United States Senate

WASHINGTON, DC 20510–6200

October 26, 2026

Maurice Smith
Chief Executive Officer
Health Care Service Corporation
300 E. Randolph Street
Chicago, IL 60601

Dear Mr. Smith,

We write to express serious concerns that Health Care Service Corporation (HCSC) worked with the Trump administration to kick qualified enrollees off their health plans without sufficient notice or compliance with consumer protections. We request responses to the questions below in order to better understand these serious threats to enrollees' health and finances, and to understand why HCSC chose to accept and act on baseless allegations of fraud from the Trump administration.

On September 22, 2026, the Trump administration announced that they, in coordination with HCSC and other issuers across the market, terminated Affordable Care Act (ACA) coverage for 760,000 enrollees. Republicans are weaponizing fraud falsehoods in order to undercut the ACA Marketplace and kick even more Americans off their health care. This year, nearly 3 million people have lost coverage while millions more are paying sky-high premiums and higher deductibles for insurance that covers less.[1] Aligning with Republicans and their so-called "war on fraud," insurance companies chose to participate in a collaborative effort with the Trump administration to inject yet more chaos and damage into the ACA Marketplace.

According to reports, these coverage terminations took place outside of the established process and regulations that govern mid-year eligibility determinations,[2] and enrollees were identified as being subject to coverage termination based on metrics such as whether their projected income made them eligible for tax credits that cover the full premium of their plan, and whether they sought care during the 2026 plan year. We understand that this represented the first phase of this work, with a second phase already underway.

As you know, there is no credible research or evidence in support of the longstanding Republican conspiracy theory that zero-dollar premium plans and zero-claims enrollment are reliable proxies for fraud. Zero-dollar premium plans exist in private Medicare plans, and zero-claims enrollees are common across private insurance markets and across types of insurance. Claims to the contrary are based on

1 https://www.kff.org/quick-insights/aca-marketplace-enrollment-is-down-by-3-million-after-big-jump-in-premium-payments/
2 https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-155/subpart-D/section-155.330#p-155.330(e)

discredited research generated by a right-wing think tank.[3] However, these facts have not stopped the Trump administration and Republicans in Congress from parroting these falsehoods to justify taking coverage away from an estimated 15 million people over the next decade.[4] Actors from across the health care system, including a coalition funded primarily by the insurance industry, have weighed in over time to rebut these falsehoods directly.[5]

The 760,000 mid-year coverage terminations that took place would not have been possible without the cooperation of insurance companies that have been quietly colluding with the Trump administration on matters related to these improper coverage terminations since at least June 2026. It is our understanding that the ten largest issuers by Federally Facilitated Marketplace (FFM) enrollment received, and voluntarily complied with, a Centers for Medicare & Medicaid Services (CMS) data request designed to terminate coverage for hundreds of thousands of enrollees. Issuers, including HCSC, took specific steps to assist CMS in their efforts, including sending unsolicited communications to enrollees asking them to verify their Social Security numbers. Issuers provided CMS with lists of enrollees who did not receive or respond to this unsolicited outreach asking for personally identifiable information. Those enrollees were deemed presumptively fraudulent, so-called "phantom enrollees" and their coverage was terminated retrospectively, effective August 31, 2026. Issuers agreed to carry out this request from CMS even though it was not supported by subregulatory guidance until such guidance was quietly modified by CMS on October 1, 2026, over one month after the 760,000 coverage terminations had been carried out.

The responsiveness to this potentially unlawful request from CMS, and the willingness to immediately act and initiate enrollee outreach efforts when asked to do so, stands in stark contrast with decisions made by issuers last year to forgo outreach to enrollees prior to the 2026 Open Enrollment Period. Despite repeated requests from Democratic lawmakers to contact enrollees so they could prepare for the historic premium increases that were about to take place due to Republican cuts to the ACA,[6] insurance companies almost universally declined to perform any additional direct enrollee outreach, citing the cost and complexity associated with doing so outside the issuer renewal notice process. Issuers also expressed concern about being put at a competitive disadvantage should their enrollees choose to shop for more affordable coverage in light of rising premiums.

