



March 13, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

Re: Patient Protection and Affordable Care Act, HHS Notice of Benefits and Payment Parameters for 2027; and Basic Health Program

Dear Administrator Oz,

The American College of Physicians (ACP) appreciates the opportunity to comment on the Patient Protection and Affordable Care Act, HHS Notice of Benefits and Payment Parameters for 2027; and Basic Health Program proposed rule. The American College of Physicians is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 163,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Standardized Plan Options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, and 156.265(B)(3)(IV))

ACP urges CMS to maintain the full suite of standardized plan option policies, including the definition of standardized options, the requirement for individual market issuers to offer standardized plans, and for such plans to be meaningfully different from other options. ACP policy supports adoption of patient-centered standardized plans and meaningful difference standards to simplify the health plan selection process, reduce choice paralysis, and promote value-based, patient-centered innovative plan designs.

Shopping for a health plan needs to be less daunting. Patients often have dozens of qualified health plans (QHPs) to choose from, adding to confusion and potentially leading to failure to make a choice (1). Many patients have inadequate knowledge of health care terms and health insurance literacy (2). Meaningfully different standardized plans may improve patients' decision-making experience and reduce the number of superfluous plan offerings. Standardized

plans are a vehicle for encouraging high-value care through uniform cost sharing and first-dollar coverage of primary care visits, specialist visits, mental health and substance use outpatient office visits, and other important benefits (3).

Eliminating the standardized plan requirements could have unintended consequences. The patient-physician relationship and care continuity could be disrupted if a standardized plan is discontinued, and enrollees are cross-walked to a new plan that doesn't include their preferred physician or benefit structure. Although CMS notes that total standardized plan enrollment was "comparatively low," one-third of Federally-facilitated Exchange (FFE) and State-based Exchanges on the Federal platform (SBE-FP) enrollees chose a standardized plan, and standardized plan enrollment grew by 65% from PY 2023 to PY 2024 and remained steady in the 2025 plan year. CMS should maintain existing simplified plan option requirements, preferably with patient-centered primary care-oriented designs, to "enhance the consumer experience, increase consumer understanding, simplify the plan selection process, and combat discriminatory benefit designs."

Non-Standardized Plan Option Limits (§ 156.202)

ACP urges CMS to maintain limits on non-standardized plan options to minimize plan proliferation. CMS argues that lifting limits on plan options would reverse market disruption and encourage "plans with tiered provider networks, plans with separate medical and drug deductibles (as opposed to integrated medical and drug deductibles), plans with separate medical and drug MOOPs (as opposed to integrated medical and drug MOOPs), HSA-eligible high-deductible health plans (HDHPs), and plans with more than four tiers of prescription drug coverage." However, these types of plan designs introduce complexity and often shift the health care cost burden to the patient. We support strict oversight of QHPs that use prescription drug tiers so that patients are not burdened with high out-of-pocket costs for medications, particularly generics and specialty drugs. At a minimum, QHPs with tiered or restrictive formularies must ensure that patient cost-sharing for specialty drugs is not set at a level that imposes a substantial economic barrier to enrollees obtaining needed medications, especially for enrollees with lower incomes.

Amending Exchange Network Adequacy Standards (§ 155.1050)

Evidence shows that many patients have difficulty accessing in-network physicians due to narrow networks, increasing the risk they will delay or skip necessary care to avoid high out-of-network costs. In 2023, 20% of Marketplace enrollees reported that their clinician was not covered by their insurance and one-quarter of enrollees reported that the clinician they needed did not have appointments available (4). On average, just 40% of local physicians were included in enrollees' QHP network, indicating that many Marketplace-based plans have relatively narrow clinician networks (4). Other challenges include inaccurate clinician directories (5) and ghost physicians, that is, those that are listed as participating in a network, but are not available to patients.

ACP has long supported the use of quantitative network adequacy standards, such as time and distance, appointment wait time, and “provider”-to-enrollee measures to gauge network robustness. We’ve also called for CMS to develop ways to measure and rate plans based on network breadth. However, states use a wide variety of methods to regulate network adequacy, and some do not use quantitative standards (6). ACP believes State-based Exchanges and SBE-FPs should continue to be required to use quantitative standards including time and distance and appointment wait time standards. Federal standards should continue to serve as a “strong floor” to provide consistency and ensure that patients in all states have sufficient, timely access to their preferred physician.

Deferral of Network Adequacy Reviews to States With an Effective Provider Access Review Program (§§ 156.230 and 155.1050)

ACP is concerned about the proposal to defer network adequacy reviews to states that the agency deems to have an effective access review program. We continue to support the existing requirement that the FFE “must ensure that the provider network of each QHP meets the standards specified in § 156.230.” This layer of federal oversight helps to ensure networks are adequate and high-quality care is accessible to patients in a timely manner. Further, we continue to support requiring QHPs to, at a minimum, adhere to quantitative standards for time and distance and appointment wait times. Eliminating these requirements for certain states would be premature since requirements for time and distance standards were initiated in January 2023 and appointment wait time standards in January 2025. We respectfully request that CMS continue to coordinate with state departments of insurance through work groups and other initiatives to communicate network adequacy-related challenges and opportunities for improvement (6).

