C-TAC
COALITION TO TRANSFORM ADVANCED CARE

March 13, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4201-P
P.O. Box 8013
Baltimore, MD 21244

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

Submitted electronically via www.regulations.gov

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this proposed notice regarding its effect on those living with serious illness.

C-TAC is a national, non-partisan, not-for-profit coalition dedicated to ensuring that all those living with serious illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC comprises 200 national and regional organizations, including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving care for serious illness in the U.S.

C-TAC defines serious illness as a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their family caregivers. This definition has been widely adopted, including by the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF). Serious illness also differs by geography. People living in rural areas are older, sicker, and lack access to the full range of health care, and we advocate for improved care for any with less access to it.

Here are our comments on aspects of this proposed notice:

Essential Community Provider (ECP) Thresholds

We do not support the proposal to reduce the overall and family planning/federally-qualified health center (FQHC+ ECP thresholds from 35% to 20%). This change has significant implications for individuals living with serious illness and their caregivers, who disproportionately rely on safety-net providers such as FQHCs, Ryan White clinics, community mental health centers, and other ECPs for ongoing, coordinated care.

For people with advanced cancer, organ failure, progressive neurologic disease, and serious mental illness, access to these providers is not discretionary; it is foundational to maintaining function, managing symptoms, and preventing avoidable hospitalizations. Lowering the minimum ECP standard risks legitimizing narrower networks that omit precisely those providers most experienced in managing complex, multi-morbidity and serious illness needs. It also risks exacerbating disparities for low-income, rural, and racially minoritized populations, for whom ECPs are often the only realistic access point for integrated primary, behavioral health, and palliative-adjacent services.

We therefore recommend the following:

- Maintain the current 35 percent ECP thresholds, or at minimum create a higher, serious illness-sensitive floor for key provider types (e.g., FQHCs, Ryan White providers, community mental health centers, and facilities delivering specialty oncology, dialysis, and advanced cardiac care).
- Incorporate explicit serious illness and palliative care access considerations into network adequacy and ECP policies, including monitoring of travel time, wait times, and continuity of care for enrollees with complex conditions.
- If HHS finalizes any reduction in ECP thresholds, require state-based marketplaces and issuers to publicly report, by plan and rating area, ECP participation and access metrics stratified by serious illness relevant diagnoses and by race, ethnicity, and disability status, and to use this information in QHP certification.

<u>Certification of Non-network Qualified Health Plans (QHPs)</u>

We do not support the proposal to allow non-network plans to be certified as QHPs as long as they demonstrate "sufficient choice" of providers who accept a fixed benefit amount as payment in full. This is concerning for people with serious illness and their caregivers for whom health care needs are inherently unpredictable: a new diagnosis, a sudden exacerbation, or a rapidly evolving treatment plan can require access to specific tertiary or quaternary centers, subspecialists, and hospital-based palliative care teams that may not be among the providers willing to accept the plan's fixed payment.

While non-network QHPs may appear attractive from a premium standpoint, the combination of fixed indemnity-like payments and the absence of a robust, regulated network creates substantial financial and clinical risk for enrollees with serious illness. If the fixed benefit amounts are materially below typical charges for chemotherapy, radiation oncology, complex surgery, or ICU-level care, seriously ill patients could face insurmountable out-of-pocket liabilities or be effectively steered away from high-quality, high-acuity care. In addition, people with serious illness often experience cognitive burden, emotional distress, and caregiver overload, which make them especially vulnerable to confusing plan designs and aggressive marketing.

We recommend the following:

- Prohibit or sharply limit the availability of non-network QHPs in metal levels commonly used by high-need enrollees (e.g., silver and gold) or at least restrict them to circumstances where robust consumer safeguards are in place.
- Establish stringent adequacy standards and monitoring requirements tailored to serious illness care, including demonstrated access to comprehensive oncology services, advanced cardiac and pulmonary care, dialysis, transplant centers where applicable, and interdisciplinary palliative care.
- Require transparent, standardized, consumer-tested disclosures—at the time of plan display and selection—clearly explaining that the plan does not use a traditional network and that coverage is based on fixed payment amounts that may not match actual charges, using concrete serious-illness examples (e.g., a typical chemotherapy regimen, a hospitalization for sepsis).
- Require issuers offering non-network QHPs to provide proactive care coordination assistance to enrollees with identified serious illness or high-risk conditions, including help identifying providers who accept the fixed payment as payment in full and ensuring continuity of care when the patient's condition escalates.
- Collect and publicly report outcomes for non-network QHP enrollees, including rates of delayed or forgone care, catastrophic out-of-pocket spending, and emergency and inpatient utilization among people with serious illness.

