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March 13, 2026

The Honorable Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
File Code CMS-9883-P
Baltimore, MD 21244–8010

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

Dear Administrator Oz:

The American Psychiatric Association (APA), the national medical specialty society representing more than 39,200 psychiatric physicians and their patients, appreciates the opportunity to comment on the proposed rule, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program*.

Psychiatrists provide care to individuals with a wide range of mental health and substance use disorders (MH/SUD), including serious mental illness (SMI) and co-occurring medical conditions, and therefore have a strong interest in policies that shape the accessibility, affordability, adequacy, and continuity of health insurance coverage in the individual and Basic Health Program markets.

The proposed rule includes sweeping changes to network adequacy standards, plan design and cost-sharing parameters, catastrophic plan eligibility and duration, enrollment and reenrollment processes, verification requirements, premium tax credit (PTC) eligibility, and oversight of marketing and consumer assistance entities. Collectively, these proposals may negatively affect patients' ability to obtain and maintain meaningful coverage for behavioral health services.

Because individuals with MH/SUD conditions are particularly sensitive to disruptions in coverage, high out-of-pocket costs, and narrow or inadequate provider networks, we are concerned that several aspects of the proposed rule could increase underinsurance or uninsurance, create coverage instability, and exacerbate longstanding disparities in access to behavioral health care at a time when MH/SUD

needs remain a continuing concern.[1,2] At the same time, we support provisions that seek to strengthen consumer protections and promote integrity in Marketplace enrollment.

We are concerned that the cumulative effect of several proposals in this rule, particularly expanded catastrophic and high cost-sharing plan designs and reduced federal network oversight, could shift Marketplace coverage further toward a model that is functionally oriented to episodic acute care rather than prevention and ongoing management of chronic conditions. In practice, enrollees would be expected to navigate complex benefit designs, anticipate future health needs, and absorb substantial premiums and out-of-pocket costs before coverage would effectively support routine care.

These assumptions are unrealistic for many enrollees and especially for individuals with MH/SUD conditions. Weakening oversight guardrails, including lowering provider access standards and essential community provider standards for QHP certification, risks directly limiting patients' ability to obtain timely in-network care and could increase reliance on already overburdened urgent care and emergency departments. For behavioral health care in particular, higher copayments and coinsurance combined with inadequate networks can undermine sustained engagement in treatment and weaken efforts to integrate behavioral health into broader care delivery.[3]

Our comments below outline specific concerns with the proposed rule and recommendations to ensure that Marketplace and Basic Health Program coverage remains robust, affordable, and consistent with the goals of the Affordable Care Act, including parity and meaningful access to mental health and substance use disorder services.

<u>Essential Health Benefits</u> *(pages 6332-6335)*

APA understands that the proposed revision to § 155.170 would effectively freeze Essential Health Benefits (EHBs) at their pre-2012 scope and require states to defray the costs of MH/SUD benefits added after 2011, including many adopted to comply with the Mental Health Parity and Addiction Equity Act (MHPAEA). Because numerous states strengthened MH/SUD coverage after 2011, particularly for opioid use disorder treatment and medications for addiction treatment, this proposal would place those gains at risk and could deter states from adopting additional evidence-based services. If finalized, the policy would likely reduce access to affordable, comprehensive MH/SUD care, undermine parity compliance, and reverse progress made during an ongoing mental health and overdose crisis. Such consequences would increase untreated mental illness and substance use disorders, leading to higher rates of relapse, overdose, hospitalization, disability, and preventable deaths. We also have concerns that this proposal exceeds statutory authority. EHBs were never meant to be frozen in time; Congress gave CMS explicit

