Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

March 13, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Ave. SW
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 (Proposed Rule)

Dear Administrator Oz:

The Catholic Health Association of the United States (CHA) appreciates the opportunity to comment on the proposed rule titled "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program" (CMS-9883-P) (the "2027 Payment Notice").

CHA is the national leadership organization representing more than 660 hospitals and over 1,600 other sites of care, including long-term care facilities, clinics, and service providers across all fifty states and the District of Columbia. Collectively, CHA members represent the largest group of not-for-profit health care providers in the nation. CHA's vision for health care is rooted in the belief that all people have inherent dignity and worth, and that access to health is a fundamental necessity for living, finding, and family and flourishing.[1]

Marketplace coverage remains a critical source of coverage for many of the patients and communities our members serve. As such, we are concerned that some provisions of the regulation will narrow provider networks and increase patient and provider uncompensated care costs by increasing patient cost sharing.

In that spirit, CHA offers the following comments and recommendations to the proposed rule, with the goal of strengthening program integrity while ensuring access to quality, affordable health care coverage for all.

- **CMS should reconsider the effects of high-deductible plan (HDP) designs and increased cost-sharing limitations on patient access, financial security, and providers' ability to provide care.**

[1] Pope Leo XIII, *"Rerum Novarum – Encyclical Letter of Pope Leo XIII on the Conditions of Labor"* (1891), *44.* Available at https://www.vatican.va/content/leo-xiii/en/encyclicals/documents/hf_l-xiii_enc_15051891_rerum-novarum.html

CHA is concerned that several proposals in the 2027 Payment Notice may expand enrollment in high-deductible health plans (including catastrophic coverage). These changes will increase patients' out-of-pocket costs, shifting the cost of care to patients and providers.

CMS proposes to allow certain individuals aged 30 and older who 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. CMS also proposes increasing the indexing methodology for determining the maximum limitation on cost-sharing – which would result in a more than 13% year-over-year increase in the maximum out-of-pocket limit.

While the Catholic Health Association of the United States (CHA) supports policies that promote enrollment in health coverage, CHA is concerned that the proposed expansion of catastrophic coverage and related increases in permissible cost sharing limitations would not provide meaningful protection against catastrophic medical expenses. Under the proposed approach, a single enrollee in a catastrophic plan could be required to satisfy a $15,400 deductible before most benefits apply—an amount nearly equal to the federal poverty level for an individual ($15,960).

Coverage that exposes an individual to cost sharing of this magnitude—independent of, and in addition to, premium obligations—cannot reasonably be characterized as affordable, and the deductible itself may be financially catastrophic for many individuals within these income ranges. It is highly probable that many enrollees will be unable to meet these obligations, thereby increasing the risk of delayed or foregone medically-necessary care and the accumulation of medical debt. Moreover, hospital financial assistance programs are not designed to substitute for comprehensive, affordable coverage, particularly if these policies accelerate movement from more robust insurance products into plans with extreme cost exposure. Hospitals will continue to provide care to individuals in need; however, they do not have the capacity to universally absorb the resulting coverage gaps.

Across the United States, approximately 4 in 10 Americans have debt due to medical or dental bills.[2] In addition, 23% of Americans reported being underinsured, meaning they had coverage for a full year that didn't provide them with affordable access to health care.[3] The proposed regulation's expansion of HDP and catastrophic plans, and the removal of dental plans from essential health

[2] The Commonwealth Fund. (n.d.). *Survey: 79 million Americans have problems with medical bills or debt* [Newsletter article]. https://www.commonwealthfund.org/publications/newsletter-article/survey-79-million-americans-have-problems-medical-bills-or-deb

[3] Collins, S. R., & Gupta, A. (2024, November 21). *The state of health insurance coverage in the U.S.: Findings from the Commonwealth Fund 2024 Biennial Health Insurance Survey.* The Commonwealth Fund. https://www.commonwealthfund.org/publications/surveys/2024/nov/state-health-insurance-coverage-us-2024-biennial-survey

benefits, will put further financial pressure on patients through higher copays and deductibles. At a time when millions of Americans are already facing higher health insurance plans as a result of the expiration of the Advanced Premium Tax Credits (APTCs) and face further cuts to health care coverage under Medicaid as a result of policy changes in H.R. 1, the expansion of HDP will place increase pressure on health care plans and put more Americans at risk of future medical debt.