<u>Enrollment and Verification Rules (SEP Verification, Income and Reconciliation Policies)</u>
We do not support the proposed expansion of pre-enrollment special enrollment period (SEP) verification and income documentation requirements, as well as the implementation of a one-year "failure to file and reconcile" lockout. They will destabilize coverage for individuals living with serious illness and their families.

These individuals often experience abrupt life changes—loss of employment, changes in family structure, relocation to be near caregivers or treatment centers—that necessitate timely SEPs. At the same time, serious illness can impair a person's ability to promptly gather documentation, navigate complex verification processes, or maintain consistent tax filing and reconciliation, especially when they are coping with intensive treatments, cognitive impairment, or caregiver burnout. For many, the caregiver managing paperwork is also juggling employment, caregiving for children, and their own health needs.

Layering more intensive verification requirements onto SEPs and income attestations and tying future APTC eligibility to prior-year filing and reconciliation, risks coverage gaps not because individuals are ineligible, but because they cannot meet documentation and administrative demands during periods of extreme vulnerability. For people whose health depends on continuous access to chemotherapy, biologics, transplant immunosuppression, or advanced symptom management, even short gaps in coverage can be life-threatening and can lead to far higher downstream costs.

We therefore recommend:

- Establishing explicit, streamlined exceptions or "good cause" processes for individuals with serious illness, disability, or caregiving responsibilities for a seriously ill household member, including the ability to attest to hardship and obtain temporary or conditional coverage while documentation is assembled.
- Requiring Exchanges to incorporate clinical vulnerability flags (e.g., based on diagnosis or utilization) into their casework systems so that enrollees with serious illness are prioritized for outreach and assistance when facing SEP verification or reconciliation-related terminations.
- Allowing flexibility in the "failure to file and reconcile" policy for households experiencing serious illness, including the ability to restore APTC prospectively once filing is completed without imposing an additional year-long lockout.
- Tracking and publicly reporting the impact of expanded verification and reconciliation policies on coverage continuity for high-risk groups, including people with cancer, advanced organ disease, severe mental illness, and serious pediatric conditions, with results used to inform future policy refinements.
- Investing in navigator and assister capacity specifically trained to support people with serious illness and their caregivers through complex documentation processes.

Catastrophic Coverage Provisions

We have serious concerns about the catastrophic coverage provisions. For those living with serious illness, marketplace coverage design is often a matter not only of affordability, but of safety, stability, and access to essential, time-sensitive care. While we appreciate the intent to expand access to coverage and protect consumers from going uninsured, we fear that the proposed catastrophic coverage changes, if finalized without additional safeguards, will channel some seriously ill people into structurally under-protective high-deductible plans and destabilize metal-tier risk pools on which many high-need patients rely.

We therefore recommend that the agency:

- Frame expanded catastrophic access explicitly as a safety-net against total uninsurance, not as a preferred coverage option for people with serious illness.
- Enhance decision support, disclosures, and marketing safeguards to reduce inadvertent or discriminatory steering of high-need individuals into catastrophic plans.
- Build specific protections into multi-year catastrophic contracts, including an event-triggered right to move to metal-tier coverage and stronger pre-enrollment counselling for high-risk applicants.
- Monitor and transparently report on the impact of catastrophic expansion on metal-tier risk pools, premiums, and serious-illness populations, with a clear commitment to iterative policy adjustment if harm emerges.

Thank you for the opportunity to comment on this proposed notice. If you have any questions,

please contact me, Dr. Marian Grant, Senior Regulatory Advisor, C-TAC, at mgrant@thectac.org.

Sincerely,

Marian Grant

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