



October 2, 2026

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

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

Submitted via email: insurance@finance.senate.gov

Dear Senator Wyden and members of the Committee on Finance,

The National Rural Health Association (NRHA) appreciates the opportunity to respond to the Senate Finance Committee's Request for Information (RFI), *Health Coverage That Works for Everyone*, released July 30, 2026.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

Rural Coverage and Access Context.

Rural residents are less likely than urban residents to have employer-sponsored insurance (47.8 percent compared to 56.0 percent), more likely to rely on public coverage (42.2 percent compared to 36.1 percent), and more likely to be uninsured (8.4 percent compared to 7.8 percent).¹ Farmers, ranchers, and agricultural managers rely on the individual market at roughly three times the rate of other workers, with more than a quarter covered through individual market plans.² Appropriately 2.8 million rural residents are enrolled in Affordable Care Act (ACA) Marketplace coverage.³

At the same time, the providers that rural coverage depend on are under significant financial strain. Nearly half of rural hospitals operate on negative margins, with an additional 417 vulnerable to closure.⁴ Since 2010, more than 200 rural hospitals have closed or stopped providing inpatient care.⁵ Research from the Center for Healthcare Quality and Payment Reform finds that many small rural hospitals lose

¹ Sarah Eisenstein et al., Health Insurance Coverage in Rural and Urban Areas in the U.S., 2023, RUPRI Center for Rural Health Policy Analysis (Sept. 2025), https://rupri.public-health.uiowa.edu/publications/policybriefs/2025/Health_Insurance_Coverage.pdf.

² Occupations with Large Shares of Workers Who Rely on Individual Market Coverage, KFF (Sept. 30, 2025), <https://www.kff.org/affordable-care-act/occupations-with-large-shares-of-workers-who-rely-on-individual-market-coverage/>.

³ Cristina Lilley & Whitney Zahnd, Role of Enhanced Premium Tax Credits in Rural America, National Rural Health Association (Aug. 2025), <https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/2025/nrha-policy-paper-enhanced-premium-tax-credits-final.pdf>.

⁴ Michael Topchik et al., 2026 Rural Health State of the State, The Chartis Center for Rural Health (Feb. 2026), <https://www.chartis.com/insights/2026-rural-state-state>.

⁵ Rural Hospital Closures, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill (last updated June 2026), <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>. Counts exclude conversions to Rural Emergency Hospitals.

money on patients with private insurance, including Medicare Advantage, because those plans pay less than the cost of delivering care.⁶

For rural America, coverage is only as meaningful as the local access it provides. NRHA urges the Committee to treat rural provider stability as a core design requirement of any coverage reform, not an afterthought. We appreciate the RFI's recognition that coverage expansion should preserve access to providers and avoid disrupting care in rural and underserved communities.

Section 1.I: Enrollment Assistance.

Rural consumers face particular barriers to enrollment. The federal Navigator program, which provides impartial in-person assistance, was cut by 90 percent in 2025.⁷ Online-only enrollment is not a workable substitute in many rural communities. More than 9 million rural residents still lack access to fixed terrestrial broadband at benchmark speeds, and roughly one in four rural residents has no wireline option at those speeds.⁸ Rural consumers are also frequent targets of aggressive broker marketing and unauthorized plan switching, and often have fewer places to turn for help when problems arise. Shortened enrollment windows and the loss of automatic re-enrollment add further hurdles for rural families who must travel or wait for in-person help.

NRHA recommends that Congress:

- 1) **Restore Navigator funding**, with a dedicated rural allocation or rural reach requirement for grantee,
- 2) **Support in-person and phone-based assistance alongside online platforms**,
- 3) **Support trusted local entities as year-round assisters**: Critical Access Hospitals (CAHs), Rural Emergency Hospitals (REHs), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), extension offices, state offices of rural health
- 4) **Reinstate the longer open enrollment period (November 1 to January 15)**,
- 5) **Create seamless transitions in coverage** to allow automatic re-enrollment in Marketplace plans, and permanently restore the monthly special enrollment period for individuals at or below 150 percent of the federal poverty level.

