

October 2, 2026

Via email to insurance@finance.senate.gov

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

RE: Comments on "Health Coverage That Works for Everyone," Request for Information Issued by Senate Finance Committee Democratic Staff (July 30, 2026)

Dear Ranking Member Wyden:

On behalf of the National Alliance for Caregiving (NAC), thank you for the opportunity to comment on "Health Coverage That Works for Everyone," the Request for Information (RFI) released by Senate Finance Committee Democratic staff on July 30, 2026. NAC is a nonprofit, nonpartisan coalition dedicated to advancing family caregiving through research, innovation, and advocacy. We work on behalf of an estimated 63 million family caregivers across the United States, individuals who provide unpaid care and support to a family member, partner, or friend managing a chronic condition, disability, serious illness, or the challenges of aging.

NAC holds firmly that coverage itself is a health intervention. Americans spend more on health care while experiencing worse health outcomes than people in other high-income countries¹. A health care system with broad, meaningful coverage produces better outcomes and lower costs than one without it, and that is as true for family caregivers as it is for the people they care for. The outcomes of caregivers and care recipients are inseparably linked: when a loved one's coverage is inadequate, the caregiver absorbs the gap, in dollars, in hours, and in health of their own. Conversely, when coverage design accounts for the caregiver, whether through respite, training, or continuity of care, the result is not an added cost but a savings that accrues to the whole system. NAC's comments below return to this point repeatedly, because we believe it is the throughline connecting family caregiving to nearly every question this RFI asks.

The RFI focuses on the individual, small-group, large-group, and employer insurance markets rather than on Medicare or Medicaid directly. Our comments are organized around the RFI's three sections, in the order the RFI presents them. These comments align with previous comments we have submitted to Congress, and through various rulemaking cycles.

¹Munira Z. Gunja et al., "U.S. Health Care from a Global Perspective, 2026," The Commonwealth Fund, May 28, 2026, <https://www.commonwealthfund.org/publications/issue-briefs/2026/may/us-health-care-global-perspective-2026> (the United States is the only developed nation that does not guarantee health coverage to all its citizens, and Americans spend more on health care while experiencing worse health outcomes than people in other high-income countries).

Section 1: Reversing Republican Cuts and Reimagining a Better Path

NAC supports reversing the 2025 reconciliation law and Trump administration rulemaking that will result in millions of individuals losing access to health care coverage, restoring the enhanced premium tax credits, and closing the Medicaid coverage gap. The scale of what is at stake is substantial. The Congressional Budget Office projects that the 2025 reconciliation law will increase the number of people without coverage by more than 10 million by 2034.² That decline comes on top of, and is compounded by, two additional pressures already facing the coverage system: the nearly 1.2 million individuals who fall into the Medicaid coverage gap in states that have not adopted the Medicaid expansion and remain uninsured altogether,³ and the scheduled expiration of enhanced premium tax credits (EPTCs), which is projected to reduce Marketplace enrollment by roughly 4.8 million people relative to 2025.⁴ These cuts fall hardest on family caregivers and the people they support: caregivers are disproportionately likely to experience a coverage or income disruption in their own household at precisely the moment their caregiving responsibilities are most demanding.

Part I – Coverage Value and Costs

The RFI asks whether services such as primary care visits or a set number of urgent care and behavioral health visits per year should be available before an individual meets their deductible with limited or no cost-sharing, on the theory that covering high-value services up front prevents costlier downstream problems. NAC asks the Committee to add caregiver support services, respite care in particular, to that same pre-deductible, low-cost-sharing category. Respite is a preventive service in exactly the sense the RFI is describing. It keeps a family caregiver from reaching a breaking point that results in a costlier, more disruptive care transition – the same logic the RFI applies to a covered behavioral health visit heading off a costlier downstream crisis.

