

LETTER *Published October 7, 2026 · 25 minute read*

Making Health Coverage Work for Everyone

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The following is Third Way's response to the Senate Finance Committee Democrats' request for information on *Health Coverage That Works for Everyone*.

October 2, 2026

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

Re: Third Way Comments on Senate Finance Committee RFI, Health Coverage That Works for Everyone

Dear Ranking Member Wyden:

Third Way appreciates the opportunity to respond to the Senate Finance Committee Democrats' request for information on *Health Coverage That Works for Everyone*. We share the Committee's goal of getting every American covered and ensuring that coverage works when people need care.

We believe Congress must reverse recent Medicaid cuts and restore Affordable Care Act (ACA) affordability assistance. Congress should also improve those programs so that people do not lose coverage when their circumstances change and ensure that public support reaches the patients and providers who need it most. But those steps alone would return us to a system that was already falling short. Millions of people with insurance, including those with employer-sponsored coverage, still struggle to afford care, find a provider, or get their plan to cover treatment.

Congress must offer a bold vision that goes beyond restoring the coverage people had before the cuts. Every American should have health care they can afford, access, and actually use, wherever they get coverage:

- **Affordable care**, with protection from high premiums, out-of-pocket costs, surprise bills, and medical debt.
- **Accessible care**, with doctors and other health providers there when and where patients need them.
- **Simple care**, with clear terms, reliable information about costs and providers, timely decisions, and a fair way to resolve problems.

Third Way's [Health Care Bill of Rights](#) lays out 10 comprehensive protections that would make that vision real.

Our comments focus on areas of the RFI where Third Way has specific recommendations. We organize them by RFI section and include the Committee's full wording below each subheading.

Section 1. Reversing Republican Cuts and Reimagining a Better Path

Congress should reverse recent Medicaid coverage cuts, remove enrollment and eligibility hurdles that cause people to lose coverage when their job or income changes, and restore the enhanced ACA tax credits. These steps are necessary to protect and strengthen coverage for millions of Americans.

But Congress should not simply return to the way the system stood before the cuts. Instead, Congress must also address the weaknesses these programs had before the Republican cuts. Hospitals that serve large numbers of Medicaid and uninsured patients need stable support that reflects where the need is greatest. States need dependable and targeted funding. And people who rely on Medicaid should be able to trust that coverage will be there when they need it. The goal is to repair the damage from recent cuts *and* fix the weaknesses those cuts exposed.

A **Health Care Bill of Rights** would establish comprehensive consumer protections, including for those with employer coverage, so that universal coverage means care everyone can afford, reach, and easily use. Together, these reforms would strengthen public programs, move us toward universal coverage, and make sure that coverage counts.

1.1 Protect shoppers from misleading coverage

RFI request, PDF pages 15–16: Senate Democrats invite proposals and feedback on approaches to ensure that consumers seeking to enroll in high-quality coverage are protected from misleading marketing and substandard coverage.

Choosing a health plan requires people to judge costs and access before they know what care they will need. Premiums are easy to see, but exclusions, cost-sharing rules, and network limits can be difficult to compare. And people often have to make these decisions quickly, with incomplete or unreliable information. Clear information and meaningful coverage standards must work together: disclosure alone cannot protect patients if major care remains uncovered.

Third Way recommends:

- **Create a standard health plan label and minimum coverage standards across plan types.** Congress should require a plain-language label, building on the ACA Summary of Benefits and Coverage, wherever a plan is marketed or sold. Before enrolling, a shopper should be able to see the premium after any assistance, deductible, out-of-pocket limit, costs for common services and drugs, major exclusions, and usable provider-network information in the same format for every plan. The label should clearly state whether the product meets ACA coverage standards. Insurers, brokers, and enrollment websites should use the same information so a limited-benefit product cannot be presented as equivalent to comprehensive coverage.
- **Hold misleading marketing accountable.** Regulators should review marketing materials and enrollment sites for claims that conflict with the plan's actual benefits and require prompt correction of misleading information. Repeated violations should carry meaningful penalties.

1.2 Cover emergency ground ambulance services

RFI request, PDF page 18: Senate Democrats invite feedback on approaches to strengthen existing federal and state essential health benefits requirements and flexibilities in order to improve the quality of coverage for consumers across private markets.

Patients cannot choose an ambulance provider during an emergency and need protection from unexpected costs.

