October 2, 2026
Senator Ron Wyden
Ranking Member, Committee on Finance
219 Dirksen Senate Office Building
Washington, DC, 20002

Re: Health Coverage That Works for Everyone

Dear Ranking Member Wyden and Members of the Senate Democratic Caucus:

The 30 undersigned organizations, representing millions of patients and consumers facing serious, acute and chronic health conditions across the country, appreciate the Committee's interest in examining ways to improve our health insurance system.

Together, our organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country, including individuals who rely on the foundational protections provided under the Affordable Care Act (ACA). Together and separately, our non-profit, non-partisan organizations are dedicated to working with policymakers across all levels of government on a bipartisan basis to protect the health and wellbeing of the patients and consumers we represent.

In March of 2017, our organizations agreed upon three overarching principles[1] to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare should be accessible, meaning that coverage should be easy to understand and not a pose a barrier to care; (2)

[1] "Partnership to Protect Coverage (PPC) Consensus Healthcare Reform Principles." August 2024. https://www.protectcoverage.org/siteFiles/760887B7-C6C4-4F0E-AA09-5AB0B6659157/custom/files/August%202024%20PPC%20Coalition%20Principles%20FINAL.pdf.

healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefit (EHB) package.

The ACA created new pathways to coverage and imposed numerous critical reforms on the private health insurance markets that have enabled tens of millions of Americans to enroll in coverage with robust benefits and protections. This includes people with preexisting conditions, who often struggled to access and afford care before Congress enacted the ACA and who remain at risk, even now, from policy proposals that would deregulate private insurance.

The ACA's reforms are foundational. They establish basic protections that everyone must be able to rely on when they enroll in health coverage. And, as with any foundation, while they are absolutely necessary to the task, they're not sufficient to get the job done. For our health care system to work for everyone, Congress must ensure the stability of the ACA's base of reforms and must build upon them.

These twin responsibilities are especially salient today. Recent federal policymaking has eroded the ACA foundation, and we urge the committee to begin the work of immediately 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 the other long-term challenges people encounter in our health system.

Today, coverage has become much less affordable and completely unaffordable for some. The costs people face to enroll and then to use health insurance are skyrocketing. These high costs have multiple causes. For people who depend on the ACA marketplaces, a key culprit is Congress' failure to reauthorize the enhanced advance premium tax credit (eAPTC) for marketplace plans.[2] More broadly, enrollees with private coverage have seen their costs spike as the health care system has become more corporatized; as industry stakeholders have pursued increasingly byzantine financial relationships with one another, patients have been left behind.[3]

Today, coverage is also becoming much more difficult to access and use. The number of people without insurance is expected to rise significantly, in part due to increasing costs and partly because Congress and the administration have restricted eligibility for Medicaid and the marketplaces, making the process of enrolling in coverage far more burdensome.[4] While others may not become uninsured, they may become *underinsured* opting for subpar insurance products that come with lower monthly premiums but increased risk and financial exposure. Meanwhile, Americans with comprehensive insurance continue to have to navigate needlessly complex insurance designs and overcome administrative barriers that result in care delays and denials, and additional financial burdens for patients.

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[2] See, e.g., Buettgens, Matthew, Michael Simpson, Jason Levitis, Fernando Hernandez-Lepe, and Jessica Banthin. 2025. "4.8 Million People Will Lose Coverage in 2026 If Enhanced Premium Tax Credits Expire." Urban Institute. September 17. https://www.urban.org/research/publication/48-million-people-will-lose-coverage-2026-if-enhanced-premium-tax-credits.

[3] Blumberg, Linda J., Kevin Lucia, and Kennah Watts. 2025. "The Complex Web of Health Care Financial Interests and Their Implications for Ever Higher Spending: An Expert Perspective." https://chir.georgetown.edu/publications/the-complex-web-of-health-care-financial-interests-and-their-implications-for-ever-higher-spending-an-expert-perspective/.

[4] Congressional Budget Office. 2025. "Estimated Effects on the Number of Uninsured People in 2034 Resulting From Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act." CBO. June 4. https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf.

The people we represent see the dysfunctions of our private health coverage system up close and are harmed by them. The problems they encounter require federal action and we are thankful for your interest in addressing them. As you continue in this work, we urge that you be guided by the principles outlined below.

Health Coverage Must be Affordable
Patients enrolled in coverage must have equitable access to needed care in a timely manner from an experienced provider without undue financial burden. People face cost burdens both when they enroll in coverage and when they use it, and a reform framework must address all of these costs. In order to ensure coverage is truly accessible, premiums and cost sharing must be reasonable in relation to the enrollee and their family, out-of-pocket expenses must be limited, and enrollees must be held harmless from surprise medical bills. Adequate financial assistance must be available to ensure affordability. Individuals with preexisting conditions must not be subject to increased premium costs based on their disease or health status.

Health Coverage Must be Accessible
All people, regardless of socioeconomic status, should be able to gain and maintain coverage without waiting periods or undue administrative burden, through adequate open and special enrollment periods. Patient protections in current law must be retained, including prohibitions on preexisting condition exclusions, coverage denials based on health status, insurance policy rescissions, gender pricing, and excessive premiums for older adults. Coverage through Medicare and Medicaid should not be jeopardized through excessive cost-shifting, funding cuts, or per capita caps or block granting.

Health Coverage Must be Adequate and Understandable
All health plans should provide benefits for a full range of needed services and treatments, including items and services within all categories of essential health benefits (EHB), and must continue to cover high-value preventive services without cost sharing. These benefits must be accessible to the enrollees who need them without undue delay or administrative burden. Plans must use a comprehensive and stable network of providers, ensure enrollees have timely access to such providers, and provide continuity of care when individuals move between coverage types and in the event of network changes. Information regarding costs and coverage must be available, transparent, and understandable to the consumer in a culturally competent manner prior to purchasing the plan.