Section 1.II: Deductibles, Cost-Sharing, and Out-of-Pocket Costs.

High deductibles and coinsurance affect rural patients and providers alike. High deductibles can disproportionately impact rural residents who generally have lower household incomes and fewer provider options. Rural residents are more likely to carry medical debt, and unpaid cost-sharing becomes bad debt and uncompensated care for rural facilities that cannot absorb it.⁹ Cost-based sharing is also a tool for steering patients in rural areas. Emergency and inpatient care cannot be shopped for, and rural patients typically have a single local option. When cost barriers cause patients to delay care, they arrive later and sicker, which raises costs for small facilities with limited capacity. Further, affordability

⁶ Rural Hospitals at Risk of Closing, Center for Healthcare Quality and Payment Reform, https://ruralhospitals.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf; see also The Causes of Rural Hospital Problems, CHQPR, <https://ruralhospitals.chqpr.org/Problems.html>.

⁷ Kaye Pestaina, A 90% Cut to the ACA Navigator Program, KFF (Feb. 14, 2025), <https://www.kff.org/quick-insights/a-90-cut-to-the-aca-navigator-program/>.

⁸ Federal Communications Commission, 2026 Section 706 Report, GN Docket No. 25-223, FCC 26-55 (rel. Aug. 14, 2026). The Report estimates that 10.5 million people, including more than 9 million rural residents, lack fixed terrestrial service at 100/20 Mbps, and that fixed wireline availability at that speed reaches 75.3 percent of the rural population.

⁹ Janet Fulk, Meredith Lair & Robert Stansbury, Rural Medical Debt: A Systemic and Structural Population Health Crisis, National Rural Health Association (Dec. 2025), <https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/2026/nrha-rural-medical-debt-policy-paper.pdf>.

calculations should consider geographic access barriers and non-medical costs of obtaining care given barriers that rural residents face in care.

Rural patients can also face higher cost-sharing because of how coinsurance is calculated at cost-based providers. In Traditional Medicare, CAH outpatient coinsurance is based on 20 percent of charges rather than a capped payment amount, which can leave rural beneficiaries paying more than they would for the same service at a prospective payment system hospital.¹⁰ Commercial plans that base cost-sharing on charges can create similar effects. Meanwhile, cuts to Medicare bad debt reimbursement have left rural hospitals absorbing more of the cost-sharing their patients cannot pay.

NRHA recommends that Congress:

- **Incorporate provisions in H.R. 3684, the *Save America's Rural Hospitals Act***, which would cap CAH outpatient and RHC coinsurance, reverse cuts to Medicare bad debt reimbursement, and make key rural payment designations permanent.¹¹

Section 1.III: Public Opinion and Other Federal Coverage Options

NRHA urges the Committee to adopt the following rural conditions for any public option, Medicare or Medicaid buy-in, or other federal coverage option.

Payment rates.

The RFI outlines three approaches to setting provider payment: HHS negotiation authority, Medicare-referenced benchmarks, and a public option fee schedule. Each option carries rural risks. Rural providers have little leverage in negotiations. Medicare rates alone do not sustain many rural facilities, especially when Medicare sequestration is applied to cost-based provider payment. In aggregate, the fee-for-service Medicare margin in aggregate for rural hospitals was projected to be about negative ten percent in 2026 by MedPAC's March report.¹² Rural hospitals already lose money on many privately insured patients, so replacing commercial rates with Medicare-based rates could widen those losses unless rural protections are built in.

We appreciate the RFI's statement that "ensuring adequate payment is especially important in rural and underserved areas where enhanced payment rates may be necessary."¹³ Any federal coverage option should, at minimum, preserve existing rural payment designations and methodologies, including CAH cost-based reimbursement, the RHC all-inclusive rate, the FQHC prospective payment system, sole community hospital designation, Medicare-dependent hospital designation, the low-volume hospital adjustment, rural emergency hospital facility payments, and swing bed payment. Rural add-ons should be built into base-line methodologies rather than added later. NRHA also asks the Committee to require modeling of the net revenue impact on rural providers, by provider type, before any payment approach is adopted.