Separately, the RFI asks about safeguards for people who churn through different coverage programs because of changes in income or eligibility. Family caregivers are frequently the ones experiencing these transitions. Reducing work hours or leaving a job to provide care is one of the most common ways a caregiving household's income, and therefore its coverage eligibility, changes. Any continuity-of-coverage safeguard the Committee designs should treat caregiving as a recognized, foreseeable driver of this kind of coverage disruption. Any continuity-of-coverage safeguard the Committee designs should treat a reduction in work

²Edwin Park, "New CBO Health Coverage Estimates of the Budget Reconciliation Law," Georgetown University Center for Children and Families, Aug. 14, 2025, <https://ccf.georgetown.edu/2025/08/14/new-cbo-health-coverage-estimates-of-budget-reconciliation-law/> (CBO projects the 2025 reconciliation law will increase the number of people without health coverage by 10 million in 2034 relative to CBO's January 2025 baseline, with the law's Medicaid and CHIP cuts alone accounting for an estimated 7.5 million of that increase).

³Sammy Cervantes et al., "How Many Uninsured Are in the Coverage Gap and How Many Could Be Eligible if All States Adopted the Medicaid Expansion?," KFF, July 27, 2026, <https://www.kff.org/medicaid/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/> (an estimated 1.2 million adults fall into the Medicaid coverage gap across the states that have not adopted the Medicaid expansion, with incomes too high to qualify for their state's Medicaid program but too low to qualify for Marketplace premium subsidies).

⁴Matt McGough et al., "What We Know So Far About 2026 ACA Marketplace Enrollment, Premiums, and Deductibles," KFF, May 19, 2026, <https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/> (average monthly effectuated ACA Marketplace enrollment is projected to fall from 22.3 million in 2025 to approximately 17.5 million in 2026, a decline of roughly 4.8 million enrollees, coinciding with the scheduled expiration of enhanced premium tax credits).

hours or departure from employment to provide family care as a qualifying event, on par with other life events that trigger special enrollment. Specifically, NAC asks the Committee to consider guaranteed special enrollment periods, streamlined or presumptive eligibility determinations when caregivers move between programs, and continuous eligibility protections that prevent coverage gaps during that transition.

Part II – Out-of-Pocket Costs

The RFI notes that roughly half of insured people cannot afford their own deductible, that individual-market deductibles rose 37 percent in 2026, and that under current administration rules, out-of-pocket maximums could reach more than \$15,000 for an individual and more than \$31,000 for a family in 2027. It specifically asks whether deductibles should be waived for non-shoppable services and whether coinsurance should be limited or banned as a cost-control tool.

NAC supports waiving deductibles for non-shoppable services and limiting coinsurance, particularly for the services family caregivers most often shoulder on a loved one's behalf. Family caregivers are very often the ones paying a loved one's deductible and coinsurance or reducing their own paid work hours to cover care gaps when a family member delays treatment because the household cannot afford it. NAC's 2025 national research found that 47 percent of family caregivers experience at least one negative financial impact as a result of caregiving, including stopping saving, taking on debt, or being unable to afford basic expenses.

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Copay accumulator adjustment programs. In the same section, the RFI observes that as consumers switch to lower-value plans, they increasingly and unknowingly forgo cost-sharing assistance they are eligible for, and it asks how to ensure consumers receive the full benefit of the assistance for which they qualify. NAC raises a related but distinct problem the RFI does not directly address – copay accumulator adjustment programs, under which health plans and pharmacy benefit managers decline to count manufacturer or third-party cost-sharing assistance toward a patient's deductible or annual out-of-pocket maximum. A 2023 federal district court decision vacated the provision permitting these programs to apply even where no generic equivalent exists, and the Department of Justice's subsequent withdrawal of its appeal leaves the narrower 2020 standard, permitting accumulators only where a generic equivalent exists, as the current federal rule⁶. A patchwork of state bans have emerged around this gap, and a federal bill, the HELP Copays Act, remains pending⁷. For family caregivers managing a loved one's high-cost specialty drug regimen, often for a condition with no generic alternative, an accumulator program can silently erase the value of assistance the family is counting on and push the caregiving household toward the unreachable deductibles this RFI is

