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March 12, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9883–P
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Administrator Oz,

The AAMC[1] welcomes this opportunity to comment on the proposed rule entitled "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program," 91 FR 6292 (February 11, 2026), issued by the Centers for Medicare & Medicaid Services (CMS or the agency).

The AAMC appreciates CMS' efforts to improve the availability of affordable health insurance coverage in the individual and small group markets. We agree that consumers must have access to high-quality, high-value healthcare providers and services. However, the AAMC is concerned about the impact of some of the proposed changes in the individual market – specifically, relaxing the regulations surrounding network adequacy and essential community providers (ECPs) for qualified health plans (QHPs), expanding eligibility for catastrophic plans, and allowing for the use of non-network plans. These changes, if finalized, may segment the insurance market, leading to de-stabilization and premium increases for sicker individuals, restrict patient access to providers, and leave providers, who treat patients that are uninsured and

[1] The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations. Its members are all 163 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 Canadian medical schools accredited by the Committee on Accreditation of Canadian Medical Schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe.

underinsured, either underpaid or not paid at all. **The AAMC urges CMS to not finalize proposals that raise costs for beneficiaries, restrict network adequacy or access to care.** The availability of the marketplace and ACA enhanced subsidies has allowed uninsured rates to reach record lows due to enrollment in QHPs. This shift in enrollee coverage has had a profoundly positive impact across the healthcare ecosystem.[2] For providers, increases in healthcare coverage improve payer mix, reduce uncompensated care costs, and ensure the ability to continue offering care to their communities. However, if these proposed changes are finalized, the result would be an estimated loss of coverage for 1.2 to 2 million enrollees in 2027. (P.6463). These coverage losses are compounded by the expiration of ACA enhanced subsidies at the end of 2025 and the implementation of the One Big Beautiful Bill Act,[3] which are estimated to result loss of coverage for 4.8 million people in 2026[4] and 10 million individuals by 2034,[5] respectively.

The recent legislative and regulatory changes leading to greater numbers of uninsured and underinsured pose significant risks to patients' access to care and to the providers who furnish that care. AAMC member academic health systems and teaching hospitals share a common mission to care for the underserved and train the nation's future health care workforce, making life-saving health care services available to all patients, regardless of their ability to pay. This commitment to high-quality care, regardless of a patient's insurance coverage, can create significant financial challenges, requiring costs to be absorbed by the hospitals themselves. Without sufficient health care coverage, uncompensated care costs rise, forcing providers to find ways to stretch already limited resources. AAMC-member academic health systems and teaching hospitals have median uncompensated care costs of $39.0 million – more than 17 times nonteaching hospitals.[6] Increases in uncompensated care that will result from these proposals pose a threat to providers' ability to maintain services and access to care for their patients. **We urge CMS to consider the cascading effect these proposals have on access and affordability and urge the agency not to finalize policies that raise costs for beneficiaries, restrict network adequacy, or hinder access to care.**

CMS Must Ensure All States Provide and Maintain Sufficient Network Adequacy for All Plans Offered on The Exchanges

CMS is proposing to remove its current network adequacy standards for State Based Exchanges (SBEs) and State-based Exchanges on the Federal platform (SBE-FPs) and allow for state review

[2] KFF, A Look at ACA Coverage through the Marketplaces and Medicaid Expansion Ahead of Potential Policy Changes (January 2025)
[3] P.L. 119-21
[4] Urban Institute, 4.8 Million People Will Lose Coverage in 2026 If Enhanced Premium Tax Credits Expire (September 2025)
[5] CBO, Distributional Effects of Public Law 119-21 (August 2025)
[6] Notes: Data reflect short-term, general, nonfederal hospitals. Data for AAMC-member teaching hospitals reflect integrated and independent AAMC members. Charity care is defined as care provided without the expectation of payment. Excludes hospital's bad debt and is measured in terms of costs, not charges.
Source: AAMC analysis of a special tabulation using FY2024 American Hospital Association Annual Survey Database. AAMC membership data, December 2025.

of network adequacy. This would also eliminate the requirement to establish and impose quantitative time and distance network adequacy standards that are at least as strong as the Federally Facilitated Exchanges (FFE) standard, so long as states can show they have an "effective provider access review program." (P.6394). CMS highlighted the need to return this authority to the states due to states' greater understanding of their state-specific needs and the use of a wide variety of approaches to assess compliance with network standards. (P. 6398). Further, CMS is proposing to allow the use of non-network plans as qualified health plans if approved by the exchanges. However, these plans are not guaranteed approval if they fail to meet network adequacy standards or other ACA requirements. (P.6407). A non-network plan is a plan that does not contract with providers for specific negotiated rates on a specific set of services. Rather, non-network plans set a benefit amount for each covered service. CMS is proposing SBEs and SBE-FPs only ensure a "sufficient access to providers in both network and non-network plans." (P.6394).