A federal option that relies on Medicare payment can only be as stable as the rural designations underneath it. Several of these designations are temporary and must be repeatedly extended, and others no

¹⁰ Medicare Payment Advisory Commission, Report to the Congress: Medicare and the Health Care Delivery System (June 2025), https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_MedPAC_Report_To_Congress_SEC.pdf.

¹¹ Fulk et al., supra note 12.

¹² Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, ch. 3 (Mar. 2026), https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch3_MedPAC_Report_To_Congress_SEC.pdf.

¹³ Health Coverage That Works for Everyone, supra note 7, at 35.

longer reach the communities that need them. To give any federal coverage option a stable rural foundation, NRHA urges Congress to:

- **Incorporate provisions in H.R. 3684, the *Save America's Rural Hospitals Act***, to make the Medicare-Dependent Hospital and low-volume hospital designations permanent.
- **Pass S. 502/H.R. 6240, the *Rural Hospital Closure Relief Act***, to update CAH distance requirements and allow states to again designate necessary providers.
- **Reject site-neutral payment reforms** that would cut payment for rural hospital outpatient departments, and ensure that any Medicare-referenced benchmark does not import those cuts into a new federal option.

Networks.

A federal option should include rural providers in its network. An approach modeled on Traditional Medicare, in which any willing provider may participate, generally works better for rural communities than narrow networks. At minimum, a federal option should be required to offer contracts to all rural safety-net providers in its service area for acute and outpatient care, psychiatric services, swing bed services, and RHC services, with no carve-outs. NRHA has made the same request for Medicare Advantage plans, which have carved rural providers out of their networks under current time and distance standards.¹⁴

Coverage gap and Medicaid.

Rural hospitals in states that have not expanded Medicaid continue to have lower margins and higher closure vulnerability.¹⁵ NRHA supports closing the coverage gap for low-income adults in non-expansion states and restoring Medicaid funding to levels prior to the passage of H.R. 1.¹⁶ Any Medicaid buy-in or expansion proposal should account for recent limits on provider taxes and state directed payments, which already constrain the Medicaid financing that supports rural hospitals.

Section 1.IV: Inadequate Insurance Plans and Shrinking Networks

NRHA strongly supports efforts to eliminate inadequate insurance products and address the growing problem of shrinking provider networks. While narrow networks may be an effective cost-containment strategy for insurers, they can have significant unintended consequences for rural communities where provider shortages already limit access to care. NRHA has long maintained that network adequacy standards must ensure reasonable geographic access, sufficient provider capacity, and timely access to services for rural residents. NRHA policy states that overly narrow networks may reduce competition, increase travel burdens, and leave rural patients without meaningful access to needed care. NRHA recommends strengthening federal network adequacy requirements for rural and frontier communities by establishing standards that account for travel time, appointment availability, access to specialty care, and emergency service availability, rather than relying solely on mileage-based measures.

In addition, health plans should be required to demonstrate meaningful participation by essential rural providers, including CAHs, REHs, RHCs, FQHCs, behavioral health providers, maternity care providers,

¹⁴ National Rural Health Association, Statement for the Record, House Energy & Commerce Health Subcommittee, Lowering Health Care Costs for All Americans: An Examination of Health Insurance Affordability (Jan. 22, 2026), <https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/2026/e-c-nrha-statement-for-the-record-lowering-health-care-costs-for-all-americans-an-examination-of-health-insurance-affordability.pdf>.

¹⁵ Topchik et al., *supra* note 5.