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[1] U.S. Government Accountability Office, *Behavioral Health: Provider Networks Are Inadequate in Many Markets and May Contribute to Poor Access to Care* (GAO-22-105912), June 29, 2022, https://www.gao.gov/assets/gao-22-105912.pdf.
[2] Reinert M, Nguyen T, Fritze D. *The State of Mental Health in America 2025*. Mental Health America; October 2025. https://mhanational.org/wp-content/uploads/2025/09/State-of-Mental-Health-2025.pdf
[3] Vargas Lopes F, Riumallo Herl CJ, Mackenbach JP, Van Ourti T. Patient cost-sharing, mental health care and inequalities: a population-based natural experiment at the transition to adulthood. *Soc Sci Med.* 2022;296:114741. doi:10.1016/j.socscimed.2022.114741. https://pubmed.ncbi.nlm.nih.gov/35144223/

authority and responsibility to review and "periodically update the [EHBs] to address any gaps in access to coverage or changes in the evidence base."[4] However, this proposal would freeze EHBs at any earlier point in time, and concerningly, one at which most states were failing to comply with these requirements. APA urges CMS not to finalize these proposals.

Network Barriers to Access

Qualifying "Non-network" Plans *(pages 6402-6417)*

We urge CMS to not move ahead with its proposal to allow carriers to offer plans without a comprehensive provider network. As clinicians treating individuals with serious mental health and substance use disorders, we care for patients who are among the most clinically vulnerable individuals in our health care system. They frequently require highly specialized, multidisciplinary, and longitudinal care including intensive outpatient services, inpatient or residential treatment, medication management, psychotherapy, and coordinated medical care. Even when a provider network formally exists, accessing in-network behavioral health services is often extraordinarily difficult. The March 2022 report issued by the GAO documented that consumers with coverage for mental health services frequently cannot obtain timely in-network appointments due to inaccurate directories, low reimbursement rates that result in clinicians being unwilling to join networks, and workforce shortages.[5] The result is patients delay or forego care and pay higher out-of-pocket costs to see a clinician not in network. These access failures are especially acute in rural communities and for patients requiring inpatient care. Similarly, a 2025 Department of Health and Human Services-Office of Inspector General report found Medicare Advantage and Medicare Managed Care plans have limited behavioral health networks.[6]

Eliminating networks does not eliminate the need for coordinated systems of care. For patients with serious mental illness, continuity, integration, and crisis responsiveness are essential components of effective treatment. Despite their flaws, provider networks provide patients with a defined system for finding providers, obtaining referrals and authorizations. Removing them shifts the burden of system navigation onto patients who are often experiencing impaired concentration, executive dysfunction, paranoia, severe anxiety, or suicidal ideation. Expecting these individuals to independently locate appropriate clinicians, determine availability, negotiate fees, and manage claims submissions is clinically unrealistic and ethically concerning.

Non-network plans would expose patients to substantial financial risk. Clinicians would have no contractual obligation to accept the plan's payment as payment in full. Patients would face balance billing and unpredictable, potentially catastrophic costs. For individuals already at increased risk of disability,

[4] 42 U.S.C. § 18022(b)(4)(H).
[5] U.S. Government Accountability Office (GAO), *Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts*, GAO-22-104597 (Mar. 2022), https://www.gao.gov/assets/gao-22-104597.pdf
[6] U.S. Department of Health and Human Services, Office of Inspector General (OIG), *Many Medicare Advantage and Medicaid Managed Care Plans Have Limited Behavioral Health Provider Networks and Inactive Providers*, OEI-02-23-00540 (Oct. 2, 2025), https://oig.hhs.gov/reports/all/2025/many-medicare-advantage-and-medicaid-managed-care-plans-have-limited-behavioral-health-provider-networks-and-inactive-providers/

unemployment, and housing instability, even modest unexpected medical bills can destabilize treatment engagement. Faced with uncertain financial exposure, many patients will delay or forgo care entirely with predictable downstream consequences including psychiatric decompensation, emergency department utilization, hospitalization, and increased risk of suicide.

