strategies that can strengthen the ACA Marketplace and reinforce its ability to provide broad access to high-quality, affordable health care.

A. Strengthening EHB standards to support affordability, access to coverage, and market stability

Strong EHB standards make health care more care affordable. Before the ACA established the concept of EHBs and related coverage requirements, most individual health insurance plans did not cover maternity care, and a significant minority did not cover any mental health or substance use disorder (SUD) services.⁵⁷ Of course, people still needed these services, but because they were not subject to coverage requirements, people would have to pay for the full service out-of-pocket.⁵⁸ Further, many of the financial protections for Marketplace enrollees and individuals in large group plans covering EHBs — such as bans on dollar limits, caps on annual out-of-pocket costs, and the use of premium tax credits — only apply to EHBs.⁵⁹

⁵⁵ *NHeLP 2027 NBPP Comments*, *supra* note 47; Shannon Schumacher et al., *KFF Health Tracking Poll: Health Care Costs, Expiring ACA Tax Credits, and the 2026 Midterms*, KFF (Jan. 29, 2026), <https://www.kff.org/public-opinion/kff-health-tracking-poll-health-care-costs-expiring-aca-tax-credits-and-the-2026-midterms/>.

⁵⁶ See Matt McGough et al., *How Much and Why ACA Marketplace Premiums Are Going Up in 2027*, KFF (Aug. 3, 2026), <https://www.kff.org/affordable-care-act/how-much-and-why-aca-marketplace-premiums-are-going-up-in-2027/> (early rate filings show that payers are proposing a median premium increase of 15% in 2027); see also 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/> (finding that ACA Marketplace enrollment was down about 17% by mid-2026, premium costs had increased, and deductibles had reached a record high).

⁵⁷ See, e.g., Michelle Lilienfeld & Héctor Hernández-Delgado., *Detrimental Effects of Allowing the States to Waive the Essential Health Benefits*, Nat’l Health Law Prog. (2017), <https://healthlaw.org/resource/detrimental-effects-of-allowing-states-to-waive-the-essential-health-benefits/>.

⁵⁸ See, e.g., Jesse C. Baumgartner, Gabriella N. Aboulafia, & Audrey McIntosh, *supra* note 7 (high cost of and difficulty accessing mental health care pre-ACA); Sarah Lueck, *Pre-ACA Health Insurance Market Isn’t Worth Returning To*, Ctr. on Budget & Pol’y Priorities (Mar. 24, 2017), <https://www.cbpp.org/blog/pre-aca-health-insurance-market-isnt-worth-returning-to> (high cost and gaps in coverage of prescription drugs pre-ACA); Elisabeth Rosenthal, *American Way of Birth, Costliest in the World*, N.Y. TIMES (June 30, 2013), <https://www.nytimes.com/2013/07/01/health/american-way-of-birth-costliest-in-the-world.html?hp> (high cost of maternity care pre-ACA).

⁵⁹ 42 U.S.C. §§ 300gg-11, 18022(c); 45 C.F.R. § 147.126.

Robust coverage of EHBs also generally improves access to primary and preventive care. Increased access to cost-free preventive care reduces the likelihood of health complications down the line.⁶⁰ For instance, after making cuts to Medicaid preventive oral health services for adults, the Idaho legislature conducted a fiscal analysis and found that providing adult dental care would result in \$2.5 million in cost savings from reduced emergency department visits and hospitalizations.⁶¹ Additionally, lawmakers found that providing adult dental coverage in Medicaid reduces treatment costs for conditions resulting from or worsened by lack of access to preventive oral health care, such as diabetes, cardiovascular disease, pneumonia, and dementia.⁶²

Strong EHB standards also promote standardization and market stability. When payers cannot “cherry-pick healthier consumers and exclude high risk patients” by offering narrower coverage, they are disincentivized from the type of “race[s] to the bottom” that were common prior to the ACA.⁶³ When coverage minimums are strong, all consumers have the power to choose; individuals in need of a higher level of services are not forced into the smaller number of plans that may still offer them.⁶⁴ This keeps the risk pool stable, which helps keep costs low and enhances access to care for everyone.⁶⁵ It also upholds the ACA’s fundamental “single risk pool” concept — another

⁶⁰ Cf. 82 Fed. Reg. 51052, 51131 (Nov. 2, 2017) (recognizing that weakening EHB coverage standards can risk “spillover effects” such as increased use of emergency services); see also HHS, Assistant Sec’y for Planning & Evaluation, *Access to Preventive Services without Cost-Sharing: Evidence from the Affordable Care Act* 10 (2022), <https://aspe.hhs.gov/sites/default/files/documents/786fa55a84e7e3833961933124d70dd2/preventive-services-ib-2022.pdf> (discussing how access to preventive services can facilitate earlier detection and treatment of chronic conditions like hypertension and diabetes).