It is well documented that without affordable, adequate coverage, people delay and forgo needed care, to the detriment of their health and financial wellbeing.[5] We applaud the Committee for undertaking this process to explore policies that will preserve the gains made with the ACA, to build on those gains, and to curb practices that put the patients we represent, and millions more, at greater risk for coverage that is unaffordable and inadequate. With this in mind, we offer the following comments and recommendations in response to specific elements of your request.

Consumer-Friendly Enrollment
<u>Navigators</u>

[5] Collins, Sara R., Carson Richard, Anvi Gupta, and Shreya Roy. 2026. "How Medical Bills and Debt Impact Americans with Private Insurance." *The Commonwealth Fund*, September 17, 2026. https://www.commonwealthfund.org/publications/surveys/2026/sep/how-medical-bills-debt-impact-americans-private-insurance.

Resources that help consumers understand and select health care coverage are an essential component of any health care system. In recognition of this, the ACA established the Navigator program to help people who need health insurance obtain free, unbiased help to compare plans and enroll in coverage through their marketplace. They have also provided information on other coverage options, including Medicaid and Medicare. Without dedicated funding for Navigators, support for this critical program has fluctuated dramatically with changes in Administration. Yet robust marketing, education, and outreach conducted by Navigators are essential to promoting a healthier, balanced risk pool, which benefits the entire market by bringing down the cost of insurance and stabilizing markets. Many Navigators also provide in-person help to low-income and rural communities, consumers with limited English proficiency, people with disabilities, and other populations for whom such assistance is not often available.

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.

- At a *minimum*, Congress should reverse the harmful policies in H.R. 1 that erode patients' ability to access meaningful coverage. Imposing burdensome requirements on consumers to verify eligibility for premium tax credits and special enrollment periods will make it much harder to obtain coverage and financial assistance. H.R. 1 relies on red tape to lock out millions and inappropriately punishes consumers for fraud committed by insurance brokers.
- Our organizations support dedicated funding for the Navigator program. Reliable funding and multi-year contracts would bring stability to Navigator grantees, allowing them to put in place staffing that would support full-year service, from outreach about coverage options to assistance with verifying eligibility for coverage and subsidies, to post-enrollment help understanding plan cost-sharing and rules.

<u>Enhanced Direct Enrollment</u>

A core goal of the ACA marketplaces was to reduce the burden of enrolling in a health plan by giving consumers a one-stop shop for coverage: a single place to view their coverage options, the tools to understand and compare them, the opportunity to apply for federal financial assistance to help pay for such coverage, and finally, the ability to enroll. Enhanced Direct Enrollment (EDE) was designed to supplement, not supplant the role of Navigators. However, over time, the growing role of EDEs in marketplace enrollment has raised concerns within our organizations. Some administration and corporate approaches to enrollment through EDEs have created unnecessary barriers to enrollment and the potential for patients to be diverted into non-ACA compliant products or qualify for premium tax credits. This is a much greater risk with the affordability challenges facing millions of consumers since Congress allowed eAPTCs to expire and imposed new burdens on eligibility and enrollment. Faced with double-digit premium hikes and reduced financial assistance, more consumers may consider alternatives to ACA, which EDEs may sell. At a minimum, Congress should impose stronger standards on EDEs by prohibiting sales of non-ACA products during open enrollment and requiring clear, full and unbiased display of all marketplace plans.

<u>Consumer Assistance Programs</u>

Our organizations strongly support dedicated funding for Consumer Assistance Programs (CAPs). The complexity of our coverage system is underscored by a multitude of studies and reports demonstrating

that healthcare coverage can be overwhelming for consumers.[6] For example, a KFF survey of privately insured individuals found that nearly half of enrollees had encountered a problem using their coverage, such as denied claims, network challenges, or eligibility issues that they could not fix themselves.[7] Resources that help consumers understand and utilize their healthcare coverage are an essential component of ensuring that individuals and families can receive the care they need in a timely fashion and focus on their health – not the complexity of our insurance and medical billing system. CAPs play a vital role for individuals and families who need assistance navigating our system of care.

CAPs assist consumers in appealing, resolving, and tracking insurance disputes including surprise medical bills and claims denials. In addition, they also help patients and consumers understand and navigate narrow networks, identify sources of charity care, and resolve issues related to advance premium tax credits. All CAPs help state residents who have private health insurance, including employer-based coverage, union-sponsored plans, and Marketplace plans, and many CAPs can also help state residents enrolled in public coverage. CAPs also provide important resources for educating the public about their health insurance options and assist people navigating transitions in health insurance coverage due to changes in employment status, evolving family configurations, age, and other factors. In addition, CAPs are key to ensuring that the insurance system works for consumers, employers, providers, and payers.

Centralized enrollment platforms

A central tenet of the ACA was to establish a "no wrong door" approach to obtaining coverage, putting the responsibility on marketplaces to determine the coverage program for which a consumer is eligible and helping them enroll. Unfortunately, that policy has not been fully realized. Over the years, across different administrations, the standards for states to transition to a state-based marketplace (SBM) have changed in ways that undermine this goal. As a central tenet of the ACA, we support requiring in law that any state transitioning to an SBM demonstrate a commitment to and the means to operationalize this policy. It will become even more critical given the changes to marketplace and Medicaid eligibility and enrollment.

The committee asks for comment on whether to establish a centralized enrollment platform across coverage programs, including employer-sponsored coverage. We recognize this holds potential to reduce burdens on consumers to understand their coverage options, much like the "no wrong door" approach. However, the current framework that renders individuals ineligible for marketplace subsidies if they have an affordable offer of employer coverage makes that difficult to operationalize and potentially confusing for consumers who may not understand how this requirement applies to them.