The proposal raises serious concerns about compliance with the mental health parity requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) and the consumer protection framework established under the Patient Protection and Affordable Care Act. These concerns are exacerbated by the recent pause in enforcement of key provisions of the 2024 MHPAEA Final Rule, which has already weakened federal oversight of network composition and access disparities, increasing the risk that plans could functionally undermine parity or lead to "ghost networks" without timely corrective action. If non-network plans disproportionately impair access to behavioral health services relative to medical and surgical services, CMS risks creating a non-quantitative treatment limitation that undermines parity protections.

While lower premiums may appear attractive, lower upfront costs are not synonymous with meaningful access to care. A plan without a provider network may function, in practice, as coverage without access, particularly for behavioral health conditions that already face workforce shortages and reimbursement inequities.

We respectfully urge CMS to prioritize policies that strengthen behavioral health networks, such as improving network adequacy standards, enforcing directory accuracy, ensuring adequate reimbursement to encourage participation, supporting workforce development, and enhancing parity enforcement. We strongly encourage CMS to withdraw this proposal.

Removal of Time and Distance Standards *(pages 6394-6399)*

Likewise, **we urge CMS to not discontinue federal time and distance network adequacy standards and to defer network adequacy oversight to individual states**. States' oversight of provider networks has historically been inconsistent, variable, and often insufficient, particularly for ensuring timely access to essential services, including mental health and substance use care. A GAO report documented wide variation in state network adequacy review practices and noted limitations in the consistency and robustness of state oversight of private health plan networks. While many states reported reviewing networks before approving plans for sale, the standards applied, including time, distance, and provider choice, varied significantly, and instances of non-compliance were identified.[7]

Further, reducing the minimum Essential Community Provider (ECP) participation threshold from 35 percent to 20 percent may reduce issuer compliance costs, but these changes would risk weakening uniform access protections, particularly for low-income and medically underserved populations who disproportionately rely on ECPs for behavioral health care. Evidence from independent analyses also

[7] U.S. Government Accountability Office (GAO), *Private Health Insurance: State and Federal Oversight of Provider Networks Varies*, GAO-23-105642 (Dec. 15, 2022), https://www.gao.gov/products/gao-23-105642

shows that state insurance regulators rarely take enforcement actions for network adequacy issues and often rely predominantly on consumer complaints as the primary source of oversight data — a mechanism that fails to capture the true extent of access problems faced by patients who may not even be aware of how or where to file a complaint.[8]

The federal government stepped in to establish uniform time and distance standards precisely because state enforcement alone was insufficient to ensure meaningful access across diverse geographic markets. These quantitative standards serve as a baseline to protect patients from plans whose networks are too narrow to allow timely access to care, especially for specialty services such as behavioral health where provider shortages and workforce constraints are well-documented. Doing away with these standards significantly risks increasing access challenges for people needing care for mental health and substance use disorder care.

As noted previously, the recent pause in enforcement of key provisions of the 2024 MHPAEA Final Rule further heightens concern because it weakens federal oversight intended to address disparities in network composition and practical access to mental health and substance use disorder services. This lapse makes the continuation of defined, enforceable federal time and distance standards even more critical to protecting patients. **We urge CMS to retain federal network adequacy requirements and not defer oversight to state regulators.**

High-Deductible Bronze/Catastrophic Plans *(pages 6368-6394, 6455-6456)*

We are concerned that CMS's proposal to expand and extend enrollment in catastrophic plans will undermine patients' access to meaningful insurance coverage for mental health and substance use disorder (MH/SUD) care while increasing out-of-pocket limits by 30 percent. Requiring individuals to spend up to $15,400 (and families up to $31,000) before most benefits take effect will likely affect timely access to outpatient psychiatric and addiction treatment. Longstanding evidence shows that high-deductible health plans are associated with reduced utilization of mental health services and shifts toward more acute, crisis-driven care, including increased mental health-related emergency department and inpatient hospitalization spending.[9]

The proposed expansion of hardship exemptions to allow broader enrollment in catastrophic plans for individuals ineligible for advance premium tax credits or cost-sharing reductions due to projected income below 100 percent or above 250 percent of the federal poverty level also raises serious concerns. While lower premiums may appear attractive to consumers looking for affordable plans, catastrophic plans are ineligible for premium tax credits, and under this proposal, would expose enrollees to extremely high out-of-pocket thresholds. In practice, these plans could quickly become unaffordable for many enrollees.

