American Lung Association.

October 2, 2026

Senator Ron Wyden
Ranking Member, Committee on Finance
219 Dirksen Senate Office Building
Washington, DC, 20002

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

Dear Ranking Member Wyden:

The American Lung Association appreciates the opportunity to provide comments in response to the Senate Finance Committee's Request for Information (RFI) on opportunities to meaningfully reform our healthcare system.

The American Lung Association is the oldest voluntary public health association in the United States, representing the more than 34 million individuals living with lung disease. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy. The Lung Association strongly supports policies that protect and expand access to quality, affordable healthcare coverage.

The Affordable Care Act (ACA) made foundational reforms to our healthcare system, expanding coverage, protecting people with pre-existing conditions, establishing Essential Health Benefits (EHB) and providing access to certain preventive services without cost-sharing. However, 26.7 million Americans remain uninsured, and recent federal policymaking has eroded this progress.[1] The expiration of the enhanced premium tax credits at the end of 2025, along with new restrictions on eligibility for Medicaid and the ACA marketplaces in H.R. 1, have led to skyrocketing premiums and created new administrative burdens, and will lead to dramatic coverage losses for patients and families.

For patients with lung disease, access to continuous, comprehensive and affordable healthcare coverage is critical. It is well documented that without affordable, adequate coverage, patients delay and forgo needed care.[2] We urge the Committee to immediately begin the work of reversing the policies in H.R. 1 that will lead millions of people to lose Medicaid coverage and restoring the enhanced tax credits that made Marketplace coverage more affordable, while also addressing long-term challenges and opportunities to ensure that everyone has access to healthcare coverage that meets their needs.

The American Lung Association urges the Committee to advance policies that ensure patients can easily enroll in coverage, protect coverage preventive services without cost-sharing, ensure affordability of coverage for patients, strengthen and expand existing pathways to coverage, eliminate junk plans and remove barriers to accessing care. In addition to robust comments submitted with other patient advocacy organizations, the Lung Association offers the following comments and recommendations.

1. Ensure patients can easily enroll in and afford coverage. (Section 1.I)

Navigators and Consumer Assistance Programs

Healthcare coverage is complex and difficult to navigate, especially for patients with chronic conditions such as lung disease. Navigators and Consumer Assistance Programs (CAPs) are two critical supports that help patients understand and enroll in healthcare coverage. Navigators are trusted partners in their communities and, because of that, are uniquely positioned to help those they serve. By providing free, unbiased and culturally competent assistance, educating individuals about health insurance and their coverage options, and facilitating enrollment, Navigators can reduce the risk that consumers lose coverage due to administrative barriers and red tape. This Navigator program is especially important with the many ongoing changes to marketplace rules, including new documentation requirements for special enrollment periods and income verification. With the elimination of autorenewals for marketplace enrollees beginning with open enrollment in the fall of 2027, outreach will be essential to helping people remain enrolled in coverage and understand – and avoid the consequences of – new requirements that put coverage and subsidies at risk.

CAPs similarly provide critical education, assist with enrollment and renewal of coverage and help people respond to denials, manage appeals and address surprise bills. However, federal funding for CAPs is insufficient.[3] Survey data from KFF found that nearly one in five (18%) of consumers who looked for coverage or actively renewed their coverage received consumer assistance in the past year.[4] Most who enrolled in coverage said the assistance made a difference, and 40% said it is unlikely they would have found coverage without help. Roughly one in four marketplace enrollees who were helped by a broker or commercial health plan representative, on the other hand, said they were offered a non-ACA compliant policy as an alternative or supplement to a marketplace policy. Another recent survey shows that half (51%) of insured adults have trouble understanding their coverage, including what it will and won't cover, what they will owe in out-of-pocket costs and where to find information about which doctors and hospitals are covered in their health plan network.[5] In addition, 58 percent had a problem using their insurance in the prior year, such as insurance paying less than expected or denying care.

