Documents for the Record

Subcommittee on Health Hearing
Legislative Proposals to Support Patient Access to Medicare Services
January 8, 2026

Majority:

1. January 6, 2026, statement from TridentCare.
2. January 7, 2026, statement from the Neuropathy Action Foundation.
3. January 7, 2026, statement from the International Pemphigus & Pemphigoid Foundation.
4. January 8, 2026, statement from AHIP.
5. January 8, 2026, statement from the Medical Group Management Association.
6. January 7, 2026, statement from the National Coalition for Assistive & Rehab Technology.
7. January 7, 2026, statement from the Oley Foundation.
8. January 8, 2026, statement from the Immunoglobulin National Society.
9. January 7, 2026, statement from the Council for Quality Respiratory Care.
10. January 7, 2026, statement from the American Association for Homecare.
11. January 7, 2026, statement from Spina Bifida Association.
12. January 7, 2026, letter to Chairman Griffith, Ranking Member DeGette, and Members of the Committee from the Academy of Cardiovascular & Pulmonary Physical Therapy, Alpha-1 Foundation, American Academy of Sleep Medicine (AASM), et al.
13. January 8, 2026, statement from the American Lung Association.
14. January 8, 2026, statement from AdvaMed.
15. April 1, 2025, letter to the Honorable Mariannette Miller-Meeks, the Honorable Randy Feenstra, the Honorable Paul Tonko, and the Honorable Jimmy Panetta from Members of the Independence Through Enhancement of Medicare and Medicaid (ITEM) Coalition.
16. January 8, 2026, letter to Chairman Griffith, Ranking Member DeGette, and Members of the Subcommittee from Shane Bare submitted by Rep. Harshbarger.
17. January 8, 2026, statement from the Infusion Access Foundation.
18. November 19, 2025, letter to Senate Majority Leader Thune, Senate Minority Leader Schumer, Speaker of the House Johnson, and House Minority Leader Jeffries from Alliance for Aging Research, Alliance for Patient Access, Alliance for Women's Health and Prevention et al. submitted by Rep. Bilirakis.
19. January 8, 2026, letter to Chairman Griffith and Ranking Member DeGette from Jen Brull, MD, FAAFP, Board Chair of the American Academy of Family Physicians.
20. January 8, 2026, statement from the Connected Health Initiative.
21. January 8, 2026, statement from the American Society of Health-System Pharmacists.

Minority:

1. December 4, 2025, article from the Kaiser Family Foundation entitled "2025 KFF Marketplace Enrollees Survey."
2. January 7, 2026, letter to Speaker Johnson and Leader Jeffries from AARP.

3. September 30, 2025, article from the Kaiser Family Foundation entitled "ACA Marketplace Premium Payments Would More than Double on Average Next Year if Enhanced Premium Tax Credits Expire."
4. January 8, 2026, statement from the American College of Physicians.
5. December 10, 2025, article from American Cancer Society entitled "ACS CAN Urges Congress to Immediately Extend the Enhanced Premium Tax Credits to Avoid a Health Care Affordability Crisis."
6. September 11, 2025, article from the Medicare Rights Center entitled "Congress Must Preserve Access to Affordable Marketplace Coverage."
7. October 15, 2025, article from Medicare Policy Initiative entitled "Damage From Inaction On ACA Tax Credits Has Begun And Will Grow With Further Delays."
8. October 2025, article from Urban Institute entitled "Eligibility Cliff on ACA Tax Credits Would Make Health Care Unaffordable for Middle-Class Families."
9. Fact Sheet from Center for Medicare Advocacy entitled "The Affordable Care Act (ACA) Helps Medicare"
10. July 2025, Fact Sheet from American Hospital Association entitled "Fact Sheet: Enhanced Premium Tax Credits."
11. November 3, 2025, article from the Center on Budget and Policy Priorities entitled "Health Insurance Premium Spikes Imminent as Tax Credit Enhancements Set to Expire."
12. January 7, 2026, letter from the American Federation of State, County and Municipal Employees.
13. December 4, 2025. article from the Center on Budget and Policy Priorities entitled "How to Evaluate Proposals to Address Expiring Premium Tax Credit Enhancements."
14. December 12, 2025, article from AARP entitled "Older Adults Face Spike in Health Insurance Costs as ACA Tax Credits Expire."
15. September 15, 2025, letter to Speaker Johnson, Majority Leader Thune, Minority Leader Schumer, and Leader Jeffries from American Medical Association, Academy of Physicians in Clinical Research, American Academy of Allergy, Asthma & Immunology, et al.
16. July 29, 2025, article from the Center on Budget and Policy Priorities entitled "Marketplace Enrollees Tell Congress: Extend the Enhanced Premium Tax Credits."
17. November 18, 2025, letter to Speaker Johnson, Majority Leader Thune, Minority Leader Schumer, and Minority Leader Jeffries from the National Association of Insurance Commissioners.
18. October 30, 2025, article from Medicare Rights Center entitled "Older Adults at Risk if ACA Subsidies Expire."
19. January 5, 2026, article from the Kaiser Family Foundation entitled "Policy Changes Bring Renewed Focus on High-Deductible Health Plans."
20. December 4, 2025, article from the Kaiser Family Foundation entitled "Poll: 1 in 3 ACA Marketplace Enrollees Say They Would 'Very Likely' Shop for a Cheaper Plan If Their Premium Payments Doubled; 1 in 4 Say They 'Very Likely' Would Go Without Insurance."
21. August 21, 2024, letter to Speaker Johnson, Senate Majority Leader Schumer, Senate Minority Leader McConnell, House Minority Leader Jeffries from Alpha-1 Foundation, ALS Association, American Cancer Society Cancer Action Network, et al.

22. December 11, 2025, letter to Senators Blunt Rochester, Blackburn, and Representatives Matsui, Bilirakis, DelBene, Malliotakis, and Craig from the National Council on Aging.
23. November 5, 2025, article from Families USA entitled "The Importance of Premium Tax Credits: Affording Health Insurance Coast to Coast."

TridentCare℠

January 6, 2026

The Honorable Brett Guthrie
Chairman
House Energy & Commerce Committee

The Honorable Frank Pallone
Ranking Member
House Energy & Commerce Committee

The Honorable Morgan Griffith
Chairman
Subcommittee on Health

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health

Dear Chairman Guthrie, Ranking Member Pallone, Chairman Griffith, and Ranking Member DeGette:

On behalf of TridentCare, its [300] sonographers, and more than 1.5 million seniors we serve each year, I write today to request your support for the Portable Ultrasound Reimbursement Equity (PURE) Act (H.R. 2477). The PURE Act would allow TridentCare and other portable imaging providers to sustainably perform ultrasound services; expand patient access to ultrasounds, particularly in rural and underserved communities; and reduce overall health care costs. We greatly appreciate the inclusion of the PURE Act in Thursday's legislative hearing and encourage the committee to advance it.

TridentCare is the largest portable x-ray and ultrasound provider in the country with operations in 35 states. Every year, we perform imaging services for more than one and a half million patients in nursing homes and assisted living facilities, many of whom are bedridden or live with dementia. While Medicare currently provides state-specific transportation rates for portable x-ray, portable ultrasound is not eligible for transportation reimbursement, and this limits our ability to respond to calls from nursing homes, perform the service in the evenings and on weekends, and limits our service area.

TridentCare launched its portable ultrasound service in 2010 in response to requests from nursing homes and skilled nursing facilities. Ultrasound imaging provides a non-invasive examination of how a patient's internal organs are functioning, helps physicians assess patients before and after surgery, and assists physicians in determining the appropriate course of care. Seniors rely on high-quality ultrasounds for diagnosing heart conditions, respiratory illnesses, abdominal pain, and other ailments.

Notably, portable ultrasound services are performed at the patient's bedside. Under the direction and order of a physician, nursing homes contact portable imaging providers, such as TridentCare, to dispatch a sonographer to perform the ultrasound. Sonographers receive specific training and are certified in their respective states to perform the service. The service is patient-friendly and convenient for seniors, as they do not need to travel in an ambulance to another facility to have the ultrasound performed. From the time the order is placed by the physician, the average time for the physician to receive the results is 3-4 hours.

Since TridentCare started offering portable ultrasound services, there has been a significant improvement in the quality of the imaging equipment and the ability to transmit the information in real time. The COVID pandemic also contributed to the growing demand for portable ultrasound services, especially for communities experiencing workforce challenges and reduced

TridentCare℠

access due to hospital and nursing home closures. Unfortunately, Medicare has not been updated to reflect these realities, and the PURE Act aims to fill these gaps in care.

The PURE Act would provide the same transportation rates available for portable x-ray to portable ultrasound. The transportation rates comprise approximately [60%] of our costs for x-ray and allow TridentCare to provide the service 24 hours a day, 7 days a week, 365 days a year. We are also able to perform x-rays to a broad service area, particularly important for rural and underserved communities, due to the transportation rates. In contrast, portable ultrasound hours and service areas are currently limited in order for us to sustainably provide the service. The PURE Act would significantly address these limitations, allowing us to expand the availability of portable ultrasound.

Thank you for the consideration of the PURE Act, for raising awareness on the need for greater patient access to portable imaging services, and for your commitment to improving seniors' access to care. We look forward to working with you to advance the PURE Act.

Sincerely,

Daniel Buning
Chief Executive Officer
TridentCare

Neuropathy Action Foundation
Awareness • Education • Empowerment

January 7, 2026

The Honorable Morgan Griffith
Chairman, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Griffith and Ranking Member DeGette:

On behalf of the Neuropathy Action Foundation (NAF), thank you for the opportunity to submit this statement for the record for the Subcommittee's January 8, 2026 legislative hearing on "Legislative Proposals to Support Patient Access to Medicare Services" in support of the Preserving Patient Access to Home Infusion Act (H.R. 2172)

NAF represents individuals living with neuropathy and related neurological conditions, many of whom experience chronic pain, numbness, weakness, impaired balance, and fatigue that make routine travel difficult and, at times, unsafe. For some patients with immune-mediated neuropathies and other complex neurologic disorders, infusion therapy can be an important part of treatment and long-term disease management. When home infusion is clinically appropriate, it can mean the difference between staying connected to daily life and being forced into repeated facility visits that exacerbate symptoms and create avoidable barriers to adherence.

From the patient perspective, the site of care is not simply a preference—it is access. Frequent trips to an infusion center can require significant caregiver support, time away from work, and transportation arrangements that are especially burdensome for seniors and people with mobility limitations. For patients with neuropathy, even short travel can carry real risk, including falls and symptom flare-ups. In contrast, receiving therapy at home when appropriate can reduce physical strain and improve the ability to complete therapy as prescribed.

Yet Medicare's current home infusion benefit has not translated into dependable access for many beneficiaries. As a practical matter, the benefit's structure can leave patients without a workable home-based option, even when their clinician believes home infusion is safe and appropriate. When the home option breaks down, patients may be pushed into higher-cost settings or face delays that can worsen outcomes and increase overall burden on patients and families.

Neuropathy Action Foundation
Awareness • Education • Empowerment

H.R. 2172 would modernize Medicare's home infusion benefit in a targeted way that supports real-world delivery of home infusion care, strengthens provider participation, and expands access to commonly needed IV anti-infective therapies. For NAF's community, these improvements would help ensure that beneficiaries are not steered into facility-based care because Medicare policy is out of step with how home infusion services are provided and supported.

NAF respectfully urges the Subcommittee to advance H.R. 2172. Thank you for your attention to policies that improve Medicare beneficiary access to medically necessary therapy while supporting safe, patient-centered care. Please do not hesitate to contact us if we can provide additional information or patient perspective.

Thank you for your consideration. Please do not hesitate to contact us with any questions.

Sincerely,

Dominick V. Spatafora
President

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January 7, 2026

The Honorable Morgan Griffith
Chairman, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Griffith, Ranking Member DeGette, and Members of the Subcommittee:

The International Pemphigus & Pemphigoid Foundation (IPPF) writes to urge the Subcommittee to advance H.R. 2172, the Preserving Patient Access to Home Infusion Act. The IPPF's core objective is to provide patients and doctors worldwide with information about pemphigus and pemphigoid, and we represent individuals and families living with these rare autoimmune blistering diseases.

Pemphigus is a group of potentially life-threatening disorders characterized by blisters in the mucous membranes and skin, and patients may develop mucosal erosions and/or blisters and erosions that can be extensive. Pemphigoid is a group of subepidermal, blistering autoimmune diseases that primarily affect the skin and can persist for months or years with periods of exacerbation and remission; in mucous membrane pemphigoid, scar formation can lead to major disability. For many people living with pemphigus or pemphigoid, access to the right therapy—and the ability to receive that therapy in a feasible setting—is not a matter of convenience. It is the difference between maintaining stability at home and being pushed into repeated facility-based care.

Infused therapies are a central part of treatment for many patients in our community. Intravenous immunoglobulin (IVIG) is one such therapy used by many pemphigus and pemphigoid patients, often in conjunction with immunosuppressant medication to control disease. To treat pemphigus, IVIG dosing can be as high as 2000 mg/kg, and because doses are high, infusions may be administered over up to five days; for some, this can become a long-term commitment. When therapy can require multi-day infusions, the practical implications of site of care become obvious: repeated trips to a facility over consecutive days can be extraordinarily burdensome for patients already dealing with severe skin and/or mucosal involvement and complex medical needs.

Home infusion, when clinically appropriate and properly supported, can help make adherence possible and reduce disruption for patients and caregivers. The IPPF has long highlighted that Medicare beneficiaries can face significant obstacles to receiving IVIG at home, and that obtaining IVIG home infusions under Medicare can be complicated. The IPPF also notes that IVIG can be given by home infusion if insurance approves that form of therapy.

The Preserving Patient Access to Home Infusion Act addresses this real-world access problem by modernizing Medicare's home infusion benefit so it functions as a workable option—aligning payment with the professional services required to support home infusion across infusion days, including services

furnished remotely or outside the home. The bill also expands coverage to include all IV anti-infective drugs, helping beneficiaries complete needed therapy at home when clinically appropriate rather than defaulting into higher-intensity settings.

For patients living with pemphigus and pemphigoid, these changes matter because they support continuity of care and make home-based treatment a realistic option when clinicians and patients determine it is appropriate and safe. The IPPF respectfully urges the Subcommittee to advance the Preserving Patient Access to Home Infusion Act.

Sincerely,

Marc Yale
IPPF Research and Policy Advisor
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Statement for Hearing on
"Legislative Proposals to Support Patient Access to Medicare Services"

Energy and Commerce Committee
Subcommittee on Health

January 8, 2026

AHIP is the national trade association representing the health insurance industry. AHIP's members provide health care coverage, services, and solutions to more than 200 million Americans through public programs such as Medicare and Medicaid, employer-sponsored insurance, and the individual insurance market.

AHIP appreciates the Subcommittee on Health's commitment to examining Medicare policies that directly affect seniors' access to care. Medicare Advantage (MA) strengthens access to care in Medicare by integrating benefits that incentivize coordinated, team-based care for the 35 million seniors and people with disabilities who choose the program. AHIP strongly believes that thoughtful updates to Medicare payment structures can enhance access, reduce administrative burden, and improve affordability and quality for Medicare beneficiaries.

The Centers for Medicare & Medicaid Services (CMS) is currently considering updates for plan year 2027 for the annual Rate Notice. Particularly as medical costs steadily rise, AHIP urges policymakers to strengthen and protect MA as a critical choice for the 35 million Americans who choose it because it delivers better services, better access to care, and better value than FFS Medicare.

MA delivers comprehensive benefits, significant cost savings, improved health outcomes, high-quality care, and robust chronic condition management. Simply put, a growing majority of seniors choose MA because it provides better and more coordinated care, better outcomes, and increased savings and financial security compared to fee-for-service (FFS) Medicare. In addition, MA offers comprehensive benefits – including prescription drugs, vision, hearing, dental, and wellness – while capping out-of-pocket costs, driving savings, and promoting prevention. MA delivers better outcomes, higher-quality care, and enhanced chronic condition management, with fewer hospitalizations and average annual savings of over $3,400 on out-of-pocket costs and premiums compared to FFS.[1, 2]

MA supplemental benefits support beneficiaries' overall health. MA plans enhance chronic disease management through care coordination programs and supplemental benefit offerings that enable proactive, personalized treatment for high-need populations, such as in-home services and disease-specific interventions. Benefits such as transportation to medical appointments, over-the-counter medications, and nutrition assistance also enable beneficiaries to better manage or even prevent chronic conditions. However, funding cuts in recent years have threatened seniors'

access to these vital benefits that help overcome health barriers and prevent costly complications.[3]

- AHIP has concerns with legislation that would create an entirely new data reporting requirement for CMS and plans on supplemental benefits. We support transparency on supplemental benefits. CMS has the authority and already collects robust data from MA plans on their supplemental benefit offerings through annual Part C reporting, encounter data, and medical loss ratio reporting. Requiring CMS to establish plans to set up new systems for additional reporting through duplicative systems could adversely impact supplemental benefit offerings by increasing unnecessary costs.

MA serves vulnerable populations. MA delivers high-quality, affordable health coverage to beneficiaries and to those with complex health needs. Data from CMS also show that MA covers a population that is lower income, more diverse, and more complex compared to FFS.[4] Black and Hispanic seniors disproportionately choose MA, as do a growing number of seniors in rural areas.[5] These data show that MA plans continue to be a vital source of coverage for low-income Medicare enrollees, diverse communities, and vulnerable populations.

Protect benefits and strengthen investment in MA. Millions of seniors and individuals with disabilities are facing fewer coverage options and increased costs in 2026. Additionally, 95% of MA beneficiaries report high rates of health care satisfaction and access to care.[6] To keep pace with rapidly increasing utilization and medical spending, AHIP urges the Subcommittee to prioritize policies that strengthen MA for those who rely on it, and take care to avoid policies that would result in benefit cuts or cost increases for MA beneficiaries.

MA delivers high-quality care at a lower cost than FFS. Seniors and individuals with disabilities who choose MA save more than $3,400 a year on out-of-pocket costs and premiums compared with those enrolled in FFS Medicare.[7] AHIP encourages the Subcommittee to pursue policies that provide MA plans with flexibilities to promote high-value care and limit low-value care, increasing the efficiency of the program.

In an apples-to-apples comparison, MA outperforms FFS Medicare. A recent study from Wakely finds that FFS Medicare costs would be 9.8% higher if FFS beneficiaries were required to be enrolled in both Part A and Part B, and if FFS Medicare were required to provide a maximum out-of-pocket limit – both of which are required under MA.[8]

- Policymakers need accurate data and sound analyses when considering policy changes affecting the 35 million seniors who choose MA. As such, AHIP urges the Subcommittee to consider proposals, like H.R. 4093 - the *Apples-to-Apples Comparison Act*, that would guarantee the use of accurate data and methodology in the government's comparisons of the MA and FFS programs.[9]

Health plans are taking action to improve MA through simplifying prior authorization. Health insurance plans have announced a series of commitments to streamline, simplify and reduce prior authorization – a critical safeguard to ensure their members' care is safe, effective, evidence-based and affordable. Building on health plans' existing efforts, these new actions are focused on connecting patients more quickly to the care they need while minimizing administrative burdens on providers. These commitments are being implemented across

insurance markets, including for those with MA, Commercial coverage, and Medicaid managed care consistent with state and federal regulations, and will benefit nearly 270 million Americans.[10] AHIP looks forward to working with the Subcommittee and sharing progress on health plans' commitment to improve prior authorization this spring.[11]

Conclusion

AHIP appreciates the Subcommittee's focus on examining policies that impact access to care for Medicare beneficiaries. AHIP remains committed to working collaboratively to strengthen MA, protect access to comprehensive benefits, and ensure affordability while maintaining program sustainability. By supporting policies that stabilize and strengthen MA in a time of increasing medical costs, plans can continue to deliver high-quality, coordinated care that improves health outcomes and lowers costs for seniors and taxpayers alike.

[1] https://www.ahip.org/news/articles/new-analysis-shows-medicare-advantage-outperforms-fee-for-service-medicare-in-improving-patient-outcomes-delivering-care-at-a-lower-cost
[2] https://bettermedicarealliance.org/news/medicare-advantage-beneficiaries-spend-nearly-3500-less-per-year-than-fee-for-service-beneficiaries-on-out-of-pocket-health-care-costs/
[3] https://bettermedicarealliance.org/publication/analysis-of-the-2025-medicare-advantage-plan-landscape/
[4] https://www.ahip.org/resources/medicare-advantage-demographics
[5] https://www.ahip.org/resources/medicare-advantage-demographics
[6] https://bettermedicarealliance.org/publication/state-of-medicare-advantage-2025/
[7] https://bettermedicarealliance.org/medicare-advantage/about-medicare-advantage/
[8] https://www.ahip.org/news/articles/in-apples-to-apples-comparison-the-facts-are-clear-medicare-advantage-outperforms-fee-for-service-medicare
[9] https://www.congress.gov/bill/119th-congress/house-bill/4093
[10] https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization
[11] 2026 Will Bring Progress on Simplifying Prior Authorization - AHIP

January 8, 2026

The Honorable Morgan Griffith
Chairman
Committee on Energy and Commerce, Subcommittee on Health
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
Committee on Energy and Commerce, Subcommittee on Health
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Griffith and Ranking Member DeGette,

The Medical Group Management Association (MGMA) thanks you for holding today's legislative hearing, "Legislative Proposals to Support Patient Access to Medicare Services," to focus on modernizing and strengthening the Medicare program to sustain and enhance seniors' access to care. With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical group practices ranging from small private medical practices to large national health systems, representing more than 350,000 physicians.

We appreciate the Subcommittee's inclusion of H.R. 5269, *the Reforming and Enhancing Sustainable Updates to Laboratory Testing Services (RESULTS) Act of 2025*, in today's hearing. Physician practice laboratories play a critical role in patient care by enabling same-day testing and rapid clinical decision making, which can prevent hospitalizations, reduce costs, and improve outcomes, especially for elderly and rural patients who face barriers to accessing laboratories. For years, MGMA has advocated for improvements to Medicare's payment system for clinical diagnostic laboratory services to ensure seniors maintain access to essential tests. The RESULTS Act addresses long-standing issues stemming from the Protecting Access to Medicare Act (PAMA) of 2014. While PAMA aimed to align Medicare lab payments with commercial market rates, flaws in its data collection process led to deeper-than-expected cuts, straining laboratories nationwide. Without congressional action, another reduction of up to 15% will take effect on February 1, 2026. The RESULTS Act would strengthen the data used to set sustainable rates under the Medicare Clinical Laboratory Fee Schedule, protecting access to testing and supporting laboratory infrastructure and innovation.

MGMA looks forward to working with the Subcommittee to support legislation that will help improve patient access to Medicare services, including the RESULTS Act. Ongoing reimbursement cuts have made it increasingly difficult for physician-owned and in-office labs to maintain adequate staffing, invest in new testing capabilities, and offer timely diagnostic services that are integral to patient care. Enacting

the RESULTS Act will help ensure that these practices can continue to deliver efficient, high-quality lab testing and avoid disruptions that could delay diagnoses and treatment for America's seniors. If you have any questions, please contact Hannah Grow, Associate Director of Government Affairs, at hgrow@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs

National Coalition For Assistive & Rehab Technology

January 7, 2026

The Honorable Morgan Griffith
Chairman, Subcommittee on Health
Committee on Energy and Commerce
Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member, Subcommittee on Health
Committee on Energy and

U.S. House of Representatives
Washington, DC 20515

Dear Chairman Griffith, Ranking Member DeGette, and Members of the Subcommittee:

On behalf of the National Coalition for Assistive & Rehab Technology (NCART), we write regarding the Health Subcommittee hearing to express support for H.R. 1703, the Choices for Increased Mobility Act of 2025. We thank the Subcommittee for focusing on policies that affect access to complex rehab technology (CRT) for individuals with disabilities.

NCART is a national trade association representing suppliers and manufacturers of CRT, including manual and power wheelchairs, seating systems, and associated accessories. Our members deliver custom, specialized mobility devices that enable individuals with disabilities to maximize independence, participate in daily activities, and live safely at home and in their communities. Access to appropriate technology is critical to meet each person's functional and clinical needs.

A change in Medicare policy by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) in December 2016 now limits beneficiaries' ability to select upgrade wheelchair materials like titanium and carbon fiber, despite the significant benefits these options can provide, including reduced weight, improved durability, and decreased risk of secondary injuries. Under current rules, Medicare beneficiaries must fully pay out of pocket for the wheelchair and wait to be partially reimbursed, creating up-front financial barriers and limiting access to equipment that could substantially enhance mobility and quality of life.

H.R. 1703 addresses this issue, providing two new wheelchair codes and enabling upgrades within a code to restore beneficiary choice without increasing spending for the Medicare program. This policy facilitates access to lighter, more durable wheelchairs using titanium and carbon fiber technology, supporting independence, reducing injury risk, and helping CRT providers deliver equipment tailored to each individual's needs.

NCART respectfully requests the Subcommittee to support H.R. 1703 to help ensure Medicare beneficiaries have meaningful access to the devices that best meet their individual needs. Thank you for your consideration and leadership on this important issue.

Sincerely,

Wayne Grau

Wayne Grau
Executive Director, NCART

The Honorable Morgan Griffith
Chairman, Subcommittee on Health
Committee on Energy and Commerce

U.S. House of Representatives
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member, Subcommittee on Health
Committee on Energy and Commerce

U.S. House of Representatives
Washington, DC 20515

Dear Chairman Griffith, Ranking Member DeGette, and Members of the Subcommittee:

The Oley Foundation respectfully submits this statement for the record in support of H.R. 2172, the *Preserving Patient Access to Home Infusion Act*. The Oley Foundation is available to serve as a resource to the Subcommittee and would welcome the opportunity to share patient perspectives directly, if helpful, as you consider this legislation.

The Oley Foundation is a national patient nonprofit and advocacy organization serving individuals who depend on home IV nutrition, home IV hydration, and tube feeding, often for years or for life. We represent patients for whom home-based therapy is neither optional nor transitional. It is the only clinically appropriate setting that allows sustained, life-preserving treatment while maintaining safety, stability, and quality of life outside of an inpatient environment.

For the population Oley serves, home is not a matter of convenience or preference. These are among the most medically complex patients, often stable enough to live outside the hospital, yet too clinically dependent to forgo continuous therapy and professional oversight. Disruption of home infusion services does not simply cause inconvenience; it places patients at risk of serious complications, forces avoidable hospitalization, or results in life-threatening interruptions in care. For patients without viable alternatives, access to well-supported home infusion is the difference between living in the community and being compelled to live in the hospital.

Unfortunately, some current Medicare policy too often creates unintended barriers that make home-based care more difficult to access than higher-intensity settings, even when clinicians agree home is safer and more appropriate. Oley patients and caregivers frequently encounter coverage limitations late in the hospital discharge process, after plans for home-based treatment are already established. When coverage gaps emerge at this critical juncture, patients face delayed therapy, prolonged hospitalizations, or repeated outpatient visits, not because home care is unsafe or ineffective, but because Medicare's structure does not fully support it, at a moment when patients are most clinically vulnerable.

Safe home infusion depends on more than the delivery of medication. Patients rely on a coordinated ecosystem that includes trained clinicians, reliable supply access, clinical monitoring, caregiver support, and responsiveness to complications that often arise between visits. Much of this work is ongoing, clinically necessary, and invisible within existing payment models. When professional services are under-resourced or insufficiently supported, patients bear the consequences in the form of instability, emergency care, and preventable harm, outcomes that undermine both patient safety and system efficiency. We fall through the cracks unseen.

H.R. 2172 represents an important and practical step toward aligning Medicare policy with the reality of long-term, home-based infusion care. By modernizing payment for home infusion professional services to reflect the continuous nature of supporting therapy across infusion days, including services furnished remotely, the bill strengthens the viability of home infusion as a safe and sustainable option for Medicare beneficiaries.

The Oley Foundation stands at the intersection of patient access and patient safety, and we view the *Preserving Patient Access to Home Infusion Act* as advancing both. We urge the Subcommittee to support and advance this legislation and thank you for your attention to policies that protect Medicare beneficiaries with complex, long-term medical needs who depend on safe, reliable care at home.

Respectfully submitted,

Beth Gore, PhD
CEO and mother to child on IV nutrition for decades
The Oley Foundation www.oley.org

January 8, 2026

The Honorable Morgan Griffith
Chairman, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Griffith and Ranking Member DeGette:

The Immunoglobulin National Society (IgNS) appreciates the opportunity to submit this statement for the record in support of the Preserving Patient Access to Home Infusion Act.

IgNS is a professional organization dedicated to advancing immunoglobulin (Ig) therapy practice across clinical indications and care settings. Our mission includes developing and sustaining evidence-based Ig Therapy Standards of Practice, providing multi-disciplinary education, supporting best practice through professional certification, and promoting patient-centric initiatives. Our membership includes the clinicians and pharmacy professionals who plan, deliver, and monitor Ig therapy in hospitals, outpatient sites, and the home.

For most patients, Ig therapy is a lifesaving and lifelong treatment. Some patients receive Ig replacement therapy to support immune function; others receive Ig for immunomodulatory purposes as part of a clinician-directed plan of care. In both cases, continuity matters. Delays, missed doses, or disruptions can lead to clinical deterioration, end-organ damage, irreversible loss of function, avoidable complications, and unnecessary use of higher-intensity settings.

Home-based administration is a safe, effective option for appropriate patients when supported by trained clinicians, robust protocols, and consistent monitoring. The work that makes Ig therapy safe in the home extends beyond the moment of administration. It includes patient selection, infusion planning, education, risk mitigation, adverse reaction preparedness and management, communication with prescribers, and ongoing clinical oversight across infusion days. Those services often occur between visits and outside the patient's home, and they are central to patient safety and adherence.

The Preserving Patient Access to Home Infusion Act helps align Medicare policy with how infusion care is delivered in practice. By modernizing the Medicare home infusion benefit to better reflect the professional services required across infusion days, including services furnished remotely or outside the home, the bill supports provider participation and strengthens beneficiary access to clinically appropriate home infusion. The bill's expansion of coverage to include all IV anti-infective drugs also improves the feasibility of discharging Medicare patients home with needed therapy, reducing reliance on facility-based defaults driven by logistics rather than clinical need.

IgNS supports advancing the Preserving Patient Access to Home Infusion Act and appreciates the Subcommittee's attention to practical Medicare improvements that strengthen access while reinforcing safe, evidence-based care.

Sincerely,

Luba Sobolevsky, PharmD, IgCP®
President | CEO
Immunoglobulin National Society

Amy E. Clarke, DNP RN IgCN®
Chief Clinical Officer
Immunoglobulin National Society

January 7, 2026

The Honorable Brett Guthrie
Chairman
Committee on Energy & Commerce
2323 Rayburn House Office Building
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Committee on Energy & Commerce
2322A Rayburn House Office Building
Washington, DC 20515

The Honorable Morgan Griffith
Chairman
Subcommittee on Health
Committee on Energy & Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
Committee on Energy & Commerce
2322A Rayburn House Office Building
Washington, DC 20515

Dear Chairman Guthrie, Ranking Member Pallone, Chairman Griffith, and Ranking Member DeGette,

The Council for Quality Respiratory Care (CQRC) commends the Health Subcommittee of the Committee on Energy and Commerce for holding the January 8 hearing entitled Improving Medicare Payment Policies for Seniors. We are pleased that Members will consider H.R. 2902, the Supplemental Oxygen Access Reform (SOAR) Act, which Reps. David Valadao, Julia Brownley, Adrian Smith, and Gabe Evans introduced earlier this Congress. This effort is led by a strong coalition of patients and their advocates, physicians, respiratory therapists, and suppliers. The SOAR Act would reform the Medicare supplemental oxygen benefit to eliminate access barriers patients who require supplemental oxygen face under current policies. The SOAR Act seeks to reform the Medicare Supplemental Oxygen benefit in three major ways:

- Protecting against fraud and abuse, which includes establishing strong patient protections;
- Creating a stable Medicare reimbursement rate to ensure access to the proper oxygen modalities for patients and promote innovation in therapy options; and
- Recognizing the importance of respiratory therapy services in the delivery of high quality care.

In 2025, more than 30 health and medical organizations sent a letter to Congress urging Members to support the SOAR Act. Read the full letter here. As the Committee considers legislation to incentivize access to innovation in the Medicare program, we urge Members to take up the SOAR Act and ensure its inclusion in the next health care package to receive consideration by the full House.

The CQRC is a coalition of the nation's six leading supplemental oxygen and sleep therapy suppliers and manufacturing companies. Together we provide in-home patient services and respiratory equipment to more than 600,000 of the more than one million Medicare patients who rely upon home oxygen therapy to maintain their independence and enhance their quality of life. Similarly, we provide homecare services, equipment and supplies to more than one million Medicare patients with Obstructive Sleep Apnea (OSA).

I. The SOAR Act Supports Innovation by Locking in the Savings from Medicare's Competitive Bidding Program and Addressing Chronic Underfunding for Liquid Oxygen

Under current law, existing federal policies often undercut the ability of patients to access the medically necessary treatments their doctors prescribe, creating care barriers for individuals facing severe asthma, pneumonia, sleep apnea, chronic obstructive pulmonary disease (COPD), and cystic fibrosis. The SOAR Act addresses the challenges faced by Americans living with serious respiratory and pulmonary conditions by stabilizing the reimbursement rates for supplemental oxygen. It locks in savings achieved in previous rounds of Medicare's competitive bidding program (CBP) by removing supplemental oxygen from future rounds of CBP. In addition to protecting patient access, stable rates mean that researchers and innovators are more likely to invest in the develop of innovative treatment options. Unlike patients with other chronic diseases, those that require supplemental oxygen have seen very little innovation during the past 25 years.

Unfortunately, previous rounds of competitive bidding have resulted in reimbursement rates that no longer support patient access to liquid oxygen. For patients with diseases such as cystic fibrosis, pulmonary fibrosis, or those in need of a lung transplant, liquid oxygen is their lifeline. The SOAR Act provides CMS with the authority it needs to evaluate the cost of providing liquid oxygen and establish a separate payment rate that acknowledges the higher cost of providing liquid oxygen. The American Thoracic Society (ATS) published that patients are unable to access liquid oxygen and patients relying upon other modalities of supplemental oxygen also experience access issues.[1] CMS claims data shows a 77 percent reduction in claims for portable liquid oxygen and a 80 percent reduction in claims for stationary liquid oxygen when there has been no new treatment option available and an actual increase in the conditions for which physicians prescribe liquid oxygen. From 2017 to 2025, CMS claims files show that the number of Medicare beneficiaries accessing portable liquid oxygen fell from 13,157 to 2,989 patients. During the same time period, the number of Medicare beneficiaries accessing stationary liquid oxygen equipment fell from 8,464 to 1,620 patients.[2] The policy changes

[1]Jacobs SS, Lindell KO, Collins EG, Garvey CM, Hernandez C, McLaughlin S, Schneidman AM, Meek PM. Patient Perceptions of the Adequacy of Supplemental Oxygen Therapy. Results of the American Thoracic Society Nursing Assembly Oxygen Working Group Survey. Ann Am Thorac Soc. 2018 Jan;15(1):24-32. doi: 10.1513/AnnalsATS.201703-209OC. PMID: 29048941.
[2]HMA. "Analysis of CMS Claims for Stationary and Portable Supplemental Oxygen." (2025).

implemented in the SOAR Act will allow more beneficiaries who require supplemental oxygen to access to liquid oxygen therapy both in their home and communities.

In December, CMS finalized the CY 2026 DMEPOS Competitive Bidding rule, notably excluding supplemental oxygen and CPAP devices and supplies from the next round. CQRC publicly commends the agency for this decision, eliminating the risk disrupting access for the approximately 1.5 million Americans who rely on home oxygen and respiratory therapy. In short, CMS has acknowledged that there is no more value to extract from competitive bidding for oxygen without harming patients.

Passage of the SOAR Act remains vital, despite the recent final rule. While oxygen delivered in tanks will continue to be reimbursed at current CBA rates—updated annually by CPI-U, with blended protections for rural areas, CMS lacks the authority to address longstanding underpayment for liquid oxygen, which remains essential for higher-acuity patients and many rural beneficiaries. This is a problem the agency simply has not been able to fix on its own. Moreover, because patients' supplemental oxygen needs change over time, particularly for people with COPD and other progressive lung diseases, many patients begin on one modality and later require higher oxygen flow rates. It is important to stabilize all supplemental oxygen modalities to sustain and enhance senior's access to supplemental oxygen at home and in their communities.

II. The SOAR Act Would Establish Innovative Strategies to Eliminate Fraud and Abuse

Historically the Medicare program has focused on paper physician medical record notes as the primary oversight tool. Yet, data from the Medicare contractors enforcing these rules consistently demonstrate that the medical records often lack the "magic words" contractors want physicians to write. The SOAR Act would use technology to make it easier for CMS to prevent fraudulent or abusive claims by requiring Medicare contractors to adopt electronic data elements (*i.e.,* a template) that CMS already has created. Adopting an electronic process in lieu of using physician's chart notes would provide for much needed clarity and accuracy in the review process. The SOAR Act would also establish specific supplier responsibilities to support and protect patients.

III. The SOAR Act Recognizes the Importance of Respiratory Therapy Services

To protect access to care delivered by respiratory therapists and help patients afford and access these essential services, the SOAR Act establishes an add-on payment for respiratory therapy services to the supplemental oxygen rate, including the blended rates for rural and other non-urban areas.

IV. Conclusion

The CQRC looks forward to working with the Committee, patient advocates, health care professionals, and supplemental oxygen stakeholders to further advance this legislation in 2026. Please do not hesitate to reach out to me if you have any questions.

Sincerely,

The Council for Quality Respiratory Care
Adapt Health
Apria
Lincare
Philips
ResMed
Rotech Healthcare, Inc.

AAHOMECARE
American Association for Homecare

January 7, 2026

The Honorable Morgan Griffith
Chairman, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Griffith, Ranking Member DeGette, and Members of the Subcommittee:

The American Association for Homecare (AAHomecare) appreciates the opportunity to submit this statement for the record in support of H.R. 2172, the Preserving Patient Access to Home Infusion Act.

AAHomecare represents the home medical equipment and medical supplies community—including the local providers and manufacturers that ensure patients can safely receive care in the home. For medically complex Medicare beneficiaries, the ability to complete therapy at home often depends on whether the full "care-at-home" infrastructure is available and operational: timely discharge coordination, reliable delivery of equipment and supplies, patient and caregiver education, and ongoing support to keep treatment on track.

From our members' perspective, home infusion is a clear example of where policy design determines whether "access" is real. When Medicare coverage is structured in a way that is difficult to operationalize—particularly for high-frequency therapies—patients can be pushed toward higher-cost facility settings because those settings are simply easier to navigate administratively. That is not a patient-centered outcome, and it is not an efficient outcome for the Medicare program.

H.R. 2172 addresses the practical barriers that have limited the Medicare home infusion benefit's reach. The bill modernizes the benefit so it aligns more closely with how home infusion is supported across infusion days, including necessary services that occur outside the patient's home and between visits. It expands access to IV anti-infective therapies, which are among the most common scenarios where a workable home option can prevent avoidable facility utilization and reduce burdens on beneficiaries and caregivers. The bill also streamlines payment by bundling disposable supplies into the services payment and includes a transition period that gives stakeholders predictability to implement operational changes.

For the home medical equipment and supplies community, predictability and workable benefit design are essential for maintaining inventory, staffing, compliance infrastructure, delivery capacity, and responsive support systems that patients and prescribers rely on when care shifts to

the home. When Medicare policy supports a stable, workable model, suppliers can help ensure beneficiaries receive needed therapy at home when clinically appropriate—rather than defaulting into facility care because the home option is structurally out of reach.

AAHomecare respectfully urges the Subcommittee to advance H.R. 2172 as a targeted, practical improvement that strengthens Medicare beneficiary access to home infusion therapy and supports fiscally responsible site-of-care decisions.

Sincerely,

Tom Ryan
President & CEO
American Association for Homecare

SPINA BIFIDA ASSOCIATION

January 7, 2026

The Honorable Morgan Griffith
Chairman, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Griffith, Ranking Member DeGette, and Members of the Subcommittee:

On behalf of the Spina Bifida Association, we appreciate the opportunity to follow up after the recent Health Subcommittee hearing to underscore the importance of H.R. 1703, the Choices for Increased Mobility Act. We thank the Subcommittee for its attention to policies that impact people with spina bifida and other mobility-related disabilities.

The Spina Bifida Association is a national consumer advocacy association representing people living with spina bifida. For many in our community, wheelchairs are used daily and often from an early age. The durability, weight, and performance of a chair can have lasting consequences for physical health, functional ability, and independence.

For people with spina bifida, protecting upper limb function is critical. Repetitive propulsion over the years places significant strain on the shoulders, elbows, and wrists, often leading to chronic pain, reduced mobility, and avoidable medical interventions. Lighter-weight wheelchairs made from titanium or carbon fiber can help reduce that strain, support efficient movement, and preserve independence.

However, a policy issued by the Durable Medical Equipment Administrative Contractors in 2016 eliminated the ability for Medicare beneficiaries to upgrade to these lighter-weight materials and pay the difference in cost. As result, individuals who would benefit from these materials must now pay for the full cost of the wheelchair out of pocket and wait to be reimbursed after the claim is partially paid or settle for equipment that may not adequately meet their long-term needs. This approach is often cost-prohibitive, limiting choice and discouraging preventative, person-centered decision making.

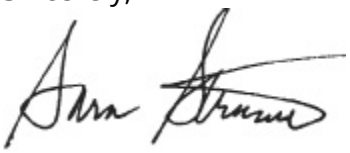
H.R. 1703 offers a reasonable and fiscally responsible path forward by establishing new wheelchair codes and allowing for upgrades within a code. This change would restore beneficiary choice while maintaining medical necessity requirements and is budget neutral to the Medicare program. For individuals with spina bifida, the ability to select a wheelchair that supports mobility over a lifetime enables them to maintain health, independence, and

participate in everyday life. Removing barriers to appropriate equipment helps prevent secondary injuries and supports care in the community.

Spina Bifida Association respectfully urges the Subcommittee to support H.R. 1703 to modernize Medicare policy, preserve mobility, and improve long-term outcomes for people living with spina bifida.

Thank you for your consideration of this important legislation.

Sincerely,



Sara Struwe
President & CEO
Spina Bifida Association
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sstruwe@sbaa.org
www.spinabifidaassociation.org

January 7, 2026

U.S. House of Representatives
Energy and Commerce Subcommittee on Health
2125 Rayburn HOB
Washington, D.C. 20515

RE: January 8, 2026 Hearing on "Legislative Proposals to Support Patient Access to Medicare Services"

Dear Chairman Griffith, Ranking Member DeGette, and Members of the Committee:

On behalf of the undersigned patient, healthcare professional, and industry organizations, we appreciate the opportunity to express our strong support for the Supplemental Oxygen Access Reform (SOAR) Act (H.R. 2902). This bipartisan, patient-centered legislation - introduced by Representatives David Valadao (R-CA), Gabe Evans (R-CO), Adrian Smith (R-NE) and Julia Brownley (D-CA) – is critical to improve access to supplemental oxygen for more than 1.5 million people living with chronic lung and heart conditions.

Supplemental oxygen is a crucial lifeline for many people living with COPD, heart disease, pulmonary hypertension, pulmonary fibrosis and other advanced chronic respiratory diseases and for people awaiting lung transplants. When patients have access to the correct form of supplemental oxygen, it enables them to manage their chronic conditions more effectively and maintain healthy, independent and full lives.

However, since 2011, supplemental oxygen has been part of Medicare's DMEPOS Competitive Bidding Program (CBP), which has resulted in significant decreases in payments for oxygen equipment and supplies. Unfortunately, this has created significant barriers for Medicare patients in accessing the correct type and amount of supplemental oxygen they need, as prescribed by their physician, in addition to essential support services like respiratory therapy.