One change the committee can make now to facilitate better understanding of coverage options is to require employers to publicly post their Summary of Benefits and Coverage (SBC) on their websites, so

[6] Norton, Mira, Liz Hamel, and Mollyann Brodie. 2014. "Assessing Americans' Familiarity With Health Insurance Terms and Concepts." *KFF*. https://www.kff.org/affordable-care-act/assessing-americans-familiarity-with-health-insurance-terms-and-concepts/. Pollitz, Karen, Justin Lo, Rayna Wallace, and Salem Mengistu. 2023. "Claims Denials and Appeals in ACA Marketplace Plans In 2021." *KFF*. https://www.kff.org/private-insurance/claims-denials-and-appeals-in-aca-marketplace-plans/. Cohen, Joshua P. 2019. "Healthcare Consumers Lack Knowledge Of Basic Health Insurance Terms." *Forbes*, December 1, 2019. https://www.forbes.com/sites/joshuacohen/2019/12/03/healthcare-consumers-lack-knowledge-of-basic-health-insurance-terms/?sh=34210d9fe225. National Association of Insurance Commissioners. (2020, October). Nearly Half of Consumers Don't Understand How Their Health Insurance Would Pay for Coronavirus Testing and Treatment. https://naic.soutronglobal.net/Portal/Public/en-US/RecordView/Index/25466.

[7] KFF. 2000. "National Survey of Consumer Experiences with Health Plans." https://www.kff.org/health-costs/national-survey-of-consumer-experiences-with-health/.

that prospective employees can see their coverage options easily and in advance of hiring. Federal rules require plans to make the SBC available at enrollment and on request. For the patients we represent, having to ask for details about an employer's coverage options may be difficult, revealing and risky. Some employers already voluntarily make their SBCs publicly available. Congress should require all employers to do so.

Coverage Value and Costs

Essential health benefits

The ACA's standards obligating individual and small-group market health insurance to cover essential health benefits (EHB) are of fundamental importance to the patients we represent. They extend coverage of needed items and services that were often not available in these markets or to people in less than perfect health before the ACA, and that are still not provided by products exempt from EHB rules.[8]

Current law expressly contemplates that the EHB package may need to change over time to "account for changes in medical evidence or scientific advancement" and to "address any gaps in access to coverage" that the Department of Health and Human Services (HHS) has identified. What's more, these changes may involve coverage of new categories of benefits beyond the 10 general categories enumerated in the law.[9] Nevertheless, federal regulators have never conducted a full review and public report that assesses whether EHB must be augmented (despite the current law requirement to conduct such periodic reviews) and the administration has halted the process under which states may update their benefits packages.[10]

- We support efforts to ensure regular, systematic reviews and updates to EHB, to ensure these benefits reflect advances in care and continue to meet the needs of enrollees. For example, there is a now well-established connection between oral health and the health and wellbeing of the whole person.[11] However, adult dental benefits have not historically been treated as EHB under federal regulations, and the current administration recently reimposed a prohibition that forbids these benefits from being deemed essential.
- We support reconsideration and refinement of statutory limitations on the scope of EHB, such as the requirement that these benefits be equal in scope to those provided by a "typical employer plan." We are concerned that such limitations could be used — inappropriately — as a

[8] See, e.g., Doty, Michelle M., Sara R. Collins, Jennifer L. Nicholson, and Sheila D. Rustgi. 2009. "Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families—Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2007." The Commonwealth Fund, July. https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2009_jul_failure_to_protect_1300_doty_failure_to_protect_individual_ins_market_ib_v2.pdf; Pollitz, Karen, Richard Sorian, and Kathy Thomas. 2001. "How Accessible Is Individual Health Insurance for Consumers in Less-than-Perfect Health?" Henry J. Kaiser Family Foundation, June. https://www.kff.org/wp-content/uploads/2013/01/how-accessible-is-individual-health-insurance-for-consumer-in-less-than-perfect-health-report.pdf; see also Long, Michelle, Emma Lee, and Sammy Cervantes. 2025. "Examining Short-Term Limited-Duration Health Plans on the Eve of ACA Marketplace Open Enrollment." KFF, October 15. https://www.kff.org/patient-consumer-protections/examining-short-term-limited-duration-health-plans-on-the-eve-of-aca-marketplace-open-enrollment/.

[9] Section 1302(b)(1) of the ACA defines EHB as including benefits from "at least" the 10 general categories.

[10] ACA sec. 1302(b)(4)(G).

[11] Spanemberg, J.C., J.A. Cardoso, E.M.G.B. Slob, and J. López-López. 2019. "Quality of Life Related to Oral Health and Its Impact in Adults." *Journal of Stomatology, Oral and Maxillofacial Surgery* 120 (3). https://doi.org/10.1016/j.jormas.2019.02.004.; Stöhr, Julia, Janett Barbaresko, Manuela Neuenschwander, and Sabrina Schlesinger. 2021. "Bidirectional Association between Periodontal Disease and Diabetes Mellitus: A Systematic Review and Meta-Analysis of Cohort Studies." *Scientific Reports* 11 (1). https://doi.org/10.1038/s41598-021-93062-6.

basis for undermining access to comprehensive coverage: to justify weakening EHB standards writ large, or to stymie updates to such benefits even where medical evidence indicates change is needed.

Affordability determinations

For health coverage to actually work for an enrollee, its costs — all of its costs — must be manageable. People must be able to afford to buy the coverage in the first place, to be sure. But they also must be able to afford the costs associated with using it. A reform framework that focuses on plan premiums alone will do little for the millions of people who delay or forgo needed care because of its cost or accrue debt from medical bills they are unable to pay.[12]

- We support reconsideration of the methodology used to determine eligibility for marketplace financial assistance. The current law test for whether a person has access to "affordable" employer-based coverage places inordinate weight on premium costs, which has the effect of barring people from accessing marketplace financial assistance even though the employer plan they have they cannot afford to use.
- To the extent coverage is not otherwise affordable, enrollees must have access to premium and cost-sharing assistance sufficient to make it affordable.
    - As noted elsewhere, we strongly support restoring the enhanced premium tax credit. Before Congress allowed it to expire, the enhanced credit made marketplace premiums newly affordable for millions of people.
    - We support a range of options to make cost sharing more affordable. In the context of the marketplaces, financial assistance could be delinked from silver tier plans and tied instead to plans with relatively more generous cost-sharing parameters: the premium tax credit could be re-benchmarked to a gold tier plan, for example, and cost-sharing reductions (CSRs) could be linked to enrollment in a gold plan instead of silver. CSRs also could be made more generous, and eligibility could be extended to people at middle incomes. More broadly, as we address below, we support more stringent limits on enrollees' exposure to out-of-pocket costs — overall and with respect to deductibles and coinsurance.

