March 13, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9883-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Comment on Proposed Rule: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program (CMS–9883–P; 91 FR 6292, February 11, 2026)

Dear Administrator Oz:

Triage Cancer is a national nonprofit organization that provides free education on the legal and practical issues that arise from a cancer diagnosis. These issues include health insurance options and navigation, employment rights, disability benefits, and financial assistance programs. We provide education directly to individuals who have been diagnosed with cancer, caregivers, and the health care professionals who serve them, including nurses, social workers, navigators, and community health workers. We also operate Triage Health, which extends this information to anyone navigating the health care system for a serious or chronic medical condition.

We submit these comments on the HHS Notice of Benefit and Payment Parameters for 2027 ("NBPP 2027") and urge CMS to withdraw or substantially revise the provisions described below. Taken together, these proposals would dismantle core consumer protections established by the Patient Protection and Affordable Care Act (ACA),[1] impose new barriers to coverage, and make it significantly harder for people with cancer and other serious illnesses to access the care they need while maintaining financial stability. These changes would also have downstream effects on the broader health care system. When individuals cannot access or maintain affordable coverage, hospitals and providers face increased uncompensated care costs, placing additional financial strain on health systems and contributing to the growing risk of hospital service reductions or closures, particularly in already underserved communities.[2]

Triage Cancer has a unique perspective in seeing which coverage structures help patients access timely diagnoses and stay in treatment, which eligibility rules create gaps that are impossible to navigate, and which plan designs leave people financially devastated despite technically being "insured." That perspective informs these comments. We address our most significant concerns below.

I. Elimination of Standardized Plan Options (45 CFR §§ 155.20, 156.201, 156.202)

The Proposal

CMS proposes to eliminate standardized plan options beginning in plan year 2027, removing all requirements that plans offered through the Exchanges conform to standardized benefit and cost-sharing designs. CMS also proposes to simultaneously eliminate limits on the number of non-standardized plan options issuers may offer.

[1] Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (2010)

[2] See, e.g., Gaffney LK et al., *Analysis of Hospital Operating Margins and Provision of Uncompensated Care,* JAMA Network Open (2023); Kaiser Family Foundation, *Key Facts about the Uninsured Population* (2024).

Why This Harms Health Care Consumers

Standardized plan options exist so that consumers can effectively compare health plans and make sound coverage decisions. Treatment for serious or chronic health conditions is often expensive, complex, and long-term. Individuals diagnosed, and their caregivers, depend on being able to accurately predict what their insurance will cover and what they will owe. When cost-sharing structures vary across dozens of non-standardized plan designs, that comparison becomes functionally impossible.

We are particularly concerned about the combined effect of eliminating standardized options and lifting non-standardized plan limits simultaneously. Without standardized benchmarks, consumers will face a marketplace where issuers can design benefit structures that make it impossible to accurately predict out-of-pocket costs for high-cost services like chemotherapy, radiation, and specialty drugs.

The proposed rule justifies eliminating standardized plan options on the grounds of issuer flexibility, reduced regulatory burden, and the promotion of "innovation in plan design."[3] However, CMS does not identify any deficiency in the current standardized option framework that this proposal is designed to fix. In fact, in 2023, CMS itself found that the number of plans available to the average consumer had grown from 25.9 in 2019 to 113.6 in 2023, that this proliferation exceeded a productive level, and that standardized options were necessary to help consumers make more informed decisions and avoid unexpected cost exposure.[4]

We urge CMS to retain standardized plan options and existing non-standardized plan option limits. At a minimum, CMS should require meaningful differentiation standards and robust consumer decision-support tools before any changes to standardization are finalized.

II. Weakening of Essential Community Provider Standards and Certification of Non-Network Plans (45 CFR §§ 155.1051, 156.235, 156.236)

The Proposal

CMS proposes to: (1) reduce the Essential Community Provider (ECP) contracting threshold; and (2) permit non-network plans to be certified as Qualified Health Plans (QHPs) for the first time.

