June 28, 2025

The Honorable Mike Crapo
Chairman
Committee on Finance
United States Senate
Dirksen Senate Office Building, Rm 219
Washington, DC 20510

The Honorable Bill Cassidy
Chairman
Health, Education, Labor & Pension Committee
United States Senate
Dirksen Senate Office Building, Rm 455
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Dirksen Senate Office Building, Room 221
Washington, DC 20510

The Honorable Bernie Sanders
Ranking Member
Health, Education, Labor & Pension Committee
United States Senate
Dirksen Senate Office Building, Room 332
Washington, DC 20510

Re: One Big Beautiful Bill Act's Impact on Patients

Dear Chair Crapo, Chair Cassidy, Ranking Member Wyden, and Ranking Member Sanders,

On behalf of millions of patients and consumers who face serious, acute, and chronic health conditions, our 36 organizations write to strongly urge Senators to oppose the proposed Senate amendments to

H.R. 1, the One Big Beautiful Bill Act, unless changes are made to eliminate the bill's sweeping cuts to Medicaid, Medicare, and Marketplace coverage. As currently drafted, the Senate Finance Committee and Senate Health, Education, Labor and Pensions (HELP) Committee's text would put lifesaving care further out of reach for the most vulnerable patients in America.

Together our organizations offer unique and important perspectives on what individuals and families need to prevent disease, cure illness, and manage their health. The diversity of our organizations and the populations we serve enables us to draw upon extensive knowledge and expertise that can be an invaluable resource as Congress considers any legislation that would reform our healthcare system.

In March of 2017, our organizations came together to form the Partnership to Protect Coverage (PPC). Together, we agreed upon three overarching principles 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 pose a barrier to care; (2) 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.

Access to high-quality, affordable health insurance is essential to maintaining and improving the health of everyone living in the United States. Our organizations stress that any changes to existing law must not jeopardize the healthcare coverage that Americans currently have through employers, the private market, Medicare, or Medicaid. Further, patients and consumers should be able to keep their existing high-quality coverage, and any policy should not undermine quality or affordability.

We therefore regret that the vast majority of health-related policies included in the released text from both committees would make it significantly harder for patients to access and afford their care. We are alarmed at the inclusion of multiple policies that would make harmful cuts to Medicaid, including more frequent, complex, and burdensome paperwork mandates for patients, in addition to the dramatic cuts to federal funding for Medicaid benefits that will pass the buck to states, leaving them to pick up the pieces. We are also concerned that the bill will put Affordable Care Act (ACA) Marketplace health coverage out of reach for many middle- and low-income American families—through both the creation of new burdens to getting and staying on coverage and the failure to extend enhanced premium tax credits beyond 2025. Finally, we are dismayed that the bill would make enormous cuts to Medicare, requiring approximately $500 billion in automatic Medicare spending cuts that would threaten seniors' access to quality care.

The absence of standard congressional processes, such as legislative hearings, expert testimony, and opportunities for public comment, has resulted in legislation that fails to reflect the needs and realities of those most affected: patients. Throughout the House committee markups on this bill, it became clear that committee members had a poor understanding of the impact of various provisions and how they would be implemented.[1] Yet, committees still advanced them. Later, House leadership added, in the middle of the night, new policies and more aggressive healthcare cuts just hours before the bill's floor vote, preventing a comprehensive analysis of the bill's provisions by the nonpartisan experts at the Congressional Budget Office (CBO). CBO's analysis, released on June 4, confirmed the devastating impact that the legislation, combined with the failure to reauthorize the ACA's tax credits, would have on our

[1] Gold, Michael. "After Muscling Their Bill Through the House, Some Republicans Have Regrets." *New York Times*, (June 3, 2025). https://www.nytimes.com/2025/06/03/us/politics/house-republicans-policy-bill-regrets.html

patients: it would cut more than one trillion dollars from critical healthcare programs and cause 16 million people to lose their health coverage. As evidence-based, non-partisan organizations, we urge Congress to stop this rushed process with artificial deadlines and, instead, engage in a transparent and informed process that will lead to better, more patient-centered policy outcomes.