⁵National Alliance for Caregiving & AARP, Caregiving in the U.S. 2025, July 2025, <https://doi.org/10.26419/ppi.00373.001> \

⁶HIV+Hepatitis Policy Institute v. HHS, No. 21-cv-2179 (D.D.C. Sept. 29, 2023) (vacating the provision of the 2021 Notice of Benefit and Payment Parameters that permitted copay accumulator adjustment programs to apply to cost-sharing assistance even when no medically appropriate generic equivalent exists);

⁷HELP Copays Act, S.864 and H.R.6423, 119th Congress (2025-2026) \

otherwise trying to fix. NAC urges the Committee to require that all cost-sharing assistance, regardless of source, count toward a patient's deductible and out-of-pocket maximum.

Part III – Expanding Pathways to Coverage

NAC shares the RFI's stated goal that coverage should be comprehensive, accessible, and easy to navigate for all Americans, regardless of socioeconomic standing.

Within that goal, NAC sees the RFI's discussion of “Strengthening the Existing Coverage Framework,” codifying comprehensive coverage standards, closing the Medicaid coverage gap in non-expansion states, and restoring enhanced premium tax credits, as the most concrete and immediately achievable near-term path. Whatever combination of approaches the Committee ultimately advances, however, NAC urges that caregiver-specific benefit design is not treated as an afterthought to be layered on once a coverage vehicle is chosen. Respite, caregiver training, and in-home support should be built into the benefit design of any new or expanded coverage option from the outset. A coverage expansion that does not account for the family caregiver will still leave that caregiver, and by extension the person they care for, without the support that determines whether the expanded coverage actually translates into better outcomes.

That principle matters most as the Committee considers designing and financing coverage to reach universal coverage that is “more generous than existing coverage.” The gap between Medicare and Medicaid is widest in home and community-based services (HCBS). Medicare's home health benefit is generally limited to short-term, skilled care for beneficiaries who are homebound, and it does not cover the ongoing personal care and in-home support that older adults and people with disabilities most often need. Medicaid HCBS fills part of that gap, but eligibility, covered services, and waiting lists vary widely from state to state. Whether a family can keep a loved one at home depends largely on where they live and their income level. NAC urges the Committee to lay the groundwork for a new or expanded Medicare home health benefit that would better standardize HCBS across states and close the gaps in coverage between Medicaid and Medicare.

NAC recommends the Committee to consider a benefit that (1) covers personal care, home health aide services, and other in-home supports based on functional need rather than homebound status or a need for skilled care; (2) sets a national floor for covered services and eligibility so that access does not vary by state; (3) coordinates with Medicaid so that people who are dually eligible do not fall between programs or lose services when they move from one to the other; and (4) includes respite, caregiver training, and support for family caregivers as covered components of the benefit.

Part IV – Junk Plans and Minimum Coverage Standards

The RFI's expresses concern that junk plans are often marketed as affordable while leaving enrollees exposed to significant costs, because the plans omit essential health benefits and pre-existing condition protections. Older adults, people with disabilities, and people managing chronic illness,

NAC's core population, are disproportionately harmed by these products, since they require continuous, comprehensive coverage rather than a plan that looks inexpensive until care is

needed. NAC urges the Committee to strengthen minimum coverage standards and increase accountability for the third-party brokers who market these plans.