Third Way recommends:

- **Include emergency ground ambulance services in the ACA's essential health benefits.** Congress should pair that coverage requirement with limits on patient cost sharing and a cap on out-of-network ground ambulance reimbursement when no applicable state, local, or contracted rate exists. This would protect patients who cannot choose an ambulance provider during an emergency.

1.3 Make the total cost of coverage and care affordable

RFI request, PDF page 18: Senate Democrats request feedback on these reforms and other approaches that would expand protections and assistance for people who cannot afford to use their health insurance.

Nearly 40% of insured people have delayed or skipped care because of cost. Congress should consider premiums and all out-of-pocket costs together, including deductibles, coinsurance, and other cost sharing. Protections should reflect a household's overall financial exposure, including likely spending for common care and its maximum financial exposure during a plan year.

Third Way recommends:

- **Cap premiums and total out-of-pocket costs based on income.** Apply these protections to ACA and employer coverage. Congress should restore enhanced ACA premium tax credits and expand cost-sharing assistance so that lower premiums do not come with unaffordable deductibles. Employers could adjust their benefits to meet these protections or use federal assistance to provide them.
- **Extend federal assistance with premiums and out-of-pocket costs to people insured through an employer.**
- **Cap employees' annual prescription drug costs at \$2,000.**

1.4 Apply cost protections across coverage sources

RFI request, PDF page 22: Senate Democrats invite detailed proposals and reforms that strengthen benefit design and cost-sharing requirements within existing coverage options. Along with specific feedback on modernized approaches to evaluating and improving affordability for consumers in an environment where out-of-pocket costs continue to skyrocket, we invite analysis and feedback on reforms that account for the unique differences in coverage, financing and purchasing across the individual, small group and large group markets while also ensuring consistency and continuity in coverage and protections for consumers who move between markets during a plan year.

People should have consistent financial protection when their job or coverage changes, without requiring every market to use the same plan design. Limits on patient costs also need to be paired with action on underlying prices.

Third Way recommends:

- **Cap premiums, deductibles, and other out-of-pocket costs based on household income.** Employers should be able to adapt their benefits to the cost caps or use federal assistance while meeting those protections.
- **Cap excessive hospital prices and adopt site-neutral payments so the same service does not cost more simply because of where it is delivered.** These proposals address a

driver of premiums; they do not prescribe the separate rate-review benchmarks discussed earlier in the RFI.

1.5 Set reachable out-of-pocket limits

RFI request, PDF page 25: Senate Democrats invite comments and feedback on approaches to reforming out-of-pocket maximums so they are reachable and reasonable for consumers, and protective across private insurance markets.

Cap Out-of-Pocket Costs

An annual out-of-pocket maximum offers little protection to someone who cannot afford the deductible needed to reach it. Deductibles can create a barrier at the start of the year, when someone needs care before they have set aside money for a large bill. In 2025, the average deductible for a worker with single coverage in an employer plan with a general deductible was \$1,886; at smaller firms, it was \$2,631. Limits on the amount people pay for care should be tied to household income and should apply to people insured through an employer or the ACA.

Congress should address both the *total amount* patients may owe and *how much they may be asked to pay at once*. To that end, **Third Way recommends:**

- **Set income-based annual limits.** Cap deductibles and total out-of-pocket costs as a share of household income in ACA plans and coverage through an employer, with lower limits for people with lower incomes. Apply the protections to individuals and families. Employers could meet the standard by redesigning benefits or using federal assistance tied to the same cost limits. An income-based approach would also reduce the risk that an insured person faces bills they cannot pay.
- **Limit deductible payments in any one month.** Congress should develop a monthly deductible limit, so one emergency visit does not leave a patient facing the full annual deductible at once. For example, patients could pay no more than \$200 toward the deductible for covered care each month. Above that amount, the plan's usual copays or coinsurance would apply. Each month's deductible payments would count toward the annual deductible. Once it is met, no further deductible payments would be required for the rest of the plan year.

End Medical Debt

Coverage is not affordable if patients leave a doctor's office with bills they cannot pay. High deductibles, uncovered services, and coverage disputes can put even insured people into

debt. Congress should address existing debt while strengthening coverage so new debt does not take its place.