Open enrollment education and outreach programs are essential to help individuals to find and select the health care coverage that is best for them and protect consumers from misleading marketing and substandard coverage. **Congress should provide robust, permanent funding for outreach and enrollment activities and ensure that consumers have access to unbiased consumer assistance throughout the enrollment and renewal process so that individuals access and enroll in the most appropriate coverage.**

Enhanced Direct Enrollment

ACA marketplaces were intended to make the process of shopping for a health plan simpler, giving consumers a single, trusted place to view and understand their coverage options. However, recent rulemaking by the Administration allows state-based marketplaces (SBMs) to

forgo a centralized, consumer-facing eligibility and enrollment website and instead have enrollments occur through a decentralized system of web brokers, referred to as the "Enhanced Direct Enrollment (EDE) Option." This is concerning, especially given the expiration of enhanced premium tax credits and new burdens on eligibility and enrollment. Consumers should not have to navigate an increasingly complex enrollment system in order to obtain affordable, comprehensive coverage.

In states that choose to decentralize the shopping experience through the EDE option, patients will be left to fend for themselves, navigating between legitimate marketplace plans and junk plans or other non-ACA compliant plans. For individuals living with chronic conditions such as asthma and chronic obstructive pulmonary disease (COPD), enrolling in coverage that provides the comprehensive protections required under the ACA is critical. If consumers are steered toward inadequate coverage or are unable to easily compare plans that meet their health needs, they may face significant barriers to accessing necessary care.

This is especially concerning given the recent expiration of the enhanced premium healthcare tax credits and new, burdensome eligibility and enrollment processes under H.R. 1. Faced with steep premium increases and reduced financial assistance, more patients may consider alternatives to ACA-compliant coverage, which EDEs may sell. **Congress should impose stronger standards on EDE platforms by prohibiting the sale of non-ACA products during open enrollment and requiring a clear, unbiased display of all Marketplace plans for which a consumer is eligible.**

Essential Health Benefits

The ACA's EHB standards are vital protections that ensure patients with and at risk for lung disease can access the comprehensive care they need. The standards have expanded access to critical preventive services like lung cancer screening and tobacco cessation treatment, prescription medications, pulmonary rehabilitation, and many other important treatments and services that support individuals living with serious and chronic respiratory conditions.

The ACA requires HHS to periodically review EHB requirements to assess whether enrollees are facing difficulties accessing care and whether updates are needed. A regularly scheduled review and update process would help identify gaps in coverage, incorporate stakeholder input and ensure that advances in medical science are reflected in benefit standards, accounting for the rapid development of precision medicine, new therapies and improved approaches to management of diseases like lung cancer. However, since EHB protections became effective more than a decade ago, the statutory review process has not yet been fully implemented. The Lung Association supports a regular, evidence-based process for reviewing and updating EHB standards.

In addition, stronger transparency, oversight and enforcement of EHB standards are needed to ensure patients can access existing coverage requirements. In 2023, the Lung Association commissioned a review of EHB-benchmark plans and silver plans offered through ACA marketplaces in five states to evaluate whether patients with COPD and lung cancer had access

to necessary treatments and services. The resulting report, Access to Care for COPD and Lung Cancer Patients under Current Essential Health Benefit Standards, identified significant challenges, including a lack of transparency in plan documents.[6] The Lung Association would support requiring greater consistency and detail in the information states submit for their EHB benchmark plans to better understand and compare coverage. Importantly, these changes should not be a prerequisite for addressing many of the known gaps in the current EHB standards.

One clear gap involves tobacco cessation. Tobacco cessation is a critical preventive service for individuals with and at risk for lung disease. The 2023 review found that many benchmark plans and marketplace silver plans were not consistently covering tobacco cessation treatment as required under current EHB standards. In 2020, the Lung Association conducted a separate review of current EHB-benchmark plan documents that found that tobacco cessation treatments are not consistently covered without cost-sharing in marketplace plans, which are all subject to EHB requirements.[7]

Ultimately, when plans do not cover these treatments and services, patients will either be forced to choose between paying more to access the care that they need or delaying recommended treatments and services, often resulting in more costly care in the future and poorer health outcomes. **Congress should ensure the HHS conducts regular, systematic reviews and updates to EHBs and improves oversight and enforcement of existing standards.**