¹⁶ Fulk et al., *supra* note 12.

and specialist access. Rural residents often have few provider options, and networks that exclude local providers can effectively deny access to care even when coverage is technically available. NRHA encourages Congress to address the continued problem of "ghost networks," where provider directories list clinicians or facilities that are not accepting patients, are no longer participating in the network, or are otherwise unavailable. Plans should not be permitted to satisfy network adequacy requirements through distant urban providers that are functionally inaccessible to rural patients due to travel distance, transportation barriers, or lengthy wait times. Meaningful network adequacy must reflect the realities of rural health care delivery and ensure that individuals can obtain timely, affordable care within their communities whenever possible.

Section 1.V: Premium Tax Credit Recapture.

Premium tax credits are the foundation of affordable individual market coverage in rural America. Before the enhanced premium tax credits (ePTCs) expired at the end of 2025, almost 80 percent of rural Marketplace enrollees were in a zero-premium plan, and the credits saved rural enrollees an average of \$890 per year, 28 percent more than their urban counterparts. Expiration was projected to raise premiums by 107 percent on average for rural residents, compared to 89 percent for urban residents.¹⁷

The elimination of income-based caps on premium tax credit recapture compounds this problem for rural workers. Farm, ranch, seasonal, and self-employed income is volatile by nature, and a strong harvest, a good year for livestock prices, or extra seasonal work should not leave a family owing the full amount of its tax credits. Nearly half of adult individual market enrollees are small business owners, small business employees, or self-employed. Fear of an unpredictable tax bill will lead many of these workers to forgo coverage altogether.

NRHA recommends that Congress:

- **Pass S. 46/H.R. 247, the *Health Care Affordability Act***, to permanently extend Marketplace ePTCs, and support bipartisan efforts to restore them, such as **H.R. 5145, the *Bipartisan Premium Tax Credit Extension Act***.
- **Restore income-based caps on premium tax credit recapture**, as proposed in **S. 3368**.
- **Expand safe harbors** for lower-income and variable-income filers, including farmers and other self-employed individuals whose income cannot be reliably projected in advance.
- Proceed cautiously with proposals to base eligibility on prior-year income, which could leave families under-assisted following a poor harvest or other income loss.

Section 2.I: Network Adequacy.

Network adequacy is one of NRHA's highest priorities in this RFI. We agree that "federal policies should incentivize broad networks of high-quality providers, particularly in rural and underserved areas."¹⁸ The 2027 Notice of Benefit and Payment Parameters eliminated uniform federal network adequacy standards and deferred to state review, and those provisions were stayed nationwide by a federal court in July 2026.¹⁹ Without a durable federal floor, rural residents face the greatest risk of narrow networks that exclude their local hospital and clinic.

¹⁷ Lilley & Zahnd, *supra* note 2.

¹⁸ Health Coverage That Works for Everyone, *supra* note 8, at 47.

¹⁹ HHS Notice of Benefit and Payment Parameters for 2027, FR Doc. 2026-10050 (May 20, 2026); Court Stays Major 2027 Marketplace Changes, Health Affairs Forefront (July 2026), <https://www.healthaffairs.org/content/forefront/court-stays-major-2027-marketplace-changes>.

The essential community provider (ECP) standard should also be strengthened for rural areas. Current rules group RHCs and REHs into an “Other ECP Providers” category alongside several unrelated provider types, and plans must contract with only one provider in that category per county.²⁰ As a result, a plan can satisfy the standard without contracting with any RHC or REH in a county where they are the primary source of care.

Limited competition makes these protections even more important. In 2026, 165 counties have only one Marketplace insurer, up from 93 in 2025.²¹ In Kansas, every Marketplace plan offered in 2026 is an exclusive provider organization plan with a narrow network.²² NRHA supports the RFI’s proposals to require Medicaid managed care organizations, state employee plans, or Federal Employee Health Benefits plans to offer coverage in bare counties and areas with limited competition, provided those plans contract with local rural providers.

Networks that appear adequate on paper are often inadequate in practice, particularly for behavioral health. Eighty-nine percent of rural census tracts are designated as behavioral health professional shortage areas,²³ so a single inaccurate directory listing can leave a rural resident with no real in-network option. Standardized plans should include strong coverage for essential services including maternity care, behavioral health care, rural emergency services and telehealth. Network adequacy standards cannot create providers where none exist; they must be paired with policies that grow the rural workforce and expand support maintenance and expansion of services rural providers offer. Telehealth is an important complement, but it should not be used to declare a network adequate where in-person care is unavailable.

