



March 13, 2026

The Honorable Robert F. Kennedy Jr.
Secretary
U.S. Department of Health and Human Services
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

Dear Secretary Kennedy:

As members of the Democratic Women's Caucus and Reproductive Freedom Caucus, we write in opposition to the U.S. Department of Health and Human Services' (HHS) proposed rule, CMS-9883-P. This rule fails to address the health care affordability crisis and limits health care options for women and families. Instead of lowering costs and expanding coverage, this rule reinforces the policies driving Republicans' manufactured health care crisis. Additionally, this rule escalates attacks on reproductive health care by further destabilizing family planning clinics and their funding. Women will pay more out-of-pocket costs, experience more difficulty maintaining their coverage, and be forced to navigate less regulated, junk insurance options as a result of this rule. Women take on 80% of the family's medical decision-making responsibilities,¹ and almost 50% of women view themselves as the chief financial officer of their household.² **We urge HHS to abandon the provisions that would drive up health care costs and restrict women's access to care.**

This rule is falsely advertised as a pathway to lower costs. In reality, this sweeping rule would increase costs by steering more individuals towards catastrophic insurance plans and raising out-of-pocket costs.³ Catastrophic insurance plans come with much higher costs for consumers through very high deductibles and limited pre-deductible coverage, leaving enrollees

1 Williamson, L. (2024, April 17). *Families Often Have Chief Medical Officers – And They're Almost Always Women*. American Heart Association. <https://www.heart.org/en/news/2024/04/17/families-often-have-chief-medical-officers-and-theyre-almost-always-women>.

2 Pomroy, K. (2025, February 2). *Half of all Households Have a Female CFO. Does Yours?* Kiplinger. <https://www.kiplinger.com/personal-finance/half-of-all-households-have-a-female-cfo>.

3 Centers for Medicare & Medicaid Services. (2026, February 9). *HHS notice of benefit and payment parameters for 2027 proposed rule*. U.S. Department of Health and Human Services. <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-payment-parameters-2027-proposed-rule>

underinsured and facing substantial out-of-pocket costs before coverage applies. The proposed rule would expand eligibility for catastrophic insurance and dramatically increase deductibles for consumers purchasing both catastrophic coverage and bronze plans.⁴ This means that outside of a limited set of preventive care services and three primary care visits, women and families that enroll in catastrophic coverage would have to pay as much as more than \$31,000 before coverage kicks in.⁵ This coverage may appear affordable on paper because enrollees' initial premiums for such coverage may be lower—but leaves the enrollee exposed when they need care most. The proposed rule goes so far as to contemplate locking catastrophic insurance enrollees into this coverage for up to 10 years or more. Women and families deserve access to affordable, comprehensive health care coverage, not bare-bones coverage that forces them to gamble on their health.

Given Republicans' failure to extend the ACA enhanced premium tax credits, historic health care cuts in the *One Big Beautiful Bill*, and this proposed rule, women could be forced into catastrophic plans as the most affordable option—to their financial demise. For pregnant and postpartum people, this change could be particularly severe. The average cost of childbirth in the United States is \$20,416 and, for individuals who require a cesarean section, costs an average of \$28,998.⁶ With the proposed deductible increase, many pregnant people would receive little to no financial assistance from catastrophic coverage. Pregnant people with catastrophic health insurance would have to pay tens of thousands of dollars out-of-pocket to give birth due to this rule's proposal to increase deductibles. For the health and well-being of the pregnant person and baby, we must reject health insurance plans that would financially ruin women and families.

Furthermore, this rule would continue to raise health care costs by forcing women to pay more for their trusted providers. Health insurance plans would not be required to maintain a robust provider network. These non-network plans would set a fixed payment for care. So, if a trusted provider charges above that rate, the enrollee must pay the difference out of pocket. Not only does this rule threaten the enrollee's ability to stay with their trusted providers, but they would also have to calculate the exact charges they may incur. Placing this burden on the enrollee creates unnecessary red tape and leaves room for error. Overall, this rule forces two choices—pay more out of pocket to stay with a trusted provider or find a new one. When women believe they can access care without unexpected costs or network disruptions, they are more likely to seek preventive services and follow through with recommended treatment.⁷ CMS-9883-P would charge women for their trust.