Such changes to network adequacy standards would add complexity for states that would be responsible for evaluating network adequacy for these unconventional types of plans. Additionally, dividing oversight of plans between states and removing specific quantitative network adequacy standards, including time and distance standards, may result in inconsistencies between plans that lead to reduced access for certain populations and limit provider choice. This can be particularly detrimental for patient groups that need specialized care or already suffer from disproportionate levels of disease, early death, and increased mortality rates. The AAMC is concerned that allowing states to determine the standards for QHP network adequacy may lead to exclusion of certain provider types, particularly those offering specialized care such as academic health systems and faculty physicians.

Many of the AAMC academic health systems and teaching hospitals are safety net providers that care for vulnerable, underserved populations and individuals who often cannot seek treatment elsewhere. These hospitals also maintain the vast majority of the country's critical standby units, including trauma centers, burn units, and neonatal and pediatric ICUs, that provide cutting edge treatments to medically complex patients.[7] Academic health systems and teaching hospitals are committed to the missions of providing critical services to their populations, advancing medical and scientific research, fostering community collaborations, and educating the next generation of physicians. However, these missions carry heavy expenses that are often under reimbursed by payers, with hospitals ultimately absorbing these costs by themselves. This is further exacerbated by plans excluding academic health systems and teaching hospitals from their networks. This exclusion would be based on these providers being deemed "high cost," without accounting for the value added by the other missions and societal benefits academic health systems provide.

[7] Notes: Data reflect short-term, general, non-federal hospitals. Data for AAMC-member teaching hospitals reflect integrated and independent AAMC members.
Source: AAMC analysis of FY2024 American Hospital Association Annual Survey Database, and the National Cancer Institute's Office of Cancer Centers, 2024. AAMC membership data, December 2025

Compounding this problem is the distance patients must travel in order to seek care when in a narrow network, particularly for specialist care. Consumers base their choice of health insurance not only on the providers included in the plan's network but also on the location of those providers. The inability to easily access providers severely limits consumer choice of where they go to seek needed care. Further, continuity of care is of particular importance in rural areas that struggle with physician shortages and is often compromised due to the lack of accessible providers, which may be exacerbated by a narrow network. These concerns highlight the need to not only have a sufficient number of providers represented in a network, but also a need to ensure manageable time and distance standards to access those in-network. Specific, quantifiable time and distance standards to determine adequate access for beneficiaries eliminate some of the concern that providers may be inappropriately excluded from plans and help to ensure reasonable access for patients. **Based on this, we strongly recommend CMS re-evaluate the proposal to eliminate specific time and distance criteria to ensure reasonable access to care and allow consumers to exercise their right to choose their health insurance and provider.**

Do Not Finalize the Use of Non-Network Plans as Proposed

Complicating the CMS network adequacy proposal is the agency's intention to allow for the use of non-network plans, as detailed above. These types of plans have historically not been offered broadly, even when regulations allow, and pose a number of questions for patients and providers. As the agency itself notes, these plans are inherently complex for patients and consumers who may not be immediately familiar with how these plans operate. (P.6411). For the lay person, this will require considerable outreach and education on how these plans work prior to enrollment, which CMS details is a factor, but does not outline how plans will measure or achieve this.

Additionally, without a contracted rate, providers are effectively cut out of the negotiation of what constitutes a sufficient benefit amount to cover the cost of care. Plans may alternatively seek to utilize reference pricing to determine benefit amounts, which is not the same as negotiated rates within a network of providers in a plan's network. These negotiated rates ensure providers are adequately paid in full for services provided while protecting patients by limiting out of pocket costs. Without these negotiated rates, providers are not required to accept the benefit amount as payment in full. This leaves patients vulnerable to additional out-of-pocket costs or balance bills, potentially making those providers prohibitively unaffordable for patients, to prevent these increased out-of-pocket costs for patients under this proposal, plans should maintain contracted rates with hospitals, especially with those in a plan's catchment area.

Further, the agency suggests patients may use existing transparency reporting from providers and plans to shop for the best value in care. (P. 6411). However, to date this information is not easily accessible for patients to navigate. Even if this data is posted and readily available to consumers, these reports may not be easy for beneficiaries to understand or process, making this an unworkable strategy for the everyday consumer. Shopping for healthcare is not one to one with shopping and comparing prices at traditional stores. This creates significant barriers for consumers seeking to compare prices and rates. While work is being done by the agency to achieve this goal, the market is not yet ready for this type of approach. Often this idea of

shopping for healthcare also fails to account for or accurately explain the nuance between rate differences for different providers and provider types. As discussed above, specific types of providers, such as academic health systems and teaching hospitals may be classified as "high cost," without accounting for the value added by the other missions and societal benefits they provide. Without deep knowledge of the value of these missions, applying the traditional shopping model may confuse patients, which is further muddled by what portion of the costs are covered by a beneficiary's plan versus what portion is subject to a patient out of pocket costs. This creates challenges for patients looking to estimate their total out of pocket cost to judge whether they are willing to pay out of pocket for that specific service. Further, the rule suggests patients may be the ones to negotiate with providers themselves to ensure the provider will accept the non-network plan's benefit amount. This is a significant barrier to care for the lay patient who is not experienced or knowledgeable on how to navigate such negotiations, causing additional burden and confusion for patients seeking care. **For these reasons, CMS should not allow the use of non-network plans as proposed.**

