March 13, 2026

The Honorable Robert F. Kennedy, Jr
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-9883-P– Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program
91 Fed. Reg. 6292 (February 11, 2026)

Dear Secretary Kennedy and Administrator Oz:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the Patient Protection and Affordable Care Act, Health and Human Services (HHS) Notice of Benefit and Payment Parameters (NBPP) for plan year (PY) 2027. 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 nonprofit, nonpartisan advocacy affiliate, ACS CAN is more determined than ever to end cancer as we know it, for everyone.

More than 2 million Americans will be diagnosed with cancer this year and more than 18.5 million Americans living today have a history of cancer.[1] At every education level, individuals with health insurance are more likely than those without it to have access to critical early detection cancer procedures.[2,3] 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 disadvantaged communities.[4]

We support the Department's goal of improving health care affordability, but we are concerned that many of the policies included in the proposal sacrifice access to comprehensive coverage – something that is vitally important to cancer patients, survivors, and those who are at risk of developing the disease. A plan that does not cover important aspects of cancer care – even if that plan's premium is more affordable – is significantly deficient to the individual who is diagnosed with cancer. While some choose health insurance based on known health conditions, illnesses like cancer are of course not bound to an open enrollment period. It is for this reason ACS CAN strongly advocates for comprehensive insurance coverage to protect against unanticipated health care costs without exposing an individual to financial ruin.

ACS CAN is concerned several policies in this proposal would sacrifice comprehensive benefits in exchange for premium affordability. Premiums are only one piece of the financial obligation of insurance for patients, and when individuals ultimately need to access care, the absence of comprehensive benefits will actually shift costs onto the enrollee. In a 2024 ACS CAN survey of cancer patients and survivors, nearly half (47%) of cancer

[1] American Cancer Society. *Cancer Facts & Figures 2026.* Atlanta: American Cancer Society; 2026.
[2] 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 J Clin, 72: 542-560.
[3] Ward E, Halpern M, Schrag N, Cokkinides V, et al. Association of Insurance with Cancer Care Utilization and Outcomes. CA: A Cancer Journal for Clinicians, 2008;58: 9–31. doi:10.3322/CA.2007.0011.
[4] Abdelsattar ZM, Hendren S, Wong SL. The impact of health insurance on cancer care in disadvantaged communities. Cancer. November 14, 2016. https://onlinelibrary.wiley.com/doi/full/10.1002/cncr.30431.

patients and survivors surveyed had medical debt related to their cancer and the plurality of those (49%) carried over $5,000 in medical debt.[5] Almost all of those surveyed (98%) were insured at the time the debt was incurred and most (34%) had a high deductible health plan (HDHP) without a health savings account. Medical debt hinders timely access to care. Those with medical debt were three times more likely to be behind on recommended cancer screenings and 25% reported they skipped or delayed care because of their medical debt. The impact of medical debt reaches far beyond health care. Twenty-seven percent of those with cancer-related medical debt reported going without adequate food, nearly half of respondents (49%) saw their credit scores decrease and 30% reported difficulty qualifying for loans.

Surviving cancer and having medical debt are both associated with medical hardship (delaying or foregoing recommended medical care) and non-medical financial hardship (such as food and housing insecurity).[6,7] Financial hardship among cancer survivors has long term health consequences. Research has shown that cancer survivors with financial hardship had higher mortality risk than survivors without financial hardship.[8]

We are concerned that by HHS' own estimates, Marketplace enrollment for 2027 is expected to decrease between 1.2 and 2 million enrollees compared to the current baseline.[9] While the Department acknowledges that "we believe it is likely that healthier enrollees are more likely to discontinue coverage" it nevertheless assumed a modest premium increase of between 2%-3%.[10] We urge the Department to provide additional clarity to better understand how the Department arrived at its estimates.

The Department proposes a number of policies that taken together would represent significant change to the existing operation of Marketplace plans. We caution that absent robust consumer education, enrollees could incur significant out-of-pocket costs, which is antithetical to the Department's goal of improving affordability. They could also encounter so many administrative and logistical challenges to using their insurance coverage that they would experience major barriers in accessing their care. We urge the Department to ensure that as it works to finalize the proposed rule that also develops, implements, and funds significant education and outreach to ensure enrollees (current and potential) are made aware of any changes to Marketplace plans.