People who obtain adequate coverage through an employer, the ACA, Medicaid, or Medicare should be eligible for forgiveness of qualifying medical debt. The federal government could purchase or refinance providers' uncollectible debt at a negotiated price, with financing from a modest provider tax. Eligibility could be verified through the information health plans already provide about a person's coverage.

Congress should also raise the standard for adequate coverage. A gold-level benchmark, covering about 80% of expected costs, would offer more protection than the current silver-level benchmark of 70%. Lower-income households should receive greater protection, with limits on what they must pay for care.

Third Way recommends three linked steps:

- **Forgive existing debt.** People with qualifying medical debt should be eligible for forgiveness if they have or obtain adequate coverage through an employer, the ACA, Medicaid, Medicare, or other forms of coverage. Verification should be automatic using the existing sources for tracking coverage, so patients do not have to assemble records themselves.
- **Pay for relief without reimbursing bills at face value.** Authorize the federal government to purchase or refinance providers' uncollectible medical debt at a negotiated price. Finance the program with a modest tax on provider revenue, with the rate set using current estimates of the debt's purchase price and the amount eligible for relief.
- **Prevent new debt.** Make stronger coverage affordable by adopting a gold-level benchmark that covers about 80% of expected costs, with greater protection for lower-income households. Pair that standard with income-based limits on deductibles and other out-of-pocket costs.

Debt forgiveness would give families relief now. Stronger coverage would reduce the chance that the next illness puts them back in debt.

1.6 End junk insurance across markets

RFI request, PDF page 41: Senate Democrats request feedback on approaches to ensuring that consumers are protected from substandard plans that provide little to no coverage or financial protection, and invite comments on whether insurance companies that market or sell junk insurance should receive taxpayer support.

A low premium is not a good deal if a plan excludes essential care or leaves a patient with bills they cannot pay. Disclosure helps people compare plans, but it cannot make inadequate coverage safe.

Third Way recommends:

- **Set and enforce minimum coverage standards.** Ban short-term, limited-duration plans that evade ACA protections, require association health plans to comply with the ACA, and set minimum federal coverage standards across plan types. Congress should enact those protections so products marketed as health insurance provide meaningful benefits and financial protection.
- **Limit taxpayer support to coverage that meets minimum standards.** Insurers should receive federal premium assistance or other public subsidies only for products that meet those standards.
- **Hold insurers accountable for misleading claims.** Regulators should also hold insurers accountable when they market such products as substitutes for comprehensive coverage, including by requiring them to correct misleading claims and imposing penalties for repeated violations. These rules would establish a floor for what insurers can sell; the clear, comparable plan information proposed in Section 1.1 would help consumers assess the coverage available above that floor.

Section 2. Making Health Care Simpler for Families

Washington has spent decades trying to make health care more affordable and more accessible. These efforts are vital, but lawmakers have overlooked a core problem that Americans feel every day: even when people have coverage, the health care system is simply too complicated.

People with employer-sponsored insurance, Medicare, Medicaid, marketplace plans, or other coverage all run into confusing rules, unclear costs, paperwork, and gaps in information. Recent polling found that 58% of insured adults had a problem using their insurance in the past year, including 60% of adults with employer-sponsored coverage, 58% of adults with Medicaid, 56% of adults with marketplace coverage, and 51% of adults with Medicare. The details differ, but the experience is often the same: health care is too hard to understand, too hard to navigate, and too hard to use.

That complexity is not a minor annoyance. Complexity drives up costs, creates barriers to care, and makes the system less accountable to the people it is supposed to serve.

Washington needs a clearer vision for how health care can work better for people who rely on it.

The recommendations in this section address ways Congress can make coverage easier to choose, use, and pay for. That means clearer plan information, reliable provider directories, faster coverage decisions, records patients can access, and bills they can understand.

2.1 Make plan choices easier to compare

RFI request, PDF page 47: We request feedback on approaches to establish minimum requirements for standardized plans. We also invite specific feedback on the types of differences in plan designs that drive meaningful value and choice for consumers, and analysis of the potential reduction in administrative costs if consumers are able to rely less on third-party brokers and agents for enrollment assistance because they are experiencing a more efficient, less confusing shopping experience.

Choosing a health plan feels like guesswork. A standard label would help people compare plans side by side, understand their likely costs, and avoid coverage that looks affordable but is hard to use when they need care.

