American Hospital Association™
Advancing Health in America

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March 13, 2026

Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: CMS–9883–P — Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program

Dear Administrator Oz:

On behalf of the American Hospital Association (AHA), representing nearly 5,000 hospitals, health systems and other health care organizations; our clinical partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed Notice of Benefit and Payment Parameters for 2027.

The AHA supports CMS' focus on marketplace innovations that expand coverage options and promote efficiency, competition and value. At the same time, it is essential that innovation is balanced with strong consumer protections to ensure patients can access needed care without being exposed to unaffordable financial risk. Hospitals are often the providers of last resort for many patients, and policies that increase patient cost-sharing or reduce network adequacy often shift uncompensated care costs onto hospitals and health systems that are already under significant financial strain. We look forward to working with CMS to ensure that patients have affordable coverage options without compromising their access to care or disrupting the long-term stability of hospitals and health systems.

Our specific comments follow.

Non-network Plans. CMS proposes to permit "non-network plans" to sell on the marketplaces and lays out the requirements such plans would need to meet in order to be certified as qualified health plans (QHPs).

The AHA supports creating more opportunities for innovative coverage options so long as they are paired with robust protections for enrollees. In particular, enrollees must be assured of adequate access to care and protection from unaffordable costs. Since non-network plans do not rely on contracted provider networks, enrollees may experience different billing and reimbursement arrangements than in traditional network-based products. To account for this, we urge CMS to ensure that enrollees are clearly informed of any potential financial risk. Hospitals frequently find that enrollees do not understand their health coverage benefits (network-based or otherwise), especially related to their own financial liability for any unpaid portions of their bill. This leaves them vulnerable to accruing medical debt and puts hospitals in a precarious financial situation as they cannot absorb these losses through financial assistance programs alone.

In an attempt to prevent non-network plan enrollees from experiencing unexpectedly high financial exposure, CMS proposes that non-network plans attest that their benefit amounts will be accepted as payment in full for enough providers to ensure adequate access to care. We are deeply concerned that attestations alone are not enough and can limit access to care. If CMS moves forward with this policy, we would suggest that plans that do not utilize a network be required to develop and demonstrate either that they have financial agreements with providers in their market that will accept the plan's specified amount as payment in full or that the plan has obtained pricing information from providers in the market showing that the plan's specified amounts meet or exceed the prices charged by a specified percentage of those providers. This is particularly true for hospital services, which, by their nature, are often more complex and therefore costly. These providers would not create a network per se, as patients would still be free to access any provider. However, these types of information would offer greater certainty that the plan's reimbursement rates are adequate and that patients would have access to a range of providers. Another alternative would be to require health plans to showcase transparent pricing and enable consumers to make informed choices while retaining the ability to seek care at any provider. This would be paired with requiring the plan to pay the provider in full and then collect the patient portion of the charge above the approved amount, maintaining the financial risk with the plan, not the providers, and incentivizing the plans to establish adequate reimbursement levels.

Catastrophic Plans. CMS proposes to allow certain individuals 30 years and older that do not qualify for premium tax credits or cost-sharing reductions (i.e., those below 100% or above 250% of the federal poverty level) to purchase catastrophic plans. In addition, CMS proposes to increase the cost-sharing parameters for bronze and catastrophic plans for 2027.

While the AHA supports having more individuals enrolled in some form of coverage, we are concerned that these plans will not provide true protection against catastrophic costs. For example, under the proposed changes, a single enrollee in a catastrophic plan could be required to meet a $15,400 deductible before most benefits apply — an

amount nearly equal to the federal poverty level for an individual ($15,960).[1] Coverage that includes as much in cost-sharing — to say nothing of premiums — as an individual's entire salary cannot be described as affordable, and the deductible amount itself could easily be considered catastrophic for many individuals in these income ranges. In this case, it is extremely likely that the individual will never be able to pay for their portion of the cost of care, thus putting them at critical risk of accruing medical debt or avoiding medically-necessary care altogether. Moreover, hospital financial assistance programs will not be able to make up the difference, especially if more individuals move from more robust coverage into these plans. While hospitals will do what they can, they do not have sufficient resources to universally cover these gaps in coverage. **We therefore urge CMS not to adopt these changes as proposed.**

Maximum Annual Limit on Cost-sharing. CMS proposes to update the annual indexing methodology for determining the maximum limitation on cost-sharing and set the 2027 out-of-pocket maximum at $12,000 for self-only coverage and $24,000 for other than self-only coverage, reflecting a 13.2% year-over-year increase. As discussed in previous sections, the AHA is deeply concerned that increases of this magnitude will expose patients to levels of cost-sharing that many households cannot realistically afford and will further erode marketplace coverage.

