Senate Finance Committee
Washington D.C. 20510

In The Matter of the Health Coverage That Works for Everyone RFI

The American Consumer Institute (ACI) is a nonprofit 501(c)(3) education and research organization. Its mission is to promote consumer welfare by enhancing the understanding and impact of public policies and regulations on consumers in a free market.

We agree with the Committee that Americans face serious problems with the cost and complexity of healthcare. Healthcare costs have grown faster than inflation since 2000,[1] insurance is unnecessarily difficult to understand and use,[2] and patients too often encounter administrative and informational barriers when accessing providers and treatment.[3] The Request for Information (RFI) is right to seek to make American healthcare more affordable, easier to access and navigate, and less burdened by administrative delays and costs.

However, many of the approaches the RFI asks commenters to consider—including a public option, single payer, standardized plans, restrictions on non-Affordable Care Act (ACA) coverage, and additional insurer regulation—would expand the government control that is responsible for much of the complexity while restricting competition and patient choice. Affordability is best achieved by reducing the underlying cost of treatments—not merely shifting that cost from a deductible or copayment into higher premiums or taxes. Likewise, access to insurance should not be confused with access to healthcare. Insurance works best when protecting patients against large, unpredictable financial risks and major injuries. Routine and shoppable care benefits from direct competition, transparent prices, consumer choice, and an abundant supply of providers. Regulation can strengthen markets if it improves information, enforces contracts, or removes barriers to entry. But regulation that dictates which products consumers may purchase, which products insurers may offer, or what prices market participants may charge suppresses competition and risks making care less competitive, affordable, and accessible.

[1] Shameek Rakshit et al., "How Does Medical Inflation Compare to Inflation in the Rest of the Economy?" Peterson–KFF Health System Tracker, August 2, 2024, https://www.healthsystemtracker.org/brief/how-does-medical-inflation-compare-to-inflation-in-the-rest-of-the-economy/.
[2] George Loewenstein et al., "Consumers' Misunderstanding of Health Insurance," Journal of Health Economics 32, no. 5 (2013): 850–62, https://pubmed.ncbi.nlm.nih.gov/23872676/.
[3] Allison Kratka et al., "Finding Health Care Prices Online—How Difficult Is It to Be an Informed Health-Care Consumer?" JAMA Internal Medicine 178, no. 3 (2018): 423–24, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2663755.

The RFI correctly identifies excessive insurance bureaucracy as a problem, but rather than reducing this burden, many of the solutions it considers would instead centralize still more healthcare decisions within the federal bureaucracy. The RFI criticizes prior authorization, claims administration, and other bureaucratic barriers, yet it also contemplates greater government control over benefits, cost sharing, permitted insurance products, networks, and provider payment rates. That would not eliminate bureaucracy; it would shift more authority to a bureaucracy controlled by fluctuating political motivations. The RFI itself recognizes this consequence when it asks how a federally administered Medicare-type option could ensure that coverage decisions remain based on facts and science rather than political intervention. The question identifies an unavoidable problem with political administration: federal healthcare decisions ultimately remain subject to politics and political incentives.[4]

A federal public option would not compete on the same terms as an ordinary private entrant. The RFI considers giving Secretary of the Department of Health and Human Services authority to negotiate provider payments, using Medicare rates as benchmarks, and having the Centers for Medicare and Medicaid Services establish an annual public-option fee schedule. Some specific proposals discussed in the RFI would also require Medicare or Medicaid providers to accept the federal plan. The federal government would therefore participate in the market while also establishing important rules and payment parameters governing that market in its favor. Single payer takes that approach further by replacing competition among primary insurers with a dominant public payer. Consumers and employers who are dissatisfied with the plan's benefit design, reimbursement model, or utilization practices lose the ability to discipline it by taking their business elsewhere. Even if patients have the option of supplemental private insurance, there is no consequence for the single payer system.

Using government-set provider payment rates as contemplated in the RFI can reduce healthcare spending for select groups. But setting a lower price does not eliminate the underlying scarcity of physicians, facilities, medicines, or capital, which drive costs and limit access. The experience of systems that rely heavily on government-administered or government-negotiated provider payments illustrates the potential access tradeoff. In the United Kingdom, for example, the National Health Service uses nationally established payment rules and prices for much secondary care, while Canadian provincial governments negotiate physician fee schedules. OECD data show that more than 10 percent of surveyed patients seeking specialist care in both Canada and the United Kingdom reported waits exceeding one year.[5]

Contrast this with price reductions from competition. Competitive markets bring down prices through innovation that reduces costs without eliminating the incentive to earn profits. Replacing competitive pressure with administratively determined prices and centralized decision-making risks addressing visible costs today by creating less visible costs in future in the form of access, supply, and innovation.