Rate Review

Rate review serves several important purposes: to ensure health insurance rates are justified and not excessive, and also to ensure they are adequate to cover the cost of paying for covered services. The ways in which state insurance regulators conduct these reviews vary greatly, despite the ACA imposing standards for states to demonstrate that they have an effective rate review program or else cede their authority to federal regulators.[13] We support reforms that elevate the role of rate review, particularly in this time of dramatic policy changes affecting rates following enactment of H.R. 1, the expiration of enhanced federal subsidies, and substantial federal regulatory changes.

[12] Collins, Sara R., Shreya Roy, and Relebohile Masitha. 2023. "Paying for It: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer: Findings from the Commonwealth Fund 2023 Health Care Affordability Survey." The Commonwealth Fund, October 26. Doi.org/10.26099/bf08-3735.

[13] Corlette, Sabrina, and Vrudhi Raimugia. 2024. "Looking Under the Hood: 'Enhanced' Rate Review to Improve Affordability." https://georgetown.app.box.com/v/looking-under-the-hood.

- Transparency: the process should be much more transparent to stakeholders, including consumers, and allow for greater public engagement in review of the rates. Multiple improvements would facilitate greater public engagement: easily accessible filings (not just publicly posted but out of view); standardized insurer narratives that provide a plain language overview of the assumptions baked into an insurer's proposed rates; and an easily accessible means for state departments of insurance to take public comment, with ample notice of the opportunity for stakeholders to do so.
- Consistency: Insurers make assumptions about the factors that will affect rates and the magnitude of those effects, for example, medical trends or the anticipated effect of major health events such as the pandemic. Assumptions about cost effects of various factors should be compared to evidence-based benchmarks. With that information, the public can see if an insurer's assumptions differ from the benchmarks and if so, how and why.
- Require prior approval of rates: Some states allow insurers to "file and use" their proposed rates, rather than requiring that they obtain approval before finalizing them (an approach known as "prior approval"). Prior approval should be required.
- Require HHS review of all rates in states without an effective rate review program: Federal regulations set a threshold for rate increases that must be reviewed by federal regulators in states where there is not an "effective rate review program." We support HHS reviewing all proposed rates in states that fail to meet that requirement and to strengthen the requirement for states to be considered to have an effective rate review program.

Deductibles

Deductibles shift financial risk from the insurer to the enrollee. They 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.[14]

From a health systems standpoint, a deductible may make sense as a tool to deter unnecessary care, or in a context where we are sure an enrollee has the resources and ability to evaluate health care providers and make an informed decision about the relative cost and quality of the options before them.

From the perspective of a patient, most health services are not in any meaningful sense discretionary; the "choice" to delay or forgo care their provider tells them they need may simply generate future costs for the patient and for their subsequent coverage provider (which can include the publicly funded coverage programs). Many services are provided in circumstances that afford a patient no meaningful opportunity to seek out an alternative provider, let alone to access any form of useful cost and quality information that could possibly produce an informed decision about where to receive care.

[14] Collins, Sara R., and Avni Gupta. 2024. "The State of Health Insurance Coverage in the U.S.: Findings from the Commonwealth Fund 2024 Biennial Health Insurance Survey." The Commonwealth Fund, November 21. https://doi.org/10.26099/byce-qc28; Young, Gregory, Matthew Rae, Gary Claxton, Emma Wager, and Krutika Amin. 2022. "How Many People Have Enough Money to Afford Private Insurance Cost Sharing?" Peterson-KFF Health System Tracker, March 10. https://www.healthsystemtracker.org/brief/many-households-do-not-have-enough-money-to-pay-cost-sharing-in-typical-private-health-plans/; Wharam, J. Frank, Fang Zhang, Jamie Wallace, Christine Lu, Craig Earle, Stephen B. Soumerai, Larissa Nekhlyudov, and Dennis Ross-Degnan. 2019. "Vulnerable and Less Vulnerable Women in High-Deductible Health Plans Experienced Delayed Breast Cancer Care." Health Affairs 38 (3): 408–15. https://doi.org/10.1377/hlthaff.2018.05026; Brot-Goldberg, Zarek C., Amitabh Chandra, Benjamin R. Handel, and Jonathan T. Kolstad. 2017. "What Does a Deductible Do? The Impact of Cost-Sharing on Health Care Prices, Quantities, and Spending Dynamics." The Quarterly Journal of Economics 132 (3): 1261–318. https://www.jstor.org/stable/26372703.

- We support rules that would require all private health plans to cover high-value services along the treatment continuum without application of a deductible and urge you to consider whether at least some such services should be required to be covered without any cost sharing.
- For the services to which such plans would be permitted to apply a deductible, that deductible should be subject to an annual cap. We encourage you to consider multiple approaches to such caps, including flat-dollar limits applicable to all plans. In the context of the marketplaces, it might involve modifications to the generosity of and income eligibility requirements for cost-sharing reductions.

Coinsurance

Coinsurance is an opaque form of cost sharing that saddles enrollees with payment obligations that are often difficult (or impossible) for them to calculate before they incur them. Costs such as these, that are less predictable and harder to comprehend even by the standards of insurance, are more difficult to budget for and may place even more stress, financial and otherwise, on patients.[15] 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.

- We support significant limitations on the application of coinsurance and urge you to consider whether there are any circumstances in which insurers should be permitted to use coinsurance in lieu of a copayment structure.

