Congress of the United States
Washington, DC 20515

March 11, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Administrator Oz:

We write to express our strong opposition to policies included in the proposed rule, "Patient Protection and Affordable Care Act (ACA), Benefit and Payment Parameters for 2027 and Basic Health Program."[1] As Ranking Members of the congressional committees with jurisdiction over health care, we have seen our constituents struggle with relentless attacks on their access to affordable health services. From new red tape to skyrocketing premiums and out-of-pocket costs due to Republicans' refusal to extend the ACA enhanced premium tax credits, this Administration has taken every possible step to raise costs on working Americans and make our health care system more complex. People purchasing coverage on their own—farmers, small business owners and their employees, and families across the country—are suffering from these draconian Republican policy decisions, and this proposed rule is just more of the same. ***We urge you to withdraw these proposals and instead work with Congress to enact policies that would bring costs down, cut red tape, and make high-quality care easier to access.***

If finalized, this rule would exacerbate coverage losses and cost increases for the more than 20 million Americans who rely on the ACA Marketplaces for coverage. By your agency's own estimates, the proposed rule would decrease enrollment by up to two million people in 2027, increase premiums for those who remain covered, and cause deductibles and out-of-pocket costs to skyrocket. Making matters worse, this rule would cost nearly $1.4 billion annually to implement, with those costs ultimately passed on to consumers. The rule would also undermine and, in some cases, illegally eliminate consumer protections enshrined in the statute. More specifically, if finalized, the proposed rule:

1. **Forces Americans to pay more for less**.[2,3] Instead of implementing policies to curb growing out-of-pocket costs and address rising medical debt, the proposed rule

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[1] Department of Health and Human Services, Center for Medicare and Medicaid Services, *Patient Protection and Affordable Care Act, Benefit and Payment Parameters for 2027 and Basic Health Program*, CMS-9883-P (Feb. 11, 2026) (proposed rule).

[2] Brookings, *In every corner of the country, the middle class struggles with affordability* (https://www.brookings.edu/articles/in-every-corner-of-the-country-the-middle-class-struggles-with-affordability/) (Dec. 2, 2025).

[3] Kaiser Family Foundation, *ACA Marketplace Premium Payments Would More than Double on Average Next Year if Enhanced Premium Tax Credits Expire* (https://www.kff.org/affordable-care-act/aca-marketplace-premium-

doubles down on Republicans' increases to ACA Marketplace out-of-pocket costs—raising the amount of cost-sharing many enrollees are subjected to and driving Americans into plans that will not provide coverage until enrollees have shelled out as much as tens of thousands of dollars, on top of their premiums.[4] Even worse, the rule contemplates *locking* consumers into catastrophic coverage for as long as *ten or more years*—regardless of how that person's health care needs may evolve over time—likely subjecting them to tens of thousands of dollars of additional medical costs. The rule even contemplates allowing insurers that offer these plans to circumvent pre-existing conditions protections by charging higher upfront costs to people with diseases like cancer.

2. **Threatens provider access and choice.** The ACA requires Marketplace plans to ensure sufficient choice of providers, which is vital to consumers receiving the care they need. The rule's proposal to establish "non-network" plans will leave patients without options, forcing them to navigate a maze of providers without a guarantee that their insurance will cover their costs. Further, it proposes to drastically cut the requirement that plans contract with a minimum percentage of available Essential Community Providers and directly attacks access to reproductive health services.

3. **Undermines high-quality coverage and doubles down on red tape.** The proposed rule undermines progress made over the past 15 years to promote coverage of essential health care services, including services like substance use disorder treatment and dental care. It also makes it harder for consumers to shop for coverage that meets their needs, eliminating standardized plans and allows for expanded "enhanced direct enrollment" operated by third-party web brokers to solicit customers without presenting them with the full scope of coverage options. The rule also heaps even more bureaucratic red tape on consumers just trying to enroll in coverage.

We provide details on specific policy concerns below.