[4] "CARES Act: Structural Characteristics That Can Help Insulate HHS Agencies against Potential Political Interference," U.S. Government Accountability Office, GAO-23-105415 (December 15, 2022), https://www.gao.gov/products/gao-23-105415.
[5] "Health at a Glance 2025: OECD Indicators," Organization for Economic Co-operation and Development, November 13, 2025, https://www.oecd.org/en/publications/health-at-a-glance-2025_8f9e3f98-en/full-report/waiting-times_3a1021fa.html.

The RFI focuses heavily on regulation instead of competition, particularly regarding insurer profits and Medical Loss Ratio requirements. But profits are not necessarily evidence of market failure. Persistent excess returns can instead signal barriers to entry regulatory advantages favoring incumbents, or a lack viable alternatives for consumers. In those circumstances, the appropriate question is what prevents another insurer from entering the market and offering a better product at a lower price.

Regulating profits can also produce unintended incentives. The ACA's Medical Loss Ratio rules require insurers to devote a minimum share of premium revenue to medical claims and qualifying quality-improvement expenses, effectively limiting the share available for administration and profit. A study of that rule found that affected insurers increased medical claims spending by approximately seven percent in the individual market and two percent in the group market, while premiums were unaffected.[6] The regulation intended to constrain insurer markups instead created an incentive for higher medical spending rather than lower premiums.

The same distinction applies to insurance design. There is a strong case for standardizing the information consumers receive so that deductibles, networks, exclusions, and out-of-pocket limits can be easily compared. But the RFI goes further by considering requirements that would limit or eliminate what it calls "junk" plans. Consumers differ in income, health needs, risk tolerance, and willingness to accept narrower networks. Standardizing insurance reduces insurers' ability to serve those different preferences and needs. The better principle is to standardize the information, not the insurance. Fraud, deceptive advertising, and undisclosed exclusions warrant enforcement, but knowingly purchasing fewer benefits in exchange for a lower premium is a consumer choice, not deception.

The deeper problem is that the RFI repeatedly treats more comprehensive insurance as synonymous with better access to healthcare. They are not the same. Making a $2,000 service cost a patient $50 at the point of care does not make the service cost $50; the remaining cost is simply recovered elsewhere through premiums, taxes, or other healthcare spending. Expanding first-dollar insurance also further separates patients from the prices of routine care and forces more ordinary healthcare transactions through costly billing systems, networks, claims administration, utilization management, and other intermediaries.

Insurance is most valuable for expenses that patients cannot reasonably shop for in advance or that would be financially catastrophic. A heart attack is an insurance problem. A scheduled MRI, routine laboratory test, or primary-care visit can instead be a market transaction in which competition disciplines prices. Lower-premium higher-deductible coverage paired with health savings accounts (HAS), transparent upfront prices, and direct payment allows patients to assume responsibility for routine expenses to pay for less expensive care while preserving insurance against catastrophic losses and emergencies. It also gives patients a reason to compare prices. Few people will drive five extra minutes to save their insurance company money, but they are more likely to do so for themselves when an MRI costs a fraction as much at another provider. MRI prices range from $259 to more than $2,000 and can vary by as much as $1,592 within a single local market.[7] For many shoppable services, the most direct way to reduce administrative burdens is to empower patients to remove the insurer from the transaction entirely.

[6] Steve Cicala et al., "Regulating Markups in US Health Insurance," American Economic Journal: Applied Economics 11, no. 4 (2019): 71–104, https://www.aeaweb.org/articles?id=10.1257%2Fapp.20180011.

[7] Dario Pasalic et al., "Nationwide Price Variability for an Elective, Outpatient Imaging Procedure," Journal of the American College of Radiology 12, no. 5 (2015): 444–52, https://pubmed.ncbi.nlm.nih.gov/25940362/.

Congress should make it easier for patients to participate directly in healthcare markets. That starts with making prices usable before care is purchased by enforcing existing transparency rules that require hospitals to disclose cash and negotiated prices in a form patients can actually compare. Congress should also expand HSAs and shared-savings arrangements, preserve high-deductible and catastrophic coverage, and encourage direct primary care, cash-pay imaging and laboratory services, and direct pharmaceutical purchasing so that patients benefit from choosing lower cost care.

Increasing affordability and access and lessening insurer interference requires moving routine healthcare toward markets rather than into a larger, politically governed bureaucracy. Government policy should make it easier for patients, insurers, and providers to transact and compete, not dictate in advance which healthcare arrangements they may choose and what those arrangements may cost.

Respectfully,
Justin Leventhal
Senior Policy Analyst
The American Consumer Institute
www.TheAmericanConsumer.Org