



October 2, 2026

The Honorable Ron Wyden
United States Senate
221 Dirksen Senate Office Building
Washington, D.C. 20510

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

Dear Ranking Member Wyden:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the policies included in the Request for Information: Health Coverage that Works for Everyone. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's (ACS) nonprofit, nonpartisan advocacy affiliate, ACS CAN is more determined than ever to end cancer as we know it, for everyone.

ACS CAN appreciates the Committees' efforts to seek stakeholder input on legislative options to expand quality coverage to more Americans, improve affordability, and lower healthcare costs. Access to healthcare is paramount for people with cancer as well as survivors, as well as all who are at risk of the disease. In the United States, there are more than 2.1 million Americans who will be diagnosed with cancer this year and an estimated 626,000 people will die from the disease.¹ An additional 18.6 million Americans living today have a history of cancer.² For these Americans, access to affordable health insurance is a matter of life or death. At every education level, individuals with health insurance are more likely than those without it to have access to critical early detection cancer procedures.^{3,4} Research has shown that across a variety of cancer sites, being diagnosed at an earlier stage results in lower health care costs compared to being diagnosed at a later stage.⁵ Evidence also shows having health insurance coverage makes an individual more likely to survive cancer, and the effects of insurance coverage on cancer survival are even more pronounced in communities that carry a heavier burden of cancer.⁶

¹ American Cancer Society. (2026). *Cancer Facts & Figures 2026*. American Cancer Society.

² *Cancer Facts & Figures 2026*.

³ Zhao, J., Han, X., Nogueira, L., Fedewa, S.A., Jemal, A., Halpern, M.T. and Yabroff, K.R. (2022). Health insurance status and cancer stage at diagnosis and survival in the United States. *CA: A Cancer Journal for Clinicians*, 72(6), 542-560. <https://doi.org/10.3322/caac.21732>.

⁴ Ward, E., Halpern, M., Schrag, N., Cokkinides, V., DeSantis, C., Bandi, P., Siegel, R., Stewart, A., & Jemal, A. (2008). Association of insurance with cancer care utilization and outcomes. *CA: A Cancer Journal for Clinicians*, 58(1), 9-31. <https://doi.org/10.3322/CA.2007.0011>.

⁵ McGarvey, N., Gitlin, M., Fadli, E. *et al.* Increased healthcare costs by later stage cancer diagnosis. *BMC Health Serv Res* 22, 1155 (2022). <https://doi.org/10.1186/s12913-022-08457-6>.

⁶ Abdelsattar, Z. M., Hendren, S., & Wong, S. L. (2017). The impact of health insurance on cancer care in disadvantaged communities. *Cancer*, 123(7), 1219-1227. <https://doi.org/10.1002/cncr.30431>.

ACS CAN believes everyone should have meaningful health insurance that is adequate, affordable, available, and administratively simple. It is through this lens that we evaluate any proposal to modify the existing healthcare landscape. Given the widespread success of the marketplace created by the Affordable Care Act (ACA), we believe that any changes to the healthcare landscape should build upon – and not diminish – the structure provided under the ACA. ACS CAN also strongly supports the consumer protections provided under the ACA, which guarantees all individuals access to plans that provide coverage of essential health benefits without an annual or lifetime limit on coverage regardless of health history.

Cancer patients, including those in active treatment, survivors and those at risk of developing the disease need access to comprehensive health insurance coverage. A cancer patient's treatment needs will differ depending on the type of cancer and the stage of diagnosis. Some cancer patients may require surgery, which may necessitate access to a sub-specialist with the unique skillset appropriate for the patient. For example, pediatric cancer patients require the services of surgeons who are specifically trained in both pediatrics and surgery. Other patients may require radiation therapy or systemic treatments administered by medical oncologists, including chemotherapy and targeted agents. Cancer tumors respond differently to treatments depending on the type of cancer, stage of diagnosis, and other factors. Therefore, cancer patients need access to a wide variety of medically necessary treatments and services, including prescription drug coverage. There is no single oncology drug that is medically appropriate to treat all cancers.

We also note that while the RFI focuses on policies related to insurance coverage, the problems cancer patients and others face in accessing care go far beyond the problems they have purchasing or using insurance coverage. ACS CAN's Survivor Views program is a national research panel that surveys cancer patients and survivors to capture their experiences and perspectives, helping inform and strengthen evidence-based cancer advocacy and public policy efforts. In a 2024 ACS CAN Survivor Views survey,⁷ nearly half of cancer patients and survivors surveyed (47%) reported having medical debt related to their cancer, and the plurality of those (49%) carried over \$5,000 in medical debt. Most relevant to this discussion, nearly all (98%) reporting having medical debt were insured at the time when the debt was incurred, most commonly by a high-deductible health plan without a health savings account (34%). The health implications of that debt are significant: those with cancer-related medical debt are three times more likely to be behind on recommended cancer screenings (18% vs 5%), 27% of those with cancer-related medical debt have gone without adequate food, and 25% have skipped or delayed care.

As the Committee considers policies focused on health insurance, we also strongly encourage the Senators to consider policies that will prevent and reduce the impact of medical debt on patients in the U.S. As our survey results show, obtaining insurance coverage does not solve the problem of patients having medical debt. While ensuring everyone has access to quality insurance coverage is an important “upstream” solution to eliminating medical debt, we encourage the Committee to also consider “downstream” solutions as well, like expanding requirements for hospital financial

⁷ American Cancer Society Cancer Action Network. (2024, April). *Survivor views: Medical debt summary*. https://www.fightcancer.org/sites/default/files/national_documents/sv_debt_summary_24.pdf.

assistance programs, prohibiting medical creditors from taking extraordinary collection actions, and removing medical debt from credit reports.⁸

SECTION 1. REVERSING REPUBLICAN CUTS AND REIMAGINING A BETTER PLAN

I. Ensuring that people can easily enroll in and afford coverage that meets their needs

Consumer-Friendly enrollment

For patients with cancer and cancer survivors, it is crucial to choose a health insurance plan that provides coverage for their unique needs. Cancer patients and survivors must pay particular attention to whether a plan covers the medications they need, whether their (often multiple) physicians are in-network, whether their treatment center is in-network, and the cost sharing that will be required of them.

