



American Society of Hematology

Helping hematologists conquer blood diseases worldwide

2026

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March 13, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
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Submitted electronically via [Regulations.gov](https://www.regulations.gov)

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

Dear Administrator Oz,

The American Society of Hematology (ASH) appreciates the opportunity to provide comments on the Notice of Benefit and Payment Parameters for 2027.

ASH represents more than 18,000 clinicians and scientists who are committed to the study and treatment of blood and blood-related diseases. These disorders encompass malignant hematologic disorders such as leukemia, lymphoma, and multiple myeloma, as well as non-malignant conditions such as sickle cell disease, thalassemia, bone marrow failure, venous thromboembolism, and hemophilia. In addition, hematologists are pioneers in demonstrating the potential of treating various hematologic diseases and continue to be innovators in the field of stem cell biology, regenerative medicine, transfusion medicine, and gene therapy. Our mission is to foster high-quality care, transformative research and innovative education to improve the lives of patients with blood and bone marrow disorders. With these goals in mind, we provide comments on the proposed changes outlined in the 2027 Notice of Benefit and Payment Parameters.

The proposed policy changes will have a profound effect on patients with hematologic conditions, including rare, genetic, and chronic blood disorders such as sickle cell disease, hemophilia, thalassemia, aplastic anemia, and hematologic malignancies. These patients depend on continuous, highly specialized care and are particularly sensitive to changes in plan benefit design, network adequacy, and coverage of supportive services. As the Centers for Medicare & Medicaid Services (CMS) considers policies that may increase insurer flexibility, it is essential that the agency considers how those changes could unintentionally create coverage gaps, disrupt access to care, and worsen health outcomes for medically complex populations.

Benefit Design Flexibility and Cost-Sharing

CMS proposes to provide insurers with greater flexibility in plan benefit design, including altering cost-sharing structures for many of the plans in the marketplace or changes in policy that could increase deductibles. CMS proposes to revise cost-sharing parameters for catastrophic plans, including increasing the maximum out-of-pocket costs by 30%. That equates to a patient and family needing to pay \$15,600 and \$27,000 out-of-pocket before healthcare services are covered, respectively. Under catastrophic plans, enrollees are allowed up to three primary care visits and some preventative care. Enrollees in a catastrophic plan would pay high out-of-pocket costs should an emergency arise or if they experience a change in health status that impacts how they utilize health care, such as obtaining a blood cancer diagnosis and seeking immediate care and treatment. The appeal of these plans are low monthly premiums, particularly as Americans struggle with rising health care costs. However, for patients with blood disorders and diseases, plan coverage that appears affordable based on premiums alone may not be adequate. People with sickle cell disease, hemophilia, thalassemia, bone marrow failure syndromes, or hematologic cancers have known, ongoing, and unavoidable medical needs. They do not experience “catastrophic” events occasionally; they have predictable, ongoing, and unavoidable health care needs, experience high-cost care routinely, and will be underinsured if they are enrolled in catastrophic plans.

Patients with hematologic conditions often require lifelong disease management involving frequent monitoring, hospital-based services, transfusions, specialty medications, and coordinated care across multiple providers. The care needs of these patients are continuous, and even slight increases in cost-sharing can have immediate and profound consequences. Cost-sharing plans that carry high deductibles may lead to delayed treatment, medication nonadherence, and avoidable complications due to the significant amount a patient would have to pay out-of-pocket prior to receiving covered benefits. While we recognize CMS’ goal to expand affordable coverage options, we are concerned about the negative impact that the proposed expansion of catastrophic plan flexibility would have on patients with chronic diseases such as those with hematologic conditions.

Additionally, CMS proposes to allow catastrophic plan term lengths of up to ten years, and allow insurers, during those ten years, to have flexibility in creating cost-sharing that may vary throughout the plan term. Under this proposal, multi-year catastrophic plans would lock consumers into high-deductible coverage for extended periods.

The Society does not support the creation of such plans given that an individual’s healthcare needs, and financial circumstances may change over the 10-year period. In fact, healthcare needs can change in an instant; an individual may be healthy when they initially enroll in a 10-year plan and not account for a change in health status that impacts their long-term care utilization and expenses. Locking enrollees into long-term plans creates risk for the enrollee by exposing them to unpredictable and potentially unaffordable health care expenses. Additionally, locking an enrollee into a plan that lasts ten years limits plan choice from year to year. Many Americans participate in an annual health insurance plan open enrollment period and can choose a plan with appropriate cost-sharing depending on their individual healthcare needs and financial circumstances. We believe that individuals within the Marketplace should also be able to choose their plan annually, and locking an individual into a ten-year plan takes away that choice.

ASH strongly opposes these proposed changes. It is imperative that people with hematologic conditions are appropriately insured under plans that meet their clinical needs, and we do not believe that catastrophic plans are appropriate for the patients our members treat.

