October 2, 2026

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

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

Dear Ranking Member Wyden:

Affordable health insurance must be easy to obtain, simple to use and designed to keep people healthy. The Alliance of Community Health Plans (ACHP) understands this because our local member plans are accountable to the communities they serve. Operating on margins of just one to three percent, these plans are focused on lowering costs and delivering better health outcomes for people covered through employers and the individual market, including the Affordable Care Act Marketplace and state-based marketplaces.

ACHP is the only national organization promoting the unique payer-provider aligned model in health care. ACHP member companies work hand in hand with clinicians to coordinate care, prevent illness and improve health outcomes for tens of millions of Americans across the nation. We are committed to working with policymakers to strengthen coverage, improve accountability and lower the cost of health coverage. We welcome the opportunity to share the practical experience of nonprofit, locally accountable health plans and are excited to serve as a trusted partner with the Senate Finance Committee on the next generation of private insurance reforms.

Our recommendations focus on the committee's three priorities: keeping coverage affordable and accessible, making health care simpler for individuals and families and strengthening accountability across the market. Achieving these goals starts with stabilizing coverage for the people and communities who depend on it.

Part I: Reversing coverage cuts and reimagining a better path

ACHP member companies have participated in the Marketplace and state-based marketplaces since the beginning and remain committed to offering affordable marketplace coverage options in their communities. Recent federal changes, including the expiration of enhanced premium tax credits, have reduced enrollment, raised costs and pushed consumers toward less comprehensive coverage. The individual market works best when coverage is affordable,

enrollment is straightforward for consumers, the risk pool is balanced and all plans operate under the same predictable rules.

Make enrollment predictable and trustworthy

ACHP supports streamlined enrollment practices that are easy and predictable for consumers, including an open enrollment that ends on December 15, with coverage beginning on January 1. We support special enrollment periods (SEPs) being reserved for qualifying life events or discrete, emergent circumstances, such as natural disasters. Routine monthly SEPs with ongoing eligibility increase administrative burden and lead consumers to delay obtaining insurance until they need imminent care, destabilizing the risk pool and increasing premium costs.

Information on qualifying events, including documentation requirements, should be widely communicated and remain simple. Enrollment assistance must also be trustworthy. ACHP strongly supports funding for navigators, who provide impartial assistance to help consumers weigh their coverage options and select the plan that best meets their needs. We also support direct oversight of third-party marketing organizations and lead generators, stronger penalties for deceptive conduct, clear consumer consent before an agent changes coverage and disclosure of total broker compensation. Brokers remain an important resource, but consumers should receive unbiased information that helps them choose high-quality coverage suited to their needs. Compensation arrangements should not reward steering consumers toward plans that pay the most.

Improve premium affordability and require transparent, evidence-based rate review

The Marketplace and state-based marketplaces are undergoing a profound period of instability. The Committee's RFI notes that average premiums across marketplaces increased 58 percent in 2026. Other analysis has found overall marketplace enrollment declined 13% in 2026, with younger, healthier individuals more likely to forgo coverage.[1] Local, nonprofit health plans have served their communities for decades, maintaining coverage as national for-profit insurers pursue more profitable markets. Sustaining that commitment requires a stable market. Plans must collect sufficient premiums to cover the cost of care and meet state solvency requirements that protect consumers. When costs rise or the risk pool deteriorates, premium increases become a financial and regulatory necessity, even for plans committed to keeping coverage affordable.

[1] https://www.cbpp.org/blog/nearly-3-million-fewer-people-secured-marketplace-coverage-after-republican-health-care-cuts?utm_)

Continued instability risks undermining future reforms as consumers leave their marketplace coverage and go uninsured. Policymakers should reinstate enhanced premium tax credits at their prior levels while working towards a durable long-term solution. ACHP also supports silver loading in the absence of cost-sharing reductions. If Congress directly funds cost-sharing reductions, federal savings should be used to finance premium assistance. Policymakers must also provide sufficient lead time for states and health plans to appropriately price products.

Protect comprehensive coverage and prevent market segmentation

Health insurance products should meet clear minimum standards for essential benefits, financial protection and accurate disclosure. ACHP supports restricting short-term, limited-duration insurance to a maximum of four months, requiring prominent notice that these plans are non-comprehensive coverage and monitoring of aggressive marketing that steers consumers away from Affordable Care Act compliant plans. More broadly, ACHP remains concerned that efforts to provide alternative coverage options through the individual market, such as Health Savings Accounts, may inadvertently divide the risk pool and leave consumers facing higher deductibles and less comprehensive coverage options. Expansion of these plans should include clear disclosures and be assessed for its effect on lower-income consumers and community-market stability.

Protect consumers from tax shocks caused by income changes

Marketplace and state-based marketplace enrollees with variable hours or self-employment income make good-faith estimates of earnings months before the end of the tax year. Congress should restore reasonable, income-based limits on premium-tax credit recapture and ensure consumers receive timely notice and assistance before losing subsidies for failure to reconcile. Eligibility systems should update information when reliable data is available, preserve due process and reserve enforcement for intentional misconduct.

