266 West 37th Street, 3rd Floor
New York, NY 10018
212.869.3850/Fax: 212.869.3532

March 13, 2026

VIA ELECTRONIC SUBMISSION

Dr. Mehmet Oz
Centers for Medicare & Medicaid Services
Baltimore, MD 21244

Re: RIN 0938-AV62: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program [CMS-9883-P]

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the **Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program** proposed rule. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to over three million people with Medicare, family caregivers, and professionals.

We are extremely disappointed by this proposed rule which will limit access to affordable coverage, increase administrative and choice barriers, and harm consumers. Our comments focus on our experiences counseling people who are attempting to shop for health coverage or to access care when network coverage is too limited or providers are otherwise not covered by their insurer.

8. Standardized Plan Options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(I)(H), 156.201, and 156.265(b)(3)(iv))
9. Non-Standardized Plan Option Limits (§ 156.202)

CMS proposes to discontinue requiring standardized plans, the differential display of standardized plans, and a meaningful difference between standardized plans. In addition, CMS proposes to remove limits on non-standardized plans. We oppose these proposals and urge CMS to withdraw them. In our experience with similar changes in Medicare Advantage (MA), people are unable to effectively evaluate their coverage options and select the best plan for their unique circumstances when faced with too many choices.

The elimination of meaningful difference and uniformity requirements[1] within MA has contributed to seemingly endless numbers of MA plans that can vary on everything from costs to coverage, sometimes in subtle but important ways. For most beneficiaries, this makes close analysis both critical and unattainable.

Indeed, research indicates comparing each plan deviation, year after year, is a challenging, intimidating, and time-consuming task that alarmingly few people with Medicare perform.[2] Enrollees who arguably have the most at stake—those who are older, have lower incomes, are living with cognitive impairments, or have serious health needs—are also the least likely to review and change their coverage.[3]

The inertia and suboptimal enrollments that can result have serious consequences. The penalty for a poor fit between what a plan offers and what an individual needs can lead to delays in care, higher out-of-pocket costs, and barriers to preferred providers.[4] Consumers who are overwhelmed by the cluttered plan landscape may suffer decision fatigue and may ultimately feel unable to make any choice at all.[5]

The Marketplace must not follow MA's lead. Although MA choice is overly burdensome and complex, with too many plans cluttering the landscape, CMS has taken important steps by adopting policies that modernize systems and empower consumers.[6] In so doing, CMS has demonstrated that, used effectively, plan standardization and proliferation guardrails can heighten transparency, improve decision-making, and streamline plan selection. We urge CMS to build upon this strategy, to do more to ease comparisons and reduce choice burdens, not less. Those shopping for coverage need better, more affordable, and higher quality choices, not a river of options to drown in.

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

CMS proposes to allow certification of non-network plans, meaning Marketplace enrollees could purchase plans that make no promises that sufficient, or any, providers will accept their payments for services as payment in full. Instead, such non-network plans would determine their own payment rates, leaving enrollees on the hook for charges above that amount. We oppose this proposal and urge CMS to withdraw it.

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[1] 86 FR 16440, 16491.
[2] Nancy Ochieng, *et al*., "Nearly 7 in 10 Medicare Beneficiaries Did Not Compare Plans During Medicare's Open Enrollment Period" (September 26, 2024), https://www.kff.org/medicare/issue-brief/nearly-7-in-10-medicare-beneficiaries-did-not-compare-plans-during-medicares-open-enrollment-period/.
[3] *Id.*
[4] Medicare Rights Center, "Medicare Advantage Proliferation: Too Much of a Complicated Thing" (July 23, 2025), https://www.medicarerights.org/policy-documents/medicare-sustainability-ma-proliferation.
[5] Mai Quattash, "The Neuroscience of Decision Fatigue: Why We Make Worse Choices at the End of the Day" (June 2, 2025), https://gc-bs.org/articles/the-neuroscience-of-decision-fatigue/.
[6] *See, e.g.*, Centers for Medicare & Medicaid Services, "HHS Notice of Benefit and Payment Parameters for 2023 Final Rule Fact Sheet," (April 28, 2022), https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2023-final-rule-fact-sheet; Karen Pollitz, *et al*., "Health Insurance Transparency under the Affordable Care Act" (March 8, 2012), https://www.kff.org/health-reform/perspective/health-insurance-transparency-under-the-affordable-care-act/.

Again, Medicare provides a good illustration of the pitfalls of CMS's proposed approach. Most providers participate in Medicare and adhere to its payment rates.[7] But many psychiatrists either formally opt-out of Medicare or do not regularly accept new Medicare patients.[8] A beneficiary who cannot find a participating psychiatrist faces a barrier to access and must either go without needed behavioral health care or pay for it on their own.[9]

For example, a caller to Medicare Rights Center's National Helpline needed psychiatric services and could not access any care in her rural county. This caused her to go without care for several months, a pattern we see repeated with other callers. Such delays can pose a particular risk or hardship for those dealing with behavioral health conditions.[10]

CMS's proposal would create this risk on an even larger scale. Non-network plan enrollees could find themselves unable to rely on their coverage for any conditions, unable to predict their health care expenses, and unable to access their providers. The proposal essentially offers enrollees a voucher or coupon with no guarantee that it will cover the cost. Under the best-case scenario, enrollees would have the burden of shopping for providers who would accept their coupon as payment in full. In the likely case where such providers are not available, enrollees would face delays in or lack of care, worse health outcomes, asymmetric negotiations with providers who have every advantage, high bills, and rising debt.

Conclusion

Thank you again for the opportunity to provide comments. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Counsel for Federal Policy at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

Fred Riccardi
President
Medicare Rights Center

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[7] Medicare Interactive, "Participating, non-participating, and opt-out providers" (March 31, 2025), https://www.medicareinteractive.org/understanding-medicare/medicare-covered-services/outpatient-provider-services/participating-non-participating-and-opt-out-providers.

[8] Alex Cottrill, *et al.*, "How Many Physicians Have Opted Out of the Medicare Program?" (January 17, 2025), https://www.kff.org/medicare/how-many-physicians-have-opted-out-of-the-medicare-program/ (estimates 8.1% of psychiatrists have opted out).

[9] Tara F. Bishop, *et al.*, "Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care" (February 2014), https://jamanetwork.com/journals/jamapsychiatry/fullarticle/1785174.

[10] Tony Leys, "Private Medicare, Medicaid Plans Exaggerate In-Network Mental Health Options, Watchdogs Say" (October 20, 2025), https://kffhealthnews.org/news/article/medicare-medicaid-private-plans-networks-mental-health-providers/.