Why This Harms Health Care Consumers

Access to an adequate provider network is integral to accessing care after a serious or chronic medical diagnosis, like cancer. Network adequacy ensures that patients can see an appropriate specialist, receive specialty infusion services, or participate in a clinical trial. Weakening network adequacy standards will lead to worse outcomes for people diagnosed with a serious or chronic health condition.

The reduction of the Essential Community Provider (ECP) contracting threshold from 35 to 20% is especially troubling. ECPs, including Federally Qualified Health Centers and safety-net hospitals, disproportionately serve individuals with low incomes and medically underserved communities. Cancer incidence and mortality are higher in these communities, in part because of gaps in access to early detection and treatment. Allowing plans to serve an area while contracting with only 20% of ECPs will increase access issues for the people most at risk of being diagnosed later and experiencing worse health outcomes.

The proposal to permit non-network plans to qualify as QHPs is a significant structural change with no demonstrated consumer benefit. Traditional health plans negotiate contracts with doctors, hospitals, and other providers, establishing in advance what those providers will be paid for providing services. Non-network plans have no such contracts, and therefore, there is no list of "in-network" providers. Instead, an individual has to find a

[3] HHS Notice of Benefit and Payment Parameters for 2027, 91 Fed. Reg. 6385 (proposed Feb. 11, 2026)
[4] HHS Notice of Benefit and Payment Parameters for 2024, 88 FR 25740 (April 27, 2023).

provider willing to see them, and the plan pays some portion of whatever that provider charges. The patient is responsible for the rest, with no cap on what any given provider can bill. This means that every visit, every infusion, every scan, and every hospital stay potentially comes with an unpredictable bill. Non-network plans shift financial risk onto consumers in a way that is incompatible with the realities of treatment for serious or chronic health conditions, which is often ongoing, expensive, and dependent on continuity with specific providers and facilities.

The proposed rule also fails to address a fundamental question: how the ACA's annual out-of-pocket maximum would function for non-network plans. The ACA's out-of-pocket maximum, $12,000 for self-only coverage in 2027, is designed to cap what an enrollee pays out-of-pocket for covered services.[5] The cap is calculated against negotiated rates. However, if there is not a network there is no defined "allowed amount" from which cost sharing can be calculated. Furthermore, if a plan sets a benefit amount for a service and a provider bills above that amount, a non-preferred provider could bill the patient for the balance. This is known as balance billing, which does not count towards an individual's out-of-pocket maximum. An individual enrolled in a non-network plan could, therefore, face costs that far exceed the statutory ceiling, with no regulatory protection. CMS has not resolved this issue in the proposed rule. Until it does, consumers cannot meaningfully evaluate the financial risk of enrolling in a non-network QHP.

We urge CMS to retain the 35% ECP contracting threshold and withdraw the proposal to permit non-network plans to qualify as QHPs.

III. Increased Cost-Sharing Flexibility for Bronze and Catastrophic Plans (45 CFR §§ 156.136, 156.155)

The Proposal

CMS proposes new cost-sharing parameters for individual market bronze plans and catastrophic plans that would allow increased out-of-pocket expenses. CMS also proposes to expand hardship exemption eligibility to allow individuals with incomes below 100% or above 250% of FPL to qualify for catastrophic plans, and to permit non-pediatric dental services to be excluded from the Essential Health Benefits (EHB) benchmark.

Why This Harms Health Care Consumers

The ACA's cost-sharing limits exist to protect enrollees from the financial hardship often seen previously when someone was diagnosed with an unexpected, serious, or chronic health condition. An individual may find these plans attractive because of their lower monthly premium, and not realize the high out-of-pocket costs until after they are diagnosed.