Medical Debt

Medical debt compounds a financial strain caregivers are already carrying. According to NAC's own research, roughly one in five family caregivers report experiencing high financial strain from providing care, and nearly a quarter report taking on additional debt as a result. The cost of the long-term care many are trying to avoid or delay only sharpens that pressure. The national median cost of non-medical home care averages \$35 per hour, assisted living runs upward of \$70,000 per year, and nursing home care can exceed \$100,000 annually. Medical debt is a consequence of unreachable deductibles, coinsurance, and weak out-of-pocket caps layered on top of that baseline.⁸ The RFI itself cites that more than 100 million Americans report medical debt, including more than four in ten people who currently have insurance. NAC asks the Committee to address this directly, tying it back to caregiving households, who already face a documented and disproportionate financial burden from caregiving itself before medical debt is added on top.

Section 2: Making Health Care Simpler for Families

Part I – Standardized Benefits

The RFI asks about expanding standardization beyond actuarial value, copayments, deductibles, and cost-sharing to include additional coverage and services that would drive value and improve consumer experience. NAC supports a truly comprehensive standard benefit package that includes caregiver support services, respite, caregiver training, and in-home support, not medical services alone. These services need to be integrated consistently across private pay, employer, public and Marketplace coverage rather than offered inconsistently as an optional extra in one corner of the market.

Caregiver benefits should not depend on which plan a family happens to have. That is especially true of coverage for caregivers' own health, including mental health. NAC's research finds that 1 in 10 family caregivers are uninsured, and uninsured caregivers report more poor mental health days, greater physical strain, and more difficulty caring for their own health than their insured peers. Mental health is worst among caregivers ages 18 to 34, who report an average of 9.6 poor mental health days a month, more than double the rate among caregivers 75 and older.⁹ NAC therefore asks the Committee to ensure that any standardized benefit package includes mental health coverage for family caregivers themselves, not only for the people they care for. On the caregiver support side, the clearest evidence that today's coverage approach is not working for caregivers comes from Medicare Advantage, where caregiver-oriented supplemental benefits already exist but remain unreliable. For 2026, only 7 percent of individual Medicare Advantage plans offer in-home support and only 5 percent offer

⁸ ⁸ National Alliance for Caregiving & AARP, Caregiving in the U.S. 2025, July 2025, <https://doi.org/10.26419/ppi.00373.001>

⁹ Ibid

caregiver support, compared to virtually all plans offering vision, dental, and hearing benefits.¹⁰ Even where caregiver benefits exist, they fluctuate sharply from year to year. Among Special Needs Plans (SNPs), in-home support rose from being included in 17 percent of plans in 2025 to 25 percent in 2026, and caregiver support services rose from being covered in 5 percent to 16 percent of plans. This growth was concentrated almost entirely in a small subset of plans rather than reflecting reliable availability across Medicare Advantage. Separately, average flex-card allowances that many beneficiaries use to access caregiver-related supports fell from \$1,430 in CY2025 to \$1,398 in CY2026, and non-medical transportation benefits saw a slight decline due to what plans describe as operational complexities.¹¹

A benefit that a family cannot count on from one plan year to the next, or that exists only for a small percentage of enrollees, is not a substitute for a standardized benefit that every plan is expected to offer. NAC asks the Committee to apply this lesson directly to the private individual, small-group, large-group, and employer markets this RFI covers. As standardized benefit requirements are developed, caregiver support services should be defined clearly enough, and required consistently enough, that a family's access to them does not depend on which insurer happens to operate in their county that year.

NAC also asks the Committee to consider families who pay for care privately, outside of any insurance product. Respite, in-home support, and caregiver training are frequently purchased directly by families with no insurance mechanism to defray the cost at all. As the Committee considers standardized benefit design, we encourage it to also examine tax-advantaged or direct-subsidy mechanisms that would extend meaningful support to caregiving families regardless of whether they are purchasing coverage on the Marketplace, receiving it through an employer, or paying for care out of pocket.

A 2024 systematic review of 16 studies found, with moderate certainty, that self-direction and caregiver-inclusive service models improve caregiver well-being, reduce unmet needs, and increase access to care.¹² Separately, a randomized trial of a self-directed care model was shown to be budget-neutral while producing significantly better recovery, employment, and education outcomes.¹³ Caregiver-oriented benefit design is not a novel or untested concept, and the evidence indicates it improves outcomes without increasing net cost.

