



October 2, 2026

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Dear Ranking Member Wyden:

The National Health Council (NHC) is pleased to respond to your request for information (RFI) on “Health Coverage That Works for Everyone.” We appreciate the opportunity to provide input on this important topic. The ability to afford and access care with appropriate coverage is critical for patients. All policy options should lower what patients actually pay out-of-pocket for care, preserve access to clinically appropriate treatments, avoid shifting costs elsewhere in the system, and include meaningful patient input.

The National Health Council (NHC) unites nearly 200 national organizations—including leading patient groups, research institutions, providers, caregivers, and businesses across the health care sector—to drive patient-centered health policy. Representing 200+ million Americans with chronic diseases and disabilities, the NHC strengthens its members’ collective influence to expand access to quality, affordable, and equitable health care. The NHC fosters collaboration to shape policies that reflect the needs of patients.

Efforts to address health care access and affordability are often piecemeal and focused on benefits to the health care system at large without addressing specific patient needs, such as lower out-of-pocket costs. The NHC appreciates that the RFI takes a more holistic approach. Together, the RFI and its companion efforts focused on drug pricing and access to long-term care represent significant progress toward addressing broken aspects of our health care system that directly impact patients.

Financial pressures across the system can directly affect patients through higher copays, coinsurance, and other out-of-pocket costs. The NHC appreciates that the RFI addresses many issues that directly affect what patients pay and prioritizes policies designed to benefit them. However, reductions in federal, plan, or system spending should not be assumed to improve affordability unless savings reach patients, and any reforms must preserve timely access to clinically appropriate treatments. Policies should also be evaluated for whether they could shift costs onto patients or create barriers to

care through higher premiums, increased utilization management, narrower formularies, or reduced access to pharmacies and other providers.

The NHC offers three overarching priorities for the Committee's consideration. First, coverage reforms should be judged by whether patients can obtain needed care when they need it, not only by whether they have an insurance card. Second, affordability should reflect the full range of costs that patients and their families incur, including premiums, deductibles, coinsurance, copayments, noncovered services, transportation, caregiving, and administrative burdens. Third, reforms should be designed and evaluated with meaningful input from patients and caregivers, particularly those living with chronic diseases, disabilities, and complex care needs.

Consistent with those priorities, the NHC urges Congress to advance policies that close eligibility and enrollment gaps, strengthen the quality and adequacy of coverage, and simplify enrollment and plan comparison. These policies should also make affordability assistance more responsive to actual patient costs, reduce or eliminate cost sharing for high-value care, and reform utilization management practices that delay or deny medically necessary services.

The NHC looks forward to continued collaboration with the Committee to ensure that reforms are meaningful, sustainable, and centered on the needs of people with chronic diseases and disabilities. The comments below focus on proposals for which the NHC can offer a distinct patient-centered perspective.

Enrollment, Coverage Options, and Closing Coverage Gaps.

The RFI asks how Congress can reverse recent coverage losses and cost increases while building a system that offers people coverage that meets their needs. From the patient perspective, this work must begin with people who are uninsured, underinsured, or unable to appropriately access care through the coverage they have. For people with chronic diseases and disabilities, gaps in coverage can mean delayed diagnosis, interrupted access to medications, missed specialist visits, loss of durable medical equipment or home-based supports, and avoidable deterioration in health. Coverage reform should pursue both breadth and depth: more people should be covered, and the coverage available to them should be comprehensive, affordable, and usable.

Close gaps in eligibility and enrollment. Congress should prioritize policies that reduce coverage churn and ensure people can remain continuously enrolled in comprehensive coverage when their income, employment, disability status, caregiving responsibilities, or state of residence changes. This includes strengthening Medicaid and Marketplace coverage, addressing gaps in non-expansion states, protecting people who lose employer-sponsored coverage, and ensuring that coverage options are clearly explained and available before a person becomes uninsured.

Efforts to close these gaps should begin with repealing onerous community engagement requirements and other provisions of H.R. 1 that are projected to result in Medicaid coverage losses¹. In addition, Congress should restore the enhanced advance

¹ [Arrington-Guthrie-Letter-Medicaid-hr1](#)

premium tax credits that expired at the end of 2025 to help afford coverage through the Affordable Care Act (ACA) Marketplaces.