Third Way recommends:

- **Restore standardized plan options in ACA Marketplaces.** This way people would be able to compare plans with the same basic cost-sharing structure.
- **Create a standard plan label across coverage sources.** This can be done by modernizing the Summary of Benefits and Coverage. Like a nutrition label for food, the standard plan label should show all out-of-pocket costs, covered drugs, provider access, and examples of what common care would cost the patient in a consistent format. A label would help people see meaningful differences in costs and access.

Plans could still differ in provider networks, benefits, and costs. The point is to make those differences visible.

2.2 Require accurate provider directories

RFI request, PDF page 48: We request feedback on these proposals and additional reforms to ensure that consumers are not being misled by inaccurate provider directories.

Patients rely on provider directories when choosing coverage and trying to get care. Directory information is not valuable if it is incomplete or out of date.

Third Way recommends:

- **Require plans to keep accurate, current provider directories.** Plans should verify that clinicians participate in the specific plan, practice at the listed location, and accept new patients. Plans should promptly correct errors reported by providers or consumers.
- **Check accuracy and enforce corrections.** Congress should require plans to verify that listed clinicians participate in the specific plan, practice at the listed location, and accept new patients. Plans should promptly correct errors reported by providers or consumers. Regulators should check a sample of listings and require plans to report how quickly they resolve inaccuracies.
- **Protect patients who rely on incorrect listings.** If a directory incorrectly lists a provider as in network, the patient should be protected from the resulting unexpected out-of-network cost. Repeated failures should trigger corrective action. Together, these steps would make the plan's advertised network more closely match the care its members can actually use.

2.3 Make the network work when people need care

RFI request, PDF page 48: Senate Democrats seek feedback on these and other proposals to strengthen networks and ensure broad access to high-quality providers.

People need a real choice of doctors and a reasonable ability to get an appointment. Insurance networks can limit that choice, and even a well-designed network cannot provide care where too few clinicians practice. The health care workforce faces growing shortages that impact a patient's ability to find and receive care. The United States is projected to have a shortage of up to 86,000 physicians, 40,400 primary care physicians, and 63,720 registered nurses by 2036.

Third Way recommends:

- **Train more clinicians where they are needed.** Expand Medicare-supported residency slots in shortage areas and provide tuition or loan support for health workers who serve underserved communities or work in professions with shortages.
- **Hold plans to meaningful access standards.** This should include primary care, specialists, mental health care, and hospitals. When a plan cannot provide appropriate covered care in the network, the patient should be able to receive it without higher cost-sharing.
- **Give workers more choice of doctors without exposing them to excessive prices.** Require employers to offer a Health Freedom Plan with limits on out-of-network

prices, building on the payment protections in the No Surprises Act.

- **Expand telehealth coverage and access across state lines.** This would help patients reach clinicians who are otherwise unavailable nearby.

Bolstering the workforce begins with expanding residency training slots. But it must also include improving workplace conditions and compensation, addressing the Medicare physician payment structure, addressing hospital consolidation, and reducing the administrative burden on physicians. There are a number of ways to achieve these goals, but Congress must support the entire workforce pipeline to ensure equal access to high-quality providers.

2.4 Reduce needless prior authorization delays

RFI request, PDF page 51: Senate Democrats request comments and analysis on the following approaches and concepts, including feedback on how they could be applied across private markets and how they would meaningfully change consumer experience:

Prior authorization can help prevent unnecessary care, but the process often makes patients wait for care their clinician has recommended.

Third Way recommends:

- **Use common forms, codes, and electronic submissions.** Clinicians should be able to submit the same core information regardless of the patient's plan. A common process across plans would reduce the work of navigating different forms and rules, especially for providers who treat patients with multiple types of coverage.
- **Require timely decisions.** Set enforceable deadlines for urgent and routine requests, measured from submission, with safeguards against unnecessary requests for more information that restart the clock.
- **Give patients clear decisions.** Plans should promptly tell patients and clinicians what was approved or denied, explain a denial in plain language, and clearly identify how to appeal.
- **Report performance publicly.** Require plans to disclose decision times and denial rates so regulators and consumers can see whether the process is improving.

2.5 Make appeals understandable and usable

RFI request, PDF page 58: Given the harm that can be caused to patients as a result of improper denials, and the need for a consumer-friendly appeals process to protect against undue medical debt or harmful delays in receiving essential care, organizations and researchers representing

patients and consumers recommend several proposals to improve internal and external appeals processes for consumers. We invite detailed comments and feedback on these approaches as well as additional reforms.

