



On July 30, 2026, Senate Finance Committee Ranking Member Ron Wyden released the Request for Information (RFI), “Health Coverage That Works for Everyone,” as part of a broader Senate Democratic effort to examine potential reforms to the nation’s private health coverage system. The RFI followed a March 2026 letter from Senator Wyden and other Senate Democrats outlining their interest in developing the next generation of health coverage reforms. The RFI sought detailed comments, data, analysis, and policy recommendations across the individual, small-group, and large-group insurance markets, including issues related to enrollment and affordability, employer-sponsored coverage, benefit design, government-driven coverage expansion proposals, transparency, vertical integration, and fraud and oversight. The collected responses are intended to help inform future policymaking efforts and legislative drafting.

The section and subsection titles used throughout NABIP’s response are taken directly from the Senate Finance Committee RFI. **They are not NABIP-created titles and should not be interpreted as NABIP’s characterization or endorsement of the framing used in those headings.**

Given the breadth of the RFI and the potential impact of the policies under consideration on consumers, employers, health plans, and licensed health insurance professionals, NABIP believed it was important to provide a comprehensive response grounded in the experience of our members. Over approximately two months, members of NABIP’s Legislative Council and dozens of members across our policy working groups reviewed the RFI, contributed subject-matter expertise, evaluated policy proposals, and helped develop and refine the recommendations contained in this response. Our response is grounded firmly in NABIP’s Healthcare Bill of Rights, which is cited throughout and listed fully at the end of the response.

We welcome all member feedback—supportive, critical, substantive, technical, or editorial—as NABIP continues its engagement with Congress. Please send comments or questions to legislative@nabip.org.

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

Dear Ranking Member Wyden:

The National Association of Benefits and Insurance Professionals (NABIP), formerly the National Association of Health Underwriters (NAHU), appreciates the opportunity to respond to the Senate Finance Committee's Request for Information (RFI) on improving the affordability, accessibility, quality, and functionality of health coverage for American families.

NABIP represents thousands of licensed health insurance agents, brokers, general agents, consultants, and benefits professionals nationwide. Across the individual, Medicare, employer, and other health insurance markets, NABIP members help consumers and employers evaluate coverage options, including costs, provider networks, prescription drug formularies, and benefits; navigate eligibility and enrollment requirements; coordinate transitions between coverage programs; and resolve billing, claims, eligibility, network, and access issues after enrollment. Their work extends well beyond the initial coverage decision. NABIP members serve as year-round resources for the individuals, families, and employers they assist, helping them understand and use their coverage as their healthcare needs and circumstances change.¹

The scale of that assistance is substantial. During the 2026 Open Enrollment Period, 76 percent of the 10.8 million active HealthCare.gov plan selections, approximately 8.2 million, were assisted by an agent or broker. Approximately 30 percent of fee-for-service Medicare beneficiaries and 31 percent of Medicare Advantage enrollees age 65 and older used insurance agents to guide their plan choice, representing roughly one in three older beneficiaries, or approximately 20 million people. ²Benefits professionals

¹ National Association of Benefits and Insurance Professionals (NABIP), "Who We Are," <https://nabip.org/who-we-are> (organization description and scope of member services).

² Centers for Medicare & Medicaid Services (CMS), Health Insurance Exchanges 2026 Open Enrollment Report (Mar. 2026), <https://www.cms.gov/files/document/health-insurance-exchanges-2026-open-enrollment-report.pdf> (10.8 million active HealthCare.gov plan selections; 76% agent- or broker-assisted); Medicare Payment Advisory Commission, "Medicare beneficiaries' use of agents and brokers to choose health plans" (Mar. 2025), https://www.medpac.gov/wp-content/uploads/2025/03/Medicare-agents-MedPAC-03.25_SEC.pdf (survey estimates for beneficiaries age 65+); CMS, 2026 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, <https://www.cms.gov/oact/tr/2026> (approximate aged enrollment used for the 20-million extrapolation). The 20-million figure is an estimate derived from survey shares and enrollment, not a direct CMS count of agent-assisted Medicare enrollments.

also serve the nation's largest coverage market. The Census Bureau estimates that approximately 180 million Americans have employment-based coverage. Among small employers purchasing or renewing employer coverage, 88 percent work with an agent or broker, and 64 percent have worked with their current agent or broker for more than five years. These long-standing relationships reflect the broader advisory role benefits professionals play in helping employers make informed decisions about plan design, financing, employee contributions, network access, regulatory compliance, vendor performance, and changing market conditions.³

NABIP's recommendations are guided by NABIP's Healthcare Bill of Rights, a consumer-centered framework built around access to affordable, high-quality care; individual choice and autonomy; privacy and confidentiality; health equity and education; affordable medications; emergency care; meaningful healthcare advocacy; and appropriate state oversight. Together, these principles reflect NABIP's commitment to preserving consumer choice, professional guidance, and individual protections while making healthcare more affordable, transparent, understandable, and responsive to the people it serves.⁴

Consistent with those principles, NABIP believes meaningful reform must address the underlying cost of healthcare services and medications. Expanding, restructuring, or standardizing coverage without confronting the prices, market dynamics, administrative burdens, consolidation, and other forces driving healthcare spending risks shifting costs rather than reducing them. Coverage reform should ultimately be evaluated by whether it improves affordability, access, quality, consumer choice, and patients' ability to use their coverage when they need care.

Policymakers should also distinguish between entities that add unnecessary cost, opacity, or administrative friction and licensed professionals who provide accountable assistance to consumers and employers. Annual agent and broker spending across Medicare Advantage, Medicare Part D, and ACA-regulated individual, small-group, and large-group markets amounts to 0.4 percent of national health spending. That figure provides important context: licensed professionals assist tens of millions of Americans

³ U.S. Census Bureau, Health Insurance Coverage in the United States: 2025, Current Population Reports P60-291 (2026), <https://www.census.gov/library/publications/2026/demo/p60-291.html> (employment-based coverage); National Federation of Independent Business, 2023 Small Business Health Insurance Survey, <https://nabip.org/media/8416/nfib-health-insurance-survey-2023.pdf> (small-employer use and tenure of agents/brokers).

⁴ NABIP, Healthcare Bill of Rights, <https://nabip.org/media/9257/nabip-healthcare-bill-of-rights-final.pdf>.

across coverage markets while accounting for a very small fraction of overall U.S. healthcare spending.⁵

None of this diminishes the need for strong accountability. NABIP supports effective consumer protections, enforcement against deceptive marketing and unauthorized enrollment, transparency, and appropriate consequences for misconduct. Policymakers can target unnecessary, opaque, anticompetitive, or extractive intermediation while preserving Americans' ability to choose regulated professionals who help them navigate an increasingly complex healthcare system.

NABIP looks forward to continuing to serve as a resource to the Committee as it considers policies to improve affordability, access, transparency, and consumer protection. We appreciate the opportunity to provide the perspective of benefits professionals who work directly with consumers and employers across the healthcare system and stand ready to assist the Committee as this work continues.

Sincerely,

Michael Andel

Senior Vice President of Government Affairs

⁵ Joint Economic Committee, "Finding: Insurance Broker Costs Rising Rapidly, Especially in Medicare Advantage Plans" (June 2026), <https://www.jec.senate.gov/public/index.cfm/republicans/2026/6/jec-issues-brief-finding-insurance-broker-costs-rising-rapidly-especially-in-medicare-advantage-plans> (annual broker spending estimated at more than \$25 billion); CMS, National Health Expenditure Projections, 2025–34, <https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf> (projected 2025 national health spending of about \$5.7 trillion). The 0.4% is an approximate calculation using the broker-spending lower bound divided by projected total spending; it is not a published CMS statistic and the source estimates may not use identical definitions.

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Section 1: Reversing Republican Cuts and Reimagining a Better Path

Section 1.I Ensuring that people can easily enroll in and afford coverage that meets their needs

Consumer Enrollment Protections and Professional Assistance

NABIP supports targeted safeguards that verify consumer authorization, strengthen enrollment-system security, require accurate information, and hold bad actors accountable, while avoiding unnecessary barriers for consumers who choose professional guidance. Consumers should know who is assisting them, understand the information submitted on their behalf, and affirmatively authorize changes to their Marketplace application or coverage.

Detailed recommendations on Marketplace program integrity, including entity-level accountability, identity proofing, authentication, verification, lead-generation activity, and due process, are addressed in Section 2.IV.

Employer Enrollment Modernization and Interoperability

Employer-sponsored coverage is administered through federal, state, carrier, and private-sector rules and systems that were developed separately and do not always align. Employers and its employees may therefore encounter different timelines, documentation requirements, and processes for enrollment, Section 125 election changes, COBRA, ACA requirements, Marketplace transitions, and carrier administration.⁶

In practice, this fragmentation can mean duplicate data entry, inconsistent systems, manual reconciliation, delayed enrollment changes, and repeated documentation. These burdens can be especially difficult for smaller employers and can create confusion for workers moving between employer coverage and other coverage options. Modernization should address these friction points through better alignment and interoperability while preserving employer choice, plan flexibility, and existing coverage arrangements.

Congress should first direct the U.S. Departments of Treasury, Labor (DOL), and Health and Human Services (HHS) to identify and align, where possible, existing eligibility, enrollment, special-enrollment, Section 125, COBRA, ACA, HIPAA, CHIPRA,

⁶ See, e.g., 29 U.S.C. §§ 1021–1025 (ERISA disclosures); 26 U.S.C. § 125 (cafeteria plans); 29 U.S.C. §§ 1161–1169 (COBRA continuation); 42 U.S.C. §§ 300gg-11 to 300gg-14 (group-market enrollment and special-enrollment protections); 42 U.S.C. § 18031 (Exchange functions). These provisions are administered through distinct federal and private-sector processes.

Marketplace, and related carrier-administration requirements rather than creating another duplicative enrollment framework. The objective should be to make existing protections easier to understand, administer, and use consistently.

As part of that effort, the agencies could harmonize documentation and timing requirements where possible and develop a single plain-language federal reference explaining how major eligibility and enrollment rules interact. Clearer coordination would help employees understand when they may enroll, what events create enrollment opportunities, what documentation is required, and how coverage programs interact, while reducing employer errors caused by overlapping or inconsistent requirements.

Enrollment modernization should focus on interoperability and accountability rather than a mandatory centralized platform. Congress could consider prioritizing uniform minimum data elements; secure application programming interfaces (APIs) or file standards connecting employers, payroll and HRIS systems, carriers, TPAs, COBRA administrators, ACA reporting vendors, State-Based Marketplaces, and the Federally Facilitated Marketplace. Features could include real-time transaction status; standardized rejection and pending codes; auditable records; model employee notices; consistent consumer authorization; secure eligibility feeds; accurate effective-date and termination processing; and privacy protections. These reforms could reduce duplicate entry, billing errors, delayed effectuations, coverage gaps, and downstream corrections without requiring employers to abandon systems already integrated with payroll, leave administration, dependent eligibility, ACA reporting, and ERISA plan administration.

By contrast, a mandatory centralized enrollment platform could increase cost and complexity if it fails to account for the vast diversity of employer coverage. Employer plans differ in plan design, employee populations, leave and furlough rules, contribution structures, wellness incentives, Section 125 elections, COBRA administration, domestic-relations orders, and dependent-eligibility. ERISA fiduciaries also retain responsibility for fiduciary functions they perform, including the prudent selection and monitoring of plan service providers, even when administrative functions are delegated. A platform that does not integrate cleanly with employer payroll and plan-administration systems risks becoming another reconciliation layer.⁷

⁷ ERISA §§ 3(21)(A), 404(a), 29 U.S.C. §§ 1002(21)(A), 1104(a); DOL, “Understanding Your Fiduciary Responsibilities Under a Group Health Plan,” <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications/understanding-your-fiduciary-responsibilities-under-a-group-health-plan> (selection and monitoring of service providers and limits of delegation).

Congress should support modernization that preserves competition, state flexibility, carrier accountability, private-sector innovation, and professional guidance. Simplicity, consistency, transparency, and ease of administration should be core objectives. Enrollment platforms and system integrations can reduce friction, but they do not eliminate the need for trained human review. Errors involving effective dates, terminations, dependent eligibility, Medicare coordination, Marketplace transitions, payroll deductions, COBRA elections, networks, formularies, or plan selection can materially harm workers and families.

State-Based Marketplaces

State-Based Marketplaces (SBMs) are a substantial part of the Affordable Care Act (ACA) coverage infrastructure. For plan year 2027, the Centers for Medicare & Medicaid Services (CMS) identifies 22 SBMs and two State-Based Marketplaces on the Federal Platform (SBM-FPs). NABIP supports the state-based model as a genuine alternative to the FFM, with state flexibility paired with clear readiness and consumer-protection standards.⁸

CMS finalized removal of the requirement that a state operates for one year as an SBM-FP before moving to a fully state-operated Marketplace. NABIP supports that flexibility: a state that can demonstrate operational readiness should not face an arbitrary transition year. Flexibility, however, should not mean reduced oversight. NABIP opposed CMS's separate decision to rescind the requirement that states provide supplemental Blueprint implementation documentation at HHS's request. Federal approval should still include end-to-end testing of eligibility and subsidy calculations, carrier enrollment and reconciliation, Federal Data Services Hub connectivity, account migration, security, customer-service capacity, contingency procedures, and a sustainable administrative and financial model.

Once operational, SBMs should have meaningful authority to administer their markets. NABIP supports primary network-adequacy oversight by SBMs and state Departments of Insurance where effective standards reflect local access conditions, with a targeted federal backstop where state standards or enforcement are insufficient. Federal requirements should establish a reliable floor without duplicating effective state review or prescribing a single operating model.

State flexibility should also preserve enrollment choice. SBMs can improve public-program coordination and support local innovation, but they should complement rather

⁸ CMS, "Marketplaces Map," plan year 2027, <https://www.cms.gov/marketplace/in-person-assisters/training-webinars/training/marketplaces-map> (22 State-Based Marketplaces and two State-Based Marketplaces on the Federal Platform).

than replace carrier, broker-assisted Enhanced Direct Enrollment (EDE), and other private enrollment channels. Where states expand EDE, NABIP supports maintaining an Exchange-operated pathway for consumers who enroll without a broker or need direct Marketplace support. Funding should prioritize infrastructure, data quality, verification, fraud prevention, consumer assistance, cybersecurity, and interoperability. Governance should include employer, carrier, regulator, public-program, technology, consumer, and licensed agent and broker perspectives.

Congress and CMS should preserve state flexibility, remove unnecessary transition barriers, and maintain strong readiness review. Federal oversight should focus on whether an SBM can reliably perform its required functions and protect consumers while allowing states that meet those standards to determine how best to administer their markets. Program-integrity lessons from SBM authentication and account-access controls are addressed in Section 2.IV.

Essential Health Benefits Requirements and State Flexibility

NABIP supports periodic, evidence-informed review of the Essential Health Benefits (EHB) framework and meaningful state flexibility to update EHB benchmarks, while maintaining the statutory “typical employer plan” standard, appropriate state financial responsibility for newly mandated benefits, and careful consideration of affordability, provider access, and implementation feasibility before expanding EHB requirements.

NABIP supports periodically revisiting the EHB framework because employer coverage, medical practice, technology, and consumer needs continue to evolve. Employer plan designs have changed materially since the original ACA benchmarks were established. NABIP has recommended that CMS consider a routine review, potentially on a biennial basis, to keep the EHB framework current.⁹

Periodic review should not mean continually rewriting the federal benefit package. Stability is also important. States, issuers, employers, agents, and consumers need sufficient lead time to incorporate benefit changes into actuarial pricing, product filings, enrollment systems, consumer materials, and provider arrangements. A predictable review cycle, coupled with the ability to respond to unusual or urgent circumstances, when necessary, would better balance modernization with operational stability.

⁹ NABIP, Response to CMS Request for Information on Essential Health Benefits (July 15, 2026), <https://nabip.org/advocacy/policy-documents/comment-letters>; CMS, Request for Information: Comprehensive Review of the Essential Health Benefits Framework and the Typical Employer Plan (June 15, 2026), 91 Fed. Reg. 32931, <https://www.federalregister.gov/documents/2026/06/15/2026-11994/request-for-information-comprehensive-review-of-the-essential-health-benefits-framework-and-typical>.

NABIP recommends that periodic EHB review use a standing evidence framework that considers clinical outcomes, premium and workforce effects, long-term spending implications, and consumer satisfaction. Before expanding a benefit requirement, CMS should conduct benefit-specific actuarial modeling; where the evidence base remains limited, standardized post-implementation utilization and consumer-satisfaction reporting can help determine whether the change is delivering the intended value.

