

AMERICA'S PHYSICIAN GROUPS

October 2, 2026

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

Submitted via insurance@finance.senate.gov

Re: Request for Information – Health Coverage That Works for Everyone (July 30, 2026)

Dear Ranking Member Wyden:

America's Physician Groups (APG) appreciates the opportunity to respond to the Senate Finance Committee Democrats' Request for Information (RFI) entitled "Health Coverage That Works for Everyone." APG commends you and your colleagues for taking a comprehensive look at how to make coverage more affordable, easier to use, and more accountable to patients and to the clinicians who care for them.

Below, APG will first provide (I) a brief description of the organization, followed by (II) a summary of the RFI, (III) APG's comments, organized using the same section and subsection headings as the RFI itself, and (IV) APG's conclusion. Together they reflect the voice of APG's membership and its commitment to working with the Committee to ensure that all Americans have consistently accessible, high-quality, equitable, person-centered health care.

I. About America's Physician Groups

APG is a national association representing more than 300 physician groups that are committed to the transition to value, and that engage in the full spectrum of alternative payment models in original Medicare and in capitated and delegated relationships with health plans in Medicare Advantage (MA). APG members collectively employ or contract with approximately 260,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians), and care for approximately 90 million patients, including an estimated one in four Americans and one in three MA enrollees. APG members also care for millions of patients covered by Medicaid, the ACA Marketplaces, and employer-sponsored insurance.

APG's motto, "Taking Responsibility for America's Health," underscores its members' preference for being in risk-based, accountable, and responsible relationships with all payers, rather than being paid by plans on a fee-for-service basis. Delegation of risk from payers to providers creates the optimal incentives for APG's member groups to provide integrated, coordinated care; make investments in innovations in care delivery; advance health equity; and manage populations of patients in more constructive ways than if APG's members were merely compensated for the units of service provided.

II. Summary of the RFI

The RFI, released July 30, 2026, seeks specific feedback, analysis, and proposals on reforms to private insurance markets and related public coverage. It is organized into three sections: (1) reversing recent coverage cuts and reimagining a better path, including enrollment, affordability, cost-sharing, and Medicare-type coverage options; (2) making health care simpler for families, including benefit design, prior authorization, denials, and administrative burden; and (3) taking on “corporate greed,” including through such means as constraining Medical Loss Ratio (MLR) reporting, vertical integration, and excessive profits due to private equity ownership of health care entities, and enhancing transparency.

APG’s comments below track the RFI’s own section and subsection headings so the Committee can easily locate APG’s input on each topic.

III. APG’s Comments

Overarching Principle: Coverage Is the Foundation of Value-Based Care

Value-based care arrangements are negotiated with, and paid for by, health insurers and public programs. It is impossible to structure them for people who are uninsured, and interruptions in coverage too often become interruptions in care. As APG has told CMS in prior comment letters, patients who lose coverage forgo preventive care, chronic disease management, and longitudinal care. They also have few options but to visit hospital emergency departments when illness becomes acute, which raises uncompensated care costs and further destabilizes the delivery system. APG therefore evaluates every proposal in the RFI against a simple test: Does it keep people continuously covered, and does it strengthen or weaken the ability of physician groups to take responsibility for the cost and quality of their patients’ care?

Section 1: Reversing Republican Cuts and Reimagining a Better Path

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

Consumer-friendly enrollment. APG supports simple, consistent enrollment that makes it as seamless as possible for consumers to attain and maintain coverage. In APG’s April 2025 comments on the Marketplace Integrity and Affordability proposed rule, APG urged CMS to modify or forgo policies that would reduce coverage and noted that the patients of APG members had benefited from automatic re-enrollment into Silver plans in State-Based Marketplaces such as Covered California.

APG thus recommends that the Committee:

- Support a centralized or standardized enrollment platform, built on the operational experience of State-Based Marketplaces, that gives consumers a consistent experience across Medicaid, CHIP, the Marketplaces, and any new coverage option.
- Preserve automatic re-enrollment and require active consumer alerts when a different plan or metal tier would provide better financial protection for an enrollee.
- Restore funding for impartial enrollment assistance and hold third-party marketers accountable for deceptive practices.