⁶¹ See Betsy Z. Russell, *Idaho House Narrowly Approves Restoring Non-Emergency Medicaid Dental Benefits*, SPOKESMAN-REVIEW (Feb. 12, 2018), <https://www.spokesman.com/stories/2018/feb/12/idaho-house-narrowly-approves-restoring-non-emerge/>.

⁶² IDAHO CODE § 56-255 (2025); HB 465 Statement of Purpose and Fiscal Note (July 1, 2018), <https://legislature.idaho.gov/wp-content/uploads/sessioninfo/2018/legislation/H0465SOP.pdf>.

⁶³ Charley E. Willison & Phillip M. Singer, *Repealing the Affordable Care Act Essential Health Benefits: Threats and Obstacles*, 107 AJPH PERSPS. 1225, 1226 (2017), <https://pmc.ncbi.nlm.nih.gov/articles/PMC5508159/pdf/AJPH.2017.303888.pdf>; see also Frank Lalli, *The Health Care Law’s 10 Essential Benefits*, AARP MAG. (Aug./Sep. 2013), <https://web.archive.org/web/20130824144349/https://www.aarp.org/health/health-insurance/info-08-2013/affordable-care-act-health-benefits.html>.

⁶⁴ See, e.g., Craig Hanna & Cori Uccello, Am. Acad. of Actuaries, *How Changes to Health Insurance Market Rules Would Affect Risk Adjustment* (2017), <https://actuary.org/how-changes-to-health-insurance-market-rules-would-affect-risk-adjustment/> (“[i]f health plans are allowed to offer major categories of benefits...as an optional benefit or have the ability to place internal limits on them, enrollees needing the benefits will enroll in plans covering those benefits without limitations”).

⁶⁵ See, e.g., Am. Acad. of Actuaries, *ARCHIVED — Risk Pooling: How Health Insurance in the Individual Market Works* (2023), <https://actuary.org/wp-content/uploads/2017/11/RiskPoolingFAQ071417.pdf>.

key feature that limits the risk of runaway costs for people with higher health care utilization needs.⁶⁶

We recommend, as we have previously, the establishment of robust federal definitions for all EHB categories and treating these definitions as a floor upon which states can build.⁶⁷ The current benchmarking approach provides states with needed flexibility to address local and regional health needs. States have used benchmarking to mount tailored responses to the opioid crisis, expand access to fertility care, and strengthen preventive services.⁶⁸ States should have the latitude to expand benefits packages in order to improve upon the national standard or account for local needs without having to defray the costs, but the national standard must provide a strong foundation upon which states may build. In particular, we emphasize the need for strong minimum coverage requirements in the areas of behavioral health, rehabilitative and habilitative services, maternity care, and chronic disease management.⁶⁹

To further strengthen EHB coverage, we also recommend the following actions geared toward providing states with the flexibility and resources they need to meaningfully undertake the benchmarking process:

- **HHS should reinstate prompt reviews of pending EHB benchmark updates** to ensure that states can continue to expand benefits to meet the needs of their residents and improve health outcomes and overall quality of life within their states without having to defray the costs of additional benefits.⁷⁰
- **HHS should restore EHB Benchmark Modernization grants** so that states have more resources to evaluate their benchmark plans for needed changes and adhere to federal actuarial requirements when making changes.⁷¹

⁶⁶ 42 U.S.C § 18032(c); 45 C.F.R. § 156.80; *see also* Mandy Spears, Sycamore Inst., *How Changes to Essential Health Benefits Could Affect Tennessee* (2017), <https://sycamoretn.org/changes-essential-health-benefits-tennessee/> (commenting that “[s]tandardizing benefits limits the potential for segmented risk pools”).