As the Senate considers what changes to make to this legislation ahead of floor consideration, our organizations offer the following perspective, focused squarely on how this legislation will impact affordable, adequate and accessible healthcare coverage for patients:

Impact on Patients with Medicaid

Medicaid and the Children's Health Insurance Program (CHIP) provide quality, affordable healthcare coverage to nearly 80 million people across the country, including low-income children and adults, pregnant individuals, people with disabilities, and seniors. Medicaid is not simply a line item in a budget—it is a lifeline for millions of working Americans. Yet this legislation decimates Medicaid expansion through work reporting requirements, mandatory copays, and other cuts that add red tape, take away coverage, and increase healthcare costs. Despite promises to protect vulnerable populations, it will make the eligibility and enrollment process harder for seniors, kids, and others, leading to significant coverage losses, and it will force states to cut or altogether eliminate Medicaid benefits that these groups rely upon for lifesaving care.

Affordability

Increasing Cost-Sharing for Patients

The Senate Finance Committee text would require states to impose copays of up to $35 for many critical treatments and services. The evidence is clear that even small copays of one to five dollars are associated with reduced use of care.[2] These costs will quickly add up for patients who require regular visits to specialists or are in active treatment for cancer, increasing the financial burden on patients with serious and chronic health conditions.

When patients ration care because of cost, their conditions worsen and often end up leading to more costly interactions with the healthcare system in an emergency department or hospital. For example, a study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[3] Like many provisions in this bill, this policy will be costly for states to administer while making patients sicker.

Accessibility

Work Reporting Requirements

Evidence has consistently demonstrated that requiring Medicaid enrollees to provide proof of employment leads to widespread coverage loss, increased administrative burdens, and significant financial costs to the state – without achieving the intended goal of increasing employment. Despite this, this legislation would impose work reporting requirements on certain Medicaid enrollees – demonstrating that they are working, doing community service, or enrolling in an educational program for at least 80 hours each month. Proof would be required when an individual first applies for coverage

[2] Artiga, S., Ubri, P., Zur, J. "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings." *KFF.* June 1, 2017. https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/)

[3] Wallace NT, McConnell KJ, et al. How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan. Health Serv Res. 2008 April; 43(2): 515–530.

as well as for those already enrolled in order to maintain coverage. As drafted, this provision requires patients to repeatedly justify their enrollment a minimum twice a year but give the states authority to implement recertifications as frequently as monthly. These initial and ongoing requirements create navigational burdens that would deter people from seeking coverage at all.

Further, this new layer of bureaucracy is also counterproductive in achieving the very goals its proponents have laid out. In fact, research consistently finds that Medicaid enrollees who are able to work are already doing so, and that enrollees who are not employed are typically unable to work because of their own health or because they are caring for others.[4,5] In fact, some researchers have argued that being enrolled in Medicaid may *improve* the likelihood of employment by providing steady and consistent access to healthcare, noting linkages between healthcare access, health status, and employment.[6]

States have tried to implement work reporting requirements, but they consistently fail in achieving Medicaid's core mission to provide health coverage for eligible individuals. In Arkansas, more than 18,000 Medicaid enrollees lost coverage during the nine-month period during which the work requirement was in effect. Many Medicaid enrollees found the reporting process confusing or inaccessible, and people who lost coverage reported delaying care and skipping medications because of costs, as well as incurring serious medical debt. In Georgia's newly enacted Pathways to Coverage program, those applying for Medicaid had to demonstrate compliance with work reporting requirements before receiving coverage. In the first year, only 4,231 people enrolled in Medicaid through the program, well below the projected 100,000 enrollees.

We recognize that this legislation attempts to create exemptions for several categories, including patients with serious or complex health conditions. From experience, we know exemptions will not protect patients. Exemptions may not happen automatically, can require complex paperwork, and regular recertifications even for those with a chronic, life-long condition. Individuals risk losing coverage if there are administrative errors, or their application is not completed or processed on time. As a result, eligible individuals who qualify for an exemption can and will be improperly disenrolled.