We have many questions about the role of HCSC in this flawed process used to terminate coverage for 760,000 enrollees, and the judgment exercised by insurance companies that chose to cooperate with CMS officials without requesting clarification about the specific authorities being relied on to support this request or raising concerns to Congress on behalf of their customers, enrollees that your companies receive billions of dollars in premiums and taxpayer support each year to serve. Given HCSC's cooperation and collaboration with the Trump administration in this process over the past several months, and the lack of specific information that the Trump administration has provided publicly or to Congress about what actually took place, we request that you provide detailed, numbered responses to each of the following questions **no later than November 6, 2026.**

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3 https://democracyforward.org/news/press-releases/court-blocks-unlawful-trump-vance-attempt-to-gut-the-affordable-care-act/; https://democracyforward.org/news/press-releases/court-again-blocks-unlawful-trump-vance-administration-attempt-to-gut-the-affordable-care-act/

4 https://www.cbpp.org/research/health/by-the-numbers-harmful-republican-megabill-will-take-health-coverage-away-from

5 https://americanscovered.org/kac-releases-report-outlining-errors-in-paper-from-opponents-of-health-care-tax-credits/

6 https://www.democrats.senate.gov/imo/media/doc/Letter%20to%20ACA%20insurers%20on%202026%20marketplaces.pdf

For each question below, please also state whether HCSC conveyed this information to CMS in connection with its response and provide any relevant correspondence.

1. When was HCSC first contacted by CMS to evaluate their list of so-called 'unauthorized enrollments'? Did CMS indicate that their intent was to terminate coverage for enrollees? Please provide copies of all correspondence and informational material HCSC received from CMS or explain why you cannot do so.

2. The process that HCSC was asked to carry out does not align with the customary mid-year eligibility redetermination process, the guidance that existed at the time in the CMS Federally Facilitated Exchange Enrollment Manual (FFE Manual), or the steps that must usually be taken for a consumer to resolve a data matching issue (DMI). In light of that fact, did CMS provide clarification about the intent of this request and what the information you provided would be used for?

    a. If not, did HCSC request this clarification? Did CMS provide a legal basis for this request? Did HCSC ask for one?

3. CMS announced in January that they disenrolled 250,000 people for "a 'fraud' reason".[7] Yes or no, did HCSC have any involvement or communication with CMS regarding those disenrollments?

    a. If yes, how did that process differ from the one discussed throughout this letter?

4. Given the inaccurate research and misleading positions taken by the Trump administration and Republican members of Congress over a period of years related to so-called fraudulent ACA enrollees,[8] including their reliance on conclusory statements and inaccurate findings from sources such as the Paragon Institute, how did HCSC assess the likelihood that the Trump administration would use the information you sent them to continue to weaponize their false fraud narrative in order to take insurance from eligible people?

5. Is it the position of HCSC that these mid-year eligibility redeterminations and subsequent disenrollments were processed by CMS consistent with federal requirements that existed at the time the request was carried out?

    a. If not, did anyone at HCSC raise this concern with CMS? If so, please provide a written record.

6. CMS updated the FFE Manual on October 1, 2026 to reflect the process that took place in July, which did not exist in the FFE Manual at the time HCSC carried it out. Please explain why HCSC chose to carry out a process in July that was inconsistent and at times in conflict with the policies in the FFE Manual at the time.

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7 https://www.cms.gov/newsroom/fact-sheets/cms-actions-protect-consumers-strengthen-exchange-program-integrity

8 https://aspe.hhs.gov/reports/aca-exchange-enrollment-2026; https://energycommerce.house.gov/posts/e-and-c-ways-and-means-and-judiciary-chairs-demand-watchdogs-review-after-report-exposes-widespread-fraud-in-obamacare-plans

7. Please explain how HCSC complied with the grace period for enrollees to resolve DMIs once they were identified.

    a. Was this process consistent with the process customarily used by issuers and Exchanges to resolve DMIs?

