FEDERAL AIDS POLICY PARTNERSHIP
HIV HEALTH CARE ACCESS WORK GROUP

March 13, 2026

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

Re: *HIV Health Care Access and the HHS Proposed Notice of Benefit and Payment Parameters for 2027*

Dear Administrator Oz:

The HIV Health Care Access Working Group (HHCAWG) works to advance policies that ensure the millions of people living with HIV and hepatitis have broad access to comprehensive care and treatment. The Affordable Care Act (ACA) has played a pivotal role in expanding coverage and guaranteeing critical care for people living with serious, chronic conditions. We appreciate the opportunity to offer comments on Health and Human Services' (HHS) proposed 2027 Notice of Benefit and Payment Parameters (2027 NBPP) but must note that a 30-day comment period is insufficient for a rule that registers over 500 pages in length.

We are concerned that many of the provisions in the 2027 NBPP move away from strengthening the ACA - increasing affordability, expanding access, and improving quality - to weakening healthcare options for vulnerable Americans – raising costs, lowering quality standards, and opening opportunities for fraud. Below we outline the policies that we believe will diminish quality health insurance and reduce coverage.

Catastrophic Plans §§155.605(d)(1), 156.155, 156.130(c)
Expanding access to catastrophic plans will not only threaten the balance of the marketplace risk pool but will also expose enrollees to serious financial harm. Catastrophic plans were meant as a stopgap, short-term coverage option for young adults to protect against major medical expenses. Opening eligibility to anyone will pull more healthy people out of the marketplace, leaving sicker, more expensive, high-healthcare users in the risk pool which will undoubtedly cause costs to skyrocket. While the low premiums can seem appealing, the tradeoff for bare-minimum coverage, extremely high deductibles, and high cost-sharing make the reality of accessing health care with a catastrophic plan as unaffordable as other coverage with high premiums.

The proposal also goes against statute and would allow issuers to establish a max out-of-pocket for catastrophic plans exceeding the allowable limits. In addition to this being legally questionable, it does little to adhere to the original purpose of catastrophic plans - to protect against major medical expenses. In a survey of non-elderly, single-person households, 45% do not have more than $2,000 in accessible cash, savings, or quick-sell assets, and 62% do not have more than $4,000; it is unreasonable that most Americans would be able to pay for any routine or emergency health care services with a maximum out-

of-pocket limit over $15,000, setting them up for medical debt.[1] Furthermore, the 2027 NBPP proposes an underdeveloped idea to allow issuers to sell multi-year, catastrophic plans with flexibility to design cost-sharing and out-of-pocket costs that will trap people in unaffordable contracts for up to 10 years. Health is not static; and while someone may choose to buy a catastrophic plan to help them get through a period when they would otherwise not be able to purchase insurance, there is no guarantee that they won't experience a health concern or be diagnosed with HIV later and be stuck without appropriate coverage.

The proposal raises many operational and policy questions; first and foremost, is this legal? The proposal does not detail how premiums would work over the course of the life of the multi-year plan term; will the benefit design and coverage remain the same over for the duration of the plan term; how will an enrollee be impacted if diagnosed with a serious, chronic condition a few years into the 10 year contract; will the enrollee be penalized if they disenroll before the end of the plan term; what happens if insurer leaves the market before the end of the plan term?

One thing is clear about the convergence of these proposals related to catastrophic plans: no one will be able to afford insurance – if more people pull out of the traditional marketplace to buy catastrophic plans, costs will rise for marketplace enrollees; and those who move to catastrophic plans will be hamstrung by the outrageous out-of-pocket costs. If a person with HIV or other chronic condition unknowingly enrolls in a catastrophic plan, they could be blindsided by the limited coverage for high-cost treatments, which could lead to foregoing necessary medical care and ultimately deteriorating health.

We do not support expanding eligibility for catastrophic plans, allowing max out-of-pocket limits to exceed the statutory amounts, nor the option to sell these "better-than-nothing" plans as multi-year products.

