

VIA ELECTRONIC TRANSMISSION

March 13, 2026
CMS Administrator Mehmet Oz
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9883
P.O. Box 8016
Baltimore, MD 21244-8016

Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program (0938-AV62)

Dear Administrator Oz,

The Center for Reproductive Rights (“the Center”) submits this comment in opposition to aspects of the Center for Medicare and Medicaid Services’ (“CMS”) proposed rule “Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program” (“Proposed Rule”).¹

Since 1992, the Center has used the power of law to advance reproductive rights as fundamental human rights worldwide. Our litigation and advocacy over the past 33 years have expanded access to reproductive health care around the nation and the world. We have played a key role in securing legal victories in the United States, Latin America, Sub-Saharan Africa, Asia, and Eastern Europe on issues including access to life-saving obstetric care, contraception, safe abortion services, and comprehensive sexuality information. We envision a world where every person participates with dignity as an equal member of society, regardless of gender; where every person is free to decide whether or when to have children and whether or when to get married; where access to quality reproductive health care is guaranteed; and where everyone can make these decisions free from coercion or discrimination.

As an organization committed to advancing policies that uphold reproductive rights as fundamental human rights, including the right to available, high quality, accessible, acceptable reproductive health care,² we believe aspects of this proposed rule, as outlined below, would weaken coverage standards and undermine access to reproductive health services. The impact of these changes would be particularly severe for low-income individuals and communities that already face systemic barriers to care. The Center urges CMS to withdraw these provisions from the final rule.

¹ Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program, 91 Fed. Reg. 6292 (proposed Feb. 11, 2026) [hereinafter “Proposed Rule”].

² Committee on Economic, Social and Cultural Rights (ESCR Committee), General Comment No. 14: The right to the highest attainable standard of health (Art. 12), (22nd Sess., 2000), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 80, para.12 (a)-(d), U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008); ESCR Committee, General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social, and Cultural Rights), U.N. Doc. E/C.12/GC/22 (2016).

I. The proposal to amend state-required benefits would undermine state efforts to innovate and expand coverage for reproductive health care.

The Affordable Care Act (“ACA”) allows states to operate as incubators of innovation when it comes to developing, testing, and advancing policies related to coverage and care, including state efforts to improve reproductive health care by expanding essential health benefits (“EHBs”). In the years since 2011, many states have adopted mandates to improve coverage and the provision of reproductive health services including: infertility treatment and fertility preservation,³ expanded contraceptive coverage,⁴ and improved maternal health care, including doula coverage, and maternal mental health care.⁵

CMS is proposing to amend § 155.170(a)(2) to provide that state-required benefits would be considered “in addition to EHB,” and therefore not EHBs, even if embedded in a state’s EHB benchmark plan, unless the benefit is required federal law.⁶ Under the proposal, the amendment *retroactively* applies to state-required benefits enacted after December 31, 2011. This unprecedented proposal would shift an immense financial burden upon states to defray the cost of these benefits for subsidized enrollees, especially if they were added with the understanding that defrayal was not required. This policy creates a substantial fiscal disincentive for states to adopt new or maintain existing reproductive health benefits, undoing years of efforts to improve coverage.⁷ Continuous access to reproductive health benefits is vital over the course of one’s lifetime. Particularly during acute periods like pregnancy, infertility, menopause, and treatment for cancers, it is imperative that continuity of coverage and care be maintained to have a chance at positive health outcomes.⁸

³ *Women’s Health FAQ: I have been trying to get pregnant. Do Marketplace plans cover infertility services?*, KFF (Sep. 29, 2025) <https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/womens-health/i-have-been-trying-to-get-pregnant-will-the-plans-on-the-exchanges-cover-infertility-services/>; FERTILITY HEALTHCARE COVERAGE, MOVEMENT ADVANCEMENT PROJECT (Last Visited 3/6/2026) https://www.lgbtmap.org/equality-maps/healthcare/fertility_coverage.

⁴ Adam Sonfield & Dana Singiser, *State-level policy options for expanding coverage and affordability of over-the-counter contraceptives in the United States*, 155 *CONTRACEPTION* 1, 1-7 (2026) [https://www.contraceptionjournal.org/article/S0010-7824\(25\)00441-X/fulltext](https://www.contraceptionjournal.org/article/S0010-7824(25)00441-X/fulltext); Liz McCaman Taylor, *Contraceptive Equity & Essential Health Benefits*, NAT’L HEALTH L. PROGRAM (Dec. 2021) <https://healthlaw.org/wp-content/uploads/2021/12/CE-EHB-12082021-final.pdf>.

⁵ *What State Legislatures are Doing in 2025 to Address Maternal Mental Health*, POL’Y CTR. FOR MATERNAL MENTAL HEALTH (Last Visited Mar. 5, 2026); Kimberly Herbert, *Private Insurance Coverage of Doula Care: Spring 2025 State of the States*, NAT’L HEALTH L. PROGRAM (Apr. 21, 2025) <https://healthlaw.org/private-insurance-coverage-of-doula-care-spring-2024-state-of-the-states/>.