Implementation should also align with employer renewal cycles. A delayed applicability date of at least one full plan year after final guidance, together with good-faith compliance relief during initial implementation, would allow employers and vendors to price the change, amend plan documents, summary plan descriptions (SPDs), summaries of material modifications (SMMs), and summaries of benefits and coverage (SBCs), revise contracts and enrollment materials, update claims and payroll systems, train HR and benefits teams, and communicate changes clearly.

Preserve State Flexibility Within a Clear Federal Framework

NABIP has supported making it easier for states to update their EHB benchmarks. CMS has already simplified that process. Beginning with plan year 2026, states may select a new set of benefits as their EHB benchmark under a consolidated process, and CMS eliminated the requirement to submit a new prescription-drug formulary unless the state is actually changing its prescription-drug EHB. NABIP supported these changes because the prior process imposed unnecessary administrative burden on states seeking to modernize their benefit packages.

State flexibility should nevertheless remain bounded by the ACA's requirement that EHB reflect the scope of a typical employer plan. Benefit mandates can improve coverage, but they also affect premiums and federal premium-tax-credit expenditures. Those tradeoffs should be transparent rather than obscured through the benchmark process.

NABIP has therefore consistently supported requiring states to bear the cost of benefits they mandate beyond the federal EHB framework. Beginning with plan year 2028, a qualifying state-required benefit enacted after December 31, 2011 will generally be treated as being in addition to EHB, even if it has been incorporated into the state benchmark, requiring the state to defray the cost for qualified health plan (QHP) enrollees.¹⁰

¹⁰ 42 U.S.C. § 18031(d)(3)(B); CMS, HHS Notice of Benefit and Payment Parameters for 2027 Final Rule (May 15, 2026), <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-payment-parameters-2027-final-rule>; 91 Fed. Reg. 29256 (May 20, 2026) (state defrayal treatment beginning in plan year 2028).

NABIP has emphasized that states need adequate implementation time because statutory mandates, state legislative sessions, benchmark filings, actuarial review, and issuer rate-development cycles do not move simultaneously. CMS ultimately finalized the new defrayal policy beginning with plan year 2028 rather than the earlier date initially proposed.¹¹

Federal policy should clarify that an EHB benchmark expansion is not intended to create an indirect or de facto mandate for self-funded ERISA plans except where separately required under federal law. Employers may voluntarily adopt evidence-based, high-value benefit designs, but federal policy should preserve plan-sponsor flexibility and avoid fragmented expectations that increase cost and administrative complexity without improving access.

Congress should also encourage CMS to complete its current EHB review and resume timely processing of state benchmark applications. CMS has paused review of state applications to modify EHB-benchmark plans for plan years beginning on or after January 1, 2027 while it conducts a comprehensive review of the EHB framework; prolonged uncertainty can complicate state legislative, actuarial, issuer, and implementation planning.¹²

ACA Affordability Determinations Beyond Premiums

The ACA's formal affordability rules remain primarily premium-based. For 2026, employer coverage is considered affordable for an employee if the employee's required contribution for the lowest-cost self-only plan providing minimum value does not exceed 9.96 percent of household income. For eligible family members, affordability is based on the employee contribution required for qualifying family coverage. The premium tax credit is also calculated using the premium of the applicable second-lowest-cost Silver plan, reduced by the household's required contribution.¹³

These rules do not necessarily describe the financial experience a consumer will have after enrollment. NABIP has cautioned that a subsidized individual-market option may appear attractive based on premium alone while exposing a family to separate

¹¹ CMS, HHS Notice of Benefit and Payment Parameters for 2027 Final Rule, 91 Fed. Reg. 29256 (May 20, 2026), <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-payment-parameters-2027-final-rule> (finalized plan-year-2028 applicability).

¹² CMS, Request for Information: Comprehensive Review of the Essential Health Benefits Framework and the Typical Employer Plan, 91 Fed. Reg. 32931 (June 15, 2026), <https://www.federalregister.gov/documents/2026/06/15/2026-11994/request-for-information-comprehensive-review-of-the-essential-health-benefits-framework-and-typical>; CMS EHB resources, <https://www.cms.gov/marketplace/resources/data/essential-health-benefits> (state benchmark-review pause during the federal review).

¹³ 26 U.S.C. § 36B(b)(3)(B), (c)(2)(C); IRS, Rev. Proc. 2025-25, 2025-32 I.R.B. 153 (2026 applicable-percentage table, including 9.96%), https://www.irs.gov/irb/2025-32_IRB.

deductibles and out-of-pocket limits, different provider and facility access, different benefits, and different levels of service and year-round coverage support.¹⁴

Current Marketplace data further illustrates the distinction between premium affordability and the cost of using coverage. CMS reported that the median deductible for a non-expanded Bronze plan on the FFM reached \$10,600 in 2026, the same amount as both the median maximum out-of-pocket limit for those plans and the 2026 statutory maximum annual limitation on cost sharing. This report does not by itself establish that deductibles should be incorporated into the statutory affordability test, but it demonstrates why a low premium cannot be treated as a complete measure of consumer affordability.¹⁵

Federal consumer guidance already reflects this reality. HealthCare.gov advises consumers to consider total healthcare spending rather than premium alone when comparing metal levels. It also explains that consumers eligible for cost-sharing reductions must select a Silver plan to receive lower deductibles, copayments, coinsurance, and out-of-pocket maximums.¹⁶

The importance of making cost-sharing reduction (CSR) eligibility and its financial value visible during plan selection is addressed separately in Section 1.II.

NABIP supports giving consumers a total-cost view of coverage rather than a premium-only view. Detailed recommendations concerning CSR visibility and standardized presentation of plan attributes are addressed in Sections 1.II and 2.I.

Congress could distinguish between improving how consumers evaluate affordability and changing the statutory test used to determine eligibility for financial assistance. A new affordability formula incorporating deductibles, actuarial value, expected utilization, or maximum out-of-pocket exposure could have significant implications for premium tax credit (PTC) eligibility, employer coverage, federal spending, and Marketplace risk pools.

¹⁴ NABIP, Comments on CMS-9883-P (Mar. 13, 2026), https://nabip.org/media/10840/nabip_comments_cms-9883-p_nbpp-2027_march-13-2026.pdf (NABIP's comments concerning Marketplace plan choice, cost sharing, and consumer assistance).

¹⁵ CMS, 2026 Marketplace Open Enrollment Period Public Use Files, <https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2026-marketplace-open-enrollment-period-public-use-files> (2026 FFM plan-level deductible and maximum-out-of-pocket data); 45 C.F.R. § 156.130(c) (annual limitation on cost sharing).

¹⁶ HealthCare.gov, "Total Costs and 'Metal' Categories," <https://www.healthcare.gov/choose-a-plan/your-total-costs/>; HealthCare.gov, "Cost-Sharing Reductions," <https://www.healthcare.gov/lower-costs/save-on-out-of-pocket-costs/>.

Detailed recommendations regarding changes to the second-lowest-cost Silver benchmark, actuarial-value requirements, or statutory out-of-pocket protections are addressed separately in Section 1.II.

Expanding Benefits Should Consider Access, Value, and the Appropriate Coverage Mechanism

From the employer perspective, Congress should distinguish between coverage expansions that improve access to high-value care and mandates that materially increase premiums or administrative complexity without a clear return on health outcomes, workforce stability, or long-term cost trend.

NABIP supports consideration of extending the preventive-care safe harbor for HSA-qualified high-deductible health plans (HDHPs) to defined high-value behavioral-health services. Treasury and the Internal Revenue Service (IRS), in coordination with HHS and DOL where applicable, could consider adding Collaborative Care Model (CoCM) codes, a bounded number of outpatient behavioral-health visits, and post-crisis follow-up visits under Internal Revenue Code Section 223(c)(2)(C), while preserving employer plan-design flexibility and providing a clear, uniform federal pathway for implementation.¹⁷

Any expansion of first-dollar or high-value care could follow implementation principles including benefit-specific actuarial review, adequate implementation lead time, and consideration of whether provider capacity is sufficient to translate coverage into meaningful access.

Section 1.II Reining in the unsustainable spikes in deductibles and out of pocket costs Trump and Republicans have piled onto American families

Marketplace-Specific Out-of-Pocket Protections

NABIP supports protecting consumers from excessive out-of-pocket exposure, improving the visibility of CSR benefits during plan selection, and preserving informed consumer choice. Marketplace affordability depends on more than the monthly premium. CSRs are an important part of the ACA's financial-protection structure because they lower deductibles, copayments, coinsurance, and maximum out-of-pocket exposure for eligible consumers. With limited exceptions, a consumer must enroll in a Silver plan to receive income-based CSRs. For plan year 2027, the maximum annual limitation on cost sharing is reduced to \$4,000 for self-only coverage for consumers

¹⁷ 26 U.S.C. § 223(c)(2)(C) (HSA-qualified HDHP preventive-care safe harbor); see also Pub. L. No. 119-21, § 71308, 139 Stat. 72 (2025) (direct primary care treatment for HSA purposes, effective beginning in 2026).

receiving the 94 percent and 87 percent actuarial value (AV) Silver CSR variants, and to \$9,600 for those receiving the 73 percent AV variant.¹⁸

NABIP supported CMS's decision to eliminate the rule that would automatically move a CSR-eligible consumer from an existing Bronze plan into a Silver plan based on premium, network, and product criteria. NABIP's concern was that a Bronze plan may still be the consumer's preferred option based on the household's circumstances, and that an automatic move could override an informed coverage decision and cause confusion.

A more sustainable approach is to make the financial consequences of the choice unmistakable. Marketplace platforms and EDE shopping tools should prominently identify when a consumer is CSR-eligible and show, side by side, the deductible, common service cost sharing, and maximum out-of-pocket exposure available under the applicable Silver CSR variant compared with the plan the consumer is considering. The objective should be to help consumers use the assistance for which they qualify without converting that assistance into a mandatory plan-selection rule.

Protecting Consumers From Higher Cost Exposure

NABIP opposed increasing allowable consumer cost sharing as the solution to the growing tension between statutory maximum out-of-pocket (MOOP) limits and AV requirements. NABIP argued that the existing annual limit already represents substantial financial exposure for many households and recommended addressing the underlying AV and cost pressures through actuarial calibration and broader healthcare cost-containment strategies rather than shifting additional costs to consumers.¹⁹

Beginning in 2027, certain Bronze designs will have a MOOP as high as 130 percent of the otherwise applicable annual limitation on cost sharing. This ceiling is \$15,600 for self-only coverage and \$31,200 for other-than-self-only coverage. CMS described the policy as allowing issuers to trade a higher overall MOOP for designs that may have lower deductibles or more pre-deductible coverage.²⁰

¹⁸ 42 U.S.C. § 18071 (cost-sharing reductions); HealthCare.gov, "Cost-Sharing Reductions," <https://www.healthcare.gov/lower-costs/save-on-out-of-pocket-costs/>; CMS, 2027 AV and Cost-Sharing Parameters Guidance (Jan. 29, 2026), <https://www.cms.gov/files/document/2027-papi-parameters-guidance-2026-01-29.pdf> (2027 variant-specific limits).

¹⁹ NABIP, Comments on CMS-9883-P (Mar. 13, 2026), https://nabip.org/media/10840/nabip_comments_cms-9883-p_nbpp-2027_march-13-2026.pdf (comments on actuarial-value and maximum-out-of-pocket policy).

²⁰ CMS, HHS Notice of Benefit and Payment Parameters for 2027 Final Rule, 91 Fed. Reg. 29256 (May 20, 2026), <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-payment-parameters-2027-final-rule> (finalized the Bronze-plan MOOP provision and dollar limits); CMS, "Statement Regarding City of Columbus v. Kennedy," No. 1:26-cv-02215 (D. Md.) (Aug. 4, 2026), <https://www.cms.gov/files/document/statement-re-city-columbus-080426.pdf> (the

This distinction is important. A higher AV or lower deductible can improve access to care before the deductible is met, but plan design changes can also shift financial exposure elsewhere. NABIP believes federal policymakers should evaluate the entire cost-sharing structure rather than focusing on a single measure such as deductible, AV, or MOOP in isolation.²¹

NABIP has supported greater flexibility around AV de minimis ranges so issuers could design actuarially sound products while maintaining premium and plan-design flexibility. That record does not support a general increase in federal AV requirements. Any proposal to raise minimum AV should be evaluated for its effect on premiums, plan availability, issuer flexibility, and the distribution of cost sharing across different services.²²

Second-Lowest-Cost Silver Plan Benchmark

The second-lowest-cost Silver plan (SLCSP) serves as the current benchmark used to calculate advance payments of the premium tax credit (APTC), regardless of whether the consumer enrolls in that plan.²³

An unusually low-premium plan can become the benchmark and thereby reduce APTC available to consumers choosing other plans. A low-premium product with materially different provider access could lower the SLCSP benchmark, increasing net premiums for consumers who want to remain in plans with broader or more established networks.

The Committee's concern warrants further examination, particularly because the benchmark does more than simply identify a low-cost plan. It determines the federal subsidy against which all other available plans are priced for an eligible consumer. NABIP supports studying effects of proposals to change or remove the SLCSP benchmark, as altering this methodology could have significant effects on premiums, federal APTC expenditures, issuer pricing, competition, and consumer plan choices.

court stayed the expansion of maximum out-of-pocket limits for individual-market Bronze plans). The stated 2027 provision was finalized but was not in effect as of Oct. 2, 2026.

²¹ 42 U.S.C. § 18022(d)(2) (actuarial value); 45 C.F.R. § 156.130(c) (annual cost-sharing limit); CMS, Final 2027 Actuarial Value (AV) Calculator Methodology, <https://www.cms.gov/files/document/final-2027-av-calculator-methodology.pdf> (cost-sharing terms inform AV); CMS, HHS Notice of Benefit and Payment Parameters for 2026 Final Rule, <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-payment-parameters-2026-final-rule> (standardized options include pre-deductible coverage for key services). These sources support the plan-design mechanics; they do not show that every higher-AV or lower-deductible design improves access or makes consumers better off, which also depends on premiums, benefits, networks, and utilization.

²² NABIP, Comments on CMS-9883-P (Mar. 13, 2026), https://nabip.org/media/10840/nabip_comments_cms-9883-p_nbpp-2027_march-13-2026.pdf (NABIP's position on actuarial-value flexibility and consumer cost sharing).

²³ 26 U.S.C. § 36B(b)(3)(B); 45 C.F.R. § 155.305(f)(2) (premium tax-credit benchmark based on the applicable second-lowest-cost Silver plan).

Section 1.III Expanding pathways to coverage for low-income people and exploring the benefits of giving all Americans access to Medicare-type choices for health care

Evaluating Coverage Expansion Proposals

NABIP recommends that Congress evaluate coverage proposals by whether they improve affordability, access, and quality of care while preserving the coverage and provider relationships on which consumers already rely. NABIP opposes the creation of a public option or a buy-in to an existing public program and supports reforms that strengthen employer and Affordable Care Act (ACA) coverage. Any federal approach must assess whether proposed alternatives expand coverage without destabilizing existing markets, displacing private coverage, disrupting provider access, or shifting costs to consumers and employers.²⁴

For each public-option, Basic Health Program (BHP), Medicare or Medicaid buy-in, or single-payer proposal, Congress should distinguish net new coverage gains from shifts among existing sources of coverage. The analysis should account for total household costs, provider access, market participation, effects on employers and existing coverage, federal and state spending, administrative and startup costs, financing sustainability, and transition readiness.

Recent Congressional Budget Office (CBO) and Joint Committee on Taxation projections underscore the scale of the existing coverage arrangements against which any expansion proposal would operate. CBO projects that nearly half of the U.S. population will be enrolled in employment-based coverage on average from 2026 through 2036, while federal subsidies for Medicare, Medicaid and CHIP, employment-based coverage, Marketplace coverage, and other health benefits total \$33.6 trillion over that period. Given that baseline, any federal approach should identify which existing public or private financing streams a proposal would replace, supplement, or expand.²⁵

U.S. and International Lessons

International comparisons can provide valuable lessons, but outcomes observed in other countries should not be assumed to transfer directly to the United States. The

²⁴ NABIP, Public Option/Medicare or Medicaid Buy-in Position Paper (July 28, 2021), <https://nabip.org/advocacy/policy-documents/position-papers/public-optionmedicare-or-medicaid-buy-in-position-paper>.

²⁵ CBO, Federal Subsidies for Health Insurance, 2026 to 2036 (July 23, 2026), <https://www.cbo.gov/publication/62539> (coverage projections and estimated \$33.6 trillion in federal subsidies across the listed health benefits).