Supplemental oxygen can be delivered in several forms. Portable oxygen concentrators (POCs), which do not provide high flow rates, are inadequate for people with the most significant oxygen needs. Instead, these people must rely on large, heavy tanks of compressed, gaseous oxygen that may provide only a couple of hours of oxygen at a time.

Liquid oxygen, which offers a continuous, high-liter flow of oxygen, is a portable, viable alternative. However, due to the inadequate reimbursement rates, suppliers have been unable to continue providing liquid oxygen widely. Without access to appropriate supplemental oxygen, patients face worsening symptoms and declining health and can become homebound which results in missing family events, struggling to attend medical appointments or being unable to engage in provider-recommended physical activity. This often leads to avoidable emergency room visits, hospitalizations and a loss of independence.

While the Centers for Medicare and Medicaid Services (CMS) has engaged in rulemaking for the CBP, the final rule does not address any of the issues the SOAR Act seeks to resolve. Congressional action remains the most prudent path to restoring reliable access to liquid oxygen and ensuring patients receive the appropriate modality of supplemental oxygen they need to breathe and live independent and full lives.

The SOAR Act would address barriers patients face in three key ways:

1. **Permanently remove supplemental oxygen from Medicare's competitive bidding process** and establish a separate payment pathway for liquid oxygen and other oxygen therapies. This would ensure that all patients prescribed supplemental oxygen can safely manage their chronic disease and maintain independence.
2. **Strengthen patient protections** by ensuring that people who need respiratory therapy services can access them, establishing an oxygen user's bill of rights, and establishing streamlined national standardized documentation requirements that better combat fraud and abuse and ensure timely patient care.
3. **Improve patient outcomes and stabilize the Medicare market**. The SOAR Act would deliver major health and quality-of-life improvements for people who rely on supplemental oxygen, including decreased mortality, reduced shortness of breath and increased exercise capacity. It would also enable individuals to receive treatment in the home and avoid facility-based care.

No one should struggle to access the oxygen modality that works best for their medical needs and lifestyle, and no one should suffer the pain and fear of struggling to breathe. The SOAR Act prioritizes patient safety and protects the system from fraud, waste and abuse. We urge the Committee to advance the SOAR Act to ensure patients with chronic conditions can access the care they need.

Thank you for your consideration,

Academy of Cardiovascular & Pulmonary Physical Therapy
Alpha-1 Foundation

American Academy of Sleep Medicine (AASM)
American Association for Respiratory Care
American Association of Cardiovascular and Pulmonary Rehabilitation
American College of Chest Physicians
American Lung Association
American Physical Therapy Association
American Thoracic Society
ARDS Alliance, Inc.
Children's Interstitial and Diffuse Lung Disease (chILD) Foundation
COPD Foundation
Council for Quality Respiratory Care
Cystic Fibrosis Research Institute
Dorney-Koppel Foundation
Foundation for Sarcoidosis Research
National Scleroderma Foundation
NTM Info & Research, Inc.
Patients Rising
PF Warriors
Pulmonary Fibrosis Foundation
Pulmonary Hypertension Association
Respiratory Health Association
Running On Air
TSC Alliance
Wescoe Foundation for Pulmonary Fibrosis

Statement for the Record
United States House Committee on Energy and Commerce Health Subcommittee
Legislative Proposals to Support Patient Access to Medicare Services
Thursday, January 8, 2026

Dear Chairman Griffith, Ranking Member DeGette, and Members of the Committee:

The American Lung Association is pleased to submit this statement on the Supplemental Oxygen Access Reform (SOAR) Act (HR 2902) and the Senior Savings Protection Act (HR 6210).

The SOAR Act, introduced by Representatives David Valadao (R-CA), Gabe Evans (R-CO), Adrian Smith (R-NE) and Julia Brownley (D-CA), will improve access to supplemental oxygen for Medicare beneficiaries. More than 1.5 million people living with chronic lung and heart diseases in the U.S. rely on supplemental oxygen, yet many face persistent barriers to accessing the oxygen equipment and services prescribed by their clinicians.

Since 2011, supplemental oxygen has been part of Medicare's DMEPOS Competitive Bidding Program, leading to significant payment reductions for oxygen equipment and supplies. This has created serious challenges for patient access and affordability - limiting the availability of appropriate oxygen modalities and essential support services like respiratory therapists – leaving many patients unable to obtain the correct type and level of oxygen that meets their medical needs and supports an independent and active life.

For many people, these barriers have tangible, everyday consequences. Patients report missing family events, struggling to attend medical appointments, and being unable to exercise, work or leave their homes safely because they cannot access portable or high-flow oxygen systems. People who require higher oxygen flow rates often cannot rely on small portable oxygen concentrators and must instead use large, heavy tanks that restrict mobility and independence. Liquid oxygen – which can provide continuous, high-flow oxygen in a more portable form – is often unavailable due to inadequate reimbursement, effectively confining people to their homes and increasing the risk of social isolation, declining health and avoidable hospitalizations.

The SOAR Act would address these affordability and accessibility challenges by creating a more patient-centric supplemental oxygen benefit, moving away from "home" oxygen to "supplemental oxygen." This legislation would remove all oxygen services and equipment from the competitive bidding reimbursement system and create a new reimbursement system so that people can access the appropriate modality of oxygen. Additionally, the SOAR Act would ensure patients have access to respiratory therapist services through their oxygen supplier. It would also establish national standardized documentation requirements that rely upon a template rather than prescriber medical records to support claims for supplemental oxygen suppliers to ensure predictable and adequate reimbursement and to protect against fraud and abuse.

The SOAR Act will address challenges that low-income, rural and medically underserved individuals are experiencing. Supplemental oxygen is a lifeline for so many people – decreasing mortality, reducing shortness of breath and increasing exercise capacity. No one should struggle to access the oxygen modality that works best for their medical needs and lifestyle, and no one should suffer the pain and fear of struggling to breathe.

In addition to supporting the SOAR Act, the American Lung Association is also supportive of the Senior Savings Protection Act, bipartisan legislation introduced by Representatives Doris Matsui (D-CA), Gus Bilirakis (R-FL), Suzan DelBene (D-WA), Nicole Malliotakis (R-NY) and Angie Craig (D-MN). The need for Medicare outreach and enrollment assistance is significant and growing. Millions of older adults already struggle to meet basic living expenses, and thousands more become Medicare-eligible each day while managing chronic conditions that require ongoing care, like chronic lung disease.

The Senior Savings Protection Act would reauthorize funding for Medicare outreach and enrollment assistance for low-income older adults and people with disabilities. Enrollment assistance funded through this program helps people understand their options and access programs that make Medicare more affordable, particularly for those living below or near the federal poverty level. This assistance has been successful in ensuring Medicare beneficiaries can access the support they're eligible for which helps them stay healthy, avoid expensive hospital stays and find stability.

The Lung Association urges Congress to advance both the SOAR Act and the Senior Savings Protection Act to ensure Medicare beneficiaries can access the care they need.

Thank you.

Sincerely,

Harold P. Wimmer
President and CEO

AdvaMed
Advanced Medical Technology Association

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AdvaMed Statement

January 8, 2026

H.R. 5269, Reforming and Enhancing Sustainable Updates to Laboratory Testing Services Act (RESULTS Act), H.R.2005, the DMEPOS Relief Act of 2025 and H.R. 2902, the Supplemental Oxygen Access Reform Act (SOAR Act)

AdvaMed, the MedTech Association, appreciates the Energy and Commerce Health Subcommittee for this hearing highlighting policies to support patient access to Medicare services. AdvaMed supports H.R. 5269, Reforming and Enhancing Sustainable Updates to Laboratory Testing Services Act (RESULTS Act), H.R. 2005, DMEPOS Relief Act of 2025 and H.R. 2901, the Supplemental Oxygen Access Reform Act (SOAR Act).

The RESULTS Act is a critical piece of legislation for millions of patients who rely on laboratory testing to make sound medical decisions. Diagnostic tests are indispensable to modern medicine. They enable early detection, prevention, and accurate diagnosis, and guide the most effective treatment decisions across the continuum of care. Innovative diagnostics—such as those for pre-cancer detection, Alzheimer's, or traumatic brain injury—are transforming patient care but unless the unsustainable cuts to the Clinical Laboratory Fee Schedule (CLFS) are not rectified we risk patients being unable to access these tests.

The RESULTS Act offers a comprehensive and effective solution for ensuring that patients have continued access to the latest laboratory testing innovations. The legislation provides CMS the authority to collect comprehensive commercial market rates representative of the clinical laboratory ecosystem by leveraging an independent not-for-profit commercial claims database for widely available tests while relying on laboratories to report private payor rates for non-widely available tests. This ensures that true private market rates are included and reduces the reporting burden, while protecting both labs and Medicare from sudden rate fluctuations by gradually phasing in any changes going forward.

In addition, AdvaMed supports H.R. 2005, the DMEPOS Relief Act of 2025 and H.R. 2902, the SOAR Act that are under consideration. Both pieces of legislation are critical for preserving patient access and choice.

Durable medical equipment and supplemental oxygen are essential components of treatment for individuals with chronic and acute conditions, enabling care in the home, reducing avoidable hospitalizations, and supporting independence, mobility, and quality of life.

Targeted DMEPOS payment relief helps ensure continued access to essential medical technologies, while the SOAR Act represents a patient-centered modernization of Medicare's oxygen benefit by promoting access to the full range of oxygen modalities and the clinical services necessary for safe and effective therapy.

AdvaMed also supports more discussion on the Wasteful and Inappropriate Services Reduction (WISeR) Model. In the Federal Register notice, CMS presents the model as a tool to reduce Medicare expenditures and remove fraud, waste, and abuse from the Medicare program. AdvaMed shares CMS's goal of providing efficient, safe, and high-quality care to all Medicare beneficiaries, and our members develop the technologies that are the backbone of health care delivery in the United States and the world. To continue serving patients and the health care system, we believe more information on how this model will be implemented and monitored is essential for the medtech industry, clinicians, health systems, and patients.

AdvaMed is proud to support the RESULTS Act, the DMEPOS Relief Act and the SOAR Act and urges the Committee to move these pieces of legislation forward. We greatly appreciate the Committee's leadership in strengthening Medicare, improving patient access, and supporting medical innovation.

April 1, 2025

The Honorable Mariannette Miller-Meeks (R-IA)
U.S. House of Representatives
504 Cannon House Office Building
Washington, DC 20515

The Honorable Paul Tonko (D-NY)
U.S. House of Representatives
2269 Rayburn House Office Building
Washington, DC 20515

The Honorable Randy Feenstra (R-IA)
U.S. House of Representatives
2434 Rayburn House Office Building
Washington, DC 20515

The Honorable Jimmy Panetta (D-CA)
U.S. House of Representatives
200 Cannon House Office Building
Washington, DC 20515

Re: ITEM Coalition Support for H.R. 2005, the DMEPOS Relief Act of 2025

Dear Representatives Miller-Meeks, Tonko, Feenstra, and Panetta:

The undersigned members of the Independence Through Enhancement of Medicare and Medicaid (ITEM) Coalition write to express our support for H.R. 2005, the *DMEPOS Relief Act of 2025*, which would provide critically-needed funding relief to many home medical equipment ("HME") providers across the country and ensure continued access to these essential medical supplies for seniors and individuals with disabilities. Specifically, the bill would re-establish the 75/25 blended Medicare reimbursement rate for DMEPOS in non-rural/non-Competitive Bidding Areas through the end of 2025. By addressing outdated Medicare reimbursement rates, this bipartisan bill would help preserve access to assistive devices and technologies for millions of Medicare beneficiaries across the country with disabilities and chronic conditions. The ITEM Coalition typically does not address reimbursement issues and tends to focus on coverage and coding of assistive devices and technologies. However, when reimbursement policies materially impact patient access to care, we feel it is important to weigh-in with our members' concerns.

The ITEM Coalition is a national consumer- and clinician-led coalition advocating for access to and coverage of assistive devices, technologies, and related services for people with injuries, illnesses, disabilities, and chronic conditions of all ages. Our members represent individuals with a wide range of disabling conditions, as well as the providers who serve them, including spinal cord injury, brain injury, stroke, limb loss, multiple sclerosis, paralysis, cerebral palsy, spina bifida, hearing, speech, and visual impairments, and other life-altering conditions.

ITEM Coalition members have had long-standing concerns that the DMEPOS competitive bidding program limits access, choice, and quality of care. In 2018, CMS paused the CBP because of design flaws that caused unsustainable payment rates resulting in access issues for Medicare beneficiaries who need DMEPOS services. CMS used the 2-year pause to redesign the program. Unfortunately, CMS maintained the previously flawed payment rates that were established in 2016 during the pause, which were 50-60% lower than the unadjusted Medicare

fee schedule rates. Congress and CMS have intervened numerous times through the years to provide additional relief, most recently providing a 75/25 blended rate for non-bid, non-rural areas through 2023 (75% Competitive Bid rate/25% unadjusted Medicare fee schedule rates). This 75/25 blended rate was a much-needed lifeline for DMEPOS suppliers and providers and afforded beneficiaries continued access to the level of care and services that they needed.

The 75/25 blended rate expired last year on January 1, 2024, and this expiration led to a 20% fee reduction across the top 25 DME HCPCS codes, creating major barriers for Medicare beneficiaries with disabilities and chronic conditions to manage their medical and functional needs at home. The *DMEPOS Relief Act of 2025*, if enacted into law, would ensure continued beneficiary access to DMEPOS services and devices, provide a much-needed measure of relief and stability for non-rural, non-CBA suppliers, and also have positive impacts on reimbursement levels from other payers who pattern their reimbursement levels off the Medicare fee schedule.

The reason the competitively bid rates are not presently adequate to support access and quality of DMEPOS care to Medicare beneficiaries is because the competitive bidding program is no longer in effect. This means that any supplier or provider who participates in Medicare can provide the DMEPOS benefit. Contracts with a limited number of suppliers in a particular competitive bidding area are no longer necessary, resulting in far less volume of patients being directed to certain suppliers, who, when the competitive bidding program was in effect, were able to discount their prices in exchange for greater volume. Without the increased volume, many suppliers are not able to remain viable at the decreased competitively bid rates. H.R. 2005 would help ameliorate this situation and increase access to patient care.

H.R. 2005 is squarely in line with the goals of the ITEM Coalition to ensure that all people can access the specialized devices and services they need to ensure their health and independent function. For these reasons, we are proud to support this critically important legislation and look forward to working with your office to ensure its enactment into law in order to preserve and protect access to affordable, timely, and quality home medical equipment for Medicare beneficiaries.

****

If you have any questions, please do not hesitate to contact ITEM Coalition co-coordinators Peter Thomas and Michael Barnett at Peter.Thomas@PowersLaw.com or Michael.Barnett@PowersLaw.com or call 202-466-6550.

Sincerely,

The Undersigned Members of the ITEM Coalition

Access Ready, Inc.
ACCSES
Alexander Graham Bell Association for the Deaf and Hard of Hearing
All Wheels Up
American Association for Homecare

American Association on Health and Disability
American Cochlear Implant Alliance
American Macular Degeneration Foundation
Association of Rehabilitation Nurses
Autistic Women & Nonbinary Network
Blinded Veterans Association
Center on Aging and DIS-Ability Policy
Clinician Task Force
3DA
Institute for Matching Person and Technology
International Registry of Rehabilitation Technology Suppliers
Lakeshore Foundation
Long Island Center for Independent Living, Inc. (LICIL)
Muscular Dystrophy Association
National Association for the Advancement of Orthotics and Prosthetics
NCART
Perkins School for the Blind
Rifton Equipment
RESNA
Spina Bifida Association*
Team Gleason*
United Cerebral Palsy

ITEM Coalition Steering Committee Member

January 8, 2026

The Honorable Morgan Griffith
Chairman
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Chairman Griffith, Ranking Member DeGette, and Members of the Subcommittee:

My name is Shane Bare, and I am a Medicare beneficiary who relies on infused therapy at home to stay healthy and independent. I am writing to share what home-based infusion means in real life for patients like me, and to express my support for H.R. 2172, the Preserving Patient Access to Home Infusion Act.

I live with chronic inflammatory demyelinating polyneuropathy (CIDP). I am also a wheelchair user because of a spinal cord injury. Home-based therapy is not a convenience for me. It is the difference between being able to manage my condition on my own terms, or being forced into a care routine that is harder, riskier, and less sustainable.

My treatment requires immune globulin therapy that I administer at home on a regular schedule. Doing it at home gives me control and consistency. It means I can complete therapy without arranging transportation, without relying on someone to drive me, and without turning every dose into a major logistical event. It also matters for safety. I know my body, I know my routine, and I can respond quickly if something feels off.

I have also seen how fragile access can be when coverage rules do not line up with how care actually works. At one point, a coverage decision left me facing out-of-pocket costs that were completely unrealistic, and I had to fight through an appeals process to keep my therapy. No patient should have to choose between going without treatment or being financially wiped out, and no one should have to become an expert in paperwork just to stay stable. Another issue I face is the denial of my treatment by my insurance provider every single year after the pre authorization process is completed, often times for the same reasons as previous denials. I have to appeal every single time. There are many people who think the denial is the final word, so they don't pursue any further action. I am not one of those people, but I would appreciate not having to be, simply for piece of mind at the beginning of each year.

Home infusion is routine across much of the health system, but Medicare beneficiaries can face a much harder path to getting care at home, even when a doctor wants that for the patient. When the home option is not workable, people get pushed into higher-cost settings and more disruptive routines, like repeated facility visits or longer stays in institutional care, simply to complete therapy that can often be managed safely at home.

That is why the Preserving Patient Access to Home Infusion Act matters. This bill helps make home infusion a dependable option for Medicare patients by modernizing Medicare's approach

so it supports home-based care in a practical way. For patients, that means more independence, fewer unnecessary trips, less disruption for families and caregivers, and a better chance to stay on track with treatment.

Thank you for considering the patient perspective as you evaluate these Medicare proposals. I strongly support the Preserving Patient Access to Home Infusion Act and urge the Subcommittee to advance it.

Sincerely,
Shane Bare
Roan Mountain, TN

Infusion Access Foundation

January 8, 2026

The Honorable Morgan Griffith
Chairman, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member, Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Griffith, Ranking Member DeGette, and Members of the Subcommittee:

For patients who rely on provider-administered treatments, access is measured in very practical terms: whether the next dose happens on time, whether a caregiver can get time off work again, and whether a patient has a choice in their most medically appropriate site of care.

The Infusion Access Foundation is a community of patients and advocates united to protect access to infusion and injection treatments. We support each other across all diseases and advocate with one voice that reaches policymakers. As a 501(c)(3) nonprofit, our mission is to expand access to these treatments and help patients live their best, healthiest lives.

Across many conditions, infused and injected therapies are ordered and managed by clinicians because consistent administration and monitoring matter. When patients face barriers to receiving these therapies (delayed starts, missed doses, or unnecessary site-of-care restrictions) health can decline quickly, symptoms can flare, and patients can end up in higher-intensity settings that are far more disruptive and costly. The burden also falls heavily on caregivers, who are often responsible for transportation, scheduling, and practical support around each appointment.

Home infusion can be an important access and continuity option for patients who need ongoing therapy and whose clinicians determine treatment can be safely administered and supported in the home. When home infusion is workable, it can reduce travel and appointment burden, support adherence, and help patients stay connected to daily life. Simply put, patients deserve to receive treatment in the setting most appropriate to their needs.

The Preserving Patient Access to Home Infusion Act helps address these access barriers by modernizing Medicare's home infusion benefit so it aligns with how home infusion care is supported across infusion days, including essential professional services that occur between visits or outside the home. The bill also expands coverage to include all IV anti-infective drugs, helping beneficiaries complete needed therapy at home when clinically appropriate rather than remaining in higher-intensity settings due to logistics.

Infusion Access Foundation

The Infusion Access Foundation respectfully urges the Subcommittee to advance the Preserving Patient Access to Home Infusion Act so Medicare beneficiaries have a dependable pathway to receive provider-administered therapies in the most appropriate setting, as determined by their clinicians.

Sincerely,

Alicia Barron, LGSW
Executive Director
Infusion Access Foundation

November 19, 2025

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable John Thune
Majority Leader
U.S. Senate
Washington, DC 20510

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
Washington, DC 20515

The Honorable Charles Schumer
Minority Leader
U.S. Senate
Washington, DC 20510

Dear Senate Majority Leader Thune, Senate Minority Leader Schumer, Speaker of the House Johnson, and House Minority Leader Jeffries:

As organizations representing millions of patients and health care consumers—including individuals impacted by chronic conditions such as cancer, diabetes, kidney disease, autoimmune disorders, liver disease, lung disease, and other serious illnesses— we write to express our strong support for **S. 2761 / H.R. 5269, the Reforming and Enhancing Sustainable Updates to Laboratory Testing Services (RESULTS) Act**.

This bipartisan, bicameral legislation would make important reforms to the clinical laboratory payment system under Medicare to ensure our nation's clinical laboratories continue to deliver routine testing services older people rely on every day, while striving to advance the next generation of diagnostics to improve and save lives.

Timely access to reliable and innovative clinical laboratory tests is critical to the prevention, early detection, therapy selection, and effective management of chronic and life-threatening diseases. For older Americans and those living with complex health conditions, clinical diagnostic tests are key to slowing progression, averting complications, and reducing hospitalizations.

In addition to generating critical, potentially life-changing insights, clinical laboratory testing provides tremendous value. Laboratory testing informs 70% of clinical decision making while spending under the clinical laboratory fee schedule represents less than 1% of total Medicare spending. But without Congressional action, Medicare reimbursement cuts—a fourth round of up to 15% on about 800 widely used tests—are scheduled to resume January 31, 2026. These drastic payment cuts threaten our nation's clinical laboratories and could compromise patient access to necessary services and increase wait times for testing and results.

The RESULTS Act would establish a modernized, data-driven payment model that reflects commercial market rates, supports innovation, and ensures access to life-saving clinical diagnostic tests. Congress has acted to delay the next round of payment cuts for the last five years, but now is the time for permanent, sustained reform to provide long-term stability for the millions of Medicare beneficiaries and patients across the country whose health decisions rely on clinical laboratory results.

Access to timely and accurate diagnostic health information is not optional—it is foundational to the health and well-being of millions of Americans. On behalf of patients across the country, we urge you to move swiftly to pass the RESULTS Act.

Sincerely,

Alliance for Aging Research

Alliance for Patient Access

Alliance for Women's Health and Prevention

Alzheimer's Association

Alzheimer's Impact Movement (AIM)

American Cancer Society Cancer Action Network

American Sexual Health Association

Applied Pharmacy Solutions

Axis Advocates

Black Women's Health Imperative

California Chronic Care Coalition

CancerCare

Caregiver Action Network

Center for Patient Advocacy Leaders

Cholangiocarcinoma Foundation

Chronic Care Policy Alliance

Community Liver Alliance

Family Heart Foundation

Gerontological Society of America

GO2 for Lung Cancer

Healthcare Institute of New Jersey

Healthy Women

ICAN, International Cancer Advocacy Network

LUNGevity Foundation

Lupus and Allied Disease Association, Inc.

Minority Health Institute, Inc.

The National Association of Directors of Nursing Administration

National Grange

National Health Council

Neuropathy Action Foundation

Partnership to Fight Chronic Disease

Retire Safe

Sepsis Alliance

Solve M.E.

AAFP

AMERICAN ACADEMY of FAMILY PHYSICIANS

January 8, 2025

The Honorable Morgan Griffith
Chairman, Health Subcommittee
House Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Diana DeGette
Ranking Member, Health Subcommittee
House Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Griffith and Ranking Member DeGette:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 128,300 family physicians and medical students across the country, I write to thank you for holding today's hearing titled "Legislative Proposals to Support Patient Access to Medicare Services." Given the significance of this issue to family physicians and the patients they serve, I want to offer the following recommendations and insights from the family physician perspective.

Spending within the Medicare program has reached an unsustainable tipping point. Total spend reached $1.03 trillion in 2023, representing more than a fifth of overall national health expenditures.[i] The Medicare Board of Trustees estimates it will reach $1.9 trillion in 2032.[ii] However, the health outcomes of Medicare beneficiaries are lagging significantly behind what we would expect for the amount we've spent. Nearly one out of every four of our nation's seniors who are not in an institutional care setting report being in fair or poor health.[iii] Of individuals 65 years and older, 93 percent have at least one chronic condition and nearly 79 percent have two or more chronic conditions.[iv] These data points make it clear that our current system isn't working to prioritize patients and their wellbeing.

According to the Medicare Payment Advisory Commission (MedPAC), the costliest five percent of beneficiaries accounted for 46 percent of annual Medicare fee-for-service (FFS) spending. Many of these individuals have multiple chronic conditions that, if prevented and/or treated with lower-cost, earlier interventions, could significantly reduce program spending. Currently, clinician services only represent about one-fourth of Medicare spending. Across payers, Medicare spends the least on primary care, dipping to only 3.4 percent in 2022.[v] Together with the Centers for Medicare and Medicaid Services (CMS), this Subcommittee and your colleagues in Congress have the opportunity to reconfigure Medicare spending to ensure that taxpayer dollars are actually being spent on the high-value care that matters to seniors – including prevention, chronic disease management, and primary care.

We applaud the Subcommittee for discussing three pieces of legislation that the AAFP has endorsed during today's hearing:

- H.R. 5269, *Reforming and Enhancing Sustainable Updates to Laboratory Testing Services (RESULTS) Act of 2025* (Rep. Hudson)

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- H.R. 5347, *Health Care Efficiency Through Flexibility Act* (Rep. Buchanan)
- H.R. 6210, *Senior Savings Protection Act* (Rep. Matsui)

However, these bills are not the end of the road when it comes to solutions. To meaningfully increase access to primary care and other essential services for seniors, Congress should also consider additional payment and coverage reforms such as:

- **Making foundational changes to the Medicare Physician Fee Schedule (MPFS)**, such as increasing investment in primary care, reforming budget neutrality requirements, and implementing an annual inflationary update to physician payment;
- **Waiving Part B patient cost-sharing for primary care services** to help incentivize uptake of high-value, low-cost codes such as chronic care management (CCM), G2211, and advanced primary care management (APCM);
- **Supporting and expanding ongoing federal efforts to accelerate value-based payment (VBP) adoption,** a system which provides primary care practices with greater flexibility and resources to meet the needs of Medicare beneficiaries; and
- **Requiring Part B to cover all recommended vaccines for beneficiaries,** ensuring that they are easily able to receive any requested vaccine in the office of their trusted family physician.

Foundational Reforms to the Medicare Physician Fee Schedule

For years, the Academy has described at-length the many flaws within FFS payment models, and more specifically the MPFS, that have contributed to our national underinvestment in primary care. Briefly, some of the biggest factors are as follows:

- FFS payment is designed to pay for discrete services in ways that favor procedural service delivery.
- FFS coding and billing is incompatible with the continuous, comprehensive nature of relationship-based primary care.
- Budget neutrality requirements are unreasonably outdated and should not be narrowly focused only on physician services.
- The lack of an inflationary update means payment has not kept pace with the inflationary costs of running a practice.

It is for these many reasons that the AAFP continues to advocate for widespread adoption of value-based payment arrangements, including in Medicare, as described in greater detail later in this letter. However, it cannot be ignored that FFS underpins and informs virtually all existing alternative payment models (APMs). Thus, the success of primary care physicians and practices in these arrangements is contingent upon comprehensive reforms being made to the MPFS and the Medicare Access and CHIP Reauthorization Act (MACRA).

We sincerely appreciate that CMS has leveraged their existing authorities in recent years to implement positive policy changes for primary care. This includes implementing new codes to pay for work that was not previously captured by existing codes (i.e.: G2211 add-on code for office and home-based visits), taking steps toward providing prospective per-member-per-month (PMPM) payments for care management services with the advanced primary care

management (APCM) codes, and using other empirical data sources to more accurately estimate the time it takes physicians to provide certain services.

However, the potential impact of many of these policies has been significantly blunted by the current zero-sum nature of the MPFS. For example:

- Extremely restrictive budget neutrality requirements – which haven't been updated since the inception of the MPFS – mean that, in most cases, new codes can't be added without triggering an across-the-board payment cut to all services.
- The budget-neutral nature of the MPFS also means that the Merit-based Incentive Payment System (MIPS), which was intended to move more physicians successfully into value-based payment, has failed in its goal. Penalties applied to "low-performing" clinicians pay for the awards provided to high-performers, creating a cycle whereby small, independent, and rural practices are consistently punished instead of offered a necessary helping hand.
- If CMS increases the valuations of any codes, it means that the valuations of other codes have to be reduced or the conversion factor is cut.
- And finally, all of this is happening within the same pot of money that has existed since 1992 – despite a growing beneficiary population, increasing costs of running a practice, and significant strides in medicine over the last several decades leading to more services and technologies being added to the MPFS. This policy framework has forced physician specialties to compete against each other for smaller and smaller pieces of the pie each year.

Comprehensively reforming the MPFS and MACRA must be a priority for Congress if there is a sincere desire to improve patient access to the care that matters. To this end, **the AAFP continues to urge Congress to provide an annual inflationary update to physician payment**, which the bipartisan *Strengthening Medicare for Patients and Providers Act* (H.R. 6160) would do. Further, we have previously provided recommendations for more modest reforms to MIPS and the Quality Payment Program that this Subcommittee should consider. We also support proposals to **provide CMS with the authority to correct over- or under-utilization assumptions when implementing new codes**, ensuring that funds within the fee schedule are not irreversibly lost due to inaccurate assumptions.

On the topic of budget neutrality, the AAFP urges Congress to consider thinking of traditional Medicare holistically, rather than as inviolable silos such as Part A and Part B. Eliminating waste and anachronistic policies across the program may serve to yield the offsets necessary to provide inflationary adjustments to the conversion factor or alleviate budget neutrality constraints. Just as Medicare expects Medicare Advantage plans, some CMMI models, and even physicians (i.e.: MIPS) to think of total cost of care, **Congress should consider the total costs of Medicare across the multiple Medicare silos and look for offsets across those silos, not just within Part B or the physician fee schedule**. As has been noted above, spending on physician services is not what's bankrupting the Medicare program. Rather, appropriately valuing and paying for the work primary care physicians provide to beneficiaries stands to save money for the Medicare program in the long-run while ultimately improving health outcomes.

Waive Patient Cost-Sharing for Primary Care Services

Statutorily, Medicare is required to charge patients a cost-sharing amount of 20 percent for many Part B services. While most preventive care is covered without cost-sharing, many primary care services delivered by family physicians remain subject to these requirements, resulting in financial barriers for patients and often low uptake.

As discussed above, FFS coding and billing has historically failed to capture much of the work provided by primary care physicians. However, CMS has taken steps to correct these errors in recent years. In 2015, Medicare began paying physicians for delivering non-face-to-face chronic care management (CCM) through separate codes. Additional coding advancements made have included implementation of the G2211 add-on code for office and home-based visits and the APCM code bundle. Overall, physicians have reported that being able to bill for these services has been a positive experience for them and their practices. However, cost-sharing requirements are limiting uptake by patients who would truly benefit from this type of additional support.

A 2022 study found that Medicare billing codes for preventive medicine and care management services are being underutilized even though primary care physicians were providing code-appropriate services to many patients. The median use of the preventive and care coordination billing codes was 2.3 percent among eligible patients.[vi] Family physicians regularly report patients opt out of receiving these services simply because the $15 or so a month they faced in cost-sharing was not financially feasible. In almost every case these are the very patients that would most benefit from CCM. Patients are not used to paying for these services and, understandably, are likely to be resistant to doing so. If we want to incentivize usage of these high-value services, we must waive patient cost-sharing.

In many ways, APCM, CCM, and other similar codes are preventive services in that they can reduce emergency department and other outpatient visits. This is a question that CMS has begun to investigate, as indicated by their RFI about whether APCM should be considered a preventive service in the proposed CY26 MPFS. Removing cost-sharing for CCM and other primary care services increases access to these services without increasing overall health care spending.[vii] The available evidence indicates that reducing or removing cost barriers to primary care increases utilization of preventive and other recommended primary care services, which improves both individual beneficiary and population health. Thus, **the AAFP urges the Subcommittee to consider advancing legislation to remove cost-sharing barriers for APCM and CCM as a starting point**.

Opportunities to Support and Expand Adoption of Value-Based Payment

Primary care physicians – particularly those in rural and underserved communities – still face significant barriers to entering and sustaining participation in VBP arrangements. Practices must comply with an ever-increasing number of federal and state regulations, negotiate contracts with multiple payers, acquire and effectively aggregate and analyze data to track patient utilization, treatment adherence, and identify outstanding needs – all while doing their primary job of taking care of patients. This creates an immediate and high barrier to entry, particularly for independent practices that don't have the upfront capital or resources.

To address this, the AAFP has called on federal policymakers to increase options for primary care practices to participate in APMs that provide upfront or advance payments and other

supports to enable the investments required to be successful. For example, practices participating in the Center for Medicare and Medicaid Innovation's (CMMI) Comprehensive Primary Care Plus (CPC+) not only received population-based, PMPM payments, but CMMI provided them with a robust data dashboard and other technical assistance that enabled new practices to join the model and successfully reduce emergency visits and hospitalizations. CMMI also partnered with state Medicaid agencies and commercial payers to drive alignment across payers in CPC+ regions, which in turn provided practices with greater financial support across their contracts and accelerated care delivery innovations.

We appreciate that CMMI has recently announced some promising models which seem to answer this call, including:

- Accountable Care Organization (ACO) Primary Care Flex – Beginning last year, this model provides low-revenue ACOs participating in the Medicare Shared Savings Program (MSSP) with a one-time upfront shared savings payment and a prospective PMPM payment.
- Long-term Enhanced ACO Design (LEAD) Model – This 10-year model, announced just last month, iterates upon past ACO models but with an eye toward bringing more rural, small, and independent practices and those that serve high-needs patients into the fold. Early details indicate LEAD will provide flexible, capitated population-based payments to support team-based care and downstream value-based care arrangements, in addition to incentivizing Medicaid-ACO partnerships and beneficiary incentives to seek care from ACO-participating clinicians.

The Academy looks forward to seeing how these models play out over the next several years and we encourage the Subcommittee to continue to partner with CMS to support their success. The emphasis of models like LEAD on bringing in new independent practices without prior ACO experience or that primarily care for underserved populations (i.e. Federally Qualified Health Centers and Rural Health Clinics) is likely to yield significant lessons learned, and may not immediately manifest in pure dollars and cents savings. For these reasons, **the AAFP continues to strongly encourage Congress to provide CMMI with additional flexibility in how it evaluates the success of primary care models.**

Currently, federal statute only allows CMMI to expand models that reduce health care spending and maintain quality, or improve performance on quality metrics without increasing spending. Demonstrating savings in primary care often takes several years as physicians build relationships with their patients, use data to better manage their care, and increase utilization of preventive and other high-value services, like care management. The current statutory framework has prevented CMMI from making important model improvements or continuing to test models that do not show significant savings within a short model test period, ultimately causing more complexity and financial instability for participating physician practices. Further, all CMMI primary care model evaluations have been done at the national level, which may be masking regional successes. Congress should consider enabling and encouraging CMMI to evaluate several other markers of success for primary care APMs, such as whether they successfully bring new physicians into value-based payment, improve patient experience measures, markedly improve care delivery transformation, enable more beneficiaries to access the behavioral health services they need, and when applicable, evaluate models both nationally and regionally. These additional criteria would allow CMMI

to continue testing models that show early markers of success and iterate upon them to meet current patient, clinician, and market needs.

Further, additional opportunities for the Subcommittee to improve the landscape of APMs include extending MACRA's advanced APM (AAPM) incentive payments, which expired at the end of performance year 2024. The AAPM incentive payments have served as an important tool for attracting physicians to participate in AAPMs, which require significant upfront (and often ongoing) investments in new staff, technology, and other practice improvements. Primary care practices have also used the bonus payments to offset the cost of investing in care delivery transformation that drives success in these models by improving patient outcomes and lowering spending.

Should the Subcommittee reauthorize these incentive payments, the Academy encourages implementation of guardrails to ensure the funds flow to the physicians and clinicians delivering care to Medicare beneficiaries in employed settings. Previous AAPM incentive payments were distributed at the organization level and did not have stipulations for how those incentives were shared or flow to physicians and clinicians delivering care. This is one reason why independent practices have better outcomes in value-based arrangements, as the resources and incentives flow directly to the practices and care teams delivering the care and are uniquely positioned to be more agile, flexible, and timely in their implementation of care interventions. To better encourage new participation in AAPMs, bonuses should be structured based on the value of what physicians and clinicians deliver, their impact on health outcomes and patient satisfaction, and both improved and sustained performance.

Finally, outside of payments, the AAFP believes there are additional changes Congress can enact to incentivize more primary care physician-led ACOs or greater primary care physician participation in MSSP. According to CMS data, in 2021, physician-led ACOs in the MSSP achieved net savings that were nearly double that of hospital-led ACOs ($237 per capita in net savings versus $124 per capita net savings).[viii] ACOs comprised of 75 percent primary care clinicians or more saw $281 per capita in net savings compared to $149 per capita in net savings for ACOs with fewer primary care clinicians. The data clearly shows primary care is essential to the success of MSSP. As such, Congress should consider the following options to encourage ACOs led by independent physician groups and/or with a larger proportion of primary care clinicians:

- Create a minimum threshold of primary care spending within an ACO to be eligible for shared savings.
- Set a minimum utilization rate of E/M encounters with primary care clinicians to be eligible for shared savings.
- Require ACO rosters to maintain a minimum ratio of primary care to other clinicians.
- Require primary care physician representation in the ACO governance structure.

Require Part B Coverage of All Recommended Vaccines

Vaccines are one of the safest and most cost-effective public health innovations we have. Current adult vaccination coverage yields an estimated 65 million averted disease cases and $185 billion in averted case costs over a 30-year period.[ix] The COVID-19 pandemic was a real-time demonstration of the invaluable role that vaccines play in saving lives when they are affordable and accessible. Yet each year, the United States spends $27 billion on four

vaccine-preventable illnesses in adults over the age of 50: flu, pertussis, pneumococcal (pneumonia), and shingles.[x]

This is in part due to remaining barriers that prevent many individuals from being able to readily access and receive all recommended vaccines in their physician's office. For example, Medicare currently splits vaccine coverage between Part B (outpatient care) and Part D (prescription drug coverage). New vaccines, such as RSV, are only covered under Medicare Part D, which was designed for pharmacies to submit claims and makes it particularly challenging for primary care physicians to deliver recommended vaccines in their office.

Approximately 8.5 million Medicare enrollees have Part B but not Part D coverage, leaving them without affordable access to Part D vaccines.[xi] For those with Part D coverage, physicians can give patients a bill to submit to their Part D plan for reimbursement, but this forces patients to pay a potentially high out-of-pocket cost upfront, which creates barriers to access. There is an online clearinghouse that allows physicians to check Part D coverage and electronically submit an out-of-network Part D claim, but physicians must pay for this service by sharing a portion of their payment. Because of these barriers to administering the vaccine in-office, physicians can recommend or prescribe a Part D-only vaccine to a patient, who must then identify and secure a separate appointment at an in-network pharmacy in order to be vaccinated. Family physicians frequently share stories of Medicare patients that come in requesting a vaccine – or agree to receive one after months of discussions – only to have to turn them away and hope they are able to access it somewhere else. This coverage gap ignores consistent findings that patients want to receive vaccinations from their usual source of care, with whom they have established trust and respect over time.

However, Congress has the authority to remedy this issue and ensure that family physicians can easily provide all recommended vaccines to Medicare beneficiaries. Specifically, **the Academy urges the Subcommittee to consider legislation to require Medicare Part B coverage of RSV, shingles, and other evidence-based, medically recommended vaccines as they come onto the market**. Such a statutory update would explicitly meet the objective of this hearing by allowing beneficiaries to more readily access vaccines from their usual source of care and ultimately improve our nation's uptake of one of the most cost-effective public health measures.

Thank you for holding this hearing on one of the most salient issues impacting family physicians and their patients. The AAFP appreciates your consideration of our recommendations and looks forward to continuing to partner with you to reform the Medicare program to better serve our nation's seniors. Should you have any additional questions, please contact Natalie Williams, Senior Manager of Legislative Affairs, at nwilliams2@aafp.org.

Sincerely,

Jon Brull, MD, FAAFP
American Academy of Family Physicians, Board Chair

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ConnectedHealthInitiative

January 8, 2026

The Honorable Morgan Griffith
Chairman
Subcommittee on Health
Committee on Energy and Commerce
Washington, District of Columbia 20515

The Honorable Diana DeGette
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
Washington, District of Columbia 20515

Dear Chairman Griffith and Ranking Member DeGette:

Thank you for the opportunity to submit a statement for the record for your hearing, titled "Legislative Proposals to Support Patient Access to Medicare Services." The Connected Health Initiative (CHI) has long advocated for improvements to the Medicare payment system to ensure greater access to digital health services. We urge you to consider a few key reforms to support digital health, telemedicine, health artificial intelligence (AI) tools, and innovation in the healthcare sector.

CHI is the leading multistakeholder policy and legal advocacy effort dedicated to improving health outcomes while reducing costs. Our work is driven by the consensus of stakeholders from across the connected health ecosystem. CHI aims to realize an environment in which Americans can see improvements in their health through policies that allow for connected health technologies to advance health outcomes and reduce costs. CHI members develop and use connected health technologies across a wide range of use cases.

CHI applauds this Subcommittee's commitment to advancing Medicare payment reforms that benefit seniors. The bills under consideration today are important steps toward a safer, smarter, and more equitable health system. We encourage you to consider additional steps like those we outline below.

Pandemic-Era Flexibilities in Reimbursement Rules

During the COVID-19 pandemic, Congress temporarily allowed the Department of Health and Human Services (HHS) to lift several outdated restrictions on the eligibility of telehealth services for reimbursement through Medicare. The main restrictions waived included originating site restrictions requiring a patient to visit a qualified site to receive telehealth services rather than remaining in their homes; geographic restrictions limiting eligible services to patients who live in rural areas; and audio-visual requirements preventing patients from receiving audio-only telehealth services. The temporary allowance for HHS to waive the restrictions expires on January 30, 2026, sunsetting provisions that have enabled large groups of Medicare beneficiaries, including those with limited broadband access, low incomes, or low technology skills, to access important health services. The lapse of these waivers late last year forced patients to adjust their care plans and increases the load on overburdened healthcare providers, all for no evidence-backed reason—and another looming deadline threatens the same consequences. We urge the

Subcommittee to extend the Medicare telehealth reimbursement waivers and work towards permanent support for Medicare telehealth services.

Another waiver for the provision of telehealth services allowed Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to serve as distant site providers for telehealth services, opening many low-income and rural patients to telehealth visits. These services resulted in increased show rates for appointments and better treatment for patients with sensitive concerns like depression. Without waivers for Medicare services and proper funding reimbursement from Medicaid, FQHCs and RHCs will be less able to support their patient populations. Although the timeline on expiration of these waivers is longer, they are still imperative to ensure full access to telehealth services for low-income and rural patients. Congress must ensure that these health centers can continue to provide key telehealth services for their patients.

Congress took a great step forward on digital health and telemedicine when they fully covered telehealth services for mental and behavioral health. Even though the other waivers still face expiration soon, this change will remain permanent law. Unfortunately, one waiver is still necessary for full coverage: in-person visit requirements. If patients do not meet geographic requirements, current law requires them to meet in-person with a behavioral health professional to subsequently receive telehealth services. This friction point reduces the availability of mental and behavioral health for patients without reliable transportation, with mobility issues, or with erratic work schedules. Congress should ensure mental and behavioral health services remain available by extending the waiver on in-person visit requirements and pushing for their permanent elimination.