QHP Certification of Non-Network Plans (§§ 155.1050, 155.1051, 156.230, 156.235, 156.236, 156.275, and 156.810)

Non-network plans (NNPs) with high physician participation could provide more flexibility and better access to care for than network plans. Although we appreciate CMS’ efforts to propose creative solutions to making health care more available, we are concerned that the proposal to promote NNPs will place a considerable burden on patients and physicians, expose patients to high out-of-pocket costs, undermine the patient-physician relationship, and lead to the spread of health plans that do not comply with the ACA’s requirements, including the mandate that QHPs ensure access to a sufficient choice of “providers,” including essential community providers. It is also unclear whether NNP-enrolled patients would be subject to balance billing. On one hand, CMS proposes that participating clinicians would accept the non-network plan’s benefit amount as payment in full but later states that NNPs would be required to have a strategy for informing the public about potential balance billing scenarios, which may conflict with the prohibition on surprise billing.

CMS predicts that NNP enrollees will use price transparency tools to negotiate with clinicians; however, existing price transparency information is not presented in a patient-friendly format and is mostly used by employers and health plans to compare prices for negotiating purposes (7). Further, the Congressional Budget Office estimates that savings from price transparency

efforts would be “very small” (8). Patients with low English language proficiency, health care literacy, or other limitations may be particularly ill equipped to negotiate with clinicians, especially if health plans do not provide adequate, understandable educational information to facilitate price comparison and negotiation. We are also concerned that the precarious nature of this model will discourage care coordination and make it difficult for patients and physicians to establish a longitudinal care relationship. Additional details are needed regarding the process to hold patients harmless if they are unable to access a sufficient choice of clinicians, including whether a special enrollment period will be available for patients who want to enroll in a network plan that includes their preferred physicians and facilities. This lack of detail is concerning since under proposed language at 156.236(b)(1) NNPs will merely have to attest that an “assessed percentage” percentage of available clinicians in the service area will accept the plan’s benefit amount as payment in full. We urge CMS to defer implementation of this proposal and instead initiate a non-network plan demonstration project to determine potential benefits and downsides of the concept.

Expansion of Hardship Exemption Eligibility (§ 155.605(d)(1)), Multi-Year Terms for Catastrophic Plans To Improve Health (§§ 156.130 and 156.155), and Cost-Sharing for Bronze and Catastrophic Plans (§§ 156.136 and 156.155)

The proposed rule seeks to codify and expand catastrophic plan eligibility to low-income individuals who are ineligible for advance premium tax credits as well as those with higher incomes who are ineligible for cost-sharing reductions. We are concerned that expanding catastrophic plan eligibility could lead to underinsurance. ACP believes that high-deductible health plans (HDHP) and health savings accounts (HSAs) alone will not achieve the goal of universal health care access, nor are they likely to have a dramatic impact on health care costs. HDHP-HSAs should be considered as one alternative within an array of reforms intended to increase access to health care services, improve quality, and reduce costs. According to the GAO, HDHP-HSAs tend to attract people who are healthy and have high incomes, indicating the plans may have limited appeal to those with complex illnesses and high price sensitivity (9). Patients enrolled in HDHPs, including those with complex needs, tend to delay or avoid evidence-based care due to cost. A 2026 study found among cancer survivors, HDHPs were associated with worse overall survival and cancer specific survival (10).

We are concerned that the proposal to bar catastrophic plans from providing benefits (except for a limited number of primary care visits and preventive care) until an amount equal to 130 percent of the annual limitation on cost sharing is reached could cause patients to delay or skip necessary care. The proposed new limits - totaling \$15,600 for an individual and \$31,200 for a family in PY 2027 – would consume the annual earnings for those at or under the federal poverty level.

Multi-year ACA-compliant plans may provide an opportunity for issuers to make long-term investments in patients’ health. The proposal to permit multi-year catastrophic plans could benefit patients if doing so would cause QHPs to meaningfully invest in primary care and preventive services to avoid and manage disease. Patients who decide to enroll in such plans must be protected against underinsurance to ensure they are not forced to cut back on needed

care or suffer severe financial and/or medical hardships. Cost sharing should not be structured in a way that causes patients to avoid care following a diagnosis.

Under this provision, CMS should broaden coverage of first-dollar preventive benefits offered by catastrophic plans, and other HDHPs as permitted, to improve the long-term health of enrollees. As a starting point, CMS should actively encourage plans to provide first-dollar coverage of the preventive care for specified conditions outlined in the Appendix of Internal Revenue Service Notice 2019-45 “Additional Preventive Care Benefits Permitted to be Provided by a High Deductible Health Plan Under § 223” and additional services listed in Notice 2024-75 (11,12). For example, a patient with diabetes could receive first-dollar coverage of insulin and other glucose lowering agents, retinopathy screening, glucometer, and hemoglobin A1c testing services to prevent further complications.

Thank you for considering our comments. If you have any questions, please contact Ryan Crowley, Manager, Health Policy at rcrowley@acponline.org.

Sincerely,



Jason Goldman, MD, MACP
President
American College of Physicians

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