4 Davis, J., & Curtis, D. (2026, February 19). *Digesting a very full plate: The proposed 2027 notice of benefit and payment parameters*. McDermott+. <https://www.mcdermottplus.com/blog/regs-eggs/digesting-a-very-full-plate-the-proposed-2027-notice-of-benefit-and-payment-parameters/>

5 Davis, J., & Curtis, D. (2026, February 19). *Digesting a very full plate: The proposed 2027 notice of benefit and payment parameters*. McDermott+. <https://www.mcdermottplus.com/blog/regs-eggs/digesting-a-very-full-plate-the-proposed-2027-notice-of-benefit-and-payment-parameters/>

6 Cox, C., Claxton, G., Rae, M., & Kurani, N. (2025, September 9). *Health costs associated with pregnancy, childbirth, and postpartum care*. Peterson–KFF Health System Tracker. <https://www.healthsystemtracker.org/brief/health-costs-associated-with-pregnancy-childbirth-and-postpartum-care/>

Additionally, this rule would roll back the very requirement that is actively improving access to cost saving family planning care. Section 1311(c)(1)(C) of the Patient Protection and Affordable Care Act (P.L. 111-148) requires that Essential Community Providers (ECPs) be included in Qualified Health Plan's (QHP) networks. ECPs are safety net providers, including providers that furnish family planning services. These providers are essential to the reproductive health safety net and play a critical role in advancing public health. ECPs make it possible for low-income and medically underserved people to access critical preventive services like cancer screenings and birth control, which improve their health and lives. Those preventive services, so often made possible by public funding, also play a key role in lowering long-term health care costs for patients and for taxpayers. Every dollar of public funding invested in family planning saves seven future taxpayer dollars.⁸

Guaranteeing the inclusion of a sufficient number of ECPs, especially Family Planning Providers, in local QHP networks improves the health and wellbeing of people with low incomes, ensures patients can choose from a greater number of eligible providers, and generates long-term savings for federal and state governments.

CMS-9883-P proposes to reduce the minimum contracting threshold from 35% to 20%, which will lead to fewer ECPs being included in QHP networks, both denying enrollees access to care through such providers and threatening ECPs' financial position and ability to serve their communities. Over the last year, people with low incomes have faced targeted impediments to accessing Family Planning Providers. The provision in the *One Big Beautiful Bill Act* banning Medicaid funding for Planned Parenthood and certain other safety net family planning providers is in effect, eliminating Medicaid patients' access to some of the only providers and health centers in their medically underserved communities. For over a year, HHS and the White House have repeatedly interfered with the administration of the bipartisan Title X Family Planning Program, including by withholding funds for months and threatening timely access to future grants. This leaves thousands of health centers in limbo and puts the 2.8 million people served by the program each year at risk of losing their family planning care, including cancer screenings, testing and treatment for STIs, birth control, and more. Collectively, these actions destabilize the safety net and make access to ECPs, particularly Family Planning Providers, even more critical.

Amid all these challenges, CMS-9883-P aims to reduce the minimum contracting threshold of ECPs, which will result in fewer in-network providers for those already grappling with reduced family planning and reproductive health care access. It will stop and reverse the progress that has been made since the 35% minimum threshold took effect to improve access to care for people where they live. As of 2024, only 65 percent of women ages 18-49 with private insurance say

7Association of American Medical Colleges Center for Health Justice. (2025, September 30). *Women's perspectives: Trust in the reproductive health care system and key sources of information.*

<https://www.aamchealthjustice.org/news/polling/womens-perspectives>

8 Gold, R. B. (2017, December). *Publicly funded family planning under unprecedented attack.* American Journal of Public Health, 107(12), 1884–1885. <https://doi.org/10.2105/AJPH.2017.304124>

contraception is easy to get in their states.⁹ With fewer local options in-network, patients would experience longer wait times, farther distances to providers, and greater difficulty finding specialists. These barriers have a disproportionate impact on women with low-incomes, women living with disabilities, and other underserved communities, who have only just started feeling the benefits of the 2023 rule change.

By permitting narrower networks that include fewer ECPs, implementation of this rule would reduce access to family planning and threaten the savings family planning services confer for the federal government. The impact on family planning alone shows that this rule fails in the mission and purpose of the ACA. Reducing insurer minimum contracting thresholds for ECPs does not lower costs, improve patient choice, or protect the taxpayer. On the contrary, maintaining the 35% minimum contracting threshold and increasing it in future rulemaking would do all three while improving access to quality care for medically underserved people across the nation.

As written, this rule would harm women's health and access to family planning services across the country. Ensuring the continued operational success of the insurers should not come at the expense of Marketplace enrollees. We urge you to exclude these harmful provisions from any final HHS rule prior to implementation.

Sincerely,



Teresa Leger Fernández
Chair
Democratic Women's Caucus



Diana DeGette
Co-Chair
Reproductive Freedom Caucus



Ayanna Pressley
Co-Chair Reproductive
Freedom Caucus



Lizzie Fletcher
Vice Chair
Reproductive Freedom Caucus



Norma J. Torres
Vice Chair
Reproductive Freedom Caucus



Hillary J. Scholten
Vice Chair
Democratic Women's Caucus

⁹ Frederiksen, B., Diep, K., & Salganicoff, A. (2024, November 22). *Contraceptive experiences, coverage, and preferences: Findings from the 2024 KFF Women's Health Survey*. KFF. <https://www.kff.org/womens-health-policy/contraceptive-experiences-coverage-and-preferences-findings-from-the-2024-kff-womens-health-survey/>