Reimbursement for Software as a Medical Device

CHI notes its longstanding support for modernization of coverage and reimbursement policies, which cannot happen without leveraging digital and connected health capabilities, both existing and in development. CHI has widely championed the responsible uptake of digital health across government and private payment systems, including but not limited to enhanced coverage and payments for synchronous Medicare telehealth services; asynchronous physiologic and therapeutic remote monitoring; the use of digital/remote capabilities for the critical Medicare Diabetes Prevention Program; and initial condition-specific support for using AI software to support clinical decision-making. More recently, we are broadly supportive of the Centers for Medicare & Medicaid Services' (CMS') new Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model, a voluntary, 10-year payment initiative that will test outcome-aligned payments in Original Medicare enabling providers to use technology-supported care for managing chronic conditions by tying reimbursements to measurable patient health improvements rather than specific services.

Despite this progress, one of the biggest challenges in the current system is ensuring proper payment for medical software, often called software as a medical device (SaMD). The current payment structure for SaMD routinely lumps costs for cutting-edge diagnostics software together with costs for scheduling and word processing programs, despite their difference in use cases and costs to the provider. Grouping these different types of software together in the lower-tier

"indirect practice expense" payment category discourages the use of high-tech SaMD by putting its cost out of reach for many healthcare providers.

Over recent years, CMS has issued multiple requests for comments and information on technology and digital medicine topics, which parallel the topics addressed in a "Software as a Service (SaaS) Request for Information" embedded within the draft 2026 Medicare Physician Fee Schedule proposed rule. Despite CMS' repeated inquiries about software-based technologies and AI, and concerns about outdated methodologies for supporting clinical decision-making in outpatient and physician office settings, the agency has yet to provide substantive policy updates to reflect the critical role that software can and should play in patient care.

While CMS has traditionally considered SaMD to be an indirect cost (effectively, a refusal to reimburse any costs for SaMD), beginning in 2022, CMS has consistently indicated its interest in revising its approach to SaMD. Until that systemic change is accomplished, CMS has been cross-walking payment rates for SaMD-inclusive codes to different services' whole rates that are similar to what CMS would have paid if the SaMD product had been included as a direct input. CHI appreciates these interim steps taken by CMS but recognizes that cross-walking is not a long-term solution. Given the rise of efficacious digital health solutions (e.g., the Food and Drug Administration has authorized more than 1,000 artificial intelligence- and machine learning-enabled medical devices), CMS now has an ethical obligation to steward Medicare beneficiary access to leading clinically validated SaMD treatment solutions. Congress should take a leadership role in advancing modernized coverage and payment policies across the U.S. healthcare ecosystem.

This overdue modernization is also necessary to make meaningful progress in transitioning today's healthcare system to one that is value-based rather than quantity-based. CHI has developed a report addressing recent payment reform efforts, examining structural obstacles, and offering targeted recommendations to better align payment policies with care model innovation, which we urge you to consider. These recommendations are available at: https://connectedhi.com/value-based-payment-reform-leveraging-saas-technologies-for-care-model-innovation/.

The Use of Artificial Intelligence in Healthcare

Implementation of AI healthcare tools can not only reduce overall healthcare costs directly, but it can also contribute to increased efficiencies that address challenges such as lack of care coordination, overtreatment, low value of care, burdensome administrative processes, and identification of fraud and abuse within medical systems. These efficiencies will enable professional medical staff to spend more time with patients by utilizing tools that rely on AI to analyze large datasets, facilitating more informed patient care. Healthcare experts see enormous promise in AI's ability to more accurately capture and leverage the range of health data available. Estimates suggest successful use of AI applications will create $150 billion in annual savings for the U.S. healthcare economy alone by the end of this year (note that this savings estimate should be considered conservative, as it only includes a "top 10" of AI scenarios, such as assisted surgery, virtual nursing assistants, and administrative workflow assistance). More efficient and timely use of health data will provide many further benefits across a range of additional

scenarios and use cases. Because improved patient outcomes for Medicare beneficiaries will entail allotting resources to services other than those addressing acute and chronic illnesses, AI can help bring the right resources to the right areas to support additional services such as therapy, tailored case management, habilitative services, and transport and translation costs.

If leading policymakers like the Subcommittee's members navigate the challenges and opportunities effectively, AI will improve beneficiaries' lives through faster and better-informed decision-making enabled by cutting-edge distributed cloud computing. AI will also provide for more effective governance through its ability to enhance infrastructure foresight and support efficient budgeting decisions. AI will beneficially impact every aspect of Americans' lives if we encourage ethical innovation at AI's beginning stages. While CMS is taking some steps to assimilate health AI tools into its Medicare reimbursement process, Congress can support the responsible use of health AI by encouraging things like pilot programs on the use of AI tools. CHI has written extensively on the use of AI in healthcare. See our fuller recommendations in these documents:

- CHI's general principles addressing how policymakers should approach the role of AI in healthcare: https://connectedhi.com/wp-content/uploads/2022/02/Policy-Principles-for-AI.pdf
- CHI recommendations on ways to improve transparency for caregivers, patients, and others necessary for the appropriate uptake of AI tools across the care continuum: https://connectedhi.com/wp-content/uploads/2022/02/AdvancingTransparencyforArtificialIntelligenceintheHealthcareEcosystem.pdf
- CHI's roles and interdependencies framework that advances a shared responsibility for efficacy and safety across the healthcare AI value chain: https://connectedhi.com/wp-content/uploads/2024/02/CHI-Health-AI-Roles.pdf

Conclusion

As we move through 2026, CHI urges the Subcommittee to continue its work on improving patient access to Medicare services. Telehealth services, health AI tools, and other software will continue to be at the forefront of next-generation healthcare delivery. Working toward a safer, smarter, and stronger healthcare system is a whole-of-government effort, and your work will lay a foundation for new strides forward on digital health innovation.

Sincerely,

Brian Scarpelli
Executive Director
Connected Health Initiative

January 8, 2026

The Honorable Chairman Morgan Griffith
The Energy and Commerce Committee
Health Subcommittee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Ranking Member Diana DeGette
The Energy and Commerce Committee
Health Subcommittee
2125 Rayburn House Office Building
Washington, DC 20515

Re: Hearing on Legislative Proposals to Support Patient Access to Medicare Services.

Dear Representatives Griffith and DeGette:

Thank you for holding this hearing on proposals to support patient access to Medicare services.

The American Society of Health-System Pharmacists (ASHP) is the largest association of pharmacy professionals in the United States, representing 60,000 pharmacists, student pharmacists, and pharmacy technicians who work collaboratively with other providers in all patient care settings, including hospitals, ambulatory clinics, and health system community pharmacies.

Pharmacists are the most accessible healthcare providers, with 9 in 10 Americans living within five miles of a pharmacy. This makes pharmacists a particularly critical point of care in rural and underserved areas. Many seniors rely on pharmacists as a trusted source of care and support, often providing the first point of contact for medication-related concerns and preventing or mitigating the impacts of chronic and infectious diseases.

Recognizing seniors' dependence on their pharmacists, states have sought to increase patient access to pharmacist services, both through expanding the scope of services pharmacists are authorized to provide and reimbursing clinical services rendered by a pharmacist. All 50 states, plus the District of Columbia and Puerto Rico, permit pharmacists to enter into collaborative practice agreements (CPAs) with physicians. CPAs enable pharmacists to engage in comprehensive medication management (CMM), including initiating, modifying, and/or discontinuing therapy regimens. Further, 30 states plus the District of Columbia permit pharmacists to independently prescribe at least one drug or device (not including vaccines).[1] Sixteen states permit pharmacists to independently order tests and treatments for COVID-19 and the flu,[2] while pharmacists in all 50 states may order and administer immunizations. Twenty-one states permit pharmacists to independently furnish drugs to prevent HIV infection.[3] Twelve states permit pharmacists to prescribe medications for opioid use disorder (MOUD)[4], while 21 states also permit pharmacists to prescribe drugs for tobacco cessation.[5] As to reimbursement for pharmacists' services, 44 states require health plans and/or Medicaid to cover at least one clinical

[1] AK, AR, AZ, CA, CO, CT, DE, HI, IA, ID, IN, KS, MA, MD, ME, MN, MO, MT, ND, NM, NV, OK, OR, RI, TN, UT, VA, VT, WV, and WY.
[2] AR, CA, CO, DE, IA, ID, IL, KS, MI, MT, NC, NM, NV, OR, VA, and WV.
[3] AR, CA, CO, CT, DE, IA, ID, IL, MD, ME, MN, MT, NC, NM, NV, NY, OR, RI, TN, UT, and VA.
[4] CA, CO, IA, ID, MA, MT, NC, NM, NV, OR, UT, and WA.
[5] AR, AZ, CA, CO, IA, ID, IN, MD, ME, MN, MO, MT, NC, ND, NM, OR, TN, UT, VA. VT, and WV.

service from a pharmacist that is not directly tied to medication dispensing, and 33 states permit pharmacists to enroll as Medicaid providers. Through these efforts, pharmacists have become critical practitioners, and have helped close care gaps, increase access to preventive care, manage conditions like diabetes and high blood pressure, reduce unnecessary visits to emergency departments, and decrease hospital readmissions by providing transition of care support services post discharge.

However, changes are necessary to ensure seniors' access to critical pharmacist patient care services. Please find our recommendations on improving seniors' access to care in Medicare below. We look forward to working with you to ensure Medicare beneficiaries, and all Americans, continue to have access pharmacists' services.

Providing Medicare Beneficiaries Access to Pharmacists' Services: Pharmacists are the most accessible healthcare provider for many seniors, often providing the first point of contact for medication-related concerns and preventing or mitigating the impacts of infectious disease. Many seniors rely on pharmacists as a trusted source of care and support. Unfortunately, since Medicare does not recognize pharmacists as providers, many seniors are denied coverage for this care. The Ensuring Community Access to Pharmacist Services (ECAPS) Act (H.R. 3164/S. 2426), would provide seniors with access to pharmacist-provided test and treatment and/or vaccines for select respiratory conditions like influenza, respiratory syncytial virus, strep throat, and pneumococcal disease. **We support passage of the ECAPS Act, which would ensure Medicare patients have access to testing, vaccination, and treatment services for respiratory infections that pharmacists are authorized by their states to provide.**

Removing Administrative Barriers to Medicare Beneficiaries Accessing Pharmacists Services in Medicare Advantage Plans: We recognize that pharmacists are not QHPs under Medicare Part B. However, they can and do provide state-authorized patient care services to Medicare beneficiaries. This care is often disrupted because CMS does not provide a clear mechanism for pharmacists to enroll in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). Pharmacists are not on the list of eligible professionals or non-physician specialty types for PECOS enrollment. This fails to account for the patient care role that pharmacists play in ambulatory clinical settings and results in care disruptions for Medicare beneficiaries. For example, because Medicare Part B only covers prescription claims issued by providers enrolled in PECOS, Medicare rejects prescription claims even for beneficiaries with a valid prescription initiated by pharmacists, as authorized by their state license. As a result, beneficiaries must go for a second, medically unnecessary visit simply to have the same prescriptions issued by a PECOS-enrolled prescriber. Limiting pharmacists this way is in direct conflict with state scope of practice laws that allow pharmacists to initiate medications for certain conditions (e.g., HIV pre-exposure prophylaxis, insulin, and diabetes supplies, etc.). Beneficiaries experience similar coverage barriers for laboratory testing and durable medical equipment ordered by pharmacists acting within their state scope of practice. **We support requiring CMS to ensure that pharmacists can enroll in PECOS as a non-physician specialty type.**

Additionally, enrolling in PECOS is also required for a pharmacist to receive a Provider Transaction Access Number (PTAN), necessary for internal processing and communication with Medicare and

Medicare Advantage. A PTAN is obtained after enrolling in PECOS and from a Medicare Administrative Contractor (MAC). It is an administrative tool used to communicate with MACs and to authenticate and manage Medicare Advantage enrollment and billing. It is different from the National Provider Identifier (NPI) in that a healthcare provider will have one NPI and can have multiple PTANs depending on which commercial plan(s) they are contracting with and enrolled in. Without a mechanism to obtain a PTAN, pharmacists enrolled in and contracting with Medicare Advantage plans are unable to follow administrative steps to bill for and reimbursed for services. **We support requiring CMS to provide an administrative mechanism for pharmacists to obtain a PTAN.**

Pass Legislation Permitting Physicians to Bill for the Full Scope of Pharmacists' Services: Pharmacists work as medication specialists on interprofessional care teams, improving patient health outcomes while reducing workload burdens of their colleagues. Medicare recognizes the critical collaborative role pharmacists play by allowing physicians to bill for services provided by pharmacists under their supervision — a practice known as "incident-to" billing. Unfortunately, federal regulations hamstring physicians' ability to fully utilize pharmacists' education, training, and experience. The CY2021 Centers for Medicare and Medicaid Services Physician Fee Schedule final rule stated that pharmacists' patient care services provided incident-to a physician or nonphysician practitioner must be billed at the lowest evaluation and management (E/M) service code (99211), eliminating the ability for pharmacists to bill incident-to for complex services that would generally be reimbursed under the higher level E/M codes (99212 – 99215) for other qualified health professionals (QHPs).[1] This policy shift undermines care models that enable pharmacists to support physicians and the care teams in which they participate in providing comprehensive care to seniors, thereby threatening patient access to critical services. **We support legislation that would require CMS to allow physicians to bill, incident-to the physician, across all levels of medical decision making for E/M services provided by a pharmacist practicing within their scope of practice, while under the general supervision of such physician.**

Clarifying the Uncertainty Over Pharmacy Residency Funding: Pharmacy residencies are postgraduate training programs that equip pharmacists to meet the challenges of today's complex healthcare environment. Unfortunately, CMS has refused to tell residency programs sponsored by hospitals that are part of health systems or academic medical centers how they should comply with agency requirements. Despite this lack of guidance, CMS alleges that standard hospital business and training practices are noncompliant, resulting in funding clawbacks from many residency programs. The Rebuild America's Health Care Schools Act (S. 1087/H.R. 1708) would require CMS to clarify the requirements health systems must meet to receive Medicare reimbursement for operating pharmacy, nursing, and allied health residency programs, and halt the clawbacks of these critical funds. **We support passage of the Rebuild America's Health Care Schools Act that would help the next generation of America's pharmacy workforce.**

[1] Centers for Medicare & Medicaid Services, Physician Fee Schedule CY 2021 Final Rule, 85 Fed. Reg. 84592-3 (Dec. 28, 2020), *available at* https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf (Limiting physicians supervising pharmacist-provided incident-to services to billing code 99211 for those services, despite the fact that many of the services provided by pharmacists meet the complexity and duration criteria set forth for code 99212-14).

Facilitate Pharmacists' Role in Treating MOUD: As medication experts, pharmacists are uniquely positioned to address the ongoing opioid crises by assuming a more active role in directly initiating and managing MOUD. Pharmacists are particularly well positioned to respond to the crisis of opioid use in rural and underserved areas that have long suffered from an absence of OUD treatment providers. While the Mainstreaming Addiction Treatment (MAT) Act was a significant step forward in enabling pharmacists to reduce deaths due to overdose, more can be done to help pharmacists expand access to MOUD. While several states have authorized pharmacists to prescribe MOUD, these pharmacists unfortunately face operational barriers to prescribing buprenorphine and other forms of MOUD. The DEA's system for registration is antiquated because it prohibits pharmacists in some states from registering as MOUD prescribers — despite state laws specifically authorizing pharmacists to prescribe MOUD. The DEA's "Mid-Level Practitioners Authorization by State" table needs to be updated to recognize states that allow pharmacist prescribing of MOUD. **We support requiring the DEA to update its online application and the Mid-Level Practitioners Authorization by State table to allow and include pharmacists in states permitting pharmacists to prescribe MOUD.**

ASHP thanks you for holding this important hearing and considering our recommendations. We look forward to continuing to work with you to ensure seniors have access to care. If you have questions or if ASHP can assist your office in any way, please contact Frank Kolb at fkolb@ashp.org.

Sincerely,

Tom Kraus
American Society of Health-System Pharmacists

cc: Chairman Brett Guthrie and Ranking Member Frank Pallone.

KFF The independent source for health policy research, polling, and news.

Poll Finding

2025 KFF Marketplace Enrollees Survey

Authors: Lunna Lopes, Grace Sparks, Mardet Mulugeta, Isabelle Valdes, and Ashley Kirzinger

Published: Dec 4, 2025

About the Survey

In 2021, during the COVID-19 pandemic, Congress passed the American Rescue Plan Act (ARPA) which temporarily increased tax credits available for adults purchasing their own health insurance through the ACA Marketplace. These enhanced tax credits increased the financial assistance available to existing Marketplace enrollees who already qualified for financial help and extended financial assistance to some middle-income adults who were previously not eligible for premium tax credits. The tax credits were extended as part of the 2022 Inflation Reduction Act and are set to expire at the end of 2025.

If Congress does not extend the tax credits beyond 2025, premium payments will increase 114% on average for the 22 million people who currently get a tax credit. To better understand how people are navigating these cost increases during the 2026 Open Enrollment period, which began on November 1st, KFF conducted a probability-based survey of 1,350 adults who purchase coverage on the ACA Marketplaces.

This report highlights their expectations for their health insurance coverage and costs for 2026, as well as how increased health care costs may affect their coverage decisions, finances, and their political preferences in the coming elections.

News Release: Poll: 1 in 3 ACA Marketplace Enrollees Say They Would "Very Likely" Shop for a Cheaper Plan If Their Premium Payments Doubled; 1 in 4 Say They "Very Likely" Would Go Without Insurance

Findings

Key Takeaways

Marketplace enrollees largely see health insurance as *very important* to their ability to access care, to their financial well-being, and to their peace of mind; however, if the enhanced premium tax credits are not extended, many of the twenty-four million adults in the U.S. who currently buy their own insurance through the ACA Marketplace may consider changes to their current coverage. When asked what they would do if the amount they pay for health insurance each month doubled, one in three enrollees (32%) say they are very likely to shop for a lower-premium plan (with higher deductibles and out-of-pocket costs) and one in four (25%) say they would be very likely to go uninsured.

Notably, with Congress potentially voting on extending the premium tax credits in December and recent discussions about a Republican health care proposal, the vast majority of enrollees (89%) expect to make a decision about the 2026 coverage by the end of the year, including many enrollees who say they have already made their decision.

Many Marketplace enrollees are already struggling with health care costs. Six in ten adults (61%) who buy their health coverage on the ACA Marketplace say it is very or somewhat difficult to afford their deductibles and out-of-pocket costs for medical care and half (51%) say it is difficult to afford the cost of health insurance premiums each month. In addition, nearly six in ten Marketplace enrollees say they would not be able to afford an annual increase of $300 in health care expenses without significantly disrupting their household finances.

The enhanced premium tax credits allow most Marketplace enrollees to pay less than the full price of their health insurance premiums, and the poll finds bipartisan support among Marketplace enrollees for Congress to extend these tax credits even as the political parties in Congress disagree about the way forward. More than eight in ten (84%) Marketplace enrollees – including nearly all Democrats and about seven in ten Republicans – say Congress should extend the tax credits. If the tax credits are allowed to expire, most enrollees who want to see the credits extended think either President Trump (41%) or Congressional Republicans (35%) deserve most of the blame.

Following the longest federal government shutdown in U.S. history, which ended without an extension of the enhanced premium tax credits, about two-thirds of Marketplace enrollees say they have either “not much” or “no confidence” in President Trump, nor in Congressional Republicans, to address health care costs for people like them. Congressional Democrats fare slightly better, but still more than half of enrollees say they lack confidence in Congressional Democrats to address this issue.

Regardless of whether Marketplace enrollees decide to continue with their current Marketplace plan, switch to a lower-premium but higher-deductible plan, or go uninsured in 2026, many will face higher health care expenses next year and many say this increased financial burden will impact how they approach the 2026 midterm election. A slight majority (54%) of enrollees who are registered to vote say if their health care expenses increase by $1,000 next year, it would have a major impact on whether they will vote in the 2026 elections and about half (52%) say it would have a major impact on which party’s candidate they will support.

Most Enrollees Are Wary About Expiring Enhanced Premium Tax Credits

Open enrollment for the ACA Marketplace began on November 1st amid a government shutdown as Congress debated extending the tax credits. The survey, conducted in the first weeks of open enrollment and as Congress passed a short-term spending bill, finds that the focus on the enhanced premium tax credits has resonated with most Marketplace enrollees. At the time the survey was fielded in mid-November, about six in ten Marketplace enrollees say they've heard "a lot" (27%) or "some" (32%) about the enhanced premium tax credits. However, four in ten enrollees say they have heard "a little" (22%) or "nothing at all" (19%) about the enhanced premium tax credits. In most states, open enrollment for ACA Marketplace plans ends on January 15th, 2026.

As of mid-November, a slight majority (56%) of enrollees say they have looked for, sought out, or received any information about what the cost of their health insurance will be in 2026. Enrollees in states that use the federal ACA Marketplace platform are more likely than those in states that have a state-run Marketplace to say they have looked for or received information about the cost of their health insurance for next year (62% vs. 49%).

Figure 1

A Slight Majority of Enrollees Say They Have Looked for or Received Information About the Cost of Their Health Insurance for 2026

Have you looked for, sought out, or received any information about what the cost of your health insurance will be next year, that is, in 2026?

Note: Among adults with health coverage purchased through the Marketplace in 2025. See topline for full question wording.

▶ Marketplace type details

Source: KFF 2025 Marketplace Enrollees Survey (November 7-15, 2025)

KFF

More than half of Marketplace enrollees (54%) expect that the cost of their health insurance coverage for next year will “increase a lot more than usual.” A further one in four (26%) expects it to increase a “little more than usual,” while fewer expect their health insurance costs to “increase about the same as usual” (12%) or to “not increase at all” (8%). Enrollees with higher incomes are somewhat more likely than those with lower household incomes to expect their costs to increase “a lot more than usual.” Notably, Marketplace enrollees with an income just above 400% of the federal poverty level (FPL), who currently pay no more than 8.5% of their income in monthly insurance premiums, would have to pay full price for their insurance coverage if the enhanced premium tax credits are allowed to expire.

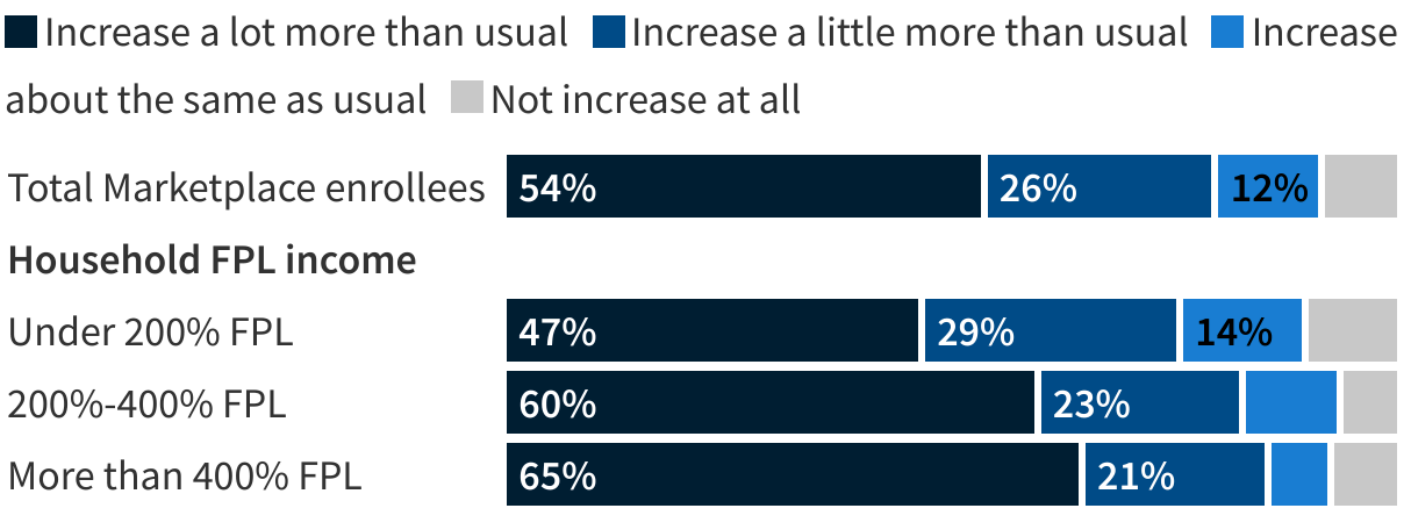
Half or more across partisans and geographies expect the cost of their health insurance for next year to increase “a lot more than usual,” including 60% of Democrats, 52% of Republicans, 54% of independents, 53% of enrollees living in

states that have expanded Medicaid, and 56% of enrollees living in states that have not expanded Medicaid.

Figure 2

Just Over Half of Enrollees Expect That the Cost of Their Own Health Insurance Coverage Will Increase a Lot More Than Usual Next Year

Next year, do you think the cost of your own health insurance coverage will…?



Note: Among adults with health coverage purchased through the Marketplace in 2025. See topline for full question wording.

Source: KFF 2025 Marketplace Enrollees Survey (November 7-15, 2025)

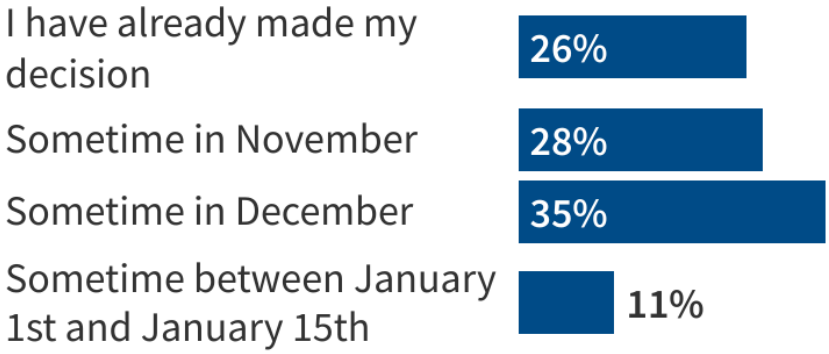
KFF

About nine in ten (89%) Marketplace enrollees say they will make a decision about their coverage for 2026 this year, including one in four (26%) who say they have already made a decision about their health insurance coverage for next year and 28% who planned to make a decision sometime in November. Enrollees must generally select a plan or be automatically reenrolled by December 15 for coverage to start on January 1, 2026. About a third (35%) of enrollees say they plan to make their health insurance decision in December, while one in ten (11%) say they plan to decide in early January.

Figure 3

Most Marketplace Enrollees Will Make a Decision About Their 2026 Coverage by the End of This Year

When do you plan on making a final decision about your health insurance coverage for 2026, whether that is continuing to pay for coverage or no longer having health insurance?



Note: Among adults with health coverage purchased through the Marketplace in 2025. See topline for full question wording.

Source: KFF 2025 Marketplace Enrollees Survey (November 7-15, 2025)

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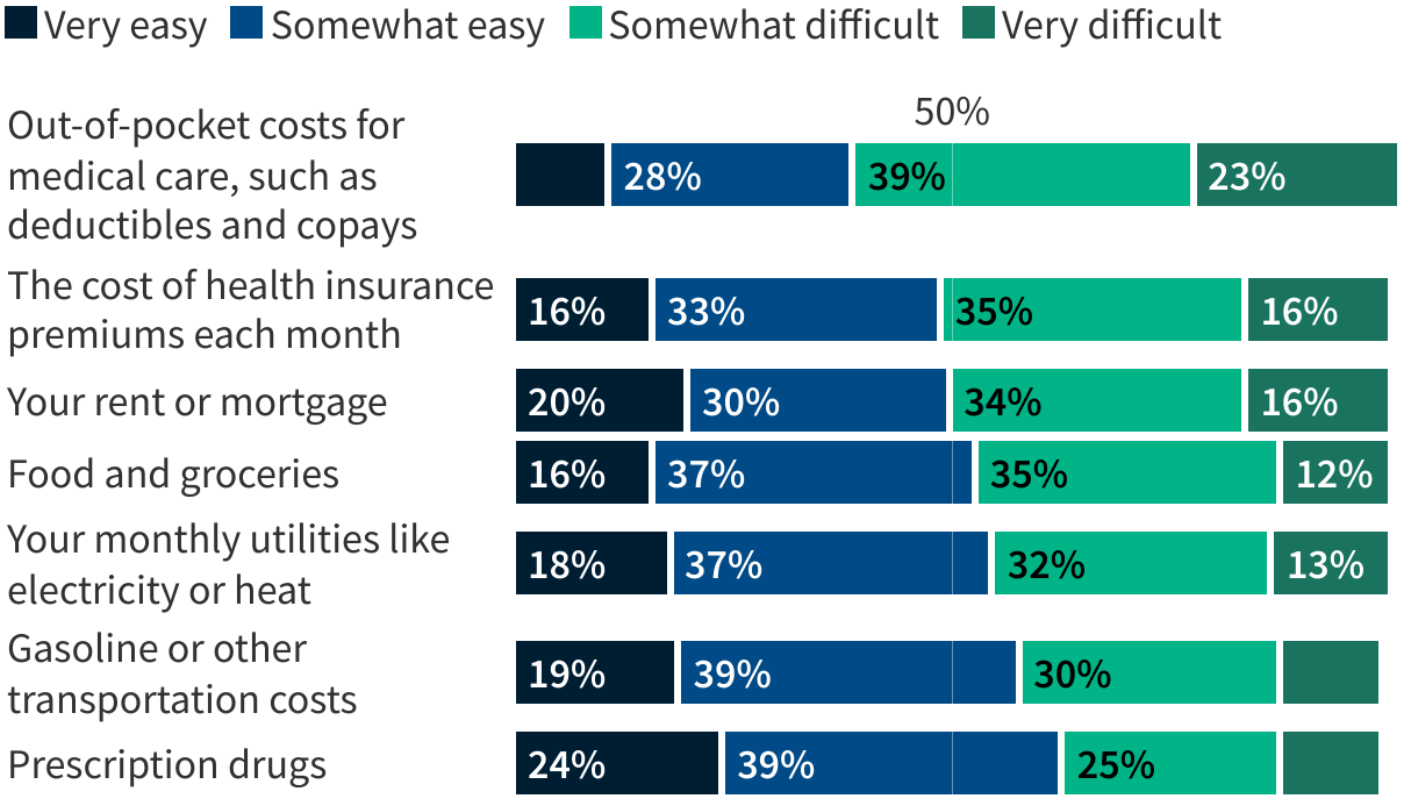
Most Enrollees See Health Insurance as Very Important – Particularly Those Ages 50 and Older

Even with the current financial help provided by the enhanced premium tax credits, many Marketplace enrollees are already struggling to afford health care costs. About six in ten (61%) Marketplace enrollees say it is very difficult or somewhat difficult for them to afford out-of-pocket costs for medical care, and about half (51%) say they already have difficulty affording their health insurance premiums. Out-of-pocket costs for medical care ranks as the top household budget item that Marketplace enrollees find difficult to afford – ranking ahead of rent or mortgage, food and groceries, utilities, and housing costs.

Figure 4

Many Marketplace Enrollees Are Already Experiencing Difficulty Affording Health Care Costs

In general, how easy or difficult is it for you to afford the following?



Note: Among adults with health coverage purchased through the Marketplace in 2025. See topline for full question wording.

Source: KFF 2025 Marketplace Enrollees Survey (November 7-15, 2025)

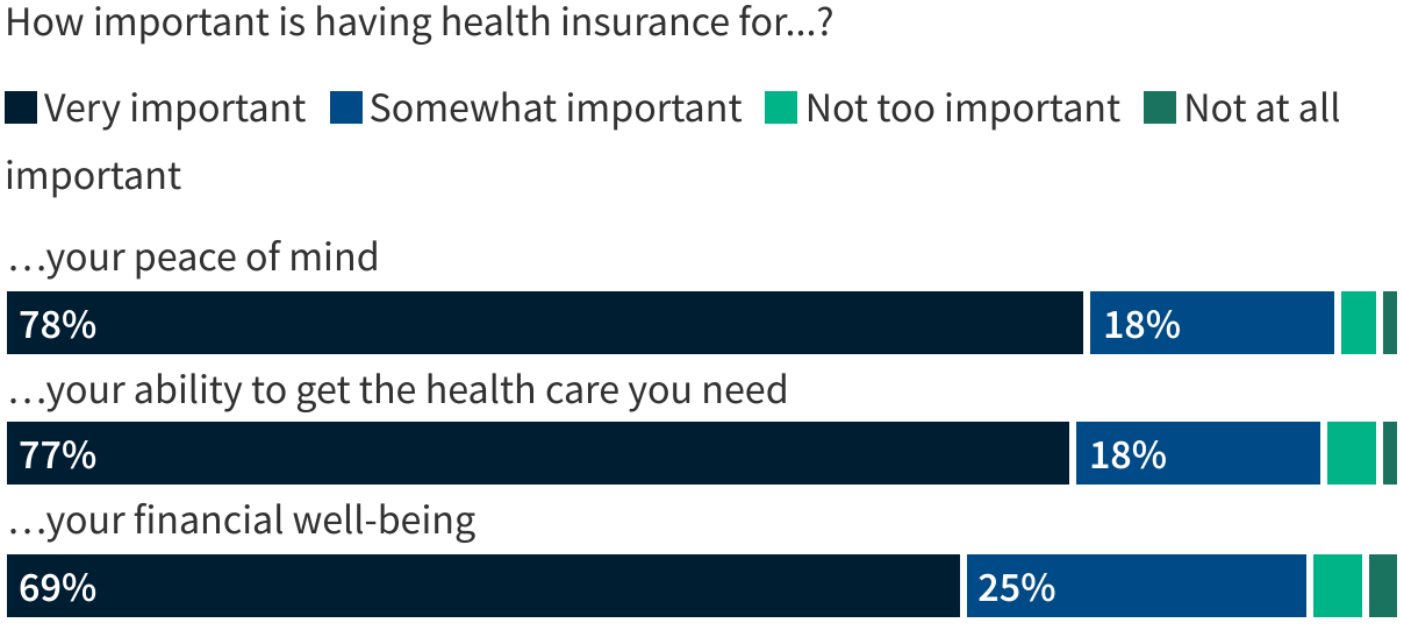
KFF

Yet, health insurance is a clear priority for Marketplace enrollees. More than three in four say having health insurance is “very important” for their ability to get the health care they need (77%) and for their peace of mind (78%). About seven in ten (69%) say it is “very important” for their financial well-being. Notably, enrollees between the ages of 50 and 64 – a group that does not yet qualify for Medicare but may have additional age-related health care needs – are more likely than younger enrollees to say that health insurance is very important to accessing needed health care, to their financial well-being, and to their peace of mind. A majority of Marketplace enrollees,

regardless of partisanship, say that health insurance is “very important” to their financial wellbeing, their peace of mind, and their ability to access health care.

Figure 5

Most Marketplace Enrollees Say Health Insurance Is Very Important to Their Peace of Mind, Ability To Get Care, and Financial Well-Being



Note: Among adults with health coverage purchased through the Marketplace in 2025. See topline for full question wording.

Source: KFF 2025 Marketplace Enrollees Survey (November 7-15, 2025)

KFF

Expiring Premium Tax Credits May Make Coverage Unaffordable for Most Marketplace Enrollees

Nine in ten Marketplace enrollees (90%) expect that the expiration of the enhanced premium tax credits will have an impact on the amount they pay monthly for their health insurance, including seven in ten (69%) who say it will have a “major impact.”

KFF analysis has found that if the enhanced premium tax credits for adults who purchase their own insurance through the ACA Marketplace are not extended, the annual amount that enrollees pay for their premiums for 2026 will more than double on average.

The KFF 2025 Marketplace Enrollees Survey finds that this type of increase could have a significant impact on the household finances of the millions of adults who purchase their own insurance through the ACA Marketplaces. Nearly six in ten enrollees (58%) say they would not be able to afford an increase of just $300 per year in the amount they pay for insurance without significantly disrupting their household finances. Those with lower incomes are likely to see smaller dollar increases in their premium payments, yet notably seven in ten (70%) enrollees with household incomes under 200% FPL say they wouldn't be able to afford a $300 increase in the amount they pay each year, which is the approximate increase for a low income person to keep a "silver plan" if the enhanced premium tax credits expire.

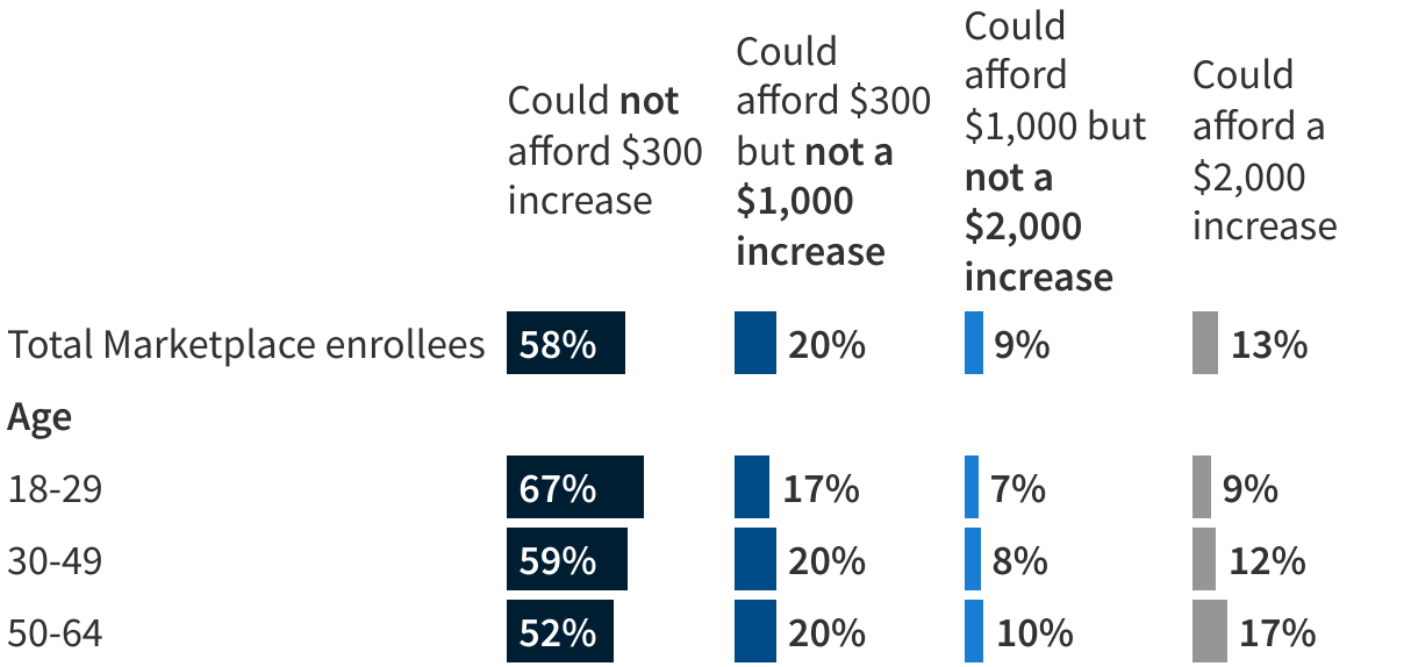
If enrollees said they could afford an annual increase of $300, they were then asked about their ability to afford larger annual increases. A further 20% of enrollees say they would be unable to afford an increase of $1,000 per year, the average projected increase, without significant financial disruption. Only one in eight Marketplace enrollees (13%) say they could afford an increase of $2,000 or more (which some people would face).

Younger adults are less likely to be able to afford any increase, including two-thirds (67%) of adults ages 18 to 29 who say they would not be able to afford a $300 annual increase without disrupting their household finances. ACA Marketplace insurers have expressed concern that the expiring tax credits will lead to younger, healthier people disproportionately dropping their coverage, and are therefore raising premiums more than they otherwise would.

Figure 6

Nearly Six in Ten Marketplace Enrollees Say They Could Not Afford To Pay an Increase of $300 for Their Health Insurance per Year Without It Disrupting Their Finances

If the amount you pay for your health insurance increased by $300 a year [*If yes:* increased by $1,000; *If yes:* increased by $2,000] would you be able to afford it without significantly disrupting your household finances?



Note: Among adults with health coverage purchased through the Marketplace in 2025. See topline for full question wording.

Source: KFF 2025 Marketplace Enrollees Survey (November 7-15, 2025)

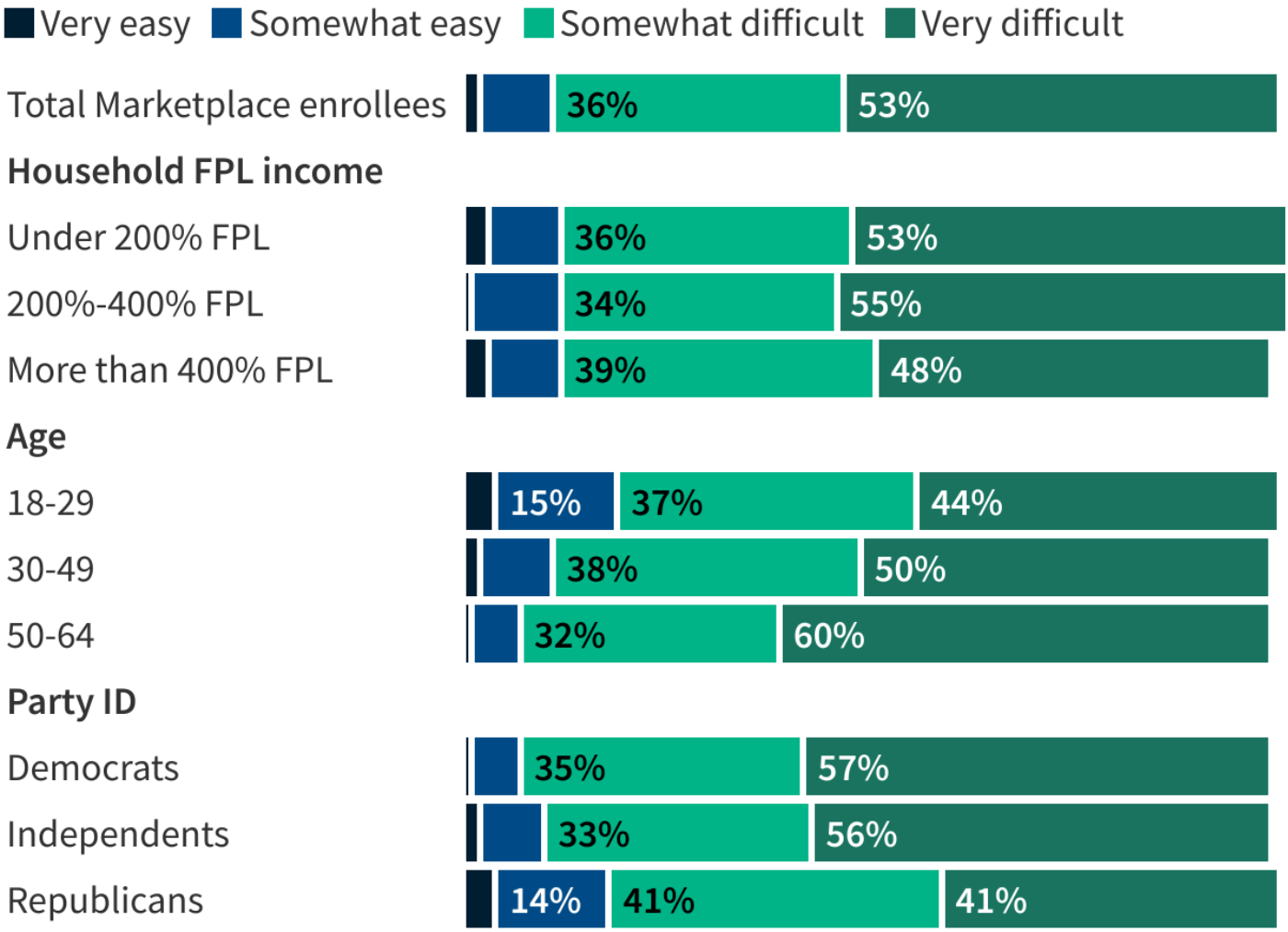
KFF

About half of Marketplace enrollees (53%) say it would be “very difficult” for them to find another source of health insurance they could afford if their current coverage became unaffordable, and a further 36% say it would be “somewhat difficult.” Majorities of enrollees, regardless of their household income or age, say it would be at least somewhat difficult to find another source of health insurance coverage.