In the most recent year in which reporting is available, Catholic Health Association members contributed more than $14.6 billion in community benefits. This included more than $2.7 billion in financial assistance at cost, also known as "charity care," and more than $7.9 billion to cover the cost of unreimbursed Medicaid and other means-tested programs.[4] In addition, Catholic health care providers had more than $25 billion in bad debt, much of it attributable to individuals who were uninsured or underinsured with copays and deductibles that were unaffordable. Further expanding the use of HDP and catastrophic plans will place even greater pressure on health care providers, particularly those already serving a higher percentage of uninsured individuals.

When cost sharing rises, patients delay or forgo medically necessary care, which can worsen health outcomes and increase the likelihood of avoidable emergency department use and hospitalization. These pressures translate into higher levels of unpaid patient obligations and uncompensated care for hospitals—especially for providers serving low-income and rural communities.

CHA is especially concerned about policies that could increase cost-sharing for bronze and catastrophic plans, as well as proposals that would allow multi-year catastrophic plans. While CHA recognizes that having some insurance is better than being uninsured, policy changes that expand and incentivize take-up of plans that leave the patient underinsured risk harming patients, creating uncertainty in the actuarial values of plans to maintain coverage for all beneficiaries, and placing greater pressure on providers.

CHA urges CMS to maintain strong consumer protections that limit out-of-pocket exposure and to avoid policy changes that would expand underinsurance. CMS should require robust monitoring and transparent evaluation of the impacts on delayed care, medical debt, and hospital uncompensated care. In addition, any new catastrophic plan policies should be paired with clear consumer disclosures and practical opportunities for individuals to reassess and change coverage as their health needs and financial circumstances evolve**.**

- **Comment on Provider Access and Essential Community Provider Standards (NPRM Section II, QHP Certification and Access Standards)**

We urge CMS, in the final rule, to strengthen and preserve robust provider access and Essential Community Provider (ECP) standards and to avoid policies that could weaken network adequacy protections. While we recognize CMS's intent to provide flexibility in QHP certification, the

[4] CHA Community Benefit Fact Sheet: https://www.chausa.org/focus-areas/community-benefit/resources/resource/community-benefit-fact-sheet

proposed expansion of non-network QHP options—particularly when contingent on state approval—risks diminishing meaningful network participation by safety-net providers in certain markets. For Catholic hospitals and health systems, strong ECP standards are essential to ensuring continued access to care for low-income, medically underserved, and rural communities that already face significant barriers to obtaining services. CMS should therefore finalize clear, enforceable access standards that require meaningful inclusion of ECPs in plan networks, limit over-reliance on non-network designs, and ensure that issuer flexibility does not come at the expense of patient access or hospital sustainability. Maintaining strong ECP requirements is critical to preserving access points for vulnerable populations and supporting hospitals that carry significant community benefit and charity care responsibilities.

- **Concerns with Reduced Coverage and Enrollment Impacts (NPRM Section II, Regulatory Impact Analysis - "Reduced Coverage and Enrollment Impacts")**

We urge CMS, in the final rule, to revise or mitigate the policies described in the NPRM's Reduced Coverage and Enrollment Impacts analysis that CMS projects will result in a loss of 1.2 to 2 million individuals from ACA Marketplace coverage in 2027. CMS should not finalize measures to preserve coverage, particularly for low-income individuals and other populations at heightened risk of becoming uninsured. Marketplace coverage remains a critical source of health insurance for the patients and communities our members serve. Absent such modifications, people could lose access to needed health care. Our members will continue to serve patients but these enrollment losses will predictably increase uncompensated care, emergency department utilization, and financial pressure on hospitals serving as essential safety-net providers. Catholic hospitals and health systems, which shoulder substantial community benefit and charity care obligations, rely on stable coverage levels to maintain access points, workforce capacity, and essential services.

CHA appreciates the opportunity to submit these comments. We welcome continued engagement with CMS as it finalizes the 2027 Payment Notice to ensure that Marketplace policies protect consumers, strengthen program integrity, and preserve meaningful access to essential community providers and hospital services. If you have any questions about these comments or need more information, please do not hesitate to contact Kathy Curran, Senior Director Public Policy, at 202-721-6300.

Sincerely,

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Vice President, Advocacy and Public Policy
Catholic Health Association of the United States