1. **The rule forces Americans to pay more for less.**

Expands High-Cost Catastrophic Plan Eligibility

Under the ACA, enrollment in catastrophic plans is narrowly limited to individuals under 30 years old, those without an affordable offer of coverage, and those who qualify for a hardship exemption. The rule proposes codifying and expanding hardship exemptions the Trump Administration established in 2025 guidance, to include individuals in all states with incomes

payments-would-more-than-double-on-average-next-year-if-enhanced-premium-tax-credits-expire/) (Sept. 30, 2025).

[4] Peterson Center on Healthcare, *The burden of medical debt in the United States* (https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/) (Feb. 12, 2024).

below 100 percent and above 250 percent of the federal poverty level, regardless of age.[5,6] This would greatly expand the pool of consumers eligible to enroll in catastrophic plans—which were always meant to serve as a last resort in narrow circumstances, given the risk a consumer must absorb when purchasing one of these plans. This proposal will effectively steer patients into plans with deductibles that are so exorbitantly high they place needed health care services out of reach for most low- and middle-income Americans, and, for those who enroll in these plans, it will eliminate access to premium tax credits used to make coverage affordable.

Locks Consumers in Multi-Year Terms for Catastrophic Plans and Threatens Pre-existing Condition Protections

Making matters worse, the proposed rule proposes to allow issuers to offer catastrophic plans with terms of *up to 10 years*—effectively locking consumers into plans that open them up to thousands of dollars of medical debt.[7] The Centers for Medicare & Medicaid Services (CMS) suggests that it may consider even longer terms and application of this new standard to other plan tiers (such as bronze plans). It is disturbing that this Administration has used false claims of ACA fraud to terminate consumer-friendly practices like auto-reenrollment that make it easier for individuals to enroll in and maintain affordable, comprehensive coverage[8]—and yet is now proposing to allow auto-reenrollment in instances designed to lock individuals into the least generous health coverage with the highest out-of-pocket costs for a decade or more.

CMS also suggests that insurers offering multi-year plans could vary the maximum out-of-pocket cost by disease, threatening the very pre-existing condition protections that are the cornerstone of the ACA. This could mean that an individual who may, for example, initially require cancer treatment, could be exposed to *even higher* out-of-pocket costs than the annual limit (which would become a staggering $31,200 for a family, as described below), provided the insurer complied with the average maximum out-of-pocket cost requirement over the 10-year period. This is altogether unacceptable.

Increases Out-of-Pocket Spending for Bronze and Catastrophic Plans

The proposed rule allows certain bronze plans to increase cost-sharing imposed on consumers, while prohibiting catastrophic plans from covering *any* services beyond the statutory

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[5] Memorandum from Peter Nelson, CMS Deputy Administrator and Director, Center for Consumer Information & Insurance Oversight, re: Guidance on Hardship Exemptions for Individuals Ineligible for Advance Payment of the Premium Tax Credit or Cost-sharing Reductions Due to Income, and Streamlining Exemption Pathways to Coverage.

[6] Department of Health and Human Services, *2026 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii)* (accessed Feb. 27, 2026).

[7] In the preamble, CMS indicates that the agency "seek[s] comment on how Federal policies could promote continuous coverage in multi-year plans and defray the risk of termination by either the enrollee or issuer…".

[8] Health Affairs, *HHS Finalizes ACA Marketplace Rule, Part 1: Enrollment Restrictions, Premiums, Actuarial Value, And More* (https://www.healthaffairs.org/content/forefront/hhs-finalizes-aca-marketplace-rule-part-1-enrollment-restrictions-premiums-actuarial) (June 23, 2025).

three primary care visits and free preventive care until the consumer meets cost-sharing of 130 percent of the statutory maximum out-of-pocket limit. As a result, a family enrolled in catastrophic coverage will need to pay $31,200 (in addition to the family's premium costs) in plan year 2027 before receiving *any* coverage for most health care services. Many individuals enrolled in high-deductible health plans already find they can't manage the gap between what their insurance pays and what they themselves owe—a gap that should be narrowed, not expanded.[9]

