

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND**

CITY OF COLUMBUS, *et al.*,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., *et al.*,

Defendants.

Case No. 1:26-cv-2215

**PLAINTIFFS' REPLY IN SUPPORT OF THEIR
MOTION FOR STAY UNDER 5 U.S.C. § 705 OR,
IN THE ALTERNATIVE, FOR PRELIMINARY INJUNCTION**

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INTRODUCTION

This Court has repeatedly reminded the Centers for Medicare & Medicaid Services (CMS) of the need to observe the statutory limits on its authority under the Affordable Care Act, and to follow basic requirements of reasoned decision-making in exercising that authority. CMS has apparently not been deterred by these warnings, and it remains intent on instituting measures that would undermine the ACA's promise of affordable health coverage for all Americans. In this year's iteration of its repeated efforts to make health coverage more expensive and more difficult to obtain, CMS seeks to re-impose many of the same measures that this Court invalidated in its reviews of last year's rulemaking and of a similar rule from the first Trump administration. These measures are just as unlawful and arbitrary as they were before, and the agency's attempt to pour old wine into new bottles should be rejected.

Nor does CMS fare any better when it invents new approaches to weaken health coverage. The ACA, for example, imposes unambiguous limits on the amount of out-of-pocket spending that an enrollee may be required to pay in a given year. CMS acknowledges that statutory command, but it asserts a right to "balance" "statutory fidelity" against other considerations while increasing the cost-sharing burden on enrollees by 30% over the statutory maximum. Defs.' Opp'n to Pls.' Mot. for Stay or Prelim. Inj. (Opp'n) at 31, ECF No. 23. This Court should unequivocally reject the agency's attempt to treat a statutory requirement as merely a suggestion.

Plaintiffs would face irreparable harm if the agency's unlawful and arbitrary measures were to go into effect. Individuals who rely on ACA coverage, like the members of Main Street Alliance, would face higher costs for less generous coverage in the upcoming 2027 plan year. And safety net providers, like the Cities of Baltimore, Columbus, and Chicago and Pima County (municipal Plaintiffs) as well as the members of Doctors for America, will inevitably face higher costs from providing care to individuals who are less likely to be insured, or to have adequate coverage even

if they are insured. In order to avoid these irreparable harms, Plaintiffs respectfully request that the Court stay the effective date of the provisions of the rule at issue in this motion no later than July 20, 2026, or that the Court preliminarily enjoin enforcement of those provisions.

ARGUMENT

I. Plaintiffs Are Injured by the Rule, and Irreparably So in the Absence of a Stay

Throughout the first and second Trump Administrations, CMS has repeatedly published rules that drive up the cost of insurance coverage on the Affordable Care Act Exchanges, drive people off that coverage, and increase the burden of uncompensated care on safety net providers. This Court has consistently held that individuals who rely on ACA coverage and municipalities that provide safety net care—including many of the exact Plaintiffs here—suffer injury in fact, fairly traceable to agency action and sufficient for purposes of standing. *See City of Columbus v. Kennedy (Columbus III)*, 796 F. Supp. 3d 123, 146-47 (D. Md. 2025) (finding municipal and small business association plaintiffs have standing to challenge provisions of 2025 CMS rule on ACA); *City of Columbus v. Cochran (Columbus II)*, 523 F. Supp. 3d 731, 743-44 (D. Md. 2021) (same for municipal and individual plaintiffs challenging 2019 CMS rule), *City of Columbus v. Trump (Columbus I)*, 453 F. Supp. 3d 770, 779 (D. Md. 2020) (same). Defendants’ arguments to the contrary fail for many of the same reasons as they have in past litigation.

To start, the rule will clearly increase healthcare costs—CMS itself concedes that provisions accounting for much of the rule, including those at issue here, will increase premiums by 1.7 to 2.4 percent, Decl. of Jason Levitis ¶ 34, ECF No. 17-8—and those increased costs, in and of themselves, constitute irreparable injury to the members of Main Street Alliance (MSA) who are Exchange enrollees. *See Columbus I*, 453 F. Supp. 3d at 787 (“The increase in premiums constitutes economic harm and is therefore ‘a classic and paradigmatic form of injury in fact[.]’” (quoting *Air Evac EMS, Inc. v. Cheatham*, 910 F.3d 751, 760 (4th Cir. 2018))); *Columbus II*, 523

F. Supp. 3d at 744 (“Likewise, the Individual Plaintiffs have demonstrated that the 2019 Rule predictably increases the premiums that they must pay to purchase health insurance, thereby constituting an economic injury that could be remedied by vacating the challenged provisions of the 2019 Rule.”).¹ Although “economic losses generally do not constitute irreparable harm, this general rule rests on the assumption that economic losses are recoverable,” *Mountain Valley Pipeline, LLC v. 6.56 Acres of Land*, 915 F.3d 197, 218 (4th Cir. 2019) (internal quotation omitted), and they are not here.

The municipal Plaintiffs, who are providers of last resort for their residents, “are likely to suffer financial injury because the Rule will directly lead to increased costs incurred by the [municipal] Plaintiffs in the form of shouldering the expense of uncompensated care.” *Columbus III*, 796 F. Supp. 3d at 147-48. These economic injuries, which are sufficient to establish standing, cannot be remedied absent a stay. *See id.* Further, despite Defendants’ contentions, these are not “self-inflicted injuries” or the “incidental effects of policies.” Opp’n at 16. The municipal Plaintiffs cannot simply avoid harm by “choosing [not] to provide services to their residents.” *Id.* Among other things, municipalities have legal obligations to provide emergency ambulance and other services for their populations. *See, e.g.,* Ariz. Rev. Stat. Ann. §§ 36-182(A), 36-190; Md. Code Ann., Pub. Safety §§ 1-101(b), 1-304(c)(1); Ohio Rev. Code Ann. § 4765.35(A); Columbus, Ohio, City Code § 1934.01. The notion that the municipal Plaintiffs could simply decide not to offer emergency ambulances or medical or fire services to their residents blinks reality. Defendants’ reliance on *Pennsylvania v. New Jersey*, 426 U.S. 660 (1976)—a case where the plaintiff state

¹ Defendants misread *United States v. Texas*, 599 U.S. 670 (2023). There, two states challenged a Department of Homeland Security nonenforcement decision related to the arrest and removal of noncitizens. The Court held that the states did not suffer a cognizable injury from the federal government’s nonenforcement policy because one party “lacks a judicially cognizable interest in the prosecution of another.” *Id.* at 677 (internal quotation and alteration omitted). The Court did not hold that healthcare costs writ large are not cognizable injuries, as Defendants imply in their opposition.

suffered a truly self-inflicted injury by offering a tax credit to residents who paid taxes to other states—is inapposite. Similarly, the reference in *Department of Education v. Brown* to “incidental effects,” 600 U.S. 551, 568 (2023), sheds no light on this case. There, the Court rejected a bank-shot theory by some plaintiffs that the invalidation of one agency rule would somehow make it more likely that the agency would adopt a second rule that would benefit them. Here, the municipal Plaintiffs (and the other Plaintiffs) suffer an injury caused directly by CMS’s decision to drive up costs and throw people off insurance coverage.

Similarly, Plaintiff DFA’s members provide care regardless of whether they are compensated by their patients’ insurance and will thus suffer as the rule increases the number of under-and uninsured patients in their care. Decl. of Dr. Janet Krommes ¶ 6, ECF No. 17-5; Decl. of Dr. Beth Oller ¶¶ 6-9, ECF No. 17-10; Decl. of Dr. Eric D. Fethke ¶¶ 5-9, ECF No. 17-3. Just as other providers of last resort were able to challenge other actions by HHS that predictably increased their costs of uncompensated care, DFA and its members may challenge the rule to protect themselves from these harms. *See Massachusetts v. HHS*, 923 F.3d 209, 225 (1st Cir. 2019); *California v. Azar*, 911 F.3d 558, 571 (9th Cir. 2018); *Pennsylvania v. Trump*, 351 F. Supp. 3d 791, 807 (E.D. Pa. 2019), *aff’d*, 930 F.3d 543 (3d Cir. 2019), *rev’d on other grounds*, 591 U.S. 657 (2020). DFA members will be harmed directly, as the rule presents an existential threat to their medical practices.² Dr. Beth Oller noted that the increase in uncompensated care created by the rule’s provisions “will lead to a decrease in [her] total compensation” that, over time, would force her to leave her job altogether. Oller Decl. ¶ 10. Dr. Eric Fethke similarly explained that his

² Defendants assert that Plaintiff DFA “attempts to establish associational standing with a declaration from a *single* member.” Opp’n at 13 (emphasis added). An association need not identify more than one of its injured members to demonstrate standing, but Defendants’ statement is incorrect in any event. Plaintiff DFA’s standing is supported by declarations from members Dr. Beth Oller and Dr. Eric Fethke, as well as DFA leader and member Dr. Janet Krommes.

“practice cannot survive increased uncompensated care costs” and, under the weight of the rule’s impacts “the network of care [he] built over the last 31 years will collapse.” Fethke Decl. ¶ 10.

The rule likewise jeopardizes the business plans of Plaintiff MSA’s members. *See* Decl. of Mike Ohlinger ¶ 10, ECF No. 17-9; Decl. of Shawn Phetteplace ¶ 5, ECF No. 17-11; Decl. of Brooke Legler ¶ 11, ECF No. 17-7. Additionally, the rule will raise both premiums and out-of-pocket expenses for the MSA members themselves. Mike Ohlinger explained that his family needs healthcare and will maintain the same levels of insurance coverage even as the rule makes that coverage more expensive, exacerbating healthcare costs that are already “as much as [their family’s] monthly mortgage payments.” Ohlinger Decl. ¶¶ 7-9. Brooke Legler likewise needs comprehensive health insurance coverage to treat her substantial medical conditions. Legler Decl. ¶¶ 7-8. The rule would cause the cost of her coverage to increase to unaffordable levels, threatening her health. *Id.* ¶ 11; *see also Columbus III*, 796 F. Supp. 3d at 142 (finding that Ms. Legler had stated “with precision” how last year’s rule would negatively impact her for purposes of establishing standing and irreparable harm).

“Absent a stay, the coverage losses and higher costs caused by the rule will be locked in for the coming year, ensuring that Plaintiffs will suffer harm before a decision on the merits can be rendered.” *Columbus III*, 796 F. Supp. 3d at 173 (internal quotations omitted). As a result, not only do Plaintiffs have standing to challenge the 2026 rule, but the prospect of irreparable harm to Plaintiffs warrants preliminary relief. *See Curtis v. Propel Prop. Tax Funding, LLC*, 915 F.3d 234, 240 (4th Cir. 2019); *see also Mountain Valley Pipeline*, 915 F.3d at 216 (plaintiffs satisfy the irreparable harm prong for injunctive relief because their injuries “cannot be fully rectified” by a later judgment in their favor (cleaned up)).

Defendants fault the declarations of the municipal Plaintiffs and of the MSA and DFA members for not “attempt[ing] to explain how any [costs] that [they] might encounter could

reasonably be attributed to any *specific* provision of the Rule.” Opp’n at 14; *see also id.* at 12, 16. But CMS itself concedes that the challenged portions of its rule will decrease Exchange enrollment and increase premiums. Levitis Decl. ¶¶ 29, 34. And the declaration of Jason Levitis outlines, in great detail, how each of the provisions of the rule that are challenged here will “impose substantial new administrative burdens and higher costs on individuals seeking to enroll in Marketplace coverage.” *Id.* ¶ 5; *see also id.* ¶¶ 52, 58, 68, 75-76, 86, 89, 94, 104-05. Defendants, however, completely fail to acknowledge his conclusions, let alone contend with the “independent analyses” that “confirm Plaintiffs’ allegations that Defendants’ actions [will] cause[] price increases.” *Columbus I*, 453 F. Supp. 3d at 789.

Defendants argue that Plaintiffs’ harms are built on “a lengthy chain of assumptions” too attenuated to qualify as irreparable injury. Opp’n at 15-16 (internal quotation omitted). But, as this Court has explained, “[a] causal chain does not fail simply because it has several ‘links,’ provided those links are not hypothetical or tenuous.” *Columbus III*, 796 F. Supp. 3d at 146. “What matters is not the ‘length of the chain of causation,’ but rather the ‘plausibility of the links that comprise the chain.’” *Nat’l Audubon Soc’y, Inc. v. Davis*, 307 F.3d 835, 849 (9th Cir. 2002) (quoting *Autolog Corp. v. Regan*, 731 F.2d 25, 31 (D.C. Cir. 1984)). A chain of causation may be shown through means like “statistical analysis, common sense, or record evidence.” *New York v. Dep’t of Com.*, 351 F. Supp. 3d 502, 576 (S.D.N.Y. 2019), *aff’d in relevant part*, 588 U.S. 752, 768 (2019). And where third parties are a link in the chain, a plaintiff need only prove that “the agency action is at least a substantial factor motivating the third parties’ actions.” *Tozzi v. HHS*, 271 F.3d 301, 308 (D.C. Cir. 2001) (internal quotation omitted). The ultimate question is whether the injury can be fairly traced through the third party’s intervening action back to the defendant, and “[w]hen third party behavior is predictable, commonsense inferences may be drawn.” *Diamond Alt. Energy, LLC v. EPA*, 606 U.S. 100, 116 (2025).

It is reasonably predictable (indeed, it is predicted by CMS itself) that the rule will cause insurers to push greater costs onto enrollees; will cause federal tax subsidies to decline, imposing even greater costs on enrollees; will cause some enrollees to resort to less generous coverage or drop out of the market altogether; and will force providers of last resort to incur greater uncompensated care costs. *See* Levitis Decl. ¶¶ 21-38, 46-106. The effects will play out soon in the absence of a stay, as insurers are already in the process of setting rates for 2027 based on CMS's rule. *See* CMS, *Qualified Health Plan Certification Information and Guidance: Timeline*, <https://perma.cc/R38P-DADT>; *see also* *Columbus III*, 796 F. Supp. 3d at 173.

II. Plaintiffs Are Likely to Succeed on the Merits of Their Claims

A. Plaintiffs Are Likely to Succeed on Their Claims Against Provisions That Impose Barriers on Coverage

1. The Failure-to-Reconcile Policy Is Unlawful and Arbitrary

When an enrollee files his or her tax return for a given year, he or she reconciles the amount of tax credits to which he or she is entitled (on the basis of actual income) with the advance premium tax credits (APTCs) that he or she received over the course of the year (on the basis of projected income). 26 U.S.C. § 36B(f)(3). CMS has established a process by which it requires applicants for coverage to report whether they have reconciled their tax credits on prior tax returns, and it checks that reporting against IRS data. 45 C.F.R. § 155.340(c). As we noted in our opening brief, this process is flawed; many people are incorrectly flagged, in part due to the considerable time lag in tax reporting. And this problem will only be compounded now as a result of IRS staff terminations. *See* Pls.' Mem. in Supp. of Mot. for Stay at 16-17, ECF No. 17-1.

Despite these flaws, CMS seeks to deprive an applicant of eligibility for APTCs if he or she does not reconcile tax credits in one of two different ways. The federally facilitated Exchange (FFE) would revoke APTC eligibility in the first year that a reconciliation issue arises. States that

operate their own Exchanges would have the option to apply this policy or to permit a one-year grace period before revoking APTC eligibility in the second year. 45 C.F.R. § 155.305(f)(4). Both the one-year and the two-year versions of this policy are unlawful, given that “[t]he statute does not contemplate that a prior tax debt affects an applicant's eligibility for APTCs in any way,” as this Court explained in staying, and then vacating, the materially identical provision from the prior rulemaking. *See City of Columbus v. Kennedy (Columbus IV)*, — F. Supp. 3d —, 2026 WL 1707125, at *21 (D. Md. June 12, 2026); *Columbus III*, 796 F. Supp. 3d at 162-63.

CMS recognizes that this Court has already ruled on the legality of this provision, and it largely rests on the arguments it presented in last year’s case. Opp’n at 19. Those arguments should be rejected for the reasons Plaintiffs have already explained.³ The agency also suggests that this Court should decline to issue a ruling now, given that the Fourth Circuit might provide guidance on the issue later this year if CMS appeals the judgment in *Columbus IV*. But insurers are preparing their 2027 rates now—with the next round of filings due to CMS in July and final applications due in August—so Plaintiffs cannot wait to avoid the harms that they face, in the form of higher costs and dropped coverage, from this unlawful rule. *See supra* at 7.

CMS also notes that Congress has adopted a version of the failure-to-reconcile provision in the One Big Beautiful Bill Act, which will become effective in 2028. *See* Pub. L. No. 119-21, § 71303(a), 139 Stat. 72, 324 (2025). The agency suggests that, in so doing, Congress ratified its rulemakings for 2026 and for 2027. Opp’n at 19-20. Quite the opposite: “By delaying the effective date of the [OBBBA], the Congress clearly indicated the statute would apply only from [2028] forward.” *Lytes v. D.C. Water & Sewer Auth.*, 572 F.3d 936, 940 (D.C. Cir. 2009); *see also AT&T*

³ In this year’s rulemaking, the agency offered a new statutory theory that the failure-to-reconcile rule was required under 42 U.S.C. § 18082(b). *See* 91 Fed. Reg. at 29,609. Plaintiffs have explained that the agency misread this provision, Pls.’ Mem. at 18, and CMS does not defend its reasoning on this score in its opposition brief.

Corp. v. Hulteen, 556 U.S. 701, 713 (2009). CMS's rulemaking must be judged under the statute that is in force now, and that statute does not authorize the failure-to-reconcile provision.

2. The Verification Policy for Low-Income Enrollees Is Arbitrary

CMS seeks, yet again, to require additional verification for enrollees who project a household income higher than the poverty level for the coming year, if IRS data indicates that their income was below that level two years earlier. 91 Fed. Reg. at 29,867 (revising 45 C.F.R. § 155.320(c)(3)). Many low-income enrollees are self-employed, have incomes that fluctuate widely from year to year, or may otherwise have difficulty obtaining documentation to support their projections. *See Columbus II*, 523 F. Supp. 3d at 762. As a result, they will be more likely to drop out of the market, and younger and healthier enrollees will be more likely to do so.

By CMS's own calculations, this policy will cause 81,000 enrollees to lose coverage. 91 Fed. Reg. at 29,836. But the agency implausibly assumed that almost all enrollees would quickly resolve any verification issues that arise. CMS ignored warnings from independent observers, who explained that it is more likely that about half of the enrollees who will be subject to verification, or 2.3 million people, would lose coverage in 2027 as a result of the two data-matching policies at issue in this case. And those rates would climb much higher in 2028 and later years, when enrollees will be barred from receiving APTCs while they wait for months until verification issues are resolved. *See* Ctr. on Budget & Policy Priorities (CBPP) comment at 19 (Mar. 13, 2026), <https://www.regulations.gov/comment/CMS-2026-0496-0922> (citing Zachary Sherman et al., *2027 Proposed NBPP: Analyzing State and Consumer Impacts* 14 (2026), <https://perma.cc/V6SA-489C>).

On the other side of the ledger, CMS contends that these coverage losses are worthwhile to combat the problem of unauthorized enrollments on the Exchanges. But even by the agency's own telling, this problem has resulted from fraudulent behavior by agents and brokers. *See* 91 Fed.

Reg. at 29,614-15. CMS has instituted measures over the past several years to address this issue, which have reduced the rate of unauthorized enrollments by about half. *See* Jason Levitis et al. comment at 12 (Mar. 13, 2026), <https://www.regulations.gov/comment/CMS-2026-0496-0989>; *see also* 91 Fed. Reg. at 29,623 (noting that existing measures have led to a “substantial decrease” in unauthorized enrollments, resulting in reports of about 24,000 such cases in January 2026 as compared to 46,000 cases in January 2025). And there are further measures that CMS could take that would be targeted at preventing brokers from accessing enrollees’ files without authorization. *See* CBPP comment at 23-24. In contrast, the agency has identified no evidence that there is any significant pattern of fraudulent behavior by enrollees themselves, as opposed to brokers.

CMS, then, committed the same errors in publishing this year’s iteration of the policy as it did in its prior rulemakings. Once again, “the agency’s decision to prioritize a hypothetical risk of fraud over the substantiated risk that its decision result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic.” *Columbus IV*, 2026 WL 1707125, at *28 (internal quotation omitted); *see also Columbus III*, 796 F. Supp. 3d at 167-68; *Columbus II*, 523 F. Supp. 3d at 762-63.

CMS acknowledges this Court’s previous rulings, but it contends that it has found a new “constellation of evidence” that fills the gaps in its prior reasoning and that justifies the coverage losses that it now seeks to impose on lower-income enrollees. Opp’n at 22. It relies primarily on a 2025 Government Accountability Office (GAO) report, which found that it is possible to enroll fictitious applicants for coverage on the Exchanges. But nothing in that report indicates that individual enrollees have tried such a gambit, let alone that low-income enrollees would be more likely to do so. *See* CBPP comment at 16. Nor is it apparent why anyone would even want to try to do so. After all, while a fictitious enrollment could be valuable for a broker who receives commissions on a per-enrollment basis, it does nothing for the individual who would like to use a

health plan to cover his or her health expenses. For this reason, the GAO itself cautioned that its findings could not be extrapolated to make any conclusions about the behavior of enrollees. *See* Levitis comment at 15.

CMS also relies on “internal data” showing that the vast majority of data-matching issues arose in cases involving agents and brokers, along with “anecdotal evidence” that agents and brokers may be using artificial intelligence to impersonate enrollees. Opp’n at 22-23. But this only proves Plaintiffs’ point. Brokers are responsible for what remains of the problem of unauthorized enrollments. So the agency should focus on measures addressing the behavior of these entities, rather than forcing millions of low-income enrollees off coverage on the basis of nothing more than a supposition that they are falsely estimating their income for the coming year.

3. The Audit Policy for Enrollees Lacking Tax Data Is Arbitrary

CMS also renews its effort to revoke the rule permitting applicants to self-attest their income if IRS data is unavailable. This policy is arbitrary as well, for many of the same reasons that the agency’s verification policy for low-income enrollees is arbitrary, and for the reasons that this Court explained in vacating the materially identical policy in last year’s rulemaking. *See Columbus IV*, 2026 WL 1707125, at *28-29; *see also Columbus III*, 796 F. Supp. 3d at 170.

Given that it is relatively common for tax data to be missing for an applicant, even CMS acknowledges that this policy would result in more than 2.7 million instances of data discrepancies that Exchanges and applicants will need to resolve, 91 Fed. Reg. at 29,814, leading to more than 400,000 enrollees losing coverage after they are unable to provide documentation that would substitute for tax data, *id.* at 29,837. Both of these calculations are substantial underestimates, for reasons that commenters explained to the agency but that CMS ignored; as noted above, it is more likely that the two data-matching policies at issue here will result in 2.3 million people losing coverage in 2027 alone, with even greater coverage losses in later years. *See supra* at 9.

CMS seeks to justify these coverage losses as necessary by-products of the agency’s effort to combat fraudulent enrollments by brokers. Opp’n at 26. But, once again, it has failed to provide any “evidence of a *nexus* between fraudulent enrollment and self-attestation to tax data such that it justifies requiring heightened income verification.” *Columbus IV*, 2026 WL 1707125, at *28. After all, an unscrupulous broker would have no way of knowing in advance whether the IRS would later fail to report tax data for an applicant. So the agency has adopted an “incongruent solution to the problem.” *Id.*

CMS also contends that it adequately considered the burden that it was imposing on enrollees. Opp’n at 24. The agency, however, merely “acknowledge[d] commenters’ concerns” on this score, and stated the agency’s belief that “this burden would [not] deter many eligible people from enrolling” because “eligible applicants would likely have documentation to verify their household income.” 91 Fed. Reg. at 29,622. This recitation tracks, almost verbatim, the agency’s explanation for this policy in last year’s rule, which this Court recognized to be overly conclusory and internally inconsistent. *Compare id. with* 90 Fed. Reg. 27,074, 27,132 (June 25, 2025); *see Columbus IV*, 2026 WL 1707125, at *28-29.

The agency also suggests (despite making precisely the opposite argument last year) that the revocation of the self-attestation option is necessary to protect enrollees from the tax liabilities that they would otherwise face if they are enrolled by a broker without their knowledge, given that the OBBBA lifted the cap on an enrollee’s obligation to repay excess APTCs. Opp’n at 24. But individuals are already held harmless if they are fraudulently enrolled by a broker. *See* Levitis comment at 15. CMS critiques its own policy on this score by describing it as a “back-end solution,” Opp’n at 25 n.4, but it does not explain why its policy is inadequate to address this problem, particularly when the alternative is a “front-end” solution that denies coverage to millions of people who have attempted to demonstrate to the agency their desire to keep subsidized

insurance coverage and their eligibility to do so.

4. The Verification Requirements for SEP Enrollments Are Arbitrary

The ACA requires Exchanges to provide for special enrollment periods (SEPs) during which qualifying individuals may enroll for coverage in between the annual open enrollment periods. 42 U.S.C. § 18031(c)(6)(C). CMS once again seeks to make it harder for enrollees to obtain coverage through these SEPs by requiring (this time on a permanent basis) that the federally-facilitated Exchange conduct pre-enrollment verification for each of its SEPs, and that it verify eligibility for at least 75% of new SEP enrollments. 45 C.F.R. § 155.420(g). This rule will generate hundreds of thousands of verification issues, driving younger and healthier people out of coverage. *See* Pls.’ Mem. at 24.⁴ As with the other provisions discussed above, CMS justifies these burdens as anti-fraud measures. But, once again, CMS has failed to provide “any evidence in the Rule to corroborate [its] conclusory assertion that abuse of SEPs is currently contributing to the program integrity concerns the agency seeks to address through this provision,” *Columbus IV*, 2026 WL 1707125, at *18, and this rule is arbitrary for the same reasons that this Court has already discussed in vacating last year’s iteration of this rule.

The agency asserts that it has new evidence that enrollees are gaming SEP enrollments. Opp’n at 27. The agency shifted policy in 2025 to require verification for one type of SEP, for applicants who have lost other forms of minimum essential coverage. Before verification was required, that SEP accounted for 330,000 enrollments, or 48% of all SEP enrollments; after the requirement was instituted, that SEP accounted for 95,000 enrollments, or 27% of all SEP enrollments. *See* 91 Fed. Reg. at 29,632. From these shifting percentages, CMS infers that

⁴ CMS implausibly asserted in the rulemaking that the new SEP verification requirements would improve the risk pool. The agency ignored both its contrary conclusion on this score in prior rulemakings, and the substantial academic evidence that younger and healthier people would be more likely to be deterred from enrolling by paperwork burdens. *See* Pls.’ Mem. at 24. The agency does not defend its reasoning on the risk pool effect of the rule, and this rule is arbitrary for this reason as well.

ineligible enrollees have been moving to other types of SEPs with looser documentation requirements. *See id.*; *see also* Opp’n at 27. Even if the agency’s inference were correct, this would not indicate that fraud is widespread; it would simply indicate that individuals who are eligible under multiple pathways choose the option that poses the least administrative burden. *See* Pls.’ Mem. at 24-25.

In any event, the agency’s inference is *not* correct. Some back-of-the-envelope math reveals why this is so. Using CMS’s own numbers, 52% of all SEP enrollments, or 357,500 individuals, would have been enrolled in other SEPs before the policy change. After the change, 73% of all SEP enrollments, or 256,850 individuals, would have been enrolled in other SEPs. So the agency’s own data reveals that there has not been an influx of fraudsters shifting from one enrollment opportunity to another. Rather, SEP enrollments have declined across the board, albeit more quickly for the one type of SEP that newly required verification, as one would expect.

CMS contends that any burdens it is imposing would be “minimal and justified.” Opp’n at 28. To the contrary, its own data reveals that, when the agency last imposed a similar verification policy, more than one quarter of SEP applicants were denied coverage, or faced delays in coverage, when they were unable to assemble required documentation. *See* Levitis comment at 26. That data suggests that about 2.2 million people would be cut off from access to coverage if the same policy were to be permitted to go into effect this year. *See* CBPP comment at 24. CMS failed even to acknowledge the extent of the burden that it was placing on individuals seeking coverage, let alone explain how such a burden could be justified.

At all events, CMS entirely fails to respond to the point that—given that it has previously correctly recognized that it was describing a problem that did not exist on state-based Exchanges, *see* 90 Fed. Reg. at 27,151—it should have looked to solutions that addressed reasons why the federally-facilitated Exchange might be unique, such as that Exchange’s policy of permitting

enhanced direct enrollment entities to submit applications on behalf of enrollees. *See* Pls.’ Mem. at 25. The agency’s “utter failure to consider obvious alternative actions” that would have directly addressed the problem that it identified, *Fishermen’s Dock Co-op. v. Brown*, 75 F.3d 164, 172 (4th Cir. 1996), coupled with the “significant mismatch” between that problem and the measures the agency chose, *Dep’t of Com. v. New York*, 588 U.S. 752, 783 (2019), demonstrate the irrationality of its approach.

B. Plaintiffs Are Likely to Succeed on Their Claims Against Provisions That Increase Costs for Enrollees

1. The Cost-Sharing Limitation Policy for Bronze Plans Is Unlawful and Arbitrary

The final rule’s expansion of the cap on cost-sharing for bronze plans is contrary to law. In resisting this conclusion, CMS merely recites statements contained in the final rule and fails to address the central problem of statutory noncompliance head-on. As Plaintiffs have explained, under 42 U.S.C. § 18022(c), the annual cost-sharing under an individual market bronze plan cannot lawfully exceed the statutory cap. Pls.’ Mem. at 25-26. CMS refers to this cap as a “standard” maximum out-of-pocket limit, or MOOP, Opp’n at 28, but, as the term implies, the amount is the *maximum* permitted by the statute. Thus, necessarily, any bronze plan MOOP exceeding that statutory maximum is contrary to the law. Indeed, CMS seems to acknowledge this inevitable conclusion in asserting that the final rule “strikes a balance between actuarial reality and statutory fidelity.” *Id.* at 31. But the agency does not have the authority to choose between its policy preferences and fidelity to the law. *Cf. Wisc. Cent. Ltd. v. United States*, 585 U.S. 274, 284 (2018) (only Congress has the “constitutional authority to revise statutes in light of” changes in circumstances, whereas executive agencies must “rely on the original meaning of the written law”). Thus, CMS’s attempt to undermine “statutory fidelity” by permitting insurers to offer bronze plans that exceed the statutory cap on annual cost-sharing is unlawful.