Protect the quality of coverage. Policies that expand coverage should not encourage enrollment in inadequate plans, as short-term limited duration insurance, that can fail to meet patients' needs when they become sick. Comprehensive benefits, meaningful limits on cost sharing, access to essential health benefits, and protections against misleading marketing are especially important for people with chronic conditions, disabilities, and complex care needs. Without affordable, comprehensive options, patients remain vulnerable to misleading marketing of lower-cost products that may not meet their needs.

Ensure that public dollars produce real patient benefit. Where private plans administer publicly funded coverage, including Medicaid managed care and Medicare Advantage, federal standards should ensure that taxpayer dollars support access, affordability, quality, and health outcomes. Plans should be accountable for network adequacy, timely access to specialists and medications, culturally and linguistically appropriate services, and transparent reporting on denials, appeals, and patient outcomes.

Affordability Determinations, Benefit Design, Transparency, and Navigation.

The RFI also seeks feedback on how to lower premiums and deductibles, simplify enrollment, improve plan comparison, strengthen consumer assistance, and ensure families can access coverage without unaffordable cost sharing. Patients need coverage they can understand, compare, enroll in, and use. The current system often requires consumers to make high-stakes decisions without the information they need. Patients may select a plan based on its premium, only to discover later that network restrictions, coinsurance obligations, or utilization management may limit their ability to access the care they need. Transparency must therefore be paired with practical assistance, standardized information, and plan designs that make care affordable at the point of service.

Invest in consumer assistance and insurance literacy. Congress should support a sustained national insurance literacy effort that helps people understand core coverage concepts, including premiums, deductibles, coinsurance, formularies, provider networks, utilization management, appeals, and financial assistance. This education should be paired with robust navigator and consumer assistance programs to provide people with individualized help when choosing plans and resolving coverage problems.

Make transparency actionable for patients. Transparency should be designed around real-world usability, not merely the public release of technical data. Plan comparison tools should allow patients to compare expected total costs and potential access barriers based on their individual health needs, including prescription drugs, specialists, facilities, behavioral health services, habilitative and rehabilitative services, durable medical equipment, and home and community-based supports. Patients should be able to identify whether a plan covers the clinicians, pharmacies, and services they rely on, whether those services are subject utilization management, how coverage differs for high-value services. Patients and caregivers should help CMS, Congress, and state regulators test whether tools and notices are understandable and useful.

Define affordability based on the ability to use coverage. Policies should consider total cost exposure, not only premiums. Patients with chronic diseases and disabilities may meet their deductibles early in the year, face ongoing coinsurance for specialty care, or delay treatment because cost sharing is due before they receive meaningful plan support. Congress should explore approaches that reduce or eliminate cost sharing for high-value care, primary care, behavioral health services, medications that prevent disease progression, habilitative and rehabilitative services, and other services that help people remain stable and independent.

Address medical debt and delayed care. Coverage should protect patients from financial harm when they become sick. Congress should examine policies that reduce patients' exposure to unaffordable bills, improve the accuracy and timeliness of financial assistance information, limit unexpected cost sharing, and ensure that billing and collections practices do not undermine patients' ability to seek needed care. Patients should not have to choose between paying for health care and meeting basic needs.

Prior Authorization, Step Therapy, Claims Denials, and Appeals.

The RFI asks how Congress should address private insurance practices that may delay or deny essential care. Utilization management protocols should be grounded in sound clinical decision-making. For example, some prior authorization protocols are intended to limit drug interactions or to prevent overprescribing of potentially addictive medications. However, prior authorization and other utilization management protocols are typically developed with little or no patient input, and the behind them is not always public or accessible to patients.

The current application of utilization management protocols can delay patient care, and disrupt medication adherence, potentially increasing the need for more intensive, higher-cost care. It can also contribute to provider burnout.

The NHC supports the implementation of electronic utilization management processes that accelerate decisions, make decision-making more transparency for patients and providers, and reduce administrative burden. These processes should include safeguards to prevent technology from being used to apply utilization management inappropriately and ensure equitable access to clinically appropriate medications, devices, treatments, and services.

Require clinical appropriateness and transparency. Utilization management protocols, including prior authorization and step therapy, should be aligned with current clinical guidelines or other valid evidence, such as peer-reviewed clinical studies when guidelines are not available or up to date. Protocols should be reviewed by clinicians with relevant expertise and developed with input from people with chronic diseases and disabilities. Plans should communicate requirements, decisions, and appeal rights in plain language that patients and caregivers can understand.