Network Adequacy and Essential Community Providers §§156.230, 155.1051

In the past, HHS has taken steps to improve network adequacy standards on the foundation established in law to ensure individuals have reasonable access to necessary care through a sufficient network of providers and specialists. The uniform quantitative requirements are not an imposition of "one-size-fits-all" policy, but rather a minimum threshold that makes certain enrollees are purchasing a product with sufficient coverage. Shifting the responsibility to FFE states to perform network adequacy reviews and eliminating time and distance standards for SBEs could lead to decreased access to essential care.

As is, specialized providers qualified to treat people living with HIV and hepatitis are becoming harder to find. Time and distance standards have helped to protect people with HIV and those newly diagnosed and in need of quick connection to care, to maintain continuous treatment. Disruptions to adherence can have severe consequences including drug resistance, advanced disease progression, worsened health outcomes, and higher-cost emergency interventions.

Additionally, guaranteed inclusion of a robust network of essential community providers (ECPs) like Ryan White HIV/AIDS Program clinics and Federally Qualified Health Centers (FQHCs) help fill a gap to ensure access to quality healthcare for under-served and low-income individuals. Removing the minimum time and distance thresholds and lowering the required contracts with ECPs will all but guarantee many enrollees will be travelling for hours across their state to a trained provider who is out-of-network and

[1] Peterson-KFF Health System Tracker, How many people have enough money to afford private insurance cost sharing? March 10, 2022, https://www.healthsystemtracker.org/brief/many-households-do-not-have-enough-money-to-pay-cost-sharing-in-typical-private-health-plans/.

left with high out-of-pocket expenses. We encourage HHS to maintain the network adequacy and ECP standards that have been put in place to protect patient access.

Non-Network Plans §155.1050

Patients also run the risk of unmanageable and unreasonable medical expenses under the proposed provision to allow the sale of non-network plans. The proposal optimistically anticipates consumers will be discerning shoppers and able to negotiate payments directly with providers. A 2024 poll showed that the majority (72%) of adults are not confident in navigating their traditional health plan.[2] Non-network plans place the burden of navigating the even more unfamiliar and complex system of providers and healthcare payments on enrollees without access to the tools or information needed to assess cost and quality that insurers have at their disposal. A primary value of health insurance is the purchasing power that insurers have to negotiate discounted rates on behalf of their large enrollee base; an inexperienced individual could easily be unknowingly overcharged. These plans will also leave enrollees without the typical patient protections guaranteed in a network plan when faced with a balance bill.

While the flexibility to see a provider of choice may be a perk, having to take on the role of care coordinator and chief negotiator for every single service will quickly drive patients into exhaustion and opt to forego care. It also remains unclear how prescription drugs will be handled in non-network plans; for people with HIV and others with chronic conditions, having clear policies for prescription drugs is a must. We encourage HHS not to finalize the proposal which would permit insurers to offer non-network plans.

Standardized Plans §155.20

One tool that has helped many people navigate the multitude of plan options is standardized plan design. The design and display of these standardized plan options (SPOs) offer uniform cost-sharing, making it easier for consumers to compare and select a plan that will fit their healthcare needs. One-third of all FFE enrollments in 2025 were in SPOs and in some states, enrollment was as high as two-thirds.[3] Option overload is a well-documented phenomenon among marketplace users which can ultimately lead to poorer decision making; more options in this case aren't necessarily better. Narrowing the choices and creating a simplified way to compare "apples to apples" has helped consumers determine the right product.

These plans can also help consumers when budgeting for their healthcare needs with required copayments for services, rather than coinsurance which can be hard to estimate final costs. The standardized plan design is also a means to prevent insurers from engaging in discriminatory plan design.[4] In the past, insurers have intentionally discriminated against people with HIV by developing formularies with adverse tiering – with all drugs used to treat HIV on the highest cost-sharing tier, including generics.[5] Standardized plan design can make it easier to identify and thus discourage insurers from these harmful practices. We strongly support standardized plan options and would encourage HHS

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[2] Patient Advocate Foundation, Most insured adults lack confidence in navigating their healthcare plans new polling data finds, November 20, 2024, https://www.panfoundation.org/most-insured-adults-lack-confidence-in-navigating-their-healthcare-plans-new-polling-data-finds/.