This change is also arbitrary. CMS fails to show that the change to bronze plans is either reasonable or reasonably explained. The agency claims that it “considered” and “addressed” the suggestion that—even accepting CMS’s narrative regarding the difficulty of designing compliant bronze plans—it could adjust the components of its actuarial value calculations to address any such issues. Opp’n at 31. But that is incorrect: the final rule did not engage at all with comments explaining that, even if designing bronze plans were someday to become the problem CMS imagines it to be, the agency could mitigate that problem by changing the actuarial value calculator to account for prescription drug rebates. *See* Matthew Fiedler comment at 3 (Mar. 13, 2026), <https://www.regulations.gov/comment/CMS-2026-0496-1027>.

Finally, CMS is wrong to state that the risk to financially vulnerable consumers by this change to bronze plan cost-sharing limitations is “mitigated” by the fact that those consumers will still have the option to select a statutorily compliant bronze plan. Opp’n at 31-32. As Plaintiffs have explained, permitting statutory violations by private actors is no more reasonable than requiring statutory violations. Pls.’ Mem. at 29. And CMS cannot have it both ways by arguing that the policy—which purports to allow private actors to violate the statute—is both optional and yet essential. *Id.* In any event, at bottom, the new bronze plan policy is unjustifiable because it violates the clear terms of the statute.

2. The Expansion of Catastrophic Plan Eligibility Is Unlawful and Arbitrary

CMS similarly fails to justify its drastic expansion of eligibility for catastrophic plans, which is contrary to the statutory text and neither reasonable nor reasonably explained.

First, CMS does not seriously engage with the text and context of the statutory provisions authorizing a limited hardship exemption. Instead, its argument rests almost entirely on the statute’s grant of “discretion” to the agency to determine the circumstances constituting a hardship.

Opp’n at 33-35. Indeed, CMS goes so far as to say that this discretion is *unlimited*. *Id.* at 35 (stating that the statute “did not enumerate or limit those circumstances” constituting hardship (emphasis added)). But, as Plaintiffs have explained, there are statutory bounds to the agency’s discretion.

The statute makes clear that eligibility for catastrophic plans is intended to be narrowly defined, extending “*only*” to those who have “not attained the age of 30” or who obtain “a certification” of an affordability or hardship exemption. 42 U.S.C. § 18022(e)(1), (2) (emphasis added). Most obviously, the latter exemption requires some kind of “hardship”—but the final rule places no upper limit on the income that can qualify an individual for the purported exemption, necessarily sweeping in consumers who suffer no income hardship whatsoever. *See* Pls.’ Mem. at 32. CMS has no answer to this contradiction.

CMS also does not address that hardship exemption requires individualized determinations based on particular circumstances, *see* 26 U.S.C. § 5000A(e)(5)—not a categorical “exemption” based on income alone that includes the majority of adult consumers. CMS disputes that the final rule creates a categorical exemption, based on its assertion that the rule still provides for an “individualized process for determining eligibility.” Opp’n at 35. This is mere wordplay. Under the final rule, an individual need only “attest” that their income falls within a broad range, without any need for documentation from the individual or independent assessment by the agency. 91 Fed. Reg. at 29,636. That is in no way an “individualized” process. And CMS appears not to appreciate the irony of its decision to accept such attestations without more, even while the agency is arguing elsewhere that self-attestations are drivers of fraud. *See* 91 Fed. Reg. at 29,621 (suggesting removal of self-attestations for IRS income discrepancies would reduce fraud); *id.* at 29,631 (similar).

Further, CMS states that the hardship exemption “provide[s] a distinct and independent pathway from the affordability exemption in 26 U.S.C. § 5000A(e)(1).” Opp’n at 34. But the agency does not respond to the crucial point that the final rule’s expansion of the hardship

exemption sharply undermines the age-related exemption and entirely swallows the affordability exemption. *See* Pls.’ Mem. at 31, 33; *Pulsifer v. United States*, 601 U.S. 124, 143 (2024) (“When a statutory construction thus renders an entire subparagraph meaningless, the canon against surplusage applies with special force.” (cleaned up)).

Second, CMS’s brief fails to provide any reasoned rationale for this policy. For example, the agency states that consumers with incomes above 250% of the federal poverty level “bear the full cost-sharing burden of metal-level plans,” Opp’n at 35, but the expansion of the hardship exemption does nothing to alleviate that. To the contrary, the cost-sharing burden will be worse for newly eligible consumers who have catastrophic plans than if they were to enroll in metal-level plans, which (unlike catastrophic plans) provide premium subsidies and have lower deductibles. *See* Pls.’ Mem. at 36–37 (collecting comments). CMS insists that the greater “*net* affordability of medical care” with metal-level plans does not “undercut [its] logic that more consumers should have access to catastrophic plans as a backstop to total uninsurance.” Opp’n at 36. That insistence, however, does not address the problem that the rule would open the door to catastrophic plans for consumers who do not require any such “backstop.” Under the ACA, that backstop should be available “only” to those consumers who *need* it based on age, income, or individualized hardship. 42 U.S.C. § 18022(e)(1). At bottom, there exists no “rational connection between the facts found and the choice made” to expand the hardship exemption beyond almost any limitation. *Motor Vehicle Mfrs. Assn. of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

C. Plaintiffs Are Likely to Succeed on Their Claims Against Provisions That Permit Insurers to Offer Less Comprehensive Coverage

1. Provisions Reducing Standards for Network Adequacy Are Arbitrary

CMS’s erosion of network adequacy standards—a reversal from its prior rulemakings in which it consistently endorsed meaningful standards for states operating on the federally-

facilitated Exchange—is not reasonably explained. CMS offers no meaningful support for its conclusion that the agency should defer network adequacy to states, beyond its own, unsupported “expert judgment.” *Nat’l Treasury Emps. Union v. Horner*, 854 F.2d 490, 499 (D.C. Cir. 1988) (appeals to agency’s judgment without pointing to data are arbitrary).

The agency primarily asserts that the elimination of uniform federal time and distance standards is necessary because those standards do not account for local features (like mountains or lakes) that create challenges for locating and contracting with providers in remote areas. Opp’n at 40. Current regulations, however, already allow insurers to submit narrative explanations to justify deviations from the time-and-distance standards that would otherwise apply for plans on the federally-facilitated Exchange, and these explanations could cite any geographic constraints. *See* 45 C.F.R. § 156.230(a)(2) (2022). The agency specifically provided for this option in response to concerns raised by commenters that geographic barriers may make compliance with a time-and-distance standard difficult in some cases. *See* 87 Fed. Reg. 27,208, 27,327 (May 6, 2022). CMS fails to explain why this safety valve did not address the issue in particular locations where geographic barriers existed, let alone why it would now be necessary to permit states to do away with the time-and-distance standards across the board even for flatter and drier parts of the country.

Consumers’ difficulties finding providers in remote or difficult to access areas is the exact problem federal network adequacy standards are designed to solve for. As commenters noted, removing the uniform federal standards would permit states to significantly *lower* their own network adequacy standards, thereby making it even more difficult for consumers to gain adequate coverage. *See* Pls.’ Mem. at 39-40. This risk is not addressed by CMS’s conclusory reasoning that states are best positioned to evaluate local provider networks and tailor standards accordingly. Without a federal floor, states would lower standards and start a “race to the bottom” amongst insurers, at the expense of enrollees. It is not the enrollee who should suffer if insurers, as a result,

face limited bargaining power because there are fewer providers to choose from in a remote area. *See* Levitis comment at 59-60; comment of Nat'l Health Law Program at 33 (Mar. 12, 2026), <https://www.regulations.gov/comment/CMS-2026-0496-0615>.

CMS similarly fails to adequately respond to commenters' concerns that states lack the ability to review and enforce network adequacy reviews. Pls.' Mem. at 41. The agency suggests that it addressed these concerns by permitting states to depart from the uniform federal standards only if CMS first certifies them to conduct their own network adequacy or essential community provider (ECP) reviews, if those states demonstrate to CMS's satisfaction that they have sufficient authority and technical capacity. Opp'n at 41. That explanation provides little comfort, however, since CMS has already shown (in this very rule, by permitting states to weaken the time-and-distance standards) that it has little interest in protecting consumers' access to plans with meaningful guarantees of network adequacy. And CMS has done little to date to ensure that states that operate their own Exchanges will meaningfully review plan offerings for network adequacy. *See* comment of Am. Acad. of Family Physicians at 14 (Mar. 13, 2026), <https://www.regulations.gov/comment/CMS-2026-0496-0634>. So there is no real cause for doubt that network standards will suffer as a result of this rule in FFE states such as Wisconsin and Ohio. *See* Levitis Decl. ¶¶ 103-104. The agency's "failure to consider or respond meaningfully to [these] significant points raised is not indicative of reasoned decision-making." *City of Columbus II*, 523 F. Supp. 3d at 752.

2. Provisions Eliminating Standardized Plans and Discontinuation of Non-standardized Plan Limits and Exceptions Are Arbitrary

The rule's discontinuance of standardized plan options, as well as its elimination of limits on non-standardized plans, provide further examples of its unreasoned departures from past policy. CMS contends that "plan standardization policies have 'failed to achieve the originally articulated

objectives’ set forth in the 2023 Payment Notice,” Opp’n at 44 (quoting 87 Fed. Reg. at 29,715), reciting that plans have proliferated from 2023 to 2026. The agency misreads its own data; the average number of bronze plan offerings has dropped by 27% since 2022, and the average number of silver plan offerings has dropped by 20% over the same period. *See* CBPP comment at 31. And the limits on non-standardized plan offerings only took effect last year, so it would be reasonable to expect that with time those statistics would drop even further. *See id.*

But even if CMS had read its data correctly, there still would be a “significant mismatch between [its] decision and the rationale [it] provided,” *Dep’t of Com. v. New York*, 588 U.S. 752, 783 (2019). The agency’s solution—removing restrictions that limit or standardize plan offerings—does not at all resolve the problem of choice overload for consumers, but only exacerbates it. Even under a deferential standard for review of agency decision-making, courts “cannot ignore the disconnect between the decision made and the explanation given,” nor are they “required to exhibit a naiveté from which ordinary citizens are free.” *Id.* at 785.

CMS claims that the standardized option policy failed to accomplish its original goal because consumers rely primarily on premiums, networks and issuer brands, rather than standardized cost-sharing parameters, in choosing a plan. Opp’n at 45. It could certainly be true that many enrollees choose their plans based on these factors. But it is also reasonable to expect that consumers consider those features *because* they are meaningfully able to compare plans on those bases against a set of standardized offerings. *See* Am. College of Obstetricians & Gynecologists comment at 2, 13 (Mar. 12, 2026), <https://www.regulations.gov/comment/CMS-2026-0496-0621> (citing academic research finding 7.3% reduction in premiums when standardized plan options force insurers to compete based on price). And enrollees would certainly be disappointed if they chose a plan with a lower premium only to learn to their surprise that the plan costs them more overall because of its different cost-sharing structure. *See* Families USA

comment at 2 (Mar. 13, 2026), <https://www.regulations.gov/comment/CMS-2026-0496-0945> (citing HHS, Ass't Sec'y for Planning and Eval., Office of Health Policy, *Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces* 2 (Dec. 28, 2021), <https://perma.cc/3ZNX-X75Y>).

CMS fails to reasonably explain why it should abandon a policy that allows consumers to make “apples-to-apples” comparisons. Instead, the agency offers two red herrings. First, CMS contends that any “marginal benefits” that come from requiring standardized plan options or limiting non-standardized plan options do not warrant “impeding insurer innovation.” Opp’n at 44, 47. Insurers, however, have always been able to innovate by offering non-standardized options so long as they offered standardized plans. Second, CMS relies on the “*comparatively* low” uptake of standardized plans as justification for eliminating them. *Id.* at 45 (emphasis added). But it concedes that nearly 8 million individuals enrolled in standardized plans last year, hardly a “low or insignificant” number. *Id.* Even in the agency’s own telling, the number of individuals enrolled in standardized plan options increased from 20% to 33% in just two years, from 2023 to 2025. *Id.* That is a significant increase, representing millions of consumers enrolled in standardized plans, even if it is less than a majority of overall enrollments. CMS offers no rationale for why these enrollees’ preferences should be discounted or deprioritized.

Finally, the agency continues to point to “other approaches to simplifying the plan selection process” like “enhancements to plan display” as justification for the rule’s policies. *Id.* at 46. But CMS has not adopted *any* of these alternatives, and it offers no explanation for its failure to do so. It is not enough for CMS to merely mention alternative solutions. An agency is “required ‘to consider responsible alternatives to its chosen policy *and* to give a reasoned explanation for its rejection of such alternatives.’” *Globalstar, Inc. v. FCC*, 564 F.3d 476, 488 (D.C. Cir. 2009) (emphasis added). CMS failed to do so.

III. The Remaining Equitable Factors Weigh in Favor of Relief

The balance of the equities and the public interest weigh heavily in favor of staying the effective date of the challenged provisions of CMS’s rule. The rule’s harms will not be limited to Plaintiffs and their members but will extend to the millions of Americans who will lose coverage on the Exchanges and who will suffer from higher health care costs as a result. Levitis Decl. ¶¶ 5-8. CMS notes that the public interest turns on the strength of the showing of a likelihood of success on the merits, Opp’n at 48 (citing *Archdiocese of Wash. v. Wash. Metro. Area Transit Auth.*, 897 F.3d 314, 335 (D.C. Cir. 2018)), a point that weighs in Plaintiffs’ favor given the patent illegality and irrationality of each of the provisions discussed above. CMS also asserts that a stay would “hamstring” its efforts to address (uncorroborated claims of) improper enrollments and interfere with its implementation of its policy priorities. Opp’n at 48. But even if CMS had legitimate concerns on this score, they wouldn’t permit it to ignore the statute or the APA’s requirements of reasoned decision-making. *See Roe v. Dep’t of Def.*, 947 F.3d 207, 230-31 (4th Cir. 2020).

IV. The Court Should Stay the Effective Date of the Challenged Provisions of the Rule

This Court has authority to “issue all necessary and appropriate process to postpone the effective date of an agency action or to preserve status or rights pending conclusion of the review proceedings.” 5 U.S.C. § 705. A section 705 stay “operates on the legal status of the challenged agency action.” *Make the Rd. New York v. Mullin*, — F.4th —, 2026 WL 1792978, at *11 (D.C. Cir. June 23, 2026). “A stay is just the preliminary form of vacatur—much like a preliminary injunction is the preliminary form of a permanent injunction.” *Id.* at *12. Because it tracks the scope of relief under section 706’s ordinary remedy of vacatur, a section 705 stay is necessarily universal. *Career Colls. & Sch. of Tex. v. U.S. Dep’t of Educ.*, 98 F.4th 220, 255 (5th Cir. 2024), *cert. granted on other issue*, 145 S. Ct. 1039 (2025); *see also Corner Post, Inc.*, 603 U.S. at 831 (Kavanaugh, J., concurring) (“When a reviewing court determines that agency regulations are

unlawful, the ordinary result is that the rules are vacated—not that their application to the individual petitioners is proscribed.”); *Sierra Club v. U.S. Army Corps of Eng’rs.*, 909 F.3d 635, 655 (4th Cir. 2018).

CMS nonetheless asks this Court to limit relief to the Plaintiffs here. Opp’n at 48-49. This request can’t be squared with the text of section 705, which instructs that “the effective date,” in the singular, of the rule should be postponed if the standards for relief are met. Each challenged provision of the rule has only one effective date, not different effective dates that apply to plaintiffs and non-plaintiffs. *See David v. King*, 109 F.4th 653, 661-62 (4th Cir. 2024) (the definite article “the” “normally indicates that the statute refers to only one such object”). Patchwork relief would be particularly inappropriate here, as Plaintiffs include national associations that require nationwide relief to remedy the harms that their members face. *See PFLAG, Inc. v. Trump*, 769 F. Supp. 3d 405, 452 (D. Md. 2025). In any event, CMS does not explain how it would be workable to limit relief only to Plaintiffs. There would be no feasible way, for example, for the agency to make standardized plans available only to the Plaintiffs, or to selectively apply network adequacy standards. And there is no way to protect the municipal and provider Plaintiffs from the burden of uncompensated care costs without protecting all providers of last resort from the same harm.

V. Plaintiffs Should Not be Required to Post Bond

Though Federal Rule of Civil Procedure 65(c) “vest[s] broad discretion in the district court” to require bonds when issuing injunctive relief, *DSE, Inc. v. United States*, 169 F.3d 21, 33 (D.C. Cir. 1999), the Supreme Court has explained that “[a]n injunction and a stay have typically been understood to serve different purposes,” *Nken v. Holder*, 556 U.S. 418, 428 (2009). “The APA only authorizes courts to ‘set aside’ and ‘postpone’ agency actions—a far narrower authority than the court’s equitable power to issue preliminary injunctive relief.” *Am. Fed’n of Tchrs. v. Dep’t of Educ.*, 779 F. Supp. 3d 584, 623 n.14 (D. Md. 2025). As this Court has noted, “[t]he APA

has no bond requirement.” *Columbus III*, 796 F. Supp. 3d at 177; *see also Neguse v. U.S. Immigr. & Customs Enf’t*, 813 F. Supp. 3d 45, 100 (D.D.C. 2025).

Nor would a bond be appropriate even under Federal Rule of Civil Procedure 65. Courts have the discretion under Rule 65 “to require no bond at all.” *P.J.E.S. ex rel. Escobar Francisco v. Wolf*, 502 F. Supp. 3d 492, 520 (D.D.C. 2020) (internal quotation omitted). And a bond “is not necessary where requiring [one] would have the effect of denying the plaintiffs their right to judicial review of administrative action.” *Phang v. Blanche*, — F. Supp. 3d —, 2026 WL 1831251, at *16 (D.D.C. June 25, 2026). Here, a stay would not cause any monetary injury for CMS. Further, the central point of this motion for emergency relief is that Plaintiffs would be devastated if they were forced to incur the costs that CMS seeks to foist upon them; it would defeat the purpose of this motion to grant interim relief only to take that relief away in the form of a bond. *See RFE/RL, Inc. v. Lake*, No. 1:25-cv-799-RCL, 2025 WL 2023252, at *8 (D.D.C. July 18, 2025). Plaintiffs thus request that the Court not require a bond.

CONCLUSION

For these reasons, the Court should stay the effective date of the challenged provisions of the final rule or, in the alternative, enter a preliminary injunction.

Dated: July 2, 2026

Respectfully submitted,

/s/ Joel McElvain

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**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND**

CITY OF COLUMBUS, *et al.*,

Plaintiffs,

v.

ROBERT F. KENNEDY, JR., *et al.*,

Defendants.

Case No. 1:26-cv-2215

**ADDENDUM OF COMMENTS CITED IN PLAINTIFFS' BRIEFING
ON THEIR MOTION FOR PRELIMINARY RELIEF**

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March 13, 2026

The Honorable Robert F. Kennedy
Secretary
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Submitted electronically via 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 Secretary Kennedy,

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,500 family physicians and medical students across the country, we appreciate the opportunity to comment on the [proposed rule](#) published in the Federal Register on February 10, 2026, regarding the annual HHS Notice of Benefit and Payment Parameters for 2027, or NBPP, proposed rule. In this rule, CMS proposes various provisions implementing the One Big Beautiful Bill Act (OBBBA), alongside widespread changes to the structure and oversight of the individual and small-group markets, Qualified Health Plan (QHP) certification, network adequacy, catastrophic plans, agent and broker conduct, and State-Based Exchange (SBE) and Federally Facilitated Exchange (FFE) Marketplace operations.

The AAFP has long [supported](#) affordable, comprehensive coverage. Family physicians see firsthand how a lack of comprehensive coverage and high out-of-pocket costs adversely impact patients and can cause them to delay necessary care out of fear of being unable to afford it.

The AAFP respectfully urges CMS to implement the following measures to protect patients as the Marketplace continues to evolve:

- **Retain federal standardized plan options on the Marketplace and maintain the requirement for issuers to distinguish a “meaningful difference” among all plans offered.**
- **Withdraw the proposed amendment to § 155.170(a)(2) to redefine certain state-mandated benefits codified in state benchmark plans as outside the Essential Health Benefits framework if those mandates were enacted after December 31, 2011, apply to the individual or small-group markets, require specific services or treatments, and are not necessary to meet federal requirements.**
- **Reinstate federal time-and-distance network adequacy standards for State Exchanges and State-Based Marketplace-Federal Platforms.**

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- **Maintain the current 35 percent Essential Community Provider contracting threshold or, at minimum, maintain the 35 percent threshold for Federally Qualified Health Centers.**
- **Require non-network plans to demonstrate functional and quantitative primary care access beyond theoretical sufficiency to secure Qualified Health Plan certification.**
- **Prohibit issuers from implementing disease-specific variation in maximum-out-of-pocket limits in multi-year catastrophic plan designs.**
- **Condition approval of multi-year catastrophic plans (≥ 2 years) on adoption of value-based insurance designs for preventive services.**

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

CMS is proposing to remove the definition of “standardized option,” repeal all federal standardized plan options across metal tiers, eliminate the requirement for issuers to “meaningfully differentiate” between standardized options, repeal the differential display of standardized plan options on *HealthCare.gov* and the corresponding display requirements for approved web-broker and QHP issuer enrollment partners, and stop developing, publishing, and maintaining federal standardized plan templates. If finalized, these provisions would take effect on January 1, 2027.

The proposed rule would also lift restrictions on the number of non-standardized plans that insurers can offer in the Marketplace. Under current rules, insurers are limited to two non-standardized plans per product network type, metal level, and inclusion of dental and/or vision coverage. CMS states that these limits have previously “constrained insurers’ ability to offer a sufficiently broad range of plans.”

AAFP Comments on Standardized Plan Options (§ 155.20, § 155.205(b)(1), §155.220(c)(3)(i)(H), §156.201, and §156.265(b)(3)(iv))

Standardized plan options are uniform plan designs with consistent cost-sharing within a metal level, including fixed copays for primary care, outpatient mental health visits, and generic drugs. By aligning benefit design across issuers, standardized plans simplify comparison, reduce cognitive burden, and help enrollees better understand their coverage.

This function is particularly important in the Marketplace, where enrollees are more likely than those with employer coverage, Medicaid, or Medicare to report difficulty comparing provider access across plans.ⁱ Moreover, excessive plan choice, when combined with subtle plan-by-plan differences in cost-sharing, has been shown to degrade coverage decision quality rather than improve it, especially for enrollees with limited health literacy.ⁱⁱ

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CMS [reinstated](#) standardized plan options in Plan Year (PY) 2023 with the explicit requirement for insurers to demonstrate a “meaningful difference” between plans in response to consumer choice overload on *HealthCare.gov*, where enrollees commonly faced more than 100 plan options—a level shown to undermine consumers’ ability to effectively compare plans and make informed enrollment decisions.ⁱⁱⁱ

The proposal to simultaneously eliminate the meaningful difference requirement while removing limits on the number of non-standardized plan offerings raises serious concerns. Absent meaningful differentiation standards, issuers would be free to introduce numerous plans with minor or opaque variations in cost-sharing, benefit design, or even plan naming, making it exceedingly difficult for consumers to identify coverage that best fits their health and financial needs.

Repealing standardized plan options would also eliminate the only Marketplace-wide requirement that routine, pre-deductible primary care be accessible before the deductible. If finalized, pre-deductible access to primary care would become optional and issuer-specific, and fixed copays for primary care and behavioral health would no longer be guaranteed. The resulting variability would disproportionately affect individuals with chronic conditions, first-time Marketplace enrollees, and consumers who rely on predictable access to routine primary care. And as cost-sharing becomes less predictable, patients defer chronic and discretionary care, medication adherence declines, and care utilization becomes less stable; effects that are particularly pronounced in primary care and behavioral health settings.^{iv,v}

Accordingly, the AAFP urges CMS to retain federal standardized plan options as a core Marketplace safeguard and maintain the requirement for issuers to distinguish a “meaningful difference” among all plans offered.

Provisions regarding Agents and Brokers’ role in State-Based Exchange Operations
(§ 155.205(b), §155.221(k), § 155.221(k), § 155.220(j), § 155.220(j)(2), and § 155.220(j)(3))

CMS is proposing changes to how State Exchanges may structure eligibility and enrollment operations by allowing them to rely entirely on private web-brokers for consumer-facing eligibility and enrollment websites through a new “State-Based Exchange-Enhanced Direct Enrollment” (SBE-EDE) model. Accordingly, CMS is also proposing to remove the requirement for State Exchanges to operate their own centralized consumer-facing eligibility and enrollment platforms, provided they retain responsibility for eligibility determinations, enrollment records, Medicaid/CHIP assessments, and compliance with all federal standards. If finalized, web-brokers would serve as the exclusive consumer enrollment pathways, while the State Exchange would continue to operate an informational website with comparative plan information and maintain legal oversight, privacy, accessibility, and program integrity controls.

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In parallel, CMS also proposes to strengthen oversight of marketing practices for QHPs offered on the Exchanges by imposing more stringent requirements on agents, brokers, and web-brokers that support QHP enrollment through FFEs and State-Based Marketplace-Federal Platforms (SBE-FPs). Specifically, CMS would distinguish conduct related to consumer enrollment from conduct related to consumer marketing; establish new standards of conduct and additional consumer protection requirements for agents, brokers, and web-brokers; and introduce new marketing requirements, including a list of prohibited marketing practices. CMS also proposes to require agents, brokers, and web-brokers to use an HHS-standardized form to satisfy eligibility application review documentation and consumer consent documentation requirements. In addition, CMS would establish standards of conduct governing how agents, brokers, and web-brokers engage in marketing activities related to assisting or facilitating enrollment of qualified individuals, qualified employers, or qualified employees in coverage through FFEs, or assisting with applications for advance premium tax credits or cost-sharing reductions for QHPs sold through FFEs or SBE-FPs.

AAFP Comments on Provisions regarding Agents and Brokers' role in State-Based Exchange Operations (§ 155.205(b), §155.221(k), § 155.221(k), § 155.220(j), § 155.220(j)(2), and § 155.220(j)(3))

The AAFP recognizes CMS's goal of increasing flexibility for SBEs but given limited real-world implementation of SBE-EDE, CMS should proceed cautiously and condition any expansion on clear, enforceable consumer protection and program integrity standards.

Under this proposed model, third-party web-brokers may inadvertently shape consumer inputs, eligibility attestations, and plan selection decisions, while the SBE would retain full legal and fiscal responsibility for eligibility determinations, program integrity, and compliance. This separation of operational control and accountability increases the risk that errors, beneficiary harm, and improper enrollments will occur without a clear enforcement pathway, leaving beneficiaries and states exposed.

This concern is heightened by CMS's recent identification of enrollments facilitated by agents, brokers, and web-brokers as a significant source of improper enrollment activity, which informed the 2025 Marketplace Integrity and Affordability [Final Rule](#). Also, the HHS Office of Inspector General has documented widespread eligibility determination errors linked to weaknesses in verification processes and reliance on applicant-reported information.^{vi} In this context, expanding an exclusive third-party enrollment pathway in SBEs without platform-level monitoring and audit requirements comparable to federal EDE standards risks recreating known integrity challenges rather than mitigating them.

SBE-EDE exclusivity also raises concerns regarding consumer access. Fragmenting the enrollment "front door" across multiple private platforms may disadvantage individuals with limited access to broadband or low digital literacy and introduce inconsistent framing of income,

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household composition, and plan options. Urban Institute analyses show that simplified and centralized application processes are associated with materially higher completion and retention rates in income-based public programs, especially among low-income populations.^{vii,viii}

Further, CMS suggests that the State-Based Marketplace Annual Reporting Tool (SMART) represents sufficient oversight to manage these risks. However, SMART is a retrospective tool that relies on annual attestations and audits. It does not provide platform-specific performance data, eligibility error metrics, or visibility into third-party enrollment operations. As such, SMART cannot substitute for dedicated guardrails when eligibility and enrollment functions are operationally offloaded outside the Exchange.

Thus, the AAFP recommends that CMS pair the expansion of the SBE-EDE model with strengthened platform-level federal oversight as states gain experience with implementation. In tandem, we urge CMS to finalize the proposed provisions strengthening agent, broker, and web-broker standards of conduct. In our [response](#) to the 2026 Notice of Benefit and Payment Parameters, and our recent [response](#) to the 2025 Marketplace and Integrity Proposed Rule, we wrote in support of CMS's policy to review and enforce compliance against lead agents for insurance agencies. We continue to support CMS in its continued efforts to protect enrollees from agents and brokers who fail to comply with regulations designed to safeguard consumers. Coverage decisions must prioritize the best interests of consumers. However, commissions earned by agents and brokers create conflicts of interest. Whenever financial incentives have the potential to influence coverage decisions, CMS must rigorously enforce regulations to prevent misconduct and protect consumers.

Provision on "Additional" Essential Health Benefits (§ 155.170)

CMS proposes to redefine certain state-mandated benefits as outside the Essential Health Benefits (EHB) framework if those mandates were enacted after December 31, 2011, apply to the individual or small-group markets, require specific services or treatments, and are not necessary to meet federal requirements. Under this approach, these benefits would be treated as "in addition to EHB" even if they are currently included in a state's EHB benchmark plan, with states required to defray their cost beginning in plan year 2027.

The cost of such benefits would also not count towards the premium for purposes of the premium tax credit (PTC) calculation. Notably, benefits classified as outside EHB would no longer be subject to core consumer protections, including nondiscrimination requirements, cost-sharing limits, and prohibitions on annual or lifetime dollar caps. If finalized, states can avoid a defrayal obligation by repealing the mandated benefit, or by exempting Marketplace plans from the coverage requirement.

AAFP Comments on "Additional" Essential Health Benefits (§ 155.170)

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In the proposed rule, CMS [cites](#) section 1311 of the ACA as justification for this provision, but the statute establishes a clear and sequential framework that this proposed provision disrupts. Section 1302 of the ACA assigns the Secretary authority to define EHB based on the ten statutory categories and the scope of benefits offered under a typical employer plan, and not on the timing of State enactment. Section 1311(d)(3)(B) of the Affordable Care Act (ACA) authorizes defrayal only for benefits that are truly additional to EHB and does not authorize CMS to redefine EHB through a timing-based reclassification. **Thus, CMS lacks the statutory authority to finalize the proposed amendment to § 155.170(a)(2) to treat State-required benefits as “in addition to EHB”, regardless of their inclusion in a CMS-approved State EHB-benchmark plan.**

Congressional intent reinforces this conclusion. Congress delegated to the Secretary the responsibility to define EHB through a stable, employer-based framework designed to promote uniformity, predictability, and nondiscrimination, while preserving State flexibility through benchmark selection. Reclassifying benchmark-included benefits as non-EHB solely based on when a State enacted a mandate, risks undermining the benchmark framework Congress authorized CMS to implement.