We support the Committee considering reversals of current harmful policies in this area, as well as discussing new policies that would help ensure consumers who have cancer, survived it, or need screening for it understand their plan options and are able to choose the plan that best meets their needs.

Centralized enrollment platforms

Healthcare.gov – especially if it retains its consumer-friendly features like standardized plans – is the only centralized enrollment platform that consumers should be exposed to, or that should be promoted. Healthcare.gov provides an important gateway to Medicaid enrollment or other quality insurance coverage and facilitates access to subsidies that help individuals afford coverage where appropriate.

ACS CAN has repeatedly expressed concerns anytime a state has proposed moving from this enrollment platform (or the official platform for state-based marketplaces (SBMs)). We oppose any efforts to offer non-Qualified Health Plan (QHP) coverage alongside QHPs or as part of a centralized platform. Offering QHP coverage alongside non-QHP coverage will be confusing for enrollees. Utilizing healthcare.gov or a similar state-based exchange allows potential enrollees a better opportunity to compare plans that provide a basic set of coverage options. Eliminating healthcare.gov without creating a state-based exchange and relying only on private web brokers increases the likelihood that healthy consumers could be steered towards non-ACA compliant plans (like short-term plans) because they would meet the medical underwriting requirements associated with these plans. Older and sicker individuals – who are less likely to meet the medical underwriting requirements – would enroll in QHPs, thus resulting in a less healthy risk pool for QHP coverage which would lead to higher premiums.

⁸ American Cancer Society Cancer Action Network. (2024, May 9). *Medical debt fact sheet*.
https://www.fightcancer.org/sites/default/files/medical_debt_factsheet_5-9-24_update.pdf.

Essential Health Benefits

The Essential Health Benefits (EHBs) framework provides the foundation of minimum coverage on which individuals rely. Most of the patient protections provided under the ACA are tied to EHB services. For example, under the ACA, plans are prohibited from imposing lifetime and annual dollar limits on EHB services.⁹ These protections are vitally important to cancer patients, many of whom faced coverage limitations before the enactment of the ACA. The medically necessary services cancer patients need will not vary based on geography but will vary depending on the type of cancer and the stage at which the cancer was diagnosed (among other factors). We urge the Committee to continue to support the EHB framework and, in fact, expand the framework to ensure that it is periodically updated to account for new and innovative technologies and therapies.

For example, oncology care has seen an increase in the use of precision medicine, which has been shown to improve cancer outcomes. Research has resulted in the availability of targeted therapies that are designed to work in patients with very specific biomarkers.¹⁰ In 2025, over two-thirds (69%) of newly approved cancer drugs were for targeted indications. More targeted cancer therapies are in the pipeline. To effectively use these targeted therapies, a cancer patient must have been tested for biomarkers. Unfortunately, medical advancements such as guideline-recommended biomarker testing are not clearly included in all EHB benchmark plans, which can impede patients' access to these vital tests. As the Committee considers changes to the EHB framework, we urge the Committee to ensure that EHB benchmarks are updated on a periodic basis to account for new technologies that may be required to access the best therapies for their diagnosis. We also urge the Committee to provide state and federal regulators with the resources needed to engage in robust oversight (including market conduct examinations) to determine the extent to which consumers have unimpeded access to EHB services, regardless of their state of residence.

Affordability determinations

As noted above, affordability is a key determinate to ensure that consumers have access to healthcare. While many consumers shop for coverage based on premiums, they are only one piece of the financial obligation of insurance for patients. When individuals ultimately need to access care, the absence of comprehensive benefits just shift costs onto the enrollee.

Unfortunately, Congress failed to enact legislation to extend the enhanced premium tax credits, which expired at the end of 2025. As a result, Marketplace enrollees face not only higher premiums but also higher cost sharing. According to KFF, premiums increased an average of 58% (from \$113 to \$178) per month, and average deductibles increased by 37% (from \$1,027 to \$3,786 per person).¹¹ We urge Congress to re-enact and permanently extend the enhanced premium tax credits to provide stability to Marketplace plans.

⁹ 42 U.S.C. § 18022(b).

¹⁰ The term “biomarkers” refers to the biological molecules found in blood, tissues, or other bodily fluids that provide insight into the physiological process, medical conditions, or diseases.

¹¹ McGough, M., Ortaliza, J., Lo, J., & Cox, C. (2026, May 19). *What we know so far about 2026 ACA marketplace enrollment, premiums, and deductibles*. KFF. <https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/>.

II. Reigning in the unsustainable spikes in deductibles and out-of-pocket costs Trump and Republicans have piled onto American families

As previously stated, it is a foundational principle of ACS CAN that everyone should have meaningful health insurance that is adequate, affordable, available, and administratively simple. Furthermore, our organization defines “affordable” coverage as meaning that enrollees can afford to buy insurance and can rely on that insurance to access needed care. Multiple studies and sources repeatedly conclude that insured cancer patients and survivors have problems affording cost sharing for their care. Nearly 60% of working-age people with a history of cancer report experiencing at least one form of medical financial hardship.¹² A 2022 ACS CAN Survivor Views survey of cancer patients and survivors found that 73% of respondents were concerned about their ability to pay current or future costs of their care and 70% were worried about incurring medical debt due to their cancer care and treatment.¹³ These concerns do not just cause patients to worry or go into debt – they prevent or delay patients from seeking and receiving medical care.¹⁴ We applaud the Committee in seeking information and proposed policy solutions that aim to help individuals better afford to actually use their health insurance, through addressing deductibles, cost-sharing amounts, and maximum out-of-pocket limits.