OECD recognizes that meaningful comparisons of health-system performance must account for the demographic characteristics of the populations being compared, as well as broader socioeconomic, cultural, and country-specific factors. These considerations are particularly relevant in the United States, which must administer health coverage and deliver care across a population of more than 340 million people with substantial racial, ethnic, linguistic, socioeconomic, and geographic variation. Census and federal health-care data demonstrate significant variation both in the composition of U.S. communities and in access to and experiences with health care across populations.²⁶

Accordingly, proposals modeled on international systems should be evaluated not only on their financing structure, but on how they would perform across the distinct populations, communities, provider markets, and geographic conditions of the United States.

Strengths and Flexibility of Employer Coverage

Employer coverage remains the primary source of coverage for millions of working families and, when functioning properly, provides financial protection, access to comprehensive provider networks, and coordinated benefits. Census data show that employment-based insurance was the most common type of coverage in 2025, covering 53.5 percent of the U.S. population for some or all of the year. CBO has also estimated that providing Marketplace subsidies or Medicaid/CHIP coverage generally costs the federal government more per person than the tax exclusion for employer-sponsored coverage.²⁷

Employer coverage allows plan sponsors to tailor benefits to workforce needs, aggregate risk, contribute toward premiums on a tax-favored basis, support dependent coverage, and provide year-round assistance. For many workers, it is both part of total compensation and an important source of support in navigating eligibility, billing, provider networks, claims, and other coverage issues.

Flexibility is a core strength of the system. Employers can choose among fully insured, self-funded, level-funded, reimbursement-based, direct-contracting, and other

²⁶ OECD, “Opportunities and Challenges for the Comparison of Health-System Performance Based on Their Institutional Characteristics,” https://www.oecd.org/en/publications/how-do-health-system-features-influence-health-system-performance_7b877762-en/full-report/opportunities-and-challenges-for-the-comparison-of-health-system-performance-based-on-their-institutional-characteristics_3f54240f.html; U.S. Census Bureau, 2025 population and coverage reports, <https://www.census.gov/library/publications/2026/demo/p60-291.html>; Agency for Healthcare Research and Quality, National Healthcare Quality and Disparities Report, <https://www.ahrq.gov/research/findings/nhqrdr/index.html>.

²⁷ U.S. Census Bureau, Health Insurance Coverage in the United States: 2025, Current Population Reports P60-291 (2026), <https://www.census.gov/library/publications/2026/demo/p60-291.html> (employment-based coverage was the most common coverage type, at 53.5% for some or all of 2025); CBO, Federal Subsidies for Health Insurance, 2026 to 2036 (July 23, 2026), <https://www.cbo.gov/publication/62539> (federal subsidy comparisons).

arrangements based on workforce needs, geography, risk tolerance, and administrative capacity. This flexibility supports private-market innovation and allows employers to design coverage around the needs of their workforce.

Survey data shows that workers continue to value employer coverage, with 75 percent of respondents satisfied with their current employer-provided coverage and 74 percent preferring to receive coverage through an employer rather than through the federal or state government.²⁸

Like other markets, employers and plan sponsors face sustained pressure from medical trends, specialty and prescription drug costs, hospital and provider consolidation, administrative complexity, and overlapping compliance obligations. The average total health benefit cost per employee rose 6 percent in 2025 and is projected to increase 6.7 percent in 2026, while prescription drug spending increased 9.4 percent among large employers. Although these increases are significant, employer coverage has experienced comparatively moderate annual cost growth relative to several other major coverage benchmarks.

For 2026, Medicare spending per enrollee is projected to increase 6.9 percent, while the standard Medicare Part B premium increased 9.7 percent. In the ACA markets, the median finalized individual-market premium increase was 20 percent for 2026, while small-group insurers sought a median 11 percent increase. These trends suggest that employer coverage has remained comparatively insulated from some of the sharper annual cost increases occurring elsewhere in the coverage system.²⁹

Lowering Underlying Costs and Preserving Employer Choice

Congress can pursue reforms that make employer coverage more sustainable. Recommended reforms include reducing underlying cost drivers through site-neutral

²⁸ America's Health Insurance Plans, "Employer-Provided Health Coverage: A Survey of American Adults" (2025), <https://ahiporg-production.s3.amazonaws.com/documents/Research/LSG-AHIP-EPC-Memo.pdf> (survey responses on satisfaction with and preference for employer coverage).

²⁹ Mercer, National Survey of Employer-Sponsored Health Plans (2025 results and 2026 forecast), <https://www.mercer.com/en-us/solutions/health-and-benefits/research/national-survey-of-employer-sponsored-health-plans/>; Mercer, "US Employers and Workers Will Face Affordability Crunch as Health Insurance Cost Is Expected to Exceed \$18,500 per Employee in 2026" (Nov. 18, 2025), <https://www.mercer.com/en-us/about/newsroom/employers-and-workers-face-affordability-crunch-as-health-insurance-cost-is-expected-to-exceed-18500-per-employee-in-2026/> (employer cost and prescription-drug trends); CMS, 2026 Medicare Parts B Premiums and Deductibles, <https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles>; KFF, 2026 ACA Marketplace premium changes, <https://www.kff.org/affordable-care-act/how-much-and-why-aca-marketplace-premiums-are-going-up-in-2026/>; KFF, 2026 small-group premium changes, <https://www.kff.org/health-costs/how-much-and-why-premiums-are-going-up-for-small-businesses-in-2026/>. CMS, National Health Expenditure Projections, 2025–34, <https://www.cms.gov/files/document/nhe-projections-forecast-summary.pdf>, estimates 9.2% growth in aggregate Medicare spending, not 6.9% spending growth per enrollee; the cited government sources do not substantiate the body's 6.9% per-enrollee figure. Verify that statistic and measure before publication.

payment reforms, PBM and prescription drug transparency, provider-consolidation oversight, meaningful price transparency, and vertical-integration accountability; simplifying employer reporting, eligibility, enrollment, and disclosure obligations. At the same time, reforms should preserve ERISA's national framework; avoid public-option or state-by-state mandates that crowd out private employer coverage; and preserve employer-funded alternatives such as ICHRAs, QSEHRAs, MERPs, telehealth-first arrangements, direct primary care, value-based plan design, and HSA-compatible pre-deductible services. Congress may also wish to consider broader HSA modernization that allows employers and employees to contribute to accounts across a wider range of plan designs, because current health reimbursement arrangement (HRA) structures.

Federal policymakers could also evaluate targeted market-stabilization tools, including reinsurance or hybrid high-risk-pool approaches that backstop high-cost claims while consumers remain enrolled in private coverage, as well as appropriate continuous-coverage incentives. Such approaches should be evaluated based on their effects on premiums, carrier participation, taxpayer costs, provider access, and whether they produce net coverage gains rather than primarily shifting individuals among existing sources of coverage.

For employers that can no longer sustain group coverage, reforms should focus on continuity rather than displacement. Workers should be able to transition to individual-market coverage without gaps, duplicative premiums, unexpected tax liability, or loss of trusted assistance. That requires clearer coordination between employer affordability determinations and Marketplace eligibility, improved notices when employer coverage is unaffordable or ending, preservation of licensed agent and broker assistance, reliable subsidy eligibility tools, and rules that allow employers to provide defined financial support without unnecessary compliance traps. Any transition pathway should protect employees from being pushed into inferior coverage and should preserve meaningful consumer protections, network transparency, and appeal rights.

Strengthening the Existing ACA Coverage Framework

The Marketplace remains a major source of individual coverage. CMS reported 23.1 million plan selections during the 2026 Open Enrollment Period, approximately 5 percent fewer than in 2025 but still above enrollment in 2024 and earlier years. That scale makes stability important. Changes to subsidies, eligibility, verification, and plan rules can affect not only whether consumers enroll, but also issuer participation, risk

pools, premiums, and the administrative workload of Exchanges and enrollment professionals.³⁰

Federal premium assistance changed substantially for 2026. The temporary enhanced PTCs in effect from 2021 through 2025 expired, returning the Marketplace to the general PTC framework, under which eligibility is generally limited to households with income between 100 and 400 percent of the federal poverty level, subject to statutory exceptions. For 2026, the applicable percentage schedule ranges from 2.10 percent to 9.96 percent of household income. CBO projects that expiration of the enhanced premium tax credits will continue to reduce Marketplace enrollment and federal PTC spending, with additional enrollment effects resulting from separate policy changes enacted in 2025.³¹

As of May 2026, Medicaid.gov identifies 41 expansion jurisdictions and 10 non-expansion states. NABIP has supported a targeted hardship-exemption access to catastrophic coverage for individuals below 100 percent FPL who are ineligible for APTCs, particularly in non-expansion states, to act as a limited pathway for consumers who otherwise lack realistic access to subsidized Marketplace coverage, while opposing broader catastrophic-plan expansion for consumers who already qualify for APTCs. Catastrophic coverage can provide baseline protection against severe medical expenses, but it is not equivalent to comprehensive subsidized metal-level coverage.³²

NABIP's position on recent Marketplace rulemaking is provision-specific, and is based on a shared goal of access and consumer protection. NABIP supported restoring the one-year Failure to File and Reconcile standard and pre-enrollment verification for Special Enrollment Periods, while emphasizing that verification must remain timely and workable for eligible consumers. NABIP has also opposed verification approaches that create unnecessary barriers for self-employed individuals and others with legitimately variable income.

The family-glitch rule provides a useful implementation lesson. NABIP supported addressing the underlying affordability problem but warned that significant eligibility

³⁰ CMS, Health Insurance Exchanges 2026 Open Enrollment Report (Mar. 2026), <https://www.cms.gov/files/document/health-insurance-exchanges-2026-open-enrollment-report.pdf> (23.1 million total 2026 plan selections and comparison with 2025).

³¹ 26 U.S.C. § 36B; IRS, Rev. Proc. 2025-25, 2025-32 I.R.B. 153, https://www.irs.gov/irb/2025-32_IRB (2026 applicable-percentage schedule); CBO, Federal Subsidies for Health Insurance, 2026 to 2036 (July 23, 2026), <https://www.cbo.gov/publication/62539> (estimated effects of expiration of enhanced premium tax credits and subsequent law changes). Enhanced PTC provisions enacted for 2021–2025 expired after 2025.

³² Medicaid.gov, Medicaid and CHIP Enrollment Data Highlights, June 2026, updated Sept. 25, 2026, <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights>; NABIP, Comments on CMS-9883-P (Mar. 13, 2026), https://nabip.org/media/10840/nabip_comments_cms-9883-p_nbpp-2027_march-13-2026.pdf (catastrophic-coverage hardship-exemption position).

changes require adequate implementation time, reliable employer-offer verification, clear consumer education, and coordination between employer and Marketplace systems. Those same principles should apply to future reforms intended to expand financial assistance or change eligibility. Coverage policy can be well designed in statute or rulemaking and still create consumer harm if Exchanges, employers, issuers, and enrollment professionals cannot operationalize it accurately before enrollment begins.³³

NABIP supports strengthening the existing ACA coverage framework through targeted reforms that preserve access to comprehensive private coverage, address identified coverage gaps, maintain appropriate program-integrity controls, and improve the consumer enrollment experience. Congress should evaluate subsidy, eligibility, and verification changes together rather than making isolated changes that shift costs or administrative burdens elsewhere in the system.

Pairing ACA Protections With New Market Reforms

NABIP supports preserving the ACA's core individual-market protections while modernizing the market-stability tools that support competition and access. This includes retaining risk adjustment, improving settlement mechanics, using MLR flexibility in demonstrably stressed markets with clear guardrails, preserving meaningful network protections, and addressing underlying healthcare costs rather than shifting additional costs to consumers. The affordability and stability challenges facing the individual market are not limited to premium subsidies. Insurer participation, risk-transfer volatility, provider access, healthcare cost growth, and regulatory predictability all affect whether coverage remains available and usable. These issues should be addressed without weakening guaranteed issue, community rating, or the other core protections that depend on a functioning risk pool.³⁴

Risk Adjustment Settlement and High-Cost Risk

Risk adjustment remains a foundational protection against risk selection. CMS's 2025 benefit-year report shows the scale of the transfers involved. In the individual non-catastrophic market, issuers in the lowest claims-cost quartile were assessed risk adjustment charges averaging 13.2 percent of premium, while issuers in the highest

³³ NABIP, Comments on Proposed Rule to Fix the ACA Family Glitch (June 6, 2022); Family Affordability of Employer Coverage, 87 Fed. Reg. 61979 (Oct. 13, 2022), <https://www.federalregister.gov/documents/2022/10/13/2022-22124/family-affordability-of-employer-coverage> (final family-affordability rule).

³⁴ NABIP, Comments on CMS-9883-P (Mar. 13, 2026), https://nabip.org/media/10840/nabip_comments_cms-9883-p_nbpp-2027_march-13-2026.pdf; Patient Protection and Affordable Care Act §§ 1201, 1343, Pub. L. No. 111-148, 124 Stat. 119 (2010), codified at 42 U.S.C. §§ 300gg-1 to 300gg-4 and 18063 (guaranteed availability, community rating, and risk adjustment); 42 U.S.C. § 300gg-18 (medical-loss-ratio requirements).

quartile received payments averaging 15.5 percent of premium. Those transfers reflect the program's intended redistribution of risk, but their magnitude makes timing and predictability operationally important.³⁵

The current payment cycle remains largely retrospective. For the 2025 benefit year, CMS released final transfer results in June 2026, began collecting charges in August, began risk adjustment payments in September, and scheduled high-cost risk pool payments to begin in November.³⁶

NABIP does not recommend changing who ultimately pays or receives risk adjustment transfers. Instead, NABIP recommends modernizing how those obligations settle through installment-payment flexibility, quarterly provisional estimates or settlements with later true-up, federal clearing or netting mechanisms, and earlier standardized transfer information for issuers and state regulators. These changes could reduce liquidity shocks and improve rate-setting visibility while preserving budget neutrality and the program's anti-selection function. NABIP has also recommended periodic review of the high-cost risk pool threshold as catastrophic claims and specialty-treatment costs evolve.³⁷

Preserve Network and Essential Community Provider Protections

Market stability should also be measured by whether consumers can obtain care, not simply by whether a plan remains available for purchase. NABIP recently opposed CMS's proposal to reduce the Essential Community Provider participation threshold from 35 percent to 20 percent. CMS ultimately retained the 35 percent standard after commenters raised concerns about access, rural communities, specialty care, and the absence of sufficient evidence that access would be preserved under the lower threshold.³⁸

At the same time, a numerical contracting threshold does not by itself establish meaningful access. Network adequacy should be evaluated using real-world availability

³⁵ CMS, Summary Report on Individual and Small Group Market Risk Adjustment Transfers for the 2025 Benefit Year (June 30, 2026), <https://www.cms.gov/ccio/programs-and-initiatives/premium-stabilization-programs/downloads/ra-report-by2025.pdf>.

³⁶ CMS, Key Dates for Calendar Year 2026 Qualified Health Plan Data Submission and Certification, Rate Review, Form Review, and Risk Adjustment, <https://www.cms.gov/files/document/cy26-key-dates-tables.pdf>.

³⁷ NABIP, Comments on CMS-9883-P (Mar. 13, 2026), https://nabip.org/media/10840/nabip_comments_cms-9883-p_nbpp-2027_march-13-2026.pdf (risk-adjustment settlement and high-cost risk-pool recommendations).

³⁸ CMS, HHS Notice of Benefit and Payment Parameters for 2027 Final Rule, 91 Fed. Reg. 29256 (May 20, 2026), <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-payment-parameters-2027-final-rule> (retaining the 35% Essential Community Provider threshold); CMS, 2027 Payment Notice Proposed Rule (Dec. 2025), <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-payment-parameters-2027-proposed-rule>; NABIP, Comments on CMS-9883-P (Mar. 13, 2026), https://nabip.org/media/10840/nabip_comments_cms-9883-p_nbpp-2027_march-13-2026.pdf.

measures rather than directory counts alone. Regulators should distinguish true provider shortages from contracting or network-management deficiencies rather than treating a directory roster as proof that care is available.³⁹

Medicaid and Other Existing Coverage Infrastructure

In 2012, HHS issued guidance allowing State-Based Marketplaces (SBMs) to permit issuers with state Medicaid managed care contracts to offer qualified health plans as Medicaid “bridge plans,” subject to specified conditions. This model can help consumers transitioning from Medicaid or CHIP to Marketplace coverage remain with the same issuer and, where applicable, the same provider network, providing an existing framework for improving continuity between Medicaid managed care and the individual market. Congress should examine whether similar incentives could encourage Medicaid managed-care organizations to participate more broadly in underserved Marketplace rating areas.⁴⁰

Similar concepts already exist in the public-employee market. Washington, for example, has required a carrier within a holding company offering state or school employee coverage to also offer Exchange coverage in the applicable county. The U.S. Office of Personnel Management (OPM) also specifically solicits new Federal Employees Health Benefits (FEHB) Program carrier applicants from states designated as medically underserved. These approaches demonstrate that government purchasers can use their contracting relationships to encourage broader geographic participation.⁴¹

Independent Oversight Entity for Private Insurance

NABIP encourages careful consideration of proposals to create a Medicare Payment Advisory Commission (MedPAC)- or Medicaid and CHIP Payment and Access Commission (MACPAC)-like entity for commercial markets. NABIP supports independent, evidence-based evaluation of private insurance markets, provided it remains advisory, transparent, and operationally balanced.