Coverage value and costs: essential health benefits. In April 2025, APG urged CMS to keep medically necessary services, including gender-affirming care, as essential health benefits (EHB) in all Marketplace plans, and to define any restricted category narrowly and consistent with accepted medical usage so that unrelated treatments (such as puberty blockers for central precocious puberty, or hormonal therapies for endometriosis and polycystic ovary syndrome) are not inadvertently excluded. APG continues to support benefit standards that reflect generally accepted standards of medical practice and that preserve states' ability to require additional coverage.

Affordability determinations and high-value care without cost-sharing. Cost-sharing that deters people from primary care, chronic disease management, and other high-value services is at odds with value-based care, which depends on patients engaging early and consistently with their care teams. APG supports building on the ACA's no-cost preventive services model by eliminating cost-sharing for primary care, behavioral health, and care-coordination services, and supports considering total exposure to costs (premiums plus cost-sharing) when determining affordability. APG has supported comparable approaches in Medicare, such as the proposed expansion of the Part B cost-sharing waiver for beneficiaries in Shared Savings Program ACOs.

Rate review. APG has not previously commented on rate review specifically, but APG's members' experience with delegated and capitated arrangements bears directly on it. Rate review should account for the cost of delegated, capitated arrangements, and should not penalize plans that pay physician groups for care coordination and quality infrastructure. A rate review standard that looks only at raw medical spending, without distinguishing payments that fund care coordination, behavioral health integration, and other quality-improving investments from payments that do not improve care, risks discouraging plans from entering into or sustaining the very value-based arrangements the Committee is seeking to encourage elsewhere in this RFI. APG recommends that any enhanced or automatic rate review standard build in a mechanism for plans to demonstrate that spending delegated to risk-bearing physician groups is producing measurable value, so that accountable care arrangements are not treated the same as undifferentiated administrative cost growth

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

It has been known since the publication of results from the RAND Health Insurance experiment -- conducted between 1971 and 1986 and considered the most influential health policy study in U.S. history -- that consumers who are required to pay out-of-pocket for a portion of their medical care use substantially fewer medical services than those who do not. They also do not distinguish readily between high-value services that may be worth paying out-of-pocket for as opposed to low-value services that are not.¹ Deductibles and coinsurance thus cause many patients to delay or forgo needed care, which is contrary to the goals of accountable care.

APG's comments here are drawn from its value-based care principles rather than from prior positions on plan design. APG recommends that the Committee undertake the following with respect to categories of cost-sharing:

- **Deductibles:** limit or eliminate deductibles for primary care and other high-value services.
- **Coinsurance:** limit its use as a utilization management tool for services that patients cannot shop for and require plans to demonstrate that use of coinsurance encourages higher-value care.

¹ Brook RH et al, "The Effect of Coinsurance on the Health of U.S. Adults: Results from the RAND Health Insurance Experiment. Prepared under a grant from the Dept. of Health and Human Services, December 1984, at [and.org/content/dam/rand/pubs/reports/2006/R3055.pdf](https://www.rand.org/content/dam/rand/pubs/reports/2006/R3055.pdf)

- **Maximum out-of-pocket caps:** set caps at levels that are affordable to consumers relative to their incomes and apply the same protections consistently across the individual, small-group, and large-group markets.
- **Reward accountable care in plan design:** encourage lower cost-sharing for patients who choose a risk-bearing physician group as their care team.