Figure 7

About Half of Marketplace Enrollees Say It Would Be Very Difficult To Find Another Source of Coverage if Their Health Insurance Became Unaffordable

If the monthly amount you pay for your health insurance became unaffordable, how easy or difficult would it be for you to find another source of health insurance coverage that you could afford?



Note: Among adults with health coverage purchased through the Marketplace in 2025. See topline for full question wording.

Source: KFF 2025 Marketplace Enrollees Survey (November 7-15, 2025)

KFF

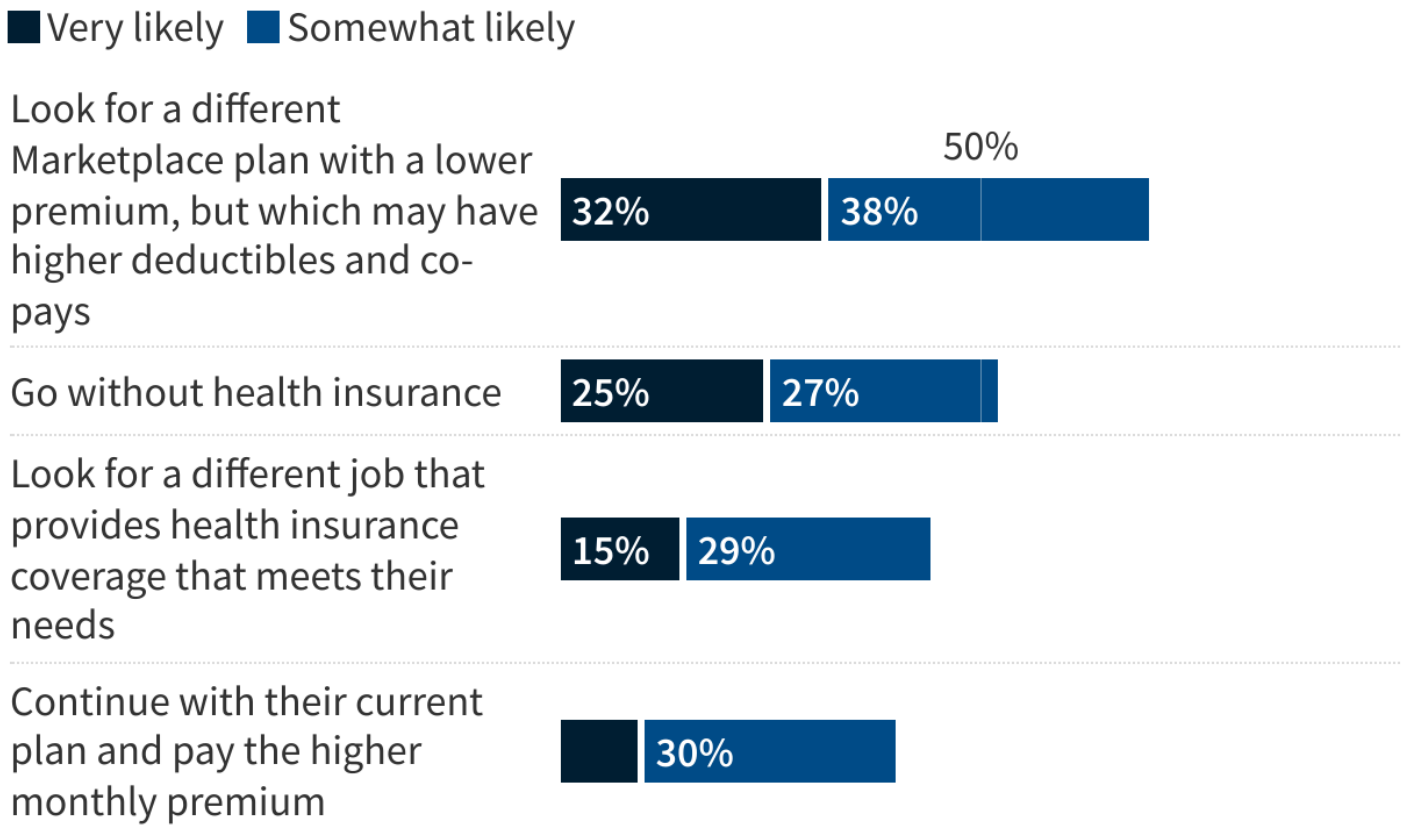
Marketplace enrollees may respond to a projected increase in premiums in different ways. If the monthly amount enrollees pay for their health insurance doubled (or

increased by $50 for those who currently do not pay a premium), about a third (32%) say they would be “very likely” to look for a different Marketplace plan with a cheaper premium, but higher deductibles and co-pays. A quarter of enrollees (25%) say they would be “very likely” to go without health insurance. About one in seven (15%) say they would be “very likely” to look for a different job that provides health insurance that meets their needs and only 10% say they are “very likely” to stay with their current insurance plan if their monthly premium payments doubled.

Figure 8

Marketplace Enrollees May Consider Different Health Insurance Options if Premium Payments for Their Current Coverage Doubled

Percent who say that if the monthly amount they pay for their health insurance doubled [*For those who currently do not pay a premium:* increased by $50] they would be **very** or **somewhat likely** to:



Note: Among adults with health coverage purchased through the Marketplace in 2025. See topline for full question wording.

Source: KFF 2025 Marketplace Enrollees Survey (November 7-15, 2025)

KFF

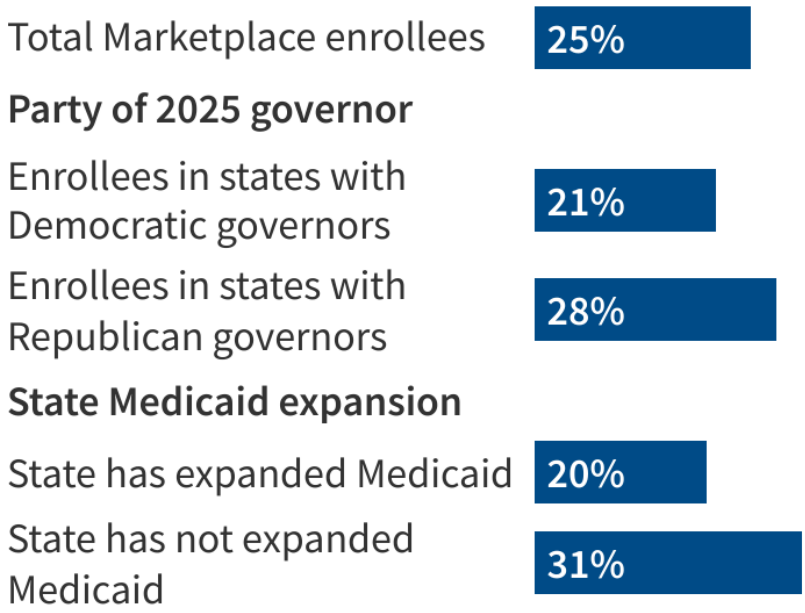
Notably, about three in ten (28%) Marketplace enrollees from states with current Republican governors say they are “very likely” to go uninsured if the monthly amount they pay for health insurance doubles, as expected on average, if the tax credits are not extended. Among Marketplace enrollees in states that have not expanded Medicaid coverage under the ACA, where more people with incomes just

above the poverty level are eligible to enroll in Marketplace coverage with premium tax credits, three in ten (31%) say they are very likely to go uninsured if faced with a doubling of their monthly health insurance premiums.

Figure 9

About Three in Ten Enrollees in Republican-Led States and States That Have Not Expanded Medicaid Say They Are Very Likely To Go Uninsured if Premium Payments Doubled

Percent who say that if the monthly amount they pay for their health insurance doubled [*For those who currently do not pay a premium:* increased by $50] they would be **very likely to go without health insurance:**



Note: Among adults with health coverage purchased through the Marketplace in 2025. See topline for full question wording.

▶ Party of 2025 governor details

▶ State Medicaid expansion details

Source: KFF 2025 Marketplace Enrollees Survey (November 7-15, 2025)

KFF

In Their Own Words: Why some current Marketplace enrollees aren't planning on buying health insurance coverage for 2026

“Without the subsidies, my monthly premiums will increase by nearly $750 a month, or $9000 for the year. My budget is tight as it is, and there’s no way I can afford that additional hit. The only way I will be able to continue with my health insurance is if Congress restores the subsidies.” — 63-year-old man, Democrat, California

“I was paying $0 then it went up to over $600 for 2026. My husband has to continue coverage in order to avoid going blind. I’m going to drop myself off the coverage and just have insurance for him so he can continue to work and pay for the insurance.” — 60-year-old woman, Republican, Missouri

“We cannot afford it. Our premium went from being $25 with subsidy to $300 for the same plan. With everything increasing in price like groceries, we simply cannot afford it” — 39-year-old woman, Democrat, Oklahoma

“Premiums are too high for my usage, will switch to cost sharing like medishare or Samaritans” — 42-year-old woman, Republican, North Carolina

“The cost of the same plan is going to be exponentially higher than the current plan and I would have to go with a “bronze” plan in order to be able to keep my premiums somewhat reasonable.” — 54-year-old woman, Democrat, Texas

“Way too expensive. There was a $231 increase in the premium!” — 46-year-old woman, independent, Indiana

“If subsidies are not extended, I can’t afford it.” — 56-year-old man, independent, Nevada

“I cannot afford the premium increase for the incredibly bad insurance.” — 55-year-old man, Republican, Idaho

How a $1,000 Annual Increase Would Affect Marketplace Enrollees

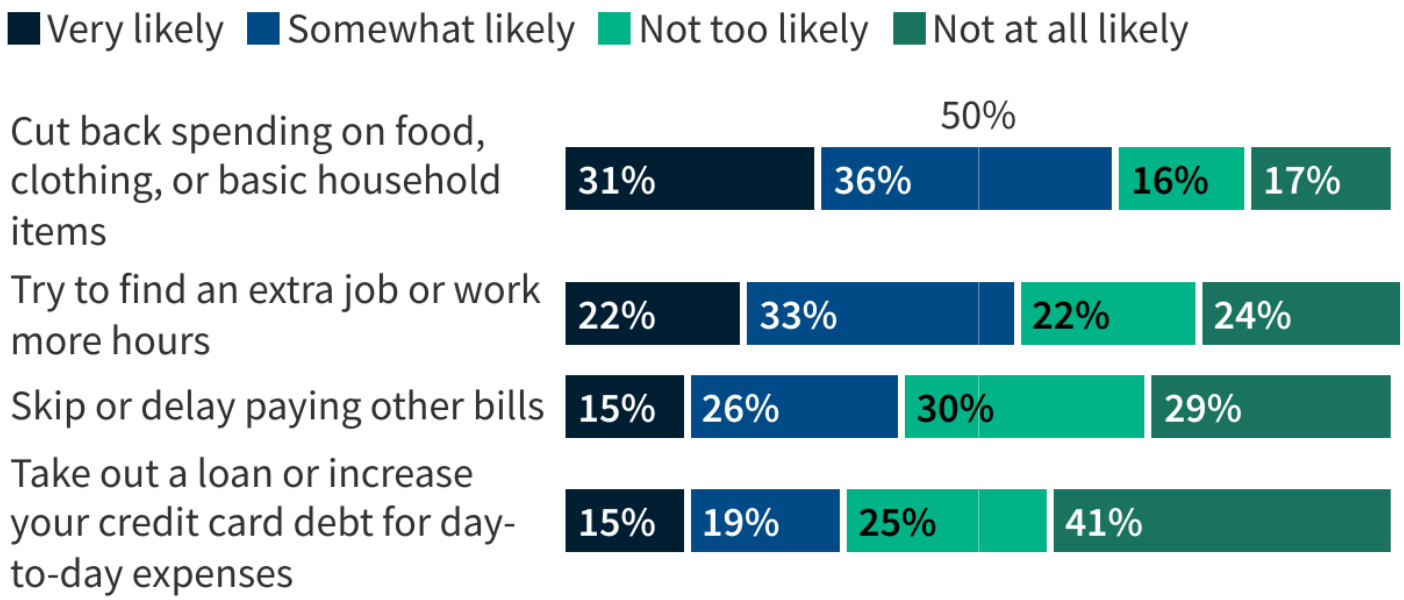
Regardless of what they decide to do about their health insurance coverage for next year, the vast majority of current Marketplace enrollees are likely to face an increase in their overall health care expenses in 2026. Those who choose to stay with their current insurance plan may face substantial premium payment increases, those who switch to a lower-premium plan will likely face increased out-of-pocket costs through higher deductibles and co-pays, and those who go uninsured may face costly medical bills if they need care.

If faced with an annual increase of $1,000 in health care expenses, most Marketplace enrollees (67%) say they are very or somewhat likely to cut back spending on food, clothing, or basic household items in order to cover additional health care costs. More than half (54%) say they would be very or somewhat likely to try to find an extra job or work more hours to cover an increase in health care expenses. About four in ten (41%) say they would skip or delay paying other bills and about a third (34%) say they would take out a loan or increase their credit card debt for day-to-day expenses if faced with an increase of $1,000 in health care expenses.

Figure 10

If Faced With an Increase of $1,000 in Health Care Expenses, About Two-Thirds of Marketplace Enrollees Would Cut Back Spending; More Than Half Would Try and Find Extra Work

If your overall health care expenses (including co-pays, deductibles, and premiums) increased by $1,000 next year, how likely would you be to do each of the following in order to cover those additional costs?



Note: Among adults with health coverage purchased through the Marketplace in 2025. See topline for full question wording.

Source: KFF 2025 Marketplace Enrollees Survey (November 7-15, 2025)

KFF

Assessing the Political Implications of Failing To Extend the Tax Credits

On October 1st, the federal government was shut down when Democratic senators attempted to negotiate a vote for continued government funding in exchange for the extension of the enhanced premium tax credits for adults who purchase their own insurance through the ACA Marketplace. As part of a deal to end the recent federal

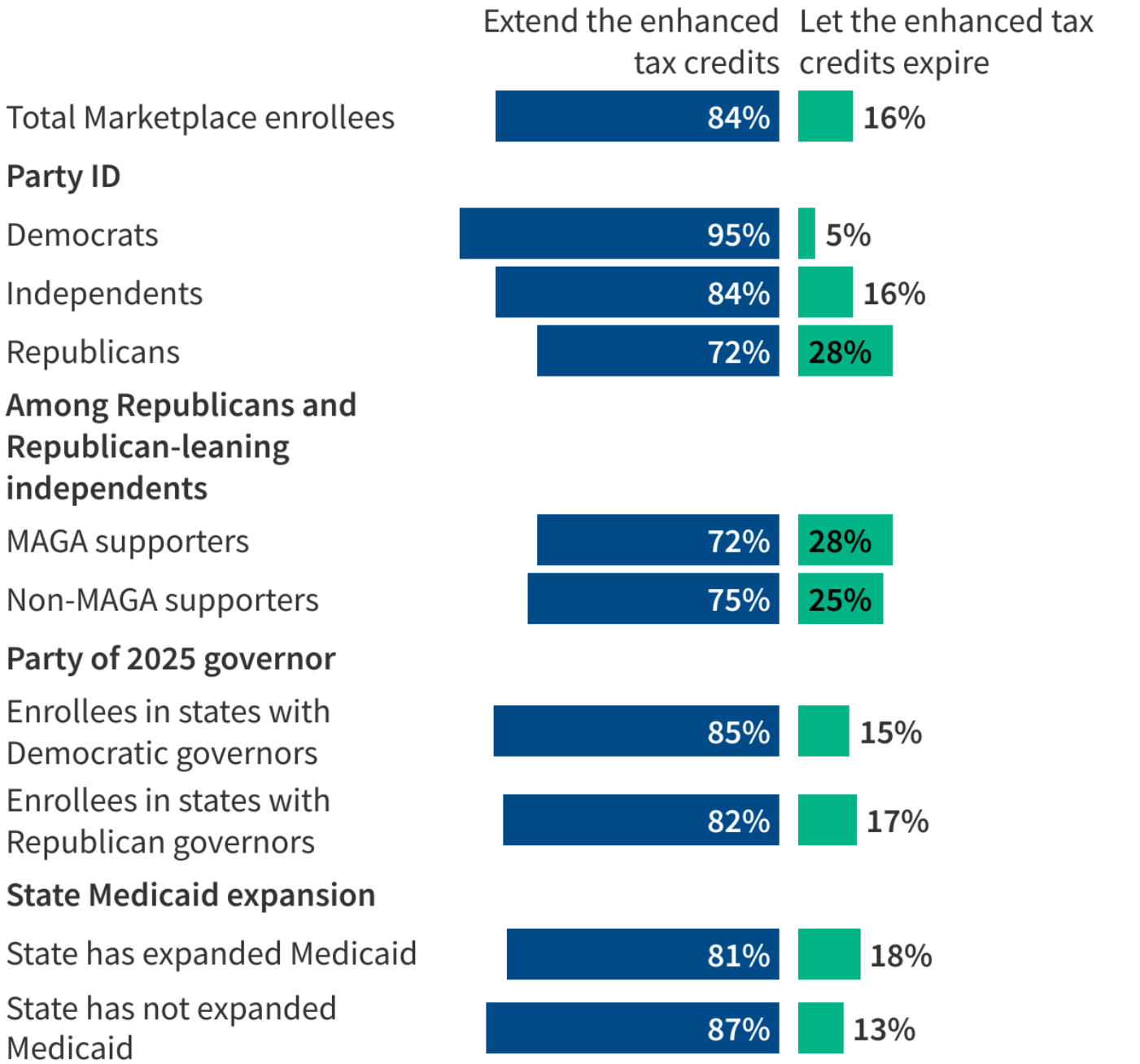
government shutdown, Republican Congressional leaders have promised Democrats a vote on the ACA Marketplace enhanced premium tax credits in December.

More than eight in ten (84%) Marketplace enrollees say that Congress should extend the enhanced tax credits, while one in six (16%) think they should let the tax credits expire. Majorities across partisanship want to extend the enhanced premium tax credits, including nearly all Democrats (95%), about eight in ten independents (84%), and about seven in ten Republicans (72%) enrolled in Marketplace plans. About seven in ten (72%) Republicans or Republican-leaning independents who support the MAGA movement and get insurance through the Marketplaces want to extend the credits, while about three in ten (28%) want to let them expire. Majorities of Marketplace enrollees, regardless of where they live, including those living in states that haven't expanded their Medicaid programs or living in states with Republican governors, want to see Congress extend these tax credits.

Figure 11

Over Eight in Ten 2025 Marketplace Enrollees Want To Extend Enhanced Tax Credits, Including Majorities Across Partisanship

Do you think Congress should extend these enhanced tax credits, or should they let these enhanced tax credits expire?



Note: Among adults with health coverage purchased through the Marketplace in 2025. See topline for full question wording.

- ▶ Party of 2025 governor details
- ▶ State Medicaid expansion details

Source: KFF 2025 Marketplace Enrollees Survey (November 7-15, 2025)

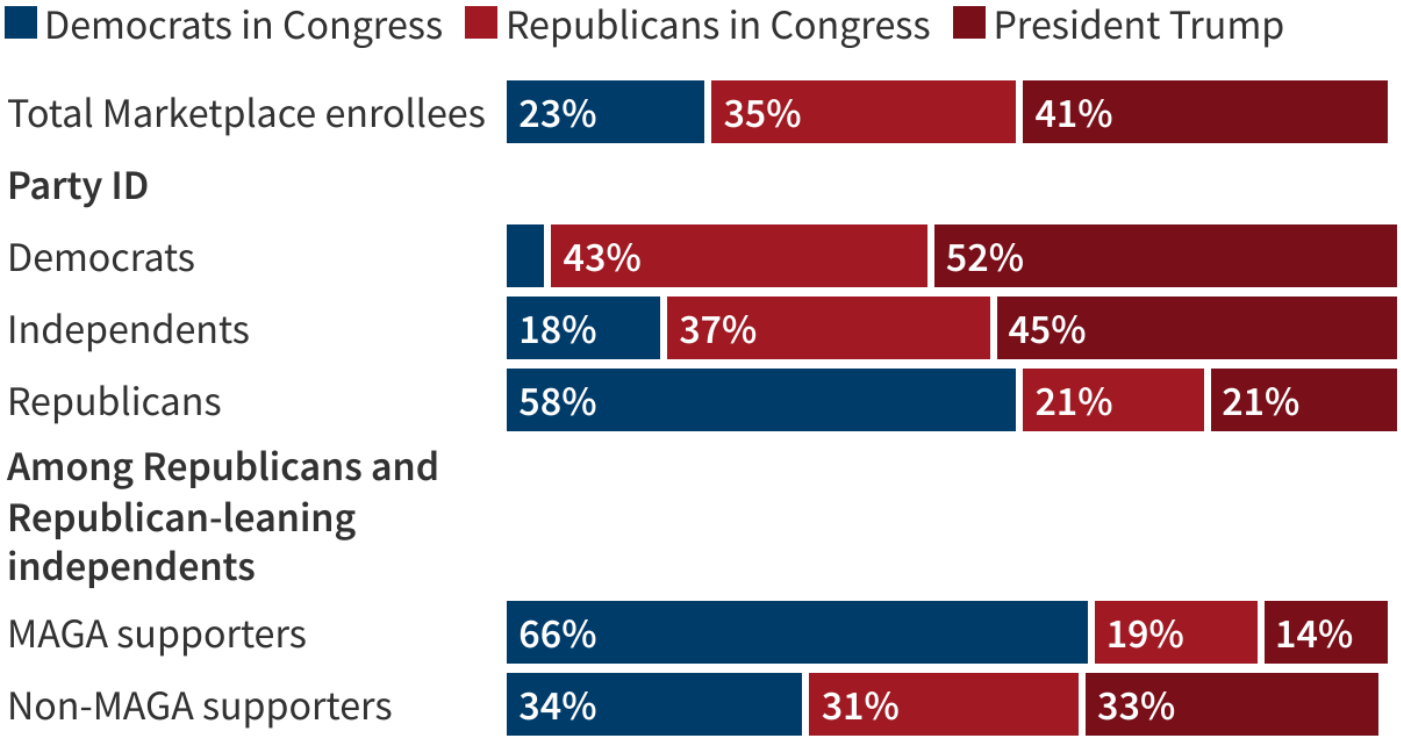
If the enhanced premium tax credits are not extended, those who want to see them extended are most likely to blame Republican leaders, including President Trump. Four in ten of those who support extending the premium tax credits say that if they are not extended, President Trump deserves most of the blame (41%, or 34% of all Marketplace enrollees) and about a third (35%, or 29% of all enrollees) say Republicans in Congress deserve most of the blame. A smaller share (23%, 19% of all enrollees) says Democrats in Congress deserve most of the blame for not extending the credits.

Unsurprisingly, partisans are most likely to say the other party deserves the blame if Congress doesn't extend the enhanced premium tax credits. However, four in ten Republican enrollees who want to see the tax credits extended say they will either place most of the blame on President Trump (21%) or Republicans in Congress (21%). Even among the most ardent supporters of President Trump, 14% of MAGA supporters say he will deserve most of the blame if the tax credits are not extended, and an additional one in five MAGA supporters (19%) say Republicans will deserve most of the blame.

Figure 12

Four in Ten of Those Who Want Tax Credits Extended Blame President Trump if They Are Allowed to Expire, About a Third Blame Congressional Republicans

AMONG THE 84% OF MARKETPLACE ENROLLEES WHO SUPPORT EXTENDING THE TAX CREDITS: If Congress does not extend the enhanced premium tax credits for people who purchase health insurance through the Affordable Care Act Marketplaces, who do you think deserves most of the blame?



Note: Among adults with health coverage purchased through the Marketplace in 2025. See topline for full question wording.

Source: KFF 2025 Marketplace Enrollees Survey (November 7-15, 2025)

KFF

Marketplace Enrollees Are About Equally Divided Across Political Affiliation

Recent KFF analysis shows that since 2020, ACA Marketplace enrollment has seen a particularly high rate of growth in a number of southern states and enrollment has grown faster in states won by President Trump in 2024 than those won by Kamala Harris.

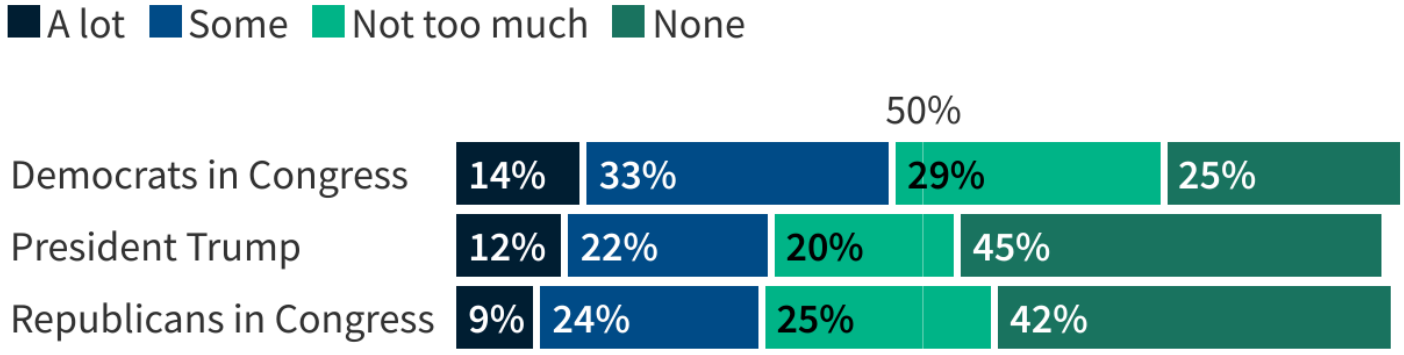
KFF's 2025 Marketplace Enrollees Survey finds that about four in ten Marketplace enrollees (39%) are Republicans or Republican-leaning independents, including 24% who say they are supporters of the Make America Great Again (MAGA) movement. Just over four in ten Marketplace enrollees (45%) identify as Democrats or Democratic-leaning independents, while 17% do not identify or lean toward either political party.

Overall confidence that Congress and President Trump can address the cost of health insurance is low. About two-thirds of Marketplace enrollees say they have "not too much" or no confidence in President Trump (66%) nor in Republicans in Congress (67%) to address health insurance costs for people like them. Congressional Democrats fare only slightly better. Just over half (53%) of enrollees say they have not much or no confidence in Democrats in Congress to address the cost of health insurance for people like them. About half (47%) of Marketplace enrollees express at least some confidence in Congressional Democrats to address insurance costs. About a third say the same about President Trump (34%) and Republicans in Congress (33%).

Figure 13

About Two-Thirds of Marketplace Enrollees Have Little or No Confidence in Trump or Republicans in Congress To Address Health Insurance Costs

How much confidence, if any, do you have in each of the following to address the cost of health insurance for people like you?



Note: Among adults with health coverage purchased through the Marketplace in 2025. See topline for full question wording.

Source: KFF 2025 Marketplace Enrollees Survey (November 7-15, 2025)

KFF

Unsurprisingly, partisans are more likely to express at least some confidence in lawmakers from their own party. For example, about three in four (73%) Democrats with Marketplace insurance say they have at least some confidence in Democrats in Congress to address the cost of insurance for people like them. On the other hand, about three-quarters of Republicans with Marketplace coverage say they have at least some confidence in Congressional Republicans (73%) and in President Trump (75%) to address the cost of health insurance. Nearly eight in ten (78%) Democrats and nearly half (48%) of independents say they have “no confidence” in President Trump to address the cost of health insurance for people like them.

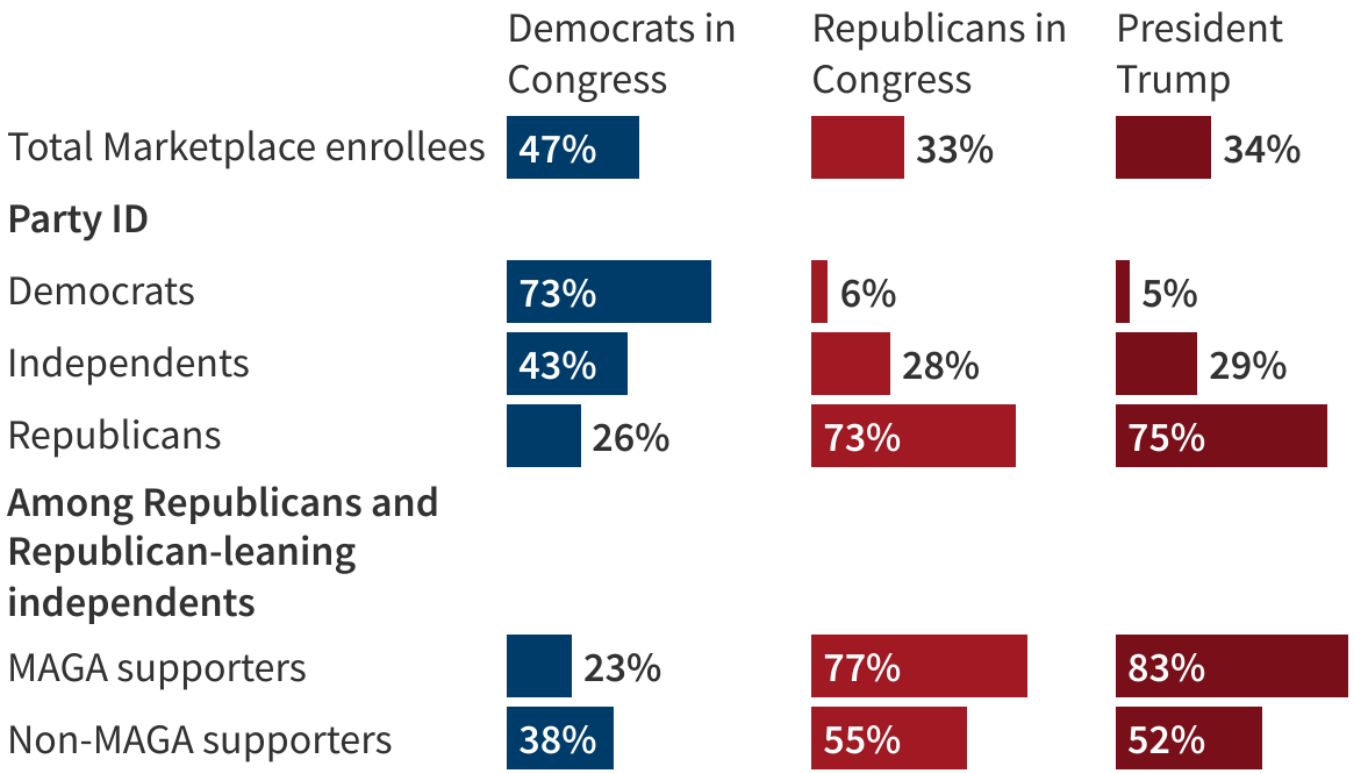
Large shares of Republicans and Republican-leaning independents with Marketplace coverage who support the MAGA movement express at least some confidence in President Trump (83%) and in Republicans in Congress (77%) to address health

insurance costs; yet notably, about one in four MAGA supporters (23%) do say they have “a lot” or “some” confidence in Democrats in Congress to address this issue.

Figure 14

Partisans Are Divided on Who They Have Confidence To Address Costs of Health Insurance

Percent of 2025 Marketplace enrollees who say they have **a lot** or **some** confidence in each of the following to address the cost of health insurance for people like them:



Note: Among adults with health coverage purchased through the Marketplace in 2025. See topline for full question wording.

Source: KFF 2025 Marketplace Enrollees Survey (November 7-15, 2025)

KFF

Increases in Health Care Expenses May Impact How Enrollees Approach the 2026 Elections

If current Marketplace enrollees are faced with increased health care expenses next year, there may also be some notable political implications. More than a third of Marketplace enrollees (37%) say President Trump would deserve most of the blame if their personal health care expenses increased by $1,000 next year. A third (33%) say the Republicans in Congress would be most to blame, while about three in ten (29%) place most of the blame on Democrats in Congress.

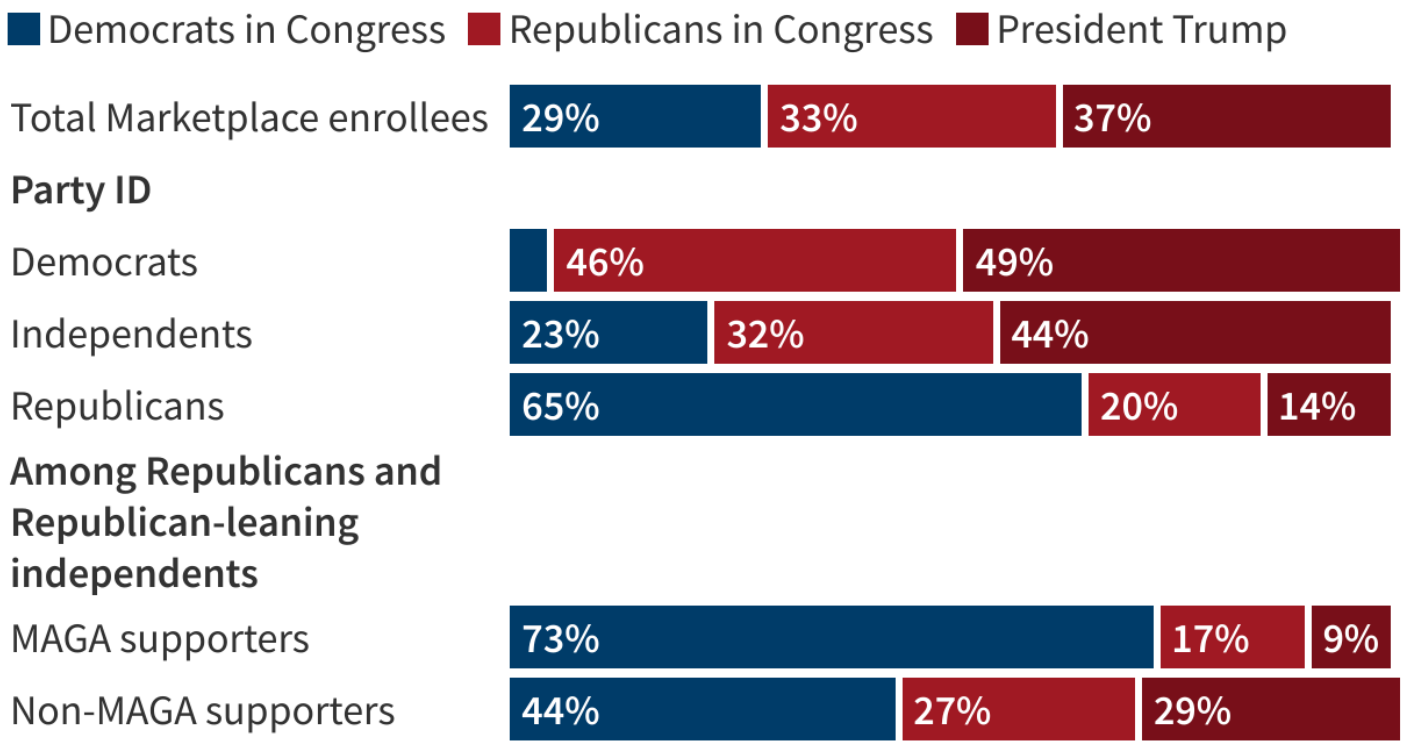
Democrats with Marketplace insurance say they would largely blame Republicans in Congress (46%) or President Trump (49%) if their health care expenses increase by $1,000 next year. Among independents, more than four in ten (44%) would blame the President, while about a third (32%) would blame Congressional Republicans, and about one in four (23%) would put most of the blame on Democrats in Congress.

Though most Republicans (65%) would blame Congressional Democrats if their health care costs increased by $1,000 next year, about a third say they would blame either Republicans in Congress (20%) or President Trump (14%). Among MAGA supporters, 17% say they would blame Republicans in Congress and a further 9% would blame President Trump if their health care expenses increase by $1,000 next year.

Figure 15

Most Marketplace Enrollees Would Blame President Trump or Republicans in Congress if Their Health Care Expenses Increased by $1,000

If your overall health care expenses (including co-pays, deductibles, and premiums) increased by $1,000 next year, who do you think would deserve most of the blame?



Note: Among adults with health coverage purchased through the Marketplace in 2025. See topline for full question wording.

Source: KFF 2025 Marketplace Enrollees Survey (November 7-15, 2025)

KFF

Additionally, for some Marketplace enrollees, an increase in health care expenses may affect how they approach the 2026 midterm elections. If their overall health care expenses, including co-pays, deductibles, and premiums, increased by $1,000 next year, about half of Marketplace enrollees who are registered to vote say it would have a “major impact” on their decision to vote in the 2026 midterm elections (54%) or which party’s candidate they will vote for (52%). About one in five say an increase in

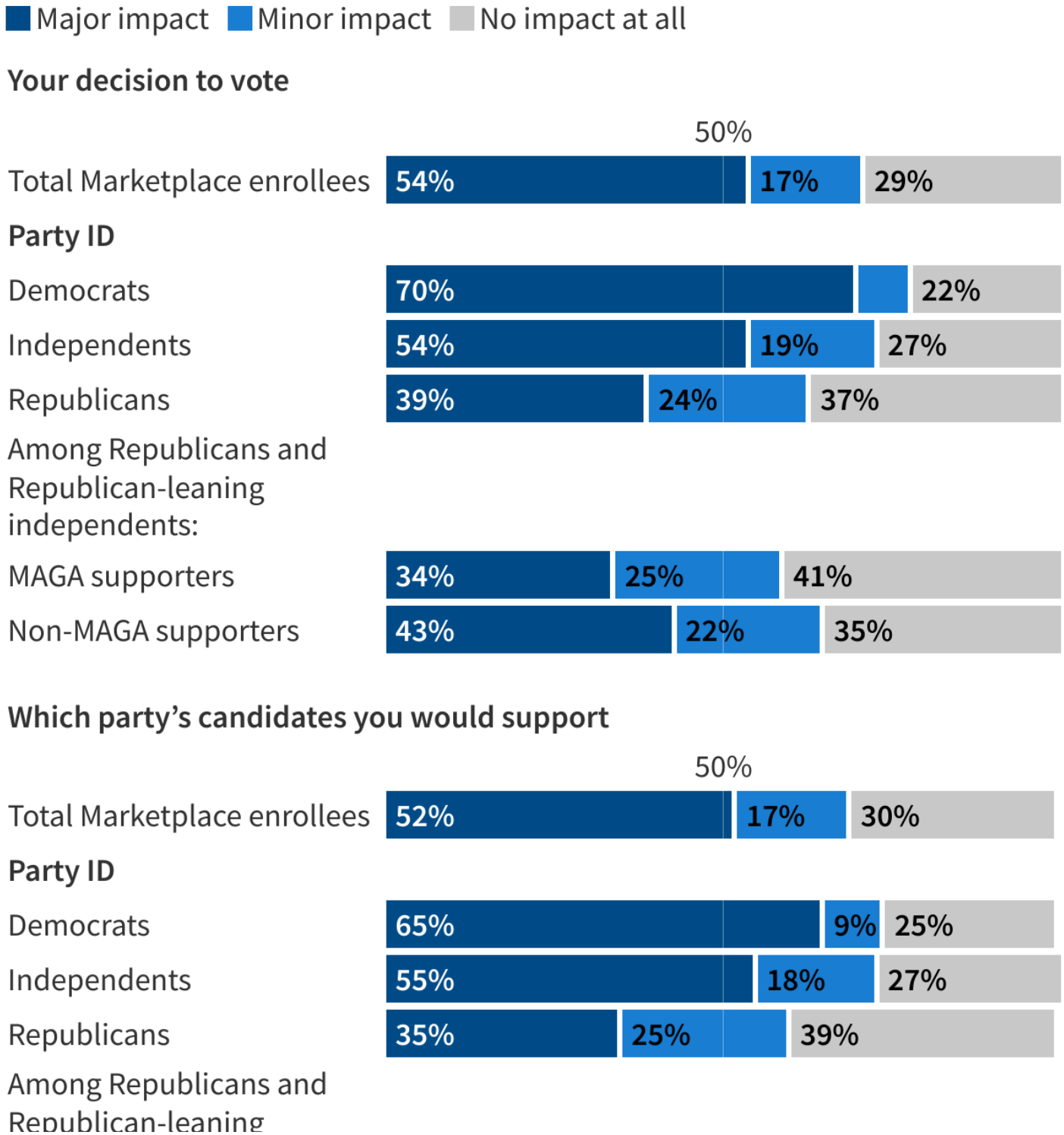
their expenses would have a “minor impact” on their decision to vote (17%) or which party they vote for (17%).

Democratic voters with Marketplace coverage are much more likely to say that a $1,000 increase in their health expenses would have a major impact on the 2026 midterm elections, both in terms of turnout and candidate choice, compared with Republican and independent voters with Marketplace coverage. Seven in ten Democrats (70%) and just over half of independents (54%) say an increase in their health care expenses would have a “major impact” on their decision to vote, as do about four in ten (39%) of Republicans. In addition, about two-thirds of Democrats (65%) as well as a slight majority of independents (55%), say an increase of $1,000 in their health care expenses next year would have a “major impact” on which party’s candidate they would support, compared to about a third of Republicans (35%). Four in ten MAGA Republican enrollees who are registered to vote say that if their health care expenses increased by $1,000 next year, it would have “no impact at all” on which party’s candidate they support in the 2026 midterm elections (40%) or whether they vote (41%).

Figure 16

Large Shares of Democrats, Independents Say Increase in Marketplace Expenses Would Have a Major Impact on Decision To Vote and Candidate Choice

If your health care expenses increased by $1,000 next year, do you think that would have a major impact, a minor impact, or no impact at all on each of the following in the 2026 midterm elections?



Note: Among adults with health coverage purchased through the Marketplace in 2025 who are registered to vote. Approximately $1,000 is the average expected increase for marketplace enrollees if the ACA enhanced premium tax credits are allowed to expire at the end of 2025. See KFF analysis for more details. See topline for full question wording.

Source: KFF 2025 Marketplace Enrollees Survey (November 7-15, 2025)

KFF

Methodology

This *KFF 2025 Marketplace Enrollees Survey* was designed and analyzed by public opinion researchers at KFF. The survey was conducted November 7-15, 2025, online and by telephone among a nationally representative sample of 1,350 U.S. adults ages 18-64 who are covered by a plan purchased through the Affordable Care Act Marketplace, in English (*n=1,301*) and in Spanish (*n=49*). To qualify for the survey respondents needed to indicate that they were 18-64 years old, covered by health insurance purchased directly from an insurance company, health insurance broker or a state or federal marketplace and not covered by COBRA extension of employer-based health insurance. The sample includes 972 adults (*n=24* in Spanish) reached through the SSRS Opinion Panel either online (*n=944*) or over the phone (*n=28*). The SSRS Opinion Panel is a nationally representative probability-based panel where panel members are recruited randomly in one of two ways: (a) Through invitations mailed to respondents randomly sampled from an Address-Based Sample (ABS) provided by Marketing Systems Groups (MSG) through the U.S. Postal Service's Computerized Delivery Sequence (CDS); (b) from a dual-frame random digit dial (RDD) sample provided by MSG. For the online panel component, invitations were sent to panel members by email followed by up to three reminder emails.