⁶⁷ Nat’l Health Law Prog., *Comments on Request for Information; Comprehensive Review of the Essential Health Benefits Framework and Typical Employer Plan Standard* 10 (July 15, 2026), <https://healthlaw.org/resource/nhelp-comments-on-essential-health-benefits-ehb-rfi/> [hereinafter “NHeLP EHB RFI Comments”]; Wayne Turner et al., *NHeLP Letter to HHS Sec. Becerra - Re: Advancing Health Equity Through Essential Health Benefits*, Nat’l Health Law Prog. (Dec. 6, 2021), <https://healthlaw.org/resource/nhelp-letter-to-hhs-sec-becerra-re-advancing-health-equity-through-essential-health-benefits/>.

⁶⁸ *See NHeLP 2027 NBPP Comments*, *supra* note 47, at 6.

⁶⁹ *NHeLP EHB RFI Comments*, *supra* note 67, at 29–30 (detailing recommendations).

⁷⁰ *Id.* at 11.

⁷¹ *Id.* at 12.

- **HHS should rescind the rule prohibiting states from covering routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, non-medically necessary orthodontia, and specified sex-trait modification procedures.**⁷² These exclusions have no basis in law, restrict states' ability to address the needs of their populations, and are contrary to the best available scientific evidence on the benefits of ensuring access to these services.
- **HHS should end the practice of allowing substitution of benefits,** which permits plans to exclude certain services from coverage that have already been identified as necessary.⁷³

B. Regulating junk insurance to facilitate access to needed health care and improve market stability

"Junk plans" like short-term limited-duration insurance (STLDI), fixed-indemnity plans, and farm bureau plans are bad for consumers. They generally are not subject to the ACA's robust consumer protection provisions, meaning that they can discriminate based on gender and health status, deny coverage for pre-existing conditions, and impose dollar limits on coverage.⁷⁴ Payers offering these plans can retroactively cancel policies following the filing of a claim and place arbitrary restrictions on coverage, like the short-term plan marketed in 13 states that generally excluded coverage for hospital services for patients admitted on a Friday or Saturday.⁷⁵ Additionally, these plans are not required to cover the 10 EHBs, so they generally do not offer comprehensive

⁷² 45 C.F.R. § 156.115(d).

⁷³ *NHeLP EHB RFI Comments*, *supra* note 67, at 31.

⁷⁴ Nat'l Women's L. Ctr., *NWLC Urges HHS to Limit Harmful Junk Insurance* (Sep. 11, 2023), <https://nwlc.org/resource/nwlc-urges-hhs-to-limit-harmful-junk-insurance/>; Jenny Deam, *He Bought Health Insurance for Emergencies. Then He Fell Into a \$33,601 Trap.*, PROPUBLICA (May 8, 2021), <https://www.propublica.org/article/junk-insurance>; Larry Levitt et al., *Why Do Short-Term Health Insurance Plans Have Lower Premiums Than Plans That Comply with the ACA?*, KFF (Oct. 31, 2018), <https://www.kff.org/affordable-care-act/why-do-short-term-health-insurance-plans-have-lower-premiums-than-plans-that-comply-with-the-aca/>.

⁷⁵ Michael Cohen et al., Wakely Consulting Grp., *Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market* 5 (2018), <https://www.communityplans.net/wp-content/uploads/2018/04/Wakely-Short-Term-Limited-Duration-Plans-Report.pdf>; Michael Hiltzik, *The Fine Print of Those Short-Term Health Plans Favored by Trump: Don't Get Sick on a Weekend*, L.A. TIMES (Apr. 26, 2018), <https://www.latimes.com/business/hiltzik/la-fi-hiltzik-short-term-insurance-20180426-story.html>.

coverage.⁷⁶ Finally, although they may tout lower premiums as evidence of their affordability, their out-of-pocket costs are still overall exorbitant.⁷⁷ All told, these plans offer little more than a pale imitation of health insurance that can leave people in the lurch when they are especially vulnerable — for example, when they need health care following an accident or during an illness.

Wider adoption of junk insurance also negatively impacts the health insurance market more broadly. Although these plans offer skimpy coverage, they are comparatively inexpensive.⁷⁸ Of course, this is precisely *because* they are not subject to the ACA's consumer protection rules; the fact that they have the latitude to deny coverage to people with pre-existing conditions, cap benefits, and exclude critical services like prescription drugs and mental health care enables them to offer cheaper — albeit worse — coverage.⁷⁹ Nevertheless, because they are generally cheaper than ACA-compliant coverage, these plans attract younger and healthier consumers, luring them away from the ACA Marketplace, destabilizing the risk pool, and increasing costs for those who remain.⁸⁰ This is not a hypothetical scenario: 2020 rate filings suggested that payers increased premiums between 0.5% and 2% for the 2020 plan year in response to increasing adoption of short-term plans. As these junk plans peel away healthy enrollees, those left behind in the ACA-compliant plans will comprise a smaller and sicker risk pool, thus facing higher costs.⁸¹ The Georgetown University Center on Health Insurance Reform (CHIR) has uncovered strong evidence that agents and brokers are