While CMS is required to apply the statutory indexing methodology, these increases, compounded with other policies in this rule that shift financial responsibility to patients, would undermine federal and state efforts to improve the affordability and value of coverage. For example, the administration and Congress have recently advanced numerous initiatives intended to lower health care costs for patients, including policies aimed at reducing prescription drug costs, expanding innovative coverage options and promoting value-based care. Such policies reflect a disconnect between federal efforts to lower certain health care costs while increasing others. For many households, a $12,000 or $24,000 liability is effectively unaffordable, increasing the likelihood that patients will delay or forgo care, accrue medical debt, and face financial distress. These outcomes also risk reducing enrollment and retention, and thus are at odds with CMS' goals of promoting marketplace stability.

Higher out-of-pocket maximums translate into greater bad debt and uncompensated care when patients are unable to pay their share of costs. Hospitals and health systems are already contending with sustained cost growth, workforce shortages and inadequate reimbursement; they cannot absorb additional losses driven by rising patient cost-sharing obligations. Over time, these pressures can affect hospitals' ability to maintain services and participate in networks, which can in turn undermine access to care for the entire community.

[1] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. 2026. 2026 poverty guidelines: 48 contiguous states (all states except Alaska and Hawaii) [PDF]. https://aspe.hhs.gov/sites/default/files/documents/b1bfa16b20ae9b89d525bc35de7c1643/detailed-guidelines-2026.pdf.

We encourage CMS to use all available policy levers to mitigate the impact of rising out-of-pocket maximums, including (1) strengthening marketplace standards that discourage plan designs with unaffordable upfront cost-sharing, (2) improving transparency and monitoring of affordability impacts, and (3) evaluating how concurrent policy changes in this rule interact to increase patient liability.

Network Adequacy Standards and Essential Community Provider (ECP) Requirements. The proposed rule would restore state authority to determine network adequacy standards and oversight for QHP issuers. Specifically, CMS proposes to remove the requirement that state-based exchanges and state-based exchanges that use the federal platform maintain quantitative time and distance network adequacy standards that are at least as stringent as those required for the federally-facilitated exchange. Instead, states would have flexibility over network adequacy requirements as long as QHPs provide sufficient provider choice to meet the applicable federal standards. Finally, CMS proposes to reduce the minimum percentage of ECPs an issuer must contract with in each service area to 20%, down from 35%. This change would apply to the overall ECP threshold as well as the federally qualified health center and family planning provider threshold.

The AHA has long supported robust network adequacy standards that ensure patients have timely access to hospital, physician, behavioral health and specialty services. At the same time, we recognize that the care delivery landscape is shifting, particularly through increasing access to virtual health care services, and that these changes open the door for an evolution of network adequacy standards.

We support CMS' approach that relies on states to manage network adequacy to the extent they are able. Critical to this proposal, however, is that states must establish an Effective Provider Access Review Program, which includes reporting requirements for provider access metrics and methodology plus procedures to ensure full and ongoing compliance with state requirements.

While state flexibility is important and can allow for new and innovative approaches to network adequacy that consider the shifting care delivery landscape, the AHA encourages the agency to monitor state oversight of networks to ensure that they in fact have the capacity to ensure health plan compliance.

In addition, the AHA strongly supports ECP requirements as a core statutory and regulatory mechanism to ensure access for low-income, medically underserved, rural and vulnerable populations. Hospitals, including disproportionate share hospitals, safety net hospitals, rural hospitals and children's hospitals, are central to the ECP framework and often serve as providers of last resort in their communities. The AHA has consistently supported strong ECP inclusion standards and meaningful enforcement to prevent issuers from meeting ECP requirements in name only while excluding key hospital providers.