Maximum Out-of-Pocket Caps

While the ACA's limitation on annual out-of-pocket spending is, for many, an important consumer safeguard against truly catastrophic costs, we believe 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. (For example, a family of four with an income of 201% of the federal poverty level (FPL) — about $65,000 for the 2026 coverage year — who enrolls in a marketplace plan with cost-sharing reductions could still be required to spend through more than a quarter of their income before reaching the $16,900 cap.)

- We support a range of options to reduce enrollees' exposure to unaffordable out-of-pocket costs. We support recalibrating the existing annual limitation on out-of-pocket costs to provide enrollees across the private health insurance markets with increased financial protection. In the context of the marketplaces, as noted above, financial assistance could be delinked from silver tier plans and tied instead to plans with relatively more generous cost-sharing parameters: the premium tax credit could be re-benchmarked to a gold tier plan, for example, and cost sharing reductions (CSRs) could be linked to enrollment in a gold plan instead of silver. CSRs also could be made more generous, and eligibility could be extended to people at middle incomes.

[15] Dusetzina, Stacie B., Juliette Cubanski, Diane Rowland, and Scott Ramsey. 2018. "Improving the Affordability of Specialty Drugs by Addressing Patients' Out-of-Pocket Spending." Health Policy Brief. Health Affairs, March 15. https://doi.org/10.1377/hpb20180116.800715; Quincy, Lynn. 2011. "Making Health Insurance Cost-Sharing Clear to Consumers: Challenges in Implementing Health Reform's Insurance Disclosure Requirements." The Commonwealth Fund, February. https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2011_feb_1480_quincy_making_hlt_ins_costsharing_clear_consumers_ib.pdf.

Strengthening the Existing Coverage Framework
We urge the committee to begin the work of strengthening our current coverage framework by reversing the policies in H.R. 1 that push people out of marketplace and Medicaid coverage; restoring eAPTCs that make coverage affordable; and reinstating eligibility for immigrant populations who, despite having legal status, are now blocked from marketplace subsidies. Together, these policies will lead to gaps in coverage with serious health consequences for the people we represent, and result in about 15 million more uninsured.

The committee also asks for comment on the firewall that keeps low-wage workers and their families from obtaining marketplace subsidies. Although intended to create a pathway for consumers to purchase subsidized marketplace plans if their job-based insurance options are unaffordable, the effect has been to lock individuals into coverage that, while technically "affordable and adequate" under ACA rules, renders access to care unreachable.

The ACA's mechanism for determining consumer affordability of employer-based insurance has two critical flaws that must be addressed to ensure consumers have affordable access to necessary health care services. First, the current test of whether employer-based insurance is adequate and meets minimum value is tied to the lowest metal level of coverage available in the marketplace and imposes few requirements on scope of coverage. Under this policy, comprehensive health plans are treated the same as plans that do not cover prescription drugs, mental health services, and other essential health benefits. As a result, consumers can be locked out of affordable marketplace coverage even if they could face tens of thousands of dollars in costs for necessary services not covered by their employer's plan.

Second, the current affordability test places inordinate weight on premium costs as a measure of whether an employer-sponsored plan is affordable. Too often plans lower premiums by increasing cost sharing, including by increasing deductibles. The test for affordability should apply a more realistic measure of the costs employees incur in order to access care through an employer-sponsored plan. We support updating the cost inputs to federal affordability standards to capture both premiums and deductible costs in comparison with employee household income.

State Authorities and 1332 Waivers
Section 1332 waivers allow states to waive specified provisions of the ACA to pursue programs that improve the affordability of comprehensive coverage. The statute expressly prohibits states from waiving many of the ACA's core patient protections and includes crucial statutory guardrails intended to ensure that state waiver programs broadly adhere to the ACA's coverage goals. These guardrails prohibit a waiver from being approved unless a state can demonstrate that, under its waiver program: coverage will be as affordable as it would be without the waiver; coverage will be as comprehensive as it would be without the waiver; a comparable number of people will be covered under the waiver as would be without it; and that the waiver will not add to the federal deficit.

As you know, nearly two dozen states have received federal approval for waivers since they became available in 2017 - most to implement reinsurance programs that lower unsubsidized individual market premiums. Several states — Colorado, Nevada, and New York — have used these waivers in relatively more expansive ways, to broaden access to affordable coverage and/or to begin to address underlying

cost drivers including excessive provider payments.[16] We note, however, that a Section 1332 waiver is not a prerequisite for such reforms: states can address provider payment rates without waiving federal law and Washington's Cascade Select program — the longest running state "public option" style initiative — does not use one.[17]

Meanwhile, we have witnessed dramatic swings in the interpretation and implementation of Section 1332 by successive federal administrations. In 2018, the Administration issued guidance and regulations that significantly undermined Section 1332's statutory guardrails. The administration's approach, among other things, made it easier for states to use federal taxpayer dollars to promote sub-standard plans (such as short-term plans) that do not provide comprehensive and affordable coverage, inviting waivers that, notwithstanding the statute, were likely to weaken the ACA's non-waivable patient protections. We believe the administration's policy was unlawful, and it was subsequently rescinded under 2021.

In light of this history, we believe that any expansion of the state authorities already provided under Section 1332 must be undertaken with great caution. To the extent you identify value in giving states greater leeway to innovate on the ACA model, we suggest that you consider carefully how to enhance the statutory guardrails to ensure a federal administration and states cannot use waiver flexibilities to circumvent the law's foundational protections.

Expanding pathways to coverage for low-income people and exploring the benefits of giving all Americans access to Medicare-type choices for health care

Our organizations share your goal of achieving universal, comprehensive coverage and more affordable, simpler access to health care for everyone, and look forward to working with you to reach it. We will be guided in our evaluation of reform approaches by the principles we articulated at the beginning of these comments.

Consistent with these principles and our other comments, we urge that any new public coverage program or option be designed to provide an affordable and accessible pathway to coverage both for people who are uninsured as well as those who are underinsured. A program that is broadly available to individuals in a variety of coverage situations, including to people who do not currently qualify for federally subsidized health insurance as well as those whose coverage is unaffordable or insufficient, is likely to be more successful in reducing uninsurance and underinsurance than a program with relatively narrow eligibility criteria.