Work requirements have serious operational challenges that states are ill-prepared to address, especially under the expedited timeline that the House included just hours before the final vote on the bill. States will face enormous administrative costs to track work activities, train staff, and put a system in place to identify and track exemptions. For example, a GAO study of work reporting requirements estimated that the administrative costs for just one state could be up to $272 million.[7] In Georgia, despite dismal enrollment numbers, the state has spent over $86 million within a year of implementing the Georgia Pathways to Coverage Program, and it is estimated that three quarters of this was for administrative and

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[4] M. Guth et al. "Understanding the Intersection of Medicaid & Work: A Look at What the Data Say." KFF: April 24 2023. Available online at: https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-work-a-look-at-what-the-data-say/

[5] S. Giled and D. Ding. "Medicaid Work Requirements Wouldn't Increase Employment and Could Imperil Future Labor Market Participation." Commonwealth Fund: May 24 2023. Available online at: https://www.commonwealthfund.org/blog/2023/medicaid-work-requirements-wouldnt-increase-employment-and-could-imperil-future-labor

[6] C. Hall and E. Hinton. "Supporting Work without the Requirement: State and Managed Care Initiatives." KFF: December 10 2019. Available online at: https://www.kff.org/report-section/supporting-work-without-the-requirement-state-and-managed-care-initiatives-issue-brief/

[7] Medicaid Demonstrations: Actions Needed to Address Weaknesses in Oversight of Costs to Administer Work Requirements. U.S. Government Accountability Office. October 1, 2019. Available at: https://www.gao.gov/products/gao-20-149

consulting costs.[8] The funds provided in this legislation are entirely insufficient for implementation, setting up states for failures that will cost patients their coverage and their health.

Adding Red Tape to the Eligibility and Enrollment Process

The bill blocks implementation of the 2024 eligibility and enrollment rules. Our organizations strongly supported these policies, which focus on reducing red tape and other barriers to enrollment for those eligible for coverage through Medicaid and CHIP.[9] Blocking these rules will make it harder for older adults, people with serious or chronic conditions, and people with disabilities to navigate the Medicaid enrollment process and allow states to reinstate waiting periods, coverage lockouts, and annual and lifetime dollar limits on services for kids in CHIP. These cuts clearly violate promises made to protect vulnerable populations in this legislation.

The Senate Finance text also increases the frequency of eligibility checks for the Medicaid expansion population, again increasing opportunities for administrative errors to remove eligible individuals from coverage. The evidence is clear that shorter redetermination periods cause coverage disruptions for people on Medicaid.[10] Battling administrative red tape in order to keep coverage should not take away from patients' or caregivers' focus on maintaining their or their family's health. This additional bureaucracy will also burden state budgets, increasing churn as people incorrectly lose coverage, reapply and are reinstated. The administrative cost of churn is estimated to be between $400 and $600 per person,[11] yet another additional cost that this legislation puts on cash-strapped states.

Adequacy

Removing Retroactive Coverage

Today, when an individual enrolls in Medicaid, states have the ability to provide retroactive coverage for the three months preceding their successful application. While there are no current retroactive coverage requirements in CHIP, this legislation would limit Medicaid's retroactive coverage period to one month for expansion populations, two months for non-expansion populations, and allow states to provide one month of retroactive coverage in CHIP. Retroactive coverage is a critical protection that prevents delays in treatment for people who are eligible for Medicaid but not yet enrolled. For example, a Medicaid-eligible patient may be diagnosed with cancer in the emergency room. Retroactive eligibility allows that patient to initiate critical, time-sensitive treatment immediately, rather than having to wait until after the state receives and fully processes the patient's Medicaid enrollment.

Reducing retroactive coverage will increase costs for both individuals and states. When Indiana implemented a waiver removing retroactive coverage, Medicaid recipients were responsible for an average of $1,561 in medical costs.[12] And when Ohio considered waiving retroactive eligibility, one estimate suggested that hospitals could accrue as much as $2.5 billion more in uncompensated care as a

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[8] Coker, Margaret. "Georgia Touts its Medicaid Experiment as a Success. The Numbers Tell a Different Story. ProPublica. February 19, 2025. Available at: https://www.propublica.org/article/georgia-medicaid-work-requirement-pathways-to-coverage-hurdles

[9] Health Partner Comments to CMS Re Medicaid Eligibility and Enrollment Rule

[10] Sugar S, Peters C, De Lew N, Sommers B.D., "Medicaid Churning and Continuity of Care: Evidence and Policy *Considerations Before and After the COVID-19 Pandemic." ASPE Office of Health Policy, Department of Health and Human Services, April 2021, https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf*

[11] Swartz, Katherine et al. Reducing Medicaid Churning: Extending Eligibility For Twelve Months or To End of Calendar Year Is Most Effective. Health Affairs July 2015 34:7, 1180-1187 Available at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1204

[12] Healthy Indiana Plan 2.0 CMS Redetermination Letter. July 29, 2016. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf

result of the waiver.[13] Our patients, families, and communities simply cannot afford to take on these additional financial burdens.