Protect continuity of care. Patients who are stable on a treatment should not be required to repeat step therapy or prior authorization solely because they change plans, providers, employers, or move between private and public coverage. Continuity protections are especially important for people whose conditions require ongoing

medication management, specialty care, durable medical equipment, home and community-based services, behavioral health care, or other services where disruption can cause harm.

Limit repeated barriers for chronic and stable conditions. Patients with ongoing conditions should not be forced to repeatedly prove the same diagnosis, treatment response, or medical necessity when their clinical circumstances have not changed. Congress should consider guardrails that require longer authorization periods, prior authorization exemptions for providers with high approval rates, and protections against reauthorization requirements that jeopardize continuity of care.

Set timely decision standards and strengthen appeals. Congress should require clear, enforceable time frames for prior authorization, step therapy exceptions, appeals, and reconsiderations, with expedited review when delay could jeopardize a patient's health. Each level of review should be meaningful, accessible, and based on the patient's clinical circumstances. Patients and clinicians should have a fair opportunity to demonstrate medical necessity, treatment response, or likely harm from delay or disruption. The bipartisan Safe Step Act^{2 3} is a critical step towards helping patients quickly address barriers step therapy might present.

Reduce administrative burden through electronic processes. Electronic prior authorization standards should be implemented in ways that reduce burden for patients and providers, support real-time or near-real-time decisions, and preserve access to human review for complex cases. Technology should be used to simplify documentation, improve communication, and allow patients to track the status of requests and appeals.

Increase oversight of denials and appeals. Plans should be required to report standardized data on prior authorization requests, denials, appeals, overturned denials, timeliness, and the clinical services most frequently affected. These data should be publicly available in a format that allows policymakers, regulators, researchers, and patient organizations to identify patterns, detect potential barriers or inappropriate use of utilization management, and address problems. Oversight should focus not only on whether plans follow procedural rules, but also on whether patients ultimately receive clinically appropriate care.

Oversight, Accountability, and Patient Outcomes.

The RFI raises cross-cutting questions about how to ensure that reforms lower costs, improve access and quality, and prevent taxpayer dollars from supporting practices that do not benefit patients. These include excessive administrative spending, executive compensation, stock buybacks, and other business practices that do not improve care. Across all reforms, Congress should ensure that patients and caregivers have a formal role in policy design, implementation, oversight, and evaluation.

² [Text - S.2903 - 119th Congress \(2025-2026\): Safe Step Act | Congress.gov | Library of Congress](#)

³ [Text - H.R.5509 - 119th Congress \(2025-2026\): Safe Step Act | Congress.gov | Library of Congress](#)

Measures of success should include whether people can enroll in coverage without unnecessary barriers, afford premiums and out-of-pocket costs, obtain needed care without harmful delay, maintain access to care during life transitions, and receive coverage information that is understandable and actionable. Savings to the federal government, plans, employers, or other entities in the health care system should not be considered patient-centered unless they are paired with demonstrable improvements in affordability, access, quality, equity, and health outcomes for patients and families.

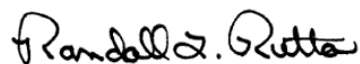
The Committee should also ensure that reforms are evaluated through measures that reflect patient experience, including delays in receiving care, rates of coverage disruption, appeal success rates, out-of-pocket spending as a share of income, access to specialists and needed medications, health-related social needs, and the experiences of historically underserved communities. Patient experience data, qualitative input, and evidence from patient organizations should be treated as essential sources of policy evidence, not as supplemental anecdotes.

Conclusion

The NHC appreciates the Committee's leadership in examining how to build health coverage that works for everyone. Patients need coverage that is affordable, comprehensive, understandable, and reliable when illness or disability makes access to care most urgent. We urge the Committee to center patients and caregivers in the development of future legislation and to ensure that any reforms improve real-world access to care, reduce financial burden, protect clinical decision-making, and advance equitable outcomes for people with chronic diseases and disabilities.

Thank you for your attention to this critical issue. Please contact Jennifer Dexter, Senior Vice President, Policy & External Affairs, at jdexter@nhcouncil.org or 202-276-0513 with any questions or requests for additional information.

Sincerely,

A handwritten signature in black ink that reads "Randall L. Rutta". The signature is written in a cursive, flowing style.

Randall L. Rutta
Chief Executive Officer