⁷⁶ See, e.g., Amy Killelea & JoAnn Volk, *The Peddling of "Junk Plans" to Consumers Facing Higher Insurance Premiums*, HEALTH AFF. FOREFRONT (Jan. 16, 2026), <https://www.healthaffairs.org/content/forefront/peddling-junk-plans-consumers-facing-higher-insurance-premiums>.

⁷⁷ For example, in 2026, catastrophic plans had an annual deductible of \$10,600 and some short-term plans had deductibles as high as \$25,000. Geraldine Doetzer, *Buyers Beware: What Marketplace Shoppers Need to Know About Junk Insurance This Year*, Nat'l Health Law Prog. (Oct. 31, 2025), <https://healthlaw.org/buyers-beware-what-marketplace-shoppers-need-to-know-about-junk-insurance-this-year/> (discussing catastrophic plans); Michelle Long et al., *Examining Short-Term Limited Duration Health Plans on the Eve of ACA Marketplace Open Enrollment*, KFF (Oct. 15, 2025), <https://www.kff.org/patient-consumer-protections/examining-short-term-limited-duration-health-plans-on-the-eve-of-aca-marketplace-open-enrollment/> (discussing short-term plans).

⁷⁸ See, e.g., Long et al., *supra* note 77 ("Short-term plans are often marketed as *less expensive* alternatives" to ACA coverage, but they provide "less comprehensive coverage and have fewer consumer protections..."") (emphasis in original).

⁷⁹ See, e.g., Sabrina Corlette, *Administration Takes Action to Limit Junk Health Insurance*, HEALTH AFF. FOREFRONT (July 10, 2023), <https://www.healthaffairs.org/content/forefront/administration-takes-action-limit-junk-health-insurance>.

⁸⁰ See, e.g., Killelea & Volk, *supra* note 76.

⁸¹ See, e.g., Georgetown U. Ctr. on Health Ins. Reforms, *Back in the Day — Lessons from Pre-Reform Days: Death to the Death Spirals* (May 10, 2014), <https://chir.georgetown.edu/back-in-the-day-lessons-from-pre-reform-days-death-to-the-death-spirals-2/> (describing a similar scenario that was common before the ACA).

actively steering “healthy” consumers toward these plans.⁸² Junk plans are also back in the spotlight given Congress’ inability to extend enhanced advanced premium tax credits (ePTCs) that expired at the end of 2025, which has led to skyrocketing premium increases and is driving consumers to seek more affordable alternatives.⁸³

There are a number of interventions that can ameliorate this issue. In 2024, HHS, along with the Departments of Labor and the Treasury, promulgated final rules that placed guardrails on short-term limited duration plans and other non-health insurance products (like hospital indemnity and fixed-indemnity plans); these included limiting the duration of short-term plans and amending notice standards to make it easier to distinguish between junk plans and comprehensive coverage.⁸⁴ The current administration has deprioritized enforcement of this rule, meaning that these products are still widely available and consumers are increasingly turning to them as health care affordability continues to be a challenge.⁸⁵ Renewing reinforcement efforts is an important first step in limiting these plans to their intended purpose — that is, STLDI plans as short-term gap coverage for periods between enrollment in comprehensive coverage and hospital indemnity/fixed-indemnity plans as *supplements* to comprehensive coverage.⁸⁶

Stronger regulation of how short-term plans, fixed-indemnity insurance, health care sharing ministries and farm bureau plans, and catastrophic plans are marketed is also crucial. Misleading marketing of such products has always been a problem, but it has taken on new significance in the wake of current affordability issues.⁸⁷ Unscrupulous

⁸² Amy Killelea, Madison Harden-Stein, & JoAnn Volk, *No Good Options: In the Wake of Marketplace Affordability Woes, Consumers Face Onslaught of Misleading Marketing of Limited Benefits Products*, Georgetown University Ctr. on Health Insurance Reforms (CHIR) (Aug., 2026), <https://georgetown.app.box.com/s/z70ump8w7beinojqf537nk1xvqi2wtkm>.