³⁹ GAO, Private Health Insurance: Insurer Provider Networks and Network Adequacy, GAO-23-105642 (2023), <https://www.gao.gov/products/gao-23-105642>; Pennsylvania Insurance Department, Provider Directory Inaccuracies Study (extended study), <https://www.insurance.pa.gov/Coverage/health-insurance/Documents/networkadequacystudy-providerdirectoryinaccuracies-extended.pdf>.

⁴⁰ HHS, FAQs on Exchanges, Market Reforms, and Medicaid, Q. 14 (Dec. 10, 2012), <https://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf> (Medicaid bridge plans).

⁴¹ Wash. Rev. Code § 41.05.820, <https://app.leg.wa.gov/rcw/default.aspx?cite=41.05.820> (requiring a carrier in a holding company that offers state or school employee coverage to offer specified Silver and Gold QHPs on the Exchange in affected counties); U.S. Office of Personnel Management, FEHB Program Carrier Information and Applications, <https://www.opm.gov/healthcare-insurance/carriers/fehb/>.

If Congress proceeds, the commission's authority should be limited to analysis and recommendations to Congress and appropriate federal and state regulators, focused on cost drivers, administrative burden, access, market failures, and inconsistent consumer protections. A useful commission would need meaningful system-wide data access with strong guardrails, including privacy and proprietary-information safeguards. Relevant data could include aggregated and de-identified claims, rate and MLR information, network and provider-directory data, denial and prior-authorization metrics, TPA/ASO and PBM fee information, and ownership or affiliate transactions. Data collection should enable cross-market comparison while protecting personally identifiable information, protected health information (PHI), proprietary provider contracts, competitively sensitive plan strategies, and employer-specific claims experience.

Independence is important, but it should not be defined as the absence of industry expertise. Governance should include balanced representation from employers, licensed agents and brokers, carriers, TPAs/ASOs, state regulators, actuaries, consumers, providers, pharmacy experts, and data-privacy professionals, with conflict-of-interest, recusal, and transparency requirements.

The entity's market scope should be broad enough to evaluate the private coverage ecosystem, but its analysis should remain market specific. Its analysis should recognize the different legal and financing structures governing self-funded ERISA plans, fully insured group coverage, and individual-market coverage, while identifying areas where greater consistency could improve value without undermining competition, plan innovation, employer choice, or state authority.

State Public-Option Experience

State experience to date is mixed and highly design dependent. Washington, Nevada, and Colorado illustrate different interactions among provider-payment rules, participation requirements, subsidies, reinsurance, and existing Marketplace competition. Those effects should be evaluated separately rather than attributed to the public-option label alone.

Washington

Washington's Cascade Select experience underscores the importance of provider participation and network adequacy. In the program's first year, public-option plans were unavailable in approximately half of the state's counties; independent analyses found that some hospitals declined to participate and that carriers had difficulty assembling networks under the program's provider-reimbursement limits. Even after availability expanded, Cascade Select networks remained narrower than other Marketplace

networks. Washington subsequently required certain hospitals to contract with at least one Cascade Select plan and also paired Cascade Care coverage with state-funded premium assistance. Those additional interventions make it important to distinguish the effects of provider-payment limits, participation requirements, and subsidies from the effects of the public-option procurement structure when evaluating later changes in availability, premiums, and enrollment.⁴²

Nevada

Nevada's Battle Born State Plan experience illustrates a different market interaction: lower Battle Born State Plan premiums can reduce the second-lowest-cost silver benchmark used to calculate federal premium tax credits, which can increase net premiums for some consumers who remain in other Marketplace plans. In revising its Section 1332 waiver, Nevada added targeted premium relief for renewing consumers who otherwise could experience that benchmark-related increase. These interactions show why public-option proposals should be evaluated across the entire market—including provider participation, plan competition, federal subsidies, consumer choice, and affordability for consumers who do not enroll in the public option. Nevada's broader waiver also combines Battle Born State Plan premium-reduction targets with a market-wide reinsurance program and other stabilization measures. Nevada law further links participation in certain public programs to contracting with at least one Battle Born State Plan, although the state waived enforcement of the provider requirement through 2026. These overlapping policies make it difficult to isolate the effects of the Battle Born State Plan structure from the rest of the waiver design.⁴³

Colorado

Colorado provides a less straightforward state comparison. The Colorado Option combines standardized benefits, statutory premium-reduction requirements, reinsurance, state affordability subsidies, and an enforcement process that can include public hearings and provider-rate intervention when applicable requirements are not met. Its experience is more useful for demonstrating how difficult it can be to separate

⁴² Washington Health Care Cost Transparency Board, Cascade Select Public Option Report to the Legislature, https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=HCCTB+Cascade+Select+Public+Option+Report_cc9df888-ee2a-4d92-9dfd-6030a5f2b9ea.pdf; Wash. Rev. Code § 41.05.405 (hospital participation requirements for public-option plans), <https://app.leg.wa.gov/rcw/default.aspx?cite=41.05.405>; Wash. Admin. Code ch. 182-400, <https://app.leg.wa.gov/WAC/default.aspx?cite=182-400&full=true>.

⁴³ CMS, Nevada Section 1332 Waiver Fact Sheet, <https://www.cms.gov/files/document/nevada-section-1332-waiver-fact-sheet.pdf>; Nev. Rev. Stat. ch. 695K, <https://www.leg.state.nv.us/NRS/NRS-695K.html>; Nevada Medicaid, Provider Announcement (Apr. 1, 2026), https://www.medicaid.nv.gov/Downloads/provider/web_announcement_Volume%2023%20Issue%201_20260401.pdf (Nevada waiver and provider-participation details).

the effects of a public-option-style plan from the broader financing and regulatory package surrounding it.⁴⁴

Taken together, these state experiences show that public-option-style plans do not operate in isolation. For purposes of federal policy, the relevant question is how a new coverage option would interact with the market that already exists—including provider participation, benchmark subsidies, plan competition, and affordability for consumers who remain in other coverage—rather than whether a particular state program can be replicated nationally. The complexity of the proposal’s impact on consumers necessitates access to professional guidance to evaluate the coverage options available to them.

Federal Public-Option Market Effects and Financing

At the federal level, CBO’s analysis similarly underscores how a public option can affect consumers who remain in private coverage through changes in benchmark premiums and premium tax credits. NABIP urges Congress to evaluate changes in gross and net premiums, APTC, deductibles, cost sharing, provider access, and private-plan participation. Federal subsidy savings should not, by themselves, be treated as evidence that every affected household is better off.⁴⁵

CBO also identifies competing possibilities for private carriers: increased competition could place downward pressure on premiums, while changes in market risk could affect issuer participation and plan availability. Congress should require market-specific analysis of carrier participation, risk selection, and consumer choice, particularly in rural or concentrated markets, rather than relying solely on national enrollment projections.⁴⁶

Federal policymakers should also examine the full financing and risk structure of any federal option, including startup funding, repayment requirements, reserves, and

44 For Colorado, H.B. 21-1232, Standardized Health Benefit Plan Colorado Option, <https://leg.colorado.gov/bills/hb21-1232> (standardized plans offered by private carriers, premium-reduction and network requirements, public hearings, and possible provider-rate intervention); S.B. 20-215, Health Insurance Affordability Enterprise, <https://leg.colorado.gov/bills/SB20-215> (state reinsurance, carrier premium assistance, and subsidies for qualifying state-subsidized coverage); Colorado Department of Regulatory Agencies, Notice of Adoption of Regulations 4-2-91 and 4-2-92 (Dec. 10, 2024), <https://content.govdelivery.com/accounts/CODORA/bulletins/3c5f3ab> (reimbursement-rate methodology and hearing procedures). The Colorado Option is a standardized plan offered by private carriers, not a government-operated insurance plan; the body uses “public-option-style” comparatively. Its effects should be considered alongside the separate reinsurance and affordability programs.

45 CBO, Public Option: Effects on Health Insurance Coverage and the Federal Budget (Dec. 2020), <https://www.cbo.gov/publication/57020>; NABIP, Public Option/Medicare or Medicaid Buy-in Position Paper (July 28, 2021), <https://nabip.org/advocacy/policy-documents/position-papers/public-option-medicare-or-medicaid-buy-in-position-paper>.

46 CBO, Public Option: Effects on Health Insurance Coverage and the Federal Budget (Dec. 2020), <https://www.cbo.gov/publication/57020>. CBO’s estimates are scenario-specific; carrier participation and market outcomes depend on proposal design.

responsibility for financial shortfalls. State experience illustrates why that distinction matters: Illinois's 2021 feasibility study described modeled public-option scenarios as budget-neutral to the state for coverage costs when participating carriers bore financial risk, while noting that state implementation and oversight costs had not yet been determined and that additional actuarial analysis would be required if the state assumed some or all claims risk. Their feasibility study did not fully demonstrate the impact on plan cost and design if carriers bore the full financial risk. Any proposal should disclose the costs of establishing and administering the program, the funding available for unexpected claims, and who would bear responsibility if premiums and other revenues fall short.⁴⁷

Administrative comparisons should be made with consistent accounting boundaries. Eligibility and enrollment, claims administration, customer service, appeals, program-integrity controls, network management, provider billing, and consumer assistance remain necessary functions regardless of whether their costs are borne by the plan, another federal agency, providers, employers, or consumers.

Medicare Buy-In Proposals

Medicare buy-in's effects should be evaluated across the broader coverage system rather than solely by the savings experienced by buy-in participants. RAND found important tradeoffs for the ACA market. In its base scenario, approximately 6 million people enrolled in the buy-in, but most shifted from existing individual-market coverage. The resulting change in the individual-market risk pool increased bronze-plan premiums by approximately 9 percent, with higher premiums for all consumers remaining in the individual market.⁴⁸

These findings illustrate why the effects of a Medicare buy-in cannot be evaluated in isolation. Congress should assess not only premiums and cost sharing for buy-in participants, but also changes in individual-market premiums, premium tax credits, risk pools, provider access and reimbursement, and federal spending. Attention should be given to whether lower premiums depend on extending Medicare payment rates to a new population and how those rates could affect provider participation, especially in rural and underserved communities.

⁴⁷ Illinois Department of Insurance, Feasibility Study of a State-Based Health Benefits Plan (Apr. 2, 2021), <https://idoi.illinois.gov/content/dam/soi/en/web/insurance/reports/reports/04-02-21-feasibility-study-report-final.pdf> (modeled scenarios, carrier risk, and unestimated implementation/oversight costs).

⁴⁸ RAND Corporation, Medicare Buy-In and the Individual Market: Effects on Coverage and Premiums (RR-4246), https://www.rand.org/content/dam/rand/pubs/research_reports/RR4200/RR4246/RAND_RR4246.pdf (illustrative scenario with approximately six million enrollees and estimated individual-market premium effects).

Any Medicare buy-in should also be financed and accounted for separately from the existing Medicare trust funds so that coverage for a newly eligible population does not shift costs to current beneficiaries. If Congress considers extending Medigap eligibility or guaranteed-issue protections to buy-in enrollees under age 65, those effects should be modeled separately, including potential changes to Medigap risk pools and premiums for existing beneficiaries.

Medicaid Buy-In Proposals

NABIP opposes creating a Medicaid buy-in that would compete with private coverage, consistent with our longstanding opposition to public options and buy-ins to existing public programs. Our priority is ensuring access to affordable, comprehensive coverage while preserving existing coverage choices.

Any Medicaid buy-in should be evaluated for its effects not only on new enrollees, but also on current Medicaid beneficiaries and existing private markets. States would need sufficient financing, administrative capacity, and provider participation to absorb additional enrollment without reducing access to care. Policymakers should specifically assess whether payment rates would support adequate access to primary, specialty, behavioral health, and rural care.

Provider access should not be assumed. MACPAC has noted that physicians frequently cite low Medicaid payment rates as a reason for not accepting new Medicaid patients, while also finding that the relationship between payment and access varies by service and market. That uncertainty reinforces the need to evaluate payment adequacy, network capacity, and provider participation for any buy-in population.⁴⁹

Illinois's 2021 state-commissioned feasibility study illustrates the potential effects on existing markets. Milliman estimated that approximately 80 to 85 percent of enrollment in a broad Medicaid buy-in would come from people previously covered through the individual or employer-sponsored markets. The study also identified potential Marketplace destabilization and concerns that some providers might not participate voluntarily at Medicaid reimbursement levels. Although specific to the Illinois designs modeled, these findings underscore the importance of distinguishing new coverage

⁴⁹ Medicaid and CHIP Payment and Access Commission (MACPAC), Evaluating the Effects of Medicaid Payment Changes on Access to Physician Services (Jan. 2025), <https://www.macpac.gov/wp-content/uploads/2025/01/Evaluating-the-Effects-of-Medicaid-Payment-Changes-on-Access-to-Physician-Services.pdf>.

gains from substitution and evaluating effects on provider access and private-market stability.⁵⁰

Any proposal should also clearly identify federal and state responsibility for startup costs, ongoing subsidies, administrative expenses, and unanticipated costs; assess the staffing and systems needed for implementation; and ensure transitions between Medicaid, Marketplace, employer-sponsored, and other coverage do not create gaps or disruptions in care. Consumers should retain access, where authorized, to state-licensed agents and brokers for coverage comparisons, enrollment, and ongoing assistance.

Congress should ultimately evaluate a Medicaid buy-in based on whether it meaningfully reduces the uninsured population, how much enrollment represents movement from existing coverage, whether provider networks can support additional enrollment, and whether federal and state agencies have the resources to administer it effectively.

Single-Payer Proposals and Transition Protections

NABIP urges Congress to expand access to affordable, comprehensive coverage through reforms that preserve consumer choice, employer benefits, and trusted provider relationships. Proposals to replace existing coverage with a single-payer system should be assessed against those priorities, including the effects on people who are satisfied with their current coverage.⁵¹

For single-payer proposals, projected reductions in premiums or cost sharing should be considered alongside the taxes or other contributions required to finance the system and estimates of administrative savings should account for functions that would continue under the new structure.

CBO's quantitative single-payer modeling illustrates the scale of these tradeoffs. Across five illustrative Medicare-based single-payer options for 2030, CBO estimated that federal health subsidies would be \$1.5 trillion to \$3.0 trillion higher than under then-current law, while total national health expenditures ranged from \$0.7 trillion lower to

⁵⁰ Illinois Department of Insurance, Feasibility Study of a State-Based Health Benefits Plan (Apr. 2, 2021), <https://doi.illinois.gov/content/dam/soi/en/web/insurance/reports/reports/04-02-21-feasibility-study-report-final.pdf> (estimates for modeled Medicaid buy-in designs; results are specific to the study's assumptions).

⁵¹ NABIP, Public Option/Medicare or Medicaid Buy-in Position Paper (July 28, 2021), <https://nabip.org/advocacy/policy-documents/position-papers/public-option-medicare-or-medicaid-buy-in-position-paper>.

\$0.3 trillion higher depending on provider payment, cost sharing, benefits, and other design choices.⁵²

CBO also found that increased demand for services could exceed the increase in provider supply, producing greater unmet demand, including delays and forgone care, particularly in scenarios with lower cost sharing and lower provider payment rates. CBO's scenarios are illustrative rather than forecasts of a specific bill, but they demonstrate that financing and access outcomes depend heavily on program design.⁵³

Coverage expansion would be tied to sufficient capacity to deliver care. Congress should examine whether proposed provider payments and increased demand would support timely appointments and adequate access, particularly in rural and underserved communities.