An additional 350 adults ages 18-64 who are currently covered by direct-purchase insurance were reached through the IPSOS Knowledge Panel online in English (n=*325*) and in Spanish (n=*25*). The IPSOS Knowledge Panel is a nationally

representative probability-based panel where panel members are recruited randomly through invitations mailed to respondents randomly sampled from an Address-Based Sample (ABS) through the U.S. Postal Service's Computerized Delivery Sequence (CDS). Another 28 adults ages 18-64 currently covered by direct-purchase insurance that were previously recruited to complete the KFF Health Tracking Polls in 2024-2025 were reached via their prepaid cell phone number. Among this prepaid cell phone component, 11 were interviewed by phone and 17 were invited to the web survey via short message service (SMS).

Respondents in the prepaid cell phone sample who were interviewed by phone received a $15 incentive via a check received by mail. Respondents in the prepaid cell phone sample reached via SMS received a $10 electronic gift card incentive. SSRS Opinion Panel respondents received a $5 electronic gift card incentive (some harder-to-reach groups received a $10 electronic gift card). Ipsos operates an incentive program that includes raffles and sweepstakes with both cash rewards and other prizes to be won. An additional incentive is usually provided for longer surveys. In order to ensure data quality, cases were removed if they failed two or more quality checks: (1) attention check questions in the online version of the questionnaire, (2) had over 30% item non-response, or (3) had a length less than one quarter of the mean length by mode. Based on this criterion, there were no cases removed.

The combined cell phone and panel samples were weighted to match the sample's demographics to the national U.S. adult population 18-64 who are currently covered by direct-purchase insurance using data from the Census Bureau's 2025 Current Population Survey (CPS). The demographic variables included in weighting are gender, age, education, census region, number of adults in household, and home tenure. The sample was also weighted to match the proportion of responses by individuals living in a Medicaid expansion state. Additionally, the weights account for differences in the probability of selection for each sample type (prepaid cell phone, IPSOS Knowledge Panel, and SSRS Opinion Panel). This includes adjustment for ownership of a prepaid cellphone and the design of the panel-recruitment procedure (IPSOS Knowledge Panel and SSRS Opinion Panel).

The margin of sampling error including the design effect for the full sample is plus or minus 3.3 percentage points. Numbers of respondents and margins of sampling error for key subgroups are shown in the table below. For results based on other subgroups, the margin of sampling error may be higher. Sample sizes and margins of sampling error for other subgroups are available on request. Sampling error is only one of many potential sources of error and there may be other unmeasured error in this or any other public opinion poll. KFF public opinion and survey research is a charter member of the Transparency Initiative of the American Association for Public Opinion Research.

Group	N (unweighted)	M.O.S.E.
Total 2025 Marketplace enrollees	1,350	± 3 percentage points
Party ID		
Democrats	445	± 6 percentage points
Independents	460	± 6 percentage points
Republicans	367	± 6 percentage points
Age		
18-29	178	± 8 percentage points
30-49	557	± 5 percentage points
50-64	615	± 5 percentage points

January 7, 2026

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
H-232, The Capitol
Washington, DC 20515

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
H-204, The Capitol
Washington, DC 20515

Dear Speaker Johnson and Leader Jeffries:

AARP, which advocates for 125 million Americans age 50 and older, urges Congress to immediately pass the three-year extension of tax credits to reverse the massive price hike in health insurance premiums that is putting health care out of reach for too many older Americans. Last week, due to Congressional inaction, millions of older Americans saw their health insurance costs skyrocket, with some people being asked to pay more than 30% of their income for health care. Nobody can afford that. We appreciate the bipartisan efforts that have gone into moving this legislation to the floor, and we urge its immediate adoption.

Nearly 5 million Americans aged 50-64 get their health care through the Marketplaces. Americans in this age group face the greatest pressures in health care: they have more health care needs but are not yet eligible for Medicare. Due to federal age rating rules, insurance premiums for this age group are already *three times higher* than those of younger people. Older Americans are the individuals hit hardest by today's higher premiums.

AARP recently highlighted some of the Americans who are impacted, including small business owners whose health care is in jeopardy. They are not wealthy people – without the enhanced premium tax credits that expired at the end of 2025, a couple with a household income of just $85,000 is now completely ineligible for help in paying for their health coverage.

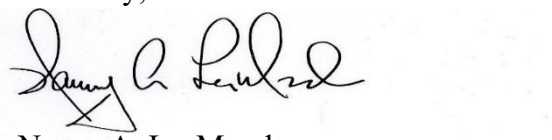
Without the additional help that Congress allowed to expire last week, the sticker shock consumers are facing is drastic. For example, a 60-year-old couple earning an annual household income of approximately $85,600 (just above 400% FPL) is now facing these types of premium increases on top of what they were already paying:

- Texas- Annual premiums increase by **$26,757, or 31% of their income**
- Idaho- Annual premiums increase by **$17,754, or 21% of their income**
- Oregon- Annual premiums increase by **$19,843**, **or 23% of their income**
- South Dakota- Annual premiums increase by **$25,382**, **or 30% of their income**
- Florida- Annual premiums increase by **$27,613, or 32% of their income**

Americans simply cannot handle those kinds of increases, especially at a time when family budgets are stretched thin. We urge Congress to pass the three-year extension of these supports.

If you have any questions, please feel free to contact me or have your staff contact Brendan Rose on our Government Affairs team at brose@aarp.org.

Sincerely,



Nancy A. LeaMond
Executive Vice President and
Chief Advocacy & Engagement Officer

KFF The independent source for health policy research, polling, and news.

ACA Marketplace Premium Payments Would More than Double on Average Next Year if Enhanced Premium Tax Credits Expire

Authors: Justin Lo, Larry Levitt, Jared Ortaliza, and Cynthia Cox

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Affordable Care Act (ACA) enhanced premium tax credits are set to expire at the end of this year. Enhanced premium tax credits were introduced in 2021 and later extended through the end of 2025 by the Inflation Reduction Act. The enhanced tax credits both increased the amount of financial assistance already eligible ACA Marketplace enrollees received as well as made middle-income enrollees with income above 400% of federal poverty guidelines newly eligible for premium tax credits.

Since the introduction of the enhanced premium tax credits, enrollment in the Marketplace has more than doubled from about 11 to over 24 million people, the vast majority of whom receive an enhanced premium tax credit. If enhanced tax credits expire, many Marketplace enrollees will continue to qualify for a smaller tax credit, while others will lose eligibility altogether and be hit by a “double whammy” of losing their entire tax credit and being on the hook for rising premiums.

Since 2014, the ACA has capped how much subsidized enrollees pay for their health insurance premiums at a certain percent of their income, on a sliding scale, with the

federal government covering the remainder in the form of a tax credit. Enhanced tax credits work by further lowering the share of income ACA Marketplace enrollees pay for a plan. For example, with the enhanced tax credits in place, an individual making $28,000 will pay no more than around 1% ($325) of their annual income towards a benchmark plan. If the enhanced tax credits expire, this same individual would pay nearly 6% of their income ($1,562 annually) towards a benchmark plan in 2026. In other words, if the enhanced tax credits expire, this individual would experience an increase of $1,238 in their annual premium payments net of the tax credit.

Table 1

ACA Marketplace Enrollees Will Pay More for Benchmark Coverage if Enhanced Tax Credits Expire

Required Contribution Percentages With and Without Enhanced Tax Credits for an Individual

Individual | Family of Four

Household income	Premium Payment, % of income (annual amount) — Enhanced Tax Credits	2026 Tax Credits	Annual Dollar Increase
$18,000 (115% FPL)	0% ($0)	2.1% ($378)	$378
$22,000 (141% FPL)	0% ($0)	3.6% ($794)	$794
$28,000 (179% FPL)	1.2% ($325)	5.6% ($1,562)	$1,238
$35,000 (224% FPL)	3% ($1,033)	7.5% ($2,615)	$1,582
$45,000 (288% FPL)	5.5% ($2,475)	9.6% ($4,311)	$1,836
$55,000 (351% FPL)	7.3% ($4,010)	10% ($5,478)	$1,469
$65,000 (415% FPL)	8.5% ($5,525)	No tax credit	Varies

Note: FPL stands for Federal Poverty Level. Required contribution percentages refer to the maximum share of income ACA Marketplace enrollees are required to pay for a benchmark plan. The "2026 Tax Credits" scenario represents the required contribution percentages that

plan. The "benchmark" scenario represents the required contribution percentage that will be in place for 2026 if enhanced tax credits are not renewed. Premium increases will vary for enrollees with incomes over 400% of poverty based on family size, age, and location.

Source: KFF analysis of 26 CFR § 601.105 Rev Proc 2023-29 and Rev Proc 2025-25

KFF

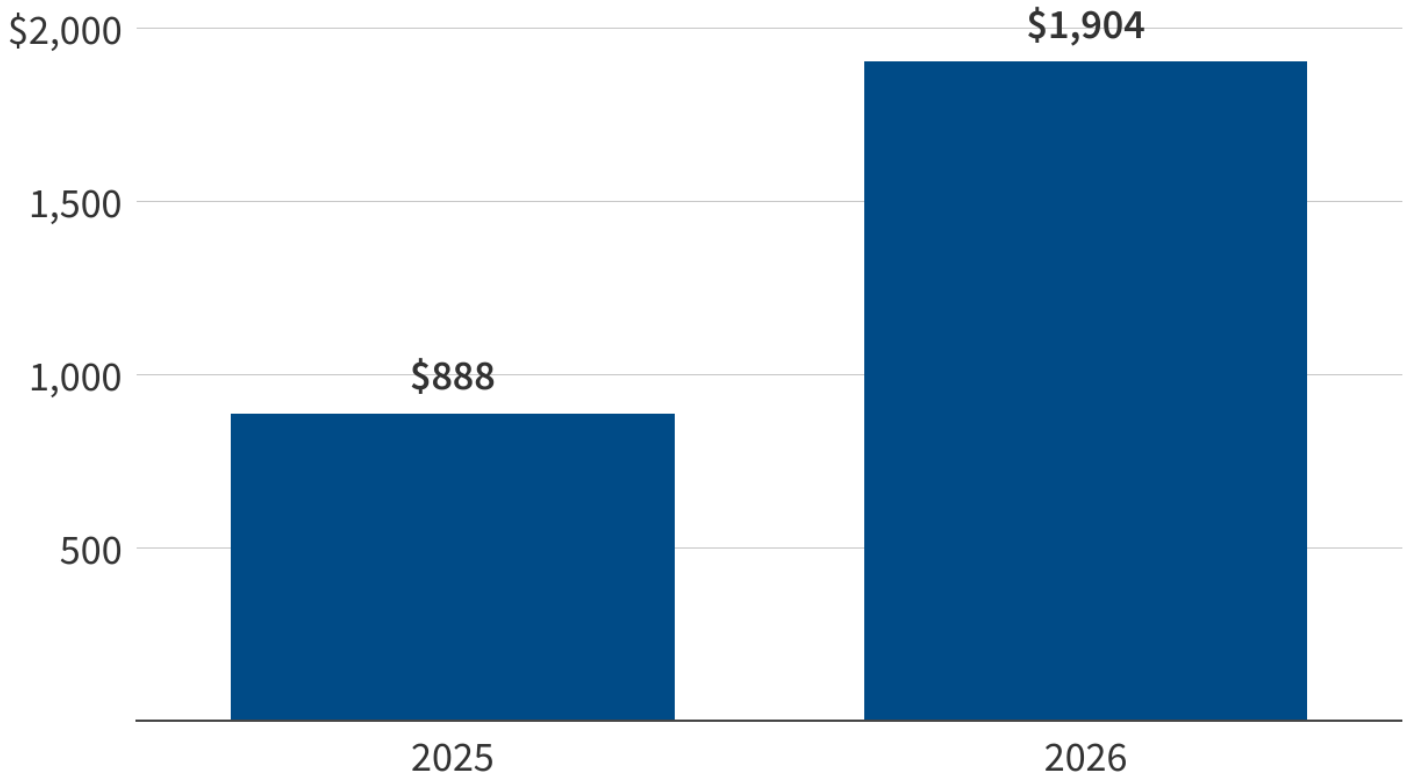
A previous KFF analysis, based on data released by the federal government, showed the enhanced premium tax credits saved subsidized enrollees an average of $705 annually in 2024, bringing their annual premium payment down to $888. Without the enhanced premium tax credits, annual premium payments in 2024 would have averaged $1,593 (over 75% higher than the actual $888). More recent data have not been released.

Based on the earlier federal data and more recent other publicly available information, KFF now estimates that, if Congress extends enhanced premium tax credits, subsidized enrollees would save $1,016 in premium payments over the year in 2026 on average. In other words, expiration of the enhanced premium tax credits is estimated to more than double what subsidized enrollees currently pay annually for premiums—a 114% increase from an average of $888 in 2025 to $1,904 in 2026. (The average premium payment net of tax credits among subsidized enrollees held steady at $888 annually in 2024 and 2025 due to the enhanced premium tax credits).

Figure 1

Premium Payments in 2026 Will More than Double if ACA Enhanced Premium Tax Credits Expire

Annual Out-of-Pocket Premium Payments for Affordable Care Act Marketplace Enrollees, 2025 and 2026



Note: The average premium payment is among people currently receiving a tax credit in 2025. The 2026 average premium payment assumes gross premiums increase of 18% for those who lose tax credit eligibility.

Source: KFF analysis of 2024 and 2025 Open Enrollment Period State-Level Public Use File and 2024 Open Enrollment Report

KFF

The increase in premium payments with expiration of the enhanced premium tax credits is even higher than previously estimated for two reasons:

- Trump administration changes to tax credit calculations, and
- Rising 2026 premiums.

The Trump administration made changes to the way tax credits are calculated, which were finalized in the ACA Marketplace Integrity and Affordability rule. The required contribution levels that will be in place for 2026 if the enhanced tax credits are not renewed will be higher relative to the required contribution levels calculated under the original methodology based on rules in effect at the time. This means that enrollees are expected to pay a higher share of their income towards a benchmark premium plan in 2026 than they otherwise would have. Additionally, inflation in private insurance premiums has led to higher premium contribution levels than previously expected.

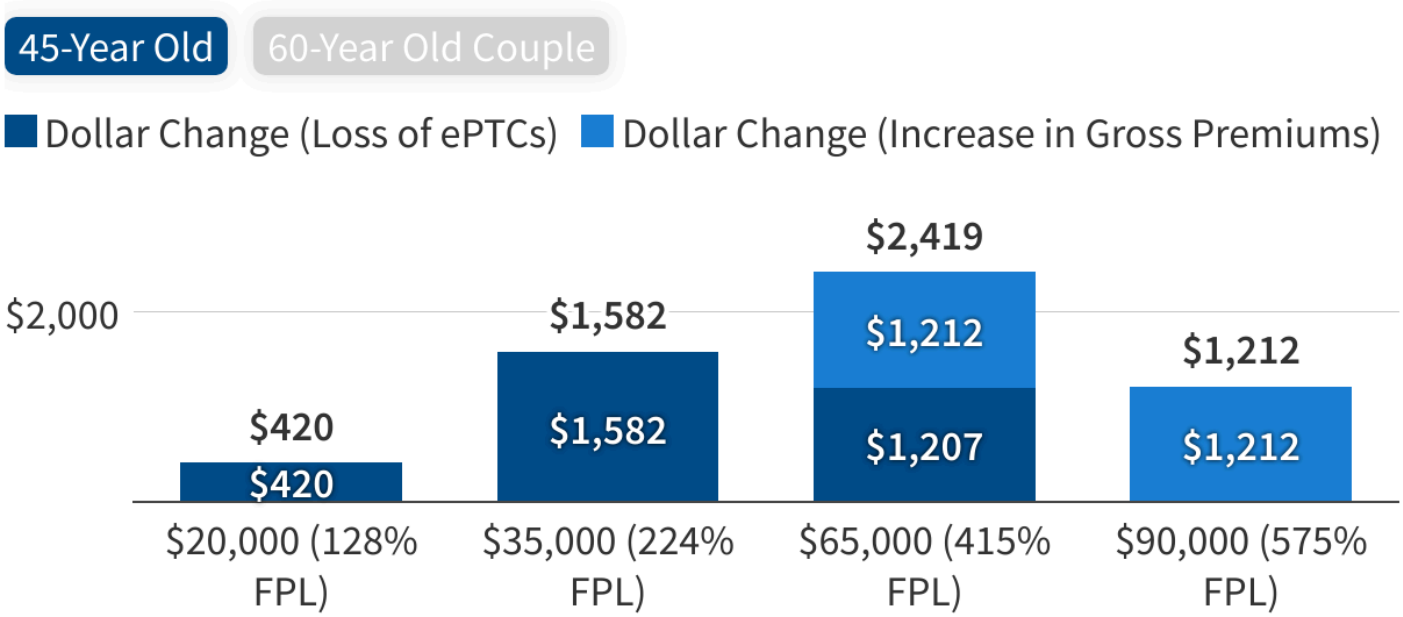
Additionally, insurers in the ACA Marketplace are proposing to raise their rates by a median of 18%. Fueled by rising health care costs and the expiration of the enhanced premium tax credits, insurers are proposing the largest rate increases in 2026 since 2018, the last time uncertainty over federal policy changes contributed to sharp premium increases. As premiums increase, the enhanced tax credits provide additional savings to enrollees that receive them. This means that middle-income enrollees, whose payment for a benchmark plan is currently capped at 8.5% of their income and will lose financial assistance altogether, will have to cover the cost of premium increases in addition to the amount their tax credits would have previously covered to keep their same plan.

Enrollees across the income spectrum can expect big increases in premium payments

Figure 2

Annual Premium Payments Would Increase for Subsidized Enrollees by an Average of $1,016 (114%) if Enhanced Premium Tax Credits Expire

Dollar Change in Average Annual Premium Payment for Benchmark Silver Plan if Enhanced Premium Tax Credits Expire, 45-Year Old



Note: 2025 poverty guidelines that will be in place for the 2026 plan year were used to calculate required contributions. 2025 national average benchmark silver premium for a 45-year old was used for this analysis. Required contribution levels for 2026 were used to calculate premium payments for the expiration scenario. Scenarios account for premiums growing by an average of 18% in 2026.
*The required contribution for a 45-year old making $90,000 is greater than the cost of the benchmark silver plan; they are ineligible for subsidies under the Inflation Reduction Act.
Source: KFF analysis

KFF

Enrollees with incomes above 400% of poverty will be subject to large increases in premium payments if enhanced premium tax credits expire. On average, a 60-year-old couple making $85,000 (or 402% FPL) would see yearly premium payments rise by over $22,600 in 2026, after accounting for an annual premium increase of 18%. This would bring the cost of a benchmark plan to about a quarter of this couple's annual income, up from 8.5%. Meanwhile, a 45-year-old earning $20,000 (or 128%

FPL) in a non-Medicaid expansion state would see their premium payments for a benchmark plan rise from $0 to $420 per year, on average, from the loss of enhanced premium tax credits. About half (45%) of ACA Marketplace enrollees have incomes between 100-150% of poverty, about a fourth (28%) have incomes between 150-250% of poverty, and roughly 1 in 10 have incomes above 400% of poverty.

Methods

The average savings by income group for 2024 were taken from the 2024 Open Enrollment report. The average yearly premium savings from enhanced premium tax credits (ePTC) for enrollees under 400% FPL were defined as the sum of the differences between the required contribution amounts with and without ePTC, using the estimated percent of plan selections with ePTC by income category and assuming a uniform income distribution within each category. To extrapolate to 2026, income was inflated by the ratio of the 2025 federal poverty guidelines to the 2023 federal poverty guidelines for an individual in the continental US. For each income category, the savings were assumed to grow as the ratio of the savings between 2026 and 2024. Due to a provision in the reconciliation bill related to subsidized ACA Marketplace eligibility for immigrants, no enrollees under 100% FPL are assumed to receive premium tax credits in 2026 and are thus not included in the calculation of average savings. For enrollees at or above 400% FPL, savings were defined as difference between the average unsubsidized premium and 8.5% of the average individual income, the required contribution under the enhanced tax credits for enrollees in this income category. For 2026, the average unsubsidized premium was assumed to be 18% higher than the 2025 average unsubsidized premium, based on analysis of rate filings. Calculations assume that there are no changes in plan selection, family composition, income relative to FPL, and geography between 2024 and 2026. The annual premium payment for 2026 comprises the estimated savings from enhanced tax credits in 2026 and the average premium payment among subsidized enrollees in 2025 obtained from the 2025 Open Enrollment State-Level Public Use File. State-funded subsidies might offset some increases of premiums but are not accounted for in the estimation. Numbers from the Open Enrollment report for estimated consumer APTC savings due to the ARP and IRA by income category (Table 8) were reported as whole numbers; a Monte Carlo method was

used to account for this rounding, keeping all observations that rounded to the grand mean listed in the report.

American College of Physicians
Statement for the Record

The U.S. House of Representatives
Energy and Commerce Health Subcommittee Hearing
on
"*Improving Medicare Payment Policies for Seniors*"
January 8, 2026

The American College of Physicians (ACP) is pleased to provide comments in response to the House Energy and Commerce Health Subcommittee's hearing on "*Improving Medicare Payment Policies for Seniors*." We thank Chairs Guthrie and Griffith and Ranking Members Pallone and DeGette for holding this important hearing to improve Medicare payment policies and access to care for American seniors. We urge the committee to work together in a bipartisan manner to explore policy solutions that would improve Medicare beneficiaries' access to high-quality, timely, and appropriate care.

ACP members include 162,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge, clinical expertise, and compassion to the preventive, diagnostic, and therapeutic care of adults across the spectrum from health to complex illness. Additionally, internal medicine is the specialty with the largest number of active physicians specializing in primary care, with 120,342 internal medicine physicians being identified as specializing in primary care in 2021.

Prevent Expansion of Prior Authorizations in Traditional Medicare

The College strongly supports policies to limit unnecessary administrative burdens, such as prior authorizations, that divert physicians from patient care. Prior authorization involves paperwork and phone calls, as well as varying data elements and submission mechanisms that force physicians to enter unnecessary data in electronic health records or perform duplicative tasks outside of the clinical workflow. This inhibits clinical decision-making at the point of care, creating a barrier to medical care for patients. Not only does it take physicians' time away from direct patient care, but it also contributes significantly to physician burnout. In 2022, a survey found that 82 percent of doctors surveyed responded that the prior authorization process was very or extremely burdensome. Additionally, the current processes for prior authorization approvals are also costly for physician practices. These issues are exacerbated by individual payers, each of whom has their own approaches, rules, and requirements for prior authorization. Data shows the average annual cost for prior authorization approval on primary care practices ranged from $2,161 to $3,430 per full-time physician. These issues are of great concern to all practicing physicians, but they're particularly burdensome for smaller practices that may not have the staff or workflows available to address the additional administrative work, potentially impeding access to care in underserved areas with clinician workforce shortages.

Historically, traditional Medicare rarely required prior authorizations, allowing Medicare beneficiaries the flexibility to see the physicians they want and to get the services and medication they need without Medicare pre-approvals. That will change with the recent implementation of the Department of Health and Human Services' (HHS) new Medicare pilot program, the Wasteful and Inappropriate Service Reduction (WISeR) Model. As of January 2026, eight states with more than 6.4 million seniors on traditional Medicare are part of the WISeR pilot.

The pilot allows prior authorization in traditional Medicare for certain outpatient procedures and services. Further, it will allow the use of artificial intelligence (AI) to make prior authorization determinations. This would be the first major expansion of prior authorizations in traditional Medicare.

While we understand HHS' aim to reduce wasteful health care spending, prevent fraud, and streamline care delivery through methods such as prior authorization, we do not agree with the WISeR model's design. ACP recently wrote a letter to HHS sharing our concerns. The WISeR model would outsource prior authorization functions to AI for Medicare beneficiaries, without imposing any safeguards to address potential bias, opacity and private/security issues. As proposed, the model would reward private-sector vendors based on cost savings achieved through denied claims. This arrangement would create a financial incentive to deny services, which could result in overly aggressive review practices and erode trust between clinicians, patients and the Centers for Medicare and Medicaid Services. While we support innovation, we strongly urge caution with this approach. Inviting the private sector to play a more active role in program design and implementation must be accompanied by strong safeguards to prevent undue influence and protect clinical decision-making. **ACP strongly supports the Ban AI Denials in Medicare Act, H.R. 6361, introduced by Representative Landsman. This legislation would prevent HHS from implementing and testing the WISeR model further. It would also prohibit HHS from implementing other similar models that would expand prior authorization practices, including through the use of AI, in traditional Medicare. We urge Congress to take action to prevent the WISeR pilot from further implementation.**

Expanding prior authorization in traditional Medicare, using AI and without oversight, could lead to higher administrative burden, delayed or foregone care, and negative health outcomes. We have seen this play out in Medicare Advantage (MA), the alternative to traditional Medicare, in which private health insurers contract with HHS to administer health plans. A 2022 HHS report detailed abuse in the prior authorization process. The report found that MA insurers "sometimes delayed or denied beneficiaries' access to services, even though the requests met Medicare coverage rules." Further, a survey of more than 600 medical groups in March 2023 showed that 84 percent reported an increase in their prior authorization requirements for MA plans. More recently, a 2024 Senate Investigative Report found that three of the largest Medicare Advantage Organizations significantly increased their use of prior authorization for post-acute care in recent years, through the use AI and machine learning systems to make prior authorization determinations. The report found that from 2019 to 2022, UnitedHealthcare, Humana, and CVS each denied prior authorization requests for post-acute care at much higher rates than they did for other types of care that are less costly, resulting in MA beneficiaries having reduced access to post-acute care.

ACP has strongly been in favor of standardizing and streamlining prior authorization processes over the years. In a policy paper, *Putting Patients First by Reducing Administrative Tasks in Health Care,* ACP advocated that, "Administrative tasks that cannot be eliminated from the health care system must be regularly reviewed, revised, aligned, and/or streamlined in a transparent manner, with the goal of minimizing burden, by all stakeholders involved. Payers, public and private oversight entities, and vendors and suppliers must work together and actively engage with clinician societies and frontline clinicians to harmonize their administrative policies, procedures, processes, and forms regarding such issues as prior authorizations, payment reviews, reporting requirements, and others." The College has repeatedly voiced support for the *Improving Seniors' Timely Access to Care Act*, first introduced in 2019, which would protect patients from unnecessary delays in care and reduce administrative burden on physicians by streamlining the prior authorization approval processes in MA.

Conclusion

ACP appreciates the Energy and Commerce Health Subcommittee's commitment to finding bipartisan solutions to improve Medicare. **We urge you to advance the Ban AI Denials in Medicare Act and to bring forward the Improving Seniors' Timely Access to Care Act for further discussion.** If you have any further questions or need additional information from ACP, please contact Vy Oxman at 202-261-4515 (voxman@acponline.org).

(/#linkedin)

=https%3A%2F%2Fwww.fightcancer.org%2Freleases%2Facs-can-urges-congress-immediately-extend-enhanced-premium-tax-credits-avoid-health-gress%20to%20Immediately%20Extend%20the%20Enhanced%20Premium%20Tax%20Credits%20to%20Avoid%20a%20Health%20Care%20Affordability%20Crisis)

All Press Releases (/landing-pages/press-room)

ACS CAN Urges Congress to Immediately Extend the Enhanced Premium Tax Credits to Avoid a Health Care Affordability Crisis

AN ACS CAN SURVIVOR VIEWS SURVEY RELEASED LAST WEEK FOUND THAT NEARLY 3 IN 4 CANCER PATIENTS AND SURVIVORS WHO RELY ON THE MARKETPLACE FOR COMPREHENSIVE COVERAGE RISK LOSING ACCESS TO LIFESAVING CARE

December 10, 2025

WASHINGTON, D.C. – As the deadline approaches for people to enroll in Marketplace coverage that starts January 1, 2026, the American Cancer Society Cancer Action Network (ACS CAN) is urging the Senate and the House to come together in a bipartisan way to pass legislation extending the enhanced premium tax credits and work to address the health care affordability crisis. If Congress fails to pass the extension and allows the tax credits to expire on December 31, millions of people, including cancer patients and survivors, will lose their only option for affordable, comprehensive health insurance.

Lisa Lacasse, president of ACS CAN, released the following statement:

"Research clearly shows that having comprehensive health insurance is one of the most significant factors in surviving a cancer diagnosis. For two years, ACS CAN has been calling on Congress to come together to ensure the enhanced premium tax credits that made it possible for millions of people to access affordable, quality health insurance, some for the first time, remain in place. Without congressional action, the imminent expiration of the enhanced premium tax credits will push affordable health insurance out of reach for millions of people, including cancer patients and survivors.

"Last week, ACS CAN released a **Survivor Views (https://www.fightcancer.org/releases/new-survey-finds-nearly-3-4-cancer-patients-and-survivors-who-rely-marketplace)** survey that paints a dire picture of what's to come for cancer patients and survivors who rely on health care tax credits to lower their monthly premiums if Congress allows the enhanced tax credits to expire. We encourage members of Congress to consider the consequences of failing to act and to prioritize the health and wellbeing of their constituents.

"ACS CAN is once again calling on Congress to work together to extend these tax credits as quickly as possible. In most states, people must enroll in a Marketplace plan by December 15 to have coverage on January 1, 2026, so the clock is ticking to prevent a national health care affordability crisis. Without access to the health care they need to get well and stay well, people will live sicker and die sooner."

###

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As lawmakers get back to work, the American Cancer Society Cancer Action Network (ACS CAN) urges legislators to prioritize passing legislation to ease the burden of medical debt on Hoosiers.

Read More → (/releases/break-burden-advocates-press-legislative-relief-medical-debt)

DECEMBER 19, 2025

Congress Must Return from the Holidays with a Plan to Extend the Enhanced Premium Tax Credits and Protect Affordable, Quality Coverage Options for Cancer Patients and Survivors (/releases/congress-must-return-holidays-plan-extend-enhanced-premium-tax-credits-and-protect)

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New Survey Finds Nearly 3 in 4 Cancer Patients and Survivors who Rely on the Marketplace for Comprehensive Coverage Risk Losing Access to Lifesaving Care if the Enhanced Premium Tax Credits are not Extended (/releases/new-survey-finds-nearly-3-4-cancer-patients-and-survivors-who-rely-marketplace)

The American Cancer Society Cancer Action Network (ACS CAN) today released results from a survey exploring the impact of the enhanced premium tax credits on cancer patients and survivors who rely on the Marketplace for comprehensive health insurance coverage.

Read more →

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Congress Must Preserve Access to Affordable Marketplace Coverage

By Lindsey Copeland | September 11, 2025 | 2 Comments

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Congress acts soon, critical tax credits that help over 22 million people buy able Care Act (ACA) Marketplace plans will expire at the end of this year, causing

premiums and coverage losses to skyrocket.

The Role of Premium Tax Credits

Since 2012, ACA premium tax credits (PTCs) have helped people with low and middle incomes pay their Marketplace premiums. In 2021, The American Rescue Plan Act (ARPA) increased the amount and availability of the credits and the Inflation Reduction Act (IRA) in 2022 delayed their expiration, but only until the end of 2025. Notably, while the July 2025 reconciliation bill continued many other tax policies sunsetting this year, it excluded these enhancements.

While the July 2025 reconciliation bill continued many other tax policies sunsetting this year, it excluded PTC enhancements.

The PTCs, including the enhancements, are effective and widely used. They help nearly 93% of Marketplace enrollees afford insurance, reducing enrollee premiums from $619 to $113 per month, on average.

The PTC Enhancements Have Improved Access, Affordability

The PTC enhancements currently in place—and at risk—have had a significant impact. Thanks to these improvements, an estimated seven million more people will be able to afford a Marketplace plan this year and four million fewer people will be uninsured. Overall, they helped Marketplace enrollment grow from 12 million in 2021 to a record 24.2 million in 2025.

The enhanced subsidies have especially benefited low-income people.

As the Commonwealth Fund notes, the enhanced subsidies have especially benefited some people, increasing enrollment among those with incomes below 250% of poverty from 8.2 million in 2021 to 15.9 million in 2024.

Similarly, the Urban Institute predicted they would help the lowest income groups see a 50 to 100% reduction in their premium amounts this year, while people at the higher end of income eligibility would see a 25% reduction. These projections align with documented successes: In 2023 and 2024, 80% of Marketplace enrollees could find a plan for $10 or less per month. In 2020, before the tax credits were increased, only 36% of PTC-eligible enrollees could find such a plan.

Enhanced Credits Critical for Older Adults

A new report from AARP explains how many older adults who are not yet eligible for Medicare rely on Marketplace coverage and premium tax credits, and that the enhanced subsidies have been vital to improving enrollment and coverage among this population. In part, the PTCs have helped millions of adults aged 50 to 64 buy coverage through the Marketplace—spurring a 50% reduction in the uninsured rate among this cohort.

> The PTCs have helped millions of adults aged 50 to 64 buy coverage through the Marketplace.

In 2024, nearly five million of the 5.2 million Marketplace enrollees aged 50 to 64 received PTCs. A previous Avalere analysis estimated the credits saved these enrollees at least $600 a year, while some saw savings of nearly $5,000. Heightened affordability is especially important to this population, since ACA premiums for older adults can be up to three times higher than those for younger adults.

What Is At Risk

If the enhancements expire at the end of the year, analysts agree that rising costs will push many people, including older adults, out of their health insurance coverage. KFF projects enrollee premium payments would increase by over 75% on average, while people in rural areas could see a 90% increase and some enrollees could end up paying more than double.

Of the 5.2 million adults ages 50 to 64 with Marketplace coverage, AARP expects most or 4.8 million of them—will see higher premiums in 2026. Middle-income midlife

enrollees could see hikes of over $4,000, likely causing many to drop their coverage and become uninsured.

> Middle-income midlife enrollees could see hikes of over $4,000, likely causing many to drop their coverage and become uninsured.

The Congressional Budget Office (CBO) reached similar conclusions, estimating that unless the credits are extended, ACA enrollment will drop from nearly 23 million in 2025 to 15 million in 2030. Other analysis is even more stark. KFF notes actuaries at Wakely have warned of a 50% decline in Marketplace enrollment, when combined with the other changes to the ACA made in the reconciliation bill.

Some who lose subsidized Marketplace plans may be able to find other insurance, but others—at least 4.2 million people, according to CBO—will become uninsured. These coverage losses will not only mean reduced access to care and worse individual health outcomes, but also higher Medicare costs, because more people will enter the program in poorer health and needing more expensive interventions than they would have otherwise.

Congress Must Act Quickly

At Medicare Rights, we will continue to work to protect the ACA's coverage gains. People must have access to high-quality, affordable health care and coverage. Allowing the enhanced PTCs to expire would have the opposite effect. It would effectively raise taxes on low- and middle-income Americans, pricing millions out of health coverage.

> Medicare Rights urges lawmakers to extend the enhanced PTCs without delay.

t end, we urge lawmakers to extend the enhanced PTCs without delay. Although dits do not expire until the end of December, their availability must be guaranteed

before open enrollment begins on November 1. Otherwise, people may have no choice but to drop coverage this fall in the face of sky-high premiums, setting in motion harmful coverage losses that undermine individual health and economic security as well as Medicare sustainability.

Read the AARP fact sheet, Premium Tax Credits Protect Affordability of Marketplace Health Coverage for Adults Ages 50 to 64.

Policy Issues: Protect Health Care Programs

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Damage From Inaction On ACA Tax Credits Has Begun And Will Grow With Further Delays

CHIR Faculty | 2025-10-15
Jason Levitis, Sabrina Corlette, and Claire O'Brien

As the nation winds through its second week of government shutdown, Affordable Care Act (ACA) policy has again taken center stage. A key sticking point in funding negotiations is upcoming reductions in the premium tax credit (PTC). Democrats say they cannot vote for a bill that allows the reductions to proceed. Republicans have expressed openness to considering some form of extension but have insisted that negotiations can wait until later, since the reductions don't take effect until 2026.

So what's the truth of the matter? In this case, the facts are clear. As we explained here last year, the timeline of health insurance rate setting and Marketplace enrollment means that the harms from a reduction are locked in well before the new plan year.

Indeed, Congress has already waited too long. Even if the enhancements were to be extended tomorrow, millions of people now inevitably face higher premiums for the year, because insurance companies have finalized their rates assuming that smaller PTCs will push healthy people out. According to Congressional Budget Office (CBO) estimates, even if Congress had extended the enhancements on September 30, gross premiums would have been 5 percent higher compared to earlier enactment. And while it will never be "too late" for action to support future coverage, the immediate harms will grow quickly in the weeks ahead. By mid-October, millions of people will learn that they face drastically higher out-of-pocket premiums, leading to cancellations and decisions to stay uninsured that will be impossible to fully reverse. If an extension passes at year's end, coverage losses will be 1.5 million due to the delays alone, according to published reports citing CBO estimates.

These delays also impose financial costs on insurance companies, Marketplaces, and state regulators that are ultimately borne by consumers and taxpayers. When and if the enhancements are extended, Marketplaces have options to mitigate (but not eliminate) coverage losses. But executing these maneuvers is costly and grows more so the longer Congress waits.

Background

The PTC enhancements were first enacted in 2021 under the American Rescue Plan Act and extended in 2022 under the Inflation Reduction Act. The

enhancements increase affordability and expand coverage in several ways. First, they reduce net premiums for virtually all PTC recipients relative to the original, smaller PTC. Second, they eliminate the eligibility cliff at 400 percent of the federal poverty line (about $60,000 for a single individual in 2025). This is especially important for older people and others facing higher premiums. For example, in 2025 a 60-year-old with income at $65,000 (which is 432 percent of the federal poverty line) would pay $12,653 annually for a benchmark silver on average without the enhancements in place, or $5,525 with the enhancements in place. Finally, the enhancements reduce gross premiums by pulling healthier people into the risk pool, which helps people ineligible for PTC. Eliminating these savings would increase health care costs for consumers and employers and, in doing so, reduce coverage.

In our piece last year, we noted the perhaps-unintuitive timeline for effects of the PTC's expiration to be felt. Tax cuts are commonly enacted or extended during or even shortly after the tax year without substantial drawbacks, given the retrospective nature of tax filing. But the unique structure of the PTC means that the enhancements' expiration is felt much sooner. Specifically, the rate filing process for a year plays out in the spring and summer of the prior year. And the enrollment process locks in place consumer responses to expected net premium changes before the coverage year has even begun. Despite this dynamic, Congress acted in the reconciliation bill to extend other tax cuts that expire at year's end, while taking no action on the PTC.

The time for acting to completely avoid higher costs and coverage losses has now passed, and certain harms are now locked in place. However, swift passage of the PTC enhancements would stop additional harms that will otherwise spread in the coming weeks.

Harms Already Locked In Place

October 1: Higher Insurance Premiums Finalized

In a normal year, health insurers participating in the ACA marketplaces finalize their premiums in mid-August and sign Marketplace contracts by the end of September. This year, the Centers for Medicare & Medicaid Services (CMS) and many states extended those deadlines to account for the uncertainty over Congressional action on the extension of enhanced premium tax credits and other federal policy changes. On September 23, CMS announced that insurers would have until October 1 to make any changes to premium rates, and until October 2 to sign their contracts with the federal Marketplace. They have now reached a "pencils down" moment.

CBO has previously estimated that extending the enhancements would reduce premiums by 7.6 percent annually on average (though as explained in this article achieving that level of reduction for 2026 would have required acting earlier). This projection is supported by a recent analysis of health insurers' individual market proposed premium rates for 178 Marketplace plans across 28 states, which found that insurers are attributing between 1 and 14 percentage points of their proposed rate increases to the expiration of the enhanced premium tax credits. This is generally because insurers assume that most of the people who drop their coverage due to a loss of enhanced premium tax credits will be young and healthy, leaving them with a smaller and sicker risk pool and higher costs.

These higher premiums mean higher costs for consumers not eligible for premium tax credits, since these individuals, unlike those who do receive premium tax credits, are not insulated from list premiums. The higher

premiums also increase costs for employers who provide coverage for employees using individual coverage health reimbursement arrangements (ICHRAs) and similar vehicles.

If Congress passes an extension in the next few weeks, some state regulators and state-based Marketplaces could, in theory, require or allow for re-submission of plans and rates even at this late date. But this scenario is unlikely due to the operational difficulties and costs associated with re-loading plans and rates into Marketplace websites and revising consumer notices and marketing materials. Indeed, CBO estimated that, even if Congress had been able to enact an extension of the enhanced tax credits by September 30, 2025, insurers were only 50 percent likely to make rate adjustments after meeting state and federal deadlines for finalizing 2026 premium rates. And the value of such adjustments is quickly declining, since insurers would know that many of the healthier people already knocked out of the market won't return. For these reasons, CBO's forecast for a September enactment is that premiums for 2026 would have fallen by just 2.4 percent had Congress extended the enhanced PTC last month, compared to the 7.6 percent reduction CBO estimated with more of a runway. ***In other words, CBO believes that a premium increase of about 5 percent is already locked in.***

Any such late rate revisions would also impose costs on issuers, Marketplaces, and state regulators that would be passed along to consumers and taxpayers.

Harms That Will Be Locked In Place In The Weeks

Ahead

While the increases in gross premiums are substantial, the much larger impact will be on PTC recipients. KFF estimates that net premiums will more than double on average if the enhanced PTC are allowed to expire. And PTC recipients generally have lower incomes and so are less able to and less likely to have other good coverage options, meaning that higher net premiums will translate into substantial uninsurance for this population.

Over the course of October, most consumers will be informed of these higher net premiums through the various avenues described below. Many considering new enrollment will choose not to enroll. Current enrollees will have premium shock and may decide not to re-enroll, including cancelling auto-reenrollment.

Congress could still restore the higher PTCs by passing an extension later, and this would restore affordability for eligible consumers and mitigate coverage losses. But some consumers won't come back, since they will lose the benefit of auto-reenrollment, lose trust in the marketplace, change their budget planning, and/or tune out.

Throughout October: Window Shopping Shows Lower PTC

Before the open enrollment period, most Marketplaces offer tools that permit "window shopping": browsing plan options and receiving an estimate of financial help. Window shopping started at the beginning of October in six states (Georgia, Idaho, Maryland, Nevada, New York, and Virginia), opens by mid-October in most other State Marketplaces, and by late October in the Federal Marketplace. Window shoppers are already seeing much higher premiums. And because window shopping tools don't

generally collect contact information, Marketplaces will have no way to contact these potential enrollees if the enhancements are later restored.

Middle To Late October: Re-Enrollment Notices Showing Higher Net Premiums

By the end of October, virtually all State Marketplaces will send current enrollees re-enrollment notices showing higher net premiums and lower financial assistance. (The federal marketplace's notices do not include 2026 premiums). The National Association of Insurance Commissioners expressed concern about the resulting premium shock in its August 21 letter, noting, "Without an extension of the enhanced credits in September, insurers and marketplaces will begin to notify over 20 million consumers in all 50 states of major premium increases in a matter of weeks."

Even if Congress passes an extension soon, revising these letters is not instantaneous. Letters already in the mail may be impossible to stop. And sending revised letters will require states to re-run their "batch" redetermination on all current enrollees and then re-print and send large numbers of new letters—a process that will vary depending on each state's IT systems and operational capacity. Any such revisions will impose additional costs on Marketplaces.

By Late October: Marketplaces Lock Down IT And other Systems

Best practices for websites and other systems serving millions of people require extensive preparation, testing, and a "code freeze" well before the go-live date. When and if an extension passes, Marketplaces may be unable to immediately change course. Timelines will depend on the agility of each Marketplace's IT systems, customer support staff, and communications apparatus. Any such changes will impose additional costs for re-

programming systems, revising communications materials, retraining customer support staff and navigators, and booking additional advertising. Last-minute changes also create more demand for call centers and other assistance.

November 1: Open Enrollment Begins Nationwide

On November 1, the open enrollment period opens nationwide (and October 15 in Idaho). At that point, both new applicants trying to enroll and current enrollees updating their applications and shopping will see the higher net premiums, deterring many from enrolling.