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[8] Sabrina Corlette, *New Report on States' Oversight of Health Plan Network Adequacy*, Center for Children and Families, Georgetown University McCourt School of Public Policy (Nov. 18, 2014), https://ccf.georgetown.edu/2014/11/18/new-report-states-oversight-health-plan-network-adequacy/

[9] Schilling CJ, Eisenberg MD, Kennedy-Hendricks A, et al. Effects of High-Deductible Health Plans on Enrollees With Mental Health Conditions With and Without Substance Use Disorders. Psychiatr Serv. 2022;73(5):518-525. doi:10.1176/appi.ps.202000914. https://pubmed.ncbi.nlm.nih.gov/34587784/

Individuals with emerging or undiagnosed behavioral health conditions may delay care until symptoms worsen, which can lead to poorer outcomes and higher system-wide downstream costs.[10, 11]

We are similarly concerned about the proposal to allow certain individual market bronze plans to exceed the ACA's statutory maximum annual limitation on cost sharing in order to meet actuarial value requirements, so long as at least one Maximum Out of Pocket (MOOP) - compliant bronze plan is offered in the same service area. The proposed rule does not establish a clear maximum on how much these plans could exceed the statutory limit. Bronze plans already carry significant deductibles and cost-sharing obligations. Further increasing these amounts may effectively make routine MH/SUD treatment, including psychotherapy, medication management, and intensive outpatient services, effectively unaffordable and disrupt continuity of care. Studies further underscore that cost-related barriers disproportionately impede access to behavioral health treatment and exacerbate unmet need among individuals with MH/SUD conditions.[12]

We also have serious concerns about permitting multi-year catastrophic plans that auto-renew for up to 10 consecutive years. Locking individuals into coverage with extremely high cost-sharing obligations for extended periods without annual reassessment will reduce consumer flexibility and increase the risk of prolonged underinsurance. Individuals who initially enroll while healthy may later develop mental health or substance use disorders and then face difficult financial requirements to treatment for multiple years. CMS should carefully evaluate how these policies interact with the ACA's guaranteed issue protections, annual cost-sharing limits, and MHPAEA requirements.

These proposals must also be considered in the context of ongoing affordability challenges in the individual market. Policies that further shift costs onto enrollees' risk exacerbating coverage instability and disrupting access to care. For individuals with MH/SUD conditions, delays in treatment can have serious consequences that could otherwise be preventable, including relapse, increased suicide risk, overdose, and psychiatric hospitalization.[13, 14]

Another consideration is how these changes allowing higher deductibles and forgoing federal network adequacy enforcement will interact with the current pause in federal enforcement of the 2024 mental health parity rule, which was intended in part to address real-world access disparities in behavioral health care. Recent evidence finds that commercial insurance markets already show large disparities in out-of-

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[10] Moon KJ, Linton SL, Mojtabai R. Medical Debt and the Mental Health Treatment Gap Among US Adults. *JAMA Psychiatry.* 2024;81(10):985–992. doi:10.1001/jamapsychiatry.2024.1861. https://pubmed.ncbi.nlm.nih.gov/39018037/

[11] U.S. Government Accountability Office. *Behavioral Health: Research on Health Care Costs of Untreated Conditions Is Limited.* GAO-19-274. U.S. Government Accountability Office; February 2019. https://www.gao.gov/assets/gao-19-274.pdf

[12] Eisenberg MD, Barry CL. High-Deductible Health Plans' Impact on Mental Health and Substance Use Disorder Treatments-Balancing Cost and Care. JAMA Psychiatry. 2023;80(10):983-984. doi:10.1001/jamapsychiatry.2023.2625