8. Please provide complete answers to each of the following questions and include in your response whether HCSC provided this information in writing to CMS as part of its response. Please attach any relevant correspondence to CMS.

    a. Yes or no, is an enrollee with a zero-dollar net premium a proxy for fraud? Why or why not?

    b. Yes or no, is an enrollee who has not generated a claim at this point in the 2026 plan year a reliable proxy for fraud? Why or why not?

    c. Yes or no, is an enrollee with a DMI on their coverage application a reliable proxy for fraud? Why or why not?

    d. Yes or no, is an enrollee not responding to unsolicited communication from their insurance company, whether sent by mail, phone, text, or email, a reliable proxy for fraud? Why or why not?

    e. Yes or no, is an enrollee choosing a zero-dollar premium plan an abnormal occurrence or a proxy for fraud? Why or why not?

9. We understand that HCSC attempted to communicate with affected enrollees via at least two of the following: text, phone, email, and/or mail. Please provide templates or examples of the language used for each of the types of communication HCSC relied on, including what specifically was communicated to enrollees about what would happen if they failed to respond.

10. How many notices were sent by HCSC and what percentage of enrollees did not respond to this unsolicited mid-year communication sent by HCSC?

11. What percentage of enrollees historically respond to HCSC's unsolicited mid-year communications related to other matters?

12. Which types of enrollee communication are more effective relative to others, and how do factors such as income and family size affect response rates? Please provide answers for each type of communication HCSC relied on to reach enrollees in order to carry out the request by CMS.

13. Yes or no, is an enrollee incurring zero claims in a given plan year an abnormal occurrence in the employer market?

    a. Approximately how many enrollees as percentage of HCSC's total enrollment traditionally generate zero claims in a given plan year?

    b. Did HCSC provide this information in writing to CMS as part of its response? If so, please provide any relevant correspondence.

14. Yes or no, is it a common practice for enrollees with employer-sponsored coverage who generate zero claims over the first half of a given plan year to have their names submitted to their employer for disenrollment?

    a. If no, why did HCSC make the decision to collaborate with CMS in generating a similar list of ACA enrollees?

15. Yes or no, is it the position of HCSC that the methodology and process established and carried out by CMS represents a sound approach to populating an accurate unauthorized enrollment list that results in the termination of nearly every enrollee included on the list?

16. The ACA prohibits issuers from rescinding coverage unless an enrollee is found to have committed an act of fraud. Is it the position of HCSC that these coverage terminations were carried out consistent with federal requirements? If so, please cite the relevant federal requirements.

17. In an environment where families are reporting unprecedented challenges affording basic necessities such as groceries and gas, has HCSC conducted any analysis on the effect that Trump administration policies have had on plan selection in 2026? Specifically, have increasing affordability challenges contributed to a greater need for individuals and families to move from Silver coverage to lower-quality Bronze coverage that may result in reduced or zero-dollar net premiums after the application of premium tax credits?

    a. If so, did HCSC provide this information to CMS as part of its response?

18. In an environment where families are reporting unprecedented challenges affording basic necessities such as groceries and gas, has HCSC conducted any analysis on the effect that Trump administration policies have had on the ability of families to see their doctor and generate claims?

    a. If so, did HCSC provide this information in writing to CMS as part of its response? Please provide any relevant correspondence.

19. CMS has asserted in its September 23, 2026 interim final rule that disenrolling so-called "phantom enrollees" who incur zero claims will reduce premiums for consumers.[9] Does removing enrollees who generate zero claims in a given plan year have a positive or negative effect on premiums and insurance risk pools?