[3] CMS, 2025 Marketplace Open Enrollment Period Public Use Files, Plan Design Public Use File, https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files.

[4] ASPE, Issue Brief, Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces, December 28, 2021, https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf.

[5] National Health Law Program, NHeLP and The AIDS Institute Complaint to HHS re. HIV/AIDS Discrimination in Florida, May 2014, https://healthlaw.org/resource/nhelp-and-the-aids-institute-complaint-to-hhs-re-hiv-aids-discrimination-by-fl/.

to maintain this beneficial plan design and limit the number of non-standardized plans as is current policy.

Essential Health Benefits §155.170

The proposal to change course on current essential health benefits (EHB) policy and defrayal of state mandated benefits undermines states' ability to select a benchmark plan and design the EHB package that reflects their healthcare priorities. The 2027 NBPP would force states to retract benefits that have been determined by state regulators and officials to be critical, or defray the cost of those benefits, even if the state's EHB benchmark plan approved by CMS includes those benefits.

In alignment with 2019 and 2025 HHS rulemaking which granted more flexibility, states have invested significant resources including undertaking actuarial analyses, to update their benchmark plans as service gaps have been identified and best practices have advanced.[6] Not only will states be burdened by the financial implications of this policy at a time when budgets are already stretched thin, it will also put consumers at risk when faced with services and treatments no longer considered EHB and therefore any cost-sharing payments will not count towards their out-of-pocket costs. Thwarting patient financial protections, limiting benefits, and subverting state decision making are not solutions to offset costs of EHB for unsubsidized enrollees, who make up only 7% of all marketplace enrollment.[7]

Furthermore, reverting to an outdated interpretation of the statute at §156.155(d) to prohibit adult dental services as EHB is counterintuitive if HHS is looking to promote cost-effective policies; limiting access to preventive oral care for adults will only increase costs as people seek out more expensive, emergency services. The inclusion of child dental as an essential health benefit demonstrates that there is no distinction between oral and other medical health; the need for routine dental care does not diminish with age. For people with HIV, dental health is imperative as a weakened immune system may increase vulnerability to oral infections, gum disease, and other systemic infections.[8] We discourage HHS from moving forward with these proposed changes to EHB.

Quality Improvement Strategy §156.1130

HHCAWG urges the Department not to finalize the proposal that would change current quality improvement strategy (QIS) requirements to no longer require QHPs to include activities to reduce health and health care disparities in their QIS. Instead, the Department proposes to allow QHPs to focus their QIS on any of the five topic areas outlined in ACA § 1311(g)(1) (42 U.S.C. § 18031(g)(1)).

The proposed rule undermines efforts to end the U.S. HIV epidemic by allowing QHPs to opt out of quality improvement activities aimed at reducing health disparities. HIV disproportionately burdens populations including racial and ethnic minorities, LGBTQ+ people, and communities in the South,[9] and

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[6] Stacey Pogue, Vrudhi Raimugia, Justin Giovannelli, Kevin Lucia, Commonwealth Fund, Enhancing Essential Health Benefits: How States are Updating Benchmark Plans to Improve Coverage, November 14, 2024, https://www.commonwealthfund.org/publications/issue-briefs/2024/nov/enhancing-essential-health-benefits-states-updating-benchmark-plans.

[7] Emma Wager, KFF, Quick Takes: Timely Insights and Analysis from KFF Staff, More Than 3 in 4 ACA Marketplace Enrollees Live in States Won by President Trump, October 3, 2025, https://www.kff.org/quick-take/more-than-3-in-4-aca-marketplace-enrollees-live-in-states-won-by-president-trump-in-2024/.