December: Enrollees Receive Bills Showing Higher Net Premiums

In December, all enrollees–including those auto-reenrolled–will receive their January 2026 bills showing their net premium for 2026. For auto-reenrollees in the federal Marketplace who don't go in to shop, this will generally be the first time they see the higher premium, resulting in an additional round of disenrollment. If Congress later restores the enhancements, Marketplaces could contact these individuals to invite them back, but evidence suggests that direct-to-consumer notifications to uninsured people leads to only a small fraction of them enrolling.

In addition, December 15 is the last day to enroll for January 1 coverage in the federal Marketplace.

January: Open Enrollment Ends

The open enrollment period ends on January 15 in the federal Marketplace and most state Marketplaces. This will lock in consumers' coverage decisions and plan choices. They will not be able to enroll in coverage without a

special enrollment period. Some consumers will still enroll but will be more likely to disenroll later due to higher out-of-pocket costs. If Congress later restores the enhancements, Marketplaces could reach out to consumers who are not enrolled and ask them to come back, but again such marketing is typically not very effective. Marketplaces could also seek to increase the ongoing monthly PTC payments for remaining enrollees, as many of them did when the enhancements were first enacted in March of 2021. But this is an imperfect process, so some consumers would likely continue to pay the higher premiums throughout the year, leading to even more disenrollment.

Conclusion

While the substance of health policy is extremely important, sometimes timing matters, too. With 2026 rates already set and consumers starting to learn of premium increases, delays in extending the PTC enhancements beyond 2025 have already led to cost increases and coverage losses that cannot be reversed.

It will never be "too late" to extend the PTC enhancements—extending them will always save consumers money and help them get covered. But the next few weeks are crucial. Every passing day will lock in additional irreversible harms.

Jason Levitis, Sabrina Corlette, and Claire O'Brien "Damage From Inaction On ACA Tax Credits Has Begun And Will Grow With Further Delays" October 8, 2025, https://www.healthaffairs.org/content/forefront/damage-inaction-aca-tax-credits-has-begun-and-grow-further-delays. Copyright © 2025

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Eligibility Cliff on ACA Tax Credits Would Make Health Care Unaffordable for Middle-Class Families

Most Americans Receive Federal Help for Health Insurance, Tax Credits Fill the Gap for Those Left Out

Jason Levitis, Claire O'Brien, and Caitlin Rowley Gallamore

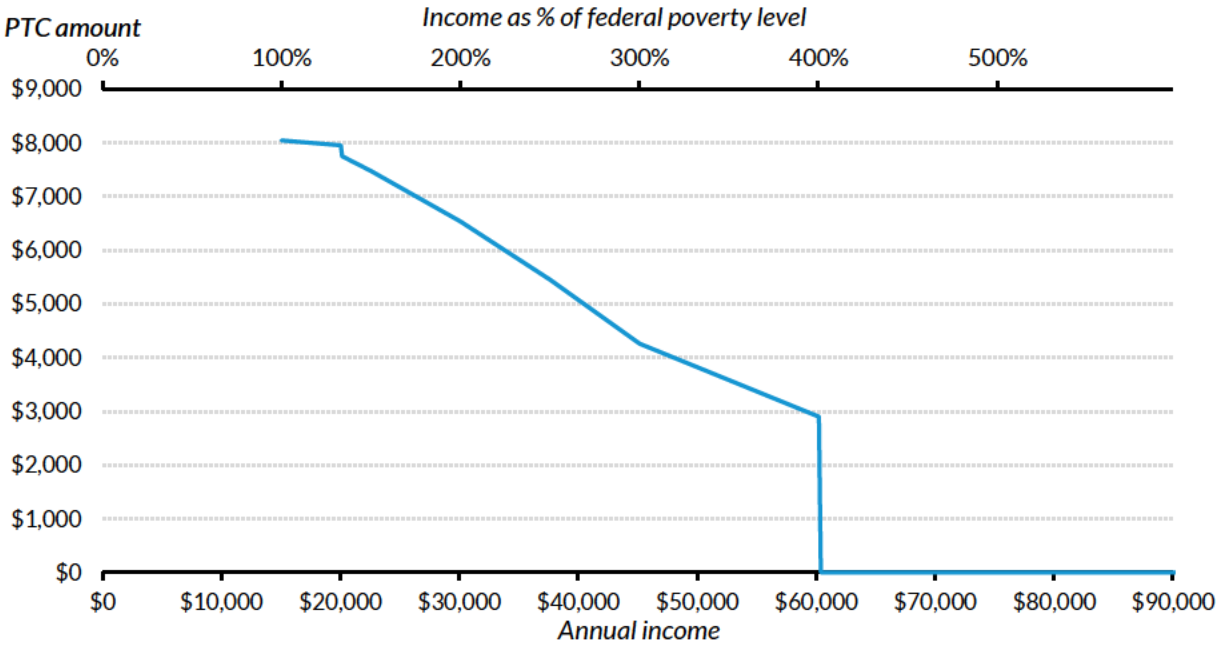
October 2025

A key sticking point in the government shutdown debate is the upcoming reductions in the premium tax credit (PTC; Buettgens et al. 2025),[1] particularly how the credit declines as income increases.[2] The reductions expected in 2026 (but already being felt; Levitis, Corlette, and O'Brien 2025) include reimposing an eligibility cliff at 400 percent of the federal poverty level (FPL)—a bit over $60,000 for a single person. With the cliff in place, the tax credit falls suddenly to zero when income crosses this line (figure 1).[3]

FIGURE 1

Without Enhancements, the PTC Cuts off in a Cliff

PTC amount without enhancements for a 50-year-old in an average premium benchmark plan, 2025



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Source: Authors' calculations using "Revenue Procedure 2024-35," IRS, 2024; and premiums from "Health Insurance Marketplace Calculator," *KFF*, October 29, 2024, https://www.kff.org/interactive/subsidy-calculator/.

Notes: PTC = premium tax credit. Income is for an individual taxfiler. Premiums in 2026 are expected to be higher. See Stacey Pogue, Bitty Dering, JoAnn Volk, and Kevin Lucia, "Early 2026 Rate Filings Show Marketplace Policy Changes Contribute to Eye-Popping Rate Increases," CHIR, June 26, 2025, https://chir.georgetown.edu/early-2026-rate-filings-show-marketplace-policy-changes-contribute-to-eye-popping-rate-increases-2/.

The cliff was originally included in the PTC as a means of reducing the Affordable Care Act's (ACA) cost.[4] It was then eliminated as part of PTC enhancements that were enacted in the American Rescue Plan Act of 2021 and extended in the Inflation Reduction Act of 2022. Without action by Congress, the enhancements will expire at the end of 2025, and the cliff will reappear. Some argue that providing the PTC past the cliff is an unnecessary giveaway to the rich. In a recent op-ed, a senior fellow at Americans for Prosperity claims that, without the "income cap,… sliding-scale subsidies are available to everyone… even millionaires."[5]

But this is not the case. In fact, the PTC without the cliff is income-limited—it just phases out gradually rather than dropping off suddenly. There are other reasons not to reimpose the cliff. Given the high cost of health coverage, virtually all Americans receive some kind of federal assistance to pay for it, whether from Medicare, Medicaid, or the tax exclusion for employer coverage. For those beyond the cliff, the enhanced PTC is already smaller on average than the tax benefit from the tax exclusion for employer-sponsored coverage. Reimposing the cliff would worsen this disparity. The cliff—and therefore this disparate treatment—falls disproportionately on older people, those in high-premium areas (which are heavily rural areas), and small business owners. More generally, cliffs are widely considered bad policy because they are inequitable and create perverse incentives. Finally, the PTC is especially ill-suited to a cliff, as it is advanceable, which creates the risk that a small income change triggers a large tax liability.

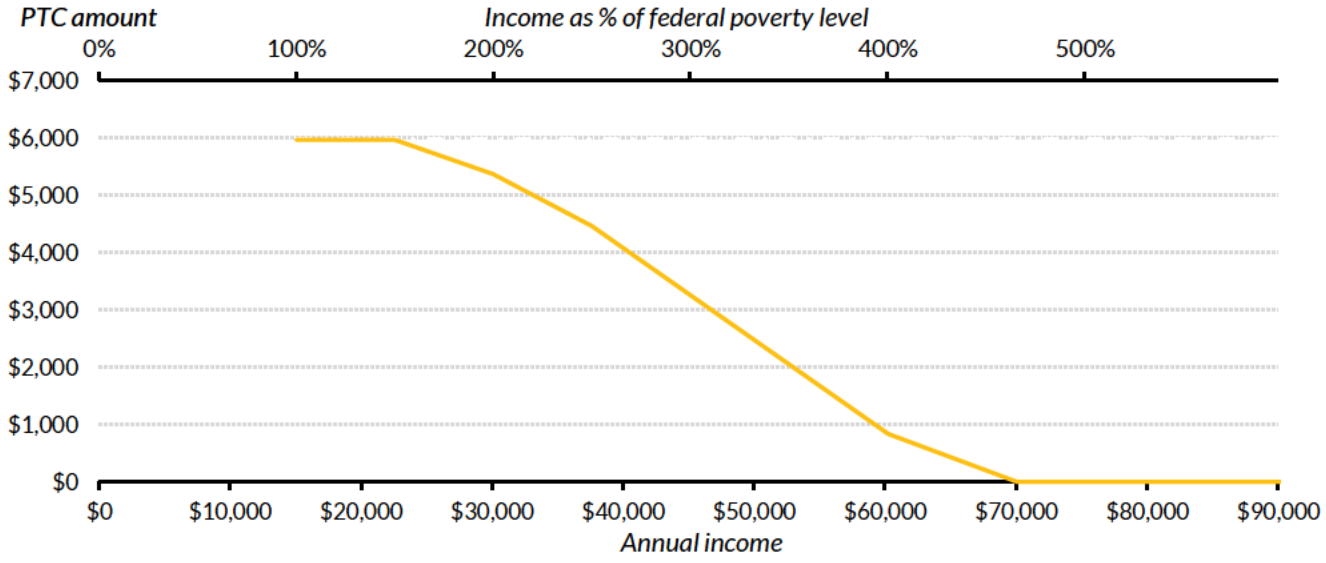
The Enhanced PTC Is Still Capped—Just without a Cliff

Even without the cliff, the PTC is income-limited, since it phases out as income increases. For example, for a 40-year-old with an average premium ($5,964 annually), the PTC hits zero at an income of $70,165, or 466 percent of FPL (figure 2). The PTC is very small at incomes just below that. For example, if the 40-year-old had an income of $68,000, their credit would be $184.

FIGURE 2

The Enhanced PTC Falls to Zero as Income Rises

PTC amount with enhancements in place for a 40-year-old in an average-premium benchmark plan, 2025



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Source: Authors' calculations using "Rev. Proc. 2024-35," IRS, 2024; and premiums from "Health Insurance Marketplace Calculator," *KFF*, October 29, 2024, https://www.kff.org/interactive/subsidy-calculator/.

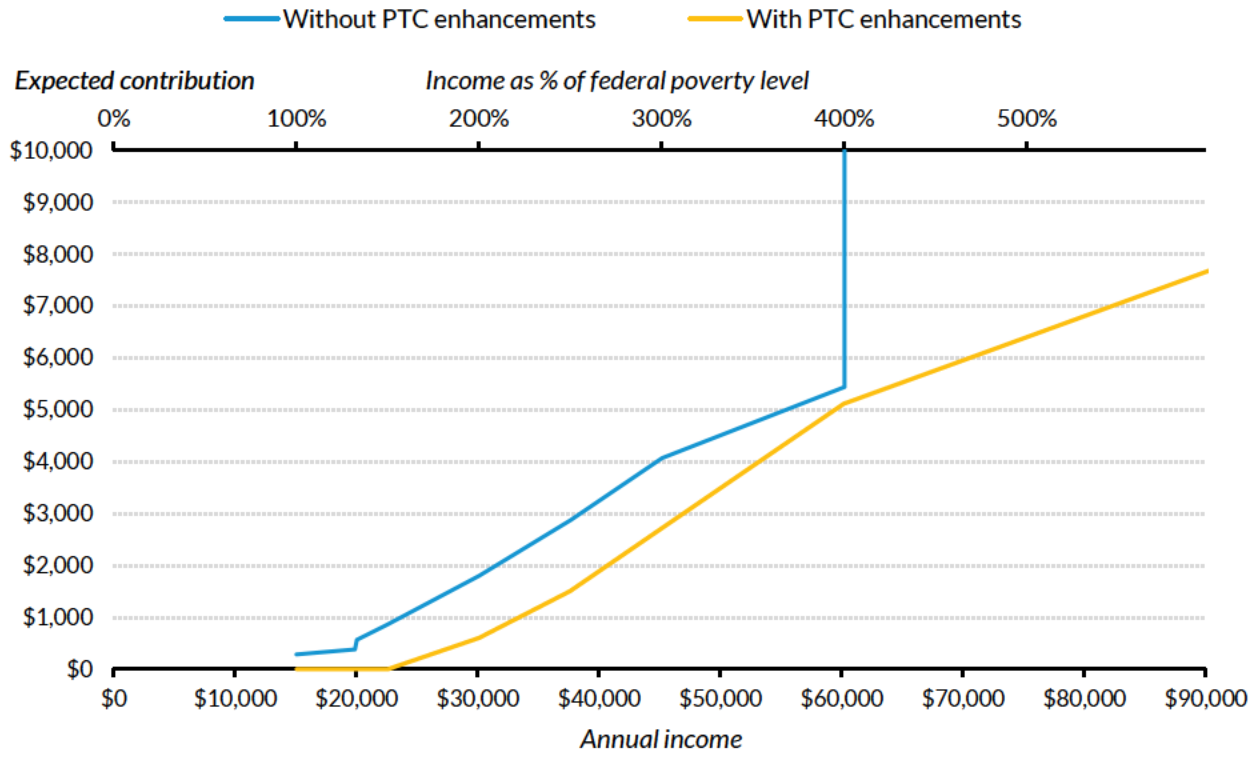
Notes: PTC = premium tax credit. Income is for an individual tax filer. Premiums in 2026 are expected to be higher. See Stacey Pogue, Bill Dering, JoAnn Volk, and Kevin Lucia, "Early 2026 Rate Filings Show Marketplace Policy Changes Contribute to Eye-Popping Rate Increases," CHIR, June 26, 2025, https://chir.georgetown.edu/early-2026-rate-filings-show-marketplace-policy-changes-contribute-to-eye-popping-rate-increases-2/.

The PTC phases down to zero because it is calculated to cap the individual contribution toward a benchmark plan at a certain percentage of income. (The benchmark premium is the second-lowest cost "silver" tier plan. If a consumer buys a more expensive plan, they pay the difference). Under the enhancements, this individual contribution percentage is 8.5 percent at incomes above 400 percent of FPL ($60,240 for a single person). For example, a person with income of $65,000 (432 percent of FPL) has to pay $5,525 (8.5 percent of $65,000) for a benchmark plan, and the PTC covers the rest (figure 3). When income grows large enough that the expected individual contribution exceeds the benchmark premium, the tax credit zeros out. Without the enhancements, an individual with an income of $65,000 gets no assistance regardless of the premium they face.

FIGURE 3

The Cliff Exposes Middle-Income Consumers to Unlimited Premiums

Expected contribution with PTC to purchase individual benchmark coverage, with and without the PTC enhancements, 2025



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Source: Authors' calculations using "Rev. Proc. 2024-35," IRS, 2024; and "Federal Poverty Level," Healthcare.gov, accessed October 14, 2025. https://www.healthcare.gov/glossary/federal-poverty-level-fpl/.
Notes: PTC = premium tax credit. Income is for an individual tax filer.

Because of this structure, people with relatively higher incomes qualify for the enhanced PTC only if they face high gross premiums. For example, a person earning $200,000 has an expected contribution of $17,000 (8.5 percent of $200,000). So they qualify for PTC only if their benchmark premium exceeds $17,000. The credit at higher incomes is generally small. For example, if a person earning $200,000 faces a gross premium of $20,000, their expected contribution is $17,000, and the credit covers $3,000—15 percent of the total premium.

The Cliff Denies Some People the Federal Help for Health Insurance That's Available to Virtually All Other Americans—and Even the Enhanced PTC Is Smaller than the Tax Benefit for Employer Coverage at Incomes Beyond the Cliff

Almost all Americans receive some kind of federal assistance in paying for health insurance: more than half benefit from the tax exclusion for employer coverage—the largest tax expenditure in the tax code—and another hundred million or more have Medicare or Medicaid.[6] The PTC is designed to help people ineligible for these other benefits. With or without the enhancements, it is available only to people without other affordable coverage options.[7] The cliff denies this group any such benefit, disadvantaging them relative to other Americans.

Eliminating the cliff mitigates but doesn't remove this disparity. Treasury data shows that, for people with incomes past the cliff, the enhanced PTC is smaller on average than the tax benefit from employer-sponsored coverage.[8] This disparity is especially harmful to those who rely disproportionately on Marketplace coverage, including older people, rural Americans, and small businesses, as explained below.

The Cliff Is Especially Harmful for Older People and People in High-Premium Areas

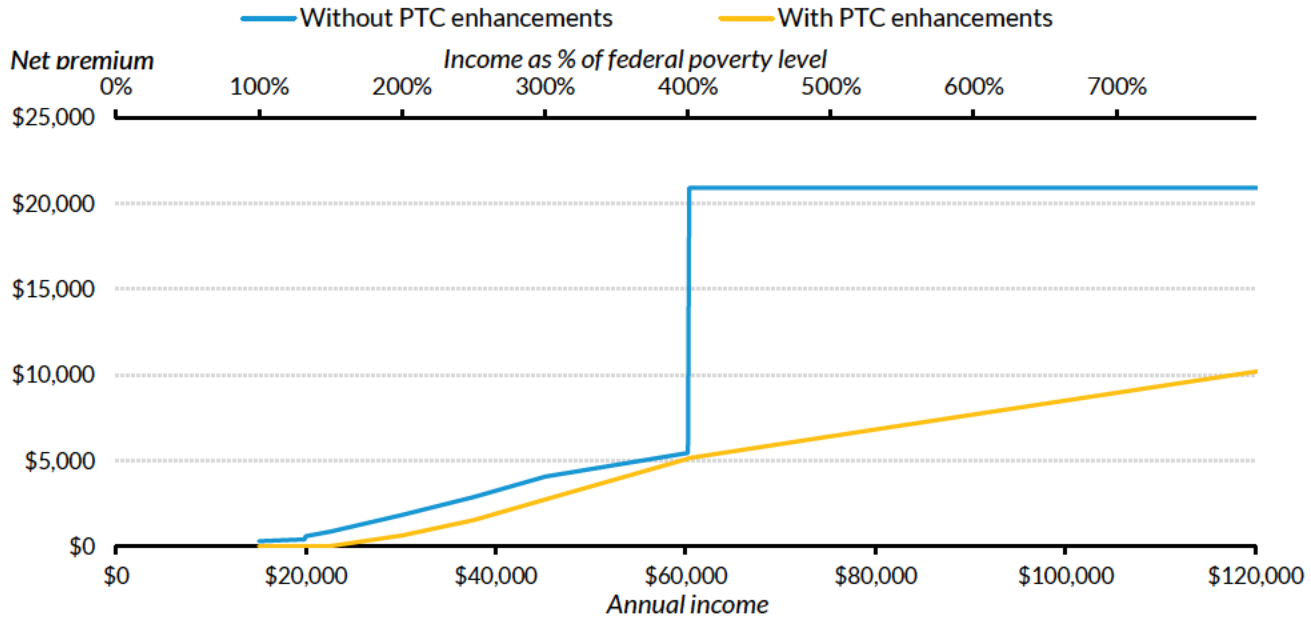
Extending the credit beyond the cliff is essential to making coverage affordable for people facing higher premiums—generally older people and people in high-premium areas (Banthin, Skopec, and Simpson 2024). With the cliff in place, those beyond it receive no assistance, even if the premium is very high.

For example, the benchmark premium for a 60-year-old in Cheyenne, Wyoming, is $20,916 annually.[9] With the cliff in place, a person with an income of $65,000 (432 percent of FPL) pays the full amount out of pocket, amounting to 32 percent of income (figure 4). They would likely also face a deductible of thousands of dollars (Holahan, Simpson, and Wengle 2025).

FIGURE 4

The Cliff Is Larger for Those Charged Higher Premiums

Net premium for a 60-year-old in a benchmark plan in Cheyenne, Wyoming, with and without PTC enhancements, 2025



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Source: Authors' calculations using "Rev. Proc. 2024-35," IRS, 2024; and premiums from "Health Insurance Marketplace Calculator," *KFF*, October 29, 2024, https://www.kff.org/interactive/subsidy-calculator/.

Notes: PTC = premium tax credit. Income is for an individual tax-filer. Premiums in 2026 are expected to be higher. See Stacey Pogue, Bill Dering, JoAnn Volk, and Kevin Lucia, "Early 2026 Rate Filings Show Marketplace Policy Changes Contribute to Eye-Popping Rate Increases, CHIR, June 26, 2025, https://chir.georgetown.edu/early-2026-rate-filings-show-marketplace-policy-changes-contribute-to-eye-popping-rate-increases-2/.

Older adults not yet eligible for Medicare are especially harmed because the ACA permits higher gross premiums based on age.[10] Under age-rating rules, premiums are generally almost twice as expensive for a 50-year-old and three times as expensive for a 64-year-old compared with a 24-year-old.[11] This group includes people who have left the workforce and no longer have employer-sponsored insurance. The cliff affects this group disproportionately: of PTC recipients with incomes above 400 percent of FPL, 42 percent are 55 or older (USDT 2025). Of the small number of enrollees with income over 800 percent of FPL, about half are 55 or older (USDT 2025).

Premiums also tend to be high in rural areas, and they vary widely across states (Banthin, Skopec, and Simpson 2024; Holahan, Wengle, and O'Brien 2022). Enrollees in Alaska, West Virginia, and Wyoming pay significantly higher premiums relative to other states. This again translates to more harm from the cliff. For example, 21 percent of PTC recipients in Wyoming have income past the cliff, compared to 14 percent nationwide (USDT 2025).

With the enhancements in effect, the 60-year-old in Cheyenne earning $65,000 would have their contribution capped at 8.5 percent of income, or $5,525. This is the central logic of the no-cliff PTC—higher-income people pay more, but the amount is limited relative to income.

The Cliff Is Harmful for Small Businesses

The Marketplace is a crucial source of insurance outside of employer-sponsored coverage for the self-employed and small business owners, especially among those with incomes above the cliff. KFF estimates that 38 percent of adults younger than age 65 with incomes above 400 percent of FPL are self-employed, compared with 7 percent of adults under age 65 overall.[12] Treasury data shows that 3.3 million self-employed workers and small business owners ages 21 to 64 enrolled in Marketplace coverage in 2022, including 285,000 with incomes above 400 percent of FPL (USDT 2024). This represents 28 percent of total Marketplace enrollment for consumers ages 21 to 64 and 18 percent of all self-employed workers and small business owners; by comparison, the Marketplace covered just 6 percent of the rest of the population. This share is even higher in some states: in Florida, North Carolina, and Wyoming, at least a quarter of self-employed workers and small business owners enrolled in the Marketplace (USDT 2024). With Marketplace enrollment growth since 2022, the Center on Budget and Policy Priorities estimates that the number of self-employed workers and small business owners enrolled in the Marketplace has increased from 3.3 million to 5 million.[13]

Cliffs Are Widely Considered Bad Tax Policy

There is broad agreement among tax policy experts that eligibility cliffs in the tax system trigger negative behavioral effects and economic distortions (Maag et al. 2012; Viswanathan 2016).[14] Cliffs create perverse incentives to work less or otherwise make suboptimal decisions to retain benefits or reduce tax liability (Roll, Despard, and Miller 2025; Viswanathan 2016).[15] They also diminish horizontal equity —the principle that similarly situated taxpayers should be treated similarly (Viswanathan 2016).

Because of this, many tax provisions include gradual phaseouts, such as the Earned Income Tax Credit, the Child Tax Credit, and the recently created additional senior deduction.[16] Other notable examples include the American Opportunity Tax Credit, the Lifetime Learning Credit, and the Saver's Credit.[17] The income bracket system has the same effect by operating on a marginal basis.[18] The cliff in the unenhanced PTC defies this principle.

The PTC Reconciliation Requirement Makes the Cliff Especially Harmful

Even more than other tax benefits, the PTC is ill-suited to a cliff because it is typically paid in advance based on projected income and then "reconciled" with the actual PTC on the tax return.[19] Advance payment is essential, since most consumers cannot pay the full premium out of pocket. For consumers within the income eligibility range, the amount that must be paid back is never more than a small fraction of the income change. But consumers who cross the income cliff may owe back thousands of dollars after only a very small change in income. The surprise tax bills that result are especially large for those charged higher gross premiums, meaning older people and those in high-premium (often rural) areas.

Such increases in income can be impossible to predict—they could result from an end-of-year bonus, for example. KFF estimates that 9 percent of households with income between 100 and 400 percent of FPL in the first three months of the year end the year with income above 400 percent of FPL, and that 15 percent of adults ages 19 to 64 with incomes near the cliff have high income volatility.[20] This risk of large paybacks may deter people from enrolling. In 2019, taxpayers who ended the year with incomes between $100,000 and $200,000 and owed back PTC faced an average repayment of about $6,400.[21]

Conclusion

There are good reasons to focus public benefits on lower-income people who most need them. However, health coverage is so expensive that even middle-income earners need help affording it. The federal government provides this help to almost every American, whether via public insurance programs or tax benefits for employer-sponsored coverage. The PTC cliff would deny similar assistance to those who rely on the Marketplace, leaving middle-income Americans with health insurance premiums in the tens of thousands of dollars.

The enhanced PTC includes a phase-out that targets the credit to those who need it, taking into account both income and the premiums people face. A cliff on top of that phase-out is both redundant and, as the analysis presented here demonstrates, harmful to many who need help.

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Center for Medicare Advocacy
MedicareAdvocacy.org

THE AFFORDABLE CARE ACT (ACA) HELPS MEDICARE

ACA Adds Years to Medicare

Overall, as of 2016, ACA increased Medicare's financial well-being by an additional 12 years.

ACA reduced Medicare Advantage overpayments (which were as much as 14% more, on average, of traditional Medicare spending), reduced annual increases to provider payments, raised additional revenue, and fostered delivery-system reforms. ACA also reduced Medicare spending growth: Average annual growth in spending per beneficiary shrank from 7.4% between 2000 and 2010 down to 1.4% between 2010 and 2015.

ACA reduces prescription drug spending for Medicare beneficiaries

Thanks to the ACA, the Part D prescription drug "Donut Hole", or gap in coverage, is shrinking and will be fully closed by 2020. Since the ACA was passed, almost 12 million Medicare beneficiaries have received discounts on prescription drugs, totaling over $26.8 billion, for an average of $2,272 per individual.

ACA expands access to preventive services

Roughly 40 million people with Medicare utilized at least one preventive service, with no copay or deductible in 2016. In addition, over 10.3 million Medicare beneficiaries had a covered Annual Wellness Visit in 2016.

Repealing ACA would increase Medicare spending

The Congressional Budget Office (CBO) estimates that full repeal of the ACA would increase the Medicare program's spending by $802 billion from 2016 to 2025.

Repealing ACA would increase individual out-of-pocket costs

Full repeal of ACA would lead to higher beneficiary premiums, deductibles and cost-sharing.

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American Hospital Association™
Advancing Health in America

Fact Sheet: Enhanced Premium Tax Credits

The Issue

The federal government offers enhanced premium tax credits (EPTCs or tax credits) to help some individuals and families purchase insurance on the health insurance marketplaces. Eligibility and tax credit amounts are based on the individual or family's income level, as well as their access to other forms of comprehensive coverage, e.g., through their employer.

In 2021, Congress increased and expanded eligibility for the tax credits; however, those policies are scheduled to expire at the end of 2025. These 2021 tax credits have resulted in an additional 10 million people gaining coverage through the health insurance marketplaces while others receiving assistance paying their health insurance costs.[1] This has increased access to health care coverage and high quality care for patients and communities served by hospitals, health systems and other providers.

AHA Take

In support of the health of our patients and communities, as well as the stability of the entire health care system, the AHA urges Congress to extend the enhanced premium tax credits.

Why?

- The tax credits helped millions of Americans purchase affordable commercial health care coverage. **The expiration of this policy would effectively be a tax increase of $700 on average for millions of people across the nation.**
- The expiration of the enhanced tax credits will result in 4.2 million people becoming uninsured by 2034.[2] There would be a disproportionate impact to those in rural states and those with lower incomes.
- Some states would see higher rates of disruption in coverage and loss of federal tax funds, particularly those that have not expanded Medicaid. Several of these states, such as Texas and Florida, experienced some of the highest enrollment growth in the health insurance marketplaces due to the enhanced tax credits.
- The loss of coverage would put considerable financial stress on hospitals, health systems and other providers, which will face more uncompensated care and bad debt. This, in turn, would make it difficult for them to maintain services in their communities KNG Health Consulting found that **allowing the EPTCs to expire would result in a $28 billion reduction in hospital spending over 10 years.**

American Hospital Association™
Advancing Health in America

Background

Certain individuals and families are eligible for prospective, monthly tax credits that lower the cost of health insurance marketplace premiums. To be eligible, these individuals or families must:

- Meet certain income thresholds, based on the federal poverty level (FPL).[3]
- Not be eligible for other comprehensive coverage, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or affordable employer-sponsored coverage (defined as costing less than 8.5% of household income).[4]
- Be a U.S. citizen or have proof of legal residency or, as of Jan. 1, 2025, be eligible for Deferred Action for Childhood Arrivals.
- If married, file taxes jointly.

The amount of tax credit that an individual or family is eligible for is based on household income, as well as the cost of the second-lowest silver plan in the individual's market. Once an individual or family has been determined eligible and selected their preferred health plan, the tax credit is immediately applied directly to the premium; thus, the enrollee only needs to pay the remaining amount.

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1 kff.org/affordable-care-act/issue-brief/a-look-at-aca-coverage-through-the-marketplaces-and-medicaid-expansion-ahead-of-potential-policy-changes

2 cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf

3 The income used to calculate the EPTCs is an estimate by the applicant based on what they expect their household income to be in the coming year. When filing taxes at the end of the year, they may receive additional tax credits if their income was lower than expected. Alternatively, they may have to repay some of their tax credit if their income was higher than expected.

4 For employer-sponsored coverage to be considered affordable, it must meet a minimum value requirement, and the annual premium must be equal to or less than 9.02% of the individual's household income.

Center on Budget and Policy Priorities

Updated: November 3, 2025 | Gideon Lukens and Elizabeth Zhang

Health Insurance Premium Spikes Imminent as Tax Credit Enhancements Set to Expire

Enhancements to premium tax credits, enacted in the American Rescue Plan and extended by the Inflation Reduction Act, are helping more than 20 million people afford health coverage in the Affordable Care Act (ACA) marketplaces. The enhancements helped spur a doubling of enrollment in the ACA marketplaces and contributed to record-low uninsured rates but are set to expire at the end of 2025. And marketplace enrollees are already starting to see the impact: insurers have finalized their 2026 premium rates, enrollees can see their 2026 premiums on marketplace websites, and open enrollment will be underway November 1. If Congress waits until the end of the year to extend the enhancements, 1.5 million more people will be uninsured in 2026 compared to an earlier extension, the Congressional Budget Office (CBO) estimates.[1]

Congress can still protect people from cost increases due to the end of the enhancements — which will exceed $1,000 annually for the average enrollee receiving premium tax credits, and many times that for some people — and minimize the number who are left uninsured by extending the enhancements as soon as possible. Since Congress has not acted sooner and many enrollees likely have already experienced sticker shock and decided not to enroll, it should also extend the open enrollment period (scheduled to end January 15 in most states) to give people more time to sign up. Appendix 2 provides state-by-state data on the premium increases if the enhancements expire.

The megabill Republicans enacted in July and a marketplace regulation the Trump Administration finalized in June will already create new barriers to marketplace enrollment and raise people's out-of-pocket costs.[2] If Congress allows the premium tax credit enhancements to expire, nearly all marketplace enrollees will face significantly higher premium costs, which will more than double on average, and 3.8 million more people will be uninsured in 2035.[3] Congress should make the enhancements permanent so that families have stability and predictability when it comes to their access to affordable health insurance.

Premium Costs Will More Than Double on Average if Enhancements Expire

A record 93 percent of marketplace enrollees, or over 20 million people, receive premium tax credits (PTCs).[4] These tax credits provide upfront financial assistance to help people afford the individual or family health insurance plans offered in their state through the ACA marketplaces.[5]

The PTC enhancements help these enrollees by:

- lowering the caps on the share of income that people at all income levels pay in premiums;

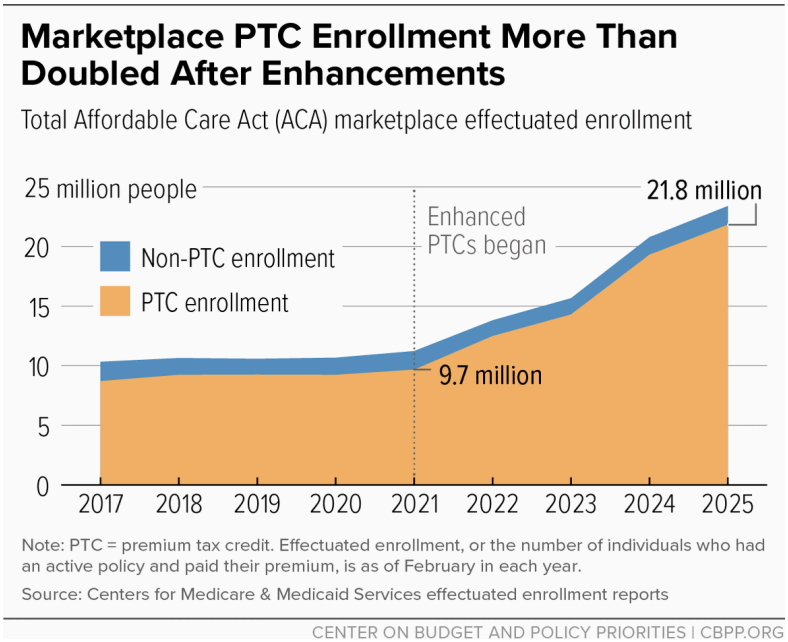
- allowing people with incomes between 100 and 150 percent of the poverty level (roughly $16,000 to $23,000 for an individual) to pay $0 in premiums for "benchmark" silver-level plans; and
- extending eligibility for PTCs to people with incomes above 400 percent of poverty (roughly $63,000 for an individual) if their benchmark premiums would exceed 8.5 percent of household income.

Without the PTC enhancements, the amount the average enrollee receiving PTCs pays in premiums out of pocket will more than double, rising by more than $1,000 a year.[6]

Enhancements Spurred Record Coverage, Especially Among Black and Latino People and Families With Lower Incomes

By making health insurance more affordable, the PTC enhancements have helped more people afford marketplace coverage: 23.4 million were enrolled as of February 2025, up from 11.2 million in February 2021, prior to the enhancements. Some 21.8 million of them receive tax credits to help pay for their coverage, more than double the 9.7 million who received tax credits in February 2021.[7] (See Figure 1.) Thanks in large part to the PTC enhancements, gains in marketplace enrollment offset much of the 2024 decline in Medicaid enrollment due to the unwinding of the pandemic-related provision that temporarily kept Medicaid enrollees covered.[8]

FIGURE 1

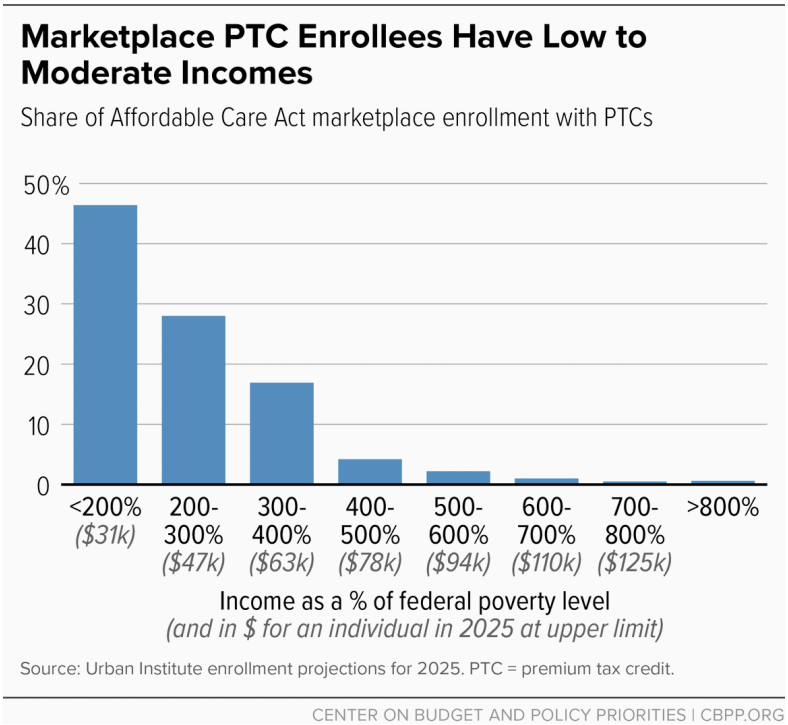


The PTC enhancements have been especially critical for increasing enrollment among Black and Latino people. People of color made up 54 percent of marketplace enrollees in 2024, up from 46 percent in 2021. Between 2021 and 2024, marketplace enrollment among Black and Latino people grew by 186 percent and

158 percent, respectively, compared to 63 percent for other racial and ethnic groups.[9] Marketplace enrollment rates of Asian American people have long been higher than other racial and ethnic groups, potentially due to robust and language-specific enrollment assistance among nonprofits and insurance brokers.[10]

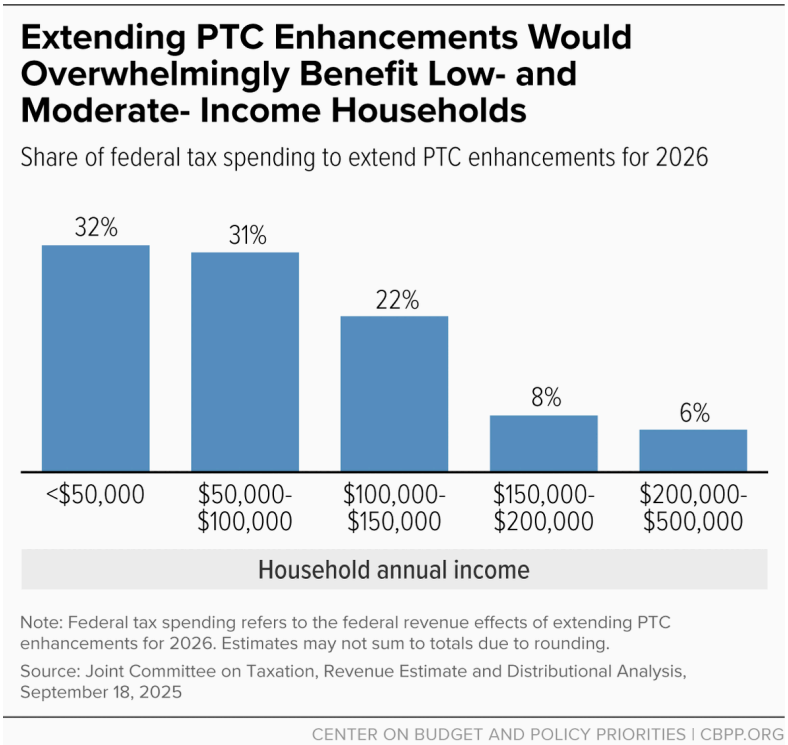
The PTC enhancements also helped spur enrollment among people with lower incomes — those just above the minimum income level for PTC eligibility. Between 2021 and 2025, marketplace enrollment among people with incomes between 100 and 200 percent of the federal poverty level grew by 143 percent, more than twice the 59 percent growth rate among those with other incomes.[11] Marketplace PTCs overwhelmingly benefit people with low to moderate incomes. More than 9 in 10 enrollees have incomes below 400 percent of the federal poverty level, or about $63,000 for an individual in 2025.[12] (See Figure 2.)

FIGURE 2



The total dollar value of the PTC enhancements is also overwhelmingly concentrated among people with low and moderate incomes. According to the Joint Committee on Taxation (JCT), if the enhancements are extended, the majority of the benefits would go to households making less than $80,000, and 94 percent would go to households with incomes under $200,000.[13] No benefits would go to households with incomes above $500,000, according to JCT. (See Figure 3.)

FIGURE 3



Finally, the PTC enhancements have been crucial for self-employed workers and small business owners who, prior to the ACA, had limited options for affordable coverage and who disproportionately benefit from the ACA marketplaces.[14] Self-employed workers and small business owners generally make up about 1 in 4 marketplace enrollees, the Treasury Department estimates; based on this figure, CBPP estimates that more than 5 million self-employed workers and small business owners are enrolled in ACA marketplaces.[15]

Many of these coverage gains will be lost if the PTC enhancements are allowed to lapse. Without the enhancements, CBO projects that 3.8 million more people will be uninsured in 2035.[16] According to the Urban Institute, the number of Black people who are uninsured in 2026 will increase by 30 percent or 925,000, the largest rate of increase among racial/ethnic groups.[17] Marketplace enrollment would decline in every state and congressional district, with the number of enrollees receiving PTCs declining by 38 percent overall.[18]

> “[M]aybe I have to hold back … eat less … take less insulin” if the PTC enhancements expire
>
> *– M. M., 45-year-old IT consultant in Illinois*

Recent focus groups convened by CBPP show the real-world impacts that the PTC enhancements have had on people’s lives — and the repercussions if they expire.[19] For Tracy, a 57-year-old customer service

representative from Georgia whose plan's out-of-pocket premiums are set to rise by $350 per month, the rise in marketplace premiums would "most likely mean sacrificing essentials: groceries, gas, basic necessities that I rely on." Losing the PTC enhancements would force tough decisions, including for people with chronic conditions. M. M., a 45-year-old IT consultant from Illinois, might "hold back on some of those medications, eat less … take less insulin to treat my diabetes."