As CMS acknowledges in the proposed rule, current regulation under [45 C.F.R. § 155.170\(a\)\(2\)](#) provides that a benefit covered in a State’s EHB-benchmark plan is considered an EHB, and only post-2011 State mandates that are not included in the benchmark are treated as “in addition to EHB.” Further, 45 C.F.R. § 155.170(a)(3) states that the “State will identify which State-required benefits are in addition to the EHB.” CMS also publicly describes EHB as being defined through state-specific EHB-benchmark plans, and CMS has approved multiple state benchmark updates pursuant to that framework.^{ix}

States that have updated their EHB benchmark plans since 2011 have done so through CMS-approved processes to refine coverage within existing EHB categories and close documented access gaps. For example, in 2022, CMS approved benchmark updates in Oregon, Michigan, New Mexico and Illinois to provide opioid use disorder treatment, which falls under the EHB category of mental health and substance use disorder. Likewise, as of 2022, CMS approved benchmark updates in numerous states including Oregon, North Dakota, and Washington to provide diabetes and weight-loss management services for obesity.^{x,xi} **These approvals reflect a longstanding CMS practice allowing states to modernize EHB coverage to address emerging clinical standards and population health needs.** CMS’s proposal would unsettle this reliance by allowing service-specific benefits embedded in approved benchmarks to be reclassified as outside the EHB framework, notwithstanding prior federal approval.

CMS’s reliance on a temporal reclassification rule is also unnecessary. The agency has long demonstrated its ability to draw principled, content-based boundaries around EHB through the benchmark framework itself. For example, long-term custodial nursing home care is routinely

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excluded from state EHB-benchmark plans based on its substantive divergence from typical employer coverage. This illustrates that CMS can and does adjudicate EHB scope based on benefit content, rather than basing approval on an arbitrary state enactment date.

Further, this proposal is inconsistent with CMS's own innovation and delivery-system priorities. Initiatives such as AHEAD and ELEVATE emphasize primary care investment, early intervention, and integrated behavioral health as essential to improving outcomes and reducing avoidable downstream utilization. Removing EHB protections from services that strengthen primary care undermines these CMMI models by discouraging use of the very services essential to their success.

Additionally, the proposed expansion of state defrayal obligations is not feasible for states to implement as proposed, given the scale of the financial exposure and the administrative infrastructure required. Under 45 C.F.R. §155.170, defrayal is not a one-time payment but an ongoing obligation that requires states to identify each benefit deemed "in addition to EHB," and requires issuers to submit benefit-specific cost reports, review and reconcile those reports, administer payments to issuers or enrollees, and maintain audit and dispute-resolution processes on a recurring basis. For example, in 2014, Utah enacted legislation requiring coverage of Applied Behavioral Analysis therapy for children with autism spectrum disorder as a benefit "in addition to EHB." To implement that mandate, the Utah Insurance Department determined that the resulting state defrayal cost would average approximately \$1.9 million per year between FY 2020 and FY 2022.^{xii} That figure reflects the recurring regulatory and fiscal impact associated with defrayal for a single service. Thus, expanding defrayal obligations to encompass post-2011 state-mandated EHBs, particularly where those benefits have long been embedded in CMS-approved benchmark plans, would substantially increase the number of benefits subject to defrayal and the magnitude of state fiscal liability, while requiring states to significantly expand financial and reporting systems that many lack the resources to maintain. Administratively, state implementation of this proposed provision would require revised systems for issuer reporting, cost reconciliation, dispute resolution, and payment administration, along with continuous oversight as benefit utilization and plan offerings change year to year. Taken together, these financial, operational, and administrative demands create a level of uncertainty and complexity that many states will struggle to implement and sustain, particularly without advance determinations that would allow states and issuers to price, design, and administer coverage with confidence.

Although this provision may reduce federal advance premium tax credit spending in the near term, reclassifying services already embedded in state EHB benchmarks as "in addition to EHB" will shift long-term costs to the point of care and across federally administered programs. When states cannot sustain ongoing defrayal obligations, they predictably narrow benefits or freeze coverage standards, weakening access to clinically valuable outpatient care and pushing utilization toward higher-cost emergency and inpatient settings. This effect will be most acute for EHB services addressing behavioral health,

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substance use, and chronic disease care where reduced outpatient access reliably translates into crisis-driven care. Reclassification also removes core EHB protections from these services, including prohibitions on annual and lifetime dollar limits, limits on cost sharing, and nondiscrimination requirements. The resulting increase in underinsurance and uncompensated care will flow into federally financed safety-net spending and downstream utilization.

For these reasons, the AAFP strongly recommends CMS withdraw this provision and preserve the integrity of state EHB benchmarks as a stable statutory foundation that supports accessible primary care, early intervention, and the success of CMS's broader innovation and care-delivery reforms.

Provision on Non-Pediatric Dental Services as EHB (§ 156.115(d))

In this rule, CMS also proposes to prohibit issuers from including routine, non-pediatric dental services as an EHB.

AAFP Comments on Non-Pediatric Dental Services as EHB (§ 156.115(d))

As the AAFP has [previously](#) stated in response to the 2025 Payment Notice, we continue to encourage CMS to enable issuers to include routine non-pediatric dental services as an EHB. The AAFP actively [encourages](#) collaboration between family physicians and dental health practitioners to provide comprehensive oral health care at all stages of life. Compromised oral health is associated with cardiovascular disease, endocarditis, diabetes, premature birth, low-birth weight, pneumonia, and malnutrition. Patients routinely raise concerns about oral health and frustration with inadequate coverage during primary care visits, making our members acutely aware of the impact limited dental coverage has on patients. As noted by CMS in the 2025 Payment Notice, "it is up to each State to consider the potential costs and network burden and determine whether to add routine non-pediatric dental services as an EHB." **Accordingly, the AAFP urges CMS to rescind this provision so that states may retain this discretion and issuers may include non-pediatric dental services as an EHB where permitted under state benchmark plans.**

Provisions regarding Noncitizens (§155.20, §155.305(f)(1), §155.320(c)(3), and §155.305(f)(2))

CMS proposes to require Exchanges to verify "eligible alien" status to limit PTC eligibility, consistent with the OBBA. CMS also proposes to update Basic Health Program (BHP) regulations to define "eligible noncitizen" and to specify that, beginning January 1, 2027, an individual must be a citizen or eligible noncitizen to be included in the calculation of federal BHP payments to states operating a BHP.

CMS also proposes to deny advance premium tax credit (APTC) eligibility to lawfully present immigrants who are not "eligible aliens" and whose household income is below 100 percent of

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the federal poverty level (FPL). States would no longer receive federal BHP payments attributable to individuals in this population who are enrolled in a BHP as of January 1, 2026.

In addition, CMS proposes to remove the special enrollment period (SEP) for individuals with household income below 100 percent of the FPL who did not enroll in coverage while awaiting verification of citizenship or immigration status.

AAFP Comments on Provisions regarding Noncitizens (§155.20, §155.305(f)(1), §155.320(c)(3), and §155.305(f)(2))

We recognize CMS's obligation to align Marketplace and BHP eligibility policies with the requirements enacted under the OBBBA. However, the cumulative effect of the proposed changes raises serious concerns about coverage loss for vulnerable populations and the stability of the Marketplace.

Prior to this proposed rulemaking, the Congressional Budget Office estimated that the OBBBA's restrictions on eligibility for federally funded health coverage for lawfully present immigrants would result in approximately 1.3–1.4 million individuals losing access to subsidized coverage nationwide, with many becoming uninsured rather than transitioning to alternative coverage options.^{xiii} These effects are compounded by this proposed rule, which would deny APTC eligibility to lawfully present immigrants who are not deemed “eligible aliens,” eliminate associated BHP payments, and remove the special enrollment period for individuals awaiting verification. Together, these changes significantly increase the risk of coverage loss during transitions and verification delays, particularly for populations that face administrative and documentation barriers outside their control.

Beyond the direct coverage effects, these changes have system-level implications for the Marketplace. Lawfully present immigrant enrollees tend to be younger and healthier than the overall Marketplace population, with lower risk scores and lower average health care utilization.^{xiv} As a result, restricting subsidies for lawfully present immigrants is likely to disproportionately reduce enrollment among a lower-cost population, worsening risk pool composition and increasing premiums for remaining enrollees. When combined with the projected loss of coverage for millions of individuals, these effects create a meaningful risk of Marketplace destabilization as eligibility pathways narrow and administrative friction increases.

The AAFP believes that all people should have access to essential health care services, regardless of their immigration status. Accordingly, we oppose this provision and urge CMS to implement these OBBBA-mandated policies with clear guidance, adequate transition periods, and operational safeguards to prevent unintended coverage disruptions. CMS should also require standardized notice and timeline protections, including clear notices and response windows, before terminating financial assistance or excluding individuals from BHP payment calculations, particularly given that this proposed rule simultaneously tightens eligibility

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standards while eliminating the SEP. **At minimum, we encourage CMS to maintain a scoped SEP for individuals who can demonstrate that their enrollment was delayed due to pending HHS verification.**

Provisions regarding Marketplace Eligibility and Enrollment (§155.305, §155.320(c)(3)(iii), §155.320(c)(5), §155.400, §155.420(d)(16), and §155.420(g))

CMS proposes a collection of provisions on eligibility and enrollment, in alignment with OBBBA and the 2025 Marketplace Integrity Final Rule. Many of these provisions were originally slated to sunset at the end of 2026 per the Marketplace Integrity Rule or delayed in implementation due to the stay granted in *City of Columbus et al. v. Kennedy et al.*

CMS now proposes to remove this sunset date and cement the following provisions beyond 2027:

- Require exchanges to implement a one-year APTC failure-to-reconcile (FTR) process by PY 2028, giving Exchanges the option to continue the current two-year process for PY 2027.
- Require income verification when an applicant's attested projected household income is at or above 100 percent of the FPL, but federal data sources indicate the consumer's household income is below 100 percent of the FPL.
- Remove self-attestation of income as an acceptable source of income verification if IRS data is unavailable and require Exchanges to apply a 90-day inconsistency period when attested household income cannot be verified.
- Permanently discontinue issuer options for fixed-dollar and gross percentage-based premium payment thresholds.
- Expand pre-enrollment verification for all types of Special Enrollment Periods (SEPs) and require pre-enrollment verification for at least 75 percent new SEP enrollments, only in FFE states.
- Eliminate monthly SEPs for individuals with household incomes at or below 150 percent of the FPL, which currently allows eligible low-income consumers to enroll in Marketplace plans at any time throughout the year.

AAFP Comments on Provisions regarding Marketplace Eligibility and Enrollment (§155.305, §155.320(c)(3)(iii), §155.320(c)(5), §155.400, §155.420(d)(16), and §155.420(g))

These proposed provisions represent a systemic shift toward front-end eligibility enforcement that will disproportionately burden low-income, rural, and underserved populations. If finalized, **policies such as the Accelerated 1-year FTR, expanded income verification, and broad SEP verification, all substantially increase the likelihood that eligible consumers lose or fail to obtain coverage due to procedural barriers rather than lack of eligibility.** As we stated in our [response](#) to the 2025 Marketplace Integrity proposed rule, stricter verification and reconciliation requirements pose significant risks for individuals with income volatility, limited financial or health literacy, language barriers, and constrained access to documentation or

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enrollment assistance. These challenges are particularly acute in rural and underserved communities, where consumers often rely on episodic employment, informal income, or seasonal work and face limited access to broadband internet to repeatedly attest eligibility. Coverage disruptions for these populations predictably lead to higher uninsured rates, delayed care, increased reliance on emergency services, and worsening health outcomes, with downstream costs borne by providers, states, and the broader health system.

The expansion of SEP verification requirements, particularly when paired with the permanent elimination of the 150 percent FPL monthly SEP, is especially concerning. Monthly SEPs for individuals at or below 150 percent of the FPL have been critical for low-income individuals experiencing frequent changes in employment, household composition, or income. These consumers are also the most likely to miss an increasingly compressed Open Enrollment Period. In rural areas, where documentation delays and limited enrollment support are common, verification-based denials can result in prolonged gaps in coverage and increased strain on rural hospitals and clinics already operating on thin margins.

Thus, we recommend CMS:

- **Focus verification efforts on high-risk categories** identified by CMS's own data as more prone to enrollment discrepancies, conserving federal and state resources while minimizing unnecessary barriers for eligible consumers.
- **Provide provisional coverage or clear interim pathways for consumers whose eligibility is under review**, ensuring continuity of care while verification is pending and reducing avoidable coverage gaps.
- **Strengthen insurer accountability**, including enhanced oversight of issuer marketing practices, enrollment transactions, subsidy reconciliation processes, and consumer outreach. Insurers possess the data, scale, and operational capacity to detect and prevent improper enrollments and should bear greater responsibility for doing so.
- **Pair verification efforts with consumer assistance**, including plain-language notices, multilingual outreach, and clear pathways for consumers with limited broadband or enrollment assistance.
- **Exempt income verifications that are triggered by data mismatches** that commonly reflect data lags, seasonal earnings, or informal work, as opposed to ineligibility, especially prevalent in rural economies.

Provisions regarding Network Adequacy and Provider Access Standards (§ 155.1050, § 155.1051, § 155.1050, and § 156.230)

a. Federal network adequacy standards

CMS proposes a series of interrelated changes to federal network adequacy and Essential Community Provider (ECP) oversight. The proposed rule would remove federal time-and-distance network adequacy standards for State Exchanges and SBE-FPs, allowing

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states to define their own network adequacy standards. In lieu of federal network adequacy standards, CMS proposes to establish an Effective Provider Access Review Program (EPARP) under § 155.1050(d), allowing FFE states that demonstrate sufficient legal authority and technical capacity to assume responsibility for provider access reviews. If an FFE state does not have the authority or capacity to maintain an EPARP, then CMS would continue to conduct network adequacy reviews for that state.

b. Essential Community Provider (ECP) standards

Further, the proposed rule would reduce the minimum ECP contracting threshold from 35 percent to 20 percent, including lowering the separate minimum requirements for Federally Qualified Health Centers (FQHCs) and family planning providers to 20 percent. CMS is also proposing to remove requirements that insurers who do not meet the threshold provide justification for, and documentation of, their efforts to contract with ECPs in their service areas. In parallel, CMS proposes to allow qualifying FFE states to conduct their own ECP certification reviews for QHPs (both network and non-network plans) under a new “Effective ECP Review Program” if qualifying states:

- Demonstrate legal authority and methodology to conduct these reviews.
- Ensure network plans maintain a “sufficient number” and geographic distribution of ECPs for low-income enrollees and individuals in Health Professional Shortage Areas.
- Ensure non-network plans maintain “reasonable and timely access” to ECPs that accept the plan’s payment as payment in full.

CMS also notes that the agency would continue to collect ECP data from issuers even in States with approved State review programs and provide standardized data back to States.

c. Non-network QHP certification

As mentioned above, CMS also proposes to allow non-network plans to qualify for QHP certification by demonstrating “sufficient” access to ECPs willing to accept the plan’s payment amount as payment in full. Under this framework, the plan would be required to show that providers within its service area are willing to accept the plan’s payment terms, rather than balance bill enrollees.

Specifically, CMS proposes that non-network plans could satisfy network adequacy requirements by demonstrating that a sufficient number of providers, including ECPs and behavioral health providers, accept the plan’s payment amount as payment in full. To support this determination, non-network plans would be required to report:

- The percentage of available providers in the service area that accept the plan’s payment as payment in full.
- Whether at least 20 percent of available ECPs accept the plan’s payment as payment in full.

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- Whether the plan offers payment-in-full arrangements with at least one ECP in each of the eight ECP categories, per county, within the plan's service area.

While CMS notes that non-network plans would remain subject to EHB requirements, the proposal does not provide additional operational detail regarding how those requirements would be assessed in the absence of a contracted provider network.

AAFP Comments on Provisions regarding Network Adequacy and Provider Access Standards (§ 155.1050, § 155.1051, § 155.1050, and § 156.230)

The AAFP appreciates CMS's stated goal of increasing flexibility for State Exchanges and issuers. However, the proposed changes to network adequacy standards and ECP requirements, taken together, represent a significant shift away from measurable, enforceable access protections at a time when Marketplace enrollment is growing, plan designs are becoming more complex, and high-cost-sharing plans may play a larger role in coverage, particularly in rural and under-resourced areas.

Primary care shortages are already severe, particularly in rural areas, with an estimated 42.6 million rural residents living in primary care Health Professional Shortage Areas in 2023.^{xv} And these shortages are exacerbated by narrow Marketplace networks. Analyses of QHP networks have found that 21 percent of plans included fewer than 25 percent of available physicians, and 21 percent of QHPs included fewer than one-third of available hospitals.^{xvi} Thus, narrow networks heighten the risk that primary care is effectively inaccessible even when nominally "covered."

a. Federal network adequacy standards

We strongly oppose eliminating the proposed provision to remove federal time-and-distance network adequacy standards for State Exchanges and SBE-FPs. The AAFP previously [supported](#) CMS's decision in the 2025 Payment Notice to establish these very important network adequacy standards, which CMS justified as necessary to ensure reasonable and timely access nationally and to reduce consumer confusion across markets. This core logic remains unchanged in 2027. Removing the federal time-and-distance standards harms patients because it replaces meaningful, real-world access with paper compliance, masking whether enrollees can actually obtain care when they need it.

When time-and-distance standards are weakened, plans can contract with fewer physicians or concentrate them geographically. Networks can appear adequate based on raw provider counts while patients still face long travel distances, closed panels, ghost networks, and delays that disrupt continuity of care—particularly for, behavioral health, post-acute care, and services in rural area. The predictable consequences are longer travel times, fewer in-network options, delayed care, and increased out-of-network requests. These access failures do not disappear, but rather surface downstream in primary care offices as higher-acuity presentations, more

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fragmented care, increased prior authorization and appeals, and greater administrative burden as practices attempt to reroute patients or document network inadequacy.

These access risks are not theoretical. In 2022, the Government Accountability Office concluded that provider network oversight varies substantially across states and federal agencies and that inadequate networks can impede timely access and push patients out of network.^{xvii} Removing federal quantitative standards would further increase variability and reduce transparency precisely when stronger oversight is needed. Further, without enforceable time-and-distance standards, plans retain flexibility to narrow networks through pricing negotiations or mid-year contract changes, while the burden falls on patients who selected coverage based on provider access and have limited ability to respond without financial and emotional harm.

Thus, we recommend CMS retain federal time-and-distance network adequacy standards for State Exchanges and SBE-FPs. Time-and-distance standards are one of the few safeguards that translate “in-network” into actual, usable access, rather than access that exists only on paper. Further, we encourage CMS to require State Exchanges and SBE-FPs with CMS-approved EPARP to report plan-level access metrics relevant to primary care, including time-and-distance compliance, appointment wait times, secret-shopper results, and provider directory accuracy error rates.

b. Essential Community Provider (ECP) standards

The AAFP urges CMS to maintain the current 35 percent ECP contracting threshold or, at minimum, maintain the 35 percent threshold for FQHCs. FQHCs represent core primary care capacity in underserved markets and should not be treated interchangeably with other ECP categories. Community health centers are foundational to primary care delivery in underserved communities. In 2024, community health centers served 32.4 million patients and provided 139 million visits, including substantial primary care and behavioral health services. HRSA reports that in 2024, health centers helped 3.6 million patients achieve controlled hypertension and 2.2 million achieve diabetes control; outcomes that depend on consistent access and stable referral relationships.^{xviii} **Lowering the ECP contracting minimum from 35 percent to 20 percent, particularly for FQHCs, weakens the safety-net access floor where it matters most.** CMS notes that average ECP contracting rates are currently high among issuers, but minimum standards are designed to constrain outlier plans and thin-network strategies, not to reflect average performance. In low-competition or geographically constrained markets, a weaker floor risks normalizing inadequate safety-net participation.

CMS itself acknowledges in the proposed rule that lower ECP minimums can lead to increased travel time, longer wait times, and reduced care continuity. That is precisely the mechanism by which family physicians experience downstream strain: delayed first-contact care translates into higher acuity, more visits per episode, and more complex chronic disease management.

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Uneven ECP enforcement destabilizes referral relationships, disrupts care coordination, and shifts additional workload onto primary care practices, while simultaneously worsening performance on quality and continuity measures for which physicians are held accountable. These risks are intensified by CMS's proposal to reduce issuer justification and documentation requirements for ECP contracting.

If CMS proceeds with delegating ECP review authority to states, that delegation must be accompanied by clear minimum contracting criteria and adequate CMS oversight. Specifically, we encourage CMS to require states conducting ECP reviews to publicly report data on ECP participation stratified by provider type, appointment availability and wait times at ECP sites, and identification of "ghost networks."

c. Non-network QHP certification

The AAFP reiterates its strong support for CMS's position stated in the 2025 Payment Notice that quantitative network adequacy reviews should occur before QHP certification. Quantitative reviews are relatively straightforward, and plans that fail initial review can be evaluated through a justification process. Certifying plans with narrow or nonexistent networks, particularly when clinicians may not be accepting new patients, predictably results in care delays and higher out-of-pocket costs.

Justifying this provision in the proposed rule, CMS suggests that non-network plans allow enrollees to lower costs through individualized price negotiations. However, individualized negotiation is not an accessible option for many patients, particularly those who are acutely ill, face language or health-literacy barriers, or lack the time and leverage to engage in one-off pricing discussions with physicians. In practice, this approach shifts financial and administrative burden onto patients and amplifies payment uncertainty for providers operating in high-volume outpatient settings. Further, this expectation sits in tension with the consumer-protection framework established by the No Surprises Act, which reflects congressional recognition that patients are poorly positioned to negotiate prices and should not bear responsibility for resolving payment disputes.

Thus, the AAFP recommends that CMS require non-network plans to maintain robust consumer protections and demonstrate functional and quantitative measures of primary care access to secure QHP certification. At minimum, CMS should require non-network plans to:

- Ensure standardized patient cost disclosures to protect patients' negotiating position.
- Uphold the No Surprises Act by maintaining robust balance-billing protections for patients and administrative simplicity for providers.
- Re-establish quantitative access metrics, such as wait times and time-and-distance standards, as conditions of non-network QHP approval.

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Absent enforceable, quantitative metrics, network adequacy becomes harder to enforce before consumers enroll, and “adequacy” risks being reduced to paper compliance rather than real-world access.

Provisions regarding Catastrophic coverage (§ 155.605(d)(1), § 156.80(d)(2)(ii), § 156.130(c) and §156.155(a)(6))

Under current regulations, Marketplace exchanges are permitted to grant hardship exemptions when circumstances, including unaffordability due to ineligibility for APTC or CSRs, prevent enrollment in a QHP. In this proposed rule, CMS aims to codify and expand this hardship exemption so that individuals with projected household income below 100 percent FPL or above 250 percent FPL who are ineligible for APTC or CSRs may qualify and enroll in catastrophic coverage, including individuals above the age of 30.

The proposed rule also includes several provisions affecting catastrophic plan design and pricing. Catastrophic plans are ACA-compliant QHPs whose benefit package includes EHBs. In these plans, aside from preventive services and at least three primary care visits, enrollees pay the full cost of covered services until a cost-sharing threshold is reached, set to \$12,000 for the individual limit. For PY 2027, the individual maximum out-of-pocket (MOOP) limit is \$12,000, as established in HHS’s annual Premium Adjustment Percentage [guidance](#) and applicable across individual and employer-sponsored coverage.

In this proposed rule, CMS seeks to set the catastrophic plan cost-sharing threshold at 130 percent of the applicable MOOP. If finalized, this would require catastrophic plan enrollees to incur up to \$15,600 in cost sharing, in addition to monthly premiums, before coverage meaningfully begins.

CMS further proposes to permit issuers to:

- Offer catastrophic plans for one year or multiple consecutive years (not to exceed 10).
- Adjust index-rate pricing to reflect the full contract term in multi-year plan designs.
- Exempt multi-year catastrophic enrollees from annual eligibility reverification.
- Allow plans with terms of at least two years to use value-based insurance design. (VBID) to cover additional, pre-deductible, preventive services.

CMS is also seeking comments on whether maximum out-of-pocket (MOOP) limits and deductible amounts should be set annually or calculated as an average over the full duration of a multi-year contract. Additionally, CMS seeks input on whether insurance issuers should be allowed to modify plan terms during a multi-year period. CMS also clarifies that enrollees will retain the right to terminate multi-year catastrophic coverage at any time without penalty.

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AAFP Comments on Provisions on Catastrophic Coverage (§ 155.605(d)(1), § 156.80(d)(2)(ii), § 156.130(c) and §156.155(a)(6))

a. Expanded enrollment in Catastrophic Coverage

Individuals who enroll in catastrophic plans, particularly through the hardship exemption, are oftentimes doing so under financial stress and time pressure – not as a preferred coverage choice. And ASPE analysis shows that individuals experiencing affordability-driven coverage disruptions are more likely to live in rural areas, have lower incomes, and rely on the individual market during periods of employment instability.^{xix} At the same time, these populations are more likely to have limited health insurance literacy, reduced access to enrollment assistance, and face challenges navigating digital-first enrollment systems. As a result, many may not fully understand how catastrophic plan deductibles, cost sharing, and pre-deductible limits operate in practice, which increases the likelihood that they will delay or forgo care and encounter access barriers only *after* a health need arises. Accordingly, the AAFP has a strong interest in ensuring that any expansion of catastrophic coverage supports access to longitudinal primary care.

We recognize that CMS is acting in a materially changed affordability environment following the expiration of enhanced premium tax credits at the end of 2025, which increased net premium exposure for many Marketplace enrollees and contributed to widespread enrollment disruptions. Recent analysis of insurer rate filings across all 50 states showed that Marketplace issuers requested a median premium increase of approximately 18 percent for plan year 2026. This figure is more than double the median request in plan year 2025 and marks the largest midpoint increase in recent years. Notably, insurers specifically attributed these premium hikes in part to policy-driven changes in the enrollment mix.^{xx} Consistent with these pressures, early state Marketplace indicators following subsidy expiration reflect the growing affordability concerns among consumers. For example, the Washington Health Benefit Exchange reported that during the 2026 open enrollment period, more than 61,000 enrollees changed plans in response to higher premiums following the expiration of enhanced federal premium tax credits. The Exchange further reported more cancellations than any year prior and anticipated additional disenrollment due to affordability pressures.^{xxi}

Against this backdrop, the **AAFP appreciates CMS exploring available regulatory levers to preserve lower-premium coverage options for individuals who may otherwise become uninsured. However, we are concerned that this proposed provision may function as a premium-focused solution that risks increasing underinsurance by shifting costs to the point of care.** The minimum statutory requirements in catastrophic plans provide important baseline protections, but access to essential health benefits and three pre-deductible primary care visits does not substitute for longitudinal primary care and chronic disease management, particularly for adults over age 30.

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We are particularly concerned that this proposed expansion of catastrophic eligibility will create a risk of underinsurance among newly eligible older adults. These individuals may select catastrophic coverage as a low-premium, short-term bridge prior to Medicare eligibility, but will be exposed to prolonged periods of full-cost liability for most services. Older adults are more likely to have chronic disease and behavioral health needs that require comprehensive care extending well beyond three primary care visits per year. The proposed multi-year catastrophic framework materially compounds this risk: allowing contract terms of up to 10 years, waiving annual eligibility reverification, and potentially averaging MOOP or deductible amounts across a multi-year period could functionally lock older, economically vulnerable adults into a coverage structure that delays meaningful access to care precisely as their health needs intensify.

These individual-level access risks also have broader market-level implications. **If multi-year catastrophic plans disproportionately attract healthier, price-sensitive enrollees, risk segmentation may worsen in remaining pools.** A 2025 study of 343,137 adults with chronic illnesses found that enrollment in high-deductible plans was associated with significantly lower receipt of guideline-concordant care across multiple domains, including clinic visits, laboratory testing, and prescription drug care (e.g. reduced likelihood of recommended clinic visits, prescriptions, and labs, with an overall reduction in recommended care versus non-HDHP coverage).^{xxii} While catastrophic plans and employer-sponsored high-deductible health plans are distinct plans, they share the same mechanism: high front-end cost sharing that places most non-preventive services behind a substantial deductible.

Thus, the AAFP appreciates CMS's effort to modernize catastrophic coverage, but we urge CMS to ensure that any expanded eligibility to catastrophic plans is paired with concrete consumer protections to preserve access to longitudinal primary care.

Specifically, we recommend that CMS:

- **Require issuers to provide robust, plain-language consumer disclosures** that accurately describe how catastrophic coverage functions in practice, including covered benefits, deductibles, cost-sharing, and pre-deductible services.
- **Require issuers to provide clear and accessible pathways and decision-support tools for consumers to transition from catastrophic coverage to comprehensive plans** when income, health status, or household circumstances change, so catastrophic enrollment does not become an unintended long-term default.
- **Prohibit insurers from averaging MOOP and deductible amounts across multi-year catastrophic plans**, as it would extend the period before meaningful coverage begins for the very enrollees most likely to defer care.
- **Prohibit insurers from making mid-term changes to provider networks or covered benefits**, which risks disrupting established care relationships, with potentially lasting clinical consequences—particularly for patients managing chronic conditions.

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b. Access to Preventive and Primary Care in Catastrophic Coverage

We greatly appreciate CMS's proposal to allow multi-year (≥ 2 year) catastrophic plans to use value-based insurance design, or VBID, to cover additional preventive services without enrollees first satisfying the deductible. This proposal largely aligns with longstanding AAFP [policy](#), and reflects an important recognition that benefit design can mitigate gaps in access set forth by high deductibles. However, optional coverage of baseline preventive services alone will not ensure effective, longitudinal primary care or chronic disease management.

Thus, we recommend CMS to finalize this provision and further strengthen it by:

- **Conditioning approval of multi-year catastrophic plans (≥ 2 years) on adoption of VBID for preventive services.**
- **Requiring insurers to develop VBID programs with meaningful input from physicians who deliver and coordinate preventive care,** thus ensuring benefit designs reflect real-world clinical practice and patient needs.
- **Requiring insurers to apply transparent, evidence-based criteria in selecting preventive services for VBID programs.**
- **Requiring insurers to include high-value primary care services in VBID designs,** such as diabetes management, blood pressure monitoring and medication management, smoking cessation interventions, and structured chronic disease management.