NRHA recommends that Congress:

- Count telehealth as a supplement to, not a substitute for, in-person access when determining network adequacy, while making Medicare telehealth flexibilities permanent through **S. 1261/H.R. 4206, the *CONNECT for Health Act***.
- Expand the rural behavioral health providers available to networks by passing **H.R. 5217, the *Rural Behavioral Health Improvement Act***, which removes limitations on behavioral health services at RHCs.
- Grow the rural workforce that networks depend on by passing **H.R. 1153, the *Rural Physician Workforce Production Act***, and **H.R. 1127, the *Rural America Health Corps Act***.
- Codify a federal floor for network adequacy, including time and distance and appointment wait-time standards calibrated to rural and frontier geography.
- Codify the 35 percent ECP contracting threshold and require plans to offer contracts to all CAHs, REHs, RHCs, and FQHCs in their service areas, or establish separate ECP categories for these provider types.

Section 2.II: Prior Authorization.

Prior authorization is one of the most frequently cited administrative barriers for rural providers and patients. Small rural facilities rarely have dedicated utilization management staff, so clinical staff are pulled away from patient care to manage requests and appeals and/or facilities are forced to reallocate

²⁰ 45 C.F.R. § 156.235(a)(2)(ii)(B).

²¹ How Has Insurer Participation in the ACA Marketplaces Changed in 2026?, KFF (June 11, 2026), <https://www.kff.org/affordable-care-act/how-has-insurer-participation-in-the-aca-marketplaces-changed-in-2026/>.

²² 2026 Affordable Care Act Health Insurance Marketplace, Kansas Health Institute (Aug. 26, 2026), <https://www.khi.org/articles/2026-affordable-care-act-health-insurance-marketplace/>.

²³ Topchik et al., *supra* note 5.

financial resources from critical services to pay for increased administrative burden. Further, delayed authorizations have greater consequences for rural patients in areas with limited alternative providers.

Delays are especially harmful at transitions of care. Rural hospitals routinely report difficulty obtaining authorization to discharge patients to post-acute care, particularly swing beds. Further, plans frequently steer patients to skilled nursing facilities far from their communities rather than to local swing bed care.²⁴ Rural Medicare Advantage patients experience stays 9.6 percent longer before discharge to post-acute care than comparable Traditional Medicare patients.²⁵ When authorization delays hold patients in small hospitals, those beds are unavailable for the next patient, and the hospital absorbs the cost. This is particularly challenging for CAHs who have length of stay constraints for the patient population.

NRHA recommends that Congress:

- **Pass H.R. 3514/S. 1816, the *Improving Seniors' Timely Access to Care Act***, which would establish electronic prior authorization, real-time decisions for routinely approved services, and transparency requirements in Medicare Advantage.²⁶ Its protections offer a ready model for the private insurance markets addressed in this RFI.
- Establish response time limits for prior authorization decisions, with requests deemed approved when deadlines are missed. Establish national standards for electronic prior authorization and increased transparency regarding denial decisions.
- Exempt or expedite inter-facility transfers and post-acute placements, including swing bed admissions, and require plans to consider local post-acute options that keep patients close to home.

Section 2.III: Claims Denials and Delayed Payment.

The RFI accurately describes insurer practices that delay payment by issuing one claims determination at a time, with each new request restarting the review clock, and notes that these practices are “particularly burdensome for less resourced providers, such as rural hospitals and solo practitioners.”²⁷ Rural hospitals operate with little cash on hand, so delayed or denied claims threaten their ability to make payroll and keep services open. NRHA members have reported up to \$800,000 in delayed or denied payments at one time. Plans also deny claims after a service was approved through prior authorization, most often for inpatient stays.²⁸

Payment adequacy is a related concern. Medicare Advantage plans frequently do not pay unique rural designations like CAHs, SHCs, and RHCs their Traditional Medicare cost-based or all-inclusive rates. NRHA members report that plans often fail to pay Traditional Medicare rates to non-contracted providers, despite federal requirements.²⁹ Similar practices in the commercial market undermine the payment systems designed to keep rural providers viable.