High-Value Care Without Cost-Sharing

Millions of people have access to preventive services – including lung cancer screening, tobacco cessation and vaccinations – at no cost due to the Affordable Care Act (ACA). When individuals access preventive care, diseases are avoided or caught at an earlier stage when they are easier and typically more affordable to treat or manage. Research has consistently shown that cost even small levels of cost sharing in the range of $1 to $5 are associated with reduced use of care, including necessary services.[8] Cost-sharing can lead to other consequences such as increased emergency room visits and negative health outcomes. For children with asthma specifically, research has found associations between higher cost-sharing for asthma medications and higher rates of asthma.[9] A 2022 survey found that 43% of U.S. adults reported that they or a family member in their household put off or postponed needed healthcare due to cost.[10] Furthermore, a survey found that 45% of American women skip preventive care services like check-ups, cancer screenings and vaccinations, often because the services are unaffordable.[11] **Congress must ensure that individuals continue to receive lifesaving preventive services without cost-sharing.**

2. Address costs to patients. (Section 1.II)

Deductibles

Despite the great strides made by the Affordable Care Act, many Americans still struggle to afford healthcare. In addition to permanently restoring the enhanced premium tax credits for

marketplace coverage, Congress must enact policies to improve the affordability of care for all. For instance, deductibles often discourage enrollees from accessing covered benefits, including benefits insurers are required by law to cover, and subject those who do seek care to often substantial cost burdens that may exceed their financial resources.[12] The average deductibles for employer-sponsored single coverage have grown by almost 43 percent over the last 10 years.[13]

From the patient perspective, most health services are not in any meaningful sense discretionary; the "choice" to delay or forgo needed care may simply generate future costs for the patient and for their subsequent coverage provider. **The Lung Association encourages Congress to expand coverage of high-value services without application of a deductible and expand services that are covered without any cost-sharing.** For example, while an initial screening for lung cancer is covered by most private health plans for people at high risk, additional follow-up testing and procedures during the diagnosis process can expose patients to significant costs. Last year, New York enacted legislation to require health insurers to provide coverage for follow-up screening or diagnostic services for lung cancer without cost-sharing.

Coinsurance

The Lung Association also supports Congressional action to limit the application of coinsurance. Coinsurance is less predictable, more difficult to budget for and may place even more stress, financial and otherwise, on patients.[14] Plan designs that feature coinsurance instead of fixed-dollar copayments are also likely to make it harder for a consumer to understand the actual benefits and limitations of a plan at the time they shop for coverage, potentially increasing the likelihood that they pick a plan not well suited to their needs.

Maximum Out-of-Pocket Costs

The ACA's limitation on annual out-of-pocket spending is an important consumer safeguard against truly catastrophic costs. However, current law sets these caps too high to offer meaningful financial security for millions of people at low and moderate incomes. In 2026, the statutory limit generally applicable to private coverage sits at $10,600 for an individual and $21,200 for a family plan. Even marketplace enrollees at lower incomes who are eligible for cost-sharing reduction assistance must incur huge costs before their spending is capped. **The Lung Association supports policy options to reduce enrollees' exposure to unaffordable out-of-pocket costs.** The Lung Association also supports recalibrating the existing annual limitation on out-of-pocket costs to provide enrollees across the private health insurance markets with increased financial protection. We also urge the Committee to consider ways to protect patients who have already reached their out-of-pocket maximum from having to restart from zero if they change plans mid-year.

Many patients with lung diseases like asthma or COPD rely on daily medications to help prevent their symptoms and live healthy lives. Unfortunately, cost can be a barrier to accessing these medications. According to a recent health tracking poll by KFF, 55% of adults are very or somewhat worried about affording their prescription drug costs.[15] **Congress should consider**

additional policies that reduce the financial barriers patients face when accessing needed medications, including monthly caps on patients' out-of-pocket costs for prescription inhalers. States including Illinois, Minnesota and Washington have enacted legislation capping the cost of asthma inhalers, similar to previous state and federal efforts to limit the cost of insulin for people with diabetes.