Deductibles

We share the Committee’s concerns about the growing prevalence of high-deductible health plans (HDHPs) and that more and more people are enrolled in plans with deductibles that they cannot afford. HDHPs are not appropriate for everyone. While some preventive services and cancer screenings are required to be exempt from deductibles, some HDHP enrollees still assume they will be charged in full for their preventive services – or don’t understand the difference between preventive services and other medical care – and are discouraged from seeking care. One study showed that switching to an HDHP was associated with a downward trend in overall colorectal cancer screening rates after two years.¹⁵

HDHPs are even more concerning for cancer patients and survivors. Once a patient is suspected of having cancer, he or she undergoes many tests that are not considered preventive services and therefore are subject to most deductibles. Costs continue after the patient is diagnosed and undergoes surgery, radiation and/or chemotherapy. These costs are high, and they come fast – many cancer patients face paying their whole deductible in the first month or two after diagnosis.¹⁶

¹² Yabroff, K. R., Shih, Y.-C. T., & Bradley, C. J. (2024). *Financial hardship following a cancer diagnosis: A family matter*. *American Family Physician*, 110(5), 457-459. <https://www.aafp.org/pubs/afp/issues/2024/1100/editorial-financial-hardship-cancer-diagnosis.html>.

¹³ American Cancer Society Cancer Action Network. (2022, February). *Survivor views: Cancer & medical debt*. https://www.fightcancer.org/sites/default/files/national_documents/survivor_views_cancer_debt_0.pdf.

¹⁴ Zheng, Z., Jemal, A., Han, X., Guy, G. P., Jr., Li, C., Davidoff, A. J., Banegas, M. P., Ekwueme, D. U., & Yabroff, K. R. (2019). *Medical financial hardship among cancer survivors in the United States*. *Cancer*, 125(10), 1737-1747. <https://doi.org/10.1002/cncr.31913>.

¹⁵ Wharam, J. F., Graves, A. J., Landon, B. E., Zhang, F., Soumerai, S. B., & Ross-Degnan, D. (2011). *Two-year trends in colorectal cancer screening after switch to a high-deductible health plan*. *Medical Care*, 49(9), 865-871. <https://doi.org/10.1097/MLR.0b013e31821b35d8>.

¹⁶ American Cancer Society Cancer Action Network. (2020, October). *The costs of cancer: 2020 edition*.

One study of women with metastatic breast cancer showed that patients enrolled in HDHPs paid 55% more out-of-pocket costs than patients in low-deductible health plans.¹⁷ Unsurprisingly, these up-front and higher costs lead to financial hardship. Having an HDHP has been shown to make a cancer survivor more likely to experience several types of financial hardship.¹⁸

Being required to pay for these high costs up front can cause treatment delays, especially for lower-income patients. Research shows the negative consequences of HDHPs for cancer treatment and outcomes. For instance, studies have shown that HDHP enrollment is associated with a decrease in imaging tests¹⁹ – the tests a patient often needs if there is a positive screening test for suspected cancer – and that women who were switched to an HDHP were more likely to experience delays in diagnostic breast imaging, breast biopsy, early-stage breast cancer diagnosis, and chemotherapy initiation.²⁰ Among individuals with a history of cancer, HDHPs are associated with more delayed or foregone care, although these access to care problems are lessened somewhat if the patient has a health savings account (HSA).²¹ Another study showed that breast cancer patients with HDHPs show delays in care even when researchers divide patients by income level²² – meaning higher incomes do not insulate cancer patients from the effect of being required to pay large bills up front for cancer care. Most compellingly, a 2026 study showed that HDHPs were associated with worse overall survival and cancer-specific survival among people with a history of cancer.²³

<https://www.fightcancer.org/costsofcancer>.

¹⁷ Leopold, C., Wagner, A. K., Zhang, F., et al. (2018). *Total and out-of-pocket expenditures among women with metastatic breast cancer in low-deductible versus high-deductible health plans*. *Breast Cancer Research and Treatment*, 171(2), 449-459. <https://doi.org/10.1007/s10549-018-4819-6>.

¹⁸ Zheng, Z., Jemal, A., Han, X., Guy, G. P., Jr., Li, C., Davidoff, A. J., Banegas, M. P., Ekwueme, D. U., & Yabroff, K. R. (2019). *Medical financial hardship among cancer survivors in the United States*. *Cancer*, 125(10), 1737-1747. <https://doi.org/10.1002/cncr.31913>.

¹⁹ Zheng, S., Ren, Z. J., Heineke, J., & Geissler, K. H. (2016). *Reductions in diagnostic imaging with high deductible health plans*. *Medical Care*, 54(2), 110-117. <https://doi.org/10.1097/MLR.0000000000000472>.

²⁰ Wharam, J. F., Zhang, F., Lu, C. Y., et al. (2018). *Breast cancer diagnosis and treatment after high-deductible insurance enrollment*. *Journal of Clinical Oncology*, 36(11), 1121-1127. <https://doi.org/10.1200/JCO.2017.75.2501>.

²¹ Zheng, Z., Jemal, A., Banegas, M. P., Han, X., & Yabroff, K. R. (2019). *High-deductible health plans and cancer survivorship: What is the association with access to care and hospital emergency department use?* *Journal of Oncology Practice*, 15(11), e957-e968. <https://doi.org/10.1200/JOP.18.00699>.