Network Adequacy and Access to Specialty Hematology Care

CMS proposes to provide states with greater flexibility in setting network adequacy standards that cover provider contracting and network composition. Currently, state-based marketplace plans must maintain time and distance network adequacy standards that match those used by plans in the federal marketplace. Time and distance standards require that health plans must be able to ensure that enrollees can reach an in-network provider within certain travel time or distance standards.

While we recognize CMS' goal of maintaining flexible network adequacy standards, the proposed emphasis on issuer discretion and minimum access metrics may lead to reducing functional access to specialty care for patients with hematologic conditions. Many blood disorders require care from a limited number of highly specialized providers, including those at academic medical centers and designated treatment programs for hemophilia; care that is not likely provided by general practitioners. Network adequacy standards that emphasize numerical thresholds based on travel time or geographic proximity without accounting for access to specialty care, including access to care provided by hematologists, may allow plans to technically meet the stated provider access requirements while excluding the only providers capable of delivering appropriate care. When patients with hematologic conditions lose access to specialized providers, they experience fragmented care, increased reliance on emergency departments, higher hospitalization rates, and poorer long-term outcomes.

We urge CMS to ensure that network adequacy standards provide meaningful access to hematology care, including the explicit inclusion of hemophilia treatment centers and academic medical centers as in-network providers, while also maintaining reasonable time and distance standards to access those providers. For example, individuals with classical hematologic conditions, like sickle cell disease, or who have blood cancers must have access to specialty providers that practice in these settings. Specialty care is often concentrated in urban settings and therefore networks must be able to ensure all enrollees have appropriate access in both time and distance to these providers. While plans may be able to adequately meet access to primary care, network adequacy standards must also ensure access to specialty care like hematology. Lower standards than the current requirements may force patients to travel longer distances or to seek care that is out of network due to their specific conditions and incur higher out-of-pocket costs.

Adult Dental Benefits and Essential Health Benefit Policy

CMS proposes that routine non-pediatric dental services do not need to be included as an essential health benefit and therefore may be excluded from standard plan coverage. The Society does not believe that plan policies which exclude adult dental care coverage as an essential plan benefit is sound policy for any patient and is particularly troublesome for people with hematologic conditions. The Society has been a strong proponent of ensuring adequate dental care and coverage for the patients our members treat. We have submitted comment letters advocating for coverage of dental care services within the Medicare Physician Fee

Schedule, and we continue to believe that for patients with hematologic conditions, dental care is not optional or cosmetic but a medically necessary component of comprehensive care.^{1,2,3}

Preventive dental care plays a critical role in avoiding complications that result in emergency department use or hospitalization. Oral infections and untreated dental disease may lead to a pain crisis in sickle cell disease (SCD) or serious systemic infections in immunocompromised patients. For individuals having a sickle cell disease SCD crisis, studies show that patients with active dental infections are 72% more likely to be admitted to the hospital compared to those without dental infections.⁴ These hospital admissions could be avoided if patients with SCD have access to, and coverage for prophylactic dental care.

Additionally, oral infections and untreated dental disease may delay or preclude treatments like chemotherapy, stem cell transplantation, and cell and gene therapy. Appropriate, timely, and preventive dental care is critically important for patients with certain hematologic conditions during specific stages of treatment. This includes patients following bone marrow or hematopoietic cell transplantation; individuals preparing for or receiving chimeric antigen receptor (CAR) T-cell therapy; patients undergoing treatment for multiple myeloma with regimens that include bisphosphonates or denosumab; individuals receiving chemotherapy for hematologic malignancies; and patients living with chronic blood disorders such as sickle cell disease and hemophilia. For these populations, access to routine and preventive dental services is an essential component of comprehensive care and plays a key role in preventing serious complications, treatment delays, and avoidable morbidity.

Due to the overwhelming importance of dental care for patients with hematologic conditions and diseases, we urge the Agency to maintain adult routine dental care as an essential plan benefit under state plans.

Thank you for consideration of our comments. If you have questions or would like to discuss any of these issues, please contact Carina Smith, Manager for Health Care Access Policy (casmith@hematology.org).

Sincerely,

A handwritten signature in black ink, appearing to read "Robert Negrin", is written over a vertical line that extends downwards to the name below.

Robert Negrin, MD
President

¹ [ASH Comments for Dental Services for Inclusion in 2024 Physician Fee Schedule](#). Feb. 7, 2023.

² [ASH Comments on CY 2024 Medicare Physician Fee Schedule Proposed Rule](#). September 11, 2023.

³ [ASH Comments on Dental Services for CY 2025 Medicare Physician Fee Schedule](#). February 9, 2024

⁴ Laurence B, Haywood, C Jr, Lanzkron. Dental infections increase likelihood of hospital admissions among adult patients with sickle cell disease. *Community Dental Health*. 2013 Sep; 30 (3): 168-72. PMID 24151791; PMCID PMC4115243.