We offer comments on the following proposals:

- *Amending Requirements for State Exchanges to Operate a Centralized Eligibility and Enrollment Infrastructure*
- *Additional Required Benefits*
- *Amending Exchange Network Adequacy Standards*
- *Permitting Plan-Level Adjustments for Multi-Year Catastrophic Plans*
- *Multi-Year Terms for Catastrophic Plans to Improve Health*
- *Cost Sharing for Bronze and Catastrophic Plans*

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[5] American Cancer Society Cancer Action Network. Survivor Views on Medical Debt. April 2024. Available from https://www.fightcancer.org/sites/default/files/national_documents/sv_debt_summary_24.pdf.

[6] Han X, Hu X, Zheng Z, Shi KS, Yabroff RK. Associations of medical debt with health status, premature death, and mortality in the U.S. AMA Netw Open. 2024 Mar 4;7(3):e2354766. doi: 10.1001/jamanetworkopen.2023.54766.

[7] Hu X, Zheng Z, Shi KS, Yabroff KR, Han X. Association of medical debt and cancer mortality in the U.S. J Clin. Oncol. 31 May 2023;41(16):6505. doi:10.1200/JCO.2023.41.16_suppl.6505.

[8] Yabroff KR, Han X, Song W, Zhao J, Nogueira L, Pollack CE, Jemal A, Zheng Z. Association of Medical Financial Hardship and Mortality Among Cancer Survivors in the United States. J Natl Cancer Inst. 2022 Jun 13;114(6):863-870. doi:10.1093/jnci/djac044.

[9] 91 Fed. Reg. at 6463.

[10] HHS assumes a 2% increase in premiums if 1.2 million enrollees leave the market and a 3% increase in premiums if 2 million people leave the market. 91 Fed. Reg. at 6463.

- *Standardized Plan Options*
- *Essential Community Provider Standards for Network Plans and Implementation of the Effective Essential Community Provider Review Program*
- *QHP Certification of Non-Network Plans*

III. Provisions of Proposed HHS Notice of Benefit and Payment Parameters for 2024

D. Part 155 – Exchange Establishment Standards and Other Related Standards

4. Amending Requirements for State Exchanges to Operate a Centralized Eligibility and Enrollment Infrastructure (§§ 155.205(b) and 155.221(k))

HHS proposes to remove the requirement that all State Exchanges operate consumer-facing centralized eligibility and enrollment platforms. If finalized, a State Exchange could choose to rely entirely on web brokers. HHS proposes to allow State Exchanges to elect a new State Based Exchange Enhanced Direct Enrollment (SBE-EDE) option, which will allow approved web brokers to serve as enrollment pathways for consumers.

ACS CAN urges HHS to not remove this requirement because we are concerned the policy would create confusion for consumers and potentially lead them to inadequate coverage. 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. Individuals who enroll in these plans are left extremely vulnerable to high out-of-pocket costs if they need to use health care services, for example, if they get diagnosed with cancer. This is particularly a problem if such individuals did not fully understand they were enrolling in a plan without ACA protections. Older and sicker individuals – who are less likely to meet the medical underwriting requirements of a non-ACA compliant plan – would enroll in Marketplace plans, thus resulting in a less healthy risk pool for Marketplace coverage which would lead to higher premiums for those individuals. In addition, private web brokers are not paid a commission for individuals found eligible for Medicaid and thus may not be inclined to inform consumers of their eligibility to enroll in the program.

5. Additional Required Benefits (§ 155.170)

HHS proposes to require that any State-required mandated benefit would be considered "in addition to Essential Health Benefits [EHBs]" if they meet the following criteria: (1) are required by state action that took place after December 31, 2011; (2) are applicable to individual and/or small group markets; (3) are specific to required care, treatment, or services; and (4) are not required for purposes of compliance with federal requirements. Under this policy, states would be required to defray the costs of these additional state-mandated benefits, even if these benefits are part of the state's Essential Health Benefit (EHB) benchmark plan. HHS solicits comments on whether to finalize this policy with an effective date of PY 2028 instead of PY 2027.