Further, as CMS acknowledges in the proposed rule, section 1302(c) of the ACA directs all Qualified Health Plans (QHPs) to comply with specified cost-sharing limits. Yet, the proposed rule disregards these requirements. Asserting that health costs are rising at a higher rate than issuers can absorb without increasing the actuarial value of a plan (and thus the "tier" of such plan—catastrophic, bronze, silver, or gold), CMS in essence claims that, facing what is "mathematically impossible," it is choosing to prioritize the availability of plans with *less* generous health coverage and *higher* cost-sharing over the inverse. Increasing cost-sharing in catastrophic plans will only deepen the affordability challenges Americans are facing and force individuals and families to delay needed care—making them sicker and increasing financial instability and medical debt.

2. The rule threatens provider access and choice.

Establishes Plans without Provider Networks, Threatening Access to Care

The proposed rule allows plans with no provider network to participate in the ACA Marketplaces—despite the statute's clear references to "health insurance plan networks" and QHP requirements to "ensure a sufficient choice of providers."[10] These non-network plans will put the onus on consumers to understand what particular services their plan will pay for, know what medical services they will need and may receive in each medical encounter, and shop for services from providers to determine the best price for that suite of services. Even when a consumer is somehow able to do all of that, without any contract between the plan and provider, the certainty of the price patients are quoted upfront for the service is not guaranteed. While CMS proposes that plans would need to demonstrate that a "sufficient" number of providers accept the plan's benefit amount as payment in full, CMS does not propose specific thresholds for what would be "sufficient," nor does it provide any insight into how it will enforce such a requirement in the absence of provider-plan contracts. This means patients can receive surprise medical bills regardless of whether their so-called health plan submits a payment to a provider.

Illness is not a choice, and medical decisions are infrequently made under calm conditions where the consumer has full information about what care they will need and how much it will cost. Americans deserve access to clear, upfront information about what providers

[9] The Commonwealth Fund, *The State of U.S. Health Insurance in 2022* (https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey) (Sept. 29, 2022).

[10] Affordable Care Act § 1311(c)(1).

their insurer contracts with and how much they will owe—not a bait-and-switch promise that they can see any provider of their choice, only to be left with astronomical out-of-pocket costs.

Undermines Vital Network Adequacy Standards

Federal time and distance standards and appointment wait time standards ensure plans' provider networks are achieving their purpose—providing meaningful access to needed care for enrollees. The proposed rule significantly scales back these consumer protections in two ways. First, CMS wants to delegate network adequacy review to states that use the Federally Facilitated Marketplace (FFM) without any specification of time and distance or wait time standards—so long as the state has processes in place that meet CMS's conditions. Second, the proposed rule rescinds the requirement that State-Based Marketplaces maintain network adequacy standards at least as stringent as those applied via the FFM. These states could develop their own network adequacy standards without a federal comparability requirement.

Research demonstrates that without robust and enforced network adequacy standards, patients struggle to access needed health care.[11] This proposal would unwind progress to establish and strengthen minimum, national network adequacy standards—putting patients' access to care in further jeopardy.

Eliminates Standardized Plan Requirements that Make it Easier for Consumers to Shop for Plans, While Promoting Third-Party Web Brokers

Standardized plans allow individuals shopping for coverage to compare plans with consistent benefit designs across metal levels. The proposed rule ends the requirements that issuers offer standardized plans, ends limits on the number of non-standardized plan options, and rolls back standardized plan design requirements. CMS asserts that standardized plan requirements have not achieved their purpose of helping consumers understand their plan options, but the rule proposes no methods to improve the plan selection process. CMS argues that the benefits of standardized plans do not "warrant imposing additional burden on issuers," despite clear research that unstandardized options make it harder for consumers to find and select plans that best fit their needs.[12] Research continues to demonstrate that enrollees' welfare improves with standardization of plans—and that additional, not fewer, standards for plan design, marketing, and enrollment would improve consumer satisfaction and health care

[11] Robert Wood Johnson Foundation, *Access to Services in Medicaid and the Marketplaces* (https://www.rwjf.org/en/insights/our-research/2022/03/assessing-federal-and-state-network-adequacy-standards-for-medicaid-and-the-marketplace.html) (Mar. 1, 2022).