Limiting States' Ability to Finance Medicaid Benefits

Unlike the federal government, most states are required to maintain a balanced budget. The Senate bill restricts state's ability to leverage tools like provider taxes and state directed payments, winding them down over time. These financing tools have allowed states to fund Medicaid expansion, increase access to behavioral health and home- and community-based services, and support safety net and rural hospitals. When combined with additional federal Medicaid funding cuts under consideration, states will be forced to cut eligibility or reduce benefits for workers with low incomes, children, seniors, and people with disabilities – the very populations Congress is claiming to protect.

Our organizations are strong supporters of Medicaid expansion. Removing the temporary boost in federal funding for states newly adopting Medicaid expansion, as well as restricting state mechanisms that support state matching funds, will make it more challenging for states to finance coverage for this population. The 1.4 million individuals in the coverage gap cannot afford to wait even longer for quality, affordable healthcare coverage.

The Finance Committee text also punishes states that use their own dollars to provide coverage to certain immigrant populations. Some states will be forced to cut coverage as a result, leaving people without lifesaving care and driving up uncompensated care, burdening healthcare systems and increasing healthcare costs for everyone. For states that do continue coverage, the financial hit will lead to cuts to benefits, provider reimbursements, and other cuts that will make it harder for *all* patients with Medicaid coverage to access the treatments and providers that they need.

Undermining ACA Market Integrity & Patient Access to ACA Coverage

Our organizations are deeply concerned about the Senate's proposals which will profoundly impact the ACA insurance marketplaces and the millions of individuals who rely on them for coverage. The ACA has made it possible for people across the country—including those with preexisting conditions—to access affordable, comprehensive health care. Any changes must preserve and strengthen that progress, not undermine it. Reforms should prioritize expanding coverage to those still uninsured, lowering costs, and advancing health equity, especially for populations that have been historically underserved due to their race, ethnicity, income, geography, gender identity, sexual orientation, disability status, or immigration status. This text fails that test on all of these measures. Instead of promoting affordability, accessibility, and adequacy in health coverage, it threatens to reverse hard-won gains, deepen inequities, and jeopardize access to care for those who need it most.

Affordability

Eliminating Tax Credit Recapture Limits

Today, 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.

[13] Virgil Dickson, "Ohio Medicaid waiver could cost hospitals $2.5 billion", Modern Healthcare, April 22, 2016. Available at: http://www.modernhealthcare.com/article/20160422/NEWS/160429965

Eliminating recapture limits would put these families at risk of large tax liabilities they cannot afford. This is not simply a matter of someone misjudging their income. Life changes—such as job loss, a mid-year raise, a divorce, or the death of a spouse—can suddenly alter a person's eligibility, leaving them responsible for repaying thousands of dollars in tax credits they reasonably believed they qualified for at the time of enrollment. Without recapture limits, low-income enrollees could face repayments so high that they wipe out other essential tax benefits, such as the Earned Income Tax Credit (EITC), undermining their financial stability and ability to meet basic needs.

This happened to a blood cancer patient in Georgia. When she was approved for Medicare in July, she repeatedly spoke to Marketplace and health plan staff to inform them of her transition. But, despite her following the rules, her plan was not canceled: She received a letter in October telling her that she had two federal healthcare plans. Despite attempts by Medicare staff to retroactively cancel her plan and an appeal to CMS to address this issue, she ended up owing approximately $300 in additional taxes.

It is especially irresponsible to consider eliminating these protections while the future of the enhanced ACA premium tax credits remains uncertain. Lifting recapture limits could have devastating consequences, particularly for working families, older adults, and those who experience life changes mid-year.