As a result, NAC urges the Committee to advance the Alleviating Barriers for Caregivers (ABC) Act (S.1227/H.R.2491), bipartisan legislation that would direct HHS to build a coordinated

¹⁰KFF, "Medicare Advantage 2026 Spotlight: A First Look at Plan Premiums and Benefits," Dec. 9, 2025, <https://www.kff.org/medicare/medicare-advantage-2026-spotlight-a-first-look-at-plan-premiums-and-benefits/>

¹¹ATI Advisory, "CY2026 Medicare Advantage Trends in Supplemental Benefits," Nov. 5, 2025, <https://atiadvisory.com/resources/cy2026-medicare-advantage-trends-supplemental-benefits/> (non-medical transportation saw a slight decline in CY2026 due to operational complexities, average flex-card allowances fell from \$1,430 in CY2025 to \$1,398 in CY2026, and growth in caregiver and in-home benefits is driven primarily by Dual-Eligible Special Needs Plans, meaning most beneficiaries enrolled in general Medicare Advantage plans see little or no access to these benefits).

¹²Supakorn Kueakomoldej et al., "Self-Directed Home- and Community-Based Services Improve Outcomes for Family Caregivers: A Systematic Review," *The Gerontologist* 64, no. 8 (2024): gnae068.

¹³Judith A. Cook et al., "Mental Health Self-Directed Care Financing: Efficacy in Improving Outcomes and Controlling Costs for Adults With Serious Mental Illness," *Psychiatric Services* 70, no. 3 (2019): 191-201.

resource helping family caregivers navigate eligibility and benefits across Medicare, Medicaid, and other federal programs – a direct complement to the simplification goals this RFI raises.

Part II – Prior Authorization

Part II asks about insurers' use of prior authorization and claims denials to limit access to care and generate profit, and it specifically invites feedback on quantifying administrative burden and holding insurers accountable for improper delays and denials. NAC's comment asks the committee to include home health, HCBS, and durable medical equipment prior authorization in their focus as they particularly affect NAC's population directly.

AHIP and dozens of participating health plans pledged in mid-2025 to reduce the scope of claims subject to prior authorization, with market-specific reductions taking effect January 1, 2026, and full FHIR-based electronic processing targeted for January 1, 2027. AHIP has since reported an 11 percent reduction in prior authorizations under the pledge. NAC views these commitments as a step forward, but voluntary and unenforceable, and asks that they be codified in statute rather than left to industry self-reporting.

Part III – Mid-Year Coverage Disruption

Within its broader discussion of holding insurers accountable for profit-driven denial practices, Part III asks directly for feedback on protecting consumers from mid-year plan and network changes imposed without notice or consent. This section speaks primarily to the individual, small-group, and employer markets the RFI covers. However, the underlying concern applies with particular force to home-based services wherever a beneficiary's coverage touches a private plan. A mid-year disruption to personal care or attendant services is not merely an inconvenience, it can mean an immediate gap in care with no transition plan in place, at a point in a person's life when even a short gap can force an institutional placement – one of the costliest interventions in our health system. NAC asks the Committee to require a minimum transition period and continuity-of-services guarantee whenever a plan discontinues or materially changes a home-based care benefit mid-year.

Part IV – Coverage Churn and Fraud Where It Actually Occurs

Part IV asks how to simplify enrollment for people who cycle through employer coverage, the ACA Marketplace, Medicaid, and Medicare over the course of their lives, which reinforces the coverage-continuity point NAC raises in Section 1, Part I above. Caregiving-driven income changes are a recognized, foreseeable cause of exactly this kind of churn and should be treated as such in any safeguard the Committee designs.