Premiums Would Rise in Every State, for All Ages and Income Levels

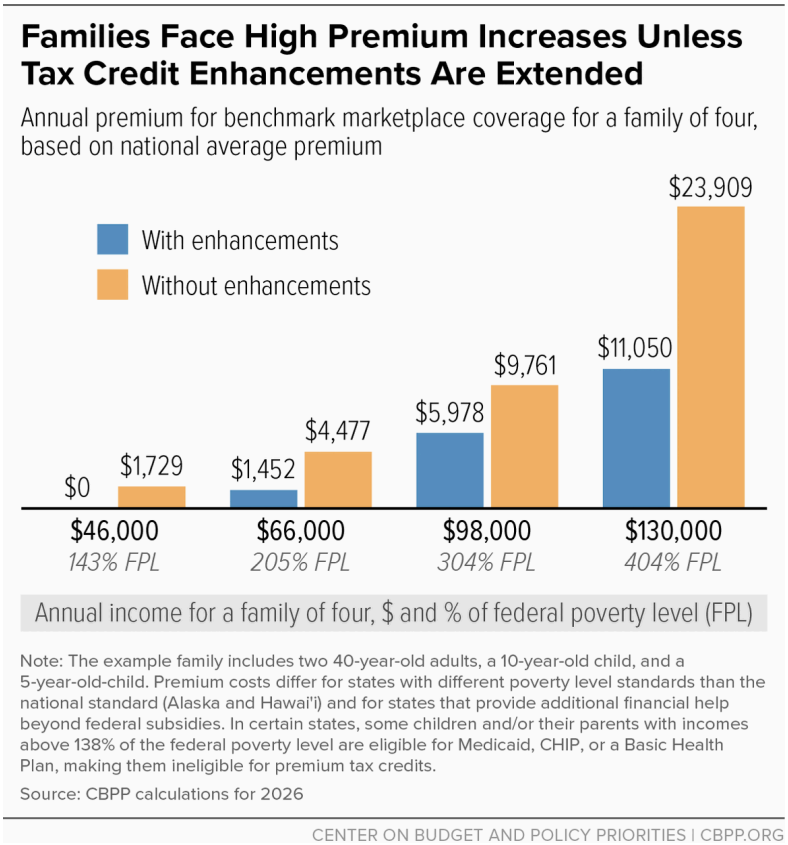
If the PTC enhancements expire, premium costs will soon increase for people across states, ages, and income levels. Many have already experienced "rate shock" and more will continue to do so, as insurers in some states have sent renewal notices showing spiking 2026 premiums and premiums are already viewable on many marketplace websites. And the premium increases would come on top of premium and other out-of-pocket cost increases already set to begin in 2026 due to a recent Trump Administration rule.[20]

People with lower incomes will tend to face the largest percentage increases in premium costs if the PTC enhancements expire. For example:

- A single individual making $22,000 (140 percent of the poverty level) will no longer be eligible for a zero-premium silver plan with cost-sharing reductions and will see their monthly marketplace premium rise from $0 to $66 — an annual increase of $786.
- A single individual making $32,000 (204 percent of the poverty level) will see their monthly marketplace premium rise from $58 to $180 — an annual increase of $1,468.
- A couple making $44,000 (208 percent of the poverty level) will see their monthly marketplace premium rise from $85 to $253 — an annual increase of $2,013.
- A family of four making $66,000 (205 percent of the poverty level) will see their monthly marketplace premium rise from $121 to $373 — an annual increase of about $3,025.

See Figure 4 for a family of four at different income levels; Appendix Table 1 for premium increases among people of various family sizes, ages, and incomes; and Appendix Table 2 for premium increases at the state level. State-by-state graphics of sample households are also available.[21]

FIGURE 4



As a result of the enhancements, people with incomes above 400 percent of the poverty level became newly eligible for PTCs if their marketplace premiums would exceed 8.5 percent of household income. This was especially beneficial for some people earning just over 400 percent of poverty, whose premiums would otherwise have taken up a large share of their income.[22] If the PTC enhancements are not extended, people in this group will face dramatic premium increases:

- A typical 60-year-old couple making $85,000 (401 percent of the poverty level) will see monthly marketplace premiums jump from $602 to $2,647 — an annual increase of roughly $24,500.
- A typical family of four making $130,000 (404 percent of the poverty level) will see their monthly marketplace premium go from $921 to $1,992 — an annual increase of about $12,900.

Dramatic premium spikes are most likely to occur:

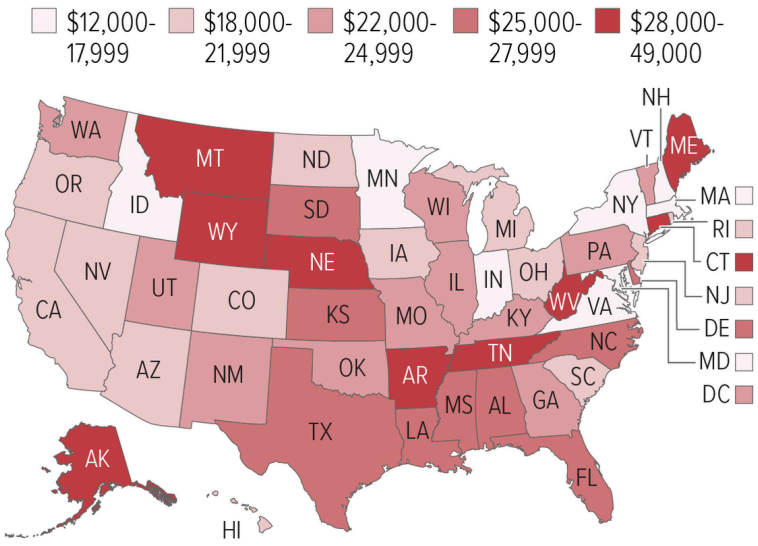
- in states with high underlying marketplace premiums, such as West Virginia and Wyoming;
- for older enrollees, who pay higher premiums under ACA rules than younger people; and
- for people with incomes above 400 percent of the poverty level (roughly $63,000 for an individual), who would lose subsidies entirely if the enhancements expired.

For example, a 60-year-old West Virginia couple making $85,000 will see annual premiums for a benchmark silver plan skyrocket from $7,225 to over $54,000. (See Figure 5 and Appendix Table 2).

FIGURE 5

Premiums Set to Rise Dramatically Without Extension of Tax Credit Enhancements

Annual premium increase, 60-year-old couple with income of $85,000 (401% FPL)



Note: FPL = federal poverty level. The FPL for these calculations is based on 2025 poverty guidelines, which are used to determine premium tax credits for 2026 marketplace coverage. Examples are illustrative and based on 2026 state average benchmark (second-lowest-cost silver plan) premiums. Calculations for Alaska and Hawai'i are for incomes of 401% of state poverty levels, which differ from the FPL. Calculations do not account for state subsidized marketplace premiums in Massachusetts, New Jersey, and New Mexico.

Source: CBPP calculations

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Appendix

APPENDIX TABLE 1

National Average Premium Increases if Enhancements Expire, by Income Level

	Annual marketplace premiums			
	With enhancements (current)	Without enhancements	Premium increase without enhancements	Percentage premium increase
		45-year-old individual		
$22,000 (140% FPL)	$0	$786	$786	N/A
$32,000 (204% FPL)	$691	$2,159	$1,468	212%
$48,000 (306% FPL)	$2,952	$4,781	$1,829	62%
$64,000 (408% FPL)	$5,440	$8,450	$3,010	55%
		60-year-old couple		
$30,000 (141% FPL)	$0	$1,090	$1,090	N/A
$44,000 (208% FPL)	$1,021	$3,034	$2,013	197%
$64,000 (306% FPL)	$3,872	$6,374	$2,502	65%
$85,000 (401% FPL)	$7,225	$31,762	$24,537	340%
		Family of four		
$46,000 (143% FPL)	$0	$1,729	$1,729	N/A
$66,000 (205% FPL)	$1,452	$4,477	$3,025	208%
$98,000 (304% FPL)	$5,978	$9,761	$3,783	63%
$130,000 (404% FPL)	$11,050	$23,909	$12,859	116%

Note: FPL = federal poverty level. The FPL for these calculations is based on 2025 poverty guidelines, which are used to determine premium tax credits for 2026 marketplace coverage. Examples are illustrative and based on 2026 national average benchmark (second-lowest-cost silver plan) premiums for essential health benefits with age adjustments. The example family includes two 40-year-old parents, a 10-year-old, and a 5-year-old. Estimates are applicable in all states except for those with different poverty level standards than the national standard and/or those that subsidize marketplace premiums beyond the federal subsidy. See Appendix Table 2 for state-specific estimates.

Source: CBPP calculations

APPENDIX TABLE 2

State-by-State Premium Increases if Enhancements Expire

	45-year-old individual; $64,000 (408% FPL)			60-year-old couple; $85,000 (401% I		
State	With enhancements (current)	Without enhancements	Premium increase without enhancements	With enhancements (current)	Without enhancements	Prem incre with enhanc
U.S. average	$5,440	$8,450	$3,010	$7,225	$31,762	$24,
Alabama	5,440	8,745	3,305	7,225	32,874	25,6
Alaska[a]	6,780	13,993	7,213	9,009	52,598	43,5
Arizona	5,440	7,213	1,773	7,225	27,115	19,8
Arkansas	5,440	10,494	5,054	7,225	39,449	32,2
California	5,440	7,756	2,316	7,225	29,153	21,9
Colorado	5,440	7,539	2,099	7,225	28,338	21,1
Connecticut	5,440	11,796	6,356	7,225	44,341	37,1
Delaware	5,440	9,369	3,929	7,225	35,218	27,9
District of Columbia	5,440	8,823	3,383	7,225	31,362	24,1
Florida	5,440	9,261	3,821	7,225	34,811	27,5
Georgia	5,440	8,556	3,116	7,225	32,160	24,9
Hawai'i [a]	6,239	7,335	1,096	8,289	27,573	19,2
Idaho	5,440	6,671	1,231	7,225	25,076	17,8
Illinois	5,440	8,217	2,777	7,225	30,886	23,6
Indiana	5,440	6,427	987	7,225	24,158	16,9
Iowa	5,440	6,793	1,353	7,225	25,535	18,3
Kansas	5,440	9,084	3,644	7,225	34,148	26,9
Kentucky	5,440	8,217	2,777	7,225	30,886	23,6
Louisiana	5,440	8,759	3,319	7,225	32,925	25,7
Maine	5,440	9,600	4,160	7,225	36,085	28,8
Maryland	5,440	5,573	133	7,225	20,947	13,7
Massachusetts [b]	5,440	6,534	1,094	7,225	20,455	13,2
Michigan	5,440	7,118	1,678	7,225	26,758	19,5
Minnesota	5,440	6,034	594	7,225	22,680	15,4
Mississippi	5,440	8,976	3,536	7,225	33,740	26,5
Missouri	5,440	8,203	2,763	7,225	30,835	23,6
Montana	5,440	9,383	3,943	7,225	35,269	28,0
Nebraska	5,440	9,627	4,187	7,225	36,187	28,9
Nevada	5,440	6,739	1,299	7,225	25,331	18,1
New Hampshire	5,437	5,437	0 [c]	7,225	20,438	13,2

APPENDIX TABLE 2

State-by-State Premium Increases if Enhancements Expire

	45-year-old individual; $64,000 (408% FPL)			60-year-old couple; $85,000 (401% I		
State	With enhancements (current)	Without enhancements	Premium increase without enhancements	With enhancements (current)	Without enhancements	Prem incre with enhanc
New Jersey [b]	5,440	7,389	1,949	7,225	27,777	20,5
New Mexico [b]	5,440	8,461	3,021	7,225	31,803	24,5
New York	5,440	9,948	4,508	7,225	19,896	12,6
North Carolina	5,440	8,650	3,210	7,225	32,517	25,2
North Dakota	5,440	7,728	2,288	7,225	29,051	21,8
Ohio	5,440	6,956	1,516	7,225	26,146	18,9
Oklahoma	5,440	8,189	2,749	7,225	30,784	23,5
Oregon	5,440	7,444	2,004	7,225	27,981	20,7
Pennsylvania	5,440	7,891	2,451	7,225	29,663	22,4
Rhode Island	5,440	6,874	1,434	7,225	25,840	18,6
South Carolina	5,440	7,688	2,248	7,225	28,898	21,6
South Dakota	5,440	8,881	3,441	7,225	33,383	26,1
Tennessee	5,440	9,640	4,200	7,225	36,238	29,0
Texas	5,440	8,962	3,522	7,225	33,689	26,4
Utah	5,440	9,077	3,637	7,225	31,156	23,9
Vermont	5,440	15,540	10,100	7,225	31,080	23,8
Virginia	5,440	6,223	783	7,225	23,394	16,1
Washington	5,440	8,284	2,844	7,225	31,141	23,9
West Virginia	5,440	14,548	9,108	7,225	54,688	47,4
Wisconsin	5,440	8,284	2,844	7,225	31,141	23,9
Wyoming	5,440	14,779	9,339	7,225	55,554	48,3

Note: FPL = federal poverty level. The FPL for these calculations is based on 2025 poverty guidelines, which are used to determine premium tax credits for 2026 marketplace coverage. Examples are illustrative and based on 2026 state average benchmark (second-lowest-cost silver plan) premiums for essential health benefits with age adjustments. The example family includes two 40-year-old parents, a 10-year-old, and a 5-year-old.

[a] Incomes in dollars for Alaska and Hawai'i differ from those shown here because these states' poverty levels differ from the federal poverty level.

[b] Massachusetts estimates do not account for extra state subsidies available through ConnectorCare Plan Type 3D, which will only be continued in 2026 if tax credit enhancements are extended. New Jersey estimates do not account for extra state subsidies of $50 per member per month for enrollees with income between 400 and 600 percent FPL. New Mexico estimates do not account for extra state subsidies that will cover the impact of the expiring enhancements in 2026 for enrollees with income over 400 percent FPL through June 2026.

[c] Premium payments without the enhancements do not exceed the income cap of 8.5 percent and are therefore equal with or without enhancements.

[d] Estimates for a family of four in New York are for an income level of $132,000 (410 percent FPL), as the CHIP income eligibility threshold for children is 405 percent FPL.

Source: CBPP calculations

END NOTES

[1] By the end of the year, open enrollment will be almost over in most states, and many peop will have decided to drop coverage after seeing large premium increases for their plans. Alsc insurers have already finalized rates assuming that the expiration of the premium tax credit enhancements will push out some healthier enrollees, driving up underlying premiums. Congressional Budget Office estimates provided to House leadership. Laura Weiss and Samantha Handler, "Johnson's To-do List of Tuesday," Punchbowl News, September 16, 202 ttps://punchbowl.news/archive/91625-am/#__thevaultwhydemswantobamacaredealnow.

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AFSCME
We Make America Happen

January 7, 2026

U.S. House of Representatives
Washington D.C. 20515

Dear Representative:

On behalf of the 1.4 million members of the American Federation of State, County and Municipal Employees (AFSCME), I urge you to vote yes on the motion to discharge and on a clean, three-year extension of the Affordable Care Act (ACA) enhanced premium tax credits to restore affordable coverage for millions of Americans.

At the end of December, House leadership declined to allow a vote on a clean extension, making a discharge petition necessary to restore the enhanced ACA premium tax credits. As a result, millions of families are now facing higher premiums, uncertainty about their coverage, and difficult decisions about whether they can continue to afford health insurance at all. While the credits have expired, Congress still has the power and the responsibility to act quickly to restore them and prevent further harm.

The enhanced premium tax credits have been essential to ensuring affordable health care in a system where costs continue to rise faster than wages. Millions of Americans rely on these credits to see a doctor, fill prescriptions and avoid medical debt. Without swift congressional action, families will be forced to delay care or drop coverage altogether, pushing more people into emergency rooms and increasing uncompensated care throughout the health care system. Those costs are ultimately shifted onto workers and families with employer-sponsored insurance, driving up premiums for everyone and placing additional strain on front-line health workers already facing staffing shortages.

Allowing the credits to lapse has already exposed millions of people to higher premiums and puts many at risk of losing coverage entirely. As uncompensated care grows, hospitals, providers, state and local governments and union members will feel the impact at the bargaining table.

AFSCME urges you to vote YES on the motion to discharge and on a clean, three-year extension of the ACA enhanced premium tax credits to restore coverage, lower costs and protect patients and families alike.

Thank you for considering the views of AFSCME. Please contact Desiree Hoffman at 202-660-8220 or dhoffman@afscme.org with any questions.

Sincerely,

Elizabeth S. Watson
Director of Federal Government Affairs

ESW/DSH:lm

American Federation of State, County and Municipal Employees, AFL-CIO
TEL (202) 429-1000 FAX (202) 429-1293 TDD (202) 659-0446 WEB www.afscme.org 1625 L Street, NW, Washington, DC 20036-5687

#525-24

Center on Budget and Policy Priorities

Off the Charts
POLICY INSIGHT
BEYOND THE NUMBERS

December 4, 2025, 9:00 am

How to Evaluate Proposals to Address Expiring Premium Tax Credit Enhancements

By Jennifer Sullivan

With just weeks to go until the premium tax credit (PTC) enhancements expire — which would increase Affordable Care Act (ACA) marketplace enrollees' annual premiums by more than $1,000 on average[1] — members of Congress have floated proposals ranging from cleanly extending the enhancements[2] to making major structural changes[3] that would raise people's costs and leave many uninsured. As proposals claiming to address expiring PTC enhancements continue to surface, they should be evaluated based on the extent to which they:

1. preserve existing coverage levels and avoid leaving more people uninsured;
2. ensure people keep access to affordable, comprehensive coverage; and
3. can take effect quickly.

Preserve existing coverage levels and avoid leaving more people uninsured: Proposals that increase marketplace enrollees' premiums (after taking into account premium credits) will result in more people becoming uninsured. If the enhancements expire completely, the Congressional Budget Office estimates that 3.8 million people[4] will lose marketplace coverage and become uninsured. This is against the backdrop of the harmful megabill that Republicans enacted earlier this year, which cuts Medicaid, Medicare, and marketplace coverage and is projected to leave an additional 10 million people[5] uninsured in 2034.

Proposals that would eliminate $0 premium plans — which have been instrumental[6] in providing a pathway to affordable coverage for people with very low incomes who are ineligible for Medicaid — would increase financial and administrative burdens and make it more likely that people with low incomes lose coverage or are covered for fewer days per year. Nearly 1 million[7] marketplace enrollees would lose coverage if they were required to pay even a few dollars a month, according to an estimate from the Brookings Institution.

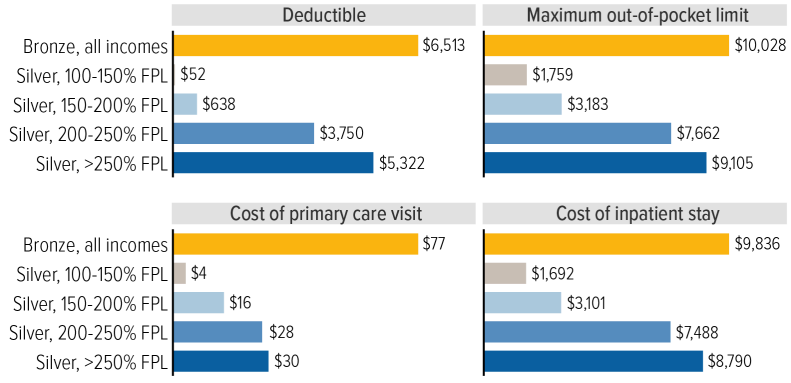
Ensure people keep access to affordable, comprehensive coverage: Although their designs vary widely, all ACA marketplace plans currently provide financial protections in the form of limited deductibles and annual out-of-pocket spending limits. People with income at 250 percent of the federal poverty level

($37,650 for an individual) and below qualify for cost-sharing reductions (CSRs) that provide even stronger protections against large health care bills and medical debt.

Proposals to replace these protections with cash or health savings account (HSA) deposits[8] or to use federal dollars to drive people into less-comprehensive coverage (e.g., bronze plans, see graphic) would leave people vulnerable to high out-of-pocket costs[9]. They'd also take federal resources[10] away from people with more health care needs to give cash or HSA deposits to people with fewer needs.

Silver Marketplace Plans Provide More Protection From High Health Care Costs Than Bronze Plans

Average plan features and example costs of care for individuals in Affordable Care Act marketplace plans, by metal level and income eligibility for silver plans with CSRs



Note: CSR = cost-sharing reduction; FPL = federal poverty level.

Source: CBPP analysis of the Centers for Medicare & Medicaid Services landscape files for healthcare.gov states. Costs of care are based on the latest national averages from the Agency for Healthcare Research and Quality adjusted for health care inflation and assume enrollees have not applied other expenses toward their deductibles.

CENTER ON BUDGET AND POLICY PRIORITIES | CBPP.ORG

Can take effect quickly: The 2026 coverage year begins on January 1, 2026, and the ability for millions of enrollees to maintain coverage hangs in the balance. Each day that passes without an extension to the PTC enhancements drives more people away[11] from marketplace coverage, and it will be hard to get them back.

> "Each day that passes without an extension to the PTC enhancements drives more people away from marketplace coverage, and it will be hard to get them back." [12]

Proposed changes to marketplace policy — including to the PTCs and premium payment requirements, CSRs, benefits, and HSAs — vary in complexity, but nearly all would be structural and impossible to implement quickly. Significant changes would take time and resources[13] for marketplaces to develop policies and operationalize, and would require yet more time to explain to enrollees (which would be especially difficult in HealthCare.gov states, where the Administration slashed federal funding[14] for enrollment assistance by 90 percent).

Extending the PTC enhancements, in contrast, would be far simpler because they are in place until the end of 2025 and could be restored quickly[15] for people purchasing 2026 coverage. If legislation also grants people more time to enroll for 2026, they will be able to return to the marketplace, assess their new options, and secure coverage.

A clean extension would be the best outcome for the more than 20 million people whose coverage and costs are hanging in the balance, and there is still time for Congress and President Trump to act.

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ADVOCACY

Older Adults Face Spike in Health Insurance Costs as ACA Tax Credits Expire

AARP is fighting for a permanent extension of savings that lower the price of Affordable Care Act coverage

By 71

Published September 19, 2025 / Updated December 12, 2025

AARP (GETTY IMAGES, 2)

Charlene Sterlace is feeling the pinch of higher health insurance premiums already.

The 61-year-old New York state resident has purchased insurance since 2019 through the state's Affordable Care Act Marketplace. She remembers her rates plunging during the pandemic when Congress enacted new tax credits. "I was so grateful," she says.

Since then, she and millions of other older adults who rely on health

those enhanced premium tax credits. Those credits, a form of savings that emerged in 2021 and expanded upon federal tax credits already available to low-income enrollees, lowered the cost of marketplace plans across the board.

But the enhanced premium tax credits are set to expire at the end of this year, and open enrollment ends Dec. 15 for coverage that starts on Jan. 1. Two proposals to address this problem — one by Democrats to extend the tax credits for three years and one by Republicans to soften the blow of higher premiums with health savings accounts — were blocked in the Senate on Thursday. That means the cost of ACA health insurance will skyrocket for many people in January.

The change will hit especially hard for nearly 5 million adults between the ages of 50 and 64 who rely on this coverage. They already pay up to three times more for private insurance than younger adults on the same plan.

Join Our Fight to Protect Older Americans

Here's what you can do to help:

- Sign up to become an AARP activist for the latest news and alerts on issues you care about.
- Find out more about how we're fighting for you every day in Congress and across the country.
- AARP is your fierce defender on the issues that matter to people 50-plus. Become a member or renew your membership today.

When the enhanced premium tax credits lapse, people with incomes above 400 percent poverty will lose their cushion entirely. Adults between the ages of 50 to 64 who have high premiums will see their average annual

enrollees will continue to receive premium reductions but will see higher premiums because of the loss of enhanced premium tax credits. Older adults with incomes at 100 to 400 percent of poverty will face average premium increases in 2026 of $600 to $1,400 per year.

In August, Sterlace estimated that the current tax credits are saving her $35 to $40 per month on her premiums.

“When you take away this extra help, even if it’s $5 a month, that’s still $5 a month, because your electric bill goes up $14 a month,” she says. “People can’t afford it.”

The importance of ACA tax credits

Health insurance rarely feels like a bargain. But enhanced premium tax credits have been a lifeline for those who otherwise felt priced out of their insurance.

Before the pandemic, people whose incomes fell between 100 percent and 400 percent of the federal poverty level and did not have access to affordable coverage through an employer could receive financial help for their ACA plans. But those limits froze out anyone above that 400 percent threshold.

“That was really hard for our folks, the 50 to 64, many of whom are right above that,” says Brendan Rose, a government affairs director at AARP. According to KFF, a nonprofit focused on health policy research and polling, 51 percent of ACA enrollees with incomes over four times poverty ($62,600 for an individual in 2025) fall in that age range.

2022, Congress extended these benefits through the end of 2025 as part of the Inflation Reduction Act.

AARP has been pushing Congress to make the enhanced premium tax credits permanent rather than letting them expire. In 2023, AARP joined Keep Americans Covered, a coalition of health care organizations and advocacy groups fighting for lower-cost premiums and a permanent extension of ACA credits.

Throughout 2025, AARP also engaged with members of the Senate, House and their staff members hundreds of times to emphasize the damage the loss of these tax credits will have in a specific state or congressional district.

"We urge Congress to act swiftly and extend the enhanced premium tax credits that help make health care more affordable and accessible for millions of Americans before they expire at the end of this month," AARP wrote in a December statement to the U.S. Senate Committee on Health, Education, Labor and Pensions. "Nowhere is that pressure heavier than on Americans ages 50 to 64, who do not yet qualify for Medicare coverage and who are more likely to need health care services than other age groups."

Without the enhanced premium tax credits, a couple with a household

year-old couple earning $85,600, just above 400 percent of poverty, could see annual premium increases of 399 percent in Texas, 384 percent in South Dakota, and 421 percent in Florida.

Health insurance sticker shock

Just over 40 percent of those enrolled in ACA marketplace health insurance are between the ages of 45 and 64, [according to a fact sheet](#) published by AARP's Public Policy Institute in September. Some retired before they were eligible for Medicare. Others work for companies

"A lot of folks are starting businesses, taking on new challenges or facing adverse circumstances where they were let go from their jobs and face a loss of coverage for the first time in decades," Rose says.

The enhanced premium tax credits meant that people with annual incomes below 150 percent of poverty may pay nothing at all for their premiums, depending on which plan they select. People with incomes above four times poverty got a break for the first time in 2021.

For example, AARP's Public Policy Institute found that a 60-year-old marketplace enrollee earning 450 percent of poverty, or $70,425, would pay an average annual premium of $5,760 for silver plan coverage in 2025. Without the 8.5 percent cap, that person would have paid $12,653 for the year.

These credits reduced the number of uninsured people and helped drive ACA marketplace enrollment to a record high of 24.3 million people in 2025, according to KFF.

"It shows that this just wasn't a pandemic crisis," says Sara Collins, senior scholar at the Commonwealth Fund, a foundation that supports health care research. "It was an affordability issue in the law itself that needed to be fixed by Congress."

KFF estimates that the premiums enrollees pay out of pocket will increase by an average of 114 percent next year for those receiving tax credits across all age groups — but the increase will likely be higher for older adults. This spike is not just about pending expiration of the enhanced premium tax credits, though. Insurers are also concerned about rising health care and labor costs, inflation and tariffs.

If ACA enrollees feel they cannot afford their new rates as premiums rise and enhanced tax credits disappear, the trade-offs they face are tough. Open enrollment ends on Dec. 15 for coverage that starts on Jan. 1, leaving little time to decide.

People may choose to downgrade to a cheaper plan, such as from a silver to a bronze plan, but that will come with more out-of-pocket costs when seeking medical care. Those who are self-employed may decide to reenter the corporate world to access group health insurance, at the cost of job flexibility or a solo business they enjoy. Others may need to cut back on other expenses to afford medical care.

“Some individuals will be left with no good option,” says Matt McGough, a policy analyst in KFF’s program on the Affordable Care Act.

Christine Meehan, who is 51 and lives in Upper Chichester, Pennsylvania, has faced the dilemma of whether or not to maintain insurance. Meehan has been a hairstylist for 32 years. At one point, she worked for a chain that offered health insurance. Otherwise, she sometimes purchased private insurance and other times risked going without before the ACA.

The cost of coverage through Pennie, Pennsylvania’s marketplace, “is not bad,” Meehan says. She pays $160 per month thanks to her premium tax credits; otherwise, her monthly rate would be $583. Meehan and her fiancé explored the cost of adding her to his group health insurance, but he

Meehan will pay $264 out of pocket for the same plan in 2026. "It's a $100 increase a month, but it's still doable," she says. "I am just going to have to watch other things."

Still, she notes that the increase in her monthly premiums between 2025 and 2026 will be 65 percent.

"That's a lot," she says.

More From AARP

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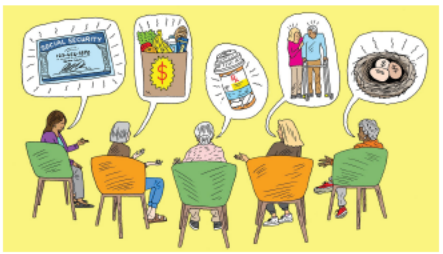

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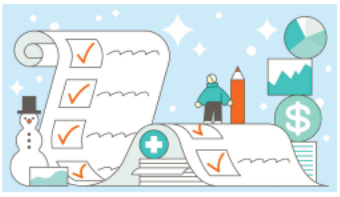

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RESTAURANTS

Moe's Southwest

September 15, 2025

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
H-232, The Capitol
Washington, DC 20515

The Honorable Chuck Schumer
Senate Minority Leader
U.S. Senate
322 Hart Senate Office Building
Washington, DC 20510

The Honorable John Thune
Senate Majority Leader
U.S. Senate
S-230, the Capitol
Washington, DC 20510

The Honorable Hakeem Jeffries
House Democratic Leader
U.S. House of Representatives
H-204, The Capitol
Washington, DC 20515

Dear Speaker Johnson, Majority Leader Thune, Minority Leader Schumer, and Leader Jeffries:

The undersigned physician organizations representing national medical societies and state medical associations write to urge Congress to enact legislation to extend the enhanced advance premium tax credits (APTCs) established under section 36B(b)(3)(A)(iii) of the Internal Revenue Code of 1986.

These enhanced credits have made health coverage more affordable for the more than 24 million Americans who purchased coverage through the Health Insurance Marketplaces in 2025, including many who are older, live in rural areas, or operate small businesses. For these individuals, the credits are a key means of securing comprehensive coverage, as the credits are only available to individuals who do not have access to such coverage outside of the Health Insurance Marketplaces.

Without congressional action, millions of Americans will face significant increases in their annual premiums, and the Congressional Budget Office projects that 4.2 million people will lose coverage entirely. The financial consequences are substantial:

- A family of four earning $64,000 annually would see the amount they pay for insurance coverage rise by approximately $2,600 in 2026.
- A 60-year-old couple with an income of $80,000 would see an increase of about $17,500 annually.

Even individuals who are not eligible for APTCs will be affected by their expiration, as the enhanced APTC drew healthier people into the insurance marketplaces, improving the risk pool and lowering premiums overall.

These increases will be evident to consumers as soon as marketplace “window shopping” begins in the fall of 2025, well ahead of the 2026 open enrollment period. Many current enrollees are already receiving insurer notices that project steep premium increases if the credits are not extended.

Extending the enhanced APTCs will continue to lower premiums across income levels, mitigate financial barriers to care, and sustain enrollment in the marketplaces. Allowing them to expire would reverse these gains, increase the uninsured rate, and raise uncompensated care costs for hospitals and physician practices nationwide.

We respectfully urge Congress to act in a timely manner so that marketplaces, insurers, and consumers have certainty well in advance of the 2026 coverage year.

Thank you for your attention to this important matter and for your continued commitment to ensuring access to affordable health coverage.

Sincerely,

American Medical Association
Academy of Physicians in Clinical Research
American Academy of Allergy, Asthma & Immunology
American Academy of Emergency Medicine
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
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American Society for Dermatologic Surgery Association
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American Society for Surgery of the Hand Professional Organization
American Society of Addiction Medicine
American Society of Anesthesiologists
American Society of Cataract & Refractive Surgery
American Society of Hematology
American Society of Neuroradiology
American Society of Plastic Surgeons
American Urological Association
American Medical Group Association
Association for Clinical Oncology
Association of American Medical Colleges
Medical Group Management Association
National Association of Medical Examiners
National Association of Spine Specialists
Renal Physicians Association
Society for Maternal-Fetal Medicine
The National Association of Medical Examiners

Medical Association of the State of Alabama

Alaska State Medical Association
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Vermont Medical Society
The Medical Society of Virginia
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Center on Budget and Policy Priorities

Off the Charts
POLICY INSIGHT
BEYOND THE NUMBERS

July 29, 2025, 4:00 pm

Marketplace Enrollees Tell Congress: Extend the Enhanced Premium Tax Credits

By Claire Heyison

No one should be forced to choose between taking care of their health or paying for other basic needs, like food or utilities. But if enhancements to the premium tax credits (PTCs) expire at the end of this year, that will be the case for millions of people who buy their insurance through the Affordable Care Act (ACA) marketplaces.

The enhanced PTCs have made marketplace coverage more affordable, resulting in a record number[1] of people gaining insurance through the marketplace. Growth has been concentrated among Black and Latino people[2], people with low incomes, and people living in states that haven't expanded Medicaid[3]. The marketplace is also an important source of coverage for small businesses and self-employed individuals[4].

But unless Congress acts, the enhanced PTCs will expire at the end of 2025, causing premiums to spike for both subsidized and unsubsidized enrollees. As a result, an estimated 4.2 million people[5] are expected to drop their marketplace coverage and become uninsured in 2034.

"Dropping the enhancement now is going to put the hurt on a lot of people who aren't going to be able to absorb those costs since everything else is going up," said Carrie, a 49-year-old Iowan who is the primary caretaker for her mother and gets her insurance through the marketplace. "This is something that is a pretty easy way to continue helping the American people who need it."

Already, insurer rate filings for 2026 are showing double-digit rate increases[6] in marketplace premiums. These rate increases reflect federal policy changes, like the impending expiration of the enhanced PTCs and a new Trump Administration rule[7] that makes it harder for people to get and keep their marketplace coverage. Insurers expect that these changes will lead people with fewer health needs to drop their marketplace coverage, meaning the marketplace risk pool will have more people with greater health needs, who are more expensive to insure.

Extending the enhanced PTCs would reduce the premiums most people pay, greatly reducing premium shocks. But Congress must act soon, as enrollees will start getting their renewal notices[8] — which include information about the next year's premiums — in late summer and early fall.

"Sacrificing Essentials"

In March, April, and May 2025, CBPP convened 21 marketplace enrollees across ten states for a series of focus groups to better understand how the imminent expiration of the enhanced PTCs would impact their lives. Most participants were surprised and alarmed to learn that the premium tax credit would drop substantially at the end of 2025 if Congress does not act, dramatically increasing their costs for coverage in 2026.

As part of the focus groups, enrollees were asked to use a KFF calculator[9] to determine how much their premiums would increase if the enhanced PTCs aren't extended. Many enrollees said that higher premiums, combined with increasing costs in other areas of their household budgets, would strain their finances and force them to either drop their health insurance or compromise on other basic needs.

"If my marketplace plan were to increase by $103 a month, I honestly don't know what I would do," said Tracy W., a 57-year-old customer service representative from Georgia. "That amount may not seem like much to the government or to the insurance companies, but for me it would most likely mean sacrificing essentials: groceries, gas, basic necessities that I rely on."

Some enrollees said that losing the enhanced PTC would force them to drop their coverage, even though they fear for their health. "The increased cost wouldn't be affordable for me right now," said B.A.P., 35, a restaurant manager from North Carolina. "I would consider dropping insurance if the cost goes up too much. I would avoid medical attention until it's an emergency. And I also think there may be a greater risk of complications from illnesses because they weren't prevented."i If the enhanced PTCs expire, B.A.P.'s premiums are estimated to increase by 185 percent in 2026, from $25 to $135 a month.

Hear more from Tracy and B.A.P.:

“Maybe I Have to Hold Back … Eat Less … Take Less Insulin”

But for some people, especially those with chronic illnesses, going uninsured is not an option. If the enhanced PTCs expire, M.M., a 45-year-old IT consultant from Illinois with Type 1 diabetes, said he “would just have to make sacrifices in other aspects of my life so I could afford the increased cost of that insurance.” His premiums are estimated to increase by $95 a month in 2026 if the enhanced PTCs end, which he says would cause him to ration care.

“I would have to consider switching to a cheaper plan which has a higher deductible, which means that at the beginning of the year I'd have to pay for my medications out of pocket,” he said. “And maybe I have to hold back on some of those medications, eat less, so take less insulin to treat my diabetes.”

Hear more from M.M.:

Workers who are self-employed as freelancers, gig workers, part-time workers, or a combination of these, don’t have employer-sponsored insurance. The enhanced PTCs have been a lifeline so these workers can affordable health insurance.

“It’s impactful for many people who might also be invisible like I am as a freelancer,” said Kat M., a 64-year-old in California who faces a possible $70 per month premium increase. “Here we are trying to make a living any way we can. There are a lot of us who don't have the access that others have with group insurance through their work.”

Hear more from Kat M.:

Overwhelmingly, the marketplace enrollees we spoke with want Congress to extend the enhanced PTCs. "This is a program that is used by millions of people around the country," said M.M., the IT consultant from Illinois. "The subsidies and the enhanced subsidies really make life easier. And I think it would greatly benefit [people] if they were extended indefinitely."

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[1] https://www.cms.gov/files/document/effectuated-enrollment-early-snapshot-2025-and-full-year-2024-average.pdf

[2] https://aspe.hhs.gov/reports/healthcaregov-plan-selections-race-ethnicity-2015-2024

[3] https://www.cms.gov/files/document/health-insurance-exchanges-2025-open-enrollment-report.pdf

[4] /research/health/5-million-small-business-owners-and-self-employed-workers-likely-enrolled-in-aca

[5] /research/health/by-the-numbers-republican-reconciliation-law-will-take-health-coverage-away-from

[6] https://www.healthsystemtracker.org/brief/individual-market-insurers-requesting-largest-premium-increases-in-more-than-5-years/#Distribution%20of%20proposed%202026%20rate%20changes%20among%20105%20ACA%20Marketplace%20insurers%20in%2019%20states%20and%20The%20District%20of%20Columbia

[7] /research/federal-budget/executive-action-watch?item=30165

[8] https://chirblog.org/delays-in-extending-enhanced-marketplace-subsidies-would-raise-premiums-and-reduce-coverage/

[9] https://www.kff.org/interactive/how-much-more-would-people-pay-in-premiums-if-the-acas-enhanced-subsidies-expired/

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

November 18, 2025

The Honorable John Thune
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Charles Schumer
Minority Leader
United States Senate
Washington, DC 20510

The Honorable Mike Johnson
Speaker
United States House of Representatives
Washington, DC 20515

The Honorable Hakeem Jeffries
Minority Leader
United States House of Representatives
Washington, DC 20515

Dear Leader Thune, Leader Schumer, Speaker Johnson, and Leader Jeffries:

We write once again on behalf of state insurance regulators to support immediate Congressional action to extend enhanced premium tax credits for health insurance. Residents of every state and DC will be adversely affected if the enhanced credits are allowed to expire, but it is not too late to provide an extension for 2026.

NAIC has advocated for continuation of the enhanced premium tax credits for Marketplace coverage for over a year. We know the enhanced credits have delivered crucial stability and affordability to individual health insurance markets in our states. The anticipated end of the enhanced credits, however, is disrupting those markets with higher premiums, insurer exits, and steep expected declines in enrollment – in particular, we expect reduced enrollment of young and healthy consumers.

While Open Enrollment for 2026 coverage is underway, Congress still has time to act to extend the enhanced subsidies, maintaining affordability for consumers and restoring stability to individual markets. We urge Congress to approve an extension before December 15 and to look to state regulators to allow any adjustments to underlying health insurance rates.

While extension of the credits would be impactful at any time, December 15 marks the next key date in the enrollment process for 2026 Marketplace coverage. It is the last date for most consumers to actively select a plan that will go into effect on January 1, 2026. After December 15, Marketplaces will reenroll 2025 enrollees who have not selected a 2026 plan into coverage for next year. New and continuing enrollees will receive a bill in December for their January coverage. Without an extension of the credits, the average consumer will see out-of-pocket premiums more than double what they paid in 2025, with many seeing even larger increases.

These high premium bills will result in many consumers choosing not to pay them, particularly younger and healthier enrollees. Without the first payment, coverage will lapse. We expect it will be very difficult to bring these consumers back into coverage, even if Congress approves an extension of the enhanced tax credits in late December or early 2026. With a disproportionately younger and healthier cohort absent from the risk pool, the individual markets in each state will suffer, leading to higher costs for those

who keep coverage and more insurers considering market exits. While markets would still welcome an extension of the enhanced tax credits after December 15, they may suffer significant deterioration if action is delayed past that date.

We also urge Congress to include in legislation to extend the credits a clarification on CMS authority to work with states in making updates to health insurance rates in the individual market so that the benefit of the credits can be realized by consumers as soon as possible. The rates now in place for 2026 reflect insurer assumptions about changes to the risk pool due to the end of the enhanced tax credits. Should the enhanced tax credits be extended AND younger/healthier consumers choose to remain in the pool, then the rates that states approved for 2026 would not reflect the latest Congressional action. States will review the rates and some may want to require insurers to make adjustments. There is currently uncertainty about whether CMS has the authority to allow mid-year rate adjustments for Marketplace coverage. Specifying this authority and the need to work in coordination with states in making mid-year adjustments would avoid uncertainties that could keep rates too high longer than necessary.

Any rate adjustments must be thoroughly considered, based on good data, and made under existing state authorities on a state-by-state basis. Despite the need for immediate action to extend the enhanced tax credits, there remains time for deliberations on the underlying rates.

State insurance regulators welcome further discussion with you, your staff, or other members of Congress on the consumer impact and market effects of changes to the tax credits for Marketplace health insurance. We agree that more must be done to address underlying healthcare costs that ultimately drive rising premiums, and we would be pleased to work with Congress on that after markets are stabilized.

Thank you for your efforts on these important issues.

Sincerely,

Jon Godfread
NAIC President
Commissioner
North Dakota Insurance Department

Scott White
NAIC President-Elect
Commissioner
Virginia Bureau of Insurance

Elizabeth Kelleher Dwyer
NAIC Vice President
Director
Rhode Island Department of Business Regulation

Jon Pike
NAIC Secretary-Treasurer
Commissioner
Utah Insurance Department

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Medicare Watch

Older Adults at Risk if ACA Subsidies Expire

By Lindsey Copeland | October 30, 2025 | 7 Comments

From funding cuts to policy reforms, the Republican-passed reconciliation bill (HR 1) 'v harms older adults, including by making health care and coverage less available ɔre expensive. As the fate of expiring Affordable Care Act (ACA) tax credits

remains uncertain, we look to a recent KFF analysis for more on how HR 1's interactions with the ACA will impact adults ages 50 and over.

HR 1's Impact on ACA Marketplaces

HR 1 makes changes to the ACA Marketplaces that will increase the number of uninsured and premium costs.

Enrollment Changes

Combined with the Trump administration Marketplace integrity rules, the new law will make it harder to sign up for a Marketplace plan, in part by shortening enrollment timelines and creating burdensome administrative requirements. As many as three million people, including older adults, are expected to lose health coverage as a result.

Premium Tax Credits

The law also fails to renew the premium tax credits that are set to expire this year. Since 2012, ACA tax credits have helped people with low and middle incomes pay their Marketplace premiums. In 2021, the American Rescue Plan Act (ARPA) increased the amount and availability of the credits and the Inflation Reduction Act (IRA) in 2022 delayed their expiration, but only until the end of 2025.

This assistance has allowed millions of adults ages 50 to 64 buy coverage—spurring a 50% reduction in the uninsured rate among this cohort.

Today, the enhanced credits ease ACA Marketplace plan affordability for more than 22 million people, including many older adults who are not yet Medicare-eligible. The credits reduce enrollee premium payments by $705 a year, on average. This assistance has allowed millions of adults ages 50 to 64 buy coverage—spurring a 50% reduction in the uninsured rate among this cohort—while helping overall Marketplace enrollment grow from 12 million in 2021 to a record 24.2 million in 2025.

Adults at Significant Risk

If the enhanced tax credits lapse, Marketplace enrollees with incomes over 400% of poverty ($84,600 for a family of two in 2025) will lose all assistance, and people with incomes between 100% ($21,000 for a family of two) and 400% of poverty will receive less support.

Older adults would be hit especially hard. Over half of all enrollees who would be cut off from subsidies are between the ages of 50 and 64. They would they be on the hook for the full costs of their premiums, which are expected to increase by at least 18% in 2026, though some could see much higher jumps. And these enrollees are already at a cost disadvantage: under the ACA, insurers can charge people in their 50s and 60s higher premiums than they charge younger adults who purchase the same plan in the same area.

Under the ACA, insurers can charge people in their 50s and 60s higher premiums than they charge younger adults who purchase the same plan in the same area.