Additionally, the AAFP strongly urges CMS to prohibit issuers from implementing disease-specific variation in MOOP limits. Although CMS presents this variation as an alternative to VBID for multi-year catastrophic plans, even raising the possibility of disease-based MOOP variation risks encouraging benefit designs that shift higher costs onto patients who require care most frequently. In practice, this approach could invite issuers to segment enrollees by health condition and tailor cost-sharing to influence enrollment and retention. This is precisely the dynamic the Affordable Care Act sought to eliminate by prohibiting discriminatory benefit structures based on medical dependency or health condition. Moreover, disease-specific MOOP variation would also create significant confusion for both physicians and patients, particularly for individuals with multiple chronic conditions whose care cannot be cleanly attributed to a single diagnosis. This complexity would make it difficult for physicians to advise their patients on expected costs, and for patients to anticipate their financial obligations.

Rather, we encourage CMS to build on this momentum by strengthening access to longitudinal primary care through potential alignment opportunities between multi-year VBID design and the Health Savings Account (HSA)–Direct Primary Care (DPC) framework clarified in the OBBBA. The OBBBA's recognition of permissible arrangements between HSAs and DPC reflects

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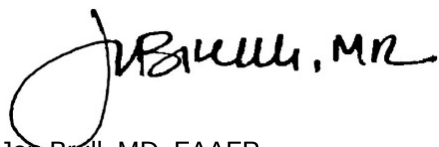
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congressional recognition that high-deductible plans require complementary mechanisms to ensure meaningful access to primary care. As bronze and catastrophic plans are now HSA-eligible, CMS has a timely opportunity to examine how these frameworks can be leveraged to support pre-deductible primary care access—particularly for enrollees facing substantial front-end cost sharing.

Thank you for the opportunity to provide comments on this important matter. For additional questions, please contact Sahana Chakravarti, Regulatory Specialist, at schakravarti@aafp.org.

Sincerely,

A handwritten signature in black ink that reads "J Brull, MD". The signature is fluid and cursive.

Jen Brull, MD, FAAFP
American Academy of Family Physicians, Board Chair

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March 12, 2026

Secretary Robert F. Kennedy
U.S. Department of Health and Human Services
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Washington, DC 20201

Administrator Mehmet Oz
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

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

Dear Secretary Kennedy and Administrator Oz,

The American College of Obstetricians & Gynecologists (ACOG) represents more than 62,000 physicians and partners dedicated to advancing women's health and the health of individuals seeking obstetric and gynecologic care. ACOG welcomes the opportunity to comment on the Department of Health and Human Services' (HHS) proposed rule on the plan year (PY) 2027 Notice of Benefit and Payment Parameters (NBPP). As physicians dedicated to providing quality care to those seeking obstetric and gynecologic care, ACOG continues to support the goals of the Affordable Care Act (ACA) to expand access to continuous and meaningful health insurance coverage. We are concerned that many of these proposals will make it harder for patients to gain access to coverage and remain covered.

Part 155: Exchange Establishment Standards and Other Related Standards

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

HHS proposes to discontinue the full suite of standardized plan option policies effective beginning in PY 2027 for federally-facilitated exchange (FFE) and state-based exchanges that use the federal platform (SBE-FP). These plans would no longer receive differential display on HealthCare.gov and brokers that use direct enrollment (DE) would not be required to differentially display these options. Standardized plans improve consumers' ability to make informed plan selections. In fact, a previous court ruling in 2021 vacated prior rulemaking eliminating standardized plans.ⁱ Standardized plans make it easier for consumers to compare options in the federal exchange. Research has demonstrated that standardized plans were associated with reduced gross premiums in 2017 and 2018 and account for a third of enrollment after only a few years on the market.^{ii,iii} Removing this option diminishes consumers' choices when selecting a health plan that meets their and their families' needs. **ACOG does not support the proposed elimination of standardized plans and encourages HHS to not finalize this proposal.**

Approval of a State Exchange (§ 155.105)

The agency proposes to rescind a requirement made in the 2025 Payment Notice that a State seeking to operate a State Exchange must first operate, for at least 1 plan year, a SBE-FP. Building and maintaining a State-based Marketplace (SBM) requires extensive startup resources including investments in infrastructure to support eligibility determinations, and working with insurers and community partners. Requiring states to operate a SBM for at least one year on the federal platform allows states time to implement critical eligibility and enrollment functions, contract with needed vendors, and coordinate with partners such as community-based organizations and the Medicaid agency.^{iv} Many of those disenrolled from Medicaid due to changes in H.R. 1 may be eligible for Marketplace coverage, and states must have the infrastructure and systems in place to ensure those seeking affordable coverage are not met with barriers. **We encourage HHS to put in place measures to ensure that a state choosing to operate a SBM has the appropriate capacity to do so to ensure smooth access to health insurance coverage for consumers.**

Amending Requirements for State Exchanges to Operate a Centralized Eligibility and Enrollment Infrastructure (§§ 155.205(b) and 155.221(k))

HHS proposes to remove the requirement that an exchange operate a centralized eligibility and enrollment platform on the exchange's website such that the exchange allows for the submission of the single, streamlined application for enrollment in a qualified health plan (QHP) and insurance affordability programs by consumers, through the exchange's website and the exchange performs eligibility determinations for all consumers based on submissions of the single, streamlined application. Further, they propose to offer flexibility to State exchanges to leverage enhanced direct enrollment (EDE) through a private sector-supported consumer engagement and enrollment strategy. The new proposal would allow State Exchanges to seek HHS approval for web brokers to serve as the exclusive enrollment pathways for operating consumer-facing websites that facilitate the eligibility and enrollment process in a State Exchange.

Currently HHS requires SBMs operate a centralized eligibility and enrollment platform on their own website so that consumers can submit a single, streamlined application for Marketplace enrollment and financial assistance. These federal programs provide critical care and services to vulnerable populations. Continuous access to coverage is crucial to addressing our nation's rising rate of maternal mortality.^v While some individuals are able to successfully transition to other sources of coverage when losing Medicaid, many are left in the untenable position of being uninsured shortly after a major medical event. The Centers for Disease Control and Prevention (CDC) considers insurance coverage disruptions to be one of many contributing factors to high rates of maternal mortality among the Medicaid-eligible population.^{vi} Importantly, half of all uninsured new mothers report losing Medicaid after pregnancy as the reason they became uninsured.^{vii} These coverage disruptions also disproportionately affect women of color; nearly half of all non-Hispanic Black women had discontinuous insurance from pre-pregnancy to postpartum and half of Hispanic Spanish-speaking women became uninsured in the postpartum period.^{viii} Moreover, we know that individuals with Medicaid coverage during their pregnancy are at increased risk for poor maternal health outcomes compared to their privately insured counterparts.^{ix} The use of an EDE platform shifts responsibility for eligibility determinations away from the state and on to third party brokers. This shift will also lead to more administrative burden for consumers who may be eligible for Medicaid and CHIP who use the exchange to find coverage. We are concerned that these individuals may not be properly assessed for eligibility for affordable health insurance programs. Additionally, EDE's have been associated with higher levels of improper enrollments via brokers, creating a greater risk to program integrity.^x Making enrollment into coverage easier for consumers by having one streamlined process helps reduce administrative barriers for individuals seeking coverage and ensure eligibility determinations for all federal programs are being assessed. **ACOG strongly recommends removing any potential barriers to coverage consumers may face and recommends HHS continue to require SBMs to operate a streamlined, centralized eligibility and enrollment platform.**

Additional Required Benefits (§ 155.170)

HHS proposes that any State-required benefits would be considered "in addition to essential health benefits (EHB)" (and thus not an EHB) if they are: required by a State action taking place after December 31, 2011; applicable to the small group and/or individual markets; specific to required care, treatment, or services; and not required by State action for purposes of compliance with Federal requirements. Rules implementing the ACA's standards for EHB delegated states the responsibility to select an EHB benchmark plan. This policy has allowed states to take advantage of the current expansive benchmarking options to effectively adopt new coverage mandates and address unmet health needs and health disparities, such as maternity services, expanded substance use disorder (SUD) treatment and non-opioid treatment alternative for pain by adding such benefits to their benchmark plans without having to bear the cost of paying for those services. States note there has been confusion around operationalizing the requirements for non-defrayal, and that some state efforts to mandate certain benefits could unintentionally be removing EHB protections from benefits already included in the state's EHB-benchmark plan. Additionally, this confusion has been deterring states from expanding their EHB benchmark plans.

The ACA requires non-grandfathered health plans in the individual and small group markets to cover EHB in ten benefit categories. These categories include ambulatory

patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder (SUD) services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventative and wellness services and chronic disease management, and pediatric services. Prior to the passage of the ACA, millions of people were unable to obtain coverage for critical health care services. In fact, more than three in five people did not have maternity coverage, one in three people did not have coverage for SUD treatment and about one in five people did not have coverage for mental health care.^{xi} Additionally, the ACA enacted vital financial protections, including an out-of-pocket maximum for individuals and families, for spending related to EHB. Thanks to the ACA and the creation of EHB, insurers in the individual marketplace can no longer charge women more than men for health plans, and pregnancy is no longer treated as a preexisting condition. These gains for those seeking obstetric and gynecologic care have been crucial to improving access to care. Under this proposal the benefits that have been added in a state's EHB-benchmark plan after 2011 would be considered in addition to EHB and would not remain subject to the various rules applicable to the EHB, including the prohibition on discrimination in accordance with § 156.125, limitations on cost sharing in accordance with § 156.130, and restrictions on annual or lifetime dollar limits in accordance with § 147.126. This will result in states having to defray the cost of new EHB. **ACOG strongly recommends HHS not finalize this change in regard to EHB and continue to encourage states to select robust EHB benchmark plans that contain a broad scope of maternity benefits.**

Ability of States to Permit Agents and Brokers and Web-Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§155.220(j))

HHS is proposing new standards of conduct and additional consumer protection standards related to agents, brokers, and web-brokers who assist consumers with enrollments through FFEs and SBE-FPs. These proposals focus on requirements related to consumer consent documentation and requirements related to marketing activities. The agency is proposing to remove language from § 155.220(j)(2)(i) that defines the term “sex” to include sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes. This proposed change would recognize a person’s sex as referring to an individual’s immutable biological classification as either male or female, consistent with Executive Order 14168. Current regulations prevent marketing or conduct regarding FFEs and SBE-FPs from discriminating on the bases of sex characteristics, including pregnancy or related conditions. ACOG believes that health care must be delivered in a way that is respectful of patient autonomy, timely and effective, evidence based, and nondiscriminatory. This includes all care related to pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related conditions.^{xii} We support equitable treatment for all patients regardless of gender identity or sexual orientation.^{xiii} Women of all sexual orientations, including lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ+) individuals face frequent barriers to health care. For example, women are more likely than men to delay care due to cost concerns.^{xiv} Women who identify as lesbian or bisexual express concerns around confidentiality, disclosure, and a limited understanding as to what their health risks may be.^{xv,xvi} Moreover, transgender individuals face a lack of adequate insurance coverage, and experience mistreatment by health care providers and health providers’ discomfort or inexperience with the transgender population.^{xvii,xviii,xix,xx} The protections currently in

place ensure that no consumer faces discrimination or misleading information when trying to access health coverage. **ACOG opposes HHS' attempt to weaken nondiscrimination protections in the marketplace, especially the removal of protections against discrimination based on pregnancy.**

Limit APTC Eligibility to "Eligible Noncitizens" (45 CFR 155.20; 45 CFR 155.305(f)(1); 45 CFR 155.320(c)(3) and 42 CFR 600.5)

For PY27, HHS proposes to add a new definition of "eligible noncitizen", providing that the term "eligible noncitizen" would have the same meaning as the term "eligible alien," as defined in 26 U.S.C. 36B(e)(2)(B). This would include any individual who is either lawfully admitted for permanent residence (sometimes referred to as a "lawful permanent resident" or "green card holder"); an individual who has been granted the status of Cuban-Haitian Entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980; or an individual who is lawfully residing in the United States in accordance with the Compacts of Free Association (COFA) as defined at 8 U.S.C. 1612(b)(2)(G). Individuals with other statuses would no longer be eligible to access advanced premium tax credits (APTC) and have an increase in the cost of their health insurance, making insurance coverage unaffordable for many. This change is expected to impact approximately 1.23 million lawfully present individuals who will lose subsidy eligibility in 2027.^{xxi}

Studies demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for chronic conditions.^{xxii} When they do seek care, it is more likely in emergency rooms as they are less likely to have a consistent provider of care.^{xxiii} Non-emergent use of emergency rooms for healthcare contribute greatly to the rising costs of health care in the United States.^{xxiv}

Additionally, lack of preventive medicine, as well as lack of treatment for chronic diseases and other health conditions, increases overall health care costs, especially during pregnancy. Prenatal care is intended to prevent poor perinatal outcomes and provide education to women throughout pregnancy, childbirth, and the postpartum period through a series of encounters between a woman and her ob-gyn or other obstetric care provider.^{xxv} Women who take advantage of prenatal care may have improved detection and management of complications and chronic health conditions, especially for those who are at risk of increased adverse outcomes.^{xxvi} The lack of affordable health insurance for individuals will lead to many forgoing coverage and an increase in uncompensated care and poor health outcomes. **ACOG does not support the proposed limits on APTCs and encourages HHS to promote policies that increase access to affordable health care coverage, a stated goal of the administration.**

Disallow APTC for Individuals Who Are Ineligible for Medicaid Due to Their Immigration Status and Have Income Below 100 Percent of the FPL (§ 155.305(f)(2))

To align with H.R.1, HHS proposes to remove the requirement for an Exchange to determine a tax filer eligible for APTC if the Exchange determines that the tax filer is expected to have household income of less than 100 percent of the FPL for the benefit

year for which coverage is requested, the tax filer or one or more applicants for whom the tax filer expects to be eligible for a personal exemption is lawfully present and ineligible for Medicaid due to their immigration status, and the tax filer otherwise meets APTC eligibility requirements. This change is expected to impact close to 300,000 FFE enrollees.^{xxvii} Gaps in coverage can result in interruptions in treatment, lack of access to prescription medicine, and disruptions in the provision of preventive services.^{xxviii} Transitions between coverage programs, also known as churn, are common amongst Medicaid, Basic Health Plan (BHP), and Marketplace enrollees.^{xxix} Due to the proximity in eligibility thresholds, many Medicaid enrollees churn between Medicaid and Marketplace or BHP coverage.^{xxx} **ACOG does not support policies that makes health care more unaffordable for patients and urges HHS to support policies that offer consumers affordable health care options.**

Failure to File and Reconcile Policy (§ 155.305)

In this rule, HHS is proposing to adopt the 1-year Failure to Reconcile (FTR) policy in PY 2027 or to continue administering a 2-tax year FTR process until PY 2028, if an Exchange does not have the resources or capacity to adopt the 1-year policy in PY 2027. These changes would make it so that all tax filers that are identified as having FTR status for 1 tax year would lose their APTC eligibility. This would lead to a disruption in the continuity of care coverage, which would serve as an obstacle to individuals in accessing services they need to address reproductive health, maternal health, and behavioral health, all due to one single year of non-compliance. Previous NBPP rules allowed a process such that an Exchange may only determine enrollees ineligible for APTC after a tax filer has failed to file a Federal income tax return and reconcile their past APTC for two consecutive years. Reducing the FTR policy from 2 years to 1 year in PY 2027 does not provide consumers with a chance to reconcile their APTC before losing their eligibility. **ACOG does not support policies that lead to the disruption of coverage that affect consumers' access to health services.**

Removal of the Requirement to Accept Attestations of Household Income When Tax Data is Unavailable (§ 155.320(c)(5))

HHS proposes in this rule to permanently rescind the requirement for Exchanges to accept attestations and to instead require Exchanges to collect documentation from applicants to verify an applicant's household income when the IRS returns no data, starting with applications for coverage for PY 2027. HHS already removed the requirement for all Exchanges to accept an applicant's annual household income attestation when the Internal Revenue Service (IRS) is successfully contacted but the IRS returns no tax data in the 2025 Marketplace Integrity and Affordability final rule, with the policy finalized to sunset after PY 2026. **ACOG does not support this proposed rule.** In previous rule making HHS noted that there are many reasons that tax data may not be available through no fault of the applicant, including that the applicant was not required to file a tax return in the prior year, or the presence of IRS privacy rules precluding sharing data if the family unit applying for coverage differs from the prior year due to marriage, divorce, birth, death, or other reasons. This policy change would require Exchanges to treat missing tax data as though it's inconsistent with attested income, creating a data matching issue (DMI) for the consumer to resolve.

In 2021, 64 percent of uninsured adults said that they were uninsured because the cost of coverage was too high.^{xxx} Many people do not have access to coverage through a job, and some remain ineligible for financial assistance for coverage. Adding administrative barriers and shortening time to address income inconsistencies will prevent patients from getting the coverage and financial assistance they need right away to help pay for their health care needs. **ACOG recommends HHS not finalize this proposal to ensure no administrative barriers are put in place when accessing affordable coverage on the Exchanges.**

Special Enrollment Period Verification (§ 155.420(g))

In the 2025 Marketplace Integrity and Affordability final rule, HHS removed the Special Enrollment Period Verification for Loss of Minimum Essential Coverage and proposed allowing Exchanges on the Federal platform to conduct verification for additional SEPs beyond loss of minimum essential coverage. Additionally, the 2025 final rule requires Exchanges on the Federal platform to conduct Special Enrollment Period Verification for at least 75 percent of new enrollments. In this NBPP for 2027 proposed rule, HHS proposes re-introducing these burdensome enrollment and income verification procedures, despite being challenged in *City of Columbus et. al. v. Kennedy et. al.* which is still in the courts.

ACOG opposes the HHS proposal to conduct verification for additional SEPs beyond loss of minimum essential coverage and to conduct Special Enrollment Period Verification (SEPV) as this will place undue burden on patients. SEPs exist to grant individuals health insurance coverage if they lose health insurance or experience a qualifying life event outside of the annual open enrollment period. Conducting SEPV will require individuals to send documentation confirming their qualifying event. This may further delay individuals from receiving the coverage and care that they need, particularly since those enrolling in the SEP have lost health care coverage. Furthermore, providing documentation may be challenging for those with low health literacy and for those whom English is not their first language. Understanding the directions and how to comply will be difficult and may further compromise coverage and care. The SEPV may also exacerbate burdens for those experiencing housing instability, those who do not have access to a computer or internet, or those who cannot afford the necessary postage. Individuals experiencing housing instability may not have an address that they can list on their mail either when enrolling in coverage or when mailing documentation and therefore may miss further instructions. Those without access to the computer or internet may not be able to access instructions or ways to submit documentation and those with financial challenges may not be able to afford to mail the required documentation. For patients navigating many challenges, this verification requirement will only exacerbate health and social care outcomes.

ACOG encourages HHS to eliminate this proposal for the above reasons and because of the current litigation. The outcome of the legal case may change the regulation and cause confusion for patients. Should HHS move forward with this proposal, ACOG encourages the agency to include directions in plain language and multiple languages, extend the time that patients have to provide documentation, and provide assistance, such as case management, to patients who may lack access to the resources needed to submit documentation. Removing administrative barriers and adding more time to address income inconsistencies will allow consumers to get the coverage and any financial assistance they need right away to help pay for their health care needs.

ACOG encourages HHS to exercise its authority to create an SEP for pregnancy.

Due to restrictions under current regulation, if an uninsured person becomes pregnant outside of the annual open enrollment period – and is not otherwise eligible for other insurance such as Medicaid or CHIP – they may be unable to access health insurance for the duration of her pregnancy. This may lead some to forgo pregnancy-related care altogether because, absent insurance, they would need to pay for the full cost of care on their own. Nationally, from 2016-2017 the average cost for a childbirth admission for an individual with employer sponsored insurance was \$13,811 with great variation between states.^{xxxii} This amount would be financially untenable for many individuals and families without the aid of insurance. Establishing an SEP based on pregnancy would eliminate this gap and get more people into timely prenatal care.

There is a large body of research which demonstrates that improved access to prenatal care improves maternal and infant health outcomes.^{xxxiii} Additional studies confirm that women with unstable health insurance coverage during pregnancy are more likely than women with stable coverage to report entering prenatal care after the first trimester.^{xxxiv} For more than thirty years, the United States – through the Medicaid program – has recognized pregnancy as a point at which women need immediate access to care through coverage expansions, presumptive eligibility based on pregnancy status, and extending postpartum Medicaid to one year.^{xxxv} Women eligible for coverage on the Exchanges have not been given the same priority status.

ACOG believes designating pregnancy as a qualifying life event that triggers a SEP could benefit all who become pregnant in individual market plans; however, it would be especially important for those who may lack access to coverage that includes maternity benefits. Enacting this policy would ultimately save the health care system money by increasing the likelihood of a positive birth outcome and a safe and successful delivery of a healthy newborn. **If HHS moves forward with adopting a pregnancy SEP, ACOG recommends that this SEP be mandatory for all Exchanges.**

Expansion of Hardship Exemption Eligibility (§155.605(d)(1))

HHS proposes to codify the expansion of hardship exemption eligibility to individuals who are ineligible for APTC or cost sharing reductions (CSR) due to projected household income below 100 percent or above 250 percent FPL. Under existing regulations, exchanges grant a hardship exemption when a person cannot afford to enroll in a qualified health plan because of unexpected expenses or other circumstances. Qualifying circumstances might include homelessness, domestic violence, bankruptcy, or a natural disaster. The White House Council of Economic Advisers believes this change will increase enrollment in catastrophic plans from about 54,000 people nationwide for 2025 to 3 million people nationwide for 2026.^{xxxvi} This “broad nationwide exemption” would apply uniformly across all states to anyone over the age of 30. Catastrophic plans have significantly higher maximum out-of-pocket costs and offer limited pre-deductible coverage, especially for reproductive health care. Pre-deductible coverage only includes ACA preventive care and three primary care visits with no other services required. These plans increase out-of-pocket costs for consumers without offering comprehensive coverage. **ACOG recommends HHS keep the current eligibility for hardship exemptions and not finalize this proposal to expand eligibility for catastrophic health plans.**

Amending Exchange Network Adequacy Standards (§ 155.1050)

HHS proposes to restore network adequacy authority back to the State Exchanges and SBE-FPs through the removal of requirements which require State Exchanges and SBE-FPs to establish and impose quantitative time and distance network adequacy standards that are at least as stringent as standards for QHPs on the FFEs. Additionally, they propose to return to the requirement that State Exchanges and SBE-FPs ensure that each QHP provides sufficient access to providers in a manner that meets applicable standards specified in § 156.230(a)(1)(ii) and (iii) for network plans, or proposed § 156.236(a) for non-network plans. **We strongly urge HHS to continue requiring uniform federal network adequacy standards that all Exchanges must meet and continue not allowing non-network plans to be certified as a QHP.**

HHS acknowledges in the preamble there is a potential risk of decreased access to care if state network adequacy standards and review processes are less protective than existing federal framework. ACOG is overall supportive of establishing network adequacy standards and ensuring the State Exchanges and SBE-FP's quantitative time and distance standards align with FFE. Network adequacy standards help to ensure strong networks of providers are available to all individuals enrolled in marketplace coverage regardless of where they reside. Requiring that all QHPs use a provider network would ensure consumer access to a sufficient choice of providers and would guarantee consumers have access to information on the availability of in-network providers.

Services provided by ob-gyns range throughout the lifespan and are critical for individuals seeking care. Applying network adequacy to all plans is a key piece in ensuring those seeking obstetrical and gynecological care have access to the providers and care they need. A non-network plan does not contract with providers for a specific negotiated rate for a specific set of services. Plans pay a set benefit amount for covered services and while enrollees chose a provider they want, they run the risk of balanced billing or higher charges than what the plan will reimburse. Enrollees receiving care from out-of-network providers often face coverage denials or substantially higher out-of-pocket expenses.^{xxxvii} Reducing the number of in-network providers can limit enrollee's choices, increase waiting times, and complicate continuity of care. Network adequacy standards are a critical piece in ensuring consumers have access to providers that will meet the full scope of their reproductive health care needs. Maternity care access, especially in rural areas, is declining due in part to provider shortages. Requiring all Marketplace plans to meet certain standards, especially for obstetric services will help address the maternal mortality crisis.^{xxxviii}

If HHS chooses to defer to states for network adequacy reviews, there are important considerations to ensure states are meeting when implementing network adequacy standards. First, many individuals receive obstetrical and gynecological care from a broad range of provider types. Women living in rural areas have less access to health care and experience poorer health outcomes than women living in urban areas—a trend exacerbated by physician shortages, the rapid rate of rural hospital closures, and shuttering of obstetric units.^{xxxix} According to the most recent available data, 49 percent of U.S. counties, home to 10.2 million women in the U.S., lacked an ob-gyn.^{xl} As HHS considers future rulemaking in this area, ACOG encourages the agency to include access to the full range of obstetric care (including all Levels of Maternal Care) and family planning services in any network adequacy requirements.^{xli} **ACOG recommends all network adequacy standards include licensed, qualified health care**

professionals providing obstetrical and gynecological care to ensure a robust network of reproductive health providers in each state.

Even before the COVID-19 pandemic, telehealth programs in obstetrics were expanding to close gaps in access to care for patients in remote locations, providing more efficient care for uncomplicated pregnancies, and allowing for more convenient postpartum care at home.^{xlii} Research has found that there are no significant differences in the rates of preterm birth, cesarean birth, neonatal intensive care unit admission, or low birth weight for patients who received virtual prenatal visits in place of some in-person visits.^{xliii,xliv} A systematic review demonstrated improved rates of breastfeeding and smoking cessation as well as fewer high-risk obstetric office visits without increases in maternal or neonatal morbidity when some services were provided via telehealth.^{xlv} Patient satisfaction has been reported to be higher among women with virtual visits.^{xlvi} Remote patient monitoring and text message interventions have also been shown to improve the rate of adherence to blood pressure monitoring guidelines and reduce the number of unscheduled visits in the postpartum period.^{xlvii} Further, telehealth has been shown to address barriers to contraceptive access and can be used to improve access to all forms of counseling, including behavioral health services and treatment for substance use disorder (SUD).^{xlviii,xlix,l} In a recent study, researchers found that opioid use disorder (OUD) treatment received via telehealth in obstetric practices did not negatively impact outcomes compared to in-person treatment.^{li} Behavioral health services and SUD treatment provided via telehealth ensure access to the continuation of comprehensive care. **ACOG recommends HHS collect information about telehealth services offered by QHP's and consider including telehealth in network adequacy standards in the future.**

Part 156: Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

State Selection of EHB-benchmark Plan for Plan Years Beginning on or after January 1, 2020 (§ 156.111)

HHS proposes to pause review of State applications to select EHB-benchmark plans, and states they are “actively conducting a comprehensive review of section 1302 of the Affordable Care Act, as we are considering future rulemaking to revise § 156.111 and other regulations relating to the EHBs”. As previously stated, EHB and state flexibility to add services to their EHB have been a vital piece in improving women’s health across the country. States have the option to choose services for their EHB benchmark plans that best meet the needs of the people in their state. In light of the ongoing maternal mortality crisis and the behavioral health crisis, **ACOG urges HHS to seize this opportunity to update and strengthen the EHB to process ensure all people have access to the care they need to thrive.**

Provision of EHB (§ 156.115(d))

HHS proposes prohibiting issuers from including non-pediatric dental services as an EHB. **ACOG strongly opposes this provision and encourages CMS to continue to include non-pediatric dental services as an EHB.**

ACOG supports access to oral health care throughout the lifespan and believes oral health care to be a key component of overall health.^{lii} ACOG guidance recommends that

patients routinely be counseled about the maintenance of good oral health habits as well as the importance of maintaining oral health care throughout their lives.^{lviii} Oral health disorders, such as periodontitis, are associated with many diseases that impact patients seeking obstetric and gynecological care, including cardiovascular disease, diabetes, Alzheimer's disease, respiratory infections, and more.^{liv} Approximately 35 percent of adults did not have a dental visit in 2019.^{lv, lvi} Access to dental care is directly related to income level; the poorest people are least likely to have received dental care due to a variety of factors such as financial constraints and lack of insurance coverage.^{lvii} Furthermore, 29 percent of low-income adults report that the appearance of their mouth and teeth affects their ability to interview for a job.^{lviii}

Allowing states to include adult dental care in their EHB would facilitate improved coverage continuity for individuals who churn between Medicaid and the Marketplace. As of October 2022, 39 states and Washington D.C. have dental benefits greater than emergency dental services and all states offer dental services for pregnancy related Medicaid coverage.^{lix} Every year, millions of adults enroll in Medicaid for a period of less than a year, many of whom reenroll within the year.^{lx} Often, individuals and families who lose Medicaid coverage will look to the Marketplace for another source of affordable care.^{lxi} In addition to the administrative challenges associated with identifying and enrolling in a new coverage program, low-and middle-income individuals transitioning from Medicaid to the Marketplace need to contend with different benefits packages and provider networks. Allowing states to include non-pediatric dental services within their EHB package would allow states to ease the transition between coverage programs and ensure that low-income individuals have consistent access to dental services, no matter which coverage program they are enrolled in. HHS notes that their reasoning for eliminating non-pediatric dental services as an EHB is to better align with the statutory requirements of the ACA which directs the scope of the EHB to be equal to the scope of benefits provided under a typical employer plan. However, we note that routine non-pediatric dental services are commonly covered as an employer-sponsored or other job-based benefit to a degree that warranted removing the prohibition on coverage of these services as an EHB. Allowing states to include non-pediatric dental services in their EHB package would facilitate individuals seeking out preventive oral health care and will leave to overall better health outcomes. **ACOG asks that HHS not finalize the proposal prohibiting states to add non-pediatric dental services to their EHB package.**

Multi-Year Terms for Catastrophic Plans to Improve Health (§§ 156.130(c) and 156.155(a)(6))

HHS proposes to codify requirements under which issuers of catastrophic coverage may enroll individuals for multiple plan or policy year terms with periods of up to 10 years. They propose modifying the requirements for catastrophic plans to specify that a catastrophic plan has a plan term of either 1 plan or policy year, or of multiple consecutive plan or policy years not to exceed 10 years. Catastrophic health plans expose consumers to high out-of-pocket costs, up to \$15,600 for an individual and \$27,600 for a family per year. With the expiration of APTCs, families may be forced to make incredibly hard decisions about the cost of their health care coverage. While this coverage may have lower premiums, consumers will be on the hook for any health crisis or needs outside of preventive care. These plans should be limited to one year to ensure individuals are able to change plans during open enrollment if their health care needs

change. **ACOG strongly opposes multi-year terms for catastrophic plans and requests that HHS limit the term to one-year contracts.**

Non-Standardized Plan Option Limits (§ 156.202)

HHS proposes to exercise the authority to discontinue non-standardized plan option limits and exception effective in PY 2027. In previous years, HHS estimated that with limits on non-standardized plan options, the weighted average number of non-standardized plan options available to consumers would be reduced from 107.8 in plan year 2022 to 37.2 in plan year 2024.^{lxii} For plan year 2023, approximately 73 percent of HealthCare.gov consumers had more than 60 plan options to choose from far higher than in previous years.^{lxiii} Research suggests too many choices can lead to “choice overload,” making it hard for consumers to find plans that best fit their needs.^{lxiv} **ACOG does not support HHS efforts to remove the limits on non-standardized plans on the Exchanges. These limits help decrease choice overload and make it easier for consumers to select a plan that meets their needs.**

Essential Community Provider Standards for Network Plans (§ 156.235)

HHS proposes changes to QHP certification requirements with respect to essential community providers (ECPs) included within a network plan issuer’s provider network. First, HHS would reduce all three ECP thresholds—the overall threshold, the threshold for FQHCs, and the threshold for family planning providers—from 35 percent to 20 percent. Family planning providers are essential providers addressing the reproductive health needs of millions across the country. Approximately 61 percent of women from 2017-2019 had ongoing or potential need for contraceptive services.^{lxv} Additionally, family planning providers in the Title X program are typically serving socioeconomically disadvantaged populations, likely to be women, young, and with low rates of insurance.^{lxvi} Decreasing the threshold standard for QHPs to contract from 35 percent of available family planning providers to 20 percent will decrease access to care for those with reproductive health care needs. In fact, HHS notes that most QHP issuers exceed the 35 percent threshold for ECPs so it is unclear why the agency is choosing to prioritize this decrease. **ACOG recommends HHS continue the 35 percent ECP threshold to support access to care, including family planning, for all patients.**

Conclusion

ACOG believes there are ways to strengthen the integrity of the Marketplace and ensure proper enrollments without putting policies in place that will force hundreds of thousands of people to lose coverage and financial assistance for care as well as access to strong provider networks and essential community providers. We strongly oppose any policy that results in loss of affordable coverage for patients and any policy that unfairly targets vulnerable populations like immigrants. ACOG urges HHS to not finalize these policies and to meet with consumer groups, plans, and physicians, on ways to improve the Exchanges and ACA policies.