⁶ Proposed Rule at 6447.

⁷ Stacey Pogue et al., *Enhancing Essential Health Benefits: How States Are Updating Benchmark Plans to Improve Coverage*, THE COMMONWEALTH FUND (Nov. 14, 2024) <https://www.commonwealthfund.org/publications/issue-briefs/2024/nov/enhancing-essential-health-benefits-states-updating-benchmark-plans>; *CMS Proposal May Increase Obstacles for State-Mandated Benefits*, AVALERE HEALTH (Feb. 25, 2020), <https://advisory.avalerehealth.com/insights/cms-proposal-may-increase-obstacles-to-adding-new-benefits-for-aca-plans>.

⁸ Tricia Brooks and Allexa Gardener, *Medicaid Continuous Eligibility Linked with Better Health, More Efficient Health Care Spending*, GEO. CTR. FOR CHILD. & FAM. (Jul. 19, 2021) <https://ccf.georgetown.edu/2021/07/19/medicaid-continuous-eligibility-linked-with-better-health-more-efficient-health-care-spending/>.

CMS's proposal runs counter to the ACA's purpose of establishing meaningful minimum coverage standards while allowing states to enhance protections.⁹ The Center vigorously opposes this amendment and urges CMS to withdraw it.

II. The proposal to reduce Essential Community Provider (“ECP”) contracting thresholds from 35% to 20% could result in reduced network adequacy and access to family planning services.

ECPs are health care providers that serve predominantly low-income, medically underserved, or otherwise vulnerable populations and are critical to ensuring equitable access to care within the health system.¹⁰ Family planning providers and Federally Qualified Health Centers (“FQHCs”) are vital types of ECPs because they deliver comprehensive, affordable services, including family planning services, preventive care, and primary care to communities that might otherwise face significant barriers to accessing timely and culturally competent care.¹¹ Qualified Health Plans (“QHPs”) offered through the ACA Marketplace must maintain a provider network that includes “a sufficient number and geographic distribution of ECPs.”¹² This requirement is to ensure that Marketplace plans meaningfully include providers, such as family planning clinics and FQHCs, so enrollees may continue accessing trusted providers.¹³ Family planning providers, including Title X clinics and other safety-net reproductive health providers, are a critical access point, and often the sole access point, in many communities for family planning services, including contraceptives, STI screening and treatments, cervical and breast cancer screening and treatments, and pregnancy-related care and counselling.¹⁴

CMS is proposing to reduce the ECP contracting threshold from 35 percent to 20 percent, including separate 20 percent thresholds for FQHCs and family planning providers.¹⁵ Reducing the threshold from 35 percent to 20 percent could meaningfully weaken the requirement that QHPs include these providers in network.¹⁶ CMS justifies this action by asserting that most issuers currently exceed 35 percent and therefore lowering the threshold will minimally impact networks.¹⁷ This reasoning misunderstands the purpose of minimum standards. Even if many issuers currently exceed the minimum, regulatory standards function as guardrails. Lowering the floor signals that narrower networks are acceptable and reduces accountability in future years. Currently, higher compliance reflects the strength of the existing requirement and lowering the

⁹ ALISON MITCHELL, CONG. RSCH. SERV., IF10399, OVERVIEW OF THE ACA MEDICAID (2021) <https://www.congress.gov/crs-product/IF10399>.

¹⁰ HHS Essential community providers, 45 C.F.R. § 156.235(c) (2026).

¹¹ Joerg Dreweke et al., *Publicly Supported Family Planning Services in the United States*, GUTTMACHER INST. (Nov. 2025) <https://www.guttmacher.org/fact-sheet/publicly-supported-FP-services-US>.

¹² HHS Essential community providers, 45 C.F.R. § 156.235(a)(1) (2026).

¹³ Cristina Jade Peña et al., *Federal and State Standards for “Essential Community Providers” under the ACA and Implications for Women’s Health*, KFF (Jan. 2015) <https://files.kff.org/attachment/issue-brief-federal-and-state-standards-for-essential-community-providers-under-the-aca-and-implications-for-womens-health>.

¹⁴ Usha Ranji et al., *Family Planning Services for Low-Income Women: The Role of Public Programs*, KFF (Dec. 1, 2025) <https://www.kff.org/womens-health-policy/financing-family-planning-services-for-low-income-women-the-role-of-public-programs/>.

¹⁵ Proposed rule at 6399.

¹⁶ Karen Pollitz, *Network Adequacy Standards and Enforcement*, KFF (Feb. 4, 2022) <https://www.kff.org/affordable-care-act/network-adequacy-standards-and-enforcement/>.

¹⁷ Proposed Rule at 6459.

threshold may cause networks to narrow over time, allowing for a strategic exclusion of reproductive health providers.¹⁸

Narrower ECP networks also have negative consequences for enrollees. This proposal could further increase out-of-network utilization and out-of-pocket cost coverage by consumers, and could subject them to longer wait times or require that they travel farther to receive care.¹⁹ For low-income enrollees, especially those in rural areas that are facing health provider shortages or growing maternity care deserts,²⁰ a reduction in in-network reproductive health providers can effectively eliminate access.²¹

The Center urges CMS to withdraw this proposal. Maintaining the 35 percent threshold standard would continue to ensure meaningful, affordable access to timely reproductive health care, especially among the communities most vulnerable to poor reproductive health outcomes.