²² Wharam, J. F., Zhang, F., Wallace, J., LeCates, R. F., Babikian, A., Gallagher, P. M., Ross-Degnan, D., & Landon, B. E. (2019). *Vulnerable and less vulnerable women in high-deductible health plans experienced delayed breast cancer care*. *Health Affairs*, 38(3), 408-415. <https://doi.org/10.1377/hlthaff.2018.05026>.

²³ Barnes, J. M., Gupta, A., Ragavan, M., Santos, P. M., Wallingford, S., & Chino, F. (2026). *High-deductible health plans and mortality among cancer survivors*. *JAMA Network Open*, 9(1), e2556451. <https://doi.org/10.1001/jamanetworkopen.2025.56451>.

ACS CAN has serious concerns about the proliferation of HDHPs – especially among enrollees who have low- and middle-incomes and may not fully understand the implications of a high-deductible plan and therefore could be ultimately ill-equipped to pay their deductible. These individuals and families are likely to experience problems accessing preventive care, cancer care and other healthcare services when they need them. We encourage the Committee to explore policies that:

- Ensure that certain healthcare services are not subject to the deductible and therefore are available for free or lower cost sharing so patients are not deterred from receiving them. This includes services that prevent disease, detect cancer early (including all follow-up tests needed to confirm or rule out a cancer diagnosis), and help maintain patient health.
- Increase enrollment assistance and financial navigation services so that potential and current enrollees can receive help understanding their insurance benefit, premiums, and what they will have to pay when they receive common healthcare services. These services should be targeted towards low- and middle-income individuals.
- Ensure that deductibles are affordable for enrollees, including policies that require deductible amounts to be scaled to enrollee income. Such policies would have to be balanced with policies focused on keeping premiums affordable.
- Monitor and track the size of deductibles and study the impact of these deductibles on enrollees' access to care and health outcomes.

Coinsurance

Copayments are more transparent to the consumer and make it easier to predict out-of-pocket costs. Plan designs using coinsurance are not transparent because consumers are unable to determine their expected out-of-pocket costs. The ability to predict and plan for costs is very important for individuals with cancer and those with chronic conditions, particularly patients who are low-income and very price sensitive.

ACS CAN supports the Committee in exploring policies that decrease the use of coinsurance in plan designs. We support efforts to ensure that when shopping for plans, consumers have the option of choosing plan designs that do not use coinsurance. At the very least, if a plan is permitted to use coinsurance, policies should require the plan to provide an estimate of out-of-pocket costs, expressed in a dollar amount, associated with all treatments for which enrollees must pay coinsurance.

Maximum Out-of-Pocket Caps

Cancer treatment is often complex and lasts many months or years, involving numerous doctors' visits, tests, surgeries, radiation treatments, prescription drugs, and other services. Cancer patients often meet their deductible soon after diagnosis because all their required tests, procedures, copays, and coinsurance costs quickly add up. As healthcare costs continue to rise and plans use coinsurance more, patients are responsible for significant costs even after they have met their deductible. A 2020 ACS CAN report on The Costs of Cancer showed that cancer patients typically reach their out-of-pocket maximums in the first 1-3 months after a positive screening test, and that

without out-of-pocket maximums, many cancer patients would be responsible for treatment costs in the tens-of-thousands of dollars.²⁴ Many already have great difficulty affording their costs before meeting the maximum.

ACS CAN strongly supports the provisions in the ACA that apply maximum out-of-pocket (MOOP) limits to most private insurance plans, as they protect people with cancer from catastrophic medical bills. We also support the Committee exploring lowering the MOOP, or changing the formula that establishes MOOP amounts, to ensure these limits keep pace with inflation rates and remain at amounts that provide meaningful protection to consumers.

Other Policies: Copay Accumulator Programs

For many patients, copay assistance is the only way they can afford the cost sharing required for their prescription drugs. Copay accumulator adjustment programs, however, prevent patients from fully benefiting from this assistance, shifting the financial responsibility from health plans to patients. When a health plan includes a copay accumulator program, the assistance the patient receives does not count towards their deductible or MOOP limit. As a result, it takes longer for the enrollee to reach their MOOP, and they pay more in cost sharing over the course of the year. Without a copay accumulator adjustment program, the enrollee would reach their MOOP sooner and spend less overall. Copay accumulator programs primarily benefit insurers – who avoid covering the costs that would otherwise count toward the MOOP – while patients continue to pay cost sharing throughout the year.

ACS CAN supports policies such as the Help Ensure Lower Patient (HELP) Copays Act (S. 864/H.R. 6423) that ensure patients benefit fully from copay assistance. We support the use of copay assistance because many individuals would otherwise be unable to afford the cost sharing associated with their prescription drugs.^{25,26}

We oppose legislative proposals that would prohibit the use of copay assistance or prevent such assistance from counting toward a patient's maximum out-of-pocket obligation, unless the prohibition is limited to instances when a lower-cost generic or interchangeable alternative exists and is covered by the patient's health plan.

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

Establishing a Federal Option

As the Committee considers policies to create a public option, we offer the following principles to ensure that cancer patients and survivors continue to have access to medically necessary care and

²⁴ American Cancer Society Cancer Action Network. (2020). *The costs of cancer: 2020 edition*.
<https://www.fightcancer.org/sites/default/files/National%20Documents/Costs-of-Cancer-2020-10222020.pdf>.

²⁵ American Cancer Society Cancer Action Network. *Copay Accumulator Programs Increase Costs for Cancer Patients*. March 2026. <https://www.fightcancer.org/policy-resources/copay-accumulator-programs-increase-costs-cancer-patients>.