###

Thank you for the opportunity to comment on the **Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program**. We hope you have found our comments and recommendations useful. Should you have any questions, please contact Taylor Platt, Senior Manager, Health Policy, at tplatt@acog.org or 202-314-2359.

Sincerely,

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March 13, 2026

Robert F. Kennedy
Secretary
Department of Health and Human Services

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services

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Center for Consumer Information and Insurance Oversight
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Submitted electronically via: www.regulations.gov

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

Dear Deputy Administrator and Director Nelson,

The Association for Community Affiliated Plans (ACAP) respectfully submits comments in response to the proposed rule updating the Notice of Benefit and Payment Parameters for 2027.

ACAP is a national trade association representing 90 not-for-profit Safety Net Health Plans (SNHPs). Our member plans provide coverage to more than 30 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP), Medicare Special Needs Plans for dually eligible individuals, the Basic Health Program, and the ACA Marketplaces. Of ACAP's SNHP Member and Partner Plans, 36 offer qualified health plans (QHPs) or Basic Health Program (BHP) plans, and our plans serve over 2 million enrollees in the ACA Marketplaces.

ACAP has chosen to respond to a subset of proposals in the update of the Notice of Benefit and Payment Parameters for 2027 that are particularly relevant to SNHPs. ACAP appreciates the Administration's desire to strengthen the integrity of the Marketplaces; our comments focus on ensuring market stability for SNHPs and the consumers they serve. ACAP member plan enrollees are generally low-income populations, and we would like to emphasize that the comments herein support SNHPs in their efforts to serve their communities.

Overall, we appreciate that CMS is considering innovative ideas to strengthen the Marketplaces and improve the consumer experience. Our comments below largely fall within the following framework:

1. **We urge CMS to, at a minimum, delay a number of the broadest proposals** in order to fully absorb stakeholder feedback so that the agency can further refine or reconsider them based on input. To that end, we recommend robust stakeholder engagement, such as RFIs, technical working groups, and white papers for comment, to further develop many of these policies before reproposing them in future rulemaking. Further, as CMS is aware, QHP certification



opens on April 16, 2026, and issuers will not have enough time to adapt their plan offerings to the novel policies CMS has proposed herein. In addition to the shortened timeline, the scope and breadth of proposals could make it more difficult for small, community-based plans to enter and remain in the market. Multiple ACAP Medicaid plans are already in the process of newly developing a QHP for 2027, and some of the more novel ideas included within could disrupt the efforts they have made to date. With many new policies already going into place, and others being considered, plans need additional data to support their operations and to provide full and complete feedback to CMS. ACAP plans are willing and ready to work with CMS to find and address gaps in data availability.

2. **We appreciate CMS' focus on the consumer experience, and we urge CMS to add additional consumer protections and disclosures.** While addressed throughout this rule, we believe that CMS could enhance consumer protection and plan disclosure requirements to ensure that any finalized proposals make clear to enrollees what they are purchasing.

We provide more complete comments and recommendations below.

Summary of ACAP Comments

Catastrophic Coverage: Expansion of Hardship Exemption: ACAP urges CMS to not finalize the proposal to expand the catastrophic coverage hardship exemption eligibility due to the potential negative impact on consumers, especially those who are eligible for advanced premium tax credits (APTCs). If CMS chooses to finalize it, we believe CMS should include strengthened marketing disclosures and consumer protections for catastrophic plans.

Catastrophic Coverage: Multi-Year Plans: ACAP urges CMS to not finalize the proposal to allow catastrophic plans to enroll individuals for multiple years. At a minimum, we believe CMS should delay finalization due to timeline concerns and remaining questions on how this would be implemented. We are concerned about negative consumer impacts and urge for increased marketing disclosures and consumer protections if this policy moves forward. We also are concerned about how this would impact risk pools.

Catastrophic and Bronze Coverage: AV and MOOP: ACAP urges CMS to not finalize the proposal to allow for higher annual maximum out-of-pocket limits (MOOPs) for both bronze and catastrophic plans. At a minimum, we believe this proposal should be delayed, as the actuarial value (AV) calculator was only released in late February. Specifically, we are concerned that this policy could harm consumers due to increased cost-sharing and destabilize risk pools.

Network Adequacy Time and Distance Standards: ACAP supports the proposal to remove the current requirement that State Based Exchanges (SBEs) and SBEs on the Federal Platform (SBE-FPs) establish and impose quantitative time and distance network adequacy standards that are at least as stringent as standards for QHPs on the Federally Facilitated Exchanges (FEEs). We believe that states are best suited to develop time and distance standards that reflect their markets.

Deferral of Network Adequacy Review to FFE States: ACAP supports the proposal to defer reviews of QHP issuer network adequacy to FFE states as states have the best understanding of their markets.

Non-Network Plans: ACAP has substantial concerns with the proposal to allow non-network plans to receive QHP certification. We strongly oppose this policy and urge CMS to not finalize it, or at a minimum, to delay finalization. We appreciate that CMS is thinking outside of the box and working to



spur plan innovation, but we are concerned about the various unknowns with this proposal and the potential for consumer harm. If this policy is finalized, we urge CMS to require that non-network plans prominently disclose on all policy documents that the amounts paid for medical services may not be enough to cover the full cost of care at a consumers' chosen provider, and that the consumer may be subject to balance billing, to help consumers make informed decisions. We also ask CMS to clarify whether and how the No Surprises Act applies to non-network plans and how it intends to protect consumers from balance billing.

Documentation and Marketing Requirements for Brokers: ACAP strongly supports CMS' proposal to expand requirements for brokers, agents, and web-brokers in FFE and SBE-FP states. We suggest additional policies for CMS to consider related to broker fraud in order to protect consumers: ensure that consumers who are fraudulently enrolled in coverage are able to choose new coverage through an exceptional circumstances special enrollment period (SEP) and be held harmless for any APTC paid; require that agents and brokers inform consumers if they are cost-sharing reduction (CSR) eligible and receive consumer attestation or confirmation to this effect; require agents, brokers, and web-brokers to act in the best interests of their customers, such as through a fiduciary responsibility.

Approval of an SBE: ACAP has concerns with the proposal to eliminate the requirement that states seeking to operate an SBE are required to operate an SBE-FP for at least one plan year. ACAP appreciates the longstanding strength of SBEs in ensuring robust and strong coverage for consumers and providing consumer-friendly shopping experiences. However, we are concerned that removing this step for states transitioning to SBEs in the future raises questions as to whether they will provide as strong a shopping experience as the Federal Marketplace and importantly, whether the state will be operationally ready to ensure a seamless experience for consumers.

SBE-Enhanced Direct Enrollment (EDE) Option: ACAP strongly opposes the proposal to provide SBEs the option to rely entirely on one or more web-brokers for implementing and operating consumer-facing websites that facilitate the eligibility and enrollment process in a State Exchange. We are concerned that this policy could lead to consumer confusion, lower enrollment in the Exchanges, and increased premiums for those who remain. We also believe this proposal is contradictory to the proposals related to documentation and marketing requirements for brokers. ACAP member plans have raised concerns about EDE entities requiring payment from issuers for plan options to be listed on their website, which ultimately raises premiums and could force those issuers to halt product offerings or leave the market altogether. Finally, we believe that additional guardrails would be needed in order to ensure there are not unintended consequences.

User Fees: ACAP supports the proposal to maintain a FFE user fee rate of 2.5 percent of total monthly premiums and an SBE-FP user fee rate of 2 percent of total monthly premiums. We urge CMS to ensure user fee funding goes toward navigators and outreach and enrollment efforts, while also providing information on programs funded by user fees to support CMS-wide transparency goals.

Standardized and Non-standardized Plan Options: ACAP supports the proposals to discontinue standardized plan options and non-standardized plan option limits and exceptions. However, ACAP has long been concerned about large issuers flooding the market with products that are not meaningfully different. We recommend that CMS retain the requirement that plan offerings must be meaningfully different. ACAP also recommends that CMS consider website functionality updates that would help meaningfully differentiate plans for consumers.



CSR Rate Justification Reporting: ACAP strongly opposes the proposal to require issuers that make a plan-level adjustment to account for unreimbursed CSRs to submit specific information in their rate justification for each PY in which CSRs are not funded. We are concerned that this would be a massive operational and financial burden for issuers, especially our small, non-profit, and community-based member plans who operate at low margins. If CMS moves forward with this proposal, we urge CMS to provide more information on the goal of this reporting requirement and to institute an exceptions process for smaller issuers that would be disproportionately burdened by the financial constraints of this proposal.

Essential Health Benefits: ACAP appreciates the proposal that any state-required benefits mandated after December 31, 2011 would be considered in addition to EHB and subject to state defrayal, which would, as CMS notes, save consumers money. However, we urge CMS to delay the effective date until at least plan year 2028, or later, to give states adequate time to update their requirements or remove state benefit mandates, if they choose to do so, and to allow issuers adequate time to implement new operational and financial analyses and procedures. To protect consumers from additional costs, we also urge CMS to ensure that states are held accountable for defraying the cost of any remaining state-mandated benefits and establishing appropriate defrayal procedures and processes with their QHPs.

MLR Comment Solicitation: ACAP urges CMS to not allow a state or CMS to impose a different medical loss ratio (MLR) in a given state due to concerns that MLRs could be lowered, which we believe would harm consumers.

Provisions Reintroduced from 2025 Integrity Rule: Pre-Enrollment Verification for SEPs: ACAP supports CMS' goal of increasing SEP verifications and would support a modified version of its current proposal. We urge CMS to adjust the 75 percent requirement to provide some flexibility or instead permit Exchanges to verify the SEPs that are most at risk of abuse.

Income Verification: ACAP urges CMS to delay its income verification proposals until after it can review data from upcoming years, as well as to ensure that issuers have adequate time to consider the impacts of the proposals on the risk pool and adjust premiums accordingly.

Premium Payment Threshold Comment Solicitation: ACAP urges CMS to permit gross percentage and fixed dollar premium payment thresholds. We believe program integrity concerns related to these provisions are minimal and urge CMS to allow this greater flexibility for issuers to determine whether and what type of premium payment threshold to institute, based on what they believe is most appropriate for their enrollee characteristics and actuarial calculations.

Expanded Comments

ACAP's comments are expanded below, with additional background.

Catastrophic Coverage: Expansion of Hardship Exemption

CMS proposes to codify an expansion of catastrophic coverage hardship exemption eligibility to individuals who are over 30 or ineligible for APTC or CSRs due to projected household income below 100 percent or above 250 percent FPL. This was previously allowed through September 2025 guidance.

ACAP has concerns with this proposal and potential negative impact on consumers, especially those who are eligible for advanced premium tax credits (APTCs). A topline concern is that consumers may be



targeted by aggressive marketing and sign up for catastrophic coverage which offers lower premiums, believing they will be receiving full, low-cost coverage. However, as CMS knows, catastrophic coverage offers limited coverage of services (such as only covering three primary care visits annually) and high out-of-pocket limits, ultimately meaning consumers may not be able to access needed care—particularly when coupled with increasing deductibles. Catastrophic plans were designed for young, healthy people who do not qualify for APTCs and may otherwise go uninsured, but the proposed expansion of the hardship exemption could negatively impact consumers. We are particularly concerned about consumers who are between 250-400 percent FPL (and are therefore eligible for APTCs) signing up for catastrophic coverage and missing out on financial assistance from APTCs for a metal plan with more comprehensive benefits. Ultimately, if consumers delay care due to high out-of-pocket costs, they risk simply deferring costs to when disease progression may be worse—impacting not just their health but overarching costs within the risk pool.

Due to these concerns for consumers, we urge CMS to not finalize this proposal. If CMS chooses to finalize it, we urge CMS to include strengthened marketing protections for catastrophic plans, as also noted below in the multi-year catastrophic coverage section, so consumers are not sold a catastrophic plan with the false promise that it offers more comprehensive, valuable up-front coverage than it does.

Catastrophic Coverage: Multi-Year Plans

CMS proposes to allow catastrophic plan issuers to enroll individuals for multiple plan years (PYs), up to a period of 10 years. CMS seeks comments on specific items, including how to treat such plans for purposes of the HHS risk adjustment program and whether multi-year terms should be permitted for individual market catastrophic and metal level plans. CMS notes that existing rules would still permit an individual enrolled in a multi-year catastrophic plan to disenroll at any time and for any reason and would allow an issuer to discontinue the product or exit the market under the same guaranteed renewability exceptions that currently exist.

CMS also outlines that multi-year catastrophic plans would be permitted to apply the annual cost-sharing limit on an annual basis or averaged over the life of the contract, as long as the average of the limit over the term met statutorily required annual limitations. CMS highlights that this flexibility would allow a multi-year plan to apply an annual cost-sharing limit that exceeds the current annual limit in the early years of the term and decrease the cost-sharing limit in later years as a way to encourage continued enrollment. This flexibility would also allow the multi-year plan to apply the annual deductible as a monthly amount (one-twelfth of the annual amount) in order to reduce variation in month-to-month costs for the enrollee.

ACAP has concerns with this proposal, and, due to many unknown details in the proposed rule, we urge CMS to not finalize this policy. At a minimum, we believe CMS should delay finalization until after such time as CMS has the opportunity to go through a more in-depth RFI process in which it makes additional data available for feedback. We acknowledge that enrolling a consumer in a plan for multiple years is a novel idea that would massively change the individual market, and because of that, we believe CMS must spend more time working out the details and potential impacts of such a massive proposal. CMS asks specific questions and seeks comment on many aspects of this proposal, which for us emphasizes the need for more time to hear from stakeholders and experts and assess how provisions of this policy could be implemented. As noted above, QHP certification opens on April 16, 2026, just one month from the closing of comments on this proposed rule. Further, as CMS must consider public comments and

then issue a final rule, this does not give issuers enough time to adapt their plan offerings to account for this novel and potentially very impactful proposal.

There are also various unknowns in this proposal that complicate plans' ability to fully respond to the proposed rule. Specifically, ACAP urges CMS to provide more information on the options described for cost-sharing, including that a deductible could be applied by the month or that deductibles could change between years. More information is needed for stakeholders to assess these options and their implications for consumers and the individual market. For example, if a consumer enrolls in multi-year coverage with a front-loaded deductible, but issuers are allowed to discontinue the product or exit the market, consumers would lose the so-called "benefit" of more affordable care in future years—potentially without any recourse.

Plans would also need additional information to respond more fully to this proposal, including on the following key aspects: 1) plan pricing, including details on how plans can or cannot adjust premiums annually in multi-year catastrophic plans; 2) any enrollment restrictions; 3) eligibility determinations, including whether it is appropriate to maintain enrollment for individuals in multi-year catastrophic plans that may no longer be eligible for catastrophic coverage; 4) provider contracting requirements; 5) plan operations, including any notice or disclosure requirements; 6) CMS' risk adjustment analyses and estimates; 7) MLR considerations, and more.

Further, a consumer could enroll in a multi-year plan, but down the line, their financial circumstances could change where they become eligible for APTCs and could qualify for a more comprehensive plan with similar or lower costs; however, if they're unaware of this opportunity and are enrolled in a plan for multiple years, they could miss out on a plan with better coverage. While we appreciate that CMS notes that existing rules would allow an individual enrolled in a multi-year catastrophic plan to disenroll at any time and for any reason, consumers may not reassess their plan enrollment annually if they choose a multi-year catastrophic plan. As a result, they could miss out on plans with more robust coverage or lower costs due to changes in their financial situation or market innovations. This is particularly concerning as consumers enrolled in a multi-year plan would not necessarily be made aware of the timing of the annual open enrollment period, further contributing to them missing opportunities to switch plans if their circumstances have changed. We also note that continued enrollment or auto-reenrollment in a multi-year catastrophic plan contradicts the policy passed by Congress in the One Big Beautiful Bill Act (OBBBA) and codified in this proposed rule that would effectively end auto-reenrollment beginning tax year 2028 for people eligible for APTCs, yet we expect many of those same APTC-eligible consumers might enroll in a multi-year catastrophic plan.

In addition, we are concerned about the potential for negative consumer impact. Consumers may be sold a multi-year catastrophic plan with low premiums, only to later discover that catastrophic plans offer limited benefits and have high out-of-pocket costs. We are concerned about the financial impact this could have on consumers who may be faced with high cost-sharing, particularly as affordability is a key CMS priority. While we strongly discourage advancing this proposal without more stakeholder input and analysis, as noted above, we also believe that it is missing key disclosure and marketing protections for consumers, which ACAP believes would be a needed component. Marketing protections and disclosure requirements ought to be developed to ensure that consumers aren't sold a catastrophic plan with the false pretense that it would include robust benefits and low cost-sharing. Further, we urge CMS to require that plan documents for catastrophic plans include information on other coverage options for consumers that could be more comprehensive and affordable, to ensure that consumers are aware of all coverage options potentially available to them. This would also align with CMS' proposal related to

broker marketing practices, which we support and discuss in further detail below. It would also align with existing disclosure requirements for short-term, limited-duration insurance (STLDI) plans, for which it is similarly important that consumers are aware of potential coverage restrictions.

In response to CMS' request for comment on how to treat catastrophic plans in the HHS risk adjustment program, ACAP has concerns both if catastrophic plans are included in the same risk pool as metal plans, and if catastrophic plans are in their own risk pool. This underscores our larger concerns with this policy and our belief that this proposal should not be finalized, or at a minimum, should be delayed while CMS seeks additional feedback and fine tunes the details. If catastrophic plans are in their own risk pool, as is currently the case, ACAP is concerned that expanding the hardship exemption and allowing for multi-year plans would pull healthy consumers out of the main risk pool—as healthy consumers are those most likely to sign up for catastrophic coverage, including multi-year catastrophic coverage. This could destabilize the main ACA risk pool, as higher acuity consumers would remain, with the potential to lead to a death spiral caused by a cycle of ever-increasing premiums causing healthier consumers to drop such coverage. Ironically, those higher premiums would actually lead to increased federal spending on APTCs and higher consumer spending—the opposite of CMS' stated goal of improving affordability. Conversely, if catastrophic plans are in the same risk pool as other plans, the statewide average premiums would be decreased, which would impact risk adjustment payables and transfers and could also destabilize the individual market. It could also have the unexpected impact of increasing premiums for catastrophic plans, as they would newly have to take into account the risk mix of metal tier coverage—again leading to a result opposite of CMS' stated goal.

In response to CMS' request for comment on whether multi-year terms should be permitted for individual market metal level plans, we oppose applying this catastrophic plan proposal to metal level plans due to our consumer and risk adjustment concerns noted above. Again, we urge CMS to provide more information on such a proposal for metal level plans so ACAP and our member plans could better assess the implications if CMS were to make such a proposal in the future.

In sum, we urge CMS to not finalize this proposal due to concerns for both consumers and potential impact on risk pooling, which we believe needs to be considered further. At a minimum, we urge CMS to delay finalization and consider an additional RFI—complete with data estimates on the impact to the risk pool—to ensure CMS can absorb stakeholder comments and work out details of this policy, including the need for enhanced consumer protections.

Catastrophic and Bronze Coverage: AV and MOOP

CMS proposes to revise cost-sharing parameters starting PY 2027 for bronze and catastrophic plans to address issues CMS outlines related to actuarial value (AV) calculations for bronze plans that make it increasingly difficult for bronze plan issuers to meet statutory AV requirements. To address that, CMS proposes to allow for higher annual maximum out-of-pocket limits (MOOPs) for both bronze and catastrophic plans. For catastrophic plans specifically, the MOOP would be required to be 130 percent of the maximum annual limit under statute and therefore would be \$15,600 for an individual and \$27,600 for a family in PY 2027. CMS notes that this proposal aims to add distinctions between bronze and catastrophic plans, which currently look similar.

Similar to our concerns noted above in the multi-year catastrophic plan section, we are concerned that this proposal, while a novel idea, could drastically change the market. Further, the AV calculator was only released in late February, complicating efforts by issuers to design their plans for 2027 QHP



certification, let alone comply with this new proposal for 2027. Therefore, we urge CMS to not finalize this proposal or, at a minimum, delay its implementation.

We have additional concerns and questions about this policy. First, we are concerned about the impact of increased MOOP on consumers, who would face higher cost-sharing under this proposal. This is contradictory to CMS' priority of improving healthcare affordability. Additionally, as noted above in the multi-year plan section, we are concerned about the impact of this proposal on risk pools and the potential for a death spiral that leads to increased costs for consumers.

CMS acknowledges in the proposed rule that there are concerns with the AV calculator and bronze plans meeting AV requirements, and CMS notes there are AV calculator options to address this. We urge CMS to lay out the AV calculator options for bronze plans to meet AV requirements for stakeholders to consider prior to moving forward with any such policy. We are also concerned about the legality of any proposal to increase AV and MOOP levels for catastrophic plans 130 percent above the current statutory MOOP limit, as that limit is in statute and is recognized as the upper bound.

Finally, CMS seeks comments on whether this should be applied to other metal plans, which we would oppose due to our concerns already noted in this section. We urge CMS to provide additional information on such a proposal to better understand what that would entail for consumers, issuers, and the Marketplaces.

Network Adequacy Time and Distance Standards

CMS proposes to remove the current requirement that SBEs and SBE-FPs establish and impose quantitative time and distance network adequacy standards that are at least as stringent as standards for QHPs on the FFEs. Instead, states would be required to ensure that plans provide sufficient choice of providers in a manner that meets applicable standards.

Previously, including in response to the 2025 NBPP, ACAP supported deferring network adequacy standards to the states, as we believe that states have a better understanding of their markets and, as such, are best suited to develop standards for their markets. We noted that the design of the Marketplaces in the ACA contemplated deference to the states, and we continue to believe that state flexibility, as opposed to one-size-fits-all requirements, is the best approach for developing time and distance standards that reflect individual state markets. While we do wish to note the potential challenges for issuers that operate in multiple states and would have to navigate multiple sets of differing standards, ultimately, we support this proposal.

Deferral of Network Adequacy Review to FFE States

CMS proposes, in PY 2027 and beyond, to defer reviews of QHP issuer network adequacy to FFE states, including states performing plan management, provided the state elects to conduct such reviews and demonstrates sufficient authority and the technical capacity to conduct network adequacy reviews by satisfying applicable criteria.

Similar to the section above, ACAP has previously urged CMS to defer network adequacy standards to the states, as we believe that states have a better understanding of their markets and, as such, are best suited to develop standards for their markets. Therefore, we support this proposal, and we appreciate that CMS would provide data and other resources to FFE states who choose to conduct their own network adequacy reviews and meet the specified criteria to do so. We urge CMS to go further with this



proposal, and the one above, by removing the requirement that FFEs that conduct plan management functions follow quantitative time and distance network adequacy standards that are at least as stringent as standards for QHPs on the FFEs.

Non-Network Plans

The rule proposes to allow plans that do not use a network (non-network plans) to receive QHP certification beginning with PY 2027. Such plans would demonstrate sufficient provider access in a different way than network-based plans. CMS proposes to establish provider access and essential community provider (ECP) standards specifically for non-network plans: a non-network QHP must ensure access to a range of providers that accept the non-network plan's benefit amount as payment in full, including ECPs and providers that specialize in mental health and substance use disorder services, to ensure that services will be accessible without unreasonable delay.

Similar to our comments above in the catastrophic coverage sections, we urge CMS not to finalize this proposal, or, at minimum to delay finalizing this policy to ensure CMS has the time to engage in further discussion with stakeholder comments on this proposal. We appreciate that CMS is thinking outside of the box in terms of plan and network design, but we are concerned about the various unknowns with this proposal, the potential for consumer harm, and the potential impact on risk adjustment transfers.

While CMS proposes provider access standards specific to non-network plans, we have concerns that CMS and states will not be able to know if a non-network plan meets those standards until the plan is in operation due to the fact that non-network plans do not contract with providers. To attempt to address this, CMS proposes that non-network plans offer an exceptions process for enrollees who cannot find providers willing to accept the benefit amount as payment in full. However, it is unclear how CMS would ensure that these exceptions processes are meaningfully enforced, consistently applied, or easily accessible to consumers in practice. Additional protections would be vital to ensure that consumers who have little choice in providers are protected from increased out of pocket costs.

Without a contract with the plan, providers would not be required to provide care for a consumer enrolled in the non-network plan and could change their prices at any point, potentially exposing consumers to higher costs via balance billing (which we discuss further below). We also are concerned about how non-network plans would approach ensuring consumer access to preventive care, as we believe that high-quality, low-cost preventive care is essential for consumers and aligns with this administration's Make America Healthy Again agenda.

If CMS chooses to finalize this proposal this year, or in future years, we urge CMS to include increased consumer protections. Previous reporting on non-network plans has noted that consumers may find that the amount of money a plan gives them for care is less than what they're charged – leaving them financially responsible.¹

First, we urge CMS to require that non-network plans prominently disclose on all policy documents that the amounts paid for medical services may not be enough to cover the full cost of care at a consumer's chosen provider, and that the consumer may be subject to balance billing. Additionally, we strongly urge the addition of a designation on Exchanges to help consumers delineate between network and non-

¹ Appleby, J. November 2021. New Health Plans Offer Twists on Existing Options, With a Dose of 'Buyer Beware' <https://kffhealthnews.org/news/article/new-health-plans-offer-twists-on-existing-options-with-a-dose-of-buyer-beware/>



network plans. Similar to the notice and disclosure requirements required for STLDI, a notice requirement would help consumers better compare non-network and network plans and help them make informed decisions. ACAP has long expressed concerns with the expansion of STLDI plans as an alternative to ACA-compliant coverage, and non-network plans have the potential for many of the same risks, including misleading marketing and consumer confusion. For these reasons, we previously expressed concerns about allowing non-network plans to receive QHP certification in response to the 2022 NBPP. Requiring disclosure of non-network plans' documentation would also align with CMS' goal of increasing transparency from the health care sector.

Second, we are concerned that because non-network plans do not have a network, consumers may not receive full protection from balance billing as is required under the No Surprises Act, which applies to in-network providers, and thus only applies to plans with a network. Consumers could be subjected to balance billing even if they receive care from a provider who has previously agreed to accept the non-network plan's benefit amount as payment in full. Without a contract, providers are not prohibited from balance billing consumers, which could expose them to significant unanticipated costs. Prior to the No Surprises Act, balance billing often led to consumers having significant medical debt and even medical bankruptcy; implementation of the No Surprises Act led to an 18 percent reduction in consumer out-of-pocket spending.² We understand that consumers would not be subject to balance billing if they receive care from a provider who accepts the non-network plan's benefit amount as payment in full, but we are concerned that without an established contract, consumers remain at risk for high out-of-pocket costs. Additionally, if consumers unintentionally or unexpectedly see a different provider, or if they choose a provider for reasons other than cost – such as quality or continuity of specialized coverage, they would be subject to balance billing and higher cost-sharing.

We are concerned about whether a consumer would ultimately be covered on the back end by MOOP requirements with respect to balance billing. Even if such protections apply, we remain concerned that consumers would be more likely to hit those requirements and have higher medical costs in general than consumers enrolled in a network-based QHP—having the opposite effect of CMS' stated goals of improving affordability. Therefore, we urge CMS, if it finalizes this proposal, to clarify whether and how the No Surprises Act applies to non-network plans, beyond coverage for emergency services, and how it intends to protect consumers from balance billing.

We further believe that any non-network plan would not be competing fairly with other, network-based plans on the Exchanges, which will have the end-result of bifurcating the individual market and may impact risk adjustment transfers. The impact of permitting non-network plans to compete in the same market as network-based plans is largely unknown, but it is not inconceivable that such plans will be able to offer lower premiums by not contracting with high-cost, specialty providers, for example. If so, we would expect that the statewide average premium would be lowered, impacting the overall dollars moving as part of risk adjustment transfers—which could artificially disadvantage plans with high-risk enrollees that must compete against them in the same risk pool. In other words, non-network plans might be able to in effect cherry pick healthier enrollees who are not concerned about obtaining high-cost care—a practice expressly prohibited for QHPs—ultimately changing market dynamics. Given these concerns, we urge CMS to consider how non-network plans might meet actuarial value and MLR

² Liu, M., Kadakia, K. T., Mein, S. A., & Wadhera, R. K. (2025). Patient healthcare spending after the No Surprises Act: quasi-experimental difference-in-differences study. *BMJ (Clinical research ed.)*, 390, e084803. <https://doi.org/10.1136/bmj-2025-084803>



standards without an underlying guarantee that the plan's benefits are sufficient to cover the provider's charges.