[12] Department of Health and Human Services, *Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces* (HP-2021-29) (Dec. 28, 2021).

affordability.[13,14] Further, the rule allows enhanced direct enrollment entities operated by third-party web brokers to solicit customers without presenting them with the full scope of coverage options—setting up a path for bad actors to obfuscate the true cost and harm of the policies this Administration has championed to promote less-robust and more costly coverage.

Winds Back Requirements that Plans Cover Essential Community Providers, Harming Patients in Rural and Underserved Areas

The ACA's Essential Community Provider requirements play a crucial role in ensuring that health care is accessible to low-income and medically underserved populations—promoting access to preventive health screenings, vaccines, counseling, and family planning services, among others. The rule proposes to slash the requirement that insurers contract with a minimum percentage of available Essential Community Providers—that is, providers such as safety net hospitals, substance use disorder treatment centers, and rural health clinics—from 35 percent to just 20 percent in each plan's service area. The rule also specifically proposes to reduce the percentage of contracted available federally qualified health centers and family planning providers that qualify as Essential Community Providers in the plan's service area from 35 percent to 20 percent, and it removes the requirement that insurers even justify how the plan's network provides an adequate level of service for low-income enrollees or people residing in Health Professional Shortage Areas.

These proposals are a direct attack on access to care for individuals living in rural and medically underserved areas—and on access to reproductive health care and family planning providers. Winding back these standards will make it easier for states and insurers to exclude trusted family planning providers, leaving patients without important access points into the health care system for essential, time-sensitive care.

3. The rule undermines high-quality coverage and doubles down on red tape.

Excludes State-Required Health Plan Benefits and Adult Dental Services from Essential Health Benefits

The ACA requires that individual and small group plans cover Essential Health Benefits that include at least 10 categories of care that are equal in scope to a typical employer plan. States may select an Essential Health Benefit "benchmark plan" for this purpose. States also may require insurers to cover benefits "in addition to" Essential Health Benefits but must cover the cost.

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[13] The Commonwealth Fund, *Lessons from the ACA: Simplifying Choices to Optimize Health Coverage* (https://www.commonwealthfund.org/publications/issue-briefs/2025/dec/lessons-aca-simplifying-choices-optimize-health-coverage) (Dec. 2, 2025).

[14] Keith M. Marzilli and Amanda Starc Ericson, *How Product Standardization Affects Choice: Evidence from the Massachusetts Health Insurance Exchange* (Dec. 2016).

The proposed rule upends this framework: Any state-required benefit enacted after December 31, 2011, will be considered "in addition to" Essential Health Benefits, and states will be required to pay for them—*even if* those benefits are included in the state's benchmark plan. Already facing tremendous budget pressures, states will either have to eliminate these benefit requirements or come up with new funding to cover them. Since 2020, at least 11 states and the District of Columbia have updated their benchmark plan, expanding coverage of items and services like hearing aids, opioid-related treatment, and applied behavioral analysis for the treatment of autism.[15] Many states have also established coverage requirements for infertility treatment that would now be at serious risk of dissolution—despite the Trump Administration's claims that coverage of infertility treatment is a priority.[16,17] Particularly at a time that states are facing more than a trillion dollars in health care cuts and budget shortfalls are widespread, this sudden cost-shift leaves the people who rely on these services vulnerable to additional cuts.[18]