Accessibility

Tax Credit Lockouts for Individuals Enrolling via Special Enrollment Periods

Provisions included in Finance Committee text would prohibit individuals from receiving advance premium tax credits if they enroll in coverage through a special enrollment period (SEP) associated with their income. This provision further locks low-income individuals out of affordable coverage. People moving out of the "Medicaid gap" due to changes in their income, as well as individuals who have fallen on hard times, will be forced to wait until the next open enrollment to receive affordable coverage.

Congress should not penalize individuals who have incomes that fluctuate due to seasonal work or unsteady work hours. For many millions of Americans, and particularly for those with lower incomes, it is exceedingly hard to accurately project the annual income of their entire household. For millions of people who are self-employed, perform seasonal work, or otherwise provide labor or services on demand, income may vary dramatically over the course of the year in ways that are not necessarily predictable and not within the worker's control. Millions more Americans earn hourly wages but have limited or no input on the number of hours they work. The result, as research demonstrates, is that most low-income workers[14] experience significant instability in work hours and income, with large and often unpredictable swings[15] from one month to the next.[16]

Imposing Additional Barriers to Enrolling in ACA Coverage

Finance Committee text would impose harmful and unnecessary barriers to coverage for the millions of people who rely on the ACA Marketplaces for their health insurance. By requiring all enrollees—both

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[14] Bauer, Lauren et al. *Low-income workers experience –by far—the most earnings and work hours instability*. Brookings. January 9, 2025. Available at: https://www.brookings.edu/articles/low-income-workers-experience-by-far-the-most-earnings-and-work-hours-instability/

[15] JPMorgan Chase&Co Institute. *Weathering Volatility 2.0: A monthly Stress Test to Guide Savings*. October 2019. Available at: https://www.jpmorganchase.com/content/dam/jpmc/jpmorgan-chase-and-co/institute/pdf/institute-volatility-cash-buffer-report.pdf

[16] Hannagan, Anthony and Jonathan Morduch. *Income Gains and Month-to-Month Income Volatility*. NY Wagner Research Paper No. 2659883. September 13, 2015. Available at: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2659883

new and returning—to annually verify their income and eliminating the Exchange's practice of automatic re-enrollment, this provision threatens the stability of coverage for millions of Americans.

If individuals fail to meet this new verification requirement, they would lose access to the ACA's advance premium tax credits and be forced to pay the full cost of their premiums up front—only seeing the savings the following year during tax filing. This change fundamentally alters how the ACA Marketplaces work, making it harder for people to stay covered and placing a significant financial strain on individuals and families, particularly those with limited incomes.

This provision is especially harmful given the reality that many individuals and families who enroll in Marketplace coverage have fluctuating incomes and work multiple jobs, making it difficult—if not impossible—to accurately project their annual income months in advance. Stripping away automatic enrollment would also increase administrative burdens for people who are satisfied with their current plans, resulting in coverage lapses due to paperwork or system barriers. Auto-enrollment is a standard feature in employer-sponsored insurance and has been proven to support sustained coverage.[17] A National Bureau of Economic Research study found that eliminating auto-enrollment reduced insurance enrollment by 33% and disproportionately excluded young, healthy, and low-income individuals. Evidence from Massachusetts' pre-ACA exchange similarly found that auto-reenrolled individuals were healthier and had costs 44% below average, strengthening the risk pool and keeping premiums more stable for everyone.[18]

This sweeping policy change would hit at the same time that this legislation would force millions of people off of Medicaid – contributing significantly to historic coverage losses. Rather than building a smoother transition into Marketplace coverage, this provision would throw up new obstacles, increasing the likelihood that *everyone* who receives coverage through the Marketplaces is substantially more likely to fall through the cracks. For people with serious health conditions, the consequences of losing coverage can be devastating. Congress should reject this dangerous provision.

Restricting Coverage for Legally Present Immigrants

Multiple provisions across the bill would limit benefits and eligibility for various health insurance programs, including Medicare, Medicaid, and the ACA, for lawfully present immigrants, including young people under the Deferred Action for Childhood Arrivals (DACA) policy. Our organizations strongly oppose proposals aimed at limiting the availability of treatment for people who have entered the U.S. legally, have been deemed lawfully present in the U.S., or who have been granted status to remain until their case can be fully adjudicated. Efforts to roll back coverage and strip these individuals of the ability to seek medical treatment and care are antithetical to the mission of our organizations, where we believe everyone should have access to the care they need to treat and manage their disease.