CMS Should Not Reduce the Standard for Demonstrating a Sufficient Number and Geographic Distribution of Essential Community Providers

Plans are currently required to contract with at least 35 percent of available Essential Community Providers (ECPs) in a plan service area. ECPs are healthcare providers that serve predominantly low-income, medically underserved individuals, inclusive of safety-net providers. This threshold was established in the 2015 plan year at 30 percent,[8] then reduced in the 2018 plan year to 20 precent,[9] and raised to the current level of 35 percent in the 2023 plan year.[10] Now, beginning with plan year 2027, CMS is proposing to reduce the threshold back to 20 percent and allow states to conduct their own certification of network and non-network plans. (P.6399). **The AAMC urges CMS to keep the current 35 percent ECP requirement in order to ensure that patients have sufficient access to providers in their communities.**

CMS highlighted the thresholds for plans, on average, are well above the required 35 percent threshold. (P. 6459). However, the agency should not lower the standard just because plans are exceeding it. By lowering this threshold, the agency signals to plans a deemphasis on ensuring beneficiaries have access to an adequate number of providers. This is especially relevant for ECPs, which include safety-net providers who take care of some of the most vulnerable patients. AAMC members are often included as ECPs and provide highly specialized health care services that may be unavailable in other settings, including oncology services, transplant surgery, trauma care, pediatric specialty care, and treatment for rare and complex conditions. Beyond specialized care, academic health system and physician faculty practices serve a disproportionately large volume of underserved, low-income individuals and provide access to essential health services for disadvantaged groups. The AAMC remains concerned that this reduction in required ECPs will negatively impact vulnerable populations that rely on these academic health systems for

[8] 79 FR 13744
[9] 83 FR 16930
[10] 87 FR 584

their care. Maintaining a sufficient number of these providers who offer specialized care is imperative to ensure providers are reasonably available to address urgent patient's needs. Lastly, having some representation of ECP providers does not always equate to sufficient access to due to patient travel and wait times, which has the potential to increase if required thresholds of ECPs decrease, along with eliminating qualitative time and distance standards, resulting in a decrease in available providers.

Non-Comprehensive Coverage and Higher Out-of-Pocket Maximums Do Not Address Patient Affordability Concerns

In addition to changes to network adequacy, CMS is proposing to expand access to catastrophic plans and increase the maximum out-of-pocket costs for these plans. The rule would expand eligibility to those above 30 years old and would expand hardship exemptions to anyone ineligible for premium tax credits or cost sharing reductions because their household income is below 100 percent of the federal poverty level (FPL) or above 250 percent FPL. (P. 6371). Additionally, the rule would increase maximum out-of-pocket cost from $12,000 for an individual to $15,600 and from $24,000 for a family to $31,200. (P. 6382). **The AAMC supports providing consumers with greater access to health insurance options, but we urge CMS to ensure beneficiaries receive coverage that improves access to providers as well as patient affordability.** While we agree that any coverage is better than no coverage, we remain concerned the proposal to expand eligibility to high deductible catastrophic plans may lead to underutilization of needed care due to high out-of-pocket costs. Catastrophic plans may appear to provide an affordable option for health insurance coverage due to their lower premiums, but these plans often leave consumers exposed to high health care costs upfront until their deductible is met. Without sufficient health insurance literacy, out of pocket costs may be misunderstood by beneficiaries and not realized until beneficiaries need coverage the most.

These limitations can disproportionately impact underserved communities who may have lower levels of health insurance literacy and be more vulnerable to aggressive or misleading marketing practices and misinformation.[11] These plans may force patients to forego needed, routine care due to limited benefits or high cost-sharing responsibilities. Insufficient coverage and affordability for health care results in poorer health outcomes for patients and may lead to the use of high-cost services, due to delayed care. Plans with limited benefits and high patient cost sharing drive consumers' medical debt, increasing financial strain on patients and providers.[12] As hospitals and their associated providers find themselves treating more patients who are uninsured or underinsured, it is imperative that CMS consider how these proposed policies may impact patient medical debt and provider uncompensated care costs.