III. Aspects of the proposed rule would weaken transparency and oversight.

CMS includes two proposals in this rule that would significantly weaken federal transparency and oversight of network adequacy and coverage. First, CMS is proposing to replace the open-ended narrative justification requirement with a streamlined process requiring issuers to report the status of contract offers to ECPs.²² The current narrative justification requires issuers that fail to meet ECP standards to explain how their network will adequately serve individuals in low-income zip codes or areas with health professional shortages, and how they will strengthen networks in future years.²³ This requirement compels issuers to articulate an access strategy and provides regulators with qualitative insight into whether network design meaningfully serves vulnerable communities.²⁴ Replacing narrative justification with a simple reporting of contract status would not only reduce transparency but it would limit CMS's ability to assess real-world access. A proper narrative qualitative review by CMS is extremely important for maintaining network adequacy.²⁵

¹⁸ Pollitz, *supra* note 16; U.S. GOV'T ACCOUNTABILITY OFF., GAO-23-105642, PRIVATE HEALTH INSURANCE: STATE AND FEDERAL OVERSIGHT OF PROVIDER NETWORKS VARIES (2022) *available at* <https://www.gao.gov/assets/gao-23-105642.pdf>.

¹⁹ Pollitz, *supra* note 16; Kinsey Hasstedt and Andrea Rowan, *Marketplace Plans' Provider Networks Are Just Not Adequate Without Family Planning Centers*, 18 GUTTMACHER POL. REV. 48, 48-55 (2015) https://www.guttmacher.org/sites/default/files/article_files/gpr1804815.pdf.

²⁰ Caitlin Murphy et al., *Stressors Stack Up on Essential Maternity Providers — Community Health Centers Need Support in a Post-Dobbs World*, THE COMMONWEALTH FUND (Jun 11, 2024) <https://www.commonwealthfund.org/blog/2024/stressors-stack-essential-maternity-providers-community-health-centers-need-support-post>.

²¹ *Id.*; Cristina Jade Peña et al., *Federal and State Standards for “Essential Community Providers” under the ACA and Implications for Women’s Health*, KFF (Jan. 2015) <https://files.kff.org/attachment/issue-brief-federal-and-state-standards-for-essential-community-providers-under-the-aca-and-implications-for-womens-health>.

²² Proposed Rule at 6459.

²³ *Id.*

²⁴ Sally McCarty and Max Farris, *ACA Implications for State Network Adequacy Standard*, STATE HEALTH REFORM ASSISTANCE NETWORK (Aug. 2013) <https://shvs.org/wp-content/uploads/2014/11/State-Network-Georgetown-ACA-Implications-for-State-Network-Adequacy-Standards.pdf>.

²⁵ *Id.*; Murphy et al., *supra* note 20; Brittni Frederiksen et al., *Recent Policy Proposals Could Weaken the Reproductive Health Safety Net as More People Become Uninsured*, KFF (Jul. 28, 2025)

CMS also proposes deferring network adequacy reviews to Federally Facilitated Exchange states that elect to conduct their own reviews and demonstrate sufficient authority and technical capacity.²⁶ This approach will weaken federal oversight and further exacerbate geographic disparities in reproductive health access by allowing states that politicize reproductive health to enforce standards that would undermine care.²⁷ Federal review of the network adequacy standards provides a critical backstop to ensure that states consider factors impacting access to timely reproductive health care, such as reasonable time and distance standards, provider-to-enrollee ratios, the inclusion of essential specialties, like maternal-fetal medicine specialists, and meaningful access for underserved populations.²⁸ Without appropriate feedback mechanisms and oversight around network adequacy, actual coverage for quality reproductive health care is at risk.

For these reasons, the Center opposes these proposals and urges CMS to withdraw them.

IV. Conclusion

The ACA established a framework designed to ensure that states provide coverage in a way that is increasingly comprehensive, accessible, and equitable. The proposals outlined above would undermine that framework. Additionally, the lack of time for public input (30 days) is not only deeply inadequate, but also represents a recklessness given the potentially devastating economic impact that these proposals could have on states, health care centers, providers, and enrollees. The Center urges CMS to withdraw the above-mentioned proposals.

The Center appreciates the opportunity to comment on this Proposed Rule. For additional information about the issues raised in this letter, please contact Vandana Ranjan, Senior Federal Policy Adviser, Maternal Health, at vranjan@reprorights.org.

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<https://www.kff.org/womens-health-policy/recent-policy-proposals-could-weaken-the-reproductive-health-safety-net-as-more-people-become-uninsured/>.

²⁶ Proposed Rule at 6460.

²⁷ McCarty and Farris, *supra* note 24.

²⁸ *Id.*