Adequacy

Undermining Silver Loading

The text released by the Senate HELP Committee would fund cost sharing reductions (CSRs). We oppose altering how cost-sharing reduction payments are paid to insurers. The ACA requires issuers to provide

[17] McIntyre, Adrianna, and Mark Shepard. "Automatic Insurance Policies — Important Tools for Preventing Coverage Loss." *The New England Journal of Medicine* 386, no. 5 (February 3, 2022): 408–11. https://doi.org/10.1056/NEJMp2114189.
[18] Shepard, Mark, and Myles Wagner. "Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment." Working Paper. Working Paper Series. National Bureau of Economic Research, December 2022. https://doi.org/10.3386/w30781.

CSRs to qualifying marketplace enrollees (generally, those with household incomes at or below 250 percent of the federal poverty level who select a silver marketplace plan). By statute, the cost to insurers of providing CSRs is to be reimbursed by the federal government. In October 2017, the Administration determined to stop providing CSR reimbursements until such time as funds to cover these costs were specifically appropriated by Congress. In response to the discontinuation of federal funding for CSRs, the vast majority of state insurance departments permitted or directed their issuers to increase premiums for on-marketplace silver plans, a practice generally known as "silver loading."

Reappropriating CSRs would end this practice, causing silver plan premiums to fall. Because advanced premium tax credits (APTCs) are based on the second-lowest cost marketplace silver plan, the value of the premium tax credit would also decrease. The end result for consumers over 250% of the federal poverty level will be less generous APTCs and higher out-of-pocket costs. When combined with other policies impacting the ACA marketplaces in this legislation, the total impact has the potential to seriously destabilize the marketplaces and reduce the buying power of patients and consumers who rely on them for coverage. At a time when pocketbook issues are front and center for the American public, it is unfathomable why Congress would include provisions, including this one, that would further increase costs for American families.

Other Considerations Impacting Patients

While not included in the Finance Committee's publicly released text, our organizations understand that additional provisions impacting patient's ability to seek and receive affordable care are still under consideration. Absent a robust Congressional process, we offer the following for your consideration as you continue to develop this legislative package.

Codifying the Marketplace Integrity and Affordability Proposed Rule

Despite its name, the one-year rule finalized by the administration earlier this month[19] would contribute to the destabilization of the ACA individual insurance markets, undermine the quality of health insurance being sold, and increase costs for patients and consumers who purchase coverage there. Further, codifying the rule would memorialize policy in statute that, by HHS's own estimates in the proposed rule, would terminate coverage for between 725,000 and almost 2 million consumers.[20] CBO similarly confirmed this by estimating that finalizing this rule would increase the number of people without health insurance by 1.8 million.[21]

Members of our coalition provided extensive comments detailing patients' concerns with the impact of the proposed rule on the patients we serve.[22] Multiple provisions included in the proposed rule would erode patients' access to meaningful coverage. This includes elements such as shortening the annual Open Enrollment period that allows consumers to enroll in comprehensive coverage, eliminating and making more complex SEPs for low-income consumers, inappropriately punishing consumers for fraud

[19] Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 12942 (Mar. 19, 2025) https://www.federalregister.gov/documents/2025/03/19/2025-04083/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability.

[20] Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 12942 (Mar. 19, 2025) https://www.federalregister.gov/documents/2025/03/19/2025-04083/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability.

[21] "E&C Reconciliation Recommendations." Congressional Budget Office, May 11, 2025. https://democrats-energycommerce.house.gov/sites/evo-subsites/democrats-energycommerce.house.gov/files/evo-media-document/cbo-emails-re-e%26c-reconcilation-scores-may-11%2C-2025.pdf.