A patient cannot decide whether to challenge a denial without understanding the decision or knowing where to get help. A patient should be able to challenge an incorrect decision without first becoming an expert in insurance rules.

Third Way recommends:

- **Require clear coverage decisions.** Patients should receive an understandable explanation of what their plan denied in plain language, why, and how to seek review.
- **Give patients one point of contact.** Plans should provide a clear place to get help with coverage problems, including a denial.
- **Require public reporting of denial rates.** Patients and regulators should be able to see how often plans deny care and identify repeated problems.

2.6 Create a single patient medical record

RFI request, PDF pages 58–59: While comprehensive reforms to electronic health records systems fall outside the scope of private insurance reforms, we request comments and feedback on the role of insurance companies in ensuring that their consumers have access to their billing records, correspondence, and information about claims denials and appeals in a centralized easy to access location that is available to them electronically at any time.

A patient's health information is about their life and their care. Today, patients have to search through separate portals and request their own records. That makes it harder for patients and providers to understand their health, make decisions, and catch mistakes. It also leads to repeated tests and added costs.

Patients should be able to see their health information in full and decide who can use it. Doctors and hospitals hold the clinical information patients need, while insurers hold claims, bills, and coverage decisions. Patients need these pieces together to understand their care, catch mistakes, and challenge an incorrect charge or denial.

The 21st Century Cures Act established a foundation for electronic access and information sharing. But access to separate records is only a starting point. Patients need a simple way to bring information from their providers and health plans together in one secure record they can access and control.

Third Way recommends:

- **Give every patient a single digital health record that they can easily access and control.** Bring together information from across the health system (including diagnoses, medications, and test results) so patients and providers can see a complete health history to make clinical decisions, avoid duplicate tests, and make care easier to understand. The record should provide a reliable source of information throughout a patient's life, so they can share their health history with a new doctor, specialist, or emergency care provider, even when they change providers or insurance.
- **Gather and update information on the patient's behalf.** Require providers and health plans to supply the information they hold through a process that automatically assembles and maintains the patient's record. Patients should not have to search multiple portals, upload documents, or arrange transfers between offices.
- **Give patients control over sharing and protect against misuse.** Patients should decide who can access their information, including providers, caregivers, researchers, and others they authorize, and what each person or organization can see and use. Strong privacy and security standards should absolutely prohibit hidden data sales, employer access, and advertising based on health records.

2.7 Give people clear information before and after care

RFI request, PDF page 64: Beyond enforcement and implementation of existing law, Senate Democrats invite feedback on ways to increase consumer transparency and ensure that consumers receive plain language information about their costs from their insurance plan.

Patients should know what care is likely to cost before they receive it and understand what they owe afterward.

Third Way recommends:

- **Provide personalized estimates before scheduled care.** Plans should provide a timely estimate for common care, showing what they expect to pay and what patients are likely to owe. Estimates should cover the full episode of care where possible, including separate facility and clinician charges, and identify costs that cannot yet be determined.
- **Provide clear explanations after care.** Once a claim is processed, a plain-language explanation of benefits should show the services billed, what the plan paid, and the patient's share. Patients should be able to easily compare it with the estimate, spot any errors, and know whom to contact about any differences. Both documents should be

available in the patient's digital record without requiring them to decipher billing codes or search multiple portals.

2.8 Make bills and payment easier to manage

RFI request, PDF page 64: We invite comments on the benefits and challenges associated with this proposal and request feedback on additional proposals to simplify billing for patients.

Patients should not receive several unexplained bills months after a visit. They need a simpler way to track and pay what they owe.

Third Way recommends:

- **Consolidate bills and resolve disputes promptly.** Move toward a single bill for an episode of care and set a clear deadline for providers, insurers, and billing companies to resolve disputes.
- **Create a Health Dividend Account.** Employers and plans could offer this single account instead of multiple health spending accounts, with the option to pay a patient's share automatically after a plan processes the claim.

2.9 Prevent avoidable coverage losses

RFI request, PDF page 68: Senate Democrats invite feedback on these proposals and other approaches to streamline eligibility and enrollment for all Americans and guarantee access to coverage throughout the plan year.