²⁶ American Cancer Society Cancer Action Network. *Copay Accumulators Sample Scenario*. March 2026.
https://www.fightcancer.org/sites/default/files/copay_accumulator_programs_increase_costs_for_cancer_patients_scenario_0.pdf.

treatment. ACS CAN believes that a public option should provide comprehensive coverage (including access to specialty care), be affordable, and complement existing coverage options. We also encourage the Committee to explore state actions, which can inform a possible federal approach.

Comprehensive coverage: Any new health coverage option must ensure that cancer patients have access to the full set of EHBs and robust access to a network of specialized providers – including facilities and medical professionals – required to treat their cancer. Access to evidence-based preventive services without cost sharing is vitally important to detecting, and in some cases, preventing cancer. Oncology drugs often have different indications, different mechanisms of action, and different side effects – all of which need to be managed to fit the medical needs of an individual. Depending on the cancer type and stage of diagnosis, an individual may need surgery and/or radiation treatments. Some cancer patients may require access to clinical trials which may be conducted at specific facilities, including cancer centers.

It is for this reason that any public option must ensure that patients have access to a variety of specialists and specialty facilities that can provide high-quality healthcare. Providers and facilities should not be disincentivized to participate in a public option. Any new healthcare option must ensure that cancer patients have access to a broad array of prescription drugs. A carefully designed public option could provide more robust and affordable access to high-quality healthcare.

Affordability: The ACA provided consumers with pre-existing conditions the opportunity to purchase comprehensive health insurance. However, many individuals who failed to qualify for subsidies could not afford marketplace coverage, and the provisions of the American Rescue Plan that temporarily expanded the availability and generosity of the subsidies have expired – causing premiums for many individuals to become out of reach again. As the Committees look to create a public option, overall affordability of high-quality coverage should be a paramount concern.

Unfortunately, many Americans struggle to afford the cost of their healthcare. This is particularly true for individuals who are in active cancer treatment or who are cancer survivors. Research has shown that privately insured cancer patients commonly face more than \$6,000 in out-of-pocket costs during the first year after diagnosis.²⁷ High out-of-pocket costs continue post treatment as cancer survivors have higher out-of-pocket costs, even many years after their initial diagnosis, compared to individuals without a cancer history.²⁸ This high out-of-pocket burden results in individuals being unable to obtain necessary medical care. As the Committee explores the possibility of creating a public option, we urge consideration be given to policies that would reduce an enrollee's out-of-pocket burden.

Complement to existing coverage: Since the repeal of the ACA's individual mandate penalty, there has been a significant increase in the availability of non-ACA-compliant health coverage such as

²⁷ Shih, Y.-C. T., Zhao, J., Han, X., Robin Yabroff, K., et al. (2021). *Trends in total and out-of-pocket costs of cancer care for patients with private insurance*. *Journal of Clinical Oncology*, 39(28_suppl), 5. https://doi.org/10.1200/JCO.2020.39.28_suppl.5.

²⁸ Guy, G. P., Jr., Yabroff, K. R., Ekwueme, D. U., Virgo, K. S., Han, X., Banegas, M. P., Soni, A., Zheng, Z., Chawla, N., & Geiger, A. M. (2015). *Healthcare expenditure burden among non-elderly cancer survivors, 2008-2012*. *American Journal of Preventive Medicine*, 49(6 Suppl. 5), S489-S497. <https://doi.org/10.1016/j.amepre.2015.09.002>.

short-term limited-duration health plans, healthcare sharing ministries, Association Health Plans, and Farm Bureau plans. A public option, if designed appropriately, could offer consumers an alternative to non-ACA-compliant health plans and/or could serve as a viable option for individuals who fall into the Medicaid gap because they reside in states that have not yet expanded their Medicaid programs.

A public option should complement existing coverage options – including Marketplace plans and employer-sponsored coverage – without causing disruptions to the availability of currently available high-quality healthcare. For example, employers offering robust, affordable healthcare coverage should not be incentivized – directly or indirectly – to drop robust health coverage that they provide to their employees.

As the Committee explores the feasibility of a public option, we urge that any new public option be available to consumers on par with existing coverage such that it minimizes any disruption to the current healthcare landscape. A public option should be just that, an *option* for individuals to make a choice for coverage. The public option should not be designed as a high-risk pool, or as a federal program that will attract the sickest and costliest enrollees. Such a policy would negatively impact the existing market landscape.

Moreover, we recognize that any major change in the U.S. healthcare landscape requires a thoughtful approach to implementation. We caution that any new system will take time and resources to develop and administer. Individuals – particularly those who need specialized services like oncology services – will need continuity of care protections to avoid disruptions to their care. The success of the ACA has depended not only on the consumer protections it provides, but also because the drafters of the legislation gave serious consideration to the long-term viability of the legislation, including the sufficient long-term federal financial commitment needed to ensure sustainability of the program. The creation of any public option structure should also be designed with the long-term impact in mind.

States as laboratories of innovation: To date there are a number of states that have enacted legislation or are poised to enact legislation that would create a public option. As the Committee considers this pathway, robust exploration of state efforts that have been considered can provide the Committee with information that can better inform a federal public option.²⁹

IV. Getting rid of junk insurance plans and ending the constant cycle of higher premiums, skyrocketing deductibles, shrinking networks and worse coverage

Ending Junk Coverage Across Markets

Individuals with or at higher risk of developing pre-existing conditions, including cancer, need access to affordable, high-quality health coverage. Junk plans fail to provide critical coverage for cancer prevention, detection, and treatment, placing cancer patients and survivors at significant medical and financial risk.³⁰

²⁹ For example, Colorado, Nevada, and Washington have enacted state legislation offering differing approaches to establish a public option.