[11] Edward, J., Wiggins, A., Young, M. H., & Rayens, M. K. (2019). Significant Disparities Exist in Consumer Health Insurance Literacy: Implications for Health Care Reform. Health literacy research and practice, 3(4), e250–e258. https://doi.org/10.3928/24748307-20190923-01
[12] KFF, Americans' Challenges with Health Care Costs (Jan. 2026)

Further, CMS should consider requiring that agents and brokers sign an attestation with consumers that the information given to the consumer by the agent or broker clearly spells out, in clear language, the terms of the coverage under the catastrophic plans and acknowledges that the consumer understands the limitations and higher financial responsibility. This would help to ensure that underserved communities and patients with chronic medical conditions who may struggle to find affordable health insurance options are not targeted by unscrupulous sales and marketing tactics.

Opening eligibility for catastrophic plans as a means to address the issue of premium affordability is not a sufficient response to address the issue at hand. As premiums continue to rise, more individuals who are younger and healthier may opt to disenroll from coverage or shift to catastrophic plans. Over time, such a justification would encourage disenrollment from other types of marketplace coverage, creating instability in the risk pools and other plans in the individual market. This would leave sicker, more vulnerable patients at greater risk of continuously increasing costs and losing access to care. CMS even acknowledges this trend and issue with high premium costs in marketplace plans in its Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability proposed rule.[13]

Lastly, CMS is also proposing to allow multi-year catastrophic plans, from one year up to ten years. (P. 6370). CMS further details how this will allow plans to use value-based insurance designs to increase the use of preventative services. The AAMC supports the agency's goal of ensuring continued longer, term coverage and seeking a way to improve access to preventative care. Investment in preventative care lowers health care costs overall. However, this proposal opposes the agency's eligibility verification requirements for other forms of coverage, which remove the ability for beneficiaries to automatically re-enroll year over year. CMS should re-evaluate both of these proposals and align them to ensure beneficiaries are not being misled towards coverage not best suited to address their health needs due to burdensome enrollment regulations. Further, under these multi-year plans CMS proposes allowing plans to sue more flexible plan designs that allow for the maximum out-of-pocket limit (MOOP) to be divided by 12 months into a monthly MOOP and vary the MOOP by diseases, such as front loading MOOP costs in the early years of a multi-year plan and resulting in lower MOOP costs in the later years. The MOOP is the most a beneficiary will pay for service in a plan year before the plan covers 100 percent of costs for covered services. (P. 6371). We caution CMS against finalizing this proposal without the proper safeguards for beneficiaries to maintain this type of coverage if regulations were to be changed in the future. Over recent years, CMS has shifted its regulatory direction on marketplace-based plans a number of times. If a beneficiary were to enroll in a plan with the costs frontloaded, only for the regulations to change in future years preventing this type of coverage, it would be the beneficiary who would lose out financially. Additional, allowing plans to shift costs based on disease may enable plans to design plans that financially disadvantage individuals with pre-existing conditions, which is not allowed under statue.[14]

[13] 90 FR 27074
[14] Public Law 111–148

Do Not Introduce Additional Barriers to Enrollment and Coverage

Further, CMS included several proposals aimed at aligning eligibility requirements for the exchanges and premium tax credits with changes in the One Big Beautiful Bill Act[15] and permanently extending provisions finalized in the Marketplace Integrity and Affordability Final Rule. (P.6342). It is important to note, many of these provisions were either stayed by the courts or finalized under a temporary timeline, set to expire in 2027, due to pending litigation.[16,17] The AAMC had previously submitted comments in response to the agency's Marketplace Integrity and Affordability proposed rule.[18] **We maintain our ask that CMS focus on advancing polices that incentivize health individuals to select and maintain coverage to prevent adverse selection, rather than create additional barriers to enrollment in coverage.** We ask that related to the proposals subject to litigation, CMS not move forward with finalizing until the courts have weighed in.

CONCLUSION

Thank you for the opportunity to comment on this proposed rule. The AAMC supports the administration's efforts to address health care coverage and affordability but encourages the agency to do so in a way that does not limit patient access due to increased out-of-pocket costs or limited network adequacy. We would be happy to work with CMS on any of the issues discussed or other topics that involve the academic community. If you have questions regarding our comments, please feel free to contact Katie Gaynor (kgaynor@aamc.org).

Sincerely,

Jonathan Jaffery, M.D., M.S., M.M.M., F.A.C.P.
Chief Health Care Officer

cc: David Skorton, M.D., AAMC President and Chief Executive Officer

[15] P.L. 119-21
[16] City of Columbus, et. al, v. Robert F. Kennedy, Jr. et. al (Civil No. 25-2114-BAH)
[17] City of Columbus, et. al, v. Robert F. Kennedy, Jr. et. al (No.25-2012)
[18] AAMC Comments on CMS' Marketplace Integrity and Affordability Proposed Rule (April 2025)