[8] NIH, National Institute of Dental and Craniofacial Research, HIV/AIDS & Oral Health, https://www.nidcr.nih.gov/health-info/hiv-aids.

[9] HIV.gov, *U.S. Statistics*, https://perma.cc/GW2T-Q5ML.

efforts to end the epidemic must acknowledge and respond to this reality.[10] Similar disparities are also reflected across a wide array of other communicable and noncommunicable health conditions.[11] In the face of these documented disparities, HHS should fully leverage the policy tools explicitly provided for under the ACA, including QIS, to ensure that QHPs are engaged in efforts to reduce health disparities for the populations most impacted by the HIV epidemic and other related conditions. We therefore urge you not to finalize the proposal that would allow QHPs to omit efforts to reduce health disparities from QIS. We urge you to retain the requirement that QHPs submit a QIS that includes a health disparities metric.

Nondiscrimination §155.220(j)(2)(i)

The proposed NBPP for 2027 seeks to remove language from § 155.220(j)(2)(i) that would require agents, brokers, and web-brokers not to discriminate on the basis of sex characteristics, including intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes.[12] HHS notes that because the Department only acknowledges a binary, immutable understanding of sex, in line with Executive Order 14168, it does not need to address discrimination on these bases in this regulation.[13] We oppose this proposed change as it is poorly reasoned and unlawful and will hinder efforts to end the HIV epidemic. The Department's reasoning ignores applicable law – Section 1557 of the Affordable Care Act (which applies to a large array of discriminatory actions[14]) – in favor of an executive order that targets and is based in animus against transgender and gender diverse people.

Furthermore, the proposed removal of language serves as a signal that discrimination based on sex characteristics is permissible under this Administration.[15] Discrimination in this area of our health care system is particularly harmful to people living with or vulnerable to HIV. A person's ability to access health care services is largely determined by their health care coverage status. While many people obtain health care coverage through a private employer or a government-sponsored health care program, those who seek to buy health insurance as an individual or as a small business employee often must look to health insurance marketplaces.[16] and marketplace coverage is more common among

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[10] *See* HIV.gov, *Ending the HIV Epidemic: Key EHE Strategies*, https://perma.cc/M3R9-KPQV (acknowledging the need to "increase awareness of, access to, and use of PrEP" among populations disproportionately impacted by HIV, such as Black and Latine gay and bisexual men and Black women).

[11] See, e.g., Wendy L Macias-Konstantopoulos et al., *Race, Healthcare, and Health Disparities: A Critical Review and Recommendations for Advancing Health Equity*, West J Emerg Med. (Sep. 2023) https://perma.cc/P7ST-PBZQ (summarizing racial health disparities data across conditions); U.S. Dep't of Health and Human Servs., Office of Disease Prevention and Health Promotion, *Health People 2030: LGBT*, https://perma.cc/6J6M-BWUB (making recommendations to improve LGBT health across conditions); Jay Maddock, *5 Charts Show Why The South Is The Least Healthy Region In The US*, The Conversation (Feb. 5, 2018), https://perma.cc/XUU6-HPY7.

[12] United States, Department of Health and Human Services, "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program" 91 Fed. Reg. 6292, 6338-9 (Feb. 11, 2026) https://www.federalregister.gov/d/2026-02769/p-425.

[13] *Id*.

[14] Section 1557 nondiscrimination standards apply to "[e]very health program or activity, any part of which receives Federal financial assistance, directly or indirectly, from the Department" 45 C.F.R. § 92.2. Health activity includes "[providing] assistance to persons in obtaining health-related services, health insurance coverage, or other health-related coverage". 45 C.F.R. § 92.4.

[15] Indeed, even reasoning this change in Executive Order 14168 acknowledges this, as the Executive Order directs agencies to "enforce laws governing sex-based rights[] [and] protections . . . to protect men and women as biologically distinct sexes". E.O. 14168, 90 Fed. Reg. 8615, 8616 (Jan. 30, 2025).