³⁰ American Cancer Society Cancer Action Network. (2025, November). *The availability of junk plans harm cancer patients.*

Junk plans are dangerous because, while marketed as cheaper insurance options, they often exclude coverage of EHBs such as emergency services, preventive and wellness services, and prescription drugs, and engage in medical underwriting to deny coverage. Because they are not ACA-compliant, these plans can refuse coverage for pre-existing conditions and arbitrarily revoke coverage, leaving beneficiaries vulnerable to medical and financial harm. For instance, if an individual is diagnosed with colon cancer in the first six months of coverage, a junk plan issuer could cite prior unexplained stomach issues to cancel the policy or deny coverage of the cancer treatment.³¹ When this occurs, consumers have limited options for recourse when their coverage is dropped or denied because consumers are not guaranteed the same protections as in ACA-compliant coverage and many of these products are not regulated by state or federal agencies. Many consumers don't know about these kinds of limitations prior to purchasing coverage and find themselves stuck with an inadequate plan.

As the Committee considers policies to regulate junk plans, we urge you to strictly limit or prohibit the sale of non-comprehensive health insurance and require these plans to adhere to all the same rules as ACA-compliant plans. To support transparency, we encourage the Committee to craft legislation requiring junk plan issuers to report data on number of enrollees, claims history, and appeals and exceptions information.

SECTION 2: MAKING HEALTH CARE SIMPLER FOR FAMILIES

I. Simplifying and standardizing plan options and benefits, so people can effectively select coverage and services that will meet their needs

Standardized Benefits

ACS CAN has long supported the decision of previous administrations to offer standardized benefits because these policies helped to address the challenges of individuals who were overwhelmed with plan options when shopping for health insurance coverage in the exchanges. The American Cancer Society operates a specialized Health Insurance Assistance Service (HIAS) which provides cancer patients information about health insurance options that may be available to them in their area. HIAS representatives often hear from individuals with cancer about how overwhelming it can be to choose from too many health insurance plans.

We believe that standardized benefit packages are beneficial to individuals as they shop for health insurance coverage. This standardization allows individuals shopping for coverage to focus on and easily compare the aspects of their health insurance plan that matter most to them, such as plan provider networks, covered benefits, quality, and premiums.³² Standardized plans also provide needed transparency to consumers so they can plan and budget for healthcare expenses. For

https://www.fightcancer.org/sites/default/files/national_documents/the_availability_of_junk_plans_harm_cancer_patient_s.pdf.

³¹ Kalmer, E. (2024, January 8). *Missourians need comprehensive affordable health coverage*. American Cancer Society Cancer Action Network. <https://www.fightcancer.org/news/missourians-need-comprehensive-affordable-health-coverage-0>.

³² Ericson, K. M. M., & Starc, A. (2016). *How product standardization affects choice: Evidence from the Massachusetts Health Insurance Exchange*. *Journal of Health Economics*, 50, 71–85. <https://doi.org/10.1016/j.jhealeco.2016.09.005>.

example, many standardized plans provide information about which prescription drugs are part of a plan's formulary as well as how much their copayment will be in dollar amount. Plan standardization can also encourage competition among plans and result in lower premiums.³³ For these reasons, we strongly encourage the Committee to consider opportunities to simplify and standardize plan options and benefits.

Network Adequacy

For a cancer patient – whether newly diagnosed, in active treatment, or cancer survivors – adequate access to needed providers is one of the most important components in fighting their disease. Cancer patients often require tailored treatment regimens and coordinated care across multiple specialists. Adequate networks ensure patient access to essential specialists and subspecialists, as well as opportunities to seek second opinions or consult out-of-network experts when necessary. Narrow plan networks can also force patients to pay out-of-pocket for essential care, contributing to the already significant financial burden of cancer treatment – nearly half of cancer patients and survivors report incurring medical debt to pay for their cancer care.³⁴ Additionally, when networks are too limited, cancer patients may be forced to go through mountains of paperwork and appeals to obtain coverage, travel long distances to receive needed care, or seek care from out-of-network providers, which is costly and can severely disrupt their treatment.

Strong network adequacy standards are particularly important for residents of rural areas. People with cancer who live in rural areas have poorer health outcomes relative to their urban counterparts, in part due to limited access to medical and technological services and evidence-based preventive services including cancer screenings.³⁵ Federal oversight ensures that states are enforcing these vital consumer protections, particularly in cases where states are not sufficiently resourced to be able to conduct this oversight. In addition, federal oversight ensures that states are enforcing these requirements in a consistent manner.

As the Committee consider policies to improve network adequacy, we urge you to consider legislation requiring the establishment of minimum physician-to-enrollee ratios for specialists and subspecialists – including medical oncologists, surgical oncologists, and radiation oncologists – for all federally regulated programs, including marketplace, Medicare Advantage, and Medicaid managed care. We also urge the enactment of legislation to ensure that networks provide sufficient coverage of essential community providers that serve low-income and medically underserved individuals, such as the Ensuring Access to Essential Providers Act (S. 2793), which would provide vital network adequacy standards with respect to Medicare Advantage plans.

³³ Hopkins, B., & Lyons, S. (2026, February 2). *The effect of offering standardized "Simple Choice" plans on premiums in the Federally Facilitated ACA marketplaces*. Congressional Budget Office.

³⁴ American Cancer Society Cancer Action Network. (2024, May 9). *Survivor views: Majority of cancer patients & survivors have or expect to have medical debt*. <https://www.fightcancer.org/policy-resources/survivor-views-majority-cancer-patients-survivors-have-or-expect-have-medical-debt>.

