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NAHDO Response to Senate Finance RFI: Health Coverage That Works for Everyone

October 2, 2026

The Honorable Ron Wyden

Ranking Member, Committee on Finance

United States Senate

Submitted via insurance@finance.senate.gov

RE: Request for Information, "Health Coverage That Works for Everyone"

Dear Ranking Member Wyden:

The National Association of Health Data Organizations (NAHDO) is pleased to respond to the Committee's Request for Information. NAHDO is a national membership association of the state and regional organizations that collect, analyze, and release health care data, including the administrators of state all-payer claims databases (APCDs) and entities that support them. NAHDO convenes the APCD Council, the national learning collaborative for state APCDs.

According to current APCD Council data, 27 states have operational statewide APCDs. They collect claims from commercial, Medicaid, Medicare, and other public payers under state authority, based on shared data standards, and they exist in states across the political spectrum. Several states the RFI holds up as examples, among them Oregon, Maine, Rhode Island, Colorado, Washington, Nevada, Minnesota, New York, California, and Maryland, have an APCD.

Our comments focus on where that infrastructure can do the most to inform the Committee's work on state authority over self-funded plan data (pp. 62-63), claims denials data (pp. 54-55), and system-wide oversight and transparency (pp. 29-30 and 85-86). In brief, NAHDO recommends that Congress:

- Authorize states to compel self-funded plans and the administrators that pay their claims to submit claims data to state APCDs, and turn the voluntary ERISA Section 735 framework into a mandate (pp. 62-63).
- Consider requiring denied-claim records, with standardized reason codes, to be reported consistently across fully insured and self-funded plans (pp. 54-55).
- Draw on existing state APCDs as a resource for any new oversight and transparency effort (pp. 29-30 and 85-86).
- Make federal health plans, and any new federal coverage option, submit claims to state APCDs from their first year (pp. 29 and 32-37).

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- Fund state APCD operations and data standards, and set access rules that protect privacy (pp. 85-86).

Self-funded plan data and state authority (pp. 62-63)

The RFI describes a bifurcated market: roughly 6 percent of Americans were in self-insured employer plans when ERISA was enacted, and now more than 60 percent are (p. 62). It also reports that coverage, denials, and appeals can differ for the same insurer, doctor, and care depending on the market, and that plan sponsors often cannot see their own plan's costs, which can limit their ability to meet their fiduciary duties under ERISA (pp. 62-63, 81-82). Congress barred contract terms that block a plan's access to its own claims data in the Consolidated Appropriations Act, 2021 (ERISA Section 724), yet some sponsors have had to sue their administrators to get it.

Addressing those reports requires claims data from both markets, and states cannot require it from one of them. In *Gobeille v. Liberty Mutual Insurance Co.* (2016), the Supreme Court held that ERISA preempts a state requirement that self-funded plans report to an APCD. Self-funded participation has since been voluntary, which leaves every state with a partial view of its employer market. In Massachusetts, a recent study in *Health Services Research* found that the commercially insured population captured in the APCD fell by 38 percent after the decision, and that the share of fatal opioid overdoses that could be linked to APCD records fell from 95 percent to under 80 percent by 2021 (Cordes et al., 2026). Your 2016 letter with Senator Murray to the Secretaries of Labor and Health and Human Services identified this problem.

Congress has already recognized it. The No Surprises Act added Section 735 to ERISA, which tasks the Department of Labor with setting a standard file format that group health plans may use, voluntarily, when they send data to state APCDs. An advisory committee convened under that section reported in 2021. Voluntary reporting has not closed the gap. Through the APCD Council, NAHDO has urged the Department of Labor to use its existing authority to collect claims from self-funded plans for state APCDs, built on the APCD Common Data Layout (APCD-CDL). We now recommend that Congress:

- Confirm in statute that a state may require self-funded plans, and the administrators that pay their claims, to submit claims and eligibility data to its APCD. Doing so closes the data gap without asking states to regulate benefit design.
- Convert the Section 735 framework from a voluntary option into a requirement.
- Base the federal format on the APCD-CDL, which the APCD Council maintains, and keep it aligned with the national X12, NUBC, and NUCC standards. Payers and administrators already produce these files for claims payment, so a common format limits burden for administrators that operate in many states.
- Recognize that the Employee Benefits Security Administration, which the RFI reports lost an estimated 25 percent of its workforce (p. 63), cannot analyze every plan alone. State APCDs already hold the infrastructure, privacy protections, and statutory data release rules to do much of this work.

If the Committee pursues the state waiver concept (p. 63), NAHDO suggests that eligibility turn on a state's demonstrated data governance, privacy, and security capacity rather than on any

particular type of entity. NAHDO also appreciates that employers want simple administration and strong protection for their data, and these recommendations are designed to respect both.

Claims denials data (pp. 54-55)

The RFI notes that federal denial reporting reaches only some plans, and that the most common reason plans gave for denials in 2024 was "other." It asks how reporting can reach the more than 160 million people with employer coverage and be detailed enough to be useful.

State APCDs collect claim-level records under common file specifications, which makes them a natural place to hold denial data. Several states, including Vermont, Oregon, Connecticut, and Colorado, already collect denied claims. However, the practice is not yet consistent. A recent review we conducted showed multiple ways that denied claims are being handled. If the Committee wishes to further study denials, NAHDO would recommend that denied-claim records be consistently reported to state APCDs alongside paid claims using standardized denial reason codes.