As a KFF example illustrates, the impacts would be severe: A 59-year-old single widow earning $63,000 (just above 400% of the poverty level, $62,600 for an individual) would pay $5,355 for her silver Marketplace plan in 2026 if Congress extends the enhanced premium tax credits before the end of this year. But if the credits expire, she could pay more than twice that—$14,213 in premiums, almost 23% of her income—for the exact same health insurance policy.

What's at Stake

If the enhancements expire, nearly all (92%) of the 5.2 million adults ages 50 to 64 with Marketplace coverage would experience higher costs next year. Analysis suggests enrollees could see premiums rise by 75% on average, while people in rural areas could see a 90% increase.

ome may be able to find other insurance, millions will not. The resulting coverage
s would mean reduced access to care and worse individual health outcomes as

well as higher Medicare costs, because more people would enter the program in poorer health and needing more expensive interventions than they would have otherwise.

> The coverage losses would mean higher Medicare costs, because more people would enter the program in poorer health and needing more expensive interventions.

Across all age groups, at least 4.2 million people are expected to become uninsured unless Congress acts.

Congress Must Act Quickly

At Medicare Rights, we will continue to work to protect the ACA's coverage gains. People must have access to high-quality, affordable health care and coverage. To that end, we urge lawmakers to extend the enhanced credits without delay. Otherwise, people may have no choice but to drop their Marketplace plans, setting in motion harmful coverage losses that could undermine individual health and economic security as well as Medicare sustainability.

Read the KFF report, What Could the Health-Related Provisions in the Reconciliation Law Mean for Older Adults?

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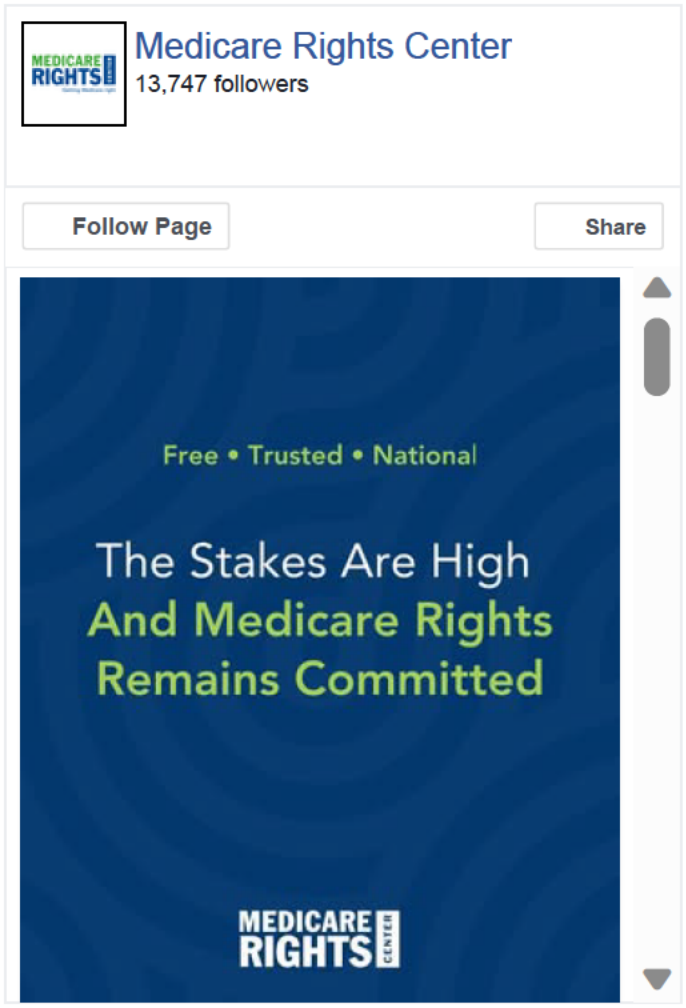

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Policy Changes Bring Renewed Focus on High-Deductible Health Plans

Authors: Michelle Long, Justin Lo, Rayna Wallace, and Kaye Pestaina

Published: Jan 5, 2026

The expiration of the Affordable Care Act's enhanced premium tax credits, along with the passage of the budget reconciliation law, implementation of new Marketplace regulations, and other administrative changes, could bring significant changes to ACA Marketplace enrollment and affordability for the 2026 plan year and beyond. Anticipated increases in what enrollees pay for premiums and new standards for health savings accounts (HSAs) could lead some consumers to consider plan options with lower premiums in exchange for higher deductibles, such as catastrophic or bronze plans. This issue brief examines key features of bronze and catastrophic plans, recent policy changes, coverage and costs, and the complicated choices for consumers.

What are some key features of Marketplace bronze and catastrophic plans?

Affordable Care Act (ACA) qualified health plans (QHPs) are categorized into four "metal levels" based on the overall amount of cost sharing they require: bronze,

silver, gold, and platinum, plus catastrophic plans, which are a separate tier of QHPs. Bronze and catastrophic plans offered through the Marketplaces must cover essential health benefits, limit the amount of annual cost sharing for covered benefits ($10,600 for an individual or $21,200 for a family in 2026), cover certain preventive services without cost sharing, and have other ACA-required consumer protections.

There are several notable differences between the characteristics of bronze and catastrophic plans (Table 1). Bronze plans usually have the lowest premiums of all metal levels, but the highest deductibles. Catastrophic plans often, but not always, have even lower premiums than bronze plans, but a higher level of cost sharing. In 2026, bronze plans have an average deductible of $7,476, while catastrophic plans have deductibles equal to the out-of-pocket maximum allowed under the ACA ($10,600 for an individual or $21,200 for a family in 2026).

Both bronze and catastrophic plans can be purchased on or off the Marketplaces, but premium tax credits are only available for metal level plans that are sold on the Marketplace, meaning they cannot be applied to any plans sold off the Marketplace, nor to catastrophic plans. (Cost-sharing reductions— which lower out-of-pocket costs for enrollees with income between 100% and 250% of the federal poverty level (FPL) —are only available for silver plans on the Marketplace.)

Actuarial value — the expected share of health care expenses a plan covers for a standard population — also differs between bronze and catastrophic plans. Bronze plans are currently required to have an actuarial value (AV) between 58% and 62%, though the AV for expanded bronze plans can be as high as 65%. (Regulations finalized in June 2025 would permit an AV as low as 56% for standard bronze plans, but a court ruling has temporarily blocked that provision (and others) from taking effect.) Catastrophic plans, on the other hand, are not required to meet minimum actuarial value targets, except that they must have a lower AV than bronze plans. However, due to the permitted range of bronze actuarial values, the “generosity” of these two types of plans can be similar.

Unlike metal level plans, which can be sold to anyone eligible for Marketplace coverage, catastrophic plans can only be sold to individuals under age 30 or individuals over 30 who qualify for a "hardship" or "affordability" exemption. Consumers may be eligible for the affordability exemption if their lowest cost coverage option available through a Marketplace or employer would cost more than 8.05% of their household income in 2026. A person may qualify for a hardship exemption if they experience one of several examples of financial or domestic circumstances, such as an unexpected natural or human-caused disaster, domestic violence, or bankruptcy.

Table 1

Comparison of General Features of Bronze and Catastrophic ACA Qualified Health Plans

	Bronze Plans	Catastrophic Plans
Eligibility	Anyone eligible to purchase Marketplace coverage	Certain individuals only
Coverage Level[1]	58% - 65%[2]	< 60%
Premiums	Often, but not always, higher than catastrophic plans	Often, but not always, lower than bronze plans
Eligible for Premium Tax Credits[3]	Yes	No
Deductibles	High - Usually the highest among the four ACA metal levels[4]	Very high - Equal to out-of-pocket maximum and usually higher than bronze plans[5]
Pre-deductible Coverage[6]	ACA preventive care required, and some other services permitted	ACA preventive care and three primary care visits required, and no other services permitted

Note: [1]Coverage Level refers to the actuarial value (AV) of coverage of the essential health benefits for a standard population. [2]The upper range for standard bronze plans is 62% while the AV for expanded bronze plans can be as high as 65%. [3]Additionally, cost-sharing reductions are only available for silver plans. [4]Silver plans have lower deductibles than bronze plans for enrollees eligible for a cost-sharing reduction. [5]The annual out-of-pocket

bronze plans for enrollees eligible for a cost-sharing reduction. [5]The annual out-of-pocket maximum for 2026 is $10,600 for an individual and $21,200 for a family. [6]Pre-deductible coverage for HSA-eligible plans includes certain insulin products and a broader list of preventive care than required by the ACA.

KFF

What recent changes have been made to catastrophic plans and bronze plans?

In September 2025, the Trump administration issued guidance expanding the catastrophic plan hardship exemption to include consumers who are not eligible for premium tax credits or cost-sharing reductions due to their income, chiefly those with incomes below 100% FPL or above 250% FPL, beginning with the 2026 plan year. This change currently applies to individuals in all states except California, Connecticut, Maryland, and the District of Columbia.

Even though those below 100% FPL are ineligible for premium tax credits, they are generally eligible for Medicaid in states that have expanded Medicaid. With varied eligibility criteria in non-expansion states, this population may fall in the coverage gap. While they could theoretically buy a catastrophic plan, they would be unlikely to be able to afford the premium or the very high deductibles.

The administration has begun streamlining the application process for this hardship exemption through HealthCare.gov and its paper applications to make it easier for consumers to enroll in a catastrophic plan. Also, HealthCare.gov now automatically displays catastrophic plans (where available) for consumers age 30 and older if they enter an income above 400% FPL or below 100% FPL. These plans are not currently displayed for consumers with incomes between 250% FPL and 400% FPL.

In addition to the hardship exemption changes, the 2025 budget reconciliation law expanded the availability of health savings accounts (HSAs) on the Marketplace. Previously, only plans that met IRS rules related to minimum annual deductible amounts, out-of-pocket maximums, and other design features were eligible to be

paired with an HSA. No catastrophic plans were HSA-eligible. Starting on January 1, 2026, all individual market bronze and catastrophic plans are considered HDHPs and eligible to be paired with an HSA even if the plan does not meet the minimum annual deductible requirement ($1,700 for individual coverage and $3,400 for family coverage in 2026) or the HSA out-of-pocket (OOP) maximum requirement ($8,500 for self-only coverage and $17,000 for family coverage in 2026) for an HDHP. New IRS guidance states that this change applies to all bronze and catastrophic plans, even those not purchased through a Marketplace ("off-exchange"). Other changes to HSA-eligible HDHPs include allowing pre-deductible coverage of telehealth and other remote care services, and allowing individuals covered by certain direct primary care arrangements to be eligible for an HSA.

Separately, congressional Republicans have recently proposed alternatives to continuing the enhanced premium tax credits that would further expand access to HSAs. While precise details vary, they generally propose directing funds to HSAs for eligible consumers enrolled in a catastrophic or bronze Marketplace plan to pay for out-of-pocket expenses. President Trump has also signaled his support for replacing tax credits with direct payments to consumers. None of these proposals has advanced.

What is the availability of and enrollment in bronze and catastrophic Marketplace plans?

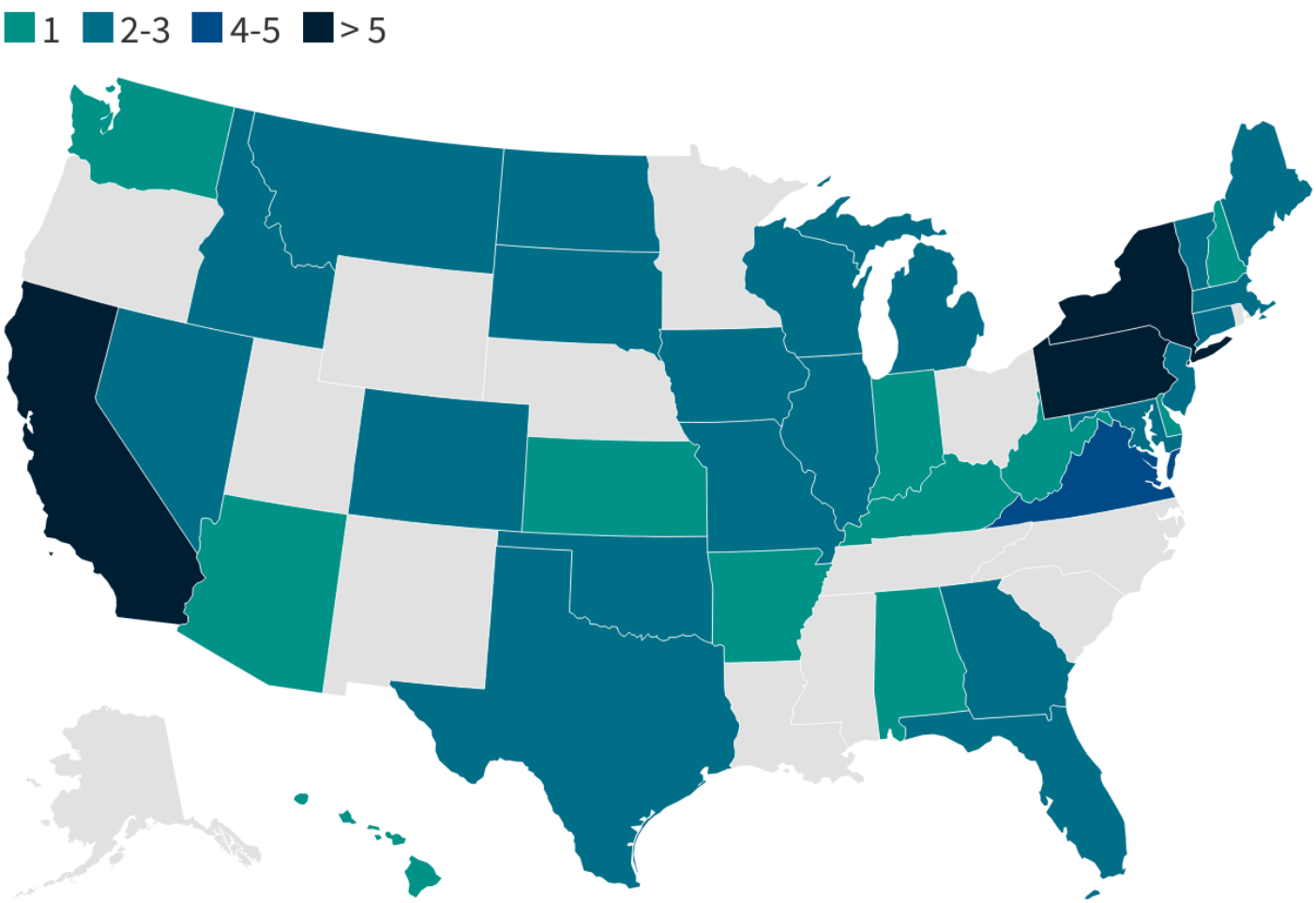
An insurer selling QHPs on the Marketplace must offer at least one silver and one gold plan in all the areas where the insurer sells Marketplace coverage. Although Marketplace insurers in most states are not required to offer a bronze plan in all areas, only one county in the US does not have a bronze plan for sale for 2026; the availability of catastrophic plans is more limited. Where catastrophic plans are available, there tend to be fewer plan choices than there are for bronze plans.

In 2026, catastrophic plans are offered in 36 states and the District of Columbia—down from 40 states and the District of Columbia in 2025. The share of Marketplace enrollees with access to catastrophic plans fell from 87% to 76% over the same period.

Figure 1

Marketplace Enrollees Have Few Options for Issuers That Offer Catastrophic Plans in Many States

Number of issuers offering catastrophic plans, 2026



Source: KFF analysis of 2025 and 2026 QHP individual medical landscape and HIX Compare data

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In 2025 (without the new hardship exemption extension in effect), less than 1% of Marketplace enrollees chose a catastrophic plan, and 30% selected a bronze plan.

The highest uptake of catastrophic plans was in the District of Columbia and Minnesota, where about 2% of Marketplace enrollees were in a catastrophic plan in 2025.

How do premiums for bronze and catastrophic plans compare?

In 2026, the average lowest-cost catastrophic Marketplace plan for a 27-year-old individual is $346 per month, a 29% increase from 2025. The average lowest-cost unsubsidized bronze plan (where catastrophic plans are also available) is $369 for a 27-year-old, a 19% increase from 2025. On average, the gap between premiums for unsubsidized bronze and catastrophic plans shrank by $19 per month for a 27-year-old individual from last year. (Differences in where catastrophic plans are offered may have contributed to this change.) The lowest-cost catastrophic Marketplace plans for 2026, where available, are, on average, $23 cheaper per month than the lowest-cost unsubsidized bronze plan for a 27-year-old individual. However, this varies a lot by county. For example, unsubsidized bronze plans offered in more than half of the counties in Oklahoma are over $200 cheaper per month than the cheapest catastrophic plan for a 27-year-old individual. Conversely, all counties in Connecticut have catastrophic plans around $200 a month cheaper than the lowest-cost unsubsidized bronze plan for a 27-year-old individual.

The Trump administration's expansion of catastrophic plan hardship exemptions was not announced until September, after many insurers had already submitted their proposed rates for the 2026 plan year. As a result, its effect on pricing for bronze and catastrophic plans is unclear and may affect the relative pricing of bronze and catastrophic plans in future years, with more data on which to base premiums.

Even with the hardship exemption expansion, potential enrollees may have difficulty finding affordable coverage options in places where catastrophic plans are available. For a 27-year-old individual earning $45,000 a year (just under 300% FPL),

expenditures on premiums would amount to 9% of income; a 50-year-old with the same income would spend 16% on premiums ($7,027 annually) on average.

One of the reasons catastrophic plans have lower premiums, on average, than bronze plans is that catastrophic plans tend to enroll younger and healthier consumers, thus lowering average claims costs per enrollee. Insurers may then be able to offer lower premiums, on average, compared to bronze plans, which may enroll an overall sicker (higher cost) population. Additionally, while all non-grandfathered individual market plans are part of the same general risk pool, for the purpose of the ACA's risk adjustment program, which redistributes funds from plans with lower-risk enrollees to plans with higher-risk enrollees, catastrophic plans are treated as a separate risk pool from the metal level plans.

What is the outlook for consumers?

Recent policy changes could have wide-reaching implications for Marketplace coverage. As a result of the anticipated expiration of enhanced premium tax credits, out-of-pocket premiums in 2026 are estimated to more than double what subsidized enrollees currently pay annually for premiums, net of tax credits. To help offset these increases, some enrollees may switch to a plan with a higher deductible, while others, such as those with incomes above 400% FPL, who will lose subsidies altogether, may choose to exit the Marketplace.

Changes to HSA eligibility may also influence some Marketplace enrollees' choice of plan. For plan year 2026, 35% of Marketplace plans sold on HealthCare.gov are HSA-eligible, compared to just 4% in plan year 2025. With all bronze and catastrophic plans now HSA-eligible, some consumers who were enrolled in a gold or silver plan, particularly those with enough income to set some aside into health savings accounts, may choose a bronze or catastrophic plan to take advantage of this change. HSAs offer a triple tax advantage: contributions are tax-deductible; withdrawals are tax-free if used to pay for qualified medical expenses; and investment earnings grow tax-free. Although more people will have access to HSA-eligible HDHPs starting in

2026, higher-income individuals typically have more disposable income to contribute to these accounts than those with lower incomes. Because they are in a higher tax bracket, higher-income enrollees save more money for every dollar contributed to their HSAs. The IRS's interpretation of the budget reconciliation law's expansion of HSA eligibility to include off-Marketplace catastrophic and bronze plans may also create new incentives for HSA vendors, who often charge fees for monthly account maintenance, making withdrawals, and other transactions, to market individual plans with HSAs outside the Marketplace.

Additionally, expanded hardship exemptions for catastrophic plans could increase uptake of these plans. The new HealthCare.gov display options for shoppers whose incomes make them ineligible for premium tax credits increase the visibility of catastrophic plans, and the streamlining of the hardship exemption process may make enrolling in these plans easier. More consumers choosing catastrophic plans could have implications for the Marketplace risk pool. To the extent that catastrophic plans pull enough healthy people out of metal level plans or off the Marketplace, premiums for these plans, which would be left with more sick people, could increase in the future.

In an already complex health insurance system, consumer awareness of these policy changes and their implications may be limited. The 2023 KFF Survey of Consumer Experiences with Health Insurance found that many individuals already have trouble understanding various aspects of health insurance. For example, 31% of Marketplace consumers reported difficulty comparing cost-sharing features, and 25% had trouble comparing premiums when presented with different coverage options. The barrage of marketing pitches consumers face during open enrollment (including through internet searches, telemarketing, and social media) can compound the challenges of making an informed decision. Some consumers could unknowingly be directed to off-Marketplace plans, which can be difficult to distinguish from on-Marketplace plans, as the websites can look very similar. While ACA-compliant plans may also be sold off-Marketplace, these websites often also sell non-ACA-compliant plans, which may make plan comparison more difficult for consumers and could result in consumers losing out on premium tax credits who would otherwise be eligible for

them if they had purchased a plan on a Marketplace. With few impartial resources, shoppers may feel less confident choosing a plan that best meets their needs or be left with unanswered questions about their specific circumstances.

Lack of understanding of plan options can have far-reaching effects on consumer finances. Price-sensitive consumers shopping for bronze and catastrophic plans can face difficult tradeoffs. While these plans typically have lower premiums than other Marketplace plans, these plans come with higher deductibles. In addition, cost-sharing reductions are only available to enrollees in silver plans. Compared to a bronze plan, a silver plan with cost-sharing reductions often leads to a lower total health expenditure even with a higher premium. If an enrollee has a medical emergency or develops a serious illness, they may be on the hook for substantial out-of-pocket costs. Many Marketplace enrollees are already struggling to afford health care costs. According to a recent KFF poll, about six in ten (61%) Marketplace enrollees report having difficulty affording out-of-pocket costs for medical care. Considering that 37% of all U.S. adults reported that they would not be able to cover a $400 expense with cash or its equivalent—only 5% of the average bronze individual deductible or 4% of the catastrophic individual deductible—many consumers in plans with high deductibles could find themselves scrambling to pay for health care when they need it.

Methods

Premium information for 2026 come from the medical individual market file of the QHP landscape file from CMS for states using the federally-facilitated platform (HealthCare.gov) and from HIX Compare for all other states and the District of Columbia. Analysis of data from HIX Compare assume that all plans are available in all counties in their respective rating areas where the issuer offers at least one plan. To assess plan availability and differences in premiums, county data were weighted by the number of plan selections in 2025. Plan eligibility for health savings accounts was obtained from the plan attributes public use file, which is only available for plans offered on HealthCare.gov

KFF The independent source for health policy research, polling, and news.

News Release

Poll: 1 in 3 ACA Marketplace Enrollees Say They Would "Very Likely" Shop for a Cheaper Plan If Their Premium Payments Doubled; 1 in 4 Say They "Very Likely" Would Go Without Insurance

As Enhanced Credits Expire, Nearly All Enrollees Expect to Make Coverage Decisions This Year

Published: Dec 4, 2025

If the amount they pay in premiums doubled, about one in three enrollees in Affordable Care Act Marketplace health plans say they would be "very likely" to look for a lower-premium Marketplace plan (with higher deductibles and co-pays) and one in four would "very likely" go without insurance next year, finds a new survey of Marketplace enrollees fielded shortly after open enrollment began in the first weeks of November.

The survey captures the views and experiences of Marketplace enrollees as they weigh their coverage options for 2026, without the enhanced ACA credits or other policy changes that the Senate could debate this month. About 22 million of the 24 million Marketplace enrollees have benefited from the expiring tax credits, and without them, their premium payments are expected to rise an average of 114%, from $888 to $1,904 annually.

Nearly six in 10 enrollees (58%) say they would not be able to afford an increase of just $300 per year in the amount they pay for insurance without significantly disrupting their household finances. An additional one in five (20%) say they would not be able to afford a $1,000 per year increase in the amount they pay for health insurance without disrupting their finances.

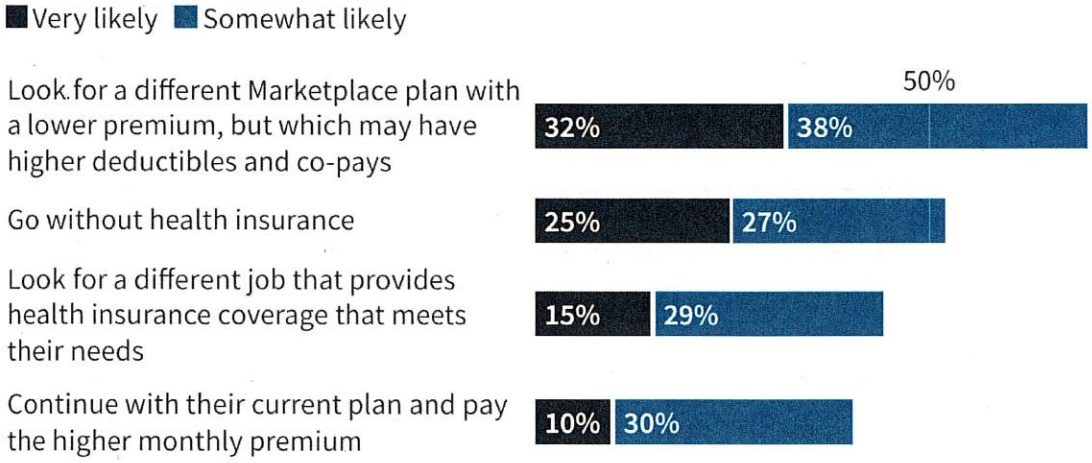
If their total health care costs, including premiums, deductibles and other cost-sharing, increased by $1,000 next year, most Marketplace enrollees (67%) say they would likely cut spending on daily household needs, about half (54%) say they would likely to try to find another job or work extra hours, and four in 10 (41%) say they would likely skip or delay paying other bills. A third (34%) say they would take out a loan or increase their credit card debt.

"The poll shows the range of problems Marketplace enrollees will face if the enhanced tax credits are not extended in some form, and those problems will be the poster child of the struggles Americans are having with health care costs in the midterms if Republicans and Democrats cannot resolve their differences," KFF President and CEO Drew Altman said.

It asked Marketplace enrollees to say how likely it was that they would take each of four different potential responses if the monthly premiums they pay doubled (or increased $50 a month for those who currently don't pay a premium).

Marketplace Enrollees May Consider Different Health Insurance Options if Premium Payments for Their Current Coverage Doubled

Percent who say that if the monthly amount they pay for their health insurance doubled [*For those who currently do not pay a premium:* increased by $50] they would be **very** or **somewhat likely** to:



Note: Among adults with health coverage purchased through the Marketplace in 2025. See topline for full question wording.
Source: KFF 2025 Marketplace Enrollees Survey (November 7-15, 2025)

KFF

Open enrollment for Marketplace coverage began Nov. 1 and runs through Jan. 15 in most states, though consumers must enroll in a plan by Dec. 15 if they want their coverage to begin on Jan. 1. The vast majority of enrollees (89%) expect to make a decision by the end of this year, with many saying they have already made their decision about coverage for next year.

More than half of Marketplace enrollees (54%) say they expect that the cost of their health insurance coverage for next year will "increase a lot more than usual." An additional one in four (26%) expect it to increase a "little more than usual," while smaller shares expect their insurance costs to "increase about the same as usual" (12%) or "not increase at all" (8%).

If their overall health care expenses, including co-pays, deductibles, and premiums, increased by $1,000 next year, about half of Marketplace enrollees say it would have a "major impact" on their decision to vote in the 2026 midterm elections (54%) or on which party's candidate they will support (52%).

People with Marketplace insurance are more likely to say that either President Trump (37%) or Congressional Republicans (33%) would deserve most of the blame if their health care costs increased by $1,000 next year than they are to say Congressional Democrats (29%).

Democrats would overwhelmingly blame Republicans in Congress (46%) or President Trump (49%). Most Republicans (65%) would blame Congressional Democrats, though about a third say they would blame either Republicans in Congress (20%) or President Trump (14%). Among independents, more than four in 10 (44%) would blame the President, a third (32%) would blame Congressional Republicans, and about one in four (23%) would blame Congressional Democrats.

Other findings include:

- Overall, about four in 10 Marketplace enrollees (39%) are Republicans or Republican-leaning independents, including about one in four (24%) who identify with President Trump's Make America Great Again (MAGA) movement. Just over four in 10 enrollees (45%) identify as Democrats or Democratic-leaning independents, while 17% don't identify or lean toward either party.
- Even with the current levels of financial assistance, many Marketplace enrollees say it is already difficult to afford their deductibles and other out-of-pocket costs for medical care (61%) and to afford the cost of health insurance each month (51%). More enrollees say their out-of-pocket medical costs are difficult to afford than say the same about other household expenses, such as their rent or mortgage, food and groceries, utilities, and gasoline or transportation costs.
- Large majorities of Marketplace enrollees, regardless of partisanship, say that having health insurance is "very important" for their peace of mind (78%), their ability to get needed health care (77%), and their financial well-being (69%). Enrollees between the ages of 50 and 64 are more likely than younger enrollees to say health insurance is very important for each of these three reasons.
- A large majority (84%) of enrollees say that Congress should extend the enhanced tax credits, while one in six (16%) think they should let the tax credits expire. Of

them, nearly all Democrats (95%), about eight in 10 independents (84%), and about seven in 10 Republicans (72%) and MAGA supporters (72%) favor extending the expiring tax credits.

Designed and analyzed by public opinion researchers at KFF, the 2025 Marketplace Enrollees Survey was conducted November 7-15, 2025, online and by telephone, in English and in Spanish, among a nationally representative sample of 1,350 U.S. adults ages 18-64 who purchase coverage on the ACA Marketplaces. The margin of sampling error is plus or minus 3 percentage points for the full sample. For results based on other subgroups, the margin of sampling error may be higher.

August 21, 2024

Speaker of the House Mike Johnson
House of Representatives
Cannon House Office Building, CHOB – B68
Washington, DC 20515

Senate Majority Leader Chuck Schumer
United States Senate
Hart Senate Office Building, SH – 322
Washington, DC 20151

Senate Minority Leader Mitch McConnell
United States Senate
Russell Senate Office Building, SR – 317
Washington, DC 20510

House Minority Leader Hakeem Jeffries
House of Representatives
Rayburn House Office Building, RHOB - 2433
Washington, DC 20515

Re: The Need to Make Permanent the Enhanced Advanced Premium Tax Credits

Dear Speaker Johnson, Senate Majority Leader Schumer, Senate Minority Leader McConnell, House Minority Leader Jeffries:

The undersigned 40 Partnership to Protect Coverage (PPC) member organizations urge Congress to permanently extend the Affordable Care Act's (ACA) enhanced advance premium tax credits (APTCs) before they expire at

the end of 2025. Permanently extending these critical subsidies is essential to prevent a sudden increase in out-of-pocket costs and the loss of insurance coverage for millions of people.

Our organizations represent millions of patients and consumers who face serious, acute, and chronic health conditions. Together, we offer unique 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 enable 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 agreed upon three overarching principles to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) health care should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) health care should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) health care must be adequate, meaning healthcare coverage should cover treatments patients need.

Overview & Impact of the Enhanced APTCs

The ACA established advance tax credits to help lower the cost of health insurance purchased in the Marketplaces. Under the ACA, individuals earning between 100% and 400% of the federal poverty level (FPL) are eligible for these tax credits on a sliding scale – the lower the income level, the higher the amount of tax credits.

In 2021, Congress made two temporary, but critically important changes to the tax credits: it increased the amount of the tax credits for those between 133% - 400% FPL; and capped premium costs at 8.5% of annual income for individuals and families earning more than 400% FPL.[1] These enhanced tax credits were in effect in 2021 and 2022. Then in response to their success, in 2022, Congress extended these enhanced tax credits again, this time through the end of 2025.

Since the enhanced APTCs were first enacted in 2021, they have helped 9.4 million Americans gain access to high-quality and affordable health coverage – reducing the number of uninsured to just 7.7 percent.[2] Today, enrollment in the ACA marketplaces is at an all-time high, with more than 21 million people now insured through the ACA.[3]

Enrollment in marketplace plans generated by enhanced APTCs have provided millions of Americans with affordable, comprehensive health coverage by allowing more people to purchase high-quality health insurance coverage that meets their health care needs. This includes services included in the Essential Health Benefits (EHB) package (such as doctor's visits, prescription drugs, hospitalizations, and preventive services), annual out-of-pocket cost caps, and prohibitions on discriminatory plan design and practices like denying coverage or charging more based on pre-existing conditions.

Congress Should Act Now to Permanently Extend the Enhanced APTCs

The enhanced APTCs are scheduled to expire by the end of 2025. If Congress fails to act by August of 2025, premiums for Marketplace enrollees will skyrocket, forcing some patients and consumers to abandon the high-quality coverage upon which they have come to rely. Action is urgent because the process for setting rates and developing plans is lengthy and complex.

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[1] 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

[2] Assistant Secretary for Planning and Evaluation, *National Uninsured Rate Reaches an All-Time Low in early 2023 after the Close of the ACA Open Enrollment Period* (August 3, 2023), https://aspe hhs.gov/sites/default/files/documents/e06a66dfc6f62afc8bb809038dfaebe4/Uninsured-Record-Low-Q12023.pdf

[3] Centers for Medicare and Medicaid Services, *Health Insurance Marketplaces 2024 Open Enrollment Report* (March 22, 2024), www.cms.gov/files/document/health-insurance-exchanges-2024-open-enrollmentreport-final.pdf

Issuers will begin finalizing rates for 2026 Marketplace plans early in 2025 - working throughout the year with state and federal regulators to ensure their products comply with state and federal standards. However, if the enhanced APTCs are not extended in time for issuers to develop rates in time for open enrollment, patients and consumers could see considerable price hikes when they begin shopping for 2026 coverage in the fall of 2025.

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.[4]

Patients with serious and chronic conditions cannot afford to go without insurance that meets their healthcare needs. As such, we urge Congress to take immediate action to permanently extend the enhanced APTCs. Please contact Katie Berge (Katie.Berge@lls.org) and Jelani Murrain (Jelani.Murrain@cancer.org) if you have questions or feedback. We thank you for your attention to this issue and welcome the opportunity to discuss it further.

Sincerely,

Alpha-1 Foundation
ALS Association
American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund
American Liver Foundation
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation of America
Cancer Support Community
Cancer*Care*
Child Neurology Foundation
Chronic Disease Coalition
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Foundation for Sarcoidosis Research
Hemophilia Federation of America
Immune Deficiency Foundation
Lupus Foundation of America
Lutheran Services in America
March of Dimes
Muscular Dystrophy Association
National Alliance on Mental Illness (NAMI)
National Bleeding Disorders Foundation
National Coalition for Cancer Survivorship
National Eczema Association
National Health Council
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
NMDP (formerly National Marrow Donor Program)
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society
The Mended Hearts, Inc.
WomenHeart

[4] 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

December 11, 2025

The Honorable Lisa Blunt Rochester
U.S. Senate
Washington, D.C. 20510

The Honorable Marsha Blackburn
U.S. Senate
Washington, D.C. 20510

The Honorable Doris Matsui
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Gus Bilirakis
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Suzan DelBene
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Nicole Malliotakis
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Angie Craig
U.S. House of Representatives
Washington, D.C. 20515

Dear Senators Blunt Rochester, Blackburn, and Representatives Matsui, Bilirakis, DelBene, Malliotakis, and Craig:

The undersigned national organizations thank you for introducing the Senior Savings Protection Act (S. 2466/H.R. 6210). This bipartisan legislation is essential to continuing outreach and enrollment assistance that helps millions of low-income older adults and people with disabilities afford Medicare and was first established under the Medicare Improvements for Patients and Providers Act (MIPPA).

The Senior Savings Protection Act, introduced by Sens. Lisa Blunt Rochester, D-Del., and Marsha Blackburn, R-Tenn., in the Senate, and Reps. Doris Matsui, D-Calif., Gus Bilirakis, R-Fla., Suzan DelBene, D-Wash., Nicole Malliotakis, R-N.Y., and Angie Craig, D-Minn., in the House, provides a five-year reauthorization of the vital funding first established under the Medicare Improvements for Patients and Providers Act (MIPPA).

Since 2008, this $50 million annual investment supports Medicare enrollment services at State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and the National Center on Benefits Outreach and Enrollment. These organizations provide free, unbiased assistance to help low-income Medicare beneficiaries enroll in programs that they qualify for, such as Medicare Savings Programs (MSPs) and Part D Low-Income Subsidy (LIS/Extra Help).

The need for continued support has never been greater. A recent National Council on Aging report found that 80% of U.S. households with older adults (nearly 47 million) are or are at risk of financially struggling, and 45% do not earn enough to cover basic living needs.

Every day, 11,000 people across the nation turn 65, many facing rising health costs, growing debt, and limited savings. With high medical expenses and cost-of-living adjustments that fail to keep pace, those living on fixed incomes—below 150% of the federal poverty level, or $22,830 a

year for a single person—rely on MIPPA-funded programs as a lifeline to maintain their health and independence.

The modest yearly federal investment in MIPPA delivers meaningful results for both older adults and their communities. Since 2008, the program has helped millions of low-income beneficiaries and their families access vital assistance. During the last federal fiscal year, 4.7 million lower-income older adults learned about programs that make Medicare more affordable. By helping beneficiaries access the support they're eligible for, this investment enables older adults to stay healthy, avoid costly hospital stays, afford essentials, and drive spending back into local economies.

The Senior Savings Protection Act builds on MIPPA's 17-year record of bipartisan success. By reauthorizing funding for five years, it will ensure community-based organizations can continue helping older adults and people with disabilities lower their health care costs and access needed medical care.

Thank you again for your leadership on the Senior Savings Protection Act and your commitment to improving the health and financial well-being of older adults and Medicare beneficiaries.

If you have any questions, please contact Natalie Zellner at natalie.zellner@ncoa.org.

Sincerely,

Ramsey Alwin
President and CEO
National Council on Aging

- AARP
- Access Ready Inc.
- ADAPT National
- ADvancing States
- AFL-CIO
- Aging Life Care Association
- AiArthritis
- Allergy & Asthma Network
- Alliance for Aging Research
- Alliance for Retired Americans
- Allies for Independence
- ALS Association
- AMDA - The Society for Post Acute and Long-Term Care Medicine
- American Association on Health and Disability
- American Cancer Society Cancer Action Network
- American Geriatrics Society
- American Kidney Fund
- American Lung Association
- Arthritis Foundation
- American Society of Consultant Pharmacists (ASCP)

- Asian & Pacific Islander American Health Forum
- Autistic People of Color Fund
- Autistic Self Advocacy Network
- Autistic Women & Nonbinary Network
- Blue Future
- Care in Action
- Caring Across Generations
- Caring Ambassadors Program
- Center for Medicare Advocacy
- Coalition of Skin Diseases
- Coalition on Human Needs
- Color of Crohn's and Chronic Illness
- Community Catalyst
- Compassion & Choices
- Disability Policy Consortium
- Disability Rights Education and Defense Fund (DREDF)
- Diverse Elders Coalition
- Futures Without Violence
- Global Liver Institute
- GO2 for Lung Cancer
- Health Care Voices
- HealthyWomen
- HIV Medicine Association
- Huntington's Disease Society of America
- Indivisible
- International Myeloma Foundation
- Justice in Aging
- Lakeshore Foundation
- LeadingAge
- Lupus and Allied Diseases Association, Inc.
- Lupus Foundation of America
- Meals on Wheels America
- Medicare Rights Center
- Mental Health America
- Muscular Dystrophy Association
- National Academy of Elder Law Attorneys (NAELA)
- National Adult Day Services Association (NADSA)
- National Alliance for Caregiving
- National Alliance on Mental Illness
- National Alliance to End Homelessness
- National Association for Home Care and Hospice
- National Association of Councils on Developmental Disabilities
- National Association of Nutrition and Aging Services Programs (NANASP)
- National Association of Social Workers (NASW)
- National Association of State Long Term Care Ombudsman Programs (NASOP)
- National Caucus and Center on Black Aging (NCBA)
- National Committee to Preserve Social Security and Medicare
- National Community Action Partnership
- National Consumer Voice for Quality Long-Term Care
- National Council on Aging
- National Council on Independent Living
- National Disability Institute
- National Disability Rights Network (NDRN)

- National Domestic Workers Alliance
- National Down Syndrome Congress
- National Eczema Association
- National Health Council
- National Health Law Program
- National Indian Council on Aging, Inc.
- National Kidney Foundation
- National Multiple Sclerosis Society
- National Psoriasis Foundation
- Network of Jewish Human Service Agencies
- New Disabled South
- Patient Access Network (PAN) Foundation
- PHI
- Public Advocacy for Kids (PAK)
- RESULTS
- Service Employees International Union
- SKIL Resource Center, Inc.
- The Arc of the United States
- The Gerontological Society of America
- The Headache & Migraine Policy Forum
- The Jewish Federations of North America
- The Leukemia & Lymphoma Society
- Triage Cancer
- Tourette Association of America
- USAging
- Village to Village Network
- Well Spouse Association
- WISER

The Importance Of Premium Tax Credits: Affording Health Insurance Coast To Coast

11.05.2025

Nearly 22 million Americans benefit from premium tax credits that help them afford comprehensive health coverage from the federal or state health insurance Marketplaces. These tax credits were enhanced in recent years, saving individuals and families money in insurance premiums and increasing enrollment. They are a lifeline for workers and their families, including those with serious and chronic health conditions like diabetes, heart disease, and cancer who need access to regular care to stay healthy and keep working when they don't get insurance through their job. Since Congress has not intervened, these workers are entering the annual open enrollment period for health coverage, hit with premiums that may be double or triple what they paid last year, and with no guarantee that any tax credit relief will be available to them later. The ripple effect on families, communities, and local economies will be devastating. Enhanced premium tax credits are having a profound impact in many areas of the country, with metrics differing state-by-state. National and some state-specific fact sheets include data and personal stories of individuals and families benefiting from premium tax credits. If you are a state advocate who does not see your state represented and would like to discuss a fact sheet, please contact **partnerships@familiesusa.org** and the appropriate parties will reach out.

National And State Fact Sheets

2025

- **National**
- **Alaska**
- **Arizona**
- **California**
- **Florida**
- **Georgia**
- **Idaho**
- **Illinois**
- **Iowa**
- **Kansas**
- **Louisiana**
- **Maine**
- **Michigan**
- **New Hampshire**
- **New York**
- **North Carolina**

- **Ohio**
- **Pennsylvania**
- **Utah**
- **West Virginia**

Spanish Translation Available

Our fact sheets are also available in Spanish. To learn more, please visit **La importancia de los créditos fiscales para las primas: Cómo costear un seguro médico a nivel nacional**.

Additional Resources

Access additional advocacy resources highlighting the **importance of enhanced premium tax credits**.

Tell Congress: Extend the Enhanced Premium Tax Credits Now!

Time is running out to extend the premium tax credit enhancements before millions face skyrocketing premium increases in just a few weeks. These subsidies are a lifeline for those who would otherwise be unable to afford health coverage or to access health care at all – but they are set to expire at the end of this year.

Congress has yet to act to prevent the expiration of these enhanced tax credits but promised to hold a vote on an extension in exchange for ending the government shutdown. Now, it is Congress's choice to either protect millions of people and families from seeing their health care costs skyrocket or let them risk losing health coverage altogether. Send a letter to your Senators and Representatives asking them to extend the enhanced tax credits and lower health care costs now.

*See the **Keep Americans Covered** coalition page for state-specific data and a cost of coverage calculator.*

Take future action with a single click.
Log in or **Sign up** for *Fast***Action**

fastaction ?

1 Details 2 Messages 3 Confirmation

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Street Address

Postal Code | City | State - State -

Email email@email.com | Mobile Phone (Optional)

Sign me up for SMS messages.
By submitting your cell phone number you are agreeing to receive periodic text messages from this organization. Message and data rates may apply. Text HELP for more information. Text STOP to stop receiving messages. SMS opt-in consent and phone numbers will not be shared with any third parties or affiliates.

Yes, sign me up for email updates.

Remember me so that I can use *Fast***Action** next time.