A path to universal coverage must reach people who already qualify for insurance but remain uninsured because signing up or staying enrolled is too difficult. Too often, eligible vulnerable Americans are kicked off of coverage due to bureaucratic hurdles and glitches. This often results in them forgoing care, skipping other necessities to afford care they do receive, and spending time fighting with agencies or insurers to get re-enrolled.

Automatic enrollment and presumptive eligibility are ways to cover millions more people through Medicaid and ACA coverage that already exists. Making coverage easier to obtain and keep is essential to getting every American covered under the current system.

Third Way recommends:

- **Use existing government data to enroll eligible people.** States should be able to use information from tax filings, Social Security, SNAP, and unemployment programs to connect people to Medicaid or low-cost ACA coverage.

- **Use the prior year's income to determine eligibility.** The ACA assesses income based on a person's current year's income, which is hard for a lot of people to predict and results in a big bill to the government when they guess too low. Using the prior year's income, as student loan applications do, would give everyone financial certainty. And if someone's income fell, they could still use their current year's income.
- **Make coverage last through changes in people's lives.** Incentivize states to provide a full year of continuous Medicaid eligibility, with renewal paperwork no more than once a year, and consider longer periods for young children.
- **Simplify enrollment when a premium is required.** Prepare an application using available information and let the person confirm coverage and authorize payment in a simple step.

Section 3. Taking on Corporate Greed

3.1 Investigate practices that raise costs and disrupt networks

RFI request, PDF page 85: Senate Democrats invite feedback on these concepts, and proposals to improve federal oversight across private insurance markets.

Oversight should examine how large health systems and the companies working for them affect prices and access to care. When a hospital system buys physician practices, it can gain leverage in negotiations with insurers and move routine care to settings that charge more for the same service. Revenue cycle managers can add to that pressure: some are paid a share of the revenue they recover and advise hospitals to threaten to leave insurance networks to secure higher rates. Patients can lose access to their clinicians during those disputes, while higher negotiated rates can increase costs for employers and families. These practices deserve scrutiny across both nonprofit and for-profit health systems.

Third Way recommends:

- **Investigate revenue cycle managers and network disruptions.** Examine how their contracts, compensation, and negotiating strategies affect prices and continuity of care. The Federal Trade Commission (FTC) should assess how these practices interact with hospital consolidation.
- **Strengthen scrutiny of hospital acquisitions and contracting.** Enforce antitrust law and prohibit anti-steering and all-or-nothing contracts that use a system's market power to limit lower-cost choices.

- **Remove the reward for moving care to a hospital-owned site.** Require equal payment—in all coverage types—for the same routine service regardless of where it is delivered.
- **Reduce incentives to leave networks.** Strengthen the No Surprises Act payment process by anchoring out-of-network payments to the median in-network rate. Expand No Surprises Act protections to non-emergency care from an out-of-network provider to incentivize in-network participation. Increase transparency and fairness in the Independent Dispute Resolution (IDR) process.
- **Cap hospital prices as a last resort.** Many hospital markets are so consolidated that it would take decades to make them competitive through antitrust and other actions. Prices well above a percentage of Medicare rates are a clear signal of market failure. A price cap (as opposed to a price control) would allow competition to continue, but without the price gouging that pervades much of the health care market.
- **Bring the 340B Prescription Drug Program under control.** 340B contributes to consolidation in hospital and doctor markets because large hospital corporations can use acquisitions to claim 340B revenue. Moreover, working-class patients often do not get the benefit of 340B revenue. Congress should pass basic reforms that bring accountability into this important program.

These steps would let regulators examine the conduct of large, integrated systems and give Congress tools to address practices that raise costs or interrupt care across the system.

Conclusion

Restoring coverage and repairing broken public programs is essential, but it will not resolve the frustration of people who pay for insurance and still cannot afford care, find a doctor, or get a claim paid. The next phase of reform should hold coverage to a clear standard: does it protect people when they need it? Congress can make that standard real by setting and enforcing stronger rules across employer plans and ACA coverage, curbing excessive prices, and removing administrative barriers that serve no patient. Third Way's approach builds on the coverage Americans already have and makes government an effective referee for the people who rely on it. Success means more people covered and fewer people left to fight their insurer, their bill, or the system on their own.

Sincerely,

Sandy Max, Deputy Director, Health Care
David Kendall, Senior Fellow for Health and Fiscal Policy
Gaby Hartney, Health Policy Advisor