As part of this discussion, we encourage Congress to permanently close the Medicaid coverage gap that impacts approximately 1.2 million uninsured people in the ten states that have not expanded Medicaid, people who have incomes too high to qualify for coverage through their states' Medicaid programs but too low to qualify for financial assistance through the Marketplace. A solution should include comprehensive coverage tailored to the populations that Medicaid serves and appropriate protection from out-of-pocket costs. Congress should also reinstate the incentives for Medicaid expansion and repeal the financial penalties for expansion states included in H.R. 1.

[16] New York's waiver facilitated an expansion of its "Essential Plan" coverage affordability program to people from 201-250% of the federal poverty level. The waiver was terminated at the state's request, effective July 1, 2026, as a result of changes to federal law under H.R. 1.

[17] Washington currently has an approved Section 1332 waiver; it relates to eligibility rules for the marketplace and is independent of Cascade Select. To be clear, other elements of these states' "public option" style programs, including state-funded coverage subsidies, standardized plan requirements, network adequacy standards, and plan and provider participation requirements, do not require a waiver either.

Ending Junk Coverage Across Markets

The proliferation of insurance products and insurance-like arrangements that do not comply with the ACA (non-compliant plans) pose particular risks to the patients we represent. Because they are not required to provide the patient protections included in the ACA, non-compliant plans can (and do) discriminate against people with preexisting conditions and otherwise offer a product that provides little value to people who need care.[18] But because they offer such limited value, non-compliant plans often come with a relatively low premium, making them superficially attractive to people who are healthy. As a result, they have the potential to pull healthy people out of the ACA-compliant insurance market risk pool, inflating premiums for those who enroll in comprehensive coverage.[19]

To make matters worse, while most non-compliant plans are not intended to be, and are prohibited from advertising themselves as replacements for comprehensive health insurance, the critical distinctions between compliant and non-compliant plans are, in practice, often blurred. Non-compliant plans frequently contain features or use nomenclature designed to mimic ACA-compliant coverage and are sometimes marketed in ways that make it difficult for consumers to understand (or even be aware of) their limitations.[20] As a result, people may sign-up for a non-compliant plan believing they have enrolled in health insurance or a product that is, in fact, functionally the same, only to discover its shortcomings when they need care.

- In the case of non-compliant plans such as short-term, limited duration insurance (STLDI), fixed indemnity products, and direct primary care arrangements (DPCAs), we support statutory protections that ensure these limited benefit, limited scope products cannot be marketed and sold as substitutes for ACA-compliant insurance. For example, Congress should:
    - Codify the definition of STLDI contained in the 2024 STLDI and Noncoordinated Excepted Benefits Coverage Final Rule (the STDLI Rule).[21] The STLDI Rule, which the Administration has now declined to enforce and is likely to rescind, includes provisions — such as a three-month duration limit and restrictions on the practice of "stacking" STLDI policies together to evade duration limits — designed to ensure short-term plans are only offered in a manner consistent with their original purpose.
    - Codify commonsense requirements for fixed indemnity products proposed in the 2024 STLDI Rule — such as a prohibition on benefit designs that pay on a per-service basis and clarifications that prohibit the misleading bundling of multiple excepted benefits

[18] Giovannelli, Justin, and Kevin Lucia. 2026. "What Consumers Need to Know About Health Coverage That Doesn't Comply with the Affordable Care Act." Commonwealth Fund, February 19. https://doi.org/10.26099/cd1j-p006.

[19] Dieguez, Gabriela, and Dane Hanseon. 2020. "The impact of short-term limited-duration policy expansion on patients and the ACA individual market." Milliman. February 24. https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market.

[20] See, e.g., Killelea, Amy; Madison Harden-Stein, and JoAnn Volk. 2026. "No Good Options: In the Wake of Marketplace Affordability Woes, Consumers Face Onslaught of Misleading Marketing of Limited Benefits Products." Georgetown University Center on Health Insurance Reforms. August. https://georgetown.app.box.com/s/z70ump8w7beinojqf537nk1xvgi2wtkm; Giovannelli and Lucia, "What Consumers Need to Know." Georgetown Center on Insurance Reforms and the Commonwealth Fund. February. https://www.commonwealthfund.org/publications/explainer/2026/feb/what-consumers-need-know-health-coverage-doesnt-comply-aca.

[21] Internal Revenue Service, Employee Benefits Security Administration, and Health and Human Services Department. 2023. *Short-Term, Limited-Duration Insurance and Independent, Noncoordinated Excepted Benefits Coverage*. https://www.federalregister.gov/documents/2024/04/03/2024-06551/short-term-limited-duration-insurance-and-independent-noncoordinated-excepted-benefits-coverage.

products — in order to limit the ability of these products to use benefit designs and sales practices that mimic fully regulated health insurance.
    - Require that entities offering fixed indemnity products or DPCAs confirm that a prospective enrollee is covered by ACA-compliant coverage.
- We support prohibiting insurance brokers from selling non-compliant plans, such as health care sharing ministries, that disclaim they are not insurance.
- We also support revisiting the federal definition of insurance to close loopholes that allow some non-compliant plans, such as underwritten coverage offered by Farm Bureaus, to wholly escape insurance regulation.
- There has been a long history of attempts to avoid state insurance regulation by exploiting a limited exemption in the Employee Retirement Income Security Act (ERISA) for single-employer plans. Most recently, attention has focused on so-called "partnership" arrangements that spuriously claim that their non-compliant plan offerings are shielded from state oversight by ERISA.[22] We support investigations into these sorts of practices and legislative action, as necessary, to ensure strong federal and state oversight.