ACS CAN is deeply concerned about this proposal and urges HHS to withdraw this provision of the proposed rule for the following reasons:

Impact on cancer patients: While the proposal does not outright prohibit state mandates, it does create a financial incentive for states to repeal or invalidate state mandates, and discourages future action to mandate benefits. Since 2012, ACS CAN has advocated for the enactment of many state laws that improve access to care for people with cancer and those who will be diagnosed in the future, including but not limited to the following:

- **Biomarker Testing Coverage**: Increasingly the use of precision medicine has been a vital component to improving cancer outcomes. Research has resulted in the availability of targeted therapies that are designed to work in patients with specific biomarkers.[11] Targeted therapies based on biomarker testing results lead to longer survival.[12,13] Biomarker testing is often used to help determine the best treatment for a patient. To use these targeted therapies, a cancer patient must have been tested for the presence of specific biomarkers. Unfortunately, medical advancements such as necessary biomarker testing are not uniformly covered by health insurance plans, which can impede patients' access to these vital tests and related treatments. In a 2023 survey of cancer patients and survivors, 77% of those who had biomarker testing agree that it gave their providers valuable information that improved their ability to treat the patient's cancer.[14] In the words of one respondent: "Biomarker testing entered me into a treatment plan that has given me a complete response after failure of two prior plans." Similarly, a 2021 survey of physicians found that 89% agree biomarker testing helps them make more informed treatment recommendations.[15] Since 2012, at least 21 states have adopted legislation to ensure that private plans cover biomarker testing.
- **Breast Imaging**: Breast cancer is the most common cancer diagnosed in women in the United States.[16] One in 8 women will be diagnosed with invasive breast cancer and 1 in 43 women will die from the disease.[17] It is the second leading cause of death from cancer among women.[18] Fortunately, early diagnosis lowers the risk of death from breast cancer and increases treatment options.[19] When detected early and before it has spread, the 5-year survival rate for breast cancer is 99%, but drops to 32% for late stage diagnosis.[20] Although screening mammograms are free to most insured women, any follow-up testing needed to rule out or confirm a breast cancer diagnosis can result in significant out-of-pocket costs. More than 70% of women in the United States face cost barriers to accessing follow-up breast cancer diagnostic tests.[21] An estimated 1.1 million women will delay necessary follow-up tests due to

[11] 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.
[12] Gutierrez, M. E., Choi, K., Lanman, R. B., Licitra, E. J., Skrzypczak, S. M., Pe Benito, R., Wu, T., Arunajadai, S., Kaur, S., Harper, H., Pecora, A. L., Schultz, E. V., & Goldberg, S. L. (2017). Genomic Profiling of Advanced Non-Small Cell Lung Cancer in Community Settings: Gaps and Opportunities. Clinical lung cancer, 18(6), 651–659. https://doi.org/10.1016/j.cllc.2017.04.004.
[13] Mendelsohn, J., Lazar, V., & Kurzrock, R. (2015). Impact of Precision Medicine in Diverse Cancers: A Meta-Analysis of Phase II Clinical Trials. Journal of clinical oncology : official journal of the American Society of Clinical Oncology, 33(32), 3817–3825. https://doi.org/10.1200/JCO.2015.61.5997.
[14] American Cancer Society Cancer Action Network. Survivor Views: Biomarker Testing. Sept. 2023. Available from https://www.fightcancer.org/sites/default/files/national_documents/survivorviews_biomarkers.pdf.
[15] American Cancer Society Cancer Action Network. Survey Findings Summary: Understanding Provider Utilization of Cancer Biomarker Testing Across Cancers. Dec. 2021. Available from https://www.fightcancer.org/sites/default/files/national_documents/provider_utilization_of_biomarker_testing_polling_memo_dec_2021.pdf.
[16] American Cancer Society. *Breast Cancer Facts & Figures 2024-2025*. Atlanta: American Cancer Society; 2024.
[17] Id.
[18] Id.
[19] Cancer Facts & Figures 2026.
[20] Breast Cancer Facts & Figures 2024-2025.
[21] American Cancer Society Cancer Action Network. Out of Pocket Costs for Follow-Up Tests After Abnormal Screening Mammogram and Their Impact on Breast Cancer Survival, January 2025. Available from https://www.fightcancer.org/sites/default/files/national_documents/acs_can_bc_oop_cost_white_paper_january_2025.pdf

the out-of-pocket costs.[22] Since 2012, 28 states have enacted legislation that eliminates these costs and improves de women's access to diagnostic and/or supplemental imaging tests.

- **Prostate Cancer Screening**: In 2026, an estimated 333,830 new cases of prostate cancer will be diagnosed in the United States and 36,320 men will die from the disease.[23] Some men are at a higher risk of developing prostate cancer than others, including African American men and those who have a first-degree relative (i.e., a parent, sibling, or child) who has been diagnosed with prostate cancer. Black men have the highest prostate cancer death rate of any racial or ethnic group, and are over twice as likely to die from prostate cancer than White men.[24] Since 2012, 9 states have enacted legislation to provide coverage of prostate cancer screening without cost sharing.
- **Fertility Preservation Coverage**: Cancer treatments can negatively impact a patient's fertility, which is particularly concerning for young people. In 2018, there were 123,591 newly diagnosed adolescent and young adult patients in the United States that would need fertility preservation care because of their type of cancer and impact of the recommended treatments on fertility.[25] Since 2012, 17 states have enacted legislation that would help preserve a person's fertility as they undergo treatment for cancer.