Section 1.IV Getting rid of junk insurance plans and ending the constant cycle of higher premiums, skyrocketing deductibles, shrinking networks and worse coverage

Distinguishing Between Legitimate and Non-Legitimate Coverage Options

NABIP supports preserving legitimate short-term and supplemental coverage options, including short-term, limited-duration insurance (STLDI) and fixed indemnity coverage, while using clear disclosures and targeted guardrails to distinguish them from comprehensive ACA coverage and prevent them from being presented as substitutes for it. The RFI asks whether products it characterizes as “junk coverage” should be prohibited or subjected to stronger minimum standards and whether carriers that sell such products should receive taxpayer support. That analysis should distinguish between different forms of non-ACA-compliant coverage, including STLDI, fixed indemnity benefits, and association health plans, because they serve different purposes and operate under different regulatory structures.

⁵² CBO, How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program, Working Paper 2020-08 (Dec. 10, 2020), <https://www.cbo.gov/publication/56811> (five illustrative options and estimated federal subsidy and national expenditure effects).

⁵³ CBO, How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program, Working Paper 2020-08 (Dec. 10, 2020), <https://www.cbo.gov/publication/56811>. These modeled outcomes are illustrative scenarios, not estimates for a specific bill.

Short-Term Limited-Duration Insurance

NABIP has recognized that STLDI is not comprehensive, and consumers may not always understand its limitations, while supporting its availability for consumers who need temporary protection between more comprehensive forms of coverage.

NABIP recommended a middle-ground approach permitting approximately six months of STLDI coverage with one renewal, or six months with renewed coverage ending January 1, whichever is shorter. NABIP also suggested that further renewals could be limited to individuals who are not eligible for Marketplace premium tax credits. NABIP also recommended stronger comparison information, including an expanded Summary of Benefits and Coverage that would help consumers understand the differences between STLDI and ACA-compliant coverage at the time of purchase.⁵⁴

Current federal duration limits are more restrictive than NABIP's prior recommendation. Under the 2024 final rule, STLDI issued on or after September 1, 2024 generally may have an initial term of no more than three months and a maximum duration of four months, including renewals or extensions. The rule also requires prominent consumer notices explaining that STLDI differs from comprehensive coverage. As of September 2026, CMS-9881, a proposed rule intended to revise the STLDI definition again, remains at the proposed-rule stage and is undergoing Executive Order review.⁵⁵

Available federal evidence also counsels against overly broad conclusions about the role of these products. GAO found that STLDI generally has lower premiums but fewer benefits and fewer federal consumer protections than ACA-compliant coverage. GAO also found insufficient and inconsistent data to determine how consumers use STLDI nationally and reported differing views among state regulators and other stakeholders about its value as temporary coverage.⁵⁶

⁵⁴ NABIP, Comments on Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements (Sept. 1, 2023), available from <https://nabip.org/membership-resources/podcast-webinars/healthcare-happy-hour/nabip-submits-comments-on-short-term-plans-aca-excepted-benefits-and-level-funded-plan-arrangements>; CMS, Summary of Benefits and Coverage resources, <https://www.cms.gov/ccio/resources/forms-reports-and-other-resources/summary-of-benefits-and-coverage>.

⁵⁵ Short-Term, Limited-Duration Insurance and Independent, Noncoordinated Excepted Benefits Coverage, 89 Fed. Reg. 23338 (Apr. 3, 2024); CMS, Short-Term, Limited-Duration Insurance, <https://www.cms.gov/marketplace/private-health-insurance/short-term-limited-duration-insurance>; Office of Information and Regulatory Affairs, RIN 0938-AV92, CMS-9881, <https://www.reginfo.gov/public/do/eoDetails?rid=1404663> (proposed-rule status as of Sept. 29, 2026).

⁵⁶ GAO, Private Health Insurance: Limited Data Hinders Understanding of Short-Term Plans' Role and Value During COVID-19 Pandemic, GAO-22-104683 (May 31, 2022), <https://www.gao.gov/products/gao-22-104683>.

Fixed Indemnity and Supplemental Coverage

Fixed indemnity coverage should be treated differently from STLDI because it is designed to supplement, rather than replace, comprehensive medical coverage. NABIP has opposed rules that would broadly prevent employees from layering fixed indemnity benefits with major medical coverage. NABIP's concern has been that eliminating the ability to combine these products could reduce financial protection for consumers who knowingly purchase supplemental benefits alongside comprehensive coverage.⁵⁷

At the same time, NABIP has supported clear disclosure. NABIP welcomed model consumer-notice language for fixed indemnity products because standardized notice language can improve compliance and help consumers understand the nature of the coverage. In 2024, CMS subsequently established notice requirements for both new and existing fixed indemnity coverage for plan years or coverage periods beginning on or after January 1, 2025.⁵⁸

The appropriate consumer-protection goal is therefore not to eliminate supplemental products that consumers use in conjunction with comprehensive insurance. It is to ensure that they are not marketed or presented as comprehensive major medical coverage when they are not.

Section 1.V Eliminating surprise tax bills levied on working people who buy their own insurance

Premium Tax Credit Recapture and Income Verification

Section 71305 of Public Law 119-21 eliminated income-based limits on repayment of excess advance premium tax credits (APTC) for tax years after 2025. Beginning with tax year 2026, taxpayers generally must repay the full amount by which APTC received exceeds the premium tax credit ultimately allowed. Because Marketplace assistance is based on projected annual household income, this increases the financial

⁵⁷ NABIP, 2023 comments on excepted-benefit coverage, available at <https://nabip.org/membership-resources/podcast-webinars/healthcare-happy-hour/nabip-submits-comments-on-short-term-plans-aca-excepted-benefits-and-level-funded-plan-arrangements>; CMS, Excepted Benefits and Independent, Noncoordinated Excepted Benefits Coverage, 79 Fed. Reg. 59130 (Oct. 1, 2014) (fixed-indemnity coverage as an excepted benefit when regulatory conditions are met).

⁵⁸ CMS, Short-Term, Limited-Duration Insurance and Independent, Noncoordinated Excepted Benefits Coverage, 89 Fed. Reg. 23338 (Apr. 3, 2024) (consumer notice requirements for fixed-indemnity coverage); NABIP, 2023 comments on excepted benefits, available at <https://nabip.org/membership-resources/podcast-webinars/healthcare-happy-hour/nabip-submits-comments-on-short-term-plans-aca-excepted-benefits-and-level-funded-plan-arrangements>.

consequences of reasonable forecasting errors, particularly for households with variable income.⁵⁹

NABIP recommends a good-faith safe harbor or repayment limit for consumers who provide reasonable income information, comply with verification requirements, and timely report material changes. Protection should account for legitimate income volatility—including variable or seasonal wages, commissions, gig or self-employment income, one-time distributions or capital gains, and employment changes—while excluding intentional misrepresentation or failure to meet tax-filing and reconciliation requirements.

NABIP recommends improving the Marketplace's mid-year income tools. Consumers with volatile income would benefit from year-to-date tracking, monthly income-entry options, clearer separation of recurring and one-time income, alerts when projected annual income approaches an eligibility threshold, and a simple change-in-circumstances recalculation tool. IRS guidance already emphasizes that changes such as retirement distributions, capital gains, debt cancellation, marriage, divorce, and changes in employer coverage can materially affect the final PTC. Better Marketplace tools would help consumers respond to those changes before they become larger eligibility or reconciliation problems.

Income verification should similarly protect program integrity without treating prior-year data as conclusive when current-year income has changed. Federal data should serve as a starting point, with practical alternative verification pathways when tax data are unavailable or do not reasonably reflect projected income. CMS finalized additional verification beginning in plan year 2027 when trusted data show income below 100 percent of the federal poverty level despite a higher applicant projection, and when IRS data are unavailable; those provisions are currently pending litigation.⁶⁰

Use Prior-Year Data as Evidence

NABIP supports additional verification when an applicant reports income above 100 percent FPL while federal data indicate prior income below that level. At the same time, NABIP has opposed eliminating income attestation when IRS data are unavailable unless consumers have workable alternative verification pathways. NABIP has also opposed unnecessarily sensitive discrepancy thresholds that can generate Data

⁵⁹ Pub. L. No. 119-21, § 71305 (2025) (repealing income-based limits on repayment of excess advance premium tax credits for tax years beginning after Dec. 31, 2025); see also 26 U.S.C. § 36B(f).

⁶⁰ CMS, HHS Notice of Benefit and Payment Parameters for 2027 Final Rule, 91 Fed. Reg. 29256 (May 20, 2026), <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-payment-parameters-2027-final-rule>; CMS, "Statement Regarding City of Columbus v. Kennedy" (Aug. 4, 2026), <https://www.cms.gov/files/document/statement-re-city-columbus-080426.pdf> (court stay affecting the challenged Marketplace verification provisions).

Matching Issues (DMIs) for ordinary income variation, particularly among self-employed and seasonal workers.

When a DMI is generated, the consumer should receive a clear notice identifying the source of the inconsistency, what information must be provided, the deadline, and how to obtain assistance. Documentation standards should be reasonable enough to accommodate wage earners, self-employed consumers, business owners, retirees, and households with mixed income sources. Exchanges should also ensure that verification can be completed quickly enough to avoid unnecessary gaps or delays in coverage.

Certain tax-return indicators can help distinguish a potentially inaccurate application from a household whose income is simply variable. NABIP has recommended that CMS and Treasury explore whether the Federal Data Services Hub can receive limited indicators showing that a prior-year return included Schedule C, Schedule F, Schedule E, Schedule SE, K-1 income, retirement distributions, or Social Security income, without transmitting the underlying tax-return details. When such indicators show that historical income may be a poor predictor of the coverage year, the Exchange should permit current-year documentation and income attestation to carry greater weight.⁶¹

The objective should be verification, not mechanical reliance on stale data. A self-employed consumer whose business has grown, a worker whose hours have changed, or a retiree with a one-time distribution should have a clear path to demonstrate expected current-year income without being forced to treat the prior tax year as dispositive.

Longer-Term Modernization

NABIP has also encouraged federal policymakers to examine whether the current prospective-income model can be modernized. One longer-term option would use verified historical income as a baseline while allowing a structured appeal, similar in concept to Medicare's income-related monthly adjustment amount (IRMAA) process, when a documented life event or material income change makes historical data unrepresentative. Such a change would require careful statutory and administrative design, but it could reduce repeated forecasting disputes while preserving responsiveness to real-time changes.⁶²

⁶¹ NABIP, Comments on CMS-9883-P (Mar. 13, 2026), https://nabip.org/media/10840/nabip_comments_cms-9883-p_nbpp-2027_march-13-2026.pdf (proposal concerning limited indicators of prior-year income types and alternative verification).

⁶² NABIP, Comments on CMS-9883-P (Mar. 13, 2026), https://nabip.org/media/10840/nabip_comments_cms-9883-p_nbpp-2027_march-13-2026.pdf; Social Security Administration, "Medicare Premiums: Rules for Higher-Income

The central principle should be that program-integrity controls verify eligibility without assuming that prior-year tax data perfectly predict current-year income. Detailed recommendations on how much excess APTC a consumer should repay are addressed separately under Premium Tax Credit Recapture Caps and Safe Harbors.

Section 2: Making Health Care Simpler for Families

Section 2.1 Simplifying and standardizing plan options and benefits, so people can efficiently select coverage and services that will meet their needs

Standardized Marketplace Plans

NABIP supports eliminating the federal standardized plan design mandate and numerical limits on non-standardized Marketplace offerings while improving how material plan differences are presented to consumers. Standardized cost sharing can simplify one aspect of comparison but plans with similar deductibles and copayments may still differ significantly in provider networks, formularies, utilization management, prior authorization, pre-deductible coverage, and other features that affect access and cost.

Rather than requiring issuers to conform to a single federal cost-sharing template, Marketplace tools should present key information—including net premium, deductible, maximum out-of-pocket exposure, common cost sharing, network characteristics, prescription-drug coverage, and significant restrictions or benefits—in a consistent, comparable format. NABIP also supports preference-based tools that help consumers sort plans based on expected utilization, provider and prescription-drug needs, premium-versus-cost-sharing preferences, and available financial assistance.

This approach would preserve meaningful plan choice, including options designed to meet the needs of consumers with chronic or high-cost conditions, while making those choices easier to evaluate. CMS finalized the elimination of standardized plan requirements and limits on non-standardized offerings in the 2027 Payment Notice; however, a federal district court subsequently stayed those provisions nationwide while litigation continues.⁶³

Beneficiaries,” <https://www.ssa.gov/benefits/medicare/medicare-premiums.html> (IRMAA reconsideration after certain life-changing events).

⁶³ CMS, HHS Notice of Benefit and Payment Parameters for 2027 Final Rule, 91 Fed. Reg. 29256 (May 20, 2026), <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-payment-parameters-2027-final-rule>; CMS, “Statement

Preserve Assistance and Transition Protections

Simpler plan displays can reduce unnecessary shopping friction, but they do not eliminate the need for professional assistance. Consumers may still need help determining whether physicians and facilities participate in a network, whether prescriptions are covered, how prior authorization applies, how a plan treats recurring care, and how financial assistance changes the relative value of available options. Those differences remain even when two plans share the same deductible or copayment structure.

If standardized-plan requirements are modified, suspended, or eliminated, plan mapping and renewal communications become especially important. NABIP has recommended clear crosswalk standards when an issuer modifies or discontinues a plan so consumers understand how their existing coverage will transition. Renewal notices should accurately describe material changes in cost sharing and provider access and should give consumers enough time to compare alternatives during Open Enrollment.⁶⁴

Congress should therefore focus on making plan differences understandable rather than making plan designs uniform. Consistent information, better sorting tools, accurate network and formulary data, and clear renewal mapping can simplify Marketplace shopping while preserving issuer innovation and consumer choice.

Ghost Networks and Provider Directories

Accurate provider-network information is essential both when a consumer selects coverage and when that consumer later seeks care. Plan comparison tools can only be effective if the underlying information regarding participating physicians, hospitals, facilities, specialties, locations, and acceptance of new patients is reliable.

The practical experience of agents and brokers demonstrates that provider-network information is often considerably more complicated than whether a provider's name appears in an online directory. Providers may participate through different group or facility contracts, network arrangements can vary geographically, and consumers may encounter discrepancies between directories, provider information, and the actual contracting status of a particular location or clinician. These complexities frequently

Regarding *City of Columbus v. Kennedy*" (Aug. 4, 2026), <https://www.cms.gov/files/document/statement-re-city-columbus-080426.pdf> (nationwide stay of the standardized-plan and non-standardized-plan-limit provisions).

⁶⁴ NABIP, Comments on CMS-9883-P (Mar. 13, 2026), https://nabip.org/media/10840/nabip_comments_cms-9883-p_nbpp-2027_march-13-2026.pdf (renewal, plan mapping, and consumer notice recommendations).

require agents and brokers to conduct additional research beyond the information displayed on an enrollment platform.

Evidence from Pennsylvania illustrates the underlying problem. A state-sponsored study of ACA Marketplace provider directories found that among provider listings previously identified as inaccurate and subsequently resurveyed, 40.3 percent continued to contain at least one inaccuracy roughly a year and a half later. The Pennsylvania Insurance Department has separately reported significant inaccuracies involving provider contact information and consumers' ability to reach listed providers.⁶⁵

NABIP supports establishing clear and enforceable expectations for directory accuracy while recognizing that accurate directories require timely information exchange among carriers, providers, facilities, and other contracting entities. Federal standards should establish common provider data elements and mechanisms for updating information and should facilitate standardized electronic exchange of provider-network data wherever feasible. Any new standards should work in coordination with state regulatory authority.

Behavioral Health Network Adequacy and Plan-Sponsor Data Access

NABIP recommends pairing directory-accuracy standards with measures of whether listed behavioral-health providers are available. For mental health and substance use disorder (MH/SUD) networks, relevant measures include provider-to-enrollee ratios, behavioral-health-specific time-and-distance standards, routine and urgent appointment wait times, the percentage of listed providers accepting new patients, and the percentage of listed providers actively submitting claims. Accountability should be attached to the issuer, TPA, PBM, behavioral-health vendor, or network vendor that controls the relevant function; plan sponsors should not be held responsible for network deficiencies they cannot see, verify, or contractually remedy.

Plan sponsors, particularly self-funded group health plans, should receive standardized, timely, aggregate information on network composition, reimbursement, appointment availability, and claims activity for the network serving their covered population, subject to appropriate privacy and confidentiality protections. Contracts should require vendors that control these functions to produce required data, certify directory accuracy, cooperate with audits, and correct deficiencies within defined timeframes. A practical safe harbor should protect plan sponsors that timely request and review available data,

⁶⁵ Pennsylvania Insurance Department, Provider Directory Inaccuracies Study (extended study), <https://www.insurance.pa.gov/Coverage/health-insurance/Documents/networkadequacystudy-providerdirectoryinaccuracies-extended.pdf> (follow-up accuracy findings, including the 40.3% figure).

escalate deficiencies, and take commercially reasonable corrective action but cannot compel a vendor to produce missing or proprietary information.