⁸³ Sarah Kwon, *Cheaper, alternative health plans are having a moment, but critics urge caution*, CBS NEWS (May 20, 2026), <https://www.cbsnews.com/news/aca-health-insurance-alternative-plans-cheaper/>.

⁸⁴ 89 Fed. Reg. 23338 (Apr. 3, 2024); *see also* Ctrs. for Medicare & Medicaid Svcs., *Short-Term, Limited Duration Insurance and Independent, Noncoordinated Excepted Benefits Coverage (CMS-9904-F) Fact Sheet* (Mar. 28, 2024), <https://www.cms.gov/newsroom/fact-sheets/short-term-limited-duration-insurance-and-independent-noncoordinated-excepted-benefits-coverage-cms>.

⁸⁵ *See* Killelea, Harden-Stein, & Volk, *supra* note 82.

⁸⁶ *See, e.g.*, Nat’l Health Law Prog., *Comments on RIN 0938-AU67; Short-Term, Limited Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance 4* (Sep. 7, 2023), <https://healthlaw.org/resource/comments-on-proposed-short-term-limited-duration-insurance-rule/> (discussing the original purpose of STLDI); CMS, *supra* note 84 (“Hospital indemnity and other fixed indemnity insurance has traditionally been used as a form of income replacement upon the occurrence of a health-related event. *It is not a substitute for comprehensive coverage*”) (emphasis added).

⁸⁷ *See, e.g.*, Doetzer, *supra* note 77 (“Open Enrollment has always been a busy time for con artists, who have been known to spoof Healthcare.gov and plaster their websites with ‘Obamacare’ references to trick unwitting consumers”); Killelea & Volk, *supra* note 76, at 1–2.

agents and brokers take advantage of affordability challenges and broader disruptions in the health care system to push their limited-benefit products on underinformed consumers, leading them away from the ACA-compliant coverage that would likely meet their needs far better.⁸⁸ Any limitations on how these products can be marketed should include, at minimum, prohibitions on advertising them as stand-alone coverage and using aggressive sales tactics to scare consumers into purchasing a subpar product.

The most immediate bulwark against wider adoption of junk insurance, however, would be the reinstatement of the ePTCs. The cost of health care is currently a significant source of “economic anxiet[y],” and the expiration of ePTCs only exacerbated the problem for ACA enrollees, with premiums up over 20% in 2026.⁸⁹ Many enrollees have opted for skinnier policies that are cheaper upfront.⁹⁰ Yet, because these plans start paying out much later and cover fewer benefits, enrollees still experience increased cost of care and less access to needed services.⁹¹ Reinstating the ePTCs is the surest way to limit the reach of these impostor products masquerading as health insurance.

C. Promoting plan standardization to enhance consumer choice, improve access to care, and guard against discrimination

Health insurance is a complex product, and research has shown that “people routinely pick bad plans.”⁹² Picking a health insurance plan requires consumers to predict their expected utilization and costs in a given year across a wide number of plans (more than 100 in some cases) with differing cost-sharing structures and provider networks.⁹³ The high number of plans available on the Marketplace engenders confusion among

⁸⁸ Killelea & Volk, *supra* note 76, at 7.

⁸⁹ Shannon Schumacher et al., *KFF Health Tracking Poll: Health Care Costs, Expiring ACA Tax Credits, and the 2026 Midterms*, KFF (Jan. 29, 2026), <https://www.kff.org/public-opinion/kff-health-tracking-poll-health-care-costs-expiring-aca-tax-credits-and-the-2026-midterms/>; John Holihan et al., *Understanding the Extraordinary Increase in ACA Premiums in 2026*, Urban Inst. (2025), https://www.urban.org/sites/default/files/2025-12/Understanding%20the%20Extraordinary%20Increase%20in%20ACA%20Premiums%20in%202026_1217.pdf.

⁹⁰ Reed Abelson, *New A.C.A. Plans Could Increase Family Deductibles to \$31,000*, N.Y. TIMES (Feb. 26, 2026), <https://www.nytimes.com/2026/02/26/health/obamacare-health-insurance-rollbacks.html>.

⁹¹ *See id.*

⁹² Margot Sanger-Katz, *It's Not Just You: Picking a Health Insurance Plan Is Really Hard*, N.Y. TIMES (Dec. 11, 2020), <https://www.nytimes.com/2020/12/11/upshot/choosing-health-insurance-is-hard.html>.