NRHA is interested in the RFI’s proposal to require large health plans to collect cost-sharing directly from patients. This approach could shift bad debt risk away from rural providers that currently absorb it. We

²⁴ NRHA Statement for the Record, *supra* note 17.

²⁵ The Growing Impact of Medicare Advantage on Rural Hospitals Across America, American Hospital Association (Feb. 2025), <https://www.aha.org/guidesreports/growing-impact-medicare-advantage-rural-hospitals-across-america>.

²⁶ NRHA Statement for the Record, *supra* note 17.

²⁷ Health Coverage That Works for Everyone, *supra* note 8, at 60.

²⁸ NRHA Statement for the Record, *supra* note 17.

²⁹ NRHA Statement for the Record, *supra* note 17.

ask the Committee to analyze the rural impact of this proposal and ensure it does not reduce or delay provider payment.

NRHA recommends that Congress:

- Pass **H.R. 4559, the *Prompt and Fair Pay Act*, and H.R. 5454/S. 2879, the *Medicare Advantage Prompt Pay Act***, and apply comparable prompt-pay standards, with interest penalties for late payment, to Marketplace, commercial, and self-insured plans.
- Limit serial requests for information by requiring plans to request all needed documentation at once.
- Prohibit retroactive denial of services that received prior authorization.
- Require plain-language explanations of the reason for each denial.
- Penalize plans with high rates of denials overturned on appeal.
- Require reporting of denial and overturn rates stratified by rural and urban provider location.

Sections 2.II and 2.III: Appeals and Self-Insured Plans.

Rural employers are typically small and have little leverage with insurers or third-party administrators. Many rural hospitals are themselves self-insured employers that must navigate the same administrators on behalf of their own staff. Rural workers in self-insured plans deserve the same appeal rights and protections as enrollees in the fully insured market.

NRHA recommends that Congress:

- Establish a unified appeals framework across markets.
- Expand access to external review, including automatic external review for eligible denials.
- Allow providers to appeal on a patient's behalf without excessive paperwork.

Section 3.1: Private Equity.

Private equity investment has reached rural hospitals, nursing homes, emergency medical services, physician and emergency department staffing, and behavioral health providers. Financially vulnerable rural facilities can be attractive acquisition targets.³⁰

NRHA recommends that Congress:

- Require ownership transparency and a public reporting database for private equity and other investor ownership of health care entities.
- Require advance notice and community impact review before acquisitions, closures, or elimination of essential services at rural facilities.

Section 3.III: Medical Loss Ratio and Quality Improvement Activities.

Medical loss ratio (MLR) requirements should ensure premium dollars pay for care. When insurers pay their own affiliated providers more than independent providers, they can inflate reported medical spending while squeezing independent rural providers and pharmacies that are paid less than an insurer's own subsidiaries.

³⁰ How Private Equity Undermines Rural Health Equity, 27 AMA J. Ethics (May 2025), <https://journalofethics.ama-assn.org/article/how-private-equity-undermines-rural-health-equity/2025-05>.



NRHA recommends that Congress:

- Exclude utilization management activities, including prior authorization, from quality improvement activity spending.
- Apply MLR requirements at the parent company level, or benchmark payments to affiliates against payments to unaffiliated providers.

NRHA appreciates the Committee's attention to how coverage reform will affect rural communities. We welcome the opportunity to serve as a resource as this work moves forward. For additional information, please contact Marguerite Peterseim at mpeterseim@ruralhealth.us.

Sincerely,

A handwritten signature in black ink, appearing to read "Alan Morgan", is written over a light gray dotted line.

Alan Morgan
Chief Executive Officer
National Rural Health Association