[16] During the 2025 Open Enrollment period, over 17 million people were enrolled in health insurance coverage through HealthCare.gov, including 2.8 million new consumers. *Health Insurance Exchanges 2025 Open Enrollment Report* https://www.cms.gov/files/document/health-insurance-exchanges-2025-open-enrollment-report.pdf.

people with HIV.[17] Agents, brokers, and web-brokers are likely to be among the first interactions a person has in search of a plan. They provide important information educating consumers about the marketplace and determining what financial assistance may be available, with the goal of helping consumers find the health care plan that best suits them.[18] These interactions require trust such that people from all backgrounds and identities feel safe sharing their personal information and health needs. Allowing discrimination on the basis of intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes at the very door of a health insurance marketplace would undermine the purpose of the Marketplace.[19]

Allowing discrimination to serve as a barrier at this stage of purchasing health insurance is also problematic for communities who *already* face disparities in health coverage and outcomes, including HIV outcomes.[20] Studies have shown that LGBTQI+ people often have higher rates of chronic health conditions and encounter barriers to care exacerbated by stigma and discrimination.[21] Getting to health care itself can be a challenge, both due to higher uninsured rates and higher rates of difficulty paying for health care.[22] The Marketplace is designed to help eliminate these barriers to care and ought to do so,

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[17] Lindsey Dawson, *How Might Expiring Premium Tax Credit Impact People with HIV?* (Oct. 7, 2025), https://www.kff.org/hiv-aids/how-might-expiring-premium-tax-credits-impact-people-with-hiv/.

[18] In-Person Assistance in the Health Insurance Marketplace "agents and brokers play an important role in educating consumers about Marketplaces and insurance affordability programs, and helping consumers receive eligibility determinations, apply for premium tax credits and cost-sharing reductions, compare plans, and enroll in coverage." https://www.cms.gov/marketplace/in-person-assisters/programs-procedures/in-person-assistance.

[19] Health insurance Marketplaces are supposed to "facilitate[] the purchase of qualified health plans". Patient Protection and Affordable Care Act, Sec. 1311(b)(1)(A).

[20] For example, HIV disproportionately impacts transgender and gender diverse people. Discouraging transgender and gender diverse people from enrolling in health care coverage will exacerbate existing barriers to HIV treatment and prevention. *See* HHCAWG Comments re: CMS-2451-P (footnotes included) (Feb. 17, 2026) https://chlpi.org/wp-content/uploads/2026/02/HHCAWGComment_NPRMMedicaidCHIP.pdf.

[21] *See, e.g.*, Kellan Baker & Jeff Krehely, How Health Care Reform Will Help LGBT Elders, 21 PUBLIC POLICY & AGING REPORT 19 (2011); Walter O. Bockting, et al., Stigma, Mental Health, and Resilience in an Online Sample of the US Transgender Population, 103 Am. J. Pub. Health 943, 943 (2013); Cecilia Chung, et al., Wellness for Our Communities (2019), https://transgenderlawcenter.org/wp-content/uploads/2019/11/17608_TLC_Positively_Trans_Needs_CrossSite_Report_Web.pdf; Andrew Cray, et al., Center for American Progress, *Seeking Shelter: The Experiences and Unmet Needs of LGBT Homeless Youth* (2013), https://www.americanprogress.org/article/seeking-shelter-the-experiences-and-unmet-needs-of-lgbt-homeless-youth/; Jody L. Herman, et al., *Suicide Thoughts and Attempts Among Transgender Adults: Findings from the 2015 U.S. Transgender Survey* 12 (2019), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Suicidality-Transgender-Sep-2019.pdf ("Respondents who reported having a disability, either by meeting the definition of disability according to the American Community Survey or by personally identifying as having a disability, had higher prevalence on all suicide-related measures than those without disabilities."); Ilan H. Meyer, Why Lesbian, Gay, Bisexual, and Transgender Public Health?, 91 AM. J. PUB. HEALTH 856, 856-57 (2001); Office of Disease Prevention and Health Promotion, *Lesbian, Gay, Bisexual, and Transgender Health* ("Lesbian, gay, bisexual, and transgender (LGBT) people are more likely to experience certain health-related challenges and disparities.")(also listing "Reduce the number of new HIV infections" as a related objective), https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/lgbt; Caleb Smith, CAP, *The Intersex Community Faced Significant Barriers and Challenges in 2024* (June 25, 2025), "The intersex community also avoided getting both preventive and needed care in order to avoid experiencing discrimination." https://www.americanprogress.org/article/the-intersex-community-faced-significant-barriers-and-challenges-in-2024/; Office of the Assistant Secretary for Health, *Advancing Health Equity for Intersex Individuals* (Jan. 2025), https://interactadvocates.org/wp-content/uploads/2025/01/intersex-health-equity-report.pdf.