We are concerned that the proposed policy would encourage states to eliminate these vitally important protections that in some cases can make the difference between life and death for a cancer patient.

Operationally challenging: HHS proposes to implement this policy beginning in PY 2027. We do not believe this is a realistic timeframe given the sequencing of events that must occur before the policy can be implemented. While HHS is proposing to require that states defray the cost of state mandates, it proposes no changes to the calculation of the cost of the state mandate. Under § 155.170(c), each issuer must quantify the cost of the state mandate[26], and the calculation must be performed in accordance with generally accepted actuarial principles and methodologies and conducted by a member of the American Academy of Actuaries.[27] We are concerned this timeframe poses an undue burden on states to meet these requirements, and it will not be operationally feasible for each state to conduct an analysis in time for PY 2027. Even if the proposal were to be delayed until PY 2028, as contemplated in the proposed rule, it would still pose a burden on states, particularly given that states would have to enact legislation to address this regulatory change at the same time as states embark on implementing significant changes to their health care systems in light of the enactment of the 2025 Budget Reconciliation legislation.

Further clarification from CMS needed: We were disappointed that HHS noted that it would not provide further guidance to states on the question of what state mandated benefits could be subject to defrayal.[28] We believe the proposed policy fails to provide sufficient guidance to states and additional information is required in order to avoid inconsistent implementation, particularly in light of the fact that many state mandates – such as those related to the early detection of, and treatment for, cancer – provide life-saving health care benefits.

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[22] Id.
[23] Cancer Facts & Figures 2026.
[24] Siegel, R. L., Kratzer, T. B., Giaquinto, A. N., Sung, H., & Jemal, A. (2025). Cancer statistics, 2025. CA: A Cancer Journal for Clinicians. Advance online publication. https://doi.org/10.3322/caac.21871.
[25] Jiang C, Yabroff KR, Hill MJ, Han X. Dobbs v Jackson and access to fertility care among newly diagnosed adolescents and young adults with cancer in the USA. Oct. 2022. The Lancet Oncology, Volume 23, Issue 10, 1240 – 1243.
[26] 45 C.F.R. § 155.170(c)(1).
[27] 45 C.F.R. § 155.170(2)(i) and (ii).
[28] 91 Fed. Reg. at 6334 ("While States are encouraged to reach out to us concerning State defrayal questions in advance of passing and implementing benefit mandates, HHS does not provide determinations of whether the cost of a State-required benefit requires defrayal by the States.")

It is not clear from the proposed changes whether clarification of the required elements of an EHB category would be considered an "additional required benefit" under the statute. For example, laboratory services are a required EHB benefit. Unfortunately, most EHB benchmark plans fail to provide sufficient detail regarding the specific tests covered under the category of laboratory services. Some state benchmark plans note coverage of "laboratory and pathology services" and/or "diagnostic tests" but fail to provide a schedule or additional information regarding specific tests that are covered. It is unclear from the proposed rule if a state were to require plans to cover a particular test for a particular population whether that action would trigger defrayal.

The proposed rule suggests "State action" would trigger defrayal. It is unclear whether this term is intended to cover all types of state action including legislation, regulations, guidance, bulletins, and any other sub-regulatory action. We are concerned that some states could be deterred from taking any action – even issuing a bulletin – for fear of triggering defrayal.

18. Amending Exchange Network Adequacy Standards (§ 155.1050)

HHS proposes for plan years beginning on or after January 1, 2027, to restore network adequacy authority back to the State Exchanges and State-based Exchanges on the Federal Platform (SBE-FPs), thus removing the requirements that these exchanges must require plans to meet quantitative time and distance standards that are at least as stringent as the federal requirements. Instead, HHS proposes that plans would have to meet criteria for an Effective Provider Access Review Program for network and non-network plans.

ACS CAN is concerned about the impact of this policy on access to specialized services. 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. 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.[29]

While we believe state regulators should have certain flexibility to regulate their insurance markets, we are concerned that the proposal fails to provide adequate consumer protections. 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. We urge HHS not to finalize this policy.