Making Health Care Simpler for Families

Health insurance consumers are also health care patients who need clear provider choices, timely access to clinicians and an administrative system that help their providers deliver care. ACHP's local member plans work closely with physicians and hospitals to connect coverage decisions with clinical expertise, helping patients navigate care and clinicians coordinate treatment. We appreciate the Committee's commitment to improving the experience of individuals and families through reforms to care access and delivery.

Modernize eligibility verification and move toward a unified consumer experience

Program integrity and consumer access are complementary goals. Marketplaces should use trusted federal, state and third-party sources to verify eligibility, provide clear notice and a reasonable opportunity to resolve discrepancies. Marketplaces should also preserve provisional eligibility for tax credits while documentation is reviewed.

ACHP supports enabling the Marketplace, state-based marketplaces and Medicaid/CHIP systems to exchange data, align notices and coordinate coverage transitions when eligibility changes. These improvements help individuals and families maintain coverage while preserving the flexibility and innovation of successful state-based marketplaces.

Improve patient access to care through improved provider directories and expansion of in-network virtual care

Consumers need accurate provider directories and timely access to in-network primary, behavioral and specialty care, including in rural communities. Providers are required to inform plans when they make a change to their information, but there is no incentive or enforcement backing the requirement. Further, there is currently no standard reporting process across public and private payors.

ACHP supports the creation of a national provider directory with a standardized reporting format for providers. Providers should be held accountable when an inability to provide timely updates leads to inaccuracies. Provider directory requirements should also align with the *No Surprises Act* and the *Interoperability and Patient Access Final Rule* to avoid confusion and duplicative requirements.

Network adequacy standards must reflect how patients receive care today, including through virtual care. Standards built around traditional office visits fail to fully account for these options. Congress must expand the share of a health plan's network that can consist of virtual care providers and create incentives to include them in-network, broadening access for patients.

Modernize prior authorization by focusing on tactics that improve patient care

ACHP supports modernizing prior authorization to improve timely access to care and reduce unnecessary burden for patients, providers and plans. ACHP member companies use their unique clinician-aligned model to "get to yes" on prior authorizations. For example, Geisinger Health Plan in Pennsylvania used real-time missing information detection and other technological innovations to decrease prior authorization turnaround times from nearly two days in 2022 (1.94 days) to ~8 hours (0.36 days) in 2024, despite a tripling of prior

authorization volume for the plan over the same period.[2] Health Alliance Plan by Henry Ford Health, based in Michigan, has brought clinical teams from both the plan and hospital side together to review authorized codes and build clinical intent and safety protections into prior authorization policies.[3]

ACHP also supports the development of electronic prior authorization APIs as required by the *CMS Interoperability and Prior Authorization Final Rule*. Any future reforms should align with existing CMS electronic prior authorization requirements and avoid duplicative reporting or mandates that add administrative burden without improving patient care.

Taking On Corporate Greed

ACHP shares the Committee's concern about corporate greed in the health insurance market. Local, nonprofit health plans operate on a fundamentally different model than large, publicly-traded insurance conglomerates. ACHP members' model supports shared clinical data, preventive care, chronic disease management and accountability for the total cost of care. Policymakers must recognize these differences and preserve a competitive market in which local, nonprofit plans remain viable and succeed on behalf of the patients and communities they serve.

Address market concentration and preserve partnerships that improve care

ACHP welcomes greater transparency and oversight of corporate ownership structures to address practices that concentrate market power and increase costs simply for shareholder returns. However, several proposals before Congress, including the *Break Up Big Medicine Act* (S. 3822) and the *Patients Over Profits Act* (S. 2836), sweep in local, nonprofit health plans whose clinical partnerships support coordinated care. Policy must distinguish arrangements based on who they answer to and what they deliver. Reforms must target anticompetitive conduct while preserving partnerships that improve care, lower costs and remain accountable to local communities. Clinically aligned health plans are proud of their affiliation with their provider partners. Penalties should target bad actors rather than banning or penalizing provider-plan integration.

Require increased transparency from pharmacy benefit managers, third party administrators and other actors in the pharmacy supply chain

Policymakers should require pharmacy benefit managers, third party administrators and other service vendors to provide plan sponsors and health plans complete, timely and usable claims,

[2] http://catalyst.nejm.org/doi/abs/10.1056/CAT.25.0201
[3] Ibid

pricing, fee reimbursement and compensation data. Primary reporting responsibility should rest with the entity that controls the underlying data. Standards should use a common data dictionary, disclose ownership and compensation relationships, protect patient privacy and avoid duplicative submissions by plans that do not possess the information. These guardrails expose hidden fees and conflicts while allowing independent and nonprofit administrators to compete on service and value.

We look forward to working with the Committee to improve health insurance affordability, make coverage simpler for families, and promote choice in the health care market. Please contact Christopher DeVore, Associate Director, Legislative Affairs at cdevore@achp.org with any questions or to discuss these recommendations further.

Sincerely,



Dan Jones
Senior Vice President, Federal Affairs
ACHP