Lastly, we are concerned that non-network plans could expose hospitals and other providers to higher rates of uncompensated care, particularly if a consumer receives care that they believe is covered but that ends up not getting reimbursed through their plan, or if the consumer cannot afford to cover the difference between the non-network plan's allowed amount and the actual cost of care. Hospitals and other providers would ultimately be forced to absorb costs from such underinsured patients if they are unable to afford their medical bill.

In sum, we urge CMS to not finalize this policy, or at a minimum, delay finalization due to the unanswered questions noted above and our concerns for consumers. In the meantime, we urge CMS to explore this proposal more through an RFI to gather more stakeholder feedback before engaging in future rulemaking with additional details on this aspect of the proposal, as unanswered questions remain regarding risk adjustment and provider access.

Specifically, we would urge CMS to propose for feedback how it would establish standards that will ensure that non-network plans provide adequate access to providers that accept the plan's benefit amount as payment in full, including: 1) what constitutes adequate access and how it may differ from network adequacy requirements; 2) how CMS will enforce adequate access; and 3) the extent to which consumers will be subject to balance billing if providers will not accept the plan's benefit amount as payment in full. If consumers are not given adequate provider choices, they will experience care delays and potentially irreparable harm. If CMS chooses to finalize this policy down the line, we suggest addressing these issues as well as inclusion of the aforementioned consumer protections.

Documentation and Marketing Requirements for Brokers, Agents, and Web-Brokers

In the proposed rule, CMS notes longstanding concerns with marketing and documentation practices by brokers, agents, and web-brokers. CMS proposes additional requirements for brokers, agents, and web-brokers in FFE and SBE-FP states. First, CMS proposes to require agents, brokers, and web-brokers to use an HHS-approved and created consumer consent form to meet the eligibility application review documentation requirements and consent documentation requirements. Second, CMS proposes that documentation showing that eligibility application information has been reviewed and confirmed to be accurate by the consumer, including specifying that the consumer must provide a hand-written or electronic signature to execute the HHS-approved and created consumer consent form and that a typed name or checked box would be insufficient. Third, CMS proposes enhanced marketing restrictions and specifies prohibited marketing practices by brokers, agents, and web-brokers.

ACAP strongly supports these proposals and has previously supported CMS efforts to eliminate broker fraud. While ACAP's member plans have many positive broker relationships that provide critical enrollment assistance to their customers, unscrupulous brokers have been a concern of our plans. ACAP's member plans are aware of consumer complaints regarding accuracy of information. Inaccurate information can be of particular concern if a consumer receives an incorrect APTC determination, impacting their tax liability, or even are unknowingly enrolled in a QHP, as was the case with increased unauthorized plan enrollments and unauthorized plan switching by brokers that was rampant in 2024. ACAP's member plans have had to deal with the fallout of confused consumers, operational issues, and QHP enrollments that needed to be termed.

We have previously supported CMS' provision of guidance and requirements on the collection, documentation, and retention of documentation of consumers' consent and eligibility. We also highlight the importance of clear documentation to ensure that consumers fully understand what they are agreeing to. Such documentation can be used as proof—or lack thereof—of compliance with enrollment applications, as well as to hold consumers harmless if warranted. Accordingly, we support CMS' proposals. However, we are concerned about the potential administrative burden for consumers when providing a handwritten or electronic signature to execute the consent form. While we support increased broker requirements that will ensure appropriate consumer consent, we urge CMS to implement the consent form in a manner that ensures consumers do not experience unnecessary barriers to enrollment and monitor whether it needs to be reconsidered in the future.

Additionally, we have three suggestions for additional ways CMS can crack down on broker fraud and protect consumers, all of which we have suggested in response to previous rulemaking. First, we urge CMS to ensure that consumers who are fraudulently enrolled in coverage, and for which documentation showing consumer consent cannot be provided by the agent or broker of record, are able to choose new coverage through an exceptional circumstances SEP and be held harmless for any APTC paid.

Second, we urge CMS to require that agents and brokers inform consumers if they are CSR eligible and receive consumer attestation or confirmation to this effect. ACAP member plans are aware of instances in which agents and brokers are enrolling CSR-eligible consumers into bronze plans instead of silver CSR options because the brokers themselves preference the bronze plan—such as, for example, due to a higher commission. We urge CMS to consider to require agents, brokers, and web-brokers 1) inform consumers if they are CSR eligible and what it means to be CSR eligible, 2) inform consumers if they are leaving CSR subsidies on the table, and 3) document consumer acknowledgement and consent accordingly.

Third, we urge CMS to consider additional rulemaking that would require agents, brokers, and web-brokers to act in the best interests of their customers, such as through a fiduciary responsibility. We know that many unscrupulous brokers act in their own best interests, rather than that of their clients, when they perform unauthorized enrollments or unauthorized plan switches, however, it goes beyond that. Because their incomes are largely commission driven, there is a strong incentive to simply enroll consumers in plans that would provide the greatest financial remuneration, however, such plan may not be in the consumer's best interest—based on premiums, benefits, and more.

ACAP applauds CMS' commitment to eliminating broker fraud and urges CMS to consider the above additional policies to further encourage brokers to act in the best interests of their customers.

Approval of an SBE

CMS proposes to eliminate the requirement that states seeking to operate an SBE are required to operate an SBE-FP for at least one plan year in recognition that states may have existing infrastructure that could support successful operation of an SBE without first operating an SBE-FP.

ACAP greatly appreciates the longstanding strength of SBEs in ensuring robust and strong coverage for consumers and providing consumer-friendly shopping experiences. We would like to emphasize that the design of the Marketplaces in the ACA contemplated deference to states, so long as states met or exceeded federal standards. We strongly believe that existing SBEs have been effective in providing a one-stop shopping platform that is as user-friendly and recognized as the way to purchase ACA coverage, and we hope that will be the case for any state seeking to operate an SBE in the future. This



proposal raises concerns for us, as we believe that removing this step for states to become SBEs in the future raises questions as to whether they will provide as strong a shopping experience as the Federal Marketplace and whether the state will be operationally ready to ensure a seamless experience that, at minimum, meets the Federal floor for running an Exchange. Therefore, we oppose this proposal.

SBE-Enhanced Direct Enrollment (EDE) Option

CMS proposes to provide SBEs the option to rely entirely on one or more web-brokers for implementing and operating consumer-facing websites that facilitate the eligibility and enrollment process in a State Exchange, called the SBE enhanced direct enrollment (SBE-EDE) option. Under the SBE-EDE option, web-broker-run websites would facilitate the online submission of eligibility applications by individuals seeking coverage through a State Exchange and facilitate consumers' selection and enrollment into QHPs on a State Exchange. Those websites would be required to interface with the back-end of the State Exchange's website, which the state would still be required to operate, and transmit information from the broker website to the state website. If this proposal is finalized, states choosing the SBE-EDE option would still be responsible for making all eligibility determinations for QHP coverage and related insurance affordability programs.

A proposal similar to this was proposed in the 2022 NBPP, and we submitted comments strongly opposing such an option. We reiterate our concerns here and strongly recommend that CMS not finalize this proposal because it could lead to consumer confusion, lower enrollment in the Exchanges, and increased premiums for those who remain.

HealthCare.gov and SBEs were created under the ACA to create a simple one-stop shop where consumers could easily find and compare plans offering comprehensive coverage. Consumers view the Exchanges as a simple way to enroll in coverage, and this proposal threatens to undo years of progress by replacing a simple, familiar system with one that is confusing, novel, and unstable. It creates the potential for a fragmented healthcare marketplace, with different websites promoting different plans, and consumers left in the lurch. While CMS notes the benefits web-brokers can provide, which we do not disagree with, we do disagree with the assertion that removing a public-sector competitor is a positive for consumers for a variety of reasons, which we outline below.

First, ACAP plans have spent years encouraging consumers to go to HealthCare.gov for eligibility and enrollment determinations, and while many of ACAP's member plans also work with third-party entities such as brokers or run their own EDE platform, they believe that such processes should augment, not replace, HealthCare.gov. Having one single platform that will direct any consumer to where they can purchase coverage—or sign up for Medicaid if they are eligible—has been one of the greatest benefits of HealthCare.gov; after years of building name recognition, it would be a shame to lose such a benefit in place of consumer confusion, in which consumers may not even know where to go to start their search if they live in such a state. Unfortunately, we are familiar with story after story of consumers searching online for ACA coverage, only to get duped into purchasing something different than they



thought they were buying.^{3,4} Not having a centralized website where they can confidently know what they are purchasing runs the risk of increased consumer shopping and buyer beware issues.

In addition, many brokers enroll consumers in not just QHPs, but also non-ACA-compliant plans such as STLDI, fixed indemnity, and other such plans on the same website. In many cases, such non-compliant plans look like comprehensive Exchange plans at first blush, but ultimately do not act like them. Further, brokers and web-brokers do not have a fiduciary responsibility to consumers. They are therefore not legally required to act in their clients' best interests, providing fair, accurate, and impartial information the way navigators do. Thus, brokers and web-brokers can have the incentive to enroll consumers into coverage that pays higher commissions but that does not cover their preexisting conditions, essential health benefits, or the full cost of their care. ACAP plans are concerned that non-ACA-compliant plans could be preferentially displayed on EDE websites, due to their ability to pay higher commissions, which could increase consumer confusion and ultimately lead to consumer harm if they purchase a product that is not suited for their needs, particularly if the differences between such types of plans are not made clear on the EDE website. Additionally, ACAP plans have noticed a greater number of APTC discrepancies due to IRS documentation issues for consumers coming from direct enrollment platforms, such as web-brokers, than through HealthCare.gov. So, even if a consumer does sign up for a QHP through an EDE, we remain concerned that the consumer may not access the full APTC amounts he or she is eligible for, or may be on the hook for excess APTC repayment at tax time.

ACAP plans have also raised pay-to-play concerns where some DE entities require a per member per month (PMPM) payment from an issuer in order for their plans to be displayed on the EDE website. Such a situation contributed to one ACAP member plan's eventual exit from the ACA market. That plan had an existing and positive relationship with the EDE, as the brokers in their market regularly used that EDE platform, but down the line the DE entity changed its policy and required a steep PMPM payment to be listed on their website. The plan was faced with the impossible choice of paying millions of dollars more—which would need to be absorbed into rates—or having their plans delisted from the EDE entity, which would result in a massive loss of enrollment since the brokers in their area all used that platform. As the trade association for smaller, community-based, non-profit health plans, with already high MLRs, our members cannot absorb such arrangements. We are further concerned that such pay-to-play issues could also be applied to preferential display on EDE platforms, creating an inequity biasing larger issuers. We are concerned that if this proposal is finalized and SBEs seek this EDE option, pay-to-play issues would become more widespread and that could not only force more issuers to halt product offerings or leave the market altogether, but ultimately increase premiums for consumers. If CMS finalizes this policy, we urge the agency to include strong guardrails to prohibit pay-to-play situations.

Similarly to our comments above surrounding a pay-to-play for preferential display, we remain concerned about the need for overarching display requirements for EDE platforms, in order to ensure that products are not displayed based on commission size or other features that may not be in the consumer's best interest. We also believe that display requirements would be needed in order to ensure

³ Havers, J. October 2025. NC woman charged a shocking \$12K after canceling confusing health insurance — but state's industry watchdog can't help. Here's her warning. <https://moneywise.com/insurance/health/nc-woman-charged-a-shocking-12k-after-canceling-confusing-health-insurance-but-states-industry-watchdog-cant-help-heres-her-warning>

⁴ Schwab, R. & Volk, J. August 2023. The Perfect Storm: Misleading Marketing of Limited Benefit Products Continues as Millions Losing Medicaid Search for New Coverage. <https://georgetown.app.box.com/v/the-perfect-storm-august-2023>



that it is clear to consumers if any plans listed on the same website are not-ACA compliant and in what ways.

Lastly, we strongly support CMS' proposals related to eliminating broker fraud, as noted above, and we believe this SBE-EDE option proposal contradicts those efforts. We urge CMS to focus its efforts on finalizing the proposed broker documentation and marketing requirements and enacting enhanced requirements for brokers to prevent fraud and protect consumers, as opposed to providing more authority to web-brokers which could harm consumers and lead to greater opportunities for fraud. In fact, SBEs currently have fewer cases of unauthorized plan switches, a form of fraud, compared to FFE states, in part because enrollment is completed through the state's official SBE platform.⁵ CMS itself acknowledges in this rule, and the 2025 Marketplace Integrity and Affordability final rule, that many program integrity concerns arise from agent, broker, and web-broker behavior, citing a 2025 Government Accountability Office (GAO) report. CMS notes that agents, brokers, and web-brokers are connected to consumers misrepresenting or overestimating their income and increased unauthorized enrollments, finding that nearly 80 percent of income data matching issues originated from those working with agents, brokers, and web-brokers in 2024. We are concerned that this proposal would undermine CMS' efforts to address these program integrity issues by agents, brokers, and web-brokers.

Because of these concerns, we strongly oppose this proposal and urge CMS to not finalize it. If CMS moves forward with this policy, we urge the agency to delay implementation to at least PY 2029 to ensure the policy is more fully fleshed out to include improved consumer protections.

User Fees

For the 2027 benefit year, CMS proposes to maintain a FFE user fee rate of 2.5% of total monthly premiums and an SBE-FP user fee rate of 2% of total monthly premiums. ACAP has historically supported low user fees which keep premiums affordable, so long as there is still sufficient funding for particular, required uses, such as navigators and other outreach and enrollment efforts. In our previous comments, we asked CMS to better outline to what extent the user fees are used for particular programs. We continue to believe greater transparency is necessary and ask CMS to provide additional information about the budgetary implications on programs funded by user fees.

We reiterate these comments here and support CMS proposing to keep user fees low; however, we urge CMS to both ensure user fee funding goes toward navigators and outreach and enrollment efforts and provide information on programs funded by user fees to support CMS-wide transparency goals.

Standardized and Non-standardized Plan Options

Beginning with PY 2027, CMS proposes to discontinue all standardized plan option policies for the federal exchange, including removing all requirements for issuers to offer these plans, ending the requirement for these plans to be meaningfully different, and removing rules for the display and publication of these plan options. CMS also specifies that issuers could continue offering existing standardized plan options. If an issuer decides to discontinue a standardized plan option, enrollees could be cross-walked to another plan under existing rules.

⁵ Norris, L. May 2024. What consumers need to know about unauthorized Marketplace plan changes. <https://www.healthinsurance.org/blog/what-consumers-need-to-know-about-unauthorized-marketplace-plan-changes/#states>

CMS also proposes to discontinue non-standardized plan option limits and exceptions beginning with PY 2027. Under this proposal, issuers would no longer be subject to two non-standardized plans per product network type, metal level, inclusion of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit in any service area.

ACAP supports these proposals and has supported similar proposals in the past in order to facilitate new and innovative plan designs. We also support CMS's proposal that the discontinuation of standardized plans would not impact SBEs' standardized plan requirements, as this provides states with autonomy to design their Exchanges to best meet their consumers' needs.

We believe that this proposal will foster consumer-driven innovation and we are excited by this opportunity. One ACAP plan, for example, offers a diabetes-focused plan that has \$0 copays for diabetes-focused medical services, such as A1C screenings, retinopathy eye screening, diabetic kidney disease screening, diabetes self-management education, nutritional counseling, and routine diabetic foot care, as well as \$0 drug coverage that includes all types of insulin, glucose meters, test strips, and even continuous glucose monitors in certain cases. Another ACAP plan has offered a chronic-condition focused plan, while yet another has offered a telehealth-first plan. We look forward to seeing greater innovation within the market.

CMS could consider features that allow issuers to share additional details about the important aspects of particular plans. In certain SBEs, for example, during the plan preview period, issuers have been able to request pop-up/hover-over fields that could be better explained to the consumer. ACAP urges CMS to consider these or other website functionality updates that would help meaningfully differentiate these plans for consumers, such as, for example, allowing disease-specific plan offerings to be filtered on HealthCare.gov based on the condition targeted by that plan, or making it easier for consumers to filter standardized plans if issuers continue to offer them.

We also remain concerned about the risk of large issuers flooding the market with products that are not meaningfully different, which can lead to consumer "choice paralysis" if there are too many similar options to choose from. Since the inception of the Exchanges, ACAP has noted that some issuers may offer multiple, similar, low-premium products in order to dominate the low-cost market and gain market share in an attempt to have the lowest or second-lowest cost silver product. As such, ACAP has long supported using a strong meaningful difference standard to prevent duplicative plan offerings, limit plan proliferation, and reduce consumer confusion.

In fact, ACAP previously urged CMS to adopt a strong meaningful difference standard instead of instituting standardized plan options, in order to ensure that consumers had true choice of meaningfully different product offerings. However, CMS' definition of meaningful differences has changed over time, ranging from a requirement that there must be one meaningfully different feature/benefit easily identifiable to a consumer, to a simple difference in deductible. We urge CMS to consider what truly makes a plan meaningfully different to a consumer and re-institute a meaningful difference standard. Specifically, we believe that CMS should consider that if an issuer offers multiple plans, such plans must have different deductibles, benefits, provider networks, or formulary IDs, and to publish additional guidance on how CMS will implement and operationalize this proposal. We also urge CMS to continue to monitor this issue to ensure that any meaningful difference standard is sufficient to prevent plan proliferation and consumer confusion.



Ultimately, ACAP supports CMS' proposal to eliminate the requirement for standardized plans and non-standardized plan limitations, in order to support plan innovation. However, we also urge CMS to consider reinstituting a robust meaningful difference standard and implementing website functionality updates that would help meaningfully differentiate plans for consumers.

CSR Rate Justification Reporting

CMS proposes to require issuers that make a plan-level adjustment to account for unreimbursed CSRs to submit specific information in their rate justification for each PY in which CSRs are not funded, beginning in PY 2027. CMS acknowledges that this new reporting requirement would pose a financial burden on plans and estimates the total cost of reporting to be \$418,790,376, or \$1,144,236 per issuer, in 2026. In 2027 and beyond, CMS estimates the total costs at \$209,395,188, or \$572,118 per issuer. CMS also estimates additional market-wide, ongoing annual costs of \$157,222 to enter proposed values and \$628,888 to provide an explanation of how the CSR load factor was determined.

ACAP is extremely concerned with this proposal due to the operational and financial burdens associated with it. As the trade association representing small, non-profit, and community-based health insurers, these costs would pose a massive challenge for our member plans who operate at low margins. This proposal would mean our plans have less money that they can invest in their enrollees and their care. Further, our health plans do not have the systems in place currently to implement this policy, and it would be a massive IT burden for our smaller member plans to get the required systems set up. If CMS moves forward with this proposal, we urge them to institute an exceptions process for smaller issuers that would be disproportionately burdened by the financial constraints of this proposal.

ACAP urges CMS to refrain from implementing it at this time. Individual states have their own established review process for evaluating CSR loading factors, and we believe states should retain the flexibility to review CSR loading factors in accordance with their existing frameworks and market. We also urge CMS to provide more information on the intended uses of this information and the goal of this reporting requirement.

Essential Health Benefits

CMS proposes that beginning plan year 2027, any state-required benefits would be considered in addition to EHB and thus not an EHB if the benefits are: required by a State after December 31, 2011; applicable to the small group and/or individual markets; specific to required care, treatment, or services; and not required by state action for purposes of compliance with federal requirements. These benefits would be considered in addition to EHB regardless of whether they are embedded in a state's EHB-benchmark plan. CMS believes that as a state enacts more benefit mandates and includes them in an EHB-benchmark, plan premiums increase, which leads to increased federal spending on APTCs. Because some consumers do not receive APTCs, CMS is concerned that unsubsidized consumers experience those higher premiums and may be disincentivized to enroll in the Marketplace. Any state that would want to avoid defrayal for benefits already in a state's EHB-benchmark would be able to do so by repealing the state requirement. Acknowledging state legislative calendars and the need for issuer to update plan filings and rates, CMS seeks comment on if the effective date should be PY 2028 instead.

ACAP appreciates that CMS is examining this policy. We agree that the current policy contributes to increased premiums for consumers by allowing states to add mandated benefits to their EHB-benchmark, effectively sidestepping state defrayal requirements. While we are generally supportive of this proposal, as we believe it will save consumers money, we urge CMS to delay the effective date to at



least plan year 2028, or later. As CMS acknowledges, some states that wish to avoid defrayal for existing benefits may repeal their state requirement. However, that will take time, and many state legislative sessions are already nearing completion. We want to ensure that states have enough time to repeal existing mandates so that this proposal can be properly implemented and not harm consumers.

Additionally, there would be logistical and operational challenges for ACAP plans to comply with this starting in 2027. For example, some ACAP member plans are still waiting for their state to approve their EHB-benchmarks. If this proposal is finalized beginning in 2027, it could still take several months before plans know whether certain services will remain part of state benchmark plans. Issuers will have to make various contingency plans to adapt their EHB-benchmarks to comply with the defrayal policy for 2027. This uncertainty also creates additional barriers to plan design for new carriers preparing to enter the market. In addition, reclassification of EHB benefits would require plans to assess whether to maintain current benefit parity or redesign cost sharing, given that these services would no longer be subject to EHB protection. This would require updates to filings, benefit configuration, Evidence of Coverage, and rate development assumptions. There is also a risk of member disruption and affordability concerns depending on how the state approaches settlement.

There will be significant implementation challenges that will be associated with this proposal, which we believe also support a delay in order to ensure there is adequate time for states and issuers to evaluate the associated per-enrollee costs of each benefit and develop a process for facilitating such defrayals. Specifically, the process requires significant advance scenario planning, to include analyzing specific codes, assessing the financial impacts, and determining precisely which costs will be defrayed. We are concerned that state timelines, including rate and regulatory filings, legislative sessions, and budget cycles may not align well with implementation of this provision for 2027. Additional time is needed to allow plans to anticipate operational impacts and minimize disruptions. Further, HHS has paused EHB benchmark reviews, creating uncertainty for states as they assess state defrayal.

ACAP member plans have also historically raised concerns that, when states previously were required to defray the costs of benefits that are in addition to EHB, states did not follow through. In those situations, not only would consumers not receive APTCs for those benefits, but without state defrayal funding, enrollees would be on the hook for those premium costs. Further, some ACAP plans previously reported that they were unaware of whether there were any state-mandated benefits for which premiums were supposed to be defrayed by the state. Therefore, if this policy is finalized, we urge CMS to ensure that states are held accountable for defraying the cost of any remaining state-mandated benefits and properly communicating with their QHPs. We are concerned that if a state elects not to defray certain mandates, plans could see benefit instability, increased rate complexity and potential member confusion. We believe CMS should monitor and oversee state benefit defrayals and the resulting impact on premiums.

Medical Loss Ratio (MLR) Comment Solicitation

While CMS does not propose any changes to MLR in this rule, the agency seeks comments on whether it should allow a state to institute a different MLR standard or if CMS should be able to impose a different MLR on a particular state.

ACAP generally opposes allowing a state or CMS to impose a different MLR in a given state due to concerns that MLRs could be lowered. ACAP member plans do not generally have difficulty meeting current MLR thresholds. In fact, only 3 percent of ACAP member plans had to pay an MLR rebate last

year, compared to about 25 percent of non-ACAP issuers. Even if some ACAP member plans do struggle to meet the current MLR, they believe that lowering the threshold could actually destabilize and harm the individual market in the long-run and could create profit incentives that are disparate from those that decrease the cost of coverage. While we understand recent concern about the potential of the MLR requirement to incentivize higher costs of care within vertically integrated systems, and to limit innovation due to high administrative costs,⁶ we believe that there are better ways to address these issues rather than a blunt lowering of MLR requirements.

Put simply, a lowered MLR threshold generally leads to fewer actual health care services for consumers, which, when combined with the proliferation of high-deductibles and cost-sharing, ultimately will not benefit consumers. And as evidenced by ACAP member plans' high MLRs and limited MLR repayments, we do not believe that the current 80 percent MLR standard needs to be changed. We urge CMS to think strategically about how to address the underlying structural issues that may lead some issuers to game the MLR—especially since those same issues can also carry over into risk adjustment transfers.

Provisions Reintroduced from 2025 Integrity Rule

CMS proposes several policies that were finalized in the 2025 Marketplace Integrity and Affordability rule but subsequently stayed by a federal court in *City of Columbus v. Kennedy*. These include requiring a pre-enrollment SEP verification for FFEs so that FFEs would have to conduct verification for at least 75 percent of new enrollments through SEPs; requiring consumers to submit documents to verify their income when data sources indicate household income is less than 100 percent of the FPL; and removing the requirement for Exchanges to accept a household's income attestation when the Internal Revenue Service returns no data for the household. Additionally, the 2025 Marketplace Integrity and Affordability final rule paused the provision that gave the option for issuers to establish a fixed-dollar and percentage-based premium payment threshold policy under which issuers could consider an enrollee to have paid all amounts through PY 2026. CMS requests comments on whether it should allow the premium payment threshold policy to resume at the end of PY 2026, permanently end, or remain as an option for state Exchanges.

ACAP submitted comments in response to the Marketplace Integrity and Affordability proposed rule, and we reiterate those comments below.

Pre-enrollment verification for SEPs: CMS proposes to require that Exchanges on the federal platform conduct pre-enrollment verification of eligibility for 75 percent of all new enrollments through SEPs (other than loss of minimum essential coverage, for which verification is already conducted). CMS notes that current SEP verification requirements do not provide enough protection against misuse and abuse, however, as it also noted in the proposed Marketplace Integrity and Affordability rule. ACAP would support a modified version of CMS' proposal and urges CMS to consider adjusting the 75 percent requirement to provide some flexibility or instead permit Exchanges to verify the SEPs that are most at risk of abuse.

First, we concur that current SEP rules are ripe for abuse that can lead to adverse selection, as has been experienced by our member plans. And while plans cannot always tell what SEP a consumer has enrolled

⁶Pate, R. W., Letchuman, S., Plummer, E., Zhao, X., Brooker, J., Lewis, L., & Bai, G. (2025). The Unintended Consequences Of The ACA's Medical Loss Ratio Requirement. <https://www.healthaffairs.org/content/forefront/unintended-consequences-aca-s-medical-loss-ratio-requirement>



through, one member plan shared the story of an enrollee who enrolled through a SEP for a December 1 start date and then received a liver transplant on December 24 of the same year and leaving their product for the following year's coverage. Plans with broad provider networks or formularies, such as a number of ACAP's member plans, are particularly at risk of seeing SEP abuse from consumers who wait until they get sick to purchase—or switch to—robust coverage.

Second, as we noted in previous comments, burdensome verification requirements can pose a barrier for healthier consumers to complete, ultimately disadvantaging the risk pool. These two competing goals must be adequately balanced in any successful policy proposal. Accordingly, we wish to note for CMS that we are concerned that the broad 75 percent SEP verification requirements may not have their intended effect. Namely, a generic threshold may be both difficult to implement and not effective, as it could lead to SEP verification based on volume or ease of verification in order to meet the 75 percent threshold, rather than verification of SEP types that have the most fraud. ACAP would recommend, for example, instead starting with SEP verification requirements for SEP types that tend to have the most instances of fraud or abuse. We urge CMS to reconsider its proposal to ensure its effectiveness before finalizing, such as by including an option for Exchanges to verify the SEPs that are most at risk of abuse.

Income verification: CMS proposes to require income verification to show proof that an individual's income is equal to or greater than 100 percent FPL when IRS data suggests their income is actually less than 100 percent FPL. CMS also proposes to remove the requirement that Exchanges accept an enrollee's self-attestation of projected annual household income. ACAP believes these two potential changes are intertwined and so has chosen to address them both at once.

We agree that there may be an incentive for consumers to inflate their incomes, particularly in states that have not expanded Medicaid. However, while we understand that there may be some consumers who overestimate their income, we believe that millions of consumers doing so is an overestimate. We also know that it is not uncommon for low-income consumers, particularly those who work in hourly, gig, or seasonal employment to have difficulty predicting their annual income, and may reasonably assume they will be able to work additional hours in the coming year, receive a promotion, or a variety of other things that could result in a higher wage estimate for future years. As long as APTC eligibility is conditioned on the upcoming year's income, there must be ways to account for changes to income that an enrollee may be aware of but are not included in previous year's tax data.

CMS references a recommendation from GAO, which was also noted in the Marketplace Integrity and Affordability proposed rule, that it should implement a verification process for "when attested income amounts significantly exceed income amounts reported by IRS or other third-party sources." As such, in conjunction with the fact that many low-income enrollees' incomes are variable, CMS may want to consider a threshold amount after which point it verifies income, such as a certain percentage or dollar amount above the previous year's income, rather than simply a blanket verification at 100 percent FPL. For example, it would not be unreasonable that someone whose reported income was 99 percent FPL could have an estimated income the following year of 110 percent FPL—which would represent not even a \$1,000 increase in income. ACAP believes it is important to balance verification requirements with ensuring that lower-income consumers who should legitimately receive APTCs are able to do so.

We urge CMS, in its efforts to ensure that consumers who should not receive tax credits do not inappropriately receive them, not overcorrect to the point where consumers who are eligible are prevented from receiving APTCs, without which they are unlikely to be able to afford health insurance at

all. For example, it is unlikely that a consumer earning \$15,000 annually could afford a full monthly health insurance premium up front and wait until tax reconciliation for repayment.

CMS has already instituted several new policies and procedures to address fraud, often driven by agents and brokers. Additional provisions included in this rule, as well as changes enacted in H.R. 1, the One Big Beautiful Bill Act, will further limit improper enrollments by brokers and web-brokers. Accordingly, we believe CMS should wait until data is available showing the full impact of these changes before making additional changes to verification rules for consumers that may have a data mismatch showing that in the previous year they made less than the poverty level.

Finally, but not insignificantly, we also urge CMS to delay the effective date of these proposals because if implemented, some consumers will lose coverage and issuers need sufficient time to understand the impact of such coverage losses on the risk pool and adjust rates accordingly.

ACAP urges CMS to delay its income verification proposals until after it can review data from upcoming years, as well as to ensure that issuers have adequate time to consider the impacts of the proposals on the risk pool and adjust premiums accordingly.

Premium Payment Threshold: In the 2026 NBPP, CMS implemented an option for issuers to establish a fixed-dollar and percentage-based premium payment threshold policy under which issuers could consider an enrollee to have paid all amounts due if the enrollee has (1) paid for some of the total premium owed and the amount unpaid is equal or less than \$10 (adjusted for inflation) or (2) paid for 98 percent or more of the gross premium, including APTC. Subsequently, in the 2025 Marketplace Integrity and Affordability final rule, CMS paused the provision through PY 2026. CMS requests comments on whether it should allow the premium payment threshold policy to resume at the end of PY 2026, permanently end, or remain as an option for state Exchanges.