Further, the proposed rule prohibits insurers from covering routine adult dental health services as an Essential Health Benefit. Oral health plays a critical role in overall health and quality of life.[19] Secretary of Health and Human Services Robert F. Kennedy, Jr. has even acknowledged this—yet, like so many of the Trump Administration's empty promises to "Make America Healthy Again," it is now proposing to roll back health insurance coverage of routine dental care.[20]

Doubles Down on Red Tape to Make it Harder for People to Get and Keep Their Coverage

As has become a theme with Republican health care policies during the Trump era, the proposed rule will bury families in red tape and make it more challenging and time-consuming to enroll in coverage by adding new unnecessary, and burdensome income verification requirements. By CMS's own estimation, requiring consumers to answer questions and submit documentation to verify that reported income is indeed under 100 percent of the federal poverty level would collectively waste 548,000 hours of consumers' time, 658,000 hours of federal and

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[15] Health Affairs, *HHS Proposes Sweeping Changes For 2027 Marketplace Plans (Part 2)* (https://www.healthaffairs.org/content/forefront/hhs-proposes-sweeping-changes-2027-marketplace-plans-part-2) (Feb. 13, 2026).

[16] Kaiser Family Foundation, *Mandated Coverage of Infertility Treatment* (https://www.kff.org/state-health-policy-data/state-indicator/infertility coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) (accessed Feb. 27, 2026).

[17] Kaiser Family Foundation, *Will Trump's Announcement Expand Access to IVF?*(https://www.kff.org/womens-health-policy/will-trumpsrewa-announcement-expand-access-to-ivf/) (Oct. 27, 2025).

[18] Pew Charitable Trusts, *Mounting Pressures Usher in a New Budget Era*(https://www.pew.org/en/research-and-analysis/articles/2026/01/12/mounting-pressures-usher-in-a-new-budget-era) (Jan. 12, 2026).

[19] Centers for Disease Control and Prevention, *Health and Economic Benefits of Oral Disease Interventions*(https://www.cdc.gov/nccdphp/priorities/oral-disease.html) (Oct. 21, 2024).

[20] House Committee on Appropriations, Budget Hearing - U.S. Department of Health and Human Services (119th Cong.) (May 14, 2025).

state staff time, and additional resources to update technical systems. That is, of course, for individuals who are able to navigate this process and for whom this administrative complexity does not simply lead to their loss of coverage. Similarly, requiring income verification rather than attestation of income for households for whom Internal Revenue Service (IRS) data are not available places undue burden on low-income households.

The rule also proposes to reintroduce and expand several policies that make it more difficult for consumers to access coverage via Special Enrollment Periods—that is, periods in which individuals can enroll in ACA Marketplace coverage outside of the annual Open Enrollment period, which the Trump Administration has already dramatically narrowed. The rule would continue the elimination of the Special Enrollment Period for people with incomes below 150 percent of the federal poverty level, expand cumbersome eligibility verification processes, and reestablish a mandate that the FFM conduct verifications for at least 75 percent of enrollees. By CMS's own admission, prior efforts to expand and require use of Special Enrollment Period eligibility verification was stayed by a federal district court in *City of Columbus v. Kennedy* (2025). This effort to work around the court's ruling does nothing to address the court's concerns.

Conclusion

Americans need and deserve access to affordable, reliable, and comprehensive health coverage. This rule does the opposite, forcing Americans to pay more for less, limiting provider access and choice, undermining high-quality coverage, and burying consumers in red tape. CMS must abandon these harmful policies intended to further dismantle the ACA by making insurance more expensive, harder to get, and harder to keep. Instead, we must focus on addressing the affordability crisis Americans are facing—including their inability to afford rising health care costs.

Sincerely,

Frank Pallone, Jr.
Ranking Member
House Committee on Energy and Commerce

Richard E. Neal
Ranking Member
House Committee on Ways and Means

Robert C. "Bobby" Scott
Ranking Member
House Committee on Education and Workforce

Ron Wyden
Ranking Member
Senate Committee on Finance