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

Strengthening the existing coverage framework: Medicaid. APG members collectively deliver care for millions of Medicaid patients. APG opposed the Medicaid cuts in the 2025 reconciliation law, largely on the ground that its provisions would cause millions to lose both Medicaid and ACA coverage.² APG has also commented on the three proposed rules implementing provisions of the law that the Centers for Medicare and Medicaid Services released in June and July 2026.³ APG has argued that CMS went beyond the underlying legislation, presumably illegally, and that provisions of all three regulations would seriously undercut, if not eliminate, Medicaid value-based care through declining Medicaid coverage and changes in such Medicaid financing mechanisms as state-directed payments and provider taxes. In addition, with respect to the Medicaid community engagement Interim Final Rule (CMS-2454-IFC), APG warned that changes in the definition of medical frailty that included the ability to work would mean that physicians could be forced into the untenable role of judging their own sick patients' ability to work.

APG's recommendations, which the organization urges the Committee to consider in any legislative response, include:

- A state-defined condition of medical frailty should be sufficient for exemption; the rule should not add a non-statutory requirement that the person also demonstrate an inability to work.
- States should be able to exempt categorically, automatically, and permanently people age 65 and older, people dually enrolled in Medicare and Medicaid, family caregivers, and people who meet the medical frailty definition.
- The look-back period for identifying medical frailty should be 36 months rather than 12, and self-attestation should be preserved beyond 2027.
- Implementation should be delayed at least one year to allow states to update systems and notify enrollees, with clear appeal rights and continued coverage pending appeal.

A federal option or Medicare-type choice.

- APG is firmly and unequivocally in favor of universal coverage, in that every American should have a clear eligibility pathway and full access to meaningful and comprehensive health coverage that should be federally subsidized for those in need, as is the case now in Medicare, Medicaid, and ACA coverage.
- APG does not oppose either a national public-option buy-in, nor individual states taking steps to offer public option buy-in arrangement or take other actions to ensure universal coverage. APG has opposed conversion of state systems to a single-payer approach unless they preserve the existence of the organized, capitated and delegated physician groups that make up a large share of APG's members, especially those that are based in California. APG formally opposed certain California

² See <https://www.apg.org/press-release/americas-physician-groups-statement-on-passage-of-senate-reconciliation-legislation/>

³ See <https://www.apg.org/wp-content/uploads/2026/07/APG-Final-Comment-Letter-To-CMS-On-Medicaid-Work-Requirements-Rule-7.26.pdf>; <https://www.apg.org/wp-content/uploads/2026/07/APG-Comment-Letter-To-CMS-On-State-Directed-Payments-Rule-Submitted-7.21.26-.pdf>; and <https://www.apg.org/wp-content/uploads/2026/09/APG-Comment-Letter-on-Medicaid-Program-Amending-the-Indirect-Hold-Harmless-Threshold-of-Health-Care-Related-Taxes.pdf>

legislative proposals because their restrictions on provider risk arrangements, contracted entities, and payment methods would dismantle these capitated and delegated models, and it would also oppose a federal single-payer or Medicare for All proposal that also did not preserve such models.

- All this said, APG believes that it is unrealistic to think that a health-care system that represents 18 percent of the U.S. gross domestic product – and that, as a hybrid public and private system, has multiple private parties with strong vested interests already participating in it -- could be funneled entirely through a single federal payment system. APG also believes that having a single benefit structure for all Americans is either desirable or realistic. In addition, APG notes that existing Medicare for All proposals presuppose that payment rates across the board will be at most 1.5 to two times current Medicare levels, which would constitute a highly unrealistic overall contraction in U.S. health care spending. What's more, payment rates benchmarked to Medicare fee-for-service, without a pathway for capitation and shared risk, would leave physician groups that have invested in care coordination, behavioral health integration, and home-based care worse off than under existing arrangements.
- APG has not endorsed a particular federal or state-specific public option buy-in, and appreciates that the RFI does not presuppose an outcome. APG offers the following design principles, drawn from its members' experience in delegated and capitated arrangements, for any new federally administered or federally financed option:
 - **Build in a value-based pathway from the start.** Any new public buy-in option, federal or state run, should allow participating physician groups to accept prospective, capitated, or two-sided risk payments, including delegation arrangements, and should not default to fee-for-service as a destination. APG has made the same point about the Merit-Based Incentive Payment System (MIPS), which should be a step on the way to Advanced APMs rather than a permanent alternative.
 - **Protect access.** Proposals should be tested for their effect on rural and underserved communities, primary care, value-based care models, and network adequacy.
 - **Provide predictable, timely payment.** Incentives for value should be paid close to the performance year, and benchmarks should not penalize the organizations that succeed in lowering spending (the "ratchet effect" that APG has documented in the Medicare Shared Savings Program).