ACAP supported CMS' proposal to allow these additional issuer flexibilities as part of the 2026 Notice of Benefit and Payment Parameters. In keeping with this, we urge CMS to resume this policy and reintroduce the gross percentage and fixed dollar premium payment thresholds. Specifically, we supported greater flexibility for issuers to determine whether and what type of premium payment threshold to institute based on what they believe is most appropriate for their enrollee characteristics and actuarial calculations.

CMS' current policy may cause disruptions in coverage and care for consumers over nominal dollar amounts. While CMS has raised program integrity concerns in its reasoning, we believe that program integrity concerns are minimal for a number of reasons. First, given that binder payments must be made in full in order to effectuate enrollment, we believe that guards against any concerns of unauthorized enrollments by agents, brokers, and web-brokers, as consumers will need to pay their first month's premium. Second, issuers do not generally make public whether they have a premium payment threshold in place, so there is little risk of being incentivized to enroll in any particular plan in the hopes of abusing premium-payment thresholds.

Third, as CMS itself has noted, improper enrollments are already likely declining due to program integrity measures implemented in recent years. CMS reported a nearly 50 percent decline in consumer complaints when comparing the first month of 2026 to the first month of 2025, acknowledging that significant progress has already been made to curb unauthorized enrollments and plan switches.



ACAP urges CMS to permit gross percentage and fixed dollar premium payment thresholds given 1) the already significant decrease of unauthorized enrollments; 2) the elimination of enhanced premium tax credits as of January 1, 2026, which CMS itself asserts will lead to a decrease in the number of unauthorized enrollments; 3) CMS' efforts to remove consumers who may be dually enrolled in Medicaid and Exchange coverage; and 4) as we have mentioned elsewhere in these comments, that new policy proposals aimed at cracking down on fraud and abuse have not yet had time to go into effect and show results. We believe program integrity concerns related to these provisions are minimal based on recent program integrity efforts, and accordingly we urge CMS to allow this greater flexibility for issuers to determine whether and what type of premium payment threshold to institute, based on what they believe is most appropriate for their enrollee characteristics and actuarial calculations.

Conclusion

ACAP thanks CMS for its willingness to consider the aforementioned issues. Once again, we appreciate that CMS is considering innovative ideas to transform the Marketplaces. However, we strongly urge CMS to reconsider or delay finalizing key policies discussed above due to timeline constraints as issuers will soon begin the QHP certification process and do not have enough time to adapt to CMS' proposals. We believe that feedback from stakeholders should be considered and incorporated before putting forth such impactful policy changes.

If you have any additional questions or comments, please do not hesitate to contact Heather Foster (202)204-7508 or hfooster@communityplans.net.

Sincerely,

Margaret A. Murray

Chief Executive Officer



**STATE OF CALIFORNIA
OFFICE OF THE
ATTORNEY GENERAL
ROB BONTA**



**COMMONWEALTH OF
MASSACHUSETTS
OFFICE OF THE
ATTORNEY GENERAL
ANDREA JOY
CAMPBELL**



**STATE OF NEW JERSEY
OFFICE OF THE
ATTORNEY GENERAL
JENNIFER DAVENPORT**

March 13, 2026

Via Federal eRulemaking Portal at www.regulations.gov

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Comments on Proposed Rule: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program Docket No. CMS-2026-0496; Agency No. CMS-9883-P; RIN 0938-AV62 91 Fed. Reg. 6,292 (Feb. 11, 2026)

Dear Dr. Oz:

We, the undersigned Attorneys General of California, Massachusetts, New Jersey, Arizona, Colorado, Delaware, Hawai'i, Illinois, Maryland, Maine, Michigan, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Washington, and Wisconsin write in response to the Proposed Rulemaking by the U.S. Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) (collectively, the Department) entitled "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program," 91 Fed. Reg. 6,292 (Feb. 11, 2026) (the Proposed Rule).¹

¹ The Department should deem all materials cited to in this comment letter as submitted into the administrative record.

The Proposed Rule creates new hurdles that will significantly reduce enrollment, weaken the risk pool, and drive up consumers' health insurance premiums and out-of-pocket costs. In doing so, it directly undermines the goal of the Patient Protection and Affordable Care Act (the ACA), which is to expand access to high quality and affordable healthcare. For the reasons discussed below, most of the Proposed Rule's changes should therefore be withdrawn.

The twin goals of covering as many Americans as possible at the lowest cost possible are central to the ACA. Indeed, Congress enacted the ACA to “*increase* the number of Americans covered by health insurance and *decrease* the cost of health care.”² To achieve these aims, Congress modeled the ACA on the system then in place in Massachusetts, which combined tax credits, market regulations, and a coverage mandate. That approach proved highly effective, resulting in an uninsured rate in Massachusetts of “2.6 percent, by far the lowest in the nation.”³

The Department is tasked with advancing the ACA's twin goals—cover as many people as possible, as affordably as possible—when implementing its provisions, while protecting the financial integrity of the marketplace. The Proposed Rule will not accomplish these goals and will, in fact, have the opposite effect. The Proposed Rule projects that up to two *million* individuals will lose their health coverage because of the proposed changes.⁴ And when these newly uninsured individuals need healthcare—as nearly everyone eventually will—the States and their residents will bear the cost.

The undersigned States have numerous concerns with the Proposed Rule. First, the nearly 200-page proposal introduces substantial and novel changes, which are complex and technical in nature, but gives the States less time than any other HHS Notice of Payment and Benefit Parameters (Payment Notice) in at least the past decade to implement those changes. This will needlessly strain State resources and increase costs, a strain that will be exacerbated by the increased probability of further delays in finalization given that the Proposed Rule's supporting data and estimated costs are replete with errors and inconsistencies.

Second, three provisions of the Proposed Rule—the two income verification provisions and the failure-to-reconcile provisions—are substantially identical to provisions in the Department's 2025 Marketplace Integrity and Affordability Rule that have been stayed as likely unlawful or arbitrary, and are the subject of continued litigation. These provisions of the Proposed Rule have not been meaningfully changed from their 2025 incarnations, and they suffer from the same defects. A separate provision of the Proposed Rule—requiring 75% verification of Special Enrollment Period (SEP) enrollees on the Federal Exchange—was similarly stayed and has been re-proposed in a way that contradicts the logic of the 2025 Rule.

Third, many of the Proposed Rule's new changes are equally problematic. The Department's embrace of catastrophic plans, including its proposal to increase maximum out-of-pocket costs to 130% of the statutory limits, as well as similar changes to bronze plans, are both unlawful and harmful to consumers. Additionally, the Department's proposal to expand eligibility for

² *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538-39 (2012) (emphases added); see *King v. Burwell*, 576 U.S. 473, 498 (2015) (“Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them.”).

³ *King*, 576 U.S. at 481.

⁴ 91 Fed. Reg. at 6,463.

catastrophic plan coverage will shift additional risk onto lower-income consumers and increase the likelihood of medical costs bankrupting them. And the Department's unprecedented introduction of multi-year catastrophic plans is unlawful and directly contrary to the statutory provisions it cites, in addition to the harms and risks mentioned above. The Department also makes significant changes to Essential Health Benefits (EHBs), reversing the 2025 Payment Notice's reform of defrayal determinations without justification, a proposal that would reintroduce significant confusion into the market and impose significant administrative burdens and costs on States and their residents. Similarly, the Department's exclusion of non-pediatric dental services as EHBs is procedurally defective and unreasonable. And the Department's remaining proposals effectuate significant changes in a rushed manner and based on flawed data or no data at all, preventing States and other interested parties from a meaningful opportunity to comment on the rule's sweeping proposals.

The undersigned Attorneys General appreciate the opportunity to provide these comments and stand ready to work with the Department to ensure a robust, affordable, comprehensive, and secure healthcare marketplace.

I. THE PROPOSED RULE IS UNTIMELY AND CONTAINS SIGNIFICANT ERRORS.

A. The Proposed Rule Provides Insufficient Time to Implement its Substantial Changes.

The Proposed Rule seeks to implement significant and novel changes to ACA exchanges through a rushed process that provides insufficient time for deliberation and implementation. Accordingly, if the Department decides to adopt the proposed changes despite the objections discussed herein, the States urge the Department to delay the effective date of the changes objected to herein until at least plan year 2028.

The 195-page Proposed Rule was published on February 11, 2026, later than any payment rule in the past decade, which leaves insufficient time for deliberation and implementation. Initially, the Department has afforded only a 30-day comment period despite the many complex and significant changes being proposed.⁵ State Exchanges and other stakeholders need sufficient time to analyze the proposed changes and determine their likely impacts on the administration of exchanges and the risk pool, among other things, and 30 days is simply not enough. This is especially so where the Department acknowledges that its proposals introduce “novel idea[s]” and “novel plan design[s],” and where the Department asks States to assess their “technical capacity” to comply with those proposals, which would require State Exchanges to make significant “technical updates” to their systems.⁶

⁵ See *Petry v. Block*, 737 F.2d 1193, 1202 (D.C. Cir. 1984) (observing that 30 days for comment “cut[s] the comment period to the bone” and 60 days is “a more reasonable minimum time for comment” for complex rules (quotation omitted)).

⁶ 91 Fed. Reg. at 6,373, 6,414, 6,451.

In addition, the Department has taken about four months to finalize the proposed Payment Notice each year.⁷ The result is that this Proposed Rule is unlikely to be finalized before July 2026, which would make it the latest-issued Payment Notice in at least a decade with an effective date that would fall even later. The Department's delay in issuing the Proposed Rule and the foreseeable delay in finalizing it have significant adverse consequences. Each year, once the proposed Payment Notice is announced, States and stakeholders must review and analyze the changes proposed by the Department and begin planning around implementation in the event the proposal is finalized. Moreover, it is only once the Payment Notice is finalized that State Exchanges and insurance departments have a clearer idea of what implementation will require and can proceed accordingly. States and stakeholders must make these adjustments each year well in advance of November, when open enrollment begins for the next plan year.⁸

Here, the Department proposes substantial changes that would require large-scale preparation, while granting States insufficient time to implement the changes. This time crunch is exacerbated by the vagueness of the Proposed Rule and its lack of guidance as to how its novel proposals would be implemented, as discussed *infra* at 8. For example, New Jersey's State Exchange, GetCoveredNJ, generally prepares plan management instructions by April or May and performs rate review in June of each year. If the Proposed Rule is not even finalized until July 2026, like many State Exchanges operating on similar timelines, GetCoveredNJ will be forced to incur additional costs and operational strain in issuing revisions to plan management instructions and expediting a delayed rate review process for plan year 2027.

State Exchanges must further prepare to implement the Payment Notice each year by updating data and technical systems, updating plan requirements, and analyzing new administrative requirements, including considering their unintended consequences and costs. For example, because the Department has not published data on the enrollment and premium impacts of the proposed changes relating to catastrophic plans, GetCoveredNJ will be required to analyze potential impacts on the risk profiles of catastrophic plan enrollees and make necessary adjustments to data and technology systems. The Proposed Rule's changes require State Exchanges to update information previously provided to carriers, update technology logic, parse for data issues, gather new data, and conduct system tests. Further, the Proposed Rule's changes related to EHBs may require significant analysis on the part of State Exchanges and programs to determine defrayal requirements. Due to the Department's delay issuing the Proposed Rule and likely delay in finalizing it, these lengthy processes will now have to be completed in a compressed amount of time, burdening State resources that are already stretched thin and causing State Exchanges to incur additional costs.

⁷ See, e.g., 90 Fed. Reg. 4,424 (2026 Payment Notice proposed October 2024 and finalized January 2025); 89 Fed. Reg. 26,218 (2025 Payment Notice proposed November 2023 and finalized April 2024); 88 Fed. Reg. 25,740 (2024 Payment Notice proposed December 2022 and finalized April 2023); 87 Fed. Reg. 27,208 (2023 Payment Notice proposed January 2022 and finalized May 2022).

⁸ See *Key Dates for Calendar Year 2026: Qualified Health Plan (QHP) Data Submission and Certification; Rate Review; Form Review; and Risk Adjustment*, CMS.gov, <https://tinyurl.com/4vzn8cte>.

B. The Proposed Rule's Cost Estimates Are Erroneous.

As discussed in this comment letter, *infra* at 9-11 and 20-21, the Department has offered cost estimates in the Proposed Rule that are unclear and do not account for the full current and future impacts on Marketplace enrollment caused by H.R. 1.⁹ Of particular concern, the Department's cost estimates appear to rely, at least in part, on data that pre-dates the passage of H.R. 1, and thus does not account for the millions of previously eligible lawfully present noncitizens who have been disenrolled or will disenroll from the Marketplace due to the changes made by H.R. 1.¹⁰ The reliance on pre-H.R. 1 data is improper and renders the Proposed Rule's cost estimates inaccurate.

H.R. 1 has made the risk pool less healthy and more fragile overall. As an initial matter, as H.R. 1's provisions are implemented, Marketplace enrollment is projected to decline in both 2027 and 2028.¹¹ Yet, the Department implausibly, and without explanation, suggests a slight increase in enrollment between 2026 and 2027, before a decline in 2028. Moreover, because H.R. 1 reduces the number of younger and healthier individuals that would have otherwise enrolled in the Marketplace,¹² as its provisions are implemented, the risk pool will weaken and costs will increase across the board.¹³ The Department relied on outdated data and failed to consider that the impacts of its proposal will be greater now, after the enactment of H.R. 1.

⁹ See H.R. 1 (119th Cong.), *codified at* Pub. L. No. 119-21 (July 4, 2025).

¹⁰ See 91 Fed. Reg. at 6,462-63 (“The baseline starts with internal CMS data of enrollment by month, premiums, and APTCs, we [sic] summarize the data using average monthly amounts. These monthly averages are projected throughout the year using historical monthly patterns during a similar environment.”).

¹¹ Cong. Budget Off., *The Estimated Effects of Enacting Selected Health Coverage Policies on the Federal Budget and on the Number of People with Health Insurance*, at 14 (Sept. 18, 2025), <https://tinyurl.com/333fe9ek>; Jeanne Lambrew, *CBO Reaffirms Forecast of a Dramatic Reduction in Health Coverage in 2026 and Beyond*, The Century Foundation (Mar. 12, 2026), <https://tinyurl.com/39ewh5s7>.

¹² *Accord* 90 Fed. Reg. 12,942, 13,010 (DACA recipients are generally younger and healthier than the overall population who participates in the exchanges).

¹³ See e.g., *Clarifying the Eligibility of DACA Recipients & Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, & a Basic Health Prog.*, 89 Fed. Reg. 39,392, 39,398 (May 8, 2024); *Kansas et al. v. United States of America*, No. 1:24-cv-150 (D. N.D. Aug. 8, 2024) ECF 156-7 at ¶¶ 32-33, ECF 156-10 at ¶¶ 24-26, ECF 156-8 at ¶¶ 7, 33.]; Zachary Sherman et al., *2027 Proposed NBPP: Analyzing State and Consumer Impacts* at 13, Health Management Associates (Mar. 10, 2026) (“CMS estimates that 1,227,000 people now receive APTCs through the Marketplaces who are lawfully present noncitizens who would lose eligibility for APTCs starting in 2027. It is expected that nearly all of those who lose eligibility for APTCs will exit the individual market. The result should be a significant decrease in enrollment as well as higher premiums due to increased morbidity in the risk pool.”), <https://tinyurl.com/48wftaan>.

II. REISSUANCE OF CHALLENGED PROVISIONS RELATED TO THE DEPARTMENT'S 2025 MARKETPLACE INTEGRITY AND AFFORDABILITY RULE

A. The Proposed Rule Reissues Provisions Substantially Similar to Provisions of the 2025 Rule That Have Been Stayed as Likely Unlawful and Arbitrary.

Three provisions of the Proposed Rule concerning income verification, are substantially identical to provisions in last year's Marketplace Integrity Rule¹⁴ that are currently subject to a stay in *City of Columbus v. Kennedy*, where a federal district court held that the plaintiffs are likely to succeed on the merits of their Administrative Procedure Act claims that the provisions are unlawful or arbitrary.¹⁵ These provisions are also the subject of summary judgment motions in the *Columbus* case as well as a similar challenge brought by a coalition of States, *California v. Kennedy*.¹⁶ Notwithstanding these challenges, the Department has re-proposed these provisions but failed to meaningfully address the issues raised in *Columbus* and *California*.

1. Income Verification Provisions (§ 155.320(c))

When verifying income, exchange plans currently accept the self-attestation of an enrollee who claims eligibility by projecting annual household income at or above 100% of the federal poverty level (FPL). This self-attestation policy is designed to ensure that the enrollees, especially those who are often younger and healthier, are not discouraged from entering the risk pool due to paperwork burdens. Self-attestation is especially important for the lowest-income workers and self-employed individuals who may work multiple jobs, may not have ready access to pay stubs, or who otherwise face challenges in obtaining documentation to help evaluate their projected income for the following year.

Once again, the States urge the Department not to adopt policies that require the Exchanges to generate and resolve a “data-matching issue” (DMI) any time an enrollee's claimed income is higher than Internal Revenue Service (IRS) data or when IRS data is missing. In either case, consumers must submit additional paperwork or risk losing the premium tax credits (PTC) that make health insurance affordable. And what's more, these policies have been stayed by court orders twice already: first in the *City of Columbus v. Cochran* litigation in 2021, where the court chastised the Department for “defy[ing] logic” and prioritizing a “hypothetical” concern over the very real harms this provision would impose on consumers;¹⁷ and again in the *City of Columbus v. Kennedy* litigation last year, where the federal district court found no “evidence of a nexus between fraudulent enrollment and self-attestation” and a “lack of sufficient data” justifying the impact on consumers.¹⁸ Undeterred, the Department has once again failed to justify these provisions commensurate to their extraordinarily harmful impact on consumers.

¹⁴ *Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability*, 90 Fed. Reg. 27,074 (June 25, 2025).

¹⁵ 796 F. Supp. 3d 123 (D. Md. 2025).

¹⁶ *California v. Kennedy*, 802 F. Supp. 3d 273 (D. Mass. 2025).

¹⁷ *City of Columbus v. Cochran*, 523 F. Supp. 3d at 731, 763 (D. Md. 2021); *see also City of Columbus v. Kennedy*, 796 F. Supp. 3d 123, 168-70 (D. Md. 2025).

¹⁸ *City of Columbus v. Kennedy*, 796 F. Supp. 3d at 168-70.

The Department fails to recognize that this policy would require Exchanges to generate DMIs based upon comparisons of an enrollee's projected income for the coming year against the most recent IRS tax data available—which is generally *two years* prior to the year being projected. Low-income Americans have volatile incomes, so income in one particular year is not a good predictor of income two years later. As a result, and as explained previously, there is little reason to believe that an individual whose projected income is significantly different from the most recent available tax data is over-claiming PTC eligibility, as the Department claims to fear.

Once again, the Department has not provided any data showing the number of enrollees who have purportedly inflated income to qualify for PTC, and it offers no evidence that this alleged fraud is in fact happening. While the Department claims that it has found “suspect attestations of income,” it acknowledges that those attestations may very well be due to “agents, brokers, and web-brokers . . . using artificial intelligence to impersonate consumers and falsely attest to household income.”¹⁹ Just as with last year's Marketplace Integrity rule, the Department, relying on unverified reports, acknowledges that the problem here lies with unscrupulous brokers and agents, not consumers, and yet doubles down on implementing twice-prohibited draconian policies that will harm millions of innocent low-income Americans with no basis in fact for its decision.

The burdens, as the Department acknowledges, are weighty. The Department estimates that these two changes will generate an additional 3.3 million DMIs per year: 548,000 in the case of the contradictory-data DMI, and 2.8 million in the case of the missing-data DMI.²⁰ Missing IRS tax data is frequently not the fault of the enrollee, and the IRS is poised to suffer extreme backlogs heading into the 2026 tax filing season because the federal Administration has slashed the workforce, as a recent report by the U.S. Treasury's Office of the Inspector General warns.²¹ The Department never acknowledges this report—or the consequences for enrollees of the extreme backlogs—in the Proposed Rule. Further, analysts believe the risk of coverage loss is far greater than what the Department has suggested: depending on the disenrollment rate, up to 2.3 million enrollees could lose coverage in 2027.²²

Nor does the Department ever acknowledge a more significant problem: H.R. 1 will eliminate eligibility for PTC while DMIs remain pending, meaning that individuals who rely on PTC may be unable to afford health insurance until their DMI is resolved. The Department has made no attempt to acknowledge or address that, due to H.R. 1, this policy will be far more burdensome than the virtually identical policy proposed last year. Given this change, external analysis suggests that the disenrollment rate will be substantially higher in 2028 with an estimated

¹⁹ 91 Fed. Reg. at 6,346.

²⁰ 91 Fed. Reg. at 6,431.

²¹ Diana M. Tengesdal, Memorandum for the Commissioner of Internal Revenue, U.S. Department of the Treasury, *The Internal Revenue Service's Readiness for the 2026 Filing Season* (Audit No.: 2026400002), Jan. 26, 2026, <https://tinyurl.com/m3tzxfr9>.

²² Sherman, *supra* n. 13, at 14 (“Wakely colleagues believe the total disenrollment estimate relies on the assumption that only 10% of people who receive DMIs ultimately will lose coverage. Our prior analysis estimated that Marketplaces, especially if they must quickly adopt the provisions, could have higher disenrollment rates. For example, if disenrollment rates were 50%, which is the high end of our estimated disenrollment resulting from DMIs, then 2.3 million enrollees would lose coverage in 2027.”).

4.7 million enrollees expected to receive DMIs and coverage losses of more than 3 million enrollees.²³

Further, the Department attempts to justify this policy by pointing to the fact that the Federally-Facilitated Exchange (FFE) cancelled 250,000 unauthorized enrollments in 2025 but makes no effort to connect those unauthorized enrollments to income-verification policies that were not yet in place.²⁴ Without demonstrating any connection between those unauthorized enrollments and income-verification policies, the Department has offered nothing to justify this proposed change.

Moreover, the Department previously represented that these DMI policies would be necessary only for plan year 2026, and then it informed the public that they would then sunset.²⁵ The Department does not explain why its prior stance was wrong nor why it has chosen to change course despite its prior public representations.

Again, the Department imposes this income verification requirement across all States but makes no attempt to justify why this provision is necessary in States that have expanded Medicaid access. Those with income below 100% of FPL have no incentive to inflate income to qualify for PTC in Medicaid-expansion States, a point made repeatedly by States and other stakeholders in comments on the Marketplace Integrity rule that the Department ignores.

2. Failure-to-Reconcile Provision (§ 155.305(f)(4))

The ACA provides PTCs to individuals whose incomes qualify them for federal assistance to pay their health insurance premiums. Because those awards are based on projections, the recipient is required to later reconcile their PTC award against their actual income, as shown in their tax filings. If the enrollee earned more than projected, the enrollee owes back the amount of PTC that was overpaid. This ensures that enrollees cannot claim and retain the benefit of credits to which they are not entitled. When an individual fails to file taxes and reconcile their projected income against their actual income, they lose eligibility for future PTC awards. This is known as failure to file and reconcile, or FTR. The Proposed Rule eliminates PTC credit eligibility for those who fall into FTR status after just one year, rather than two years under the existing policy.

The *City of Columbus* court blocked this provision and found the entire FTR scheme unlawful. Because the ACA “does not contemplate that the existence of a prior tax debt affects an applicant’s eligibility for advanced payments of the premium tax credit (APTCs) in any way.”²⁶ Therefore, as to PY 2027 the Department should rescind the FTR provision.

²³ Sherman, *supra* n.13, at 14.

²⁴ 91 Fed. Reg. at 6,436 & n.112.

²⁵ See 90 Fed. Reg. at 27,199–200 (June 25, 2025) (“[After 2026], this policy will no longer be effective.”).

²⁶ *City of Columbus v. Kennedy*, 796 F. Supp. 3d at 162 (internal citations omitted).

Once again, the Department entirely fails to consider how this policy will impact consumers in light of significant understaffing at the IRS, which will likely lead to vastly more FTR issues than normal due to slow IRS processing, not wrongdoing by consumers.²⁷

It remains true, additionally, that many more people receive one-year FTR codes than two-year FTR codes, indicating that the vast majority of people who fall into FTR status are able to clear that status before the second FTR year.²⁸ This proposal remains just as ill-justified as it was the last time it was proposed (and enjoined), and it should be withdrawn.

B. The Department’s Reimposition of the 75% Verification Requirement on the Federal Exchange for SEP Enrollees (§ 155.420(g)) Is Inconsistent with the 2025 Rule.

The Department should not finalize the proposed regulations requiring the Federal Exchange to verify 75% of Special Enrollment Period (SEP) enrollees. Last year, the Department argued that the then-imminent expiration of enhanced PTCs would “appropriately deter future levels of improper enrollments” and “obviate” the need for “ongoing higher levels of program integrity policies,” and it expressly recognized that “the burden of continuing such policies will reach a point at which they outweigh any benefits.”²⁹

Now, the Department reverses its own previous representations and conclusion, without adequate justification. The Department claims that increases in SEP enrollees claiming eligibility via pathways that do not currently require verification shows that consumers “shifted their SEP attestation so as not to have to provide verification of eligibility for the SEP.”³⁰ However, in the very next paragraph, the Department “acknowledge[s] that some shift in SEP volumes was expected due to our best SEP logic.”³¹ Further, the Department makes no attempt to explain why these shifting enrollment numbers would suddenly indicate fraud *now*, when the verification rules have not changed.

The absence of this showing is significant, because this verification requirement can impose substantial, if not insurmountable, barriers that prevent consumers from obtaining health insurance. The paperwork to verify the sort of life events that qualify an enrollee for SEP enrollment is not always readily available. For example, a small employer that suddenly goes bankrupt may be unable to provide former employees with the paperwork that would verify eligibility, or a local government might need over a month to mail a birth certificate to a new parent. In those situations, the enrollee faces the prospect of going without coverage due to these burdensome paperwork requirements that they may be unable to promptly satisfy due to no fault of their own.

²⁷ See Tenegsdal, *supra* n.21 (describing IRS understaffing concerns).

²⁸ See State of California, Commonwealth of Massachusetts, State of New Jersey, et al., Comment Letter on Proposed Rule (Apr. 11, 2025), at 35, available at <https://tinyurl.com/7ythx77m> (attachments).

²⁹ 90 Fed. Reg. at 27,151.

³⁰ 91 Fed. Reg. at 6,353.

³¹ *Id.*

The Department again acknowledges data it cited in last year's Marketplace Integrity rule showing that 75,500 individuals were unable to resolve SEP verification issues in plan year 2019, yet it claims that this is a "minimal burden[]" without justification.³² Nor does the Department attempt to justify the 293,073 SEP verification issues this policy is likely to generate for consumers,³³ many of whom will be unable to clear the verification process and enroll in coverage. The Department further acknowledges that "[t]his policy may deter enrollments among younger people at higher rates, which could worsen the risk pool and increase premiums," but estimates that this effect would be "minimal" without offering any supporting evidence.³⁴ The Department should withdraw this proposal.

III. THE NEW PROVISIONS OF THE PROPOSED RULE WOULD MAKE SIGNIFICANT AND NOVEL CHANGES THAT WOULD HARM THE STATES

A. Provisions Relating to Catastrophic Plans and Bronze Plans

The Proposed Rule introduces numerous troubling changes to catastrophic and bronze plans that will harm consumers: increasing the maximum out-of-pocket (MOOP) beyond statutory limits for both plans and imposing an eye-popping 130% limit for catastrophic plans without statutory authority; potentially combining the risk adjustment transfer calculations for both plans; dramatically expanding eligibility for catastrophic plan coverage, and; allowing multi-year catastrophic plans for the first time ever. These proposals are contrary to law and the purposes of the ACA, and they lack sufficient reasoning. The undersigned States offer these comments on the policies as we understand them while noting that the Department failed to provide sufficient detail or data to fully assess and meaningfully comment on these potential changes. The Department's expansive support for catastrophic plans is dangerous and unprecedented: such plans cover minimal services and expose consumers to extraordinary out-of-pocket costs. Far from making healthcare more affordable, the proposed changes will increase financial risks and harm for consumers and undermine the broader risk pool in a way that could increase premiums for all consumers; they should be withdrawn.

1. Increasing Maximum Out-of-Pocket Cost Limits for Bronze and Catastrophic Plans (§ 156.155(a)(3), § 156.136)

Catastrophic plans are extremely limited health insurance plans that afford enrollees essentially no coverage until after the consumer has incurred significant out-of-pocket costs: \$12,000 for an individual or \$24,000 for a family in plan year 2027 under existing rules.³⁵ Because these plans have higher a MOOP, they are able to offer consumers lower premiums, but enrollees are not able to use PTCs toward catastrophic plans' premiums.

³² 91 Fed. Reg. at 6,352.

³³ See 91 Fed. Reg. at 6,432.

³⁴ 91 Fed. Reg. at 6,452.

³⁵ See 91 Fed. Reg. at 6,382. As discussed later on in the comment letter, the proposed rule would also raise the maximum out of pocket for catastrophic plans to \$15,600 individual / \$31,200 family. See *id.*

The Proposed Rule would permit bronze plans to offer cost-sharing that exceeds the statutory annual maximum out-of-pocket limit established by the ACA and would further require catastrophic plans to impose out-of-pocket costs of 130% of that limit before covering any care other than preventive services and three primary care visits.³⁶ For plan year 2027, the latter requirement translates to a MOOP of \$15,600 for an individual and \$31,200 for a family, well over the statutory limits of \$12,000 / \$24,000 for plan year 2027.³⁷ These proposals conflict with the plain text of the ACA, expose consumers to financial harm that the statute was designed to prevent, increase the risk of States having to bear the cost of uncompensated care, and rest on an inadequate evidentiary basis. These proposals should thus be withdrawn.

This provision is also contrary to law. The Secretary lacks the authority to unilaterally permit plans to exceed the limits imposed by statute. Section 1302(c) of the ACA establishes annual limits on cost-sharing for qualified health plans, and Section 1302(e)(1)(B) of the ACA separately and explicitly requires catastrophic plans to comply with the “annual limitation [on cost-sharing] in effect under subsection (c)(1)” of the ACA.³⁸ These are not aspirational targets; they are statutory commands that guarantee consumers protection against ruinously high medical bills. The Department acknowledges as much when it characterizes the catastrophic plan MOOP requirement as a binding obligation that “*requires* catastrophic plans to have a deductible and MOOP set to the maximum annual limitation on cost sharing,”³⁹ but then proposes to override it anyway by requiring catastrophic plans to impose cost limits at 130% of the statutory limit without identifying a lawful basis for doing so. Whatever the Department’s view of the underlying policy, it cannot exempt itself from a plain statutory command by declaring the command inconvenient.