Fraud where it actually occurs. The RFI pushes back directly on Republican claims that ACA Marketplace enrollees are committing widespread fraud, arguing that Republicans have not produced credible evidence and are instead relying on a partisan think tank's flawed analysis to justify coverage cuts, and it calls for fraud enforcement that targets bad-actor brokers rather than beneficiaries. NAC asks the Committee to apply that same evidence-based skepticism to a parallel narrative playing out in Medicaid home and community-based services (HCBS).

HCBS allows people to remain in their homes and communities rather than institutions, it carries decades of bipartisan support, and it is substantially less expensive than the

alternative. Per a 2024 Mathematica analysis, average Medicaid spending per beneficiary was \$48,143 for institutional long-term services and supports, compared to \$16,491 for beneficiaries receiving HCBS.¹⁴ Separately, private-room nursing home care exceeds \$108,000 per year, compared to approximately \$42,000 per year for home care¹⁵. In February and March 2026, CMS announced a crackdown on Medicaid fraud in personal care and HCBS programs and deferred \$259.5 million in federal Medicaid funds owed to Minnesota, with an additional \$91 million deferred in April, bringing the total to roughly \$350 million, and it has continued to warn of further withholding in future quarters. CMS has since sent program integrity inquiry letters to at least four other states.

Health policy researchers have pushed back on this narrative directly, arguing that HCBS growth reflects decades of federal policy responding to demographic change and civil rights priorities under strict fiscal guardrails and that blunt enforcement risks destabilizing a program built over decades and harming the disabled and aging people who depend on it.¹⁶ NAC's own statement for the record to the Senate Budget Committee makes the same point using CMS's own FY2025 data: 77 percent of Medicaid's 6.12 percent improper payment rate was attributable to insufficient documentation, not fraud.¹⁷ Much of what is flagged as fraud in HCBS is more accurately evidence of documentation gaps, administrative complexity inherent to the self-directed model, or billing and modifier errors, not documented intentional wrongdoing. This is same evidence-based distinction this RFI already draws for ACA Marketplace enrollment. NAC asks the Committee to extend the scrutiny it is applying to unsubstantiated ACA fraud claims to unsubstantiated Medicaid HCBS fraud claims.

Section 3: Taking on Corporate Greed

Private equity, MLR, and nursing home ownership transparency. The RFI asks for feedback on "establishing safeguards to ensure that private equity-backed entities cannot raise costs, worsen care, or extract profit margin at the expense of employers, families and patients." Private equity firms have been acquiring home care and HCBS provider agencies, and there are documented cases where PE ownership correlates with lower attendant pay, higher turnover, and worse care even as agency margins increase. NAC asks the Committee to require MLR reporting that distinguishes caregiver-support investments, respite, training, care coordination, from generic administrative overhead, since insurers and Medicare Advantage plans otherwise have no incentive to count these services toward the medical-cost side of the ratio.

¹⁴Christal Stone Valenzano Murray et al., "Trends in Users and Expenditures for HCBS as a Share of Total Medicaid LTSS Users and Expenditures, 2022," Mathematica, Aug. 29, 2024 (average Medicaid spending per beneficiary was \$48,143 for institutional long-term services and supports, compared to \$16,491 for beneficiaries receiving home and community-based services).

¹⁵AARP, Home Care Cost LTSS, <https://ltsschoices.aarp.org/scorecard-report/2023/dimensions-and-indicators/home-care-cost> (private-room nursing home care exceeds \$108,000 per year, compared to approximately \$42,000 per year for home care).

¹⁶Jane Tavares et al., "The Real Story Behind Rising Medicaid HCBS Spending," Health Affairs Forefront, March 2026.

¹⁷National Alliance for Caregiving, Statement for the Record to the U.S. Senate Committee on the Budget, "Medicaid: The Reality," Aug. 18, 2026 (citing Centers for Medicare & Medicaid Services, "Fiscal Year 2025 Improper Payments Fact Sheet": Medicaid's improper payment rate rose to 6.12 percent in FY2025, of which 77 percent was attributable to insufficient documentation rather than fraud).