20. In 2025 Senate Democrats made repeated requests to insurance companies to notify their enrollees of historic premium increases prior to Open Enrollment. Insurance companies repeatedly cited the complexity and cost associated with initiating new types of mid-year contact with enrollees and delays in finalizing premiums as an explanation for why they were unable to comply with this request to provide <u>any</u> information to enrollees outside the normal issuer notice process. In contrast, enrollee communications were initiated within weeks, if not days, in response to this request from Republicans. Please explain this disparity.

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9 https://www.federalregister.gov/public-inspection/2026-19493/patient-protection-and-affordable-care-act-temporary-moratoria-on-certain-agent-and-broker

21. How many total enrollees were included on the so-called “unauthorized enrollment” list HCSC returned to CMS? Please provide a total number as well as a breakdown by state and family size.

22. How many enrollees with zero-dollar net premiums after tax credits were included on the so-called "unauthorized enrollment” list HCSC returned to CMS? Please provide a total number as well as a breakdown by state and family size.

23. How many children (under age 18) were included in the so-called "unauthorized enrollment” list HCSC returned to CMS for disenrollment? Please provide a total number as well as a breakdown by state.

    a. Did CMS consider providing additional time to resolve DMIs for policies that included children enrolled as dependents?

    b. Did HCSC propose to CMS that they should provide additional time to resolve DMIs for policies that included children as dependents?

24. If disenrollments were processed at the household level, did a DMI for one individual in the household trigger disenrollments for all enrollees in the household?

25. Has HCSC evaluated the effect that these disenrollments will have on potential risk adjustment payments, medical loss ratio calculations, or plan year 2027 premiums? Please quantify where applicable.

26. We understand that people who had their coverage terminated on August 31, 2026 have since generated claims and/or sought to reinstate their coverage, thereby disproving the assertion by CMS that these terminations consisted only of so-called ‘phantom’ or unauthorized enrollees.

    a. Have any of HCSC’s terminated enrollees that were included on the so-called ‘unauthorized enrollment’ list provided to CMS generated claims since the list was submitted? If so, how many?

    b. Have any of HCSC’s terminated enrollees requested reinstatement? If so, how many?

    c. How long does it take to fully reinstate enrollees that are determined to have been improperly terminated and what specific steps must be taken by enrollees and HCSC?

    d. Will HCSC be providing full financial protection for these individuals and families from any balance bills they may receive as a result of being terminated from their coverage without cause?

    e. Are reinstated enrollees receiving retroactive coverage? If so, what is the retroactive date of coverage?

27. We understand the process and coverage terminations discussed in this letter reflect the first phase of this flawed and misguided effort, with a second phase currently underway. Is anyone at HCSC participating in the second phase of this work, or aware of future phases of similar work? If so, what is HCSC’s understanding of the second phase and any subsequent phases?

a. Is HCSC once again collaborating with or intending to collaborate with CMS in this next phase?

b. Have the results of the first phase altered HCSC's approach to collaborating with CMS on this next phase? If so, how?

28. Yes or no - has HCSC signed, or does HCSC intend to sign, the "Issuers Pledge to Combat Marketplace Fraud" that CMS recently sent to issuers, or any similar pledge requesting among other things a commitment to support CMS's broader fraud prevention strategy?

Please submit complete written responses to Ian_Hunter@finance.senate.gov as soon as possible but no later than November 6, 2026.

Sincerely,

Ron Wyden
United States Senator
Ranking Member, Committee on Finance

Bernard Sanders
United States Senator
Ranking Member, Committee on Health, Education, Labor, and Pensions

Tammy Baldwin
United States Senator

Angela D. Alsobrooks
United States Senator

Elizabeth Warren
United States Senator

Cory A. Booker
United States Senator

Tammy Duckworth
United States Senator

Mazie K. Hirono
United States Senator

Jeffrey A. Merkley
United States Senator

Andy Kim
United States Senator

Chris Van Hollen
United States Senator

Maria Cantwell
United States Senator

Edward J. Markey
United States Senator