E. Part 156-Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

6. Multi-Year Terms for Catastrophic Plans to Improve Health (§§ 156.130(c) and 156.155(a)(6))

HHS proposes to allow issuers of catastrophic coverage to be able to enroll individuals for multiple consecutive policy or plan year terms (up to 10 years). Issuers of multi-year catastrophic plans can choose to apply the annual cost-sharing limitation for each year or over the life of the contract (with the limitation being higher for some years and lower for others). HHS offers an example of an issuer being able to vary the annual limitation on cost sharing in the plan by disease if that disease requires treatments that span multiple years. HHS seeks comment on how federal policies could promote continuous coverage in multi-year plans.

[29] Unger JM. McAneny BL, Osarogiagbon RU. Cancer in rural America: Improving access to clinical trials and quality of oncologic care. CA: A Cancer Journal for Clinicians. 2025;75(4):341-361. doi:10.3322/caac.70006.

ACS CAN has a number of concerns with the proposal to allow for multi-year catastrophic plans.

Disease-specific plans: The proposed rule suggests that under this policy an issuer could offer a multi-year plan that would vary the annual limit on cost sharing by disease (using cancer as an example) if that disease requires treatment that spans multiple years as long as the annual limitation on cost sharing averages out over the course of the plan term. While we appreciate the Department's recognition that cancer patients often incur expenses over multiple years, we are concerned with this example.

As noted in the discussion on the proposed cost sharing for catastrophic plans below, we are gravely concerned that the significant deductible for these plans will present a barrier to care. The proposed rule states that an issuer could impose a higher annual limit in the early years, followed by a lower annual limit in the later years "to entice participants to remain in the plan for its duration."[30] Under this scenario, a cancer patient could face an annual limit of more than $15,600 in the first year of a multi-year plan. We fail to see how that solves the affordability issue for the enrollee.

Moreover, we are concerned that a disease-specific plan option violates the anti-discrimination provisions of the statute because it subjects cancer patients to higher out-of-pocket costs in the first year of the multi-year plan.

Multi-year plans would be confusing to consumers: We are very concerned that allowing the offering of multi-year plans will be confusing to consumers. All major lines of health insurance products (commercial insurance, employer-sponsored coverage, Medicare, etc.) offer consumers an annual election period in which they can reevaluate their plan options based on their current health care needs (even if the consumers do not always take advantage of the opportunity). We fear that consumers would be confused by a multi-year plan, particularly given that HHS is not proposing any standardization of plan offerings.

We are also concerned about the negative consequences the existence of multi-year plans will have on enrollees of calendar year plans. Absent clear and robust information specific to multi-year plans, it is foreseeable that consumers could assume that all Marketplace plans were offered on a multi-year basis and then neglect to reenroll in a Marketplace plan during the annual election period. Given the elimination of auto-enrollment for all Marketplace enrollees beginning in PY2028, this could have disastrous effects as the consumer would be unable to enroll in coverage for the remainder of the plan year.

Operational issues: We have a number of questions about such a product:

- Currently, individuals who meet certain conditions may qualify for a Special Enrollment Period (SEP) into any Marketplace plan. It is unclear how enrollment outside the initial enrollment period would work for a multi-year plan. Would an individual who enrolls outside the initial enrollment period be provided the same benefit design as someone who enrolled when the plan first began? For example, if there was an issuer who offered a 5-year plan that imposed a higher annual limitation on cost sharing in the initial years (with a lower annual cost sharing in later years), could someone enroll in the plan in its fourth year and qualify for the lower cost sharing? Would there be different enrollment rules depending on whether the individual is making a plan selection during the annual open enrollment period vs. a SEP? Failing to allow mid-plan year enrollment could violate the guaranteed issue requirements provided under the statute.
- Similarly, what happens if a person decides to disenroll from the multi-year plan before the end of the plan years? Would that individual be entitled to any refund of a prorated amount of the annual limitation on cost sharing they may have accrued in the initial years of the plan?

[30] 91 Fed. Reg. at 6371.

- Would the plan be permitted to make any changes to premium or benefit design over the course of the plan years? If premiums and plan designs are allowed to fluctuate year-to-year, it is not clear how the consumer benefits in this plan offering.
- How would these products be marketed? Would these products be permitted to be marketed in the same manner as other Marketplace products? If so, we are concerned that consumers shopping on premium alone may enroll in these products without understanding their limitations.
- Rules and regulations pertaining to the Marketplaces change on an annual basis. It is unclear how a multi-year arrangement could accommodate any future rulemaking and/or congressional action governing benefit design. This could pose significant harm to enrollees in that they would not have access to the latest medical advancements. For example, if multi-year plans were an option in PY2019 an individual could have been enrolled in a plan in 2020 that failed to cover the COVID-19 vaccine or any treatment thereof.

