

CANCER LEADERSHIP COUNCIL

A PATIENT-CENTERED FORUM OF NATIONAL ADVOCACY ORGANIZATIONS
ADDRESSING PUBLIC POLICY ISSUES IN CANCER

March 13, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program, CMS-9883-P

Dear Dr. Oz:

The undersigned organizations represent people with cancer, cancer care health professionals, cancer researchers, and the families and caregivers of cancer patients. We appreciate the opportunity to comment on the proposed Notice of Benefit and Payment Parameters (NBPP) for 2027 and outline below our concerns about the potential adverse impact of the proposed standards for Affordable Care Act (ACA) plans on cancer patients' access to affordable and adequate health insurance.

In announcing the proposed rule, the Centers for Medicare & Medicaid Services (CMS) said that the proposal would expand consumer choice, ensure coverage that is more affordable, and promote innovative coverage. We are concerned, in contrast, that the expansion of catastrophic coverage, the certification of non-network health plans, changes in essential health benefits standards, and changes in eligibility verification requirements may adversely affect people with cancer.

Cancer patients need a marketplace of insurance plans that offers them meaningful health insurance coverage without exposing them to crippling financial burdens. They need insurance coverage that provides them access to quality cancer care. A cancer diagnosis is life-changing; lack of access to adequate and affordable care should not further shatter one's life after cancer diagnosis. We fear that key provisions of the NBPP will further block access to adequate health insurance and exacerbate the financial toxicity already facing people with cancer.

Catastrophic Coverage Expansion

The agency proposes to increase the maximum out-of-pocket limits for catastrophic plans by 30%. The proposed rule would also allow catastrophic plan issuers to enroll individuals for multiple plan years, up to ten years. Although the NBPP would implement a provision from the One Big Beautiful Bill Act (OBBBA) ending Affordable Care Act auto-enrollment, it would allow auto-enrollment in catastrophic plans for up to ten years.

The result of these changes would be that individual enrollees would have no benefits except three primary care visits and preventive care, until they have spent \$15,000 out-of-pocket. For families, the out-of-pocket spending limit would be \$27,000. These spending limits would be in place even as enrollees are paying monthly premiums.

The agency makes the case that the changes in catastrophic coverage will provide consumers cheaper coverage options. We think instead that these options will result in limited access to life-saving care for people with cancer and financial toxicity for cancer patients and their families. These plans move the marketplace in the direction opposite of the needs of cancer patients.

There may be young consumers who consider themselves healthy and even “invincible” at the time they are choosing coverage. These individuals may not have a cancer diagnosis at the time of plan choice, but some of them will be diagnosed during their plan year. If those young adults have chosen a catastrophic plan option, they will be left with serious financial burdens and poor coverage for their care.

A disturbing recent trend in cancer diagnosis and incidence has been the increase in the diagnosis of cancer – especially but not limited to colorectal cancer – in young adults. Catastrophic plans are not a promising option for many Americans, and certainly not for a term of ten years, but the adverse effects for young Americans diagnosed with cancer may be especially dire.

We urge CMS to reconsider its proposal related to catastrophic plans in its entirety.

Non-Network Health Plans

The proposed rule would certify as Qualified Health Plans (QHPs) those plans that do not use traditional provider networks. These plans would set fixed payment amounts, and plan enrollees could receive care from any provider who accepts the fixed amount as payment in full.

The agency suggests that this change in the standards for Qualified Health Plans would encourage consumers to search for lower prices. CMS suggests that the longer term benefit will be lower premiums.

We strongly object to this change in the standards for Qualified Health Plans. We already know that narrow networks can put cancer patients at risk, as narrow networks may deny them access to the specialists they need to provide them with multidisciplinary, coordinated cancer care and long-term survivorship care. Eliminating network standards is a recipe for disaster for people with cancer. We do not accept that encouraging people with cancer to shop smarter is a recipe for access to quality cancer care. People facing a life-threatening diagnosis should not have to comparison shop for their cancer care.

At the very least, non-network plan enrollment may cause enrollees delays in access to care. We are concerned the impact will in fact be much worse.

Essential Health Benefits

The agency proposes significant changes to essential health benefits standards for ACA plans. The proposed rule requires states to cover the costs of any benefits that are mandated by state law and that exceed federal requirements. We object to this change, as state coverage standards have been critically important to protecting access to quality cancer care. The proposed rule would discourage states from responding to the needs of people with cancer.

The proposed rule would also prohibit states from including adult dental care as an essential health benefit. We oppose this change, as dental care is an “essential” health benefit for many cancer patients. Dental care coverage is especially critical for head and neck cancer patients, but the coverage is important for all cancer patients.

Eligibility Verification Requirements

The proposed rule would “revive” eligibility verification requirements that have previously been blocked by court order.

We will not attempt to “relitigate” these requirements except to urge that CMS reconsider: 1) income verification requirements for those below 100% of the poverty level; 2) changes to special enrollment periods that would require pre-enrollment verification; and 3) limits on tax credits for those who fail to reconcile their taxes within one year. We have previously articulated the difficulties that people with cancer who are undergoing treatment face in meeting enrollment, income verification, and other requirements related to their insurance enrollment. We have also previously urged caution about Medicaid enrollment requirements,

and now we urge caution about ACA-related requirements imposed on people who are undergoing cancer treatment.

The cancer organizations below appreciate the opportunity to participate in the rulemaking process for setting ACA plan standards. We urge that several elements of the proposed rule be withdrawn because of their potential adverse effects on people with cancer.

Sincerely,

Cancer Leadership Council

Academy of Oncology Nurse & Patient Navigators
Association of Oncology Social Work
CancerCare
Cancer Nation
Cancer Support Community
Children's Cancer Cause
Fight Colorectal Cancer
International Myeloma Foundation
LUNgevity Foundation
Lymphoma Research Foundation
Ovarian Cancer Research Alliance
Susan G. Komen