[22] "Over one-third (36%) of LGBT adults say they or a family member living with them has had problems paying for health care, compared to one in five (21%) non-LGBT adults." Lindsay Dawson & Lunna Lopes, *Health Care Access and Financial Barriers Among LGBT People Amidst Looming Health Care Cuts* (July 17, 2025), https://www.kff.org/health-costs/health-care-access-and-financial-barriers-among-lgbt-people-amidst-looming-health-care-cuts/ "Cost is a high barrier to care, with 60 percent of intersex individuals postponing accessing medical care due to cost in the year prior to the survey, compared with 15 percent of nonintersex people." Caleb Smith, *The Intersex Community Faced Significant Barriers and Challenges in 2024* (June 25, 2025), https://www.americanprogress.org/article/the-intersex-community-faced-significant-

not only by ensuring the plans it sells are affordable and of high quality, but also by making sure that the very people responsible for helping consumers enroll in these plans do not discriminate against them based on who they are or their medical history. For the above reasons, we strongly oppose the proposed removal of language from § 155.220(j)(2)(i).

The patient and provider groups represented by HHCAWG look to HHS to continue to expand access to health care, make coverage more affordable, and increase patient protections through thoughtful and evidence-based policies. We believe there are opportunities to achieve these goals, however, many of the proposed provisions in this NBPP will definitively do the opposite.

We appreciate the opportunity to share our insights for your consideration of the impact of these policies on the patient community. Please reach out to the HHCAWG co-chairs should you have any questions: Liz Kaplan (ekaplan@law.harvard.edu), Rachel Klein (rklein@taimail.org), Leslie McGorman (LMcGorman@aidsunited.org), Terri Wilder (twilder@sageusa.org), or Dori Molozanov (dmolozanov@nastad.org).

AHF
AIDS Alabama
AIDS Alliance for Women, Infants, Children, Youth & Families
AIDS Foundation Chicago
AIDS United
Aliveness Project
American Academy of HIV Medicine
APLA Health
Association of Nurses in AIDS Care
Center for Health Law and Policy Innovation
Community Access National Network (CANN)
Community Research Initiative, Inc (CRI)
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HealthHIV
HIV Dental Alliance
HIV Medicine Association
HIV+Hepatitis Policy Institute
iHealth
International Association of Providers of AIDS Care
National Alliance of State and Territorial AIDS Directors (NASTAD)
Positive Women's Network-USA
Prism Health North Texas
SAGE
San Francisco AIDS Foundation
The AIDS Institute
The Holistic Healing Source for Marginalized Society
U=U plus
Vivent Health
Whitman-Walker Health

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barriers-and-challenges-in-2024/. *See also* Caroline Medina & Lindsay Mahowald, *Discrimination and Barriers to Well-Being: The State of the LGBTQI+ Community in 2022* (Jan. 12, 2023), https://www.americanprogress.org/article/discrimination-and-barriers-to-well-being-the-state-of-the-lgbtqi-community-in-2022/ and Ankit Rastogi, et al., *Health and Well Being: A Report of the 2022 U.S. Transgender Survey* (June 2025), https://transequality.org/sites/default/files/2025-06/USTS_2022Health%26WellbeingReport_WEB.pdf.