The RFI's own citations already recognize ownership transparency as a missing piece of health care accountability in the insurance context. NAC asks the Committee to extend that same principle to nursing homes. CMS's November 2023 rule requiring skilled nursing facilities to disclose private equity and real estate investment trust ownership took an important first step¹⁸, but disclosure alone does not address the underlying quality concern. Private equity ownership of nursing homes has been associated with a 10 percent increase in short-term mortality among Medicare residents during their stay and the 90 days following discharge.¹⁹ Family caregivers are often the ones left to fill gaps in care quality at an owned facility, or to manage a crisis discharge when a private-equity-owned facility cuts staffing. NAC asks the Committee to pair continued ownership transparency with

quality and staffing accountability measures specifically tied to private equity and REIT-owned nursing facilities.

Third-party administrators as PBM-style middlemen. The RFI describes third-party administrator (TPA) middlemen as using tactics "similar to those used by pharmacy benefit managers." NAC [filed extensive comments](#) on PBM accountability, net drug pricing, and formulary-placement incentives in response to the Committee's companion drug-pricing RFI earlier this year, and the same vertical-integration and rebate-driven distortions NAC flagged for PBMs, opaque fee structures, financial incentives that do not track patient benefit, and consolidation with the same insurers and providers they are meant to hold accountable, apply directly to the TPA middlemen this RFI addresses. NAC asks the Committee to draw on that record rather than treat TPA accountability as a separate problem.

Rural access should include the caregiving workforce. In Section 1, Part III, the Committee notes that coverage expansion should preserve access to "doctors, hospitals, and other health care providers," and not cause disruption to care, "including in rural and underserved communities." NAC asks the Committee to read "other health care providers" to explicitly include the home care and personal care attendant workforce, not only doctors and hospitals. Direct-care workforce shortages and reduced access to paid home care services are persistent, well-documented problems in rural communities, and any coverage-expansion design that does not account for that workforce gap will fail rural families and rural caregivers specifically, even if it succeeds on paper for physician and hospital access.

Conclusion

NAC returns, in closing, to the premises with which we opened. Caregiver support is not a cost this Committee needs to weigh against affordability, it is one of the more direct paths to affordability the Committee has available. The outcomes of caregivers and the people they care for are interlinked, and cost savings to the health care system, avoided institutionalization,

¹⁸Centers for Medicare & Medicaid Services, "Disclosures of Ownership and Additional Disclosable Parties," 88 Fed. Reg. 80,141 (Nov. 17, 2023), effective Jan. 16, 2024 (requiring skilled nursing facilities and nursing facilities to disclose private equity companies and real estate investment trusts among their owners and additional disclosable parties on Form CMS-855A).

¹⁹Atul Gupta et al., "Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes," National Bureau of Economic Research Working Paper No. 28474, April 2021, <https://www.nber.org/papers/w28474> (private equity ownership of nursing homes is associated with a 10 percent increase in short-term mortality among Medicare residents during their stay and the 90 days following discharge).

avoided hospital readmission, avoided emergency care, is a cost savings to the family caregiver as well, in dollars, in hours, and in health. Every recommendation in this letter, adding respite to pre-deductible services, standardizing caregiver benefits across markets, closing the copay accumulator gap, protecting continuity of home-based care, and applying the RFI's own fraud and ownership-transparency principles evenhandedly, follows from that same premise. NAC urges the Committee to build caregiver support into whatever coverage system it ultimately advances, not as an add-on, but as one of the more cost-effective tools available for making health coverage actually work for everyone. Thank you for the opportunity to comment, and NAC welcomes the opportunity to serve as a resource to the Committee as this work continues. For questions, please reach out to Blaire Bryant at blaire@caregiving.org.

Respectfully submitted,

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National Alliance for Caregiving