We caution that the concept of a multi-year plan is very much in its nascent stage. We do not believe the Department has provided sufficient information on which to allow stakeholders to sufficiently comment. We strongly recommend the Department not proceed with this policy.

7. Cost Sharing for Bronze and Catastrophic Plans (§§ 156.136 and 156.155)

HHS proposes to change the permissible cost-sharing parameters for bronze plans and to update cost-sharing requirements for catastrophic plans, beginning in PY 2027. HHS proposes that if an issuer offers at least one bronze plan in the individual market that complies with existing requirements, then it may also offer (within the same service area in the individual market), bronze plans that exceed the maximum annual limitation on cost sharing. HHS proposes that catastrophic plans not provide benefits for a plan year (except for three primary care visits and preventive services) until the enrollee has incurred 130% of the maximum annual limit on cost sharing, rounded down to the next lowest multiple of $50, which would amount to $15,600 for an individual ($31,200 for family coverage) in PY 2027.[31]

ACS CAN strongly opposes these proposals. While we appreciate HHS' interest in providing consumers with plan options that have a lower premium, we caution that the affordability of health insurance coverage should not be based on the amount of the premium alone. For cancer patients and survivors, a plan with a lower premium (and lower actuarial value) but a higher deductible may result in the enrollee paying more over the course of the plan year because lower actuarial value plans have higher cost sharing. In fact, in a survey of cancer patients, 70% of respondents preferred to have a plan with a low deductible.[32]

We are gravely concerned with the proposal to allow catastrophic plans that would provide very few services pre-deductible, particularly in light of the significant deductible of $15,600 for an individual/$31,200 for family coverage. This is unaffordable for the vast majority of people. The deductible alone represents a quarter of the

[31] The proposed rule notes the maximum annual limit on cost sharing for 2027 under this proposal would be $15,400 for an individual, based on the following formula: $12,000 (2027 maximum annual limit on cost sharing) times 130%. 91 Fed. Reg. at 6382. However, we believe that $15,400 is in error. Following the formula provided in the Federal Register notice yields a maximum annual limit on cost sharing of $15,600 ($12,000 X 1.3).

[32] American Cancer Society Cancer Action Network: Survivor Views on Open Enrollment. Jan. 2023. Available from https://www.fightcancer.org/policy-resources/survivor-views-open-enrollment.

median worker's annual salary in the U.S.[33]

An astronomical deductible would be a barrier to care for someone with cancer – or for someone who needs to be tested for cancer. Once a patient is suspected of having cancer, they undergo many tests that are not considered preventive services and therefore are subject to the deductible. 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.

Being required to pay for these high costs up-front can cause delays in treatment, especially for low-income patients. One study showed that high deductible health plan (HDHP) enrollment was associated with a decrease in imaging tests[34] – the tests a patient needs if they have a positive screening test for suspected cancer. Another study showed that switching to a HDHP was associated with a downward trend in overall colorectal cancer screening rates after 2 years.[35] A 2026 study showed that HDHPs were associated with worse overall survival and cancer-specific survival among people with a history of cancer.[36]

8. Standardized Plan Options (§§ 155.20. 155.205(b)(i), 155.220(c)(3)(i)(H), 156.201, and 156.265(b)(3)(iv))

HHS proposes, beginning in PY 2027, that qualified health plan (QHP) issuers in the individual market in Federally-facilitated Exchanges (FFEs) and State-based Exchanges on the Federal Platform (SBE-FPs) would no longer be required to offer standardized plan options. This proposal does not impact SBEs, but standard options for SBEs would no longer be differentially displayed on healthcare.gov.

ACS CAN opposes the decision to discontinue the standardized plan designs. We have historically supported the prior decision to offer such plans, because these policies helped to address the challenges of individuals who may be 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 allowed individuals shopping for coverage to focus on the aspects of their health insurance plan that matter most to them, such as plan provider networks, covered benefits, quality, and premiums.[37] Standardized plans also provide needed transparency to consumers so they can plan and budget for health care expenses. For 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

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[33] According to the Bureau of Labor Statistics, the median weekly earnings for full-time workers was $1,204 in 2025, which amounts to an annual salary of roughly $62,608. Bureau of Labor Statistics. Usual Weekly Earnings of Wage and Salary Workers – 2025. Press release. Jan, 28, 2026. Available from https://www.bls.gov/news.release/pdf/wkyeng.pdf.