The proposed rule would allow issuers to offer plans with even higher deductibles and out-of-pocket maximums than currently allowed, and expands hardship exemption eligibility for catastrophic plans, making them available to a broader population. The problem is that Catastrophic plans provide little to no benefits until an enrollee meets their deductible, which under this proposed rule would be $15,600 for an individual in 2027. Given that approximately half of U.S. adults say they could not pay an unexpected medical bill of $500 out of pocket, and that nearly one-third of single-person households with private insurance do not have more than $2,000 in savings, meeting a $15,600 deductible is not realistic for most.[6]

We urge CMS to withdraw proposals that expand cost-sharing parameters in bronze and catastrophic plans and to ensure marketplace plans provide meaningful coverage.

[5] 42 U.S.C. § 18022(c)(1)

[6] Rakshit S, Rae M, Claxton G, Amin K, Cox C. The Burden of Medical Debt in the United States. Peterson-KFF Health System Tracker. February 12, 2024.

IV. Multi-Year Catastrophic Plan Terms (45 CFR §§ 156.130, 156.155)

The Proposal

CMS proposes to allow catastrophic plans to offer plan terms of up to 10 consecutive years, during which cost-sharing requirements could apply over the life of the contract rather than annually. CMS also proposes to allow multi-year catastrophic plans to utilize value-based insurance design for preventive services.

Why This Harms Health Care Consumers

Locking a person into a catastrophic plan for up to 10 years removes the ability to adjust coverage as health needs change. Someone who enrolls while healthy could be diagnosed with cancer in year two and remain trapped in a plan that provides little meaningful coverage for the remaining eight years of the contract. The ACA's annual coverage structure was designed specifically to allow people to reassess their coverage needs each year, multi-year catastrophic plans eliminate that flexibility entirely.

The proposed rule's inclusion of value-based insurance design for preventive services does not cure this problem. Covering a preventive screening before the deductible is met may make these plans appear more comprehensive than they are. While the plan may cover a mammogram at no cost, if the individual is then diagnosed with cancer, they would have to pay $15,600 out of pocket before the plan would cover cancer treatment. This feature may cause people to underestimate the true financial risk of long-term catastrophic coverage.

Finally, the proposed rule does not adequately address what happens when an enrollee in a multi-year catastrophic plan is diagnosed with a serious illness. Can they withdraw from the plan? What are the financial consequences of doing so? What protections exist against discrimination in renewal or continuation? The absence of clear answers to these questions makes this proposal especially concerning.

We urge CMS to withdraw this proposal. If CMS proceeds, it must require prominent consumer disclosure, a meaningful exit pathway for people who are diagnosed with serious medical conditions, and annual cost-sharing resets for any multi-year plan design.

Section V: Cumulative Enrollment Barriers for Individuals with Low Incomes and Seriously Ill Individuals (45 CFR §§ 155.320(c)(5), 155.420(d)(16), 155.420(g))

The Proposal

CMS proposes three changes that restrict access to coverage for individuals with low incomes and those with serious illness. First, CMS proposes to permanently eliminate the requirement that Exchanges accept a household's income attestation when the IRS returns no tax data for the household. Second, CMS proposes to expand pre-enrollment verification requirements to 75% of new special enrollment period (SEP) enrollments, increasing documentation burdens for individuals enrolling outside of open enrollment. Third, consistent with the WFTC legislation, the proposed rule permanently eliminates the special enrollment period available to individuals with household income at or below 150% of the federal poverty level, the only year-round enrollment pathway available to individuals with low incomes who do not experience a discrete qualifying life event.

Why This Harms Health Care Consumers

Taken individually, each of these proposals raises serious concerns. Taken together, they create overlapping barriers that will systematically prevent individuals with low incomes and those with serious illness from accessing or maintaining coverage.