[13] Courtney Burke and Asmaul Shukh, *Closing the Coverage Gap: Improving Access to Mental Health and Substance-Use Disorder Services* (Albany, NY: Rockefeller Institute of Government, December 2024), https://rockinst.org/wp-content/uploads/2024/12/Closing-the-Coverage-Gap-report.pdf

[14] Anika Reichart and Rowena Jacobs, "The Impact of Waiting Time on Patient Outcomes: Evidence from Early Intervention in Psychosis Services in England," Health Economics 11 (November 2018): 1772–87, https://pmc.ncbi.nlm.nih.gov/articles/PMC6221005/

network use between mental health and substance use services and medical-surgical care, reflecting longstanding challenges with network composition and parity enforcement.[15]

Because these utilization gaps exist under the current regulatory framework, proposals in the rule that scale back aspects of federal network adequacy oversight while allowing greater flexibility for higher-deductible plan designs could reinforce the same dynamics that have historically contributed to inadequate in-network behavioral health access, particularly when parity enforcement has been paused.[16]

Finally, we are concerned that eliminating the requirement to offer standardized plan options and ending the differential display on Healthcare.gov would make it more difficult for consumers to compare plan designs and understand cost-sharing obligations. **We urge CMS to reconsider these proposals ensuring that exchange plans provide meaningful, affordable coverage that supports early intervention and sustained treatment for mental health and substance use disorders.**

Barring Automatic Reenrollment and New Pre-Enrollment Verification Requirements Beginning In 2028
(pages 6430-6433)

APA is concerned about the provisions implementing the proposed pre-enrollment verification requirements and effective sunset of automatic reenrollment beginning in 2028. These sweeping verification changes would impose significant new administrative burdens on consumers seeking Marketplace coverage and premium tax credits (PTCs), including requirements to submit additional documentation and complete pre-enrollment verification before receiving financial assistance. This represents a substantial departure from current Exchange processes, which already rely on extensive eligibility verification through trusted electronic data sources, such as the Internal Revenue Service, Social Security Administration, Department of Homeland Security, and state Medicaid agencies.

Requiring consumers themselves to provide and verify "applicable enrollment information," including income, family size, immigration status, health coverage status, and other factors identified by CMS, would effectively eliminate automatic reenrollment, a streamlined approach that has been critical to maintaining stable coverage for millions of Americans, including individuals living with mental health and substance use disorders (SUD). This policy will increase data matching issues (DMIs), which could increase burden on Marketplaces and enrollees and result in reduced enrollment.

APA is concerned that CMS estimates average Marketplace enrollment in 2027 could decrease by 1.2 to 2 million enrollees relative to baseline projections, in part because many individuals would lose eligibility for premium tax credit subsidies and healthier enrollees would be more likely to discontinue coverage,

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[15] Kannarkat JT, Smith NN, Carlo AD. Driving Access in Commercial Behavioral Health Networks. *JAMA Psychiatry*. 2026;83(3):227-228. doi:10.1001/jamapsychiatry.2025.4344 https://pubmed.ncbi.nlm.nih.gov/41563784/
[16] Mark, T. L., & Parish, W. J. (2024). Behavioral health parity – Pervasive disparities in access to in-network care continue. RTI International. https://www.rti.org/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue

potentially worsening the risk pool and increasing premiums for remaining enrollees.[17] [18]

Further, requiring new pre-enrollment verification steps to receive PTCs will likely result in coverage disruptions for patients. Even short gaps in coverage can interrupt access to ongoing MH/SUD treatment with existing in-network clinicians. For those patients with serious SMI, disruptions in coverage can destabilize recovery and increase the risk of psychiatric hospitalization, emergency department utilization, overdose, or crisis care.[19] A growing body of research demonstrates that greater continuity of care for individuals with SMI is associated with fewer emergency department visits and reduced hospitalizations, while interruptions in care are linked to poorer clinical outcomes.[20] Adding complex new verification requirements onto the enrollment process risks deterring eligible individuals from obtaining or maintaining coverage and exacerbating longstanding disparities in access to behavioral health services.