Eliminating surprise tax bills for working people who buy insurance on their own

H.R. 1 repealed a provision of the ACA that capped the tax liability of people with incomes under 400 percent FPL who underestimate their income and owe back PTCs during the PTC reconciliation process. Prior to this, the amount of excess PTCs a Marketplace enrollee would owe back during tax time was determined on a sliding scale based on income. Recapture limits protect low- and middle-income families from owing large unexpected sums at tax time. These limits are a vital safeguard because individuals applying for Marketplace coverage must estimate their annual income in advance to determine their eligibility for tax credits. For many – especially self-employed individuals, gig economy workers, hourly or seasonal employees, and others with fluctuating incomes – accurately predicting annual income is extremely difficult.

We strongly support reinstatement of this provision. For plan year 2025, the maximum amount a single individual earning less than 200 percent FPL could be required to pay back was $375; at 400 percent FPL the maximum amount was $1,625. This means that many low- and moderate-income families who file their 2026 tax returns in early 2027 will owe the IRS unexpectedly large amounts if their income rose or their household size changed in the prior year. This is likely to have a chilling effect on many people's willingness to enroll in subsidized coverage. Nationally, CBO has estimated this provision will increase the number of uninsured by 100,000 in 2034.

Standardized Benefits

Standardized plans significantly simplify enrollment for consumers by preventing the choice overload that often leads to poor plan selection or uninsurance. The number of marketplace plans available to consumers has increased drastically over time — to about 100 per county in 2025 — and research shows a negative relationship between greater choice and informed enrollment decisions.[23] Requiring health plans to follow uniform cost-sharing parameters helps ensure that differences among options are

[22] Partnership to Protect Coverage. Letter to Keith Sonderling and Daniel Aronowitz. 2026. "Re: Potential Settlement in Data Marketing Partnership v. U.S. Department of Labor." Statement Letter, August 11, 2026. https://www.protectcoverage.org/siteFiles/55471/b17eeeb829d24cb7a4a9878f5eacca2c_08_10_26_DMP_Settlement_Letter_to_DOL_EBSA_-_FINAL.pdf.

[23] Forsberg, Vanessa C. 2025. "Health Insurance Exchanges and Qualified Health Plans: Overview and Policy Updates." https://www.congress.gov/crs-product/R44065#fn136.

meaningful and allows consumers to draw clearer comparisons using premiums and the information most relevant to their coverage needs, such as plan networks and prescription formularies.

Standardized plans can also be used as a tool to improve coverage access and affordability. For example, standard designs can and should exempt services such as primary and mental health care from the deductible. These exemptions not only add immediate value to consumers' coverage but also lower cost barriers to services and supplies that address health conditions that disproportionately affect people of color and others who historically have been underserved.

- We support a requirement that marketplace plans offer standardized plans (as designed and regularly updated through regulation) as a condition of participation. We also support complementary offering rules that would work in concert with standardized plan policy to enhance the consumer shopping experience and improve plan value. Such rules include, for example, a limitation on the number of non-standard designs insurers can offer.

Network Adequacy

The ACA established the first federal network adequacy standard applicable to private market coverage, for plans sold through the marketplaces. This statutory protection, while drafted at a high level, has been of vital importance to the patients we represent. It has been the basis for significant pro-consumer regulations that have sought to ensure timely access to providers and appropriate oversight of network composition. Yet, as in other areas of marketplace administration, we have experienced (and are currently experiencing) significant regulatory and enforcement retreat from these protections, to the jeopardy of our patients.

With respect to provider directories, the situation is at least somewhat different. The No Surprises Act (NSA) includes strong requirements regarding directory standards and a hold harmless provision for enrollees who rely on an out-of-date or otherwise inaccurate directory. However, these requirements have never been implemented and in practice, insurers appear to face no meaningful consequences for noncompliance.

- While Administration rules that would have relaxed federal network adequacy standards for marketplace plans are, at this moment, subject to a federal court injunction, it is possible these rules (or ones similar to them) could eventually take effect. We support 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.
- Notwithstanding the NSA's requirements, ghost networks continue to plague enrollees with private health coverage. We favor stronger supports and cost protections for enrollees who cannot timely obtain needed care from an in-network provider. Congress should also consider additional accountability measures for insurers and providers to reduce directory inaccuracies.

Prior Authorization

The ACA prohibits insurers from using many of the tools they historically employed to avoid covering individuals with acute and chronic conditions and the care they require. However, insurers retain the ability to control costs through utilization management, including the use of prior authorization. While prior authorization can help reduce unnecessary care and ensure patients are getting the optimal care for their condition, the increasing use of prior authorization raises significant concerns that insurers are turning to this tool to restrict access to needed care.

The committee seeks comment on various reforms that have been implemented at the state level, including gold carding, establishing standards for the qualifications of reviewers, standardizing the prior authorization process, and setting time limits for insurer review of prior authorization requests. We believe a foundational policy 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 (denied or approved), the basis for any denials, and the time required to render a decision. Data should be publicly available and disaggregated by factors including service type, provider type, diagnosis, geography, income, disability, gender, race and ethnicity and age in order to shed light on where prior authorization requests are occurring, for what health conditions, and for which patients.

In communicating prior authorization outcomes to providers and patients, we support requiring denial determinations to provide sufficient detail on the rationale for the decision to enable patients and providers to take action. For example, denials due to missing supporting documentation should clearly stipulate the necessary documents for proper review. Denials based on "medical necessity" could cover a wide range of potential factors. States, plans, and QHP insurers should be obligated to provide a more granular response than "failure to establish medical necessity." Insurers and health plans must explicitly state the coverage policy or clinical criteria standard used to determine a denial, and provide information on covered alternatives. 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.

Claims Denials

Even *after* care has been received, enrollees may and too often do face administrative barriers that delay or deny payment. Indeed, denying payment, post-claim, is another mechanism by which insurers, ostensibly seeking to control costs associated with inappropriate care, in practice shift significant financial burdens for medically necessary care to patients themselves.