³⁵ Unger, J. M., McAneny, B. L., & Osarogiagbon, R. U. (2025). *Cancer in rural America: Improving access to clinical trials and quality of oncologic care*. *CA: A Cancer Journal for Clinicians*, 75(4), 341-361. <https://doi.org/10.3322/caac.70006>.

II. Ensuring that patients do not face hurdles or delays in accessing the care they need

Prior Authorization

ACS CAN is concerned about misuse of utilization management (UM) tools, including prior authorization and step therapy. These policies can delay access to clinically appropriate treatment and, in some cases, require patients to incur additional costs before receiving the therapy best suited for their care. Cancer patients often require tailored treatment regimens, which may involve multiple, concurrent prescription drugs. Because of coverage rules and prior authorization requirements, out-of-pocket costs can vary widely across plans and medications, navigating these benefits can be confusing and burdensome.

ACS CAN supports proposals to shorten the prior authorization decision timeframes and ensure standardization across types of services and payers to limit the burden on patients and providers. Fast notification provides patients with quicker access to recommended treatments, or more time to file an appeal if necessary or work with their provider to adjust their treatment plan. Delays in access to medically appropriate treatment can lead to disease progression, making timely prior authorization decisions and notifications essential.

The need for timely access to clinically appropriate treatment is especially critical for cancer patients. Within oncology, National Comprehensive Cancer Network (NCCN) guidelines are regarded as the standard for oncology care. The NCCN recently clarified that “step therapy, within a line of therapy, is not clinically recommended within any NCCN Guideline.”³⁶ For cancer patients — whose treatment is often tailored to their specific diagnosis and condition — any barriers to getting the specific drug they need could jeopardize the outcome of their treatment.

Despite these concerns, the full extent of UM practices is not always transparent to the patient, provider, or even the regulating entity. In August 2026, ACS CAN released a report examining UM tools for certain drugs to treat multiple myeloma, including Ninlaro, Pomalyst, Revlimid, Thalomid, and Xpovio. Across these drugs, the report found that commercial plans required prior authorization 73% of the time.³⁷ Although no plans explicitly included step therapy in their formulary design, this report found that some plans effectively implemented “embedded” step therapy through their prior authorization requirements — occurring 45% of the time in commercial plans. We urge the Committee to support the Centers for Medicare & Medicaid Services’ (CMS) and state regulators’ undertaking of a thorough and robust formulary review process.

These findings underscore the need for stronger oversight and accountability to ensure that UM practices do not create inappropriate barriers to care. Accordingly, voluntary agreements to improve UM practices are insufficient to protect patients’ access to care. We urge the Committee to provide CMS with additional resources and to support collaboration with state regulators to practice more meaningful oversight. ACS CAN also strongly supports establishing penalties for payers who fail to

³⁶ National Comprehensive Cancer Network. (2026). *NCCN payer relations resource page*. <https://www.nccn.org/business-policy/business/payer-relations>.

³⁷ American Cancer Society Cancer Action Network. (2026, August). *Utilization Management in Multiple Myeloma*. https://www.fightcancer.org/sites/default/files/acs_can_report_um_in_multiple_myeloma_final.pdf.

adhere to prior authorization timeframes and other utilization management requirements.

Mid-Year Plan Changes

When an individual enrolls in a health plan, they are prohibited from changing plans until the end of the plan year (absent special circumstances). ACS CAN has long supported policies that hold plans accountable to providing the coverage they committed to providing when the consumer selected the plan at the beginning of the plan year. When a cancer patient is in active treatment, losing access to a provider who leaves the plan's network can disrupt the patient's ability to receive essential care. Because cancer treatment is highly specialized and tailored to each patient, a change in providers can have serious consequences for their treatment plan, especially when their current clinician has deep knowledge of their medical history. If a consumer were to use the special enrollment period (SEP) to enroll in a new plan that allowed them to keep their provider, their deductible and MOOP amount would also re-set, meaning that any cost sharing the patient had expended up to that point would no longer count toward the patient's MOOP costs. In many cases, this change could cost the patient several thousands of dollars and not be financially feasible or wise.

Similarly, a health plan may change its formulary during the plan year. Cancer patients may select a plan based on the coverage and cost of certain drugs, so formulary changes in the middle of a plan year are problematic and disruptive to care. Currently there is no prohibition on an insurer removing coverage of a drug, moving the drug to a higher formulary cost-sharing tier, or increasing the copay, coinsurance, or deductible applied to the drug during a single plan year.

ACS CAN supports a prohibition on a plan's ability to make mid-year changes to the benefit design and provider network. We urge the Committee to ensure that consumers can maintain access to their providers and prescriptions throughout the plan year and are not exposed to avoidable financial burden.

Consumer Appeals

ACS CAN supports robust Committee attention to consumer appeals processes, including bolstering consumer awareness, given the growing role these processes play in helping cancer patients obtain medically necessary care. Public and private payers are demonstrating a growing reliance on measures designed to limit spending on high-cost services, such as cancer therapies.³⁸ As a result, cancer patients increasingly have to go through appeals or exceptions processes in order to access medically necessary drugs or services – either because their prescribed product or service is subject to UM tools or because their insurer may choose not to cover a particular therapy or service as part of its benefit design. Without coverage for a needed service or treatment, cancer patients face having to pay the full cost out of pocket or making the difficult decision to forego care that could save their lives.