People coping with serious or chronic illnesses, like cancer, frequently experience income disruptions that create gaps in their tax filing history: they may reduce work hours due to treatment side effects, leave employment entirely, or experience periods of irregular income during active treatment. These are precisely the individuals for whom the attestation exception served as an important safety net. Permanently eliminating it means that individuals who cannot produce tax documentation while managing a serious illness may be denied coverage entirely. Additionally, this change was previously proposed, challenged in court, and was stayed by a federal district court in City of Columbus et al. v. Kennedy.[7] Now CMS is proposing the change again without providing new data or analysis to cure the deficiencies the court found. Finalizing these provisions through the NBPP 2027 would be subject to the same legal vulnerability, and will likely lead to another round of litigation that will again disrupt Exchange operations and impact individuals' access to health insurance.

The proposed rule also requires that Exchanges verify eligibility before coverage begins for at least 75% of new special enrollment period enrollments. People use SEPs because something disruptive just happened to them; perhaps they lost a job, got divorced, or moved to a new state. For a person with cancer, these changes can mean losing insurance in the middle of treatment. Pre-enrollment verification introduces a waiting period between the loss of coverage and the start of new coverage. The length of that gap depends on how quickly someone can gather the required documents and how quickly the Exchange can process them. For someone mid-treatment, that gap can mean missing or delaying lifesaving care. The proposed rule is also silent on how Exchanges should implement this requirement. Because making individualized determinations about which enrollees must provide documentation would impose significant administrative burden, Exchanges are likely to require everyone to complete pre-enrollment verification, without mechanism to identify or fast-track people with urgent medical needs.

Finally, the permanent elimination of the 150% FPL SEP removes the only year-round enrollment pathway for individuals with low incomes without a qualifying life event. We recognize this change is compelled by statute and that CMS's discretion is limited. We raise it here because its impact cannot be evaluated in isolation: its elimination, combined with the attestation and verification changes described above, leaves individuals with low-income with additional burdens and fewer options to access coverage.

We urge CMS to retain a hardship exception to the attestation requirement for individuals who can demonstrate active treatment for cancer or another serious health condition; establish an expedited verification pathway for individuals with documented serious medical needs; and, to the extent discretion remains regarding the 150% FPL SEP elimination, prioritize clear communication about remaining enrollment options.

Conclusion

While not perfect, the ACA transformed the individual insurance market, particularly for people who do not receive health insurance coverage through an employer, and those with cancer and other serious illnesses. It prohibited exclusions for preexisting conditions, established meaningful benefit standards, created accessible enrollment pathways, and provided financial assistance that made accessing health insurance possible for millions of Americans.

The proposals in this rule, taken together, represent a systematic rollback of those protections. They prioritize insurer flexibility over patient protection, shift financial risk onto health care consumers, reduce coverage accessibility for vulnerable populations, and undermine the comparability and predictability that make the marketplace function. The concerns addressed in this letter do not represent the full scope of our objections to the proposed rule. For example, the elimination of APTC eligibility for lawfully present immigrants will result in coverage loss for people who are working, contributing to their communities, and playing by the rules, but who work in jobs that do not offer employer-sponsored insurance and whose immigration status makes them ineligible for Medicaid,

[7] City of Columbus v. Kennedy, No. 1:25-cv-02114 (D.Md. 2025)

leaving marketplace subsidies as their only pathway to affordable coverage. We understand that some changes are compelled by statute and that CMS's discretion may be narrow. However, to the extent any discretion remains, we urge CMS to ensure that impacted individuals receive meaningful advance notice of impending coverage loss, that exchanges and navigator programs are resourced and directed to provide active outreach and assistance, and that every available option for alternative coverage, however limited, is clearly communicated before enrollment is terminated.

Triage Cancer is committed to ensuring that people diagnosed with serious or chronic health conditions, like cancer, can focus on their health, not on navigating a coverage system designed to work against them. We appreciate the opportunity to comment and would welcome the chance to provide additional information or participate in further dialogue on any of these issues.

Respectfully submitted,

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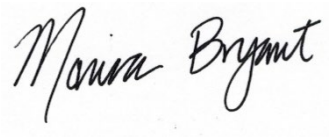

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