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

- APG supports minimum coverage standards, including essential benefits packages, that give consumers real financial protection and access to a broad network of clinicians. Coverage that lacks adequate networks or meaningful benefits undermines continuity of care and makes it harder for physician groups to coordinate care and help to deliver superior care outcomes for their patients.
- APG recommends that the Committee hold all plans that receive federal support to consistent benefit, network adequacy, and consumer protection standards, and that it preserves the ability of physician groups to contract with plans on a risk-bearing basis.

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

- APG is concerned about the compounding effect of two changes that have already taken effect in 2026. First, the enhanced premium tax credits (ePTCs) expired at the end of December 2025, and working people who buy their own insurance are now facing the return of steep subsidy cliffs and, for many, premiums that have more than doubled for the 2026 plan year. Provisions of the 2025 reconciliation law (Public Law 119-21) have layered new administrative burdens and sources of surprise tax liability on top of that premium increase.

Although some provisions of law and regulation related to the 2025 reconciliation law have been stayed at least temporarily via litigation, potential changes include a shortened annual open enrollment period, the elimination of the year-round special enrollment period for people with income at or below 150 percent of the federal poverty level, new pre-enrollment verification requirements for income and immigration status before subsidies can be applied, and the end of \$0-premium auto-re-enrollment for many enrollees (which increases the risk that consumers are re-enrolled in coverage that no longer matches their eligibility and are later billed for a subsidy repayment they did not expect). Taken together, the expiration of the ePTCs and these legislative and regulatory changes would mean that many working people will not learn that they owe money back to the IRS, or that their coverage has changed, until they file taxes the following year.

These changes also threaten the value-based care arrangements that APG members have built to care for the Marketplace enrollees who are their patients. As APG has noted throughout these comments, value-based and capitated arrangements are negotiated with, and paid for by, a patient's health plan, and they depend on a stable, continuously covered patient panel so that a physician group can be held accountable for that panel's cost and quality over time. The premium spikes that have followed the ePTCs' expiration, combined with a potential shortened enrollment window, new pre-enrollment verification steps, and narrower auto re-enrollment, will increase plan-switching and coverage churn in the Marketplace. Every instance in which an enrollee drops coverage, switches carriers, or is administratively disenrolled and later re-enrolled, breaks the continuity that value-based arrangements require. Risk-adjusted benchmarks reset, care coordination and quality-reporting investments made for that patient are lost, and physician groups bear the cost of restarting management for patients who cycle in and out of their panels.

A Marketplace with higher churn is one in which accountable, physician-led care models are harder to sustain and harder to scale, which runs counter to the Committee's stated goal of coverage that is easy to get, easy to use, and truly protective of patients. APG urges the Committee to restore and make permanent the enhanced premium tax credits, and to reverse or narrow the verification and re-enrollment provisions described above, both to eliminate surprise tax liability and to preserve the continuity of coverage that value-based care in the Marketplace depends on.

Section 2: Making Health Care Simpler for Families

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

- APG supports standardized benefits and plan designs that make it easier for consumers to compare options. APG recommends that standardized designs also allow consumers to see and choose accountable care arrangements, such as a network built around a risk-bearing physician group, and that

plans standardize what they require of practices, including quality measures and data submissions, so that multi-payer practices are not managing conflicting reporting frameworks.

