



AMERICA'S ESSENTIAL HOSPITALS

March 4, 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

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

Dear Administrator Oz:

America's Essential Hospitals appreciates the opportunity to comment on the proposed rule related to qualified health plans (QHPs) and essential community providers (ECPs). We are concerned about how efforts to narrow provider networks and increase patient cost sharing will limit access to care and increase hospital uncompensated care costs.

America's Essential Hospitals is the leading association and champion for hospitals dedicated to high-quality care for all. Since 1981, America's Essential Hospitals has advanced policies and programs that promote health and access to health care. We support our nearly 400 members with advocacy, policy development, research, education, and leadership development. Communities depend on essential hospitals for care across the continuum, health care workforce training, research, public health, and other services. Supported by Essential Hospitals Institute, the association's research and education arm, essential hospitals innovate and adapt to lead all of health care toward better outcomes and value.

The mission of essential hospitals closely aligns with President Trump's vision to make all Americans healthy. Essential hospitals are committed to serving people in all communities that need access to quality care. Although essential hospitals account for only 6% of acute-care hospitals nationwide, in 2023 they provided 29% of the nation's charity care. About three-quarters of the patients our members serve are uninsured or enrolled in Medicaid or Medicare.¹ In addition, nearly two-thirds of essential hospitals provide services to rural patients and communities.² To meet the needs of all patients, essential hospitals constantly work to improve

¹ Miu R, Kelly K, Nelb R. *Essential Data 2025: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2023 Annual Member Characteristics Survey*. America's Essential Hospitals. November 2025. essentialdata.info. Accessed Feb. 19, 2026.

² America's Essential Hospitals. Policy Brief: Essential Hospitals Ensure Access to Care in Rural Areas. March 2025. <https://essentialhospitals.org/policy-brief-essential-hospitals-ensure-access-to-care-in-rural-areas/>. Accessed Feb. 19, 2026.

quality and access, including through efforts to combat chronic health conditions, all while lowering health care costs and spending.

Many patients who receive care at essential hospitals have gained coverage through the Affordable Care Act marketplaces, and many are likely to transition into and out of marketplace coverage over time. To maintain their health and continued participation in the workforce, it is critical that these patients maintain access to their preferred provider. Lowering ECP thresholds without guaranteeing that QHPs include essential hospitals will narrow provider networks and compromise consistent access to preferred providers.

Furthermore, we are concerned that increased patient cost sharing through high-deductible health plans (HDHPs) will limit access to care and increase hospital uncompensated care costs. In 2023, essential hospitals had \$11 billion in uncompensated care and \$11.4 billion in under-reimbursed care, costs that go unpaid from patients who are uninsured or underinsured.³ From 2019 to 2023, charity care for insured patients increased at essential hospitals by 15%. Due to Medicaid and marketplace eligibility policy changes from the Working Families Tax Cut legislation (WFTCL) and the expiration of advanced premium tax credits (APTCs), the number of uninsured and underinsured patients at essential hospitals will continue to grow along with hospital's uncompensated care.^{4,5} To mitigate these concerns, we ask CMS to use essential health system designation to identify ECPs that should be included in QHP networks and to examine how uncompensated costs from HDHPs affect access to care.

1. CMS should ensure that QHP networks include essential hospitals.

To be sold on the health care marketplace, QHPs must include a sufficient number of ECPs to ensure reasonable and timely access to a broad range of services, such as inpatient hospital care, for low-income individuals or individuals residing in Health Professional Shortage Areas. The current policy requires QHPs to contract with a minimum of one provider per category or meet a minimum ECP threshold set by HHS. To meet ECP threshold requirements, QHPs often only need to include one inpatient hospital. While the ECP threshold has recently increased to 35%, the threshold is low enough that it does not guarantee that essential hospitals are included in QHPs. Lowering the threshold will make their inclusion even less likely.