[34] Zheng S, Ren ZI, Heineke J, Geissler KH. Reductions in diagnostic imaging with high deductible health plans. Medical Care. 2016 Feb;54(2):110-117. doi:10.1097/MLR. 0000000000000472.

[35] Wharam JF, Graves AJ, Landon BE, Zhang F, Soumerai SB, Ross-Degnan D. Two-year trends in colorectal cancer screening after switch to a high-deductible health plan. Med Care. 2011 Sep;49(9):865-71. doi: 10.1097/MLR.0b013e31821b35d8.

[36] Barnes JM, Gupta A, Ragavan M, Santos PM, Wallingford S, Chino F. High-Deductible Health Plans and Mortality Among Cancer Survivors. *JAMA Netw Open.* 2026;9(1):e2556451. doi:10.1001/jamanetworkopen.2025.56451.

[37] 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.

standardization can also encourage competition among plans and result in lower premiums.[38] ACS CAN is disappointed that HHS is proposing to not continue this requirement.

Before HHS proceeds with its decision to discontinue standardized plan options, it should conduct research to determine the extent to which the feature was successful in accomplishing its goals. The lack of standardized plans, combined with other policies contained elsewhere in this proposal, will make it harder for consumers to compare and shop for health plans during open enrollment 2027.

11. Essential Community Provider Standards for Network Plans (§ 156.235) and Implementation of the Effective Essential Community Provider Review Program (§ 155.1051)

HHS proposes to make a number of changes to the Essential Community Provider (ECP) requirements, including lowering the ECP threshold from 35 to 20 percent and to allow FFE states to conduct their own ECP certification reviews of QHP issuers' plans if the State chooses to do so.

ACS CAN is concerned this proposal will limit access to specialized cancer care. A stronger ECP in-network threshold is a critical step to improving access to care, especially given that ECPs serve as an entry point into the broader health care system and serve as an ongoing source of care for millions of families. We are particularly concerned about the ECP standards because cancer hospitals and children's hospitals (which are a primary provider of pediatric oncology services) are included within the ECP hospital category. We are concerned that by lowering the ECP standard from 35% to 20% enrollees will have a harder time accessing these vital oncology services. We have long advocated for HHS to make modifications to the ECP standards so that cancer patients can have better access to these specialized facilities.

12. QHP Certification of Non-Network Plans (§§ 155.1050, 155.1051, 156.230, 156.235, 156.236, 156.275, and 156.810)

HHS proposes to allow non-network plan offerings in Marketplaces. These plans would not contain a network of providers who agree to accept the plan's reimbursement for services as payment in full. Instead, non-network plans would determine what they pay for services. If a provider determines the plan's allowance to be insufficient, the enrollee bears financial responsibility for any remaining balance.

While we support patients having a robust choice of providers to meet their need, we are gravely concerned this proposal would harm consumers. In lieu of permitting non-network plans, we would encourage HHS to expand network adequacy standards to ensure enrollees have access to an adequate number of providers.

The proposed rule notes that non-network plans would have to ensure access to a range of providers that accept the plan's benefit amount as payment in full. However, we note that networked plans have to comply with network adequacy standards, including provisions that ensure that the plan network standards are met throughout the plan year – even as providers may move in and out of the network. We are concerned that even if a non-network plan were to ensure access to a panoply of providers at the beginning of the plan year, it is unclear the mechanism by which HHS or the states would ensure these standards are maintained throughout the plan year. Simply requiring that the non-network plans report a strategy for conducting "continuous" outreach to providers is insufficient oversight.

Health insurance issuers perform a number of important functions, many of which would not be provided in a non-network situation envisioned under the proposed rule. For example, health insurance issuers contract with clinicians and reimburse them for covered services. The proposed rule is silent on the issue, but absent

[38] Ben Hopkins and Sean Lyons. The effect of offering standardized "Simple Choice" plans on premiums in the Federally Facilitated ACA marketplaces. Congressional Budget Office. Feb. 2, 2026.

additional clarification, a non-network plan could require the enrollee to bear the responsibility for incurring the cost of reimbursement for clinician services up front and then have to submit reimbursement from the health plan. This would impose a tremendous burden on the enrollee – not only in terms of having to incur the upfront costs, but also having to manage the submission of the claim to the plan.