⁹³ *See* Joachim O. Hero et al., *Decision-Making Experiences of Consumers Choosing Individual-Market Health Insurance Plans*, 38 HEALTH AFF. 464, 464 (2019), <https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2018.05036>; *see also, e.g.*, David Anderson, *Choice Overload on Healthcare.gov*, BALLOON JUICE (Nov. 6, 2020), <https://balloon-juice.com/2020/11/06/choice-overload-on-healthcare-gov/> (Seminole County, Florida had 174 plans available on the Marketplace for plan year 2021).

shoppers, who often do not understand complicated concepts like deductibles, co-insurance, or maximum out-of-pocket costs (MOOP).⁹⁴

It is true that “[t]he ACA relies on a competitive private plan model” to increase the value of health care, and some amount of plan choice is therefore essential to its structure.⁹⁵ But actually *realizing* value under that model “requires informed consumers” to make meaningful choices between competing plans.⁹⁶ When the market is saturated with too many choices, consumers may make worse enrollment choices simply due to the difficulty of understanding complex health insurance information.⁹⁷ Moreover, “choice overload” — a phenomenon wherein a glut of choices leads consumers to make worse decisions — can cause shoppers to enroll in lower-quality plans and increase dissatisfaction with their choices.⁹⁸ In some cases, the number of choices may prevent them from enrolling at all.⁹⁹ Further, when there are too many choices, consumers are less likely to switch plans, which dampens competition and leads to increased costs.¹⁰⁰

When plans share a “common benefits structure” (including, but not limited to, tiering and cost-sharing structures), consumers are able to make “apples-to-apples comparisons of plans and benefits,” which facilitates better decision-making.¹⁰¹ Standardization also pushes plans to “compete more directly” on features like premiums and provider networks, which ultimately benefits the consumer by improving plan quality and making it easier to understand their plan options.¹⁰² Finally, plan standardization promotes equity in two significant ways. First, it discourages discriminatory practices like “adverse tiering” (a practice where payers put all drugs for certain conditions, such as HIV, in the highest cost-sharing tier to discourage individuals with those conditions from enrolling in their plans) and manipulating benefits to exclude certain specialists that treat people who have chronic conditions (such as

⁹⁴ Rose C. Chu et al., *Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces* 3, HHS Assistant Sec’y for Planning & Evaluation (2021), <https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf>.

⁹⁵ *Id.* at 4.

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.* at 3–4.

⁹⁹ Sabrina Corlette, *Standardizing Health Plan Benefit Design: Opportunities and Implications for States*, State Health & Value Strategies (Nov. 18, 2019), <https://shvs.org/resources/standardizing-health-plan-benefit-design-opportunities-and-implications-for-states/>.

¹⁰⁰ Chu et al., *supra* note 94, at 4.

¹⁰¹ Wayne Turner, *Comments on RIN 0938-AU97; CMS-9899-P Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024* 14, Nat’l Health Law Prog. (Jan. 30, 2023), <https://healthlaw.org/resource/nhelp-comments-on-patient-protection-and-affordable-care-act/>.

¹⁰² Chu et al., *supra* note 94, at 2.

endocrinologists and psychiatrists).¹⁰³ Second, research suggests that underserved and marginalized groups may be especially harmed by choice overload; as such, reducing the risk of choice overload will improve access to health care for these groups.¹⁰⁴

VII. Conclusion

Thank you for the opportunity to provide comments on this RFI. NHeLP is committed to advancing policies that build upon the achievements of past health reforms in ways that protect access to health care for low-income and underserved individuals. We encourage lawmakers to ensure that any future health reforms guarantee that no one living in this country is left behind, either because they cannot afford health insurance or because their coverage does not provide the services they need. If you have any questions about our comments, please contact Héctor Hernández-Delgado (hernandez-delgado@healthlaw.org) or David Machledt (machledt@healthlaw.org).

Sincerely,



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¹⁰³ Douglas Jacobs, *CMS' Standardized Plan Option Could Reduce Discrimination*, HEALTH AFF. FOREFRONT (Jan. 6, 2016), <https://www.healthaffairs.org/content/forefront/cms-standardized-plan-option-could-reduce-discrimination>; see also Chu et al., *supra* note 94, at 5.

¹⁰⁴ Chu et al., *supra* note 94, at 12; see also Sanger-Katz, *supra* note 92 ("The people most likely to make bad choices appear to be those least able to afford it").