The AHA is concerned that CMS' proposal to reduce the ECP threshold could significantly weaken access for underserved populations. Lowering the threshold risks further exclusion of safety net and hospital-based ECPs from QHP networks, especially in rural areas. **The AHA recommends maintaining the existing 35% threshold, or, at a minimum, requiring issuers seeking to meet a lower threshold to demonstrate that access for underserved populations will not be adversely affected.**

Medical Loss Ratio (MLR). The MLR is a critical consumer protection that ensures premiums are spent on patient care, not excessive administrative activities or profit. By requiring insurers to devote a substantial share of premiums to health care services and quality improvement, the MLR holds plans accountable for how they use patient premiums. First implemented in 2011, the benefit of the MLR to patients was immediate, with the regulation achieving total consumer benefits (reduced expenses and issuance of patient rebates) estimated at over $5 billion during its first three years.[2]

The AHA urges CMS not to weaken or dilute this standard and cautions against reducing plan responsibilities for efficiently delivering patient coverage. Current regulations governing state adjustments to the MLR appropriately balance market competition with the fundamental goal of ensuring that premiums meaningfully benefit patient health outcomes. Such profound impact shows the vital role that the MLR plays in controlling inappropriate plan expenditures, revealing that plans, when left unchecked, spend substantial amounts of premiums on expenses that do not benefit the patient.

MLR and Vertical Integration in the Health Care Market. The AHA is concerned about the ways in which vertical integration within some of the largest insurers can enable plans to channel excessive funds to their affiliated health care and data services providers at patients' expense. To be clear: We do not view all plan payments to affiliated entities as problematic, such as when an integrated system's health plan pays affiliated clinicians an appropriate rate for patient care. What is problematic, however, is when a plan directs excessive amounts to its own affiliated vendors and service entities in ways that inappropriately increase health system costs, as well as when plans use their benefit design to steer patients to affiliated providers to benefit the insurer financially in a way that is not in the best clinical or financial interest of the patient.

The AHA is concerned with how payments to affiliated vertically-owned entities (e.g., owned by the same parent company) can be used to manipulate the MLR. For example, the three largest pharmacy benefit managers (PBMs) — CVS Caremark, Express Scripts and OptumRx — are all owned by large, national insurers that offer Medicaid managed care coverage throughout the country. Pharmaceutical purchasing from PBMs is a prominent expense for these plans, and the amounts spent on such procurement

[2]Michael J. McCue and Mark A. Hall, The Commonwealth Fund. March 2015. The Federal Medical Loss Ratio Rule: Implications for Consumers in Year 3**.** https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2015_mar_1808_mccue_med_loss_ratio_year_3_rb.pdf

are classified as medical claim expenses for MLR calculations. The vertical integration of PBMs and insurers offering managed care could enable plans to manipulate their PBM expenses by paying larger sums to their owned or affiliated PBM. In fact, the Federal Trade Commission released a July 2024 report finding that large health insurance conglomerates were engaging in this exact type of behavior, with affiliated PBMs paying up to 40 times the non-affiliated price for the same generic cancer drug and steering patients towards such pharmacies.[3]

Such MLR gamesmanship is an issue recently raised by members of Congress. They wrote to the Government Accountability Office to express their concerns about the ways in which large insurance organizations circumvent MLR requirements by acquiring related health care businesses and allocating payments for medical expenses to companies the organization owns, ultimately benefiting the insurer's bottom line and reducing fair competition.[4]

The AHA lauds the administration's goal of improving competition in the health insurance market, but we are concerned that pursuing such competition by reducing the efficacy and patient protections created by MLR requirements may ultimately be to the detriment of patients. We encourage the administration to pursue other means of promoting additional market competition by establishing additional controls on dominant health insurer methods to evade oversight and ensuring that policies do not unintentionally disadvantage smaller or newer entrants.

Thank you for your consideration, and we look forward to working with the administration to ensure efficient and affordable marketplaces. Please contact me if you have questions, or feel free to have a member of your team contact Ariel Levin, AHA director of coverage policy, at 202-626-2335 or alevin@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President
Public Policy Analysis and Development

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[3] Federal Trade Commission. July 2024. Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies. https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

[4] Letter from Rep. Lloyd Doggett and Rep. Gregory F. Murphy, M.D. to the Honorable Gene L. Dodaro, Comptroller General of the United States (Apr. 16, 2025). https://doggett.house.gov/sites/evo-subsites/doggett.house.gov/files/evo-media-document/gao-ma-vertical-integration-request-4.16.25.pdf