Medical Debt

One in twelve adults in the U.S., or nearly 20 million people, owe some form of medical debt, despite the coverage options and protections currently in place.[16] A further three in ten adults in the U.S. who do not already have medical debt are unable to unexpectedly pay a $500 bill without borrowing money, and are vulnerable to falling into debt.[17] The consequences of medical debt are overwhelming, particularly for patients with health conditions.[18] Patients and families are often forced to forgo other necessities in order to manage their debt, including basic household needs like utilities, rent or mortgage and food, to get care and manage their health conditions.[19] Patients with medical debt may also delay or avoid healthcare in order to make ends meet, which can worsen health outcomes for patients with chronic lung disease.[20]

The burden of medical debt is not equally distributed: Medical debt is more likely to impact low- and middle-income adults and those without health insurance.[21] An estimated 47% of patients with cancer and cancer survivors, including lung cancer, carry medical debt related to their cancer.[22] While we appreciate the Committee's focus on forward looking policies that prevent patients from incurring medical debt, **congressional action is also needed to address the current severe and unequal burden of medical debt in the U.S.**

3. Expand pathways to coverage. (Section 1.III)

Strengthening the Existing Coverage Framework

Congress should improve coverage parity for mental health and substance use disorder services, including stronger enforcement of existing law, and ensure that people living with chronic lung disease can access these services as part of comprehensive coverage. Anxiety and depression are both more common in people living with chronic conditions, including COPD, than they are in the general population. Unfortunately, these mental health conditions often go unrecognized and untreated by patients, caregivers and providers. Approximately 35 percent of people who smoke cigarettes have a behavioral health condition and often need more help to quit smoking and have their comorbid behavioral health condition treated,[23] and access to mental health and substance use disorder services is an important component of comprehensive coverage for people living with lung disease.

ACA Firewall

The ACA firewall prevents low-wage workers offered employer-sponsored insurance (ESI) from obtaining Marketplace premium tax credits when their employer-sponsored coverage is considered affordable under federal standards. This can leave workers and families with

coverage that may be unaffordable in practice, especially when considering deductibles and other elements of cost-sharing, but that nevertheless prevents them from receiving Marketplace financial assistance. **Congress should eliminate the ESI firewall so that low-wage workers and their families can access marketplace tax credits when marketplace coverage would better meet their needs.**

Medicaid

Ten states have not adopted the ACA Medicaid expansion, leaving an estimated 1.2 million uninsured people in the coverage gap.[24] Congress must permanently close the coverage gap in states that have not expanded Medicaid. A solution must include comprehensive coverage tailored to the populations that Medicaid serves and protection from out-of-pocket costs. **Congress should permanently close the Medicaid coverage gap, reinstate incentives for Medicaid expansion and repeal the financial penalties for expansion states included in H.R. 1.**

Additionally, continuous eligibility reduces gaps in coverage that can delay access to preventive care, medications, and other treatments and services for patients with lung disease. **Congress should expand 12-month continuous eligibility for adults in Medicaid to reduce unnecessary coverage churn and prevent gaps in access to medications, preventive care and other necessary services.**

4. Eliminate junk plans and surprise tax bills. (Sections 1.IV and 1.V)

Junk Plans

Junk or "skimpy" plans that are not required to adhere to the protections included within the ACA pose a grave threat to the health of many individuals, especially patients with pre-existing conditions. For example, these plans do not have to cover preventive services like lung cancer screening or tobacco cessation treatment, nor do they have to cover essential health benefits like hospitalizations and prescription drugs. This creates confusion for consumers trying to purchase comprehensive coverage and can leave patients with massive medical bills or force them to forgo needed treatment if they get sick. Individuals who buy a short-term plan, for instance, and then receive a new lung disease diagnosis in the middle of a plan year could find the coverage for their disease rescinded, leaving them without any coverage options until the open enrollment period for individual marketplace comes around.