- Simplification also depends on data about individuals' health and care moving smoothly and in timely fashion across payers, providers, and patients. In APG's September 2026 comments on the CY 2027 Physician Fee Schedule and Shared Savings Program proposed rule, APG urged CMS to press EHR vendors toward greater standardization, to support TEFCA and CEHRT Direct messaging, and to expand the eligibility data available to practices through the 835/837 system, such as current primary care assignment and date of last visit. APG makes the same recommendation here: Plans and regulators should adopt common data standards so that physician groups can use all the clinical and claims data available to them to manage populations.

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

APG members experience administrative complexity from both sides: as clinicians whose patients are denied care or receive it on a delayed basis, and as organizations that absorb the cost of prior authorization and claims processes. Physician groups that hold delegated financial risk already manage utilization for their patients and are accountable for both cost and quality. In its March 2023 comment letter to CMS on the prior authorization proposed rule, APG stated that "prior authorization is an essential component of strategies to address the problem of low-value health care," and did not ask that risk-bearing or value-based physician groups be exempted from it. Instead, APG focused on standardizing and speeding up the process for all payers and providers alike. Building on that position, APG recommends that the Committee:

- Require payer-side Provider Access and Prior Authorization APIs that automate submission and reduce administrative burden, consistent with APG's March 2023 recommendations to CMS.
- Set enforceable decision timeframes — no more than 72 hours for expedited requests and 7 calendar days for standard requests — and require that payers state specific reasons for every denial.
- Require payers to publicly report prior authorization approval, denial, and overturn rates annually, consistent with APG's prior recommendations to CMS.
- Require timely, plain-language decisions and clinician-to-clinician review for denials.
- Maintain broad networks and continuity-of-care protections, including for patients who must switch coverage mid-year.

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

APG supports transparency and accountability for claims denials and delays. APG recommends that the Committee:

- Require insurers to publish approval, denial, and overturn rates by service and by plan, and to report the administrative burden they impose on practices.
- Guarantee an appeals process that puts patients and physicians on a level playing field with the plan, with timelines and penalties for improper delay or denial.
- Ensure that physician groups in delegated arrangements have timely access to the claims and eligibility data needed to manage the populations for which they are accountable.

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

The RFI expresses concern about unsubstantiated fraud claims being used to remove people from coverage. APG supports appropriate oversight of every form of coverage, but APG’s experience is that targeted safeguards outperform blanket mandates to banish fraud. In APG’s recent comments on CMS’s proposed 2027 Medicare Physician Fee Schedule rule on remote patient monitoring, for example, APG recommended physician ordering requirements, outcome reporting, EHR integration, and vendor registration in place of a blanket mandate requiring that the personnel carrying out remote patient monitoring be directly employed by providers, as such a mandate would end many clinically effective programs operated by vendors working with provider groups.⁴

APG urges the Committee to apply the same principle to coverage: Pursue documented sources of improper payment and abuse and protect the beneficiaries and clinicians who are doing the right thing from the collateral effects of overbroad policies. APG also recommends that eligibility verification rely on automated data wherever possible, preserve beneficiaries’ ability to self-attest to eligibility, provide plain-language notices in multiple languages, and guarantee appeal rights with continued coverage pending appeal, as APG recommended in its comments on the Medicaid community engagement interim final rule.

Section 3: Taking on Corporate Greed

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

APG shares the Committee’s goal that – consistent with the medical loss ratio requirements on insurers adopted under the Affordable Care Act -- the vast majority of premiums and taxpayer dollars should be spent on care rather than on executive compensation or stock buybacks. Dollars that plans delegate to physician groups through capitation and risk arrangements fund care managers, home visits, behavioral health integration, remote monitoring, and quality infrastructure that fee-for-service does not pay for, and they reach patients through the clinicians who know them best. APG recommends that the Committee:

- Pursue precision, not blunt force: Target documented sources of overpayment and margin (for example, coding intensity and unlinked chart reviews in Medicare Advantage) rather than across-the-board reductions that fall equally on plans and provider arrangements that deliver superior value and those that do not.
- Protect and strengthen two-sided risk pathways, so that physician groups taking on downside risk are not penalized alongside arrangements that take on none.
- Require CMS to assess and report the impact of any proposed savings provision on beneficiaries’ access to accountable, capitated, and two-sided risk arrangements before enactment.