CMS currently has ECP provider thresholds for several provider types but does not have a specific threshold for hospitals. We urge CMS to consider establishing a higher threshold of participation for hospitals, especially essential hospitals that meet the criteria described in the bipartisan Reinforcing Essential Health Systems for Communities Act (H.R. 7145). Many patients that essential hospitals serve have incomes near Medicaid eligibility thresholds and transition between marketplace coverage as their work hours vary. The WFTCL community engagement requirements likely will increase the number of patients in this situation. As patients' employment status and number of work hours change, so will their eligibility for

³ Miu R, Kelly K, Nelb R. *Essential Data 2025: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2023 Annual Member Characteristics Survey*. America's Essential Hospitals. November 2025. essentialdata.info. Accessed Feb. 23, 2026.

⁴ Nelb R. *Additional Hospital Uncompensated Care Costs Projected Under Proposed Senate Revisions to H.R. 1. America's Essential Hospitals*. June 2025. <https://essentialhospitals.org/wp-content/uploads/2025/06/Additional-Hospital-Uncompensated-Care-Costs-Projected-Under-Proposed-Senate-Revisions-to-H.R.-1.pdf>. Accessed March 2, 2026.

⁵ Lo J, Levitt L, Ortaliza J, et al. *ACA Marketplace Premium Payments Would More than Double on Average Next Year if Enhanced Premium Tax Credits Expire*. Kaiser Family Foundation. Sept. 30, 2025. <https://www.kff.org/affordable-care-act/aca-marketplace-premium-payments-would-more-than-double-on-average-next-year-if-enhanced-premium-tax-credits-expire/>. Accessed Feb. 27, 2026.

employer-based, marketplace, or public insurance. As patients' health insurance changes, participation of essential hospitals in QHP networks is vital for maintaining access to services and ensuring continuity of care.

As uninsured patients or Medicaid beneficiaries gain or switch to marketplace coverage, or vice versa, they should retain access to their same providers. Finding new providers because of a change in insurance disrupts care, particularly in communities essential hospitals serve. Maintaining the same provider across health coverage improves health outcomes. Continuity of care is associated with decreased emergency department use and hospitalizations, lower costs, and higher patient satisfaction, as well as lower mortality rates.^{6,7} To support progressive upward economic ability gained through community engagement requirements, staying healthy will be just as critical for patients' self-sufficiency. Maintaining access to their providers will be key to continued success.

To ensure beneficiaries can maintain access to their providers, CMS should designate essential hospitals that should be included in the networks for the QHPs in the health care marketplace. In 2000, the Institute of Medicine convened a wide variety of stakeholders and experts to develop a consensus definition of safety net providers as those that serve a high share of uninsured, Medicaid, and other disadvantaged patients.⁸ Building on this definition and feedback from essential hospital leaders about how to make a designation easy to implement and responsive to state variation, the bipartisan Reinforcing Essential Health Systems for Communities Act (H.R. 7145) includes a set of evidence-based measures for identifying essential health systems.⁹

2. CMS should consider the effects of high-deductible plans on hospital uncompensated care.

CMS proposes to expand catastrophic plans, allowing terms for multiple consecutive years up to 10 years. With more people losing Medicaid eligibility and others unable to afford higher-premium plans without APTCs, more patients will enroll in catastrophic plans for health care coverage because it is the only coverage they can afford.

While having some health insurance coverage is better than being uninsured, having a HDHP, such as a catastrophic plan, often leaves patients underinsured. In 2022, 44% of people with coverage through the individual market and marketplaces were underinsured, meaning their

⁶ Goodwin J. Continuity of care matters in all health care settings. *JAMA Network Open*. 2021;4(3):e213842. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2777855>. Accessed Feb. 27, 2026.

⁷ Gray D, Sidaway-Lee K, White E, et al. Continuity of care with doctors—a matter of life and death? A systematic review of continuity of care and mortality. *BMJ Open*. 2018;8:e021161. <https://bmjopen.bmj.com/content/8/6/e021161#main-content>. Accessed Feb. 27, 2026.