It is also unclear from the proposal whether non-network plans would be able to enforce plan benefit limitations such as medical necessity and whether the plan would be required to disclose if a service is covered by the plan. If an enrollee is permitted to seek the services of any clinician, how will the enrollee be made aware of whether the requested service is covered by the plan and/or whether the requested service is subject to any kind of utilization management requirement (such as prior authorization, step therapy, quantity limits, etc.)? In network plans, the clinician is able to connect with the plan to determine whether or not a service is covered (and even then according to a recent report of healthcare.gov claims, 16% of claims denials were due to the fact that the claim was for an excluded service[39]). In a non-network plan scenario, there is no contract between the plan and the clinician and no typical method of communication. Thus, the clinician is made no more aware than the enrollee as to whether a service is covered – and the clinician may have less incentive to assist the patient in this process. This could expose an enrollee to significant cost sharing as well as extreme burdens on their time.

The proposal notes that a non-network plan would still be required to meet the EHB requirements, which include prescription drug coverage and access to laboratory services. It is unclear how enrollees would maintain access to these services in a non-network plan. For example, if a plan is not required to maintain a pharmacy network, how would prescription drug cost sharing work? Would the plan have to provide enrollees with a detailed list of every covered drug and the corresponding cost sharing amount, leaving the enrollee to search for a pharmacy that would accept the plan's benefit in full? That would impose a significant burden on enrollees, particularly those who may take multiple medications, thus necessitating a visit to multiple pharmacies.

Similarly, it is unclear how an enrollee would access laboratory services in a non-network plan. For example, if an enrollee were to undergo a cancer biopsy, would the individual have to identify a laboratory that accepted the plan's benefit payment in full before the procedure? Presumably, in that case it would be incumbent upon the enrollee to not only identify an appropriate laboratory, but also coordinate with the physician performing the biopsy to ensure that the sample is sent to the appropriate laboratory. This imposes a significant burden on patients.

We also question the extent to which a non-network plan would be subject to the consumer protections provided under the No Surprises Act, which protects consumers against surprise billing in plans that maintain a network. Patients with cancer are particularly susceptible to surprise billing. An ACS CAN survey conducted before the implementation of the No Surprises Act found that 24% of respondents received a surprise bill, and of those 61% were for over $500 and 21% were for $3,000 or more.[40] If there is no network of providers, then absent additional statutory protections which heretofore do not exist, the consumer could be subject to significant out-of-pocket costs (which the No Suprises Act was meant to prevent).

We note that network plans are also subject to other important consumer protections such as appeal and exception rights, which allow enrollees to appeal for coverage of a non-network provider when an in-network

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[39] Justin Lo, Michelle Long, Rayna Wallace, Meghan Salago, and Kaye Pestaina. Claims denials and appeals in ACA Marketplace plans in 2023. Jan. 27, 2025. *KFF*. Available from https://www.kff.org/private-insurance/claims-denials-and-appeals-in-aca-marketplace-plans-in-2023/.

[40] American Cancer Society Cancer Action Network. Survivor Views: Surprise Billing and Prescription Cost and Coverage. Oct. 2019. Available from https://www.fightcancer.org/policy-resources/survivor-views-surprise-billing-and-prescription-cost-and-coverage-survey-findings.

provider is not available, and continuity of coverage provisions, which allow consumers with serious and complex conditions to continue seeing an in-network provider if the provider leaves the network or, in cases of new enrollees, when joining a new plan. These policies protect cancer patients who often need access to specialized providers, depending on the type of cancer they have and the stage of diagnosis. It is unclear whether a non-network plan would have to contain such vital patient protections.

We strongly urge HHS to not implement this policy until it can provide additional clarity on these proposals and address the extreme consequences to enrollees with a serious diagnosis such as cancer. Even then we note that consumers are used to health plans with networks and may be confused about their responsibilities under a non-network plan. Were HHS to proceed with a non-network plan option, we would strongly urge the Department to devote significant resources to develop materials to inform consumers about the limitations and logistics of these plans and the shifted administrative burden for patients.

CONCLUSION

Thank you for the opportunity to comment on the Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for plan year 2027. If you have any questions, please feel free to contact me or have your staff contact Anna Schwamlein Howard, Interim Managing Director, Public Policy at Anna.Howard@cancer.org.

Sincerely,

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President
American Cancer Society Cancer Action Network