There is widespread evidence of aggressive and misleading marketing of short-term plans.[25] Even those consumers who seek a comprehensive ACA plan may be diverted to a short-term plan through deceptive marketing and websites.[26] A recent study found that more than half of consumers eligible for $0 premium and $0 deductible ACA plans were instead directed by sales representatives to purchase limited benefit plans.[27] Representatives also frequently made false or misleading claims about these plans. **Congress must take action to limit the sale and purchase of junk plans to safeguard consumers and ensure that non-compliant plans cannot be marketed or sold as substitutes for ACA-compliant insurance.**

5. Simplify and standardize plan options and benefits. (Section 2.I)

Standardized Benefits

Standardized plans are an important tool to help patients make informed choices, allowing them to compare healthcare plans and choose the best coverage option for their needs. These plans reduce barriers to care for patients with lung disease by establishing standardized cost-sharing, including pre-deductible coverage of key services like primary care, specialist visits, mental health and substance use services, and some prescription drugs. **The Lung Association has long supported their use on HealthCare.gov as well as in individual SBMs and supports a requirement that marketplace plans offer standardized plans as a condition of participation.**

Network Adequacy

Network adequacy standards are important for individuals with lung disease to access primary care providers and a range of different specialists to manage their health conditions. While recent regulations that would have relaxed federal network adequacy standards for marketplace plans are currently subject to a federal court injunction, it is possible these rules could eventually take effect. **The Lung Association supports statutory changes that clarify that marketplace plan networks cannot be considered adequate unless they satisfy quantitative measures of provider access, including with respect to essential community providers.** The Lung Association also supports stronger protections for enrollees who cannot timely obtain needed care from an in-network provider.

6. Remove barriers to accessing care. (Section 2.II)

Prior Authorization and Claims Denials

Prior authorization is a time-consuming process that has been shown to delay necessary health services for patients and even lead some patients to abandon care entirely. When patients with chronic lung disease put off or delay care, they may face more serious symptoms later. For example, among states where Medicaid plans did not impose prior authorization for smoking cessation services, the increase in quit attempts was twice as high as states that did have barriers to cessation services.[28] Patients who are denied approval have the right to appeal denials, but doing so comes with additional burden and delay at a time when patients and their caregivers may be overwhelmed with complex and intensive care. Many patients and providers may be confused by the multiple steps required by insurers to complete this process. In 2024, insurers offering plans through HealthCare.gov denied 19 percent of in-network claims, and consumers appealed fewer than 1 percent of denied claims.[29]

The Lung Association strongly supports policies that make healthcare services available without these barriers. A starting point for any federal reforms to prior authorization is to require greater reporting on insurer data on prior authorization considerations, beginning with the number of requests received, outcome of reviews, including denied or approved, the basis for any denials, and the time required to render a decision. In communicating prior authorization

outcomes to providers and patients, the Lung Association supports requiring denial determinations to provide sufficient detail on the rationale for the decision to enable patients and providers to take action. This information would better inform patients and providers of their next steps. Denial notices should also be written in plain language and include standardized instructions for requesting reconsideration or filing an appeal, including applicable timelines, deadlines and clear next steps. Patients and providers should receive notice at the same time, in a form that complies with appropriate language-access and accessibility standards so that patients and caregivers can understand the decision and take timely action.

Finally, as the RFI notes, patients can face serious disruptions when health plans make changes during the plan year.[30] For example, a change in a provider's network status may result in unexpected out-of-pocket costs, and changes to drug formularies can affect whether patients are able to maintain access to ongoing treatment. **The Lung Association supports policies that protect patients from unexpected costs and interruptions in access resulting from mid-year plan changes.**

Conclusion

Access to quality, affordable health care is essential to people living with lung disease. The Lung Association appreciates the opportunity to provide these recommendations and urges Congress to take action to strengthen our existing coverage framework by providing robust consumer outreach and assistance, protecting access to preventive services without cost-sharing, ensuring affordability, expanding pathways to coverage, prohibiting junk plans, improving the quality of coverage, removing unnecessary barriers to care and streamlining eligibility and enrollment. The Lung Association looks forward to working more with the Committee as it develops more detailed policy proposals to protect and strengthen access to care.

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