Patients with MH/SUD conditions may face particular challenges navigating complex administrative requirements. Individuals who experience housing instability, limited access to technology, or other social barriers make repeated documentation and verification especially burdensome. These policies move the Marketplaces in the opposite direction of modern, streamlined enrollment systems and risk reversing progress made under the Affordable Care Act to expand access to affordable, comprehensive behavioral health coverage.

In addition, we are also concerned about the operational feasibility and timing of these changes. State-based exchanges and state Medicaid agencies require substantial lead time, clear federal guidance, and adequate resources to design and implement new IT systems and verification workflows, particularly while simultaneously undertaking other significant eligibility and enrollment system changes. As CMS has acknowledged, these requirements carry considerable complexity, cost, and potential enrollment impacts. Without sufficient flexibility and implementation time, the result may be administrative strain, consumer confusion, and avoidable coverage losses.

For these reasons, **APA strongly urges CMS to not implement these additional pre-enrollment verification and reenrollment restrictions.** At a minimum, implementation should be postponed until after plan year 2028 to allow for meaningful stakeholder engagement, careful assessment of coverage impacts, extensive consumer education, and adequate operational preparation at the state and federal level. **Protecting stable, affordable access to comprehensive coverage, including essential mental health and substance use disorder services, must remain a central priority to safeguard continuity of care and improve outcomes for patients.**

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[17] Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program, 91 Fed. Reg. 6292, pg. 6463 (proposed Feb. 11, 2026). https://www.govinfo.gov/content/pkg/FR-2026-02-11/pdf/2026-02769.pdf

[18] Panhans, M. (2019). Adverse Selection in ACA Exchange Markets: Evidence from Colorado. *American Economic Journal: Applied Economics*, *11*(2), 1–36. https://www.jstor.org/stable/26727310

[19] Alexandra L. Breslau et al., *Continuity of Care and Health Outcomes in Patients With Serious Mental Illness: A Systematic Review*, Psychiatric Services 72, no. 10 (Oct. 2021): 1202–1210, https://pubmed.ncbi.nlm.nih.gov/34448985/

[20] Ingemar Engström et al., *Relational Continuity May Give Better Clinical Outcomes in Patients With Serious Mental Illness: A Systematic Review*, BMC Psychiatry 23, no. 952 (Dec. 18, 2023), https://pubmed.ncbi.nlm.nih.gov/38110889/

Proposals Related To Creating Standards of Conduct Related To Marketing and Mandating a Standard Consumer Consent Form *(pages 6427-6429)*

APA supports efforts to strengthen standards of conduct for insurance agents, brokers, and web-brokers and to prohibit misleading or fraudulent marketing practices. These proposals should enhance consumer protection, improve the integrity of enrollment decisions, and reduce the risk that individuals are steered into coverage that does not meet their needs or exposes them to unexpected costs, particularly for mental health and substance use disorder treatment. Strong oversight and accountability for individuals and entities that facilitate enrollment are essential to ensure that marketplace coverage functions as intended, and that vulnerable consumers are not harmed by deceptive conduct.

Similarly, we support CMS's proposal to strengthen and standardize consumer consent requirements by requiring clear, verifiable documentation through a standardized HHS-created consent form to ensure that individuals fully understand and authorize eligibility submissions and plan enrollment assistance.

Thank you for the opportunity to provide comments. We look forward to working with you to ensure meaningful health insurance coverage for people with mental health and substance use disorders. Please contact Becky Yowell (qualityandpayment@psych.org) with any questions or for more information.

Sincerely,

Marketa Wills, MD, MBA, FAPA
CEO and Medical Director
American Psychiatric Association