Directory audits should leverage claims-based verification and periodic outreach to confirm actual provider availability. Appointment wait time and acceptance of new patients should be measured directly, and telehealth capacity should count toward network adequacy only when it provides timely, clinically appropriate access, continuity of care, and appropriate escalation to higher-acuity or in-person services when needed. Licensed agents, brokers, consultants, and benefits advisors should have access to reliable performance information so they can help employers compare network products, evaluate renewal options, and communicate access limitations to participants.

Consumers should not bear the financial consequences of inaccurate information. Existing federal protections for consumers who rely on inaccurate provider-directory information provide an important foundation.⁶⁶

For enforcement, Congress could consider a graduated framework that distinguishes isolated or promptly corrected errors from persistent or systemic directory failures. Corrective-action requirements and data-quality improvement plans may be appropriate for initial problems. Any remedies should create meaningful incentives for accuracy without encouraging plans to address compliance risk simply by removing providers from directories when network status cannot immediately be verified.

Section 2.II Ensuring that patients do not face hurdles or delays in accessing the care they need

Mid-Year Network Changes and Continuity of Care

Consumers should not face unexpected costs or disruptions in medically necessary care because a provider or facility leaves a plan's network during the plan year. Existing federal law provides continuity-of-care protections for certain patients for up to 90 days following a qualifying network change. Congress should ensure these protections are implemented consistently, with timely notice, clear information on cost sharing and available alternatives, and a simple process for continuing treatment.⁶⁷

⁶⁶ ERISA § 719, 29 U.S.C. § 1185i; Public Health Service Act § 2799A-5, 42 U.S.C. § 300gg-115 (provider-directory accuracy, response protocols, and consumer protections when a patient relies on incorrect network information).

⁶⁷ ERISA § 718, 29 U.S.C. § 1185g; Public Health Service Act § 2799A-3, 42 U.S.C. § 300gg-113 (continuity of care for qualifying continuing-care patients, generally for up to 90 days after a network-contract termination); CMS, No Surprises Act continuity-of-care overview, <https://www.cms.gov/initiatives/no-surprise-billing/overview/policies-resources/provider-requirements-resources>.

NABIP also supports considering targeted extensions beyond 90 days when an active course of treatment cannot reasonably be completed or safely transitioned within that period. Rather than imposing a uniform extension in every case, continued in-network treatment should be available through an appropriate clinical transition point when interruption would create meaningful risk or disruption for the patient. Consumers who reasonably relied on plan information or began treatment while a provider was in network should be protected from additional financial liability caused solely by a subsequent network change.

Section 2.III Holding Big Insurance accountable to patients and providers for practices that generate profits by stepping between patients and their doctors to delay or deny access to care

Voluntary Direct Contracting and Alternative Purchasing Models

Congress may consider whether direct contracting, direct primary care, bundled-payment, centers-of-excellence, and cash-payment arrangements reduce total consumer costs, improve access to care, shorten wait times, and improve health outcomes. NABIP supports evaluation of these arrangements as voluntary tools that may supplement comprehensive employer coverage.

The potential administrative savings vary by arrangement and come from reducing the number of intermediaries involved in pricing, billing, claims submission, repricing, payment, and appeals. Direct primary care may reduce claims-processing expenses for routine primary care by using a predictable membership or direct-payment model. Direct contracting may reduce certain administrative costs by limiting intermediary involvement in pricing, billing, payment, and network administration. Bundled-payment arrangements and cash-payment models may reduce administrative complexity and costs when the service can be priced in advance and purchased through a simplified process. These approaches can be used for primary care, imaging, musculoskeletal care, outpatient surgery, maternity care, select specialty services, and centers of excellence. However, these models generally supplement rather than replace comprehensive medical coverage and should be evaluated according to the specific services they address.⁶⁸

Federal policymakers could request evidence that distinguishes headline price reductions from actual net savings to plans and employees. Relevant evidence should include total per-member-per-month administrative costs, claims-processing and

⁶⁸ CMS Innovation Center, Direct Contracting Model resources and evaluations, <https://www.cms.gov/priorities/innovation/innovation-models/direct-contracting-model>; GAO, CMS Innovation Center: Obligations and Model Testing Progress, GAO-26-107953 (Mar. 30, 2026), <https://www.gao.gov/products/gao-26-107953>. Evidence is model- and service-specific; these sources do not establish that every direct-contracting or cash-payment arrangement yields net savings.

repricing fees, network access fees, TPA or ASO fees, stop-loss impacts, utilization changes, quality outcomes, referral patterns, employee premium contributions, employee cost-sharing, deductible and out-of-pocket maximum treatment, balance-billing experience, provider access, and whether savings are passed through to employees through lower contributions, waived cost-sharing, HSA or HRA funding, or improved access.

The success of these arrangements should not be measured solely by negotiated prices. Employee awareness, understanding, and utilization of available options are critical factors in achieving meaningful savings and improved outcomes. Even when employers establish high-value arrangements, projected savings may not materialize if employees are unaware of available services, face navigation challenges, or receive inadequate decision-support resources. Employee education, communication, navigation support, and licensed advisor guidance remain important components of successful implementation.

Price Transparency and Cash-Payment Treatment

Cash-payment arrangements can be more effective when employers and consumers have access to clear, upfront, and comparable pricing information. The Government Accountability Office has found that stakeholders had trouble locating hospital price-transparency data and identified concerns with inconsistent formats and incomplete or inaccurate information, although CMS has since taken steps to standardize reporting requirements. Congress can continue to strengthen enforcement and implementation of existing price-transparency requirements so that employers, consumers, and their advisors can more readily compare cash prices and negotiated rates across providers. These reforms should focus on making existing price information accessible, standardized, and usable—not on establishing government-set prices or limiting providers' ability to negotiate rates. Greater transparency can support voluntary cash-payment and direct-contracting arrangements while preserving market competition and consumer choice.⁶⁹

Plan design should also reward patients who find lower prices. In many cases, a provider's cash price is lower than the plan's negotiated rate, yet a patient who pays cash for a covered service generally receives no credit toward the deductible or out-of-pocket maximum. The result penalizes the patient for reducing costs to

⁶⁹ GAO, Health Care Transparency: CMS Needs More Information on Hospital Pricing Data Completeness and Accuracy, GAO-25-106995 (May 2025), <https://www.gao.gov/products/gao-25-106995>; CMS, Hospital Price Transparency, <https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency> (required standard-charge disclosures include cash prices and negotiated charges; GAO identified completeness and accuracy concerns). These sources establish the disclosure framework and data limitations, not the degree to which cash prices are lower than negotiated rates.

both the patient and the plan. Several states now require carriers to credit such payments, but these laws cannot reach self-funded ERISA plans, which cover 67 percent of workers with employer coverage. Congress can establish a uniform federal framework under which qualifying cash payments for medically necessary covered services, made at a price at or below the plan's negotiated rate, are credited toward the patient's deductible and out-of-pocket maximum upon submission of reasonable documentation. The framework should use the negotiated-rate data plans already published under federal transparency rules as the benchmark, minimize documentation burden on patients, and bar provider contract terms that penalize providers for offering lower cash prices to insured patients.⁷⁰

Barriers to Direct Contracting for Employers

Direct contracting has significant potential to improve affordability and provide employers greater control over healthcare purchasing. However, substantial barriers remain. Establishing direct provider relationships often requires significant legal, operational, and administrative resources. Employers must account for their existing ERISA fiduciary duties, including prudent selection and monitoring, when structuring direct arrangements. Development of voluntary standardized employer-provider contracting templates could reduce legal and administrative costs while preserving flexibility for employers and providers to negotiate appropriate business terms.

Direct contracting also depends on the plan-sponsor data and audit rights discussed in Section 3.IV. Employers cannot meaningfully evaluate alternative purchasing arrangements without usable claims, pricing, quality, and utilization information.

Provider market concentration presents an additional challenge. In many markets, hospital systems and large provider organizations possess significant negotiating leverage that can limit employers' practical ability to establish direct contracts. This

⁷⁰ Tex. Ins. Code § 1301.140, <https://tcss.legis.texas.gov/resources/IN/htm/IN.1301.htm>; Tenn. Code Ann. § 56-7-610; Me. Rev. Stat. tit. 24-A, § 4318-B, <https://www.legislature.maine.gov/legis/statutes/24-A/title24-Asec4318-B.html> (state requirements differ in scope and apply to insured plans); KFF, 2025 Employer Health Benefits Survey, <https://www.kff.org/health-costs/2025-employer-health-benefits-survey/> (67% of covered workers were enrolled in self-funded plans); CMS, Hospital Price Transparency, <https://www.cms.gov/priorities/key-initiatives/hospital-price-transparency>; GAO, Health Care Transparency: CMS Needs More Information on Hospital Pricing Data Completeness and Accuracy, GAO-25-106995 (May 2025), <https://www.gao.gov/products/gao-25-106995>. Federal disclosures allow comparison of cash prices and negotiated rates, but the cited government sources do not establish that cash prices are lower in many cases nationally; the comparison is provider- and service-specific and should be verified before publication.

challenge is particularly acute in rural communities and highly consolidated healthcare markets where few meaningful alternatives exist.⁷¹

Small and midsize employers face particularly significant barriers. Unlike many large employers, they often lack sufficient claims volume to negotiate favorable pricing, spread risk effectively, conduct meaningful utilization analysis, or justify the administrative investment required to establish direct arrangements. Many also lack access to usable claims data, actuarial support to identify service-line savings, legal support, or internal benefits staff to manage contracting, employee communications, navigation, eligibility feeds, payment reconciliation, and quality monitoring. One industry response has been the establishment of voluntary “purchaser coalitions” which may enable small and midsize employers to aggregate their health plan purchasing power. Congress could remove one potential barrier to this approach by ensuring that such activities do not put the employers at risk of antitrust violations.

Fully insured employers may have limited ability to carve out services from traditional networks, while level-funded and self-funded employers may face TPA or other restrictions related to network contracts, anti-steering or all-or-nothing provisions, stop-loss limitations, provider reluctance to contract directly with smaller purchasers, ERISA fiduciary considerations, HIPAA privacy requirements, state insurance-law issues, and COBRA or ACA reporting coordination challenges. HSA compatibility may also require consideration for arrangements that fall outside the statutory protections now available for qualifying direct primary care service arrangements.⁷²

ERISA Preemption and State Waiver Authority

NABIP opposes broad state waiver authority over self-funded ERISA plans and urges caution regarding any waiver framework that would allow states to regulate core aspects of self-funded plan design or administration. ERISA’s national framework enables employers operating across state lines to design, finance, and administer uniform health plans for geographically dispersed employees. Allowing states to impose different requirements would increase cost, litigation risk, and administrative fragmentation. Congress should strengthen federal minimum consumer protections, EBSA enforcement, and service-provider accountability while supporting coordinated state-federal enforcement where appropriate.

⁷¹ GAO, Health Care Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation, GAO-25-107450 (2025), <https://www.gao.gov/products/gao-25-107450> (review of consolidation, spending, prices, quality, and access; effects vary across markets and studies).

⁷² Pub. L. No. 119-21, § 71308 (2025) (HSA treatment of qualifying direct-primary-care arrangements beginning in 2026); IRS, “Working Families Tax Cuts,” <https://www.irs.gov/newsroom/working-families-tax-cuts>; 26 U.S.C. § 223(c)(2).

Congress can improve protections by establishing national standards for denial reason codes, adverse-benefit notices, appeal timelines, external review, access to medical-necessity criteria, continuity of care, gag-clause protections, data-access rights, and TPA/ASO/PBM transparency.

Congress could consider cooperative federalism tools short of an ERISA waiver, including state referral pathways for participant complaints, coordinated audits of licensed TPAs and PBMs, state data-sharing arrangements, and federal model consumer-protection standards. These tools would allow states to contribute enforcement capacity without fragmenting employer plan administration.

EBSA Oversight

NABIP supports stronger federal oversight and enforcement against practices that prevent participants from receiving benefits to which they are entitled. To be successful, EBSA must have sufficient staffing, funding, data tools, and specialized expertise—including clinicians, actuaries, claims-administration experts, data analysts, ERISA and health-law attorneys, cybersecurity and privacy specialists, and pharmacy benefit experts—to oversee an increasingly complex market administered through TPAs, ASOs, PBMs, utilization-management vendors, repricers, networks, and affiliated service providers.

EBSA should prioritize transparency and standardized reporting of denials and appeals. Plans and service providers could clearly explain adverse benefit decisions, identify the entity responsible, and provide participants with understandable information about their appeal rights. Congress should also support standardized reporting on denial and appeal patterns and ensure that EBSA has authority to examine the contracts, financial arrangements, administrative practices, and conflicts of interest that may affect claims and utilization-management decisions.

Good-Faith Employer Safe Harbor and Vendor Accountability

Congress may consider establishing a good-faith employer safe harbor tied to prudent process. Employers should generally be protected from punitive or enhanced liability when they select qualified service providers through a reasonable process, execute written agreements defining delegated authority, maintain accurate plan documents and summary plan descriptions, require access to claims and fee data, monitor vendors at reasonable intervals, investigate credible evidence of systemic problems, and take timely corrective action. The safe harbor should not protect employers that knowingly approve unlawful terms, ignore repeated evidence of improper conduct, fail to monitor

service providers, or use delegation as a shield against their own fiduciary responsibilities.

Employers that prudently delegate and monitor plan administration should be evaluated under a process-based fiduciary standard, while accountability for an improper claim, utilization-management, payment, or other administrative decision should attach to the entity that made or controlled that decision. That entity should be subject to direct review for compliance with plan terms, ERISA's full-and-fair-review requirements, applicable federal mandates, clinical standards, required timelines, and conflict-of-interest safeguards. Remedies should incentivize good behavior and be proportionate to the conduct involved, with corrective-action requirements for isolated errors and stronger remedies for systemic or knowing misconduct. Penalties should apply to the benefiting entity, including parent companies or affiliates.

Employers must also have access to the information necessary to satisfy their monitoring obligations, as discussed in Section 3.IV.

Section 2.IV Simplifying the process to get insurance, and protecting people from losing coverage each year due to unexpected costs or red tape

Addressing ACA Fraud Where It Occurs

NABIP supports aggressive enforcement against unauthorized enrollment, deceptive marketing, identity misuse, fraudulent subsidy activity, and other Marketplace misconduct. Enforcement should be directed toward the individual or entity responsible for the conduct. CMS should be able to remove individual bad actors, hold agencies and marketing organizations accountable when misconduct is attributable to them, and pursue lead generators, centralized call centers, web-brokers, enrollment platforms, and other entities that enable patterned or systemic abuse. At the same time, compliant licensed professionals should receive appropriate due process, and regulatory requirements should reflect differences in role, conduct, and risk across the distribution chain.

CMS's enforcement action involving TrueCoverage and Benefitalign, which CMS treated collectively as Speridian for purposes of the action, illustrates the importance of entity-level accountability. Following a compliance audit and review, CMS determined that the entities had engaged in specific and patterned noncompliance sufficiently severe to support termination of their Enhanced Direct Enrollment (EDE) and Web-broker Agreements. In November 2025, CMS finalized a five-year denial of Speridian's ability to enter new Exchange Agreements, through Plan Year 2030. Effective enforcement must therefore reach beyond the individual who submits an application to

the agency, marketing organization, web-broker, enrollment platform, or other entity responsible for systemic misconduct.⁷³

Compensation structure, standing alone, should not be treated as evidence of misconduct. Commission-based compensation is a longstanding method of compensating licensed insurance professionals for enrollment and ongoing service. The relevant enforcement questions are whether the consumer authorized the transaction and whether the individual or entity complied with applicable Marketplace, licensing, marketing, and consumer-protection requirements.

Recent findings on unauthorized enrollment reinforce the need for stronger controls at the point where misconduct occurs. GAO found that confirmed complaints involving unauthorized enrollments and plan switches increased from 2023 through 2025 and identified weaknesses in FFM controls. Its recommendations focused on strengthening consumer authorization and Marketplace security. Those findings support stronger authentication, verification, monitoring, and accountability rather than treating legitimate enrollment assistance itself as suspect.⁷⁴

That distinction is important because agents and brokers remain a central source of Marketplace enrollment assistance. During the 2026 Open Enrollment Period, CMS reported that 76 percent of the 10.8 million active HealthCare.gov plan selections were agent- or broker-assisted. GAO likewise recognizes that millions of Marketplace consumers rely on agents and brokers for assistance and that those assisting consumers through the federal Marketplace must be licensed and registered. Congress and CMS should preserve that access while strengthening controls that identify and stop unauthorized activity. Specific security and verification recommendations are addressed below.⁷⁵

Coordinate Existing Enforcement Authority

Federal and state agencies already possess complementary enforcement authorities. The statutory Health Care Fraud and Abuse Control program directs HHS and the U.S.