Reported this way, denial rates, reasons, and appeal outcomes can be compared by payer, plan type, and market, including between fully insured and self-funded plans. That supports the appeals oversight the RFI describes (p. 58) and allows outlier patterns to be audited. As with all APCD data, denial records would stay subject to state privacy protections, and NAHDO can work with its members to document state experience for the Committee.

Oversight and system-wide transparency (pp. 29-30, 85-86)

The RFI seeks ideas on designing an oversight and reporting body with authority to analyze cost data (p. 30), and on collecting data that is centralized, standardized, and usable by employers, researchers, and policymakers, including through APCDs (pp. 85-86). NAHDO agrees with the RFI's assertion that transparency alone will not solve affordability. Its value is as the evidence base for oversight and accountability.

NAHDO recommends building that evidence base on the state APCDs that exist today, with shared standards and a defined federal role, before creating a new national entity. State APCDs already hold the statutory authority, payer reporting relationships, and privacy practices that a national effort would need. In the areas the RFI raises, their data can support:

- Rate review, including justification of cost and utilization trends (pp. 19-21). Oregon's insurance regulators use the state's APCD to review individual and small group premiums, and the Maryland Insurance Administration uses Maryland's claims database to check payer submissions.
- Affordability measures that calculate total cost of care and cost drivers, not premiums alone (pp. 18, 23-24).
- Assessing how state public options and Section 1332 waivers are performing, as in Colorado, Washington, and Nevada (pp. 30-31).
- The data gaps the RFI identifies for any federal public option (p. 34).
- Transparency into third-party administrator payments and fees (pp. 80-83).

APCDs already produce this kind of evidence. When Oregon capped hospital payments in its state employee plan in 2019, evaluations built on the state's APCD found about $107.5 million in savings over the first two years, roughly 4 percent of plan spending, and a 9.5 percent drop in out-of-pocket spending per outpatient procedure for enrollees in higher cost-sharing plans (Murray et al., *Health Affairs* and *JAMA Health Forum*, 2024). Evidence like this is what the Committee will need to judge payment benchmarks for a public option (pp. 34-35).

The RFI also asks how to see inside vertically integrated insurers (pp. 73-76). APCD data already show what consolidation does to prices. In Massachusetts, physicians who joined or jointly contracted with large health systems saw commercial prices rise about 12 percent for primary care and 6 percent for specialists (Curto, Sinaiko, and Rosenthal, *Health Affairs*, 2022). Claims alone cannot show intercompany transfers, but standardized identifiers for payers, administrators, pharmacy benefit managers, and providers that link to ownership would let states and federal bodies connect claims to corporate structure.

Because the RFI asks for publicly available data, we note that state APCDs already separate public reports from restricted-access data released under data use agreements. Any federal standard should preserve that distinction. Research the RFI itself cites, from Georgetown's Center on Health Insurance Reforms and from Brookings, makes the same case.

Federal plans and new federal coverage options (pp. 29, 32-37)

State APCDs generally cannot obtain claims for residents covered through federal programs such as TRICARE, VA health care, and FEHB plans. Medicare claims, whether fee-for-service, Part D, or Medicare Advantage, reach state APCDs unevenly. Each missing program means a state is analyzing only part of its market.

The RFI considers several new sources of coverage: FEHB plans and state employee plans offering individual market coverage (p. 29), a federal public option (pp. 32-36), and Medicare or Medicaid buy-ins (pp. 36-37). NAHDO recommends that any such option, and any federal plan entering a state market, submit claims to that state's APCD beginning in its first year. Otherwise new coverage would create new blind spots in exactly the markets the Committee wants to evaluate.

A federal role: standards, funding, and access (pp. 85-86)

NAHDO recommends that the federal role focus on four things, with governance staying with state-designated entities.

- **Standards.** Support and maintain health care data standards and common data layouts, so that submissions are comparable across states and do not multiply reporting burden.
- **Funding.** Create stable federal funding for state APCD operations and for maintaining common formats and incentivizing their use. Funding models vary widely today: Maine's legislature sets its program's budget and assesses hospitals, payers, and third-party administrators to pay for it, while Arkansas relies on its general fund, federal funds, and private grants. State programs often depend on short-term funding, and stable support is what makes multi-year analysis possible.

- **Access.** Let federal agencies, researchers, and any commercial-market oversight body the Committee creates analyze APCD data across states, but only with a state's consent and under a data use agreement that covers appropriate fees. States should keep control of de-identification and release rules.
- **Coordination.** Define roles for HHS, the Department of Labor, and the Treasury Department to support collaboration among federal and state agencies toward common goals. The RFI notes that agencies and states must collaborate on data they cannot each analyze alone (p. 85).

Thank you for the Committee's focus on complete, accountable data across private insurance markets. These comments are coordinated with the response of Civitas Networks for Health, which addresses related points. NAHDO and the APCD Council are glad to brief Committee staff, offer technical help, and draw on our members' experience as the Committee develops its proposals.

Sincerely,

Norm Thurston



Executive Director, National Association of Health Data Organizations