[22] "PPC Program Integrity Comments." Partnership to Protect Coverage, April 11, 2025. https://www.protectcoverage.org/siteFiles/50693/04%2011%2025%20PPC%20Program%20Integrity%20Comments.pdf.

committed by insurance brokers, terminating coverage for DACA recipients, and increasing paperwork burdens on enrollees and states. The rule would additionally place financial penalties and burdens on consumers for no clear benefit. For example, the rule would require low-income enrollees to pay an arbitrary $5 premium unless they fill out paperwork stating their circumstances have not changed. This is clearly contrary to the goal of improving coverage affordability and instead, like many other policies included in the House legislation, would push people out of coverage. Further, the rule undermines the autonomy and flexibility of states to manage and regulate their state-regulated health insurance markets. This rule and, therefore, its enshrinement in legislation clearly violate PPC's principles for health reform, and we oppose them.

Stabilization Funds

We are concerned by reports that policymakers are considering the use of "stabilization funds" in response to the fiscal challenges that stakeholders may face as a result of this legislation. These funds would do nothing to protect the patients we represent, who face coverage losses, care disruptions, higher out-of-pocket costs, and worsening health outcomes as a result of this legislation. Their inclusion will not change our organizations' opposition to these devastating cuts. The solution can and should be much simpler – remove the underlying policies from this legislation.

Revising Matching Rates for New Expansion Enrollments

Our organizations understand that the Senate is also considering policies that would reduce funding for new Medicaid expansion-eligible individuals. Our organizations strongly oppose this measure as it would put yet more downward pressure on state budgets and therefore patient access to coverage. Medicaid expansion has been a critical tool in reducing the number of uninsured. This policy would force states to consider whether or not they can maintain their expansion, potentially jeopardizing the health and wellbeing of millions of people.

Reauthorizing the Enhanced Advanced Premium Tax Credits

Despite instituting expansive reforms to our healthcare system included in this bill, one critically important policy is absent: the reauthorization of the ACA's enhanced advanced premium tax credits (enhanced APTCs). The enhanced APTCs are scheduled to expire by the end of 2025. If Congress fails to act soon, premiums for Marketplace enrollees will skyrocket, forcing some patients and consumers to abandon the high-quality coverage upon which they have come to rely. When the failure to reauthorize the tax credits is combined with other policies included in the House-passed bill text, CBO estimates that more than 16 million Americans will lose coverage.[23]

The drastic change in premium cost could be devastating for the patients and consumers we represent. For example, a family of four making $60,000 (200% of FPL) would see their monthly marketplace premium increase from $100 to $326—an annual increase of about $2,700. A 60-year-old couple making $45,000 (228% of FPL) would see monthly marketplace premiums increase from $117 to $283 — an annual increase of almost $2,000.[24] We urge Congress to act swiftly to reauthorize these important tax credits.

[23] *Estimated Effects on the Number of Uninsured People*, Congressional Budget Office, June 4, 2025, https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf

[24] Center for Budget and Policy Priorities, *Health Insurance Costs Will Rise Deeply If Premium Tax Credit Improvements Expire.* https://www.cbpp.org/research/health/health-insurance-costs-will-rise-steeply-if-premium-tax-credit-improvements-expire

Conclusion

The concerns we have outlined in this letter represent just those that we have been able to address within the short period of time the public has had access to these documents. These programs are literal lifelines for the millions of patients, their families, and survivors who continue to experience the side effects of illness and care. Our organizations, therefore, urge Members of the Senate to oppose this legislation. If you have any questions or would like to discuss our comments further, please contact Katie Berge, Senior Director of Federal Government Affairs at katie.berge@lls.org, and Ashleigh Tharp, Advocacy and Government Affairs Manager at the Cystic Fibrosis Foundation at atharp@cff.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
CancerCare
Coalition for Hemophilia B
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation of America
EveryLife Foundation for Rare Diseases
Foundation for Sarcoidosis Research (FSR)
Hemophilia Federation of America
Hypertrophic Cardiomyopathy Association
Immune Deficiency Foundation
Lupus Foundation of America
Lutheran Services in America
Muscular Dystrophy Association
National Alliance on Mental Illness (NAMI)
National Bleeding Disorders Foundation
National Coalition for Cancer Survivorship
National Health Council
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Sickle Cell Disease Association of America, Inc.
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society
WomenHeart: The National Coalition for Women with Heart Disease
ZERO Prostate Cancer