⁷³ CMS, Notice of Final Determination Regarding Speridian Technologies, LLC (Nov. 2025), <https://www.cms.gov/files/document/speridian-notice-final-determination.pdf> (five-year denial of new Exchange Agreements and related findings).

⁷⁴ GAO, Health Insurance Marketplaces: CMS Needs Stronger Controls to Prevent Unauthorized Actions by Agents and Brokers, GAO-26-108297 (July 13, 2026), <https://www.gao.gov/products/gao-26-108297> (complaints involving confirmed unauthorized enrollments and plan switches increased more than fourfold from 2023 through 2025).

⁷⁵ CMS, Health Insurance Exchanges 2026 Open Enrollment Report (Mar. 2026), <https://www.cms.gov/files/document/health-insurance-exchanges-2026-open-enrollment-report.pdf>; GAO, Health Insurance Marketplaces: CMS Needs Stronger Controls to Prevent Unauthorized Actions by Agents and Brokers, GAO-26-108297 (July 13, 2026), <https://www.gao.gov/products/gao-26-108297> (millions use agent/broker help; federal Marketplace agents and brokers must be state-licensed and CMS-registered).

Department of Justice (DOJ) to coordinate federal, state, and local law-enforcement activity with respect to investigations, audits, evaluations, and prosecutions involving health care fraud. DOL also has direct investigative authority under ERISA over employer coverage and relevant service providers. State Departments of Insurance remain central to producer licensing and market-conduct enforcement.

The principal need is therefore not simply more rules. It is timely coordination, information sharing, and the ability to connect conduct across entities and jurisdictions. Marketplace enforcement should allow CMS and its law-enforcement partners to identify patterns that span multiple agents, agencies, lead sources, or enrollment platforms and to refer potential criminal conduct promptly to the appropriate authorities. At the same time, NABIP has consistently emphasized that suspension and termination actions should be based on reliable evidence and include meaningful due process, particularly where an enforcement action could prevent a licensed professional from serving existing clients.⁷⁶

Leveraging SBM Success

NABIP supports secure, interoperable technology across State-Based Marketplaces and Enhanced Direct Enrollment that reduces manual enrollment friction, uses reliable federal data before requesting consumer documentation, applies consistent verification and security controls across enrollment pathways, and records effectuated enrollment changes. Technology should prevent improper activity before it occurs while making legitimate enrollment easier to complete.

Selected SBMs also offer useful program-integrity models. GAO examined Covered California, Georgia Access, and BeWell New Mexico and found that all three use consumer-authorization or account-access controls that go beyond those used by the FFM, including one-time passcodes, access restrictions, and consumer notifications. GAO further reported that officials from two of the three selected SBMs, along with other stakeholders, did not consider unauthorized enrollment and plan switching to be significant issues in those Marketplaces.⁷⁷

⁷⁶ NABIP, Comments on CMS-9883-P (Mar. 13, 2026), https://nabip.org/media/10840/nabip_comments_cms-9883-p_nbpp-2027_march-13-2026.pdf (evidence, appeal, and due-process concerns in Marketplace enforcement).

⁷⁷ GAO, Health Insurance Marketplaces: CMS Needs Stronger Controls to Prevent Unauthorized Actions by Agents and Brokers, GAO-26-108297 (July 13, 2026), <https://www.gao.gov/products/gao-26-108297> (three selected State-Based Marketplaces—California, Georgia, and New Mexico—used additional consumer-authorization controls, including one-time passcodes).

Standardize Security and Verification Across Platforms

Consumers should receive the same core program-integrity protections regardless of which approved enrollment pathway they use. NABIP has recommended standardized verification checkpoints, eligibility validation, documentation processes, and security protocols across Exchange and EDE platforms, including MFA or two-factor authentication (2FA) when accessing or updating consumer eligibility information.⁷⁸

Risk-based technology can appropriately determine when additional verification is needed, but a risk flag should trigger a verification step rather than serve as an unsupported conclusion that a consumer or enrollment professional committed fraud. System-generated indicators should be transparent enough for consumers and assisters to understand what additional action is required, and adverse enforcement decisions should remain subject to evidentiary and due-process protections.

Evaluate the New EDE Authorization Framework Before Adding More Layers

CMS is implementing a significant new EDE program-integrity framework for Open Enrollment 2027. Under EDE Change Request 109, EDE partners must systematically enforce consumer identity proofing and agent, broker, or web-broker authorization for applications submitted through the EDE agent/broker pathway no later than October 12, 2026. All applications require agent/broker authorization. Applications meeting CMS's high-risk criteria require identity proofing before authorization, while lower-risk applications may use a lightweight mechanism such as a one-time passcode or confirmation link.⁷⁹

CMS states that this new authorization requirement does not replace the separate consumer-consent documentation requirement under 45 CFR § 155.220(j)(2)(iii). CMS should first evaluate how the new identity-proofing and authorization controls affect unauthorized enrollment, plan switching, completion time, consumer abandonment, and agent workflows before adding further overlapping requirements.⁸⁰

If that evaluation shows that the EDE authorization transaction reliably verifies the consumer, identifies the assisting professional, records affirmative permission, and

⁷⁸ NABIP, Comments on CMS-9883-P (Mar. 13, 2026), https://nabip.org/media/10840/nabip_comments_cms-9883-p_nbpp-2027_march-13-2026.pdf (recommended verification and security standards).

⁷⁹ CMS, EDE Change Request 109: Identity Proofing and Agent/Broker Authorization FAQs, <https://www.cms.gov/marketplace/agents-brokers/files/ede-identity-proofing-agent-broker-authorization-faqs.pdf> (implementation deadline and risk-based identity-proofing and authorization requirements).

⁸⁰ 45 C.F.R. § 155.220(j)(2)(iii); CMS, EDE Change Request 109 FAQs, <https://www.cms.gov/marketplace/agents-brokers/files/ede-identity-proofing-agent-broker-authorization-faqs.pdf> (authorization framework does not replace required consumer-consent documentation).

creates an auditable record, CMS should eliminate duplicative consent-documentation steps that do not add a distinct consumer protection. The objective should be one secure and understandable authorization process, not multiple overlapping records of the same consumer decision.

Use Federal Data Before Requiring Documents

NABIP has consistently recommended that Exchanges use trusted federal data sources before generating manual documentation requests. NABIP has recommended automated verification through existing federal data sources, pre-enrollment eligibility tools for consumers and enrollment professionals, clear verification-status indicators, standardized documentation requests and submission processes, and consistent verification checkpoints across Exchange-operated and EDE systems.⁸¹

Manual documentation should be the fallback when reliable electronic data cannot resolve an eligibility question, not the first step. This approach can reduce Data Matching Issues, shorten resolution times, and focus administrative resources on cases that require additional evidence. Detailed recommendations concerning variable income and when prior-year tax information is not representative are addressed separately under Income Verification and Good-Faith Estimate Protections.

Preserve a Centralized Marketplace Pathway

NABIP supports the continued expansion of EDE because it can provide efficient, integrated enrollment and post-enrollment experience for consumers working with agents and brokers. That support does not extend to eliminating a State Exchange's own consumer-facing pathway.

CMS finalized a centralized eligibility and enrollment requirement for State Marketplaces. In the 2027 rulemaking, CMS proposed allowing a State Exchange to rely exclusively on web-brokers through a State Exchange EDE model but did not finalize that proposal and retained the centralized-platform requirement. This decision is consistent with NABIP's recommendation. Consumers who enroll independently or rely on Exchange call centers, Navigators, or community assistance should continue to have a direct Exchange-operated pathway and a reliable escalation channel when eligibility or enrollment problems arise.⁸²

⁸¹ NABIP, Comments on CMS-9883-P (Mar. 13, 2026), https://nabip.org/media/10840/nabip_comments_cms-9883-p_nbpp-2027_march-13-2026.pdf (use of federal data and alternatives to manual documentation requests).

⁸² CMS, HHS Notice of Benefit and Payment Parameters for 2027 Final Rule, 91 Fed. Reg. 29256 (May 20, 2026), <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-payment-parameters-2027-final-rule> (CMS retained

Section 3: Taking on Corporate Greed

Section 3.I Putting patients over profits by making sure federal dollars are being used to drive enrollee satisfaction, not corporate profits, executive compensation and stock price

Capital Allocation, Executive Compensation, and Stock Buybacks

NABIP supports a patient-first accountability framework that gives consumers, employers, and taxpayers greater transparency into executive compensation, stock buybacks, affiliate transactions, and capital distributions when entities receive substantial taxpayer-supported revenue or operate in federally subsidized healthcare markets. Congress should scrutinize financial practices that reward higher costs, denied care, market consolidation, or opaque affiliate transactions, while ensuring any restrictions are targeted, transparent, and evidence-based so they do not discourage competition, market entry, or legitimate investments in technology, care management, network development, solvency, compliance, cybersecurity, or consumer support.

Heightened scrutiny is appropriate when large capital distributions or compensation programs coincide with premium increases, reduced provider access, increased prior authorization or denial rates, market exits, narrow-network disruption, inaccurate provider directories, delayed claims payment, MLR reporting concerns, or substantial federal subsidy flows. Congress could require enhanced disclosure above defined revenue or subsidy thresholds and condition extraordinary distributions on compliance with network, claims, appeals, transparency, rate-review, and MLR integrity standards. Detailed recommendations on enterprise-wide ownership, affiliate payments, financial flows, and MLR treatment and enforcement are addressed in Sections 3.II and 3.III.

Foreign and non-health investments should be evaluated based on whether they strengthen or weaken the healthcare value chain. Investments that improve access, data security, payment accuracy, care coordination, consumer service, or provider capacity may be appropriate; investments that divert premium dollars into unrelated assets, offshore structures, or opaque affiliate transactions warrant scrutiny.

Private Equity and Investor-Backed Ownership

NABIP supports transparency that allows employers, consumers, and policymakers to evaluate whether investor-backed ownership changes healthcare costs, access, staffing, service availability, or quality. Oversight should target transactions that extract

the centralized-platform requirement for State Exchanges); NABIP, Comments on CMS-9883-P (Mar. 13, 2026), https://nabip.org/media/10840/nabip_comments_cms-9883-p_nbpp-2027_march-13-2026.pdf.

value through excessive leverage, short holding periods, dividend recapitalizations, sale-leasebacks, affiliate fees, staffing reductions, aggressive revenue-cycle practices, or management-services arrangements that reduce access, quality, affordability, clinical autonomy, or community stability.⁸³

Review should be calibrated to transaction risk, with heightened scrutiny for essential community services, including hospitals, emergency departments, nursing homes, behavioral-health facilities, specialty practices, anesthesia, radiology, emergency medicine, oncology, dialysis, home health, and hospice. Conditions or restrictions should focus on practices most likely to harm patients, including excessive leverage, dividend recapitalizations funded by operating cash, sale-leasebacks that impair facility viability, related-party management fees, forced referrals, restrictive clinician covenants, and investor control over staffing, scheduling, clinical protocols, payer contracting, coding, billing, or discharge decisions.

Ownership Transparency and Public Reporting

Ownership reporting for private equity-backed healthcare entities should identify beneficial owners, private equity sponsors, management companies and management-services organizations, real-estate affiliates and related-party landlords, debt holders with control rights, and entities receiving material management fees, monitoring fees, lease payments, dividends, loans, guarantees, or other transfers. It should also identify sale-leasebacks and control structures that may affect staffing, clinical autonomy, payer contracting, or other material operational decisions.

Congress could consider supporting a public, searchable ownership and transaction database for entities above an appropriate size or risk threshold, covering ownership chains, affiliates, transaction dates, material changes in control, service-line closures, bankruptcy filings, sale-leasebacks, management-services relationships, and enforcement actions. Reporting should protect PHI and legitimate proprietary contracting information, permit comparison across states and markets, and avoid disproportionate burdens on small independent practices that are not part of investor-backed consolidation strategies.⁸⁴

⁸³ NABIP, Comments on CMS-9883-P (Mar. 13, 2026), https://nabip.org/media/10840/nabip_comments_cms-9883-p_nbpp-2027_march-13-2026.pdf; GAO, Health Care Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation, GAO-25-107450 (2025), <https://www.gao.gov/products/gao-25-107450> (available evidence on ownership, consolidation, prices, quality, and access).

⁸⁴ GAO, Nursing Homes: Limitations of Using CMS Data to Identify Private Equity and Other Ownership, GAO-23-106163 (2023), <https://www.gao.gov/products/gao-23-106163>; GAO, Health Care Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation, GAO-25-107450 (2025), <https://www.gao.gov/products/gao-25-107450>. These reports identify gaps in available ownership and consolidation evidence; the proposed database is NABIP's policy recommendation.

Reinvestment and Purchaser Protections

Targeted domestic health reinvestment requirements may be appropriate where entities receive substantial taxpayer-supported revenue, own essential community infrastructure, or make extraordinary distributions while reducing access or quality. Rather than a rigid formula, Congress could tie requirements to risk indicators such as high leverage, repeated quality deficiencies, service-line reductions, rural or underserved-market dependence, material federal subsidies, or large capital distributions. Eligible reinvestment could include staffing, cybersecurity, patient safety, care coordination, facility maintenance, underserved-area access, behavioral-health capacity, primary care, or technology that improves patient service and payment accuracy.

Any private-equity framework should also provide healthcare purchasers with usable ownership and affiliation information needed to evaluate how investor-backed ownership may affect cost, access, quality, or network performance.

Broader plan-sponsor data-access, audit, and service-provider disclosure rights are addressed in Section 3.IV.

Section 3.II Ending the shell games Big Insurance exploits to raise prices, eliminate competition, and place unaccountable middlemen between patients and affordable care

Vertical Integration and Market-Power Oversight

NABIP supports oversight of vertically integrated healthcare entities that follows control, money, and market power across the full enterprise and ensures integration delivers measurable value to consumers and employers rather than simply shifting profits among affiliated entities. Where integration reduces competition, increases prices, or limits patient choice, regulators and enforcement agencies should exercise their existing antitrust authority and take corrective action. Anticompetitive risk can be significant when a large for-profit conglomerate controls multiple points in the healthcare value chain and profits when costs do not fall for patients, employers, or taxpayers.⁸⁵

Federal policymakers should distinguish large for-profit conglomerates from provider-sponsored and closed-network integrated systems and evaluate whether each model is transparent, clinically accountable, open about ownership and financial flows, capable

⁸⁵ Sherman Act § 1, 15 U.S.C. § 1; Federal Trade Commission Act § 5, 15 U.S.C. § 45; GAO, Health Care Consolidation: Published Estimates of the Extent and Effects of Physician Consolidation, GAO-25-107450 (2025), <https://www.gao.gov/products/gao-25-107450>.

of demonstrating measurable value, and preserves meaningful consumer and purchaser choice. Provider-sponsored or closed-network models may provide value when they offer reliable access, coordinated care, predictable cost-sharing, and transparent provider relationships.

Enterprise Ownership and Financial-Flow Transparency

Congress should require ownership and financial reporting across the consolidated enterprise. Regulators also need resources that match the complexity of the market. State insurance departments, CMS, EBSA, HHS Office of Inspector General (OIG), DOJ, Federal Trade Commission (FTC), and state attorneys general should have sufficient authority, staff, expertise, and data systems to analyze consolidated ownership, claims and denial patterns, network adequacy, PBM and pharmacy economics, affiliate payments, provider acquisition trends, and steering behavior. Oversight teams should include actuaries, clinicians, antitrust economists, ERISA and insurance-law experts, pharmacy experts, data analysts, and forensic accountants.

Contracting Restrictions, Steering, and Purchaser Choice

NABIP supports targeted reforms to prevent vertically integrated entities from using restrictive contracting or steering practices to limit competition or patient choice. Congress should examine all-or-nothing, anti-steering, anti-tiering, and similar contractual provisions that may prevent participants from lower-cost or higher-value care, while preserving legitimate value-based network design.

Contractual terms should not prevent employers and their advisors comparing provider value, designing tiered or selective networks, or directing participants to higher-value settings. Steering toward affiliated entities should be transparent and supported by legitimate clinical or value-based considerations. These protections are particularly important where concentrated provider systems or networks have substantial negotiating leverage. Data access, audit rights, and contractual protections in self-funded arrangements are addressed separately in Section 3.IV.