- We support strengthening insurer reporting requirements regarding claims denials and appeals and suggest it may be appropriate to require regular agency reports to Congress to ensure full and regular implementation of these obligations.
- We also support exploring how the claims submission process could be standardized and otherwise streamlined to reduce unnecessary complexity, confusion, and the risk of administrative error.
- The ACA exempted certain health plans already in existence at the time of enactment in 2010, from some of its patient protections, including the requirement that enrollees have guaranteed access to an external appeal of a claim denial. We support revisiting whether there is value in allowing plans to retain "grandfathered" status 16 years after enactment and suggest it may well be time to extend all ACA protections, including the right to external appeal, to enrollees in these plans.

Medical Loss Ratio Oversight

The Medical Loss Ratio is an essential protection that ensures consumers get some minimum level of benefit from their insurance in return for the premiums they pay. When insurers fail to meet the

threshold -- spending less than 80 percent of premium dollars on health care for individual and small group market plans, or less than 85 percent for large group plans – the ACA requires them to return excess profits to enrollee as rebates. Alternatively, insurers have responded by lowering their premiums to ensure profits and administrative expenses don't exceed the allowable share of enrollee premiums.

Research finds that MLRs increased after the MLR requirement took effect, particularly in the individual market and among for-profit insurers.[24] Another analysis estimates that a total of $14.4 billion in rebates has been issued to individuals and employers, with another $759 million in rebates expected in 2026.[25] A GAO study found evidence that some insurers moderated premium increases after the MLR requirement took effect.[26]

However, there is also evidence that some insurers have been able to use MLR regulations to meet the thresholds by increasing their costs and classifying some payments as administrative. For example, evidence indicates some insurers are able to meet the threshold by paying above-market provider rates, upcoding to indicate higher health care needs of enrollees, overestimating future claims payments, and counting intercompany transfers to subsidiaries that provide clinical services (such as a PBM, pharmacies or physician groups) as spending on health care.[27]

We support closer examination of MLR definitions and regulations and the ways in which insurers can meet the thresholds without providing benefit to patients. The MLR was a key reform in the ACA that responded to substandard coverage that, prior to the ACA, had multiple mechanisms for avoiding covering the care of people with pre-existing conditions. We urge lawmakers to keep that goal in mind and preserve the intent of the MLR when considering policies that would guard against misuse.

Conclusion

The Partnership to Protect Coverage thanks the Committee and members of the Senate Democratic Caucus for their invitation to provide feedback to this request for information. We welcome the opportunity to continue working with the Committee and staff to advance policies that ensure people living with serious and chronic illnesses have affordable, accessible and adequate health insurance

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[24] Abraham, Jean M., Pinar Karaca-Mandic, and Kosali Simon. 2014. "How Has the Affordable Care Act's Medical Loss Ratio Regulation Affected Insurer Behavior?." *Medical Care* 52 (4): 370–77. https://doi.org/10.1097/mlr.0000000000000091.; Michael, Mark Hall, and Xinliang Liu. 2013. "Impact Of Medical Loss Regulation On The Financial Performance Of Health Insurers." *Health Affairs* 32 (9): 1546–51. https://doi.org/10.1377/hlthaff.2012.1316.

[25] McGough, Matt, Jared Ortaliza, and Cynthia Cox. 2026. "2026 Medical Loss Ratio Rebates." KFF. https://www.kff.org/private-insurance/medical-loss-ratio-rebates/.

[26] GAO, Private Health Insurance: Early Effects of Medical Loss Ratio Requirements and Rebates on Insurers and Enrollees, GAO-14-508, 2014.

[27] Rooke-Ley, Hayden, Anika Shah, Corrie Mook, and Erin Fuse Brown. 2026. "Health Care Conglomerates: Policy and Legal Options for Addressing Vertical Integration." *Center for Advancing Health Policy through Research (CAHPR) Digital Collection*, January. https://doi.org/ https://doi.org/10.26300/3asf-mq68; Cicala, Steve, et al. "Regulating Markups in US Health Insurance." American Economic Journal: Applied Economics, vol. 11, no. 4, 2019, pp. 71–104. JSTOR, https://www.jstor.org/stable/26794322; Accessed 28 Sept. 2026. Eastman, Evan M., David L. Eckles, and Andrew Van Buskirk. 2025. "Accounting-Based Regulation: Evidence from Health Insurers and the Affordable Care Act." The Accounting Review 96 (2): 231–259. March. https://doi.org/10.2308/tar-2019-0173; Angeles, January, Michael Bailit. 2025. "How Insurers That Own Providers Can Game The Medical Loss Ratio Rules," Health Affairs Forefront. September 29. Arnold, Daniel and Brent D. Fulton. 2025. "United Healthcare Pays Optum Providers More than Non-Optum Providers." Health Affairs 44:11, 1395-1403. November 23. https://doi.org/10.1377/hlthaff.2025.00155; Kakani, Pragya, Eric Yde, Genevieve P. Kanter, Richard G. Frank, and Amelia M. Bond. 2026. "Profit Regulation and Strategic Transfer Pricing By Vertically Integrated Firms: Evidence From Health Care." Working Paper. National Bureau of Economic Research. April. http://www.nber.org/papers/w35043

coverage. If you have questions about our comments or would like to schedule a meeting to speak further, please contact Katie Berge, Senior Director of Federal Affairs at katie.berge@bloodcancerunited.org.

Sincerely,

AiArthritis
American Cancer Society Cancer Action Network
American Diabetes Association
American Kidney Fund
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation of America
Autoimmune Association
Blood Cancer United
Cancer Nation
CancerCare
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Diabetes Patient Advocacy Coalition
Epilepsy Foundation of America
Foundation for Sarcoidosis Research
Hemophilia Federation of America
Hypertrophic Cardiomyopathy Association
Immune Deficiency Foundation
Lupus Foundation of America
Muscular Dystrophy Association
National Alliance on Mental Illness (NAMI)
National Bleeding Disorders Foundation
National Kidney Foundation
National Patient Advocate Foundation
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Susan G. Komen
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