⁸ Institute of Medicine Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers. Lewin ME, Altman S, eds. *America's Health Care Safety Net: Intact but Endangered*. Washington, D.C.: The National Academies Press; 2000. https://www.ncbi.nlm.nih.gov/books/NBK224523/pdf/Bookshelf_NBK224523.pdf. Accessed Feb. 23, 2026.

⁹ Reinforcing Essential Health Systems for Communities Act, H.R. 7154, 119th Cong. (2026). <https://essentialhospitals.org/wp-content/uploads/2026/01/Reinforcing-Essential-Health-Systems-for-Communities-Act-Text.pdf>.

out-of-pocket costs, excluding premiums, were at least 10% of their household income.¹⁰ Higher out-of-pocket costs lead patients to forgo clinical and specialist care, recommended testing, and prescriptions, worsening their health and increasing hospital inpatient and outpatient care.¹¹ This leaves underinsured patients with medical bills they cannot afford.

In 2023, essential hospitals provided almost three times as much charity care to underinsured patients as non-essential hospitals. For underinsured patients, essential hospitals provide charity care or payment plans to cover the cost of hospital care. All essential hospitals have a financial assistance policy or sliding scale fee schedule for low-income patients. For patients that cannot pay their out-of-pocket costs, a hospital can forgive the patient's bill, offer the services at a discount, or provide a payment plan for partial payment. Regardless of the option, they all shift health care costs from the health care plan to the essential hospital. **As more people get health care coverage through HDHPs, CMS should evaluate the impact of increased hospital uncompensated care on access to care**, particularly in rural areas, where uncompensated care is highest.¹²

3. CMS should expand hardship exemption eligibility for catastrophic coverage.

The association supports CMS' proposal to expand hardship exemption eligibility for catastrophic plans for individuals over 30 if they experience a change in their household income and otherwise qualify for a catastrophic plan. Again, any health coverage is better than none. The lack of health insurance is associated with increased risk of mortality, and people with insurance receive preventive care, seek care when they need it, and are more likely to be screened for cancer.^{13,14,15,16} The hardship exemption will allow continued health coverage while individuals work to increase their household income.

America's Essential Hospitals appreciates the opportunity to submit these comments. For questions, please contact Director of Policy Robert Nelb, at 202-585-0127 or rnelb@essentialhospitals.org.

Sincerely,

Jennifer DeCubellis
President and CEO

¹⁰ Collins S, Haynes L, Masitha R. The State of U.S. Health Insurance in 2022. *The Commonwealth Fund*. Sept. 29, 2022. <https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey>. Accessed Feb. 27, 2026.

¹¹ Ibid.

¹² Keese E, Gurzenda S, Thompson K, et al. Uncompensated Care is Highest for Rural Hospitals, Particularly in Non-Expansion States. *Medical Care Research and Review*. 2023;81(2):164–170. <https://journals.sagepub.com/doi/10.1177/10775587231211366>. Accessed Feb. 27, 2026.

¹³ Wilper A, Woolhandler S, Lasser K, et al. Health insurance and mortality in US adults. *AMJ Public Health*. 2009;99(12):2289–2295. <https://pubmed.ncbi.nlm.nih.gov/19762659/>. Accessed Feb. 27, 2026.

¹⁴ Lines L, Urato M, Halpern M, et al. *Insurance Coverage and Preventive Care Among Adults*. Research Triangle Park, N.C.: RTI Press; 2014. <https://collections.nlm.nih.gov/catalog/nlm:nlmuid-101511510-pdf>. Accessed Feb. 27, 2026.

¹⁵ Institute of Medicine. *Care Without Coverage: Too Little, Too Late*. Washington, D.C.: National Academies Press; 2002. <https://www.ncbi.nlm.nih.gov/books/NBK220636/>. Accessed Feb. 27, 2026.

¹⁶ Sabatino S, Thompson D, White M, et al. Up-to-Date Breast, Cervical, and Colorectal Cancer Screening Test Use in the United States, 2021. *Preventing Chronic Disease*. 2023;20:E94. <https://pubmed.ncbi.nlm.nih.gov/37884318/>. Accessed Feb. 27, 2026.