From a consumer's perspective, the number of levels of review can be daunting and can deter a beneficiary from filing an appeal. In addition, multiple levels of appeal delay a consumer's access to medically appropriate products or services. Even when the appeals process allows for expedited

³⁸ American Cancer Society Cancer Action Network. (2026). *Utilization management in non-small cell lung cancer*. American Cancer Society Cancer Action Network. https://www.fightcancer.org/sites/default/files/acs_can_report_um_in_nslcl.pdf.

consideration, each level of review has various timeframes by which the reviewing entity must act. Adding up all of those timeframes can result in a consumer – even one experiencing, by definition, exigent circumstances for which expedited review is warranted – being unable to access the product or service that is on appeal for several days or weeks (depending on how many levels of review are undergone). We urge the Committee to consider opportunities to enact legislation to fund policies and programs that support consumer education related to this complex process, including Certified Application Counselors (CACs) and non-navigator consumer assisters.

The CAC Program allows community organizations and individuals to become certified as enrollment assisters. While navigators and in-person assistants (IPAs) are specifically described in the ACA, CACs are not included in the law. CACs were created by CMS to fill the need for more enrollment assisters, and include Community Health Centers, hospitals, healthcare providers, Indian health providers, Ryan White HIV/AIDS providers, behavioral or mental health providers, and social services agencies. They can serve underserved populations because they often already have access to them via normal functions and are trusted members of their communities. Funding for CACs can come from federal and state grants as well as private donations, allowing for a greater degree of flexibility than IPAs and navigator programs. Despite the potential for this program, there is a lack of awareness around how CACs can support navigation of the appeals process, and we encourage the Committee to support use of the program for navigating consumer appeals.

Unfortunately, there is little data available on consumers' use of the appeals system. To improve the process and support oversight, it is crucial that there is greater transparency into how many consumers attempt to and successfully use the appeals process. We urge the Committee to set mandatory reporting at the plan – not issuer – level and to work with CMS and state regulators to strengthen agency oversight of appeals, including establishing penalties for bad actors. The appeals process is confusing and can be cumbersome and time-consuming, particularly for someone who is also battling a serious illness like cancer. As such, we encourage the Committee to support policies that would streamline the process, simplify the terminology, improve regulatory oversight, and reduce consumer burden overall.

IV. Simplifying the process to get insurance, and protecting people from losing coverage each year due to unexpected costs or red tape

Streamlining Eligibility

ACS CAN supports policies to improve the enrollment process, making it easier for consumers to enroll in affordable, comprehensive health insurance options. For example, ACS CAN supports efforts like the Maryland Easy Enrollment Program, which allows residents to check a box on their state tax returns to determine eligibility for Medicaid or subsidized coverage through Maryland Health Connection and to receive enrollment assistance.

In addition, we support funding for health insurance navigators because they help consumers with the enrollment process and determining which coverage option best meets their needs. Navigators also help to increase public awareness about comprehensive coverage options, subsidized plans and enrollment deadlines. Continued investment in navigators – particularly those who have ties to the community – is critical to promoting a healthy risk pool and ensuring that consumers, especially

those who are low-income or have health literacy or other access challenges, enroll in a plan that suits their needs. We urge the Committee to enact legislation to require continued, robust funding of the navigator program.

SECTION 3. TAKING ON CORPORATE GREED

IV. Stopping corporate insurance companies and third parties from making money by acting as unaccountable middlemen that delay care and deny claims

Third-Party Administrators (TPAs)

ACS CAN is concerned with the rise of TPAs – including Pharmacy Benefit Managers (PBMs) – and the role they play in the administration of healthcare in the U.S. Currently, TPAs are not always regulated to the same extent as plan sponsors, despite the fact that they can be responsible for the development and administration of plan benefit designs.

ACS CAN supports efforts to address incentives throughout the prescription drug supply chain that contribute to higher costs for patients. Specifically, PBMs' formulary and rebate arrangements can create incentives favoring higher-cost drugs or placing lower-cost competitors on less favorable formulary tiers. For cancer patients, these decisions can significantly affect treatment access.

We support policies that increase PBM accountability to help ensure that formulary and contracting decisions are made in patients' best interest. We encourage the Committee to build upon existing transparency requirements by strengthening enforcement of the prohibition on PBM gag clauses and ensuring it extends to all contracting arrangements between pharmacies, insurance plans, and (where applicable) PBMs. Removing gag clauses allows pharmacists and pharmacies to have the opportunity to have a more open dialogue regarding questions the patients may have about their prescription drugs. Patients should be informed whenever a prescription can be obtained at a lower cost outside their insurance benefit. Greater transparency at the pharmacy counter can help patients make more informed decisions and avoid unnecessary out-of-pocket expenses.

Patients are often provided with insufficient information when prescriptions are rejected at the pharmacy counter, leading to confusion, treatment delays, and potential treatment abandonment. ACS CAN encourages the Committee to require greater transparency around denials and strengthen written denial requirements for health plans to ensure patients know the reason for denial and available appeal options. Health plans and PBMs should also be held accountable when the pharmacy rejections are inappropriate or inconsistent with the patient's coverage.

We are also concerned by reports from patients indicating a growing use of retroactive rescissions, which occurs when health plans revoke previously granted prior authorization requests after the service or drug has been provided. Retroactive rescissions are detrimental to patients because they impose substantial financial burdens on patients and can interrupt medically necessary treatment. To protect patients, we encourage the Committee to work with regulators to ban this harmful practice.

CONCLUSION

Thank you for the opportunity to comment on the Request for Information: Health Coverage that Works for Everyone. If you have any questions, please feel free to contact me or have your staff contact Elizabeth Darnall, Senior Director, Federal Advocacy, ACS CAN, at Elizabeth.Darnall@cancer.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Lisa A. Lacasse". The signature is fluid and cursive, with the first name "Lisa" being the most prominent.

Lisa A. Lacasse, MBA
President
American Cancer Society Cancer Action Network