Affiliate Payments, Benchmarking, and Financial-Flow Reporting

Payments to affiliated entities should be reported separately from payments to unaffiliated entities and evaluated against commercially reasonable benchmarks so regulators can distinguish bona fide healthcare or administrative services from internal profit transfers. The treatment of those payments for MLR purposes is addressed in Section 3.III.

Affiliate-payment benchmarks should be used as transparency and audit tools, not automatic commercial rate-setting formulas. Benchmarks may include comparable unaffiliated market rates for the same service and geography, Medicare or Medicare Advantage reference rates where clinically and operationally comparable, state All-Payer Claims Database (APCD) data, independent fair-market-value analyses, percentile-based commercial benchmarks, and historical non-affiliate rates before a merger or acquisition. They should trigger additional review when affiliated payments materially exceed comparable rates, increase faster than market trend, replace claims payments with opaque non-claims transfers, or coincide with premium increases, MLR pressure, network narrowing, elevated denials, or reduced access.

Reporting should follow the full chain of control and material financial flows across the consolidated enterprise. Covered entities should identify parent and subsidiary ownership; beneficial owners; domestic and foreign affiliates; vendors; and other related parties receiving premium-derived, employer, or taxpayer-supported dollars. Reports should separately identify intercompany payments and eliminations, affiliate markups, management and shared-service fees, capitation or value-based payments, rebate and spread revenue, referral flows, administrative-service fees, loans, guarantees, leases, dividends, distributions, and compensation arrangements. Public reporting should be standardized and searchable, with appropriate protection for protected health information and legitimate proprietary contracting terms.

NABIP supports transparency regarding compensation and material financial relationships involving agents, brokers, benefits consultants, TPAs, ASOs, and other service providers so employers can understand how their advisors are compensated and whether an ownership, referral, affiliate, revenue-sharing, or other financial relationship could reasonably affect a recommendation.

Federal law already establishes requirements for this transparency. ERISA section 408(b)(2)(B), as amended by the Consolidated Appropriations Act, 2021, requires covered brokerage and consulting service providers that reasonably expect to receive \$1,000 or more in direct or indirect compensation in connection with services to an ERISA-covered group health plan to disclose specified compensation information to the responsible plan fiduciary. DOL has explained that these disclosures enable plan fiduciaries to evaluate the reasonableness of compensation and potential conflicts arising from indirect compensation, including compensation received from parties other than the plan or plan sponsor.⁸⁶

⁸⁶ ERISA § 408(b)(2)(B), 29 U.S.C. § 1108(b)(2)(B), as added by Consolidated Appropriations Act, 2021, div. BB, tit. II, § 202; DOL, Field Assistance Bulletin No. 2021-03 (Dec. 30, 2021), <https://www.dol.gov/agencies/ebsa/employers->

NABIP has previously supported making these requirements clearer and more effective. A licensed advisor with a material ownership, affiliate, referral, or compensation relationship with a recommended TPA, ASO, PBM, network, or other vendor should clearly disclose that relationship to the plan sponsor in a form that allows the employer to evaluate the potential conflict before making a purchasing decision. This subsection addresses compensation and financial-relationship disclosure; functional ERISA fiduciary accountability based on discretion or control is addressed in Section 3.IV.⁸⁷

Section 3.III Eliminating Big Insurance gaming that hides profits, and ensure that those dollars are spent on providing care and lowering costs for consumers

Strengthening MLR Accountability in Vertically Integrated Markets

MLR reform should focus on the incentives created by the current percentage-based structure and on transactions within vertically integrated enterprises, rather than simply changing the statutory percentage. Congress could consider complementary qualitative measures of plan performance, including prior authorization and denial rates, appeal outcomes, claims-payment practices, and other indicators of consumer and provider experience, rather than relying on spending ratios alone as a proxy for plan quality.

Congress should also ensure that MLR accountability follows plan dollars when they are transferred to affiliated, controlled, or closely held entities. Entities should not be able to inflate the MLR numerator by paying their own subsidiaries or affiliated providers above reasonable market amounts, nor should dollars characterized as quality-improvement or other qualifying expenditures escape scrutiny simply because they flow through a related entity. MLR rules should therefore capture relevant transactions throughout the affiliated enterprise and include safeguards against excessive intercompany charges or other arrangements that artificially increase reported medical spending without corresponding improvements in care or quality.

Remedies should incentivize good behavior and be proportionate to the conduct involved, with corrective-action requirements for isolated errors and stronger remedies for systemic or knowing misconduct. Penalties should apply to the benefiting entity, including parent companies or affiliates.

and-advisers/guidance/field-assistance-bulletins/2021-03 (disclosure of covered broker and consultant compensation to responsible plan fiduciaries).

⁸⁷ NABIP, Comments on CMS-9883-P (Mar. 13, 2026), https://nabip.org/media/10840/nabip_comments_cms-9883-p_nbpp-2027_march-13-2026.pdf (compensation and conflict-of-interest transparency recommendations).

Section 3.IV Stopping corporate insurance companies and third parties from making money by acting as unaccountable middlemen that delay care and deny claims

TPA/ASO Oversight and Functional Fiduciary Accountability

NABIP supports modernizing TPA and ASO oversight to reflect the roles service providers play in self-funded coverage. Employers and plan sponsors retain ERISA responsibilities, including the duty to prudently select and monitor service providers, while service-provider accountability should follow the functions performed. Participants and plan sponsors should be able to identify who is responsible for material administrative decisions, the basis for adverse benefit determinations, and available review or appeal processes.

Congress and DOL should clarify when TPAs, ASOs, and other service providers act as ERISA fiduciaries. A service provider that exercises discretion over plan administration or benefit determinations, authority or control over plan assets, or otherwise satisfies ERISA's functional fiduciary standards should be accountable for those functions regardless of contract language. Purely ministerial vendors, however, should not become fiduciaries solely because they process claims or data, perform clerical functions, or carry out decisions under established plan terms. This approach preserves the plan sponsor's duty to prudently select and monitor service providers while aligning responsibility with each party's actual authority and control.⁸⁸

Congress and DOL should also examine variation in state TPA licensing requirements, the scope and usability of federal reporting on self-funded plan administration, and whether EBSA has sufficient expertise, data, and resources. These issues are particularly challenging for small and midsize employers without extensive in-house benefits expertise.

The specific compensation, data-access, and contracting reforms needed to address these concerns are discussed below.

Compensation, Conflicts, and Role-Based Accountability

Beyond the compensation and financial-relationship disclosure requirements discussed in Section 3.II, service-provider accountability should address shared-savings

⁸⁸ ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A) (functional fiduciary status based on discretionary authority or control); ERISA § 404(a), 29 U.S.C. § 1104(a) (fiduciary duties); DOL, "Understanding Your Fiduciary Responsibilities Under a Group Health Plan," <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications/understanding-your-fiduciary-responsibilities-under-a-group-health-plan>. Contract labels do not displace the statutory functional test.

arrangements, repricing fees, affiliate payments, and other compensation that may influence claims administration, utilization management, provider payment, recovery activities, or plan assets. These safeguards should apply under the functional fiduciary framework described above.

Licensed agents, brokers, and benefits consultants that provide non-discretionary advisory, procurement, enrollment, compliance, or participant-assistance services should be distinguished from entities exercising discretionary authority over claims adjudication, provider reimbursement, plan administration, or plan assets.

Additional safeguards should ensure that medical-necessity determinations are transparent and reviewable; overpayment recoveries are credited to the appropriate plan; and cross-plan offsetting is prohibited or carefully constrained where it could shift obligations between plans or harm participants.

Plan-Sponsor Data Access and Service-Provider Disclosure

NABIP supports enforceable disclosure and reporting requirements that give plan sponsors timely, usable access to the information needed to evaluate service-provider performance, manage plan assets prudently, negotiate lower costs, and protect participants. Depending on the functions performed, disclosures should include claims, denial and appeal data; prior-authorization and medical-necessity criteria; relevant network and provider-contract information; fees and compensation; ownership and affiliate relationships; and conflicts of interest that may affect claims administration, network design, utilization management, referral patterns, or payment decisions. Transparency should be operational and available before a dispute arises, not merely a general right to request information after the fact.

Congress should also distinguish between requiring service providers to furnish information to plan sponsors and imposing compliance obligations on plan sponsors that only service providers can practically fulfill. Where carriers, TPAs, PBMs, or other service providers possess the underlying data necessary for federal reporting, attestation, or disclosure requirements, Congress could consider imposing those obligations directly on the entities that hold the data and providing DOL with corresponding enforcement authority. This approach could improve the consistency of reporting and reduce duplicative compliance burdens, particularly for small employers, while preserving plan sponsors' responsibility to prudently select and monitor service providers. This framework could apply to requirements such as RxDC reporting, gag-clause compliance and attestations, and applicable service-provider disclosures.

Contracting Restrictions, Audit Rights, and Affiliate-Payment Data

Congress should build on and enforce existing federal protections that ensure plan sponsors can access the information necessary to oversee their health plans. Federal law already prohibits agreements that restrict access to provider-specific cost and quality information, electronic access to de-identified claims and encounter data, or the sharing of that information with authorized business associates.⁸⁹

Federal standards should also prohibit other contract terms that impede plan-sponsor fiduciary oversight, including unreasonable limits on audit rights or prepayment review and termination provisions that lock employers into opaque arrangements. Plan sponsors should have access to the affiliate-payment and pricing information necessary to evaluate service-provider arrangements and determine whether those arrangements increase plan costs or inflate reported savings.

Technical Assistance for Plan Sponsors

NABIP supports unbiased, vendor-neutral technical assistance, particularly small and midsize employers without extensive in-house benefits, actuarial, legal, pharmacy, cybersecurity, or data-analytics expertise. Assistance should support fiduciary decision-making and should not steer employers toward vendors, networks, or payment arrangements that benefit the advisor, administrator, or platform.

Congress could support vendor-neutral technical assistance, including EBSA model contract clauses, procurement checklists, independent fee-based TPA certification or transparency standards, public benchmarking tools for claims, fees, denials, appeals, provider payments, and administrative performance, and grants or safe harbors that allow employers to obtain independent actuarial, legal, broker, consultant, and data-analytics support.

Preserving Value-Producing TPA/ASO Administration

TPAs and ASOs can provide substantial value when they are transparent, accountable, and aligned with the plan sponsor. They can provide functions employers could not efficiently build internally, including claims and eligibility administration, network access, compliance, reporting, data analytics, recovery services, and member support. Federal policymakers should preserve competition among administrators while requiring sufficient transparency for plan sponsors to compare vendors using standardized

⁸⁹ ERISA § 724, 29 U.S.C. § 1185m; Consolidated Appropriations Act, 2021, div. BB, tit. II, § 201 (prohibition on gag clauses that restrict access to provider-specific cost or quality information, electronic access to de-identified claims/encounter data, or sharing data with authorized business associates).

metrics, exercise meaningful audit rights, terminate opaque arrangements without punitive barriers, and retain independent advisors to evaluate whether administrators reduce total cost, improve access, and protect participants.

Caution on Mandatory Medicare/Marketplace Administrative Models

NABIP cautions against assigning Medicare administrative contractors or Marketplace-based administrative entities to manage employer coverage functions. Medicare operates under standardized statutory benefits, federal payment rules, and direct agency supervision, while self-funded employer plans vary in design and must integrate with compliance obligations and internal systems and processes. Medicare- or Marketplace-style support may offer lessons for standardization and auditability but should not become mandatory employer-plan infrastructure.

Appendix: NABIP's Healthcare Bill of Rights

NABIP's Healthcare Bill of Rights serves to protect and uphold the rights of every American to access affordable, high-quality healthcare. It is our fundamental belief that healthcare should be comprehensive, equitable, and compassionate for all individuals. The NABIP Healthcare Bill of Rights outlines 10 key articles that serve as a guiding framework to ensure that healthcare remains privately accessible and affordable for all Americans:⁹⁰

We, the people of the United States, recognizing the importance of access to affordable, high-quality healthcare, hereby establish this Healthcare Bill of Rights. It is our fundamental belief that every individual deserves the right to obtain healthcare that is comprehensive, equitable, and compassionate. This bill serves to protect and uphold these rights for all Americans.

Article I: Right to Access Affordable Healthcare

1. Every American shall have the right to access affordable healthcare that meets the Consumer's needs, regardless of age, gender, race, ethnicity, socioeconomic status, or pre-existing conditions.
2. The healthcare sector shall strive to ensure that essential healthcare services, including preventive care, medical treatments, medications, and mental health and substance abuse disorder services, are accessible and affordable for all individuals.

Article II: Right to Quality Care

1. When accessing healthcare, every American shall expect to receive quality healthcare services that meet or exceed established standards of care that are transparent and clinically appropriate.
2. Healthcare providers and institutions shall be held accountable for maintaining the highest levels of quality, safety, and efficacy in their practices.

⁹⁰ NABIP, Healthcare Bill of Rights, <https://nabip.org/media/9257/nabip-healthcare-bill-of-rights-final.pdf>. The following appendix reproduces NABIP's advocacy principles; its broad statements of rights should not be read as a summary of generally enforceable federal entitlements.

Article III: Right to Privacy and Confidentiality

1. Every American shall have the right to privacy and confidentiality in all healthcare-related matters.
2. Healthcare providers and institutions shall protect the privacy and confidentiality of patients' medical information, adhering to strict standards and regulations.

Article IV: Right to Individual Autonomy

1. Every American shall have the right to make informed decisions regarding their healthcare, including the right to refuse or consent to medical treatment.
2. Healthcare providers shall respect and honor the autonomy of patients, providing them with all relevant information to make informed decisions about their health.

Article V: Right to Health Equity

1. Every American shall have the right to healthcare that is equitable, just, and free from discrimination. The healthcare sector shall take necessary measures to address and eliminate health disparities, ensuring that underserved populations have equal access to healthcare resources and services.
2. Create awareness of social determinants of health, including economic stability, education access and quality, neighborhood and physical infrastructure, social and community context.

Article VI: Right to Health Education

1. Every American shall have the right to access comprehensive health education and information to promote personal well-being and prevention of diseases.
2. The healthcare sector shall prioritize health education programs, including public health campaigns, to empower individuals with the knowledge to make informed decisions about their health.

Article VII: Right to Affordable Medications

1. Every American shall have the right to access affordable medications necessary for their health and well-being.

2. The healthcare sector shall implement policies to ensure the affordability and availability of essential medications, including the oversight and transparency of drug prices and the promotion of generic/biosimilar alternatives.

Article VIII: Right to Emergency Care

1. Every American shall have the right to emergency medical care without fear of financial hardship.
2. Healthcare providers shall be obligated to provide emergency care to all individuals in need, regardless of their ability to pay, ensuring that no one is denied life-saving treatment due to financial constraints.⁹¹

Article IX: Right to Healthcare Advocacy

1. Every American shall have the right to an effective and accessible healthcare advocacy system.
2. Every American shall have the right to file complaints, refer concerns and grievances, and pursue an expedited appeal of coverage determinations.⁹²
3. The government shall establish mechanisms for individuals to seek assistance and resolve grievances related to their healthcare, ensuring that their rights are protected and upheld.

Article X: State Rights

1. Consumers access healthcare and insurance markets locally.
2. Each state regulates the healthcare and insurance markets and is charged with protecting the consumer.⁹³

⁹¹ Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd; CMS, EMTALA overview, <https://www.cms.gov/medicare/regulations-guidance/legislation/emergency-medical-treatment-labor-act>. EMTALA requires Medicare-participating hospitals with emergency departments to screen and stabilize emergency medical conditions regardless of ability to pay; it does not impose the same duty on every provider or create a general right to emergency care without financial liability.

⁹² Public Health Service Act § 2719, 42 U.S.C. § 300gg-19 (internal claims and external-review protections for covered non-grandfathered plans and coverage); 29 C.F.R. § 2560.503-1 (ERISA claims procedures). The broad wording in the NABIP appendix states an advocacy principle; the statutory appeal rights have defined scope.

⁹³ McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1015 (state regulation of the business of insurance); ERISA § 514, 29 U.S.C. § 1144 (preemption framework). State authority differs across insurance, provider regulation, and self-funded ERISA plans; the sentence is an advocacy statement, not a complete description of jurisdiction.

3. States will embody these principles of consumer protection and be permitted to have oversight within the healthcare eco-system within their state borders, except not to compete directly with the private healthcare market.

NABIP's Healthcare Bill of Rights serves as a guiding framework to ensure that healthcare remains privately accessible and affordable for all Americans. It is a commitment to promoting health, dignity, and equality, and it is the responsibility of all individuals and the healthcare sector to uphold and protect these rights.