The evidence supporting the value of physician groups that take financial responsibility for costs and quality has found that physician organizations bearing risk in Medicare Advantage achieve better outcomes than is the case under traditional Medicare, including for dually eligible and socially vulnerable populations, and that the benefits of the care modalities that they adopt for their MA patients “spill over” to their traditional Medicare patients as well.⁵

⁴ <https://www.apg.org/wp-content/uploads/2026/09/APG-comment-2027-proposed-rule-MPFS-MSSP-09.14.26.pdf>

⁵ See Cohen KR et al, Medicare risk arrangement and use and outcomes among physician groups. JAMA Network Open 8(1):e2456074. <https://doi.org/10.1001/jamanetworkopen.2024.56074>; Vabson B et al, Potential spillover effects on traditional Medicare when physicians bear Medicare Advantage risk. Am J Manag Care, published online February 26, 2025, doi:10.37765/ajmc.2025.89686; Cohen K et al, Health Outcomes in Full Risk Medicare Advantage versus Traditional Medicare. Am J Manag Care. Published online May 9, 2025 (volume 31). doi:10.37765/ajmc.2025.89740; Cohen K et al, Health Outcomes of Dually Eligible Beneficiaries Under Different Medicare

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

APG has previously stated, in its response to the Patients First Act RFI, that ownership structure is a poor proxy for whether physicians direct clinical care or patients receive high-quality, coordinated services. Physician-led, risk-bearing organizations often require capital and scale to build the infrastructure that supports accountable care, and in turn support smaller independent practices. APG therefore recommends that safeguards be tied to conduct and outcomes rather than to corporate form:

- Define prohibited practices directly, such as steering, self-dealing, unreasonable restrictions on clinicians, and interference with clinical decision-making, rather than excluding organizations based on ownership share or board composition.
- Assess entities on value-based performance measures already in use, including total cost of care, quality performance, and shared savings record, and on who develops and controls clinical protocols and treatment decisions.

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

APG supports strengthening medical loss ratio (MLR) oversight, provided that the rules recognize and consider how delegated arrangements work. APG recommends that the Committee:

- Ensure that MLR reporting and any refinement of quality improvement activity definitions count payments to providers under delegated and capitated arrangements as medical spending. These definitions also should require plans to report how much of each premium dollar reaches clinicians and delegated entities versus retained by the plan or affiliated entities.
- Close intercompany-transfer and affiliated-entity gaps that allow plans to classify their own administrative costs or margins as medical expense.

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

APG supports expanded transparency and reporting across private markets, including claims, price, and denial data, and supports addressing anticompetitive practices by third-party administrators and other middlemen affiliated with insurers. APG recommends that the Committee require these entities to disclose their affiliations and financial arrangements, and that physician groups in delegated arrangements have access to the data needed to manage the populations for which they are accountable. Transparency should be paired with reforms to plan design, as the RFI recognizes, since patients cannot be expected to shop for most care.

IV. Conclusion

APG commends the Committee Democrats for undertaking this comprehensive review and for inviting the perspective of physician groups that take responsibility for the cost and quality of care. APG looks forward to

Payment Arrangements. Am J Manag Care. 2026; 23(5):26270, <https://doi.org/10.37765/ajmc.2026.89827>; Cohen K et al, Health Outcomes of Socially Vulnerable Populations in Different Medicare Payment Arrangements. Am J Manag Care. 2026;32(5):262-270. <https://doi.org/10.37765/ajmc.2026.89827>

working with the Committee as these ideas are refined. If you have any questions, please contact Valinda Rutledge, Executive Vice President of Policy and Advocacy, at VRutledge@apg.org.

Sincerely,

A handwritten signature in black ink that reads "Susan Dentzer". The signature is fluid and cursive, with the first name "Susan" and last name "Dentzer" clearly legible.

Susan Dentzer
President and CEO
America's Physician Groups
sdentzer@apg.org