The Department’s rationale for the bronze plan exception is equally flawed. It argues that rising healthcare costs will eventually make it “mathematically impossible” for insurers to design bronze-tier plans that simultaneously comply with Section 1302(c)’s MOOP limits and the actuarial value standards prescribed for bronze plans.⁴⁰ This prediction may or may not prove accurate. But the Department does not demonstrate that the problem has materialized today, nor that it will materialize during plan year 2027 or at any point in the near future. The proposed fix—allowing insurers to offer bronze plans that expose enrollees to unlimited out-of-pocket risk, subject only to the self-serving condition that the same insurer also offer at least one compliant plan in the same service area—is unreasonable and wholly disproportionate to a speculative future contingency. Additionally, labeling such a plan as a “bronze” plan while allowing it to deviate from the bronze-plan actuarial value targets set by the ACA leads to unnecessary confusion and strips the metal-tier structure of its meaning. By way of example, customers in Washington State report that metal level designations are a helpful way to quickly compare whether plans are offering a similar amount of coverage. The monthly premium is generally the most important factor in plan selection. This proposal will cause customers to switch to the lower premium offering

³⁶ 91 Fed. Reg. at 6,380, 6,382.

³⁷ The Department does the math wrong, writing on page 6382: “For PY 2027, this amount would be \$12,000 x 1.3, or \$15,400.” 91 Fed. Reg. at 6,382. The correct figure is \$15,600.

³⁸ 42 U.S.C. § 18022(c), (e)(1)(B).

³⁹ 91 Fed. Reg. at 6,382 (emphasis added).

⁴⁰ 91 Fed. Reg. at 6,373–74.

without understanding their increased cost-sharing obligations and ultimately be unable to afford care when they need it.

Further, the Department does not explain why updating the actuarial value calculator's spending cap, an option it acknowledges,⁴¹ would be insufficient, aside from a conclusory allegation that it "believe[s] no administrable alternatives exist because the issue is one of innate mathematical incongruence, not methodological decisions."⁴² But this is belied by the Department's own preceding discussion of how the measurement of actuarial value can be changed to account for market dynamics.⁴³ Nor does the Department offer any alternative intermediate measures that would not require overriding statutory consumer protections. An agency must consider less harmful alternatives before taking the most drastic available action, and the Department's failure to do so here would be arbitrary and capricious.

The consequences of these proposals will fall hardest on the consumers least able to absorb catastrophic medical bills. The statutory MOOP for plan year 2027 is \$24,000 per family—a figure that is already inflated due to the methodological changes adopted by the Department in the Marketplace Integrity rule and already represents a significant financial burden for most households, which have a median balance of liquid cash of just \$8,000, according to 2022 Federal Reserve data.⁴⁴ The Department asserts that healthier consumers will be "more motivated to select a catastrophic plan in lieu of a bronze plan" in exchange for lower premiums, and asserts without evidence that this "is plainly what Congress intended."⁴⁵ But abundant evidence shows the exact opposite: the purpose of the ACA is to "increase the number of Americans covered by health insurance and decrease the cost of health care."⁴⁶ Healthier enrollees dropping metal-tier coverage in favor of catastrophic plan coverage harms the risk pool⁴⁷ and is the *opposite* of Congress's intent. And consumers who enroll in a catastrophic plan and then face a severe medical crisis might forego needed care until they can switch back into a more-generous plan, harming their health and potentially increasing the cost of care needed later. The extensive literature on cost-sharing and healthcare utilization confirms that even modest increases in out-of-pocket costs lead to reductions in the use of necessary medical services—and the increases contemplated here are substantial.

The Department also offers no serious analysis of how these proposals will interact with the expanded eligibility for catastrophic plans proposed elsewhere in the same rule. The Proposed Rule makes these plans available to a far broader swath of the population without grappling with the impact that will have on the broader risk pool and without acknowledging that H.R. 1, passed last year, significantly reduced the number of eligible noncitizens who may enroll in subsidized

⁴¹ 91 Fed. Reg. at 6,777–79.

⁴² 91 Fed. Reg. at 6,779.

⁴³ See 91 Fed. Reg. at 6,777–79.

⁴⁴ See *Changes in U.S. Family Finances from 2019 to 2022: Evidence from the Survey of Consumer Finances*, Board of Governors of the Federal Reserve System (Oct. 2022), at 16 (median value of transactional accounts was \$8,000 in 2022), <https://tinyurl.com/64hjxrui>.

⁴⁵ 91 Fed. Reg. at 6,382.

⁴⁶ *Nat'l Fed. of Indep. Bus.*, 567 U.S. at 538–39.

⁴⁷ Sherman, *supra* n. 13, at 4 ("Expanded catastrophic enrollment could affect the individual market risk pool, resulting in higher premiums for consumers; without an understanding of the risk-adjustment impact, these effects become even more unclear.").

health insurance. That, too, throws off the Department's analyses, because the Department is relying in part on data that predates that action by Congress and fails to account for the reduced population of noncitizen enrollees.⁴⁸ H.R. 1 is estimated to have ended eligibility for coverage of 1.3 million noncitizen enrollees,⁴⁹ who tended to be younger and healthier on average.⁵⁰ Thus, H.R. 1 made the risk pool less healthy and more fragile overall. The Department fails to consider that the impacts of its proposed policies in this Rule will be greater than they would have been pre-H.R. 1.

The Department's claim that these proposals enhance "choice"⁵¹ is not a reasoned policy justification; it is an unreasoned rationalization for stripping away the protections that Congress provided. The Department should withdraw both the bronze MOOP exception and the catastrophic plan MOOP increase because both run afoul of the plain text of the ACA.

2. The Expansion of Hardship Exemption Eligibility (§155.605(d)(1))

Catastrophic plans were designed to offer a coverage option to younger individuals who could not afford to buy coverage in the Marketplace but needed to meet the ACA's individual coverage mandate. Congress intended only a limited number of individuals to be eligible for this coverage: those under the age of 30 or those certified as exempt from the individual mandate because of a hardship or unaffordable coverage (such as homelessness, domestic violence, bankruptcy, or a natural disaster).⁵² These are statutory requirements that have been unchanged since the ACA was enacted in 2010.

If Congress wanted to amend these requirements, it could have. But Congress has not done so and has, rather, maintained limited eligibility under Section 1302(e) even when making other statutory changes to catastrophic plans. In H.R. 1, for instance, Congress made catastrophic plans eligible to be paired with a health savings account but did not amend the statutory eligibility criteria.⁵³ And the U.S. Senate recently *rejected* legislation that would have done what the

⁴⁸ See 91 Fed. Reg. at 6,462–63 (“The baseline starts with internal CMS data of enrollment by month, premiums, and APTCs, we [sic] summarize the data using average monthly amounts. These monthly averages are projected throughout the year using historical monthly patterns during a similar environment.”).

⁴⁹ Patti Boozang et al., *How H.R. 1 Impacts Coverage for Non-Citizens*, Princeton University: State Health & Value Strategies (Sep. 5, 2025), <https://tinyurl.com/3293zsf9>.

⁵⁰ See, e.g., *Key Facts on Health Coverage of Immigrants*, Kaiser Family Foundation (Jan. 15, 2025) (“[i]mmigrants have lower health care expenditures than their U.S.-born counterparts reflecting lower use of care due to a combination of them being younger and healthier”), <https://tinyurl.com/d7vchbsy>; 89 Fed. Reg. at 39,398 (DACA recipients tend to be younger and healthier than the overall population who participates in the exchanges); 90 Fed. Reg. at 13,010 (same).

⁵¹ See 91 Fed. Reg. at 6,381 (“we believe that individual market consumers in particular would be interested in more plan choices offering lower deductibles and lower premiums”).

⁵² 42 U.S.C. § 18022(e); 91 Fed. Reg. at 6,294 (noting ACA's requirements for catastrophic plans).

⁵³ H.R. 1, § 71307, <https://tinyurl.com/3u5va6af>.

Department now seeks to do in the Proposed Rule.⁵⁴ Until Congress amends these criteria, the Department must comply with Section 1302(e) as it is written.

The Proposed Rule would dramatically expand eligibility for catastrophic plan coverage to anyone, regardless of age and in all States, whose household income is below 100% of the federal poverty level (FPL) or above 250% FPL.⁵⁵ Such a proposal is contrary to the text of the ACA, not supported by evidence, and is counterproductive. The Department justifies the expansion of eligibility on the basis that premiums for comprehensive coverage plans are too high and consumers need more affordable alternatives.⁵⁶ But, as Congress made clear in Section 1302(e), catastrophic plans are not (and were never meant to be) a broadly available alternative to comprehensive coverage under the ACA. Catastrophic plans have lower premiums due to their sky-high deductibles, higher out-of-pocket caps, and weaker consumer protections. The expansion of these plans thus runs counter to the goals of the ACA by providing considerably worse coverage with few of the statutory protections.

The expansion of catastrophic plan eligibility will only benefit healthier and higher-income individuals, who can afford large upfront medical bills and are able to set aside money in tax-advantaged health savings accounts (HSA). This proposal will shift additional risk onto consumers and increase the likelihood that medical costs will bankrupt lower-income individuals and families. Of significance, 24% of American households have no emergency savings, and the median amount of liquid cash available in checking and savings accounts is \$8,000.⁵⁷ Expanding eligibility for catastrophic plans will expose lower-income consumers to steep medical bills and increased medical debt, and it will burden providers with higher uncompensated care costs. Patients will forgo care due to the high out-of-pocket maximums, which, as even the Proposed Rule acknowledges, will result in even higher overall premiums.⁵⁸

Expanding eligibility for catastrophic plans could also hurt those who choose to remain in comprehensive coverage due to broader effects on the risk pool, although the Department has not provided sufficient detail about this proposal to allow for meaningful comment. Although the catastrophic and metal-tier plan risk pools are considered separately for purposes of certain risk-adjustment calculations, they are considered together for purposes of the index rate calculation. On balance, the large-scale adoption of catastrophic plans may have a significant impact on the risk pool. Allowing healthier individuals to migrate from the individual market to catastrophic plans could result in a smaller and sicker risk pool for comprehensive coverage in the Marketplace, meaning that the high premiums for comprehensive coverage (which the Department cites as its

⁵⁴ Health Care Freedom for Patients Act, §104, <https://tinyurl.com/2jbh69a3>.

⁵⁵ 91 Fed. Reg. at 6,301, 6,353-54.

⁵⁶ 91 Fed. Reg. at 6,353-54.

⁵⁷ See *Changes in U.S. Family Finances from 2019 to 2022*, *supra* n. 44 at 16.

⁵⁸ See 91 Fed. Reg. at 6,371 (“[W]hen individuals receive preventive services and effective disease management, those interventions can help reduce costs in the long run, which in turn may ease pressure on premiums.”); *see also* 89 Fed. Reg. at 39,396 (noting that lack of coverage “can have downstream impacts that further disrupt individuals’ health and financial stability, and therefore their ability to work or study,” and that “[d]elays in care can lead to negative health outcomes ... whereas being unable to pay medical bill puts individuals at higher risk of food and housing insecurity”).

justification for expanding catastrophic eligibility)⁵⁹ would go even higher. This could result in a death spiral: more people will choose catastrophic coverage over comprehensive coverage, further splitting the risk pool, driving premiums even higher, and thereby motivating even more people to choose catastrophic coverage. If this dynamic emerges and is not addressed, the cumulative result could be a smaller risk pool and a sicker population that must pay more for lower-quality health coverage, justified in the name of lowering healthcare costs. The Department entirely fails to grapple with any of these implications, saying only that this provision “has the potential to impact the individual catastrophic and individual non-catastrophic market risk pools.”⁶⁰ Such a cursory remark is insufficient to reasonably explain such a drastic change.

Premiums are rising because Congress allowed the enhanced PTCs to expire. This is why the cost of comprehensive coverage is becoming unaffordable to more Americans every day. Replacing comprehensive coverage with catastrophic coverage does not fix this, and it undermines the Department’s stated goal of “providing quality, more affordable coverage to consumers.”⁶¹

The Department has wholly failed to consider the costs that these changes will impose on consumers, and has not explained why, in its view, the purported benefits of these changes outweigh the very significant harms. Because it has not done so, the Department should withdraw these proposals.

3. Permitting Plan-Level Adjustments for Multi-Year Catastrophic Plans (§ 156.80(d)(2)(ii)) and Multi-Year Terms for Catastrophic Plans (§§ 156.130(c) and 156.155(a)(6))

The Proposed Rule also allows insurers to create multi-year catastrophic plans, with durations of up to ten years and without requiring enrollees to verify eligibility or affirmatively re-enroll each year.⁶² The Department proposes to allow these multi-year plans to exceed the statutory MOOP in some years so long as the average MOOP across all ten years complies with the limit.⁶³

This proposal is unprecedented and illegal. The Department cites the preventative services requirement as its primary authority to allow multi-year catastrophic plans, claiming that such plans qualify as “value-based insurance design” and that the agency has broad flexibility to redefine plan duration, benefit design, and the MOOP.⁶⁴ It does not. Section 2713(c) of the Public Health Service Act authorizes the Secretary of HHS to develop guidelines that allow “value-based insurance designs.”⁶⁵ But Section 1302(e) of the ACA repeatedly references single plan years, requires compliance with the *annual* MOOP, and bases catastrophic plan eligibility on exemptions to the individual mandate penalty which are administered on an annual basis.⁶⁶ Indeed, the entire architecture of the ACA is designed around an annual plan year, with annual open enrollment periods, annual premium recalculation, and annual recertification of Qualified Health Plan (QHP)

⁵⁹ 91 Fed. Reg. at 6,353-54.

⁶⁰ 91 Fed. Reg. at 6,322.

⁶¹ 91 Fed. Reg. at 6,293.

⁶² 91 Fed. Reg. at 6,368-71.

⁶³ 91 Fed. Reg. at 6,370-73.

⁶⁴ 91 Fed. Reg. at 6,371-72.

⁶⁵ 42 U.S.C. § 399gg-13(c).

⁶⁶ 42 U.S.C. § 18022.

status. The Department does not have authority to authorize multi-year contracts that operate outside of this annual statutory framework.

This proposal is also harmful to consumers. While the Department’s proposal is unclear and inconsistent in explaining how the multi-year option would operate, averaging the MOOP across ten years means that an enrollee who experiences a serious injury or illness in the beginning of the multi-year contract could face out-of-pocket costs that are significantly higher than under a standard annual catastrophic term. Not only will this increase medical debt and bankruptcy, but it will also result in those who fall ill earlier being strongly incentivized to exit the multi-year plan, leaving only healthier enrollees enrolled for the end of the contract. This is counterproductive to the stated goal of these proposed multi-year plans: promoting continuity of care and stopping the churn of individuals cycling out of particular individual market plans.⁶⁷ The Department also suggests, without explanation, that consumers could be “locked into” multi-year catastrophic plans⁶⁸, which would also be inconsistent with the ACA’s overall structure and consumers’ ability to, for instance, switch plans during the annual open enrollment period.

The Department also proposes allowing insurers that offer multi-year catastrophic plans to impose different MOOPs for different diseases, although the Department offers little detail or data to explain how such a policy would operate such that interested parties have not had a meaningful opportunity to comment.⁶⁹ But any policy that allows insurers to charge higher cost sharing based on health condition is illegal and violates the prohibitions against discrimination by condition or disease. Section 1557 and Section 1302(b)(4) of the ACA prohibit disability discrimination or disease specific cost-sharing variations.⁷⁰ Section 2705 of the Public Health Service Act also prohibits discrimination in group and individual market coverage based on health status.⁷¹ This proposal also is deeply harmful. Issuers will be incentivized to set a higher MOOP for diseases such as cancer or heart disease in the beginning of the contract, knowing that the enrollees who become ill will likely leave mid-term rather than capture later-year benefits. This creates a system whereby the greatest costs are front-loaded onto the sickest enrollees.

This proposal should not be finalized until the Department has, at a minimum, proposed and finalized, through separate notice-and-comment rulemaking, the risk adjustment and medical loss ratio (MLR) frameworks that will govern multi-year catastrophic plans. The Proposed Rule asks for comments and openly acknowledges that it has not been able to resolve how multi-year catastrophic plans will be treated under the Department-operated risk adjustment program or the MLR requirements.⁷² The Department also asks whether insurers should be able to change any terms of coverage during a multi-year term and expressly acknowledges the “potential interactions” between this proposal and the ACA’s market reforms and consumer protections—including guaranteed issue, age rating, and uniform modifications to coverage.⁷³ The Department cannot place these foundational questions on the shoulders of commentators—especially with the truncated comment period as discussed above—and must engage in reasoned decision making

⁶⁷ 91 Fed. Reg. at 6,371–72.

⁶⁸ 91 Fed. Reg. at 6,455.

⁶⁹ *Id.*

⁷⁰ 42 U.S.C. §§ 18116, 18022(b)(4).

⁷¹ 42 U.S.C. §§ 399gg-4.

⁷² 91 Fed. Reg. at 6,372.

⁷³ 91 Fed. Reg. at 6,373.

under the ACA. To finalize the multi-year catastrophic plan structure while leaving these issues open would create significant regulatory uncertainty, harming both issuers and consumers.

4. **Risk Adjustment Proposal – Catastrophic and Bronze-Tier Plan Risk Transfer Calculation**

Under existing rules, the Department calculates risk adjustment transfers separately for the individual catastrophic plans and individual non-catastrophic plans. The Department seeks comment on whether that practice should continue, or whether the Department should combine those plans for purposes of risk calculation under the State payment transfer formula.⁷⁴

The Department has not provided sufficient information to allow the States, or the public at large, to meaningfully comment on this proposal. The need for such a policy would depend heavily on projected enrollment, anticipated risk scores for consumers, and the degree to which insurers offer new products (such as multi-year catastrophic plans) that the Department proposes here. Yet, the Department does not project any of these inputs or otherwise explain its view of the likely effect of the combining the risk calculations of these two markets. In future rulemaking, the Department should provide more information on the risk adjustment calculations, how they have changed over time, and what the estimated impact on catastrophic and non-catastrophic plan enrollment would be, so that the public may offer meaningful feedback on this provision.

B. **Essential Health Benefits**

Prior to the ACA, insurance plans could exclude certain key services from coverage. To address this problem, the ACA required certain individual and small group health plans to cover a set of Essential Health Benefits, or EHBs, which must be “equal to the scope of benefits provided under a typical employer plan.”⁷⁵ The inclusion of EHBs as minimum standards for what must be provided improved coverage for those who previously did not have access to these services.⁷⁶

⁷⁴ 91 Fed. Reg. at 6,322.

⁷⁵ EHBs are comprised of services in the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care. Centers for Medicare and Medicaid Servs., *Information on Essential Health Benefits (EHB) Benchmark Plans*, <https://tinyurl.com/3jbebvzc> (last updated Jan. 14, 2025).

⁷⁶ Sarah Lueck, *If “Essential Health Benefits” Standards Are Repealed, Health Plans Would Cover Little*, Ctr. on Budget & Policy Priorities (Mar. 23, 2017), <https://tinyurl.com/44b8e9z2> (explaining that the consequences of repealing EHBs would include leaving people with pre-existing conditions without healthcare coverage, women being charged more than men, and lead to many people with health insurance to have prohibitively expensive bills); Lois K. Lee, et al., *Women’s Coverage, Utilization, Affordability, And Health After The ACA: A Review Of The Literature*, 39 *Health Affairs* 387, 390 (2020), <https://tinyurl.com/3adau3rm>.

Mandating coverage for EHBs also improves the quality of coverage, as EHB rules prohibit discrimination and impose restrictions on cost sharing and annual and lifetime dollar limits.⁷⁷

The ACA and its effectuating regulations permit significant latitude to the States in determining how EHBs are defined.⁷⁸ As such, States submit their “benchmark” plans to the Department for approval. As the name suggests, EHBs are a minimum standard, and benchmark plans can choose to offer “additional health benefits, like vision, dental, and medical management programs (for example, for weight loss).”⁷⁹ Each State maintains a benchmark plan on file with the Department, against which private insurers must compare plans to ensure compliance with the standards set forth therein.

Section 1311(d)(3)(B) of the ACA authorizes States to require QHPs to cover benefits beyond EHBs.⁸⁰ If a State mandates these additional benefits, it must defray associated costs, either by making payments to individuals enrolled in QHPs or to the QHPs directly on behalf of covered individuals.⁸¹ The 2025 Payment Notice reformed defrayal determinations, clarifying that, so long as a State-mandated benefit is included in the State’s EHB benchmark plan, it is considered an EHB.⁸² This regulatory change followed a 2018 FAQ where the Department confirmed that states updating their EHB benchmark plans would not trigger new defrayal obligations for benefits incorporated in those plans through the benchmark update process.⁸³ That guidance made clear that benchmark plan selection alone does not create new State mandates for purposes of the defrayal framework at 45 C.F.R. §155.170. As EHBs, State-mandated benefits became subject to EHB rules, including annual and lifetime dollar limits, restrictions on cost sharing, and the ban on discrimination.⁸⁴ Additionally, the rule clarified that States did not have to defray the costs of these State-mandated benefits because they were no longer “in addition” to EHBs.

The 2025 Payment Notice also, for the first time, permitted States to include non-pediatric dental care in EHB-benchmark plans as EHBs. The Proposed Rule would undo both of these changes, without adequate justification. If finalized, the defrayal reversal would create uncertainty and generate higher costs, and the non-pediatric dental care exclusion would be procedurally invalid.

⁷⁷ *Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program*, 89 Fed. Reg. 26,218, 26,225 (Apr. 15, 2024); *see also* 45 C.F.R. §§ 147.126, 156.125, 156.130.

⁷⁸ Center on Budget and Policy Priorities, *Essential Health Benefits Under Threat*, <https://tinyurl.com/4cyym92> (last visited March 12, 2026).

⁷⁹ Jared Ortaliza et al., *The Affordable Care Act 101*, Kaiser Family Found. (May 28, 2024), <https://tinyurl.com/yz5utdrn>.

⁸⁰ 42 U.S. Code § 18031(d)(3)(B)(i).

⁸¹ 42 U.S. Code § 18031(d)(3)(B)(ii).

⁸² 89 Fed. Reg. at 26,225.

⁸³ Centers for Medicare & Medicaid Services, *Frequently Asked Questions on Defrayal of State Additional Required Benefits* (Oct. 23, 2018), <https://tinyurl.com/4wu56jsa>.

⁸⁴ 89 Fed. Reg. at 26,225; *see also* 45 C.F.R. §§ 147.126; 156.130; 156.125.

1. **The Reversal of the 2025 Payment Notice’s Defrayal Change Will Cause Confusion, Increase State Costs, and Is Unsupported by Evidence**

Prior to 2025, implementing regulations explained that a State-mandated benefit is only considered an EHB if the State enacted the mandate on or before December 31, 2011 or if the State enacted the mandate to comply with federal requirements.⁸⁵ Even if a State-mandated benefit were later incorporated into the State’s EHB benchmark plan, it was considered “in addition” to EHBs if it was enacted after December 31, 2011, and was not enacted to satisfy federal requirements. So, for example, if a State enacted a benefit mandate in 2013 and later added the benefit to its EHB-benchmark plan—so long as that incorporation was not in response to federal requirements—the benefit would be “in addition” to EHBs, and the State would have to defray its cost. The 2025 Payment Notice reformed defrayal determinations, clarifying that, so long as a State-mandated benefit is included in the State’s EHB benchmark plan, it is considered an EHB. As EHBs, State-mandated benefits became subject to EHB rules, including annual and lifetime dollar limits, restrictions on cost sharing, and the ban on discrimination.⁸⁶ Additionally, States no longer had to defray the costs of these State-mandated benefits because they were no longer “in addition” to EHBs. The Proposed Rule seeks to reverse the defrayal clarification in the 2025 Payment Notice, which will cause confusion within States, will increase State administrative and defrayal costs, and is unsupported by the supplied justifications.

The Proposed Rule will revive pre-2025 confusion endured by States working to determine defrayal obligations. Before the 2025 Payment Notice, States faced difficulty in understanding the requirements of 45 C.F.R. § 155.170, the regulation governing and implementing additional required benefits. State agencies struggled to discern when a State-mandated benefit necessitated defrayal, and the Department has acknowledged as much in its 2025 Payment Notice.⁸⁷

Furthermore, States had to reconcile inconsistent definitions of “essential benefits.” As some commenters noted before the Department finalized the 2025 Payment Notice, there was a conflict between 45 C.F.R. §§ 155.170 and 156.111, “under which a benefit could be ‘essential’ for purposes of a State’s EHB-benchmark plan selected by each State under § 156.111, but ‘not essential’ for purposes of the defrayal requirement under § 155.170.”⁸⁸ Among those supporting

⁸⁵ *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017; Corrections*, 81 Fed. Reg. 12,204, 12,242 (Aug. 11, 2016). Each of these factors has long been a mainstay in the defrayal analysis, but the Proposed Rule formally incorporates all of them into § 155.170.

⁸⁶ 89 Fed. Reg. at 26,225; *see also* 45 C.F.R. §§ 147.126; 156.130; 156.125.

⁸⁷ 89 Fed. Reg. at 26,265–66 (“In our experience, States are often unsure whether they are making correct defrayal determinations due to the complexity of the [pre-2025] policy.”).

⁸⁸ 89 Fed. Reg. at 26,265.

the 2025 Payment Notice were State agencies in Massachusetts,⁸⁹ California,⁹⁰ New Jersey,⁹¹ New York,⁹² and Washington.⁹³

The 2025 Payment Notice cleaned up the mess, clarifying that if a benefit is in a State's EHB-benchmark plan, EHB protections apply, and the State does not have to defray the benefit's costs.⁹⁴ But this Proposed Rule would force States back into confusion, reviving the inconsistency between §§ 155.170 and 156.111, the lack of clarity around whether State mandates remove benefits from EHB-benchmark plans, and the pre-2025 uncertainty about defrayal determinations. This would leave States in the lurch. State agencies will be sent on a wild goose chase, expending precious resources trying to find answers on defrayal determinations that do not exist. The Department is already aware of these consequences because they amended § 155.170 in the 2025 Payment Notice.⁹⁵

The Proposed Rule will further impose unjustified costs on States and their residents. The Proposed Rule will impose defrayal and administrative costs on States, as well as out-of-pocket costs on residents. After the 2025 Payment Notice, any States that were defraying the cost of State-mandated benefits ceased doing so if those benefits were incorporated into the States' EHB-benchmark plans. But this Proposed Rule puts States on a seesaw, forcing those States to once again undertake the onerous process of both determining whether defrayal is required and making such payments when necessary. States may also have enacted new benefit mandates in reliance on the 2025 Payment Notice. So long as the benefits were in the States' EHB-benchmark plans, no defrayal would be necessary. The Proposed Rule means that these States might have to *start* paying defrayal costs. As the Proposed Rule explains, if a State-mandated benefit is in the State's EHB-benchmark plan, "the proposed revision to §155.170 would simply render the benefit's inclusion in the EHB-benchmark plan null and void for purposes of defining the EHB in the State."⁹⁶ The Proposed Rule's only solution for the States that might have to resume or start paying defrayal costs is a suggestion that they "repeal[] the applicable State requirement."⁹⁷

⁸⁹ Massachusetts Connector, Comment Letter on Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025, CMS-2023-0191 (Jan.8, 2024), <https://tinyurl.com/5265uvxp>.

⁹⁰ Covered California, Comment Letter on Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025, CMS-2023-0191 (Jan.8, 2024).

⁹¹ New Jersey Department of Banking and Insurance, Comment Letter on Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025, CMS-2023-0191 (Jan.8, 2024).

⁹² NY State of Health, Comment Letter on Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025, CMS-2023-0191 (Jan. 9, 2024), <http://tiny.cc/my90101>.

⁹³ Washington Health Benefit Exchange Comments: Proposed Federal Rule -- Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2025 -- CMS-9895-P (Jan. 5, 2024), <https://tinyurl.com/hpxeemar>.

⁹⁴ States relied on the 2025 Payment Notice for important policy changes. For example, the Washington Legislature spent five years working with its deaf and hard of hearing community to add a hearing aid benefit to Washington's EHB benchmark plan that finally went into effect for the 2026 plan year. Wash. Rev. Code § 48.43.135. The proposed rule threatens to undo this work.

⁹⁵ 89 Fed. Reg. at 26265 (explaining that CMS "understand[s] that whether a State mandate will require defrayal is an important consideration for State policymakers.").

⁹⁶ 91 Fed. Reg. at 6334.

⁹⁷ 91 Fed. Reg. at 6334. The Proposed Rule even acknowledges that State legislative session timing could make it difficult for States to avoid paying defrayal costs and thus solicits

If, as the Proposed Rule suggests, States should take legislative action to avoid defrayal costs, those States could be forced to expend other resources—on both legislation-related costs and implementation costs. Furthermore, given the confusion around defrayal determinations, the Proposed Rule will force every State to reevaluate all State-mandated benefits required on or after January 1, 2012. As commenters noted prior to the finalization of the 2025 Payment Notice, conducting mandate reviews is “a costly and time-intensive process for States.”⁹⁸ The Proposed Rule makes it clear that States will not receive any assistance from the federal government in determining whether specific benefits require defrayal, so all administrative costs will be borne on the States alone.⁹⁹

The Proposed Rule will cause confusion. Further, to the extent it results in benefits in State EHB benchmark plans being stripped of their EHB status, it will remove important ACA consumer protections associated with those services, such as the EHB cost-sharing limits and antidiscrimination provisions.¹⁰⁰

In addition, the Proposed Rule’s reversal of the 2025 Payment Notice’s defrayal policy is unsupported by evidence. After acknowledging that the Proposed Rule could burden States, the preamble explains that the changes are nonetheless “necessary to return to the longstanding read of section 1311(d)(3)(B) of the Affordable Care Act and better balance the cost of the EHB for unsubsidized enrollees.”¹⁰¹ Yet, the Proposed Rule fails to provide support for these justifications—namely, why the “longstanding read”¹⁰² is superior to the 2025 Payment Notice’s interpretation and whether a lack of State defrayals since 2025 has made premiums unaffordable for unsubsidized enrollees.

The Proposed Rule does not adequately explain how the 2025 Payment Notice presented an inferior interpretation of section 1311(d)(3)(B). As explained above, section 1311(d)(3)(B) permits States to require QHPs to cover benefits in addition to EHB, and, if they do, States must defray the cost of those benefits. The EHB-benchmark selection process, left unchanged by the 2025 Payment Notice, still requires States to select plans equal to the scope of a typical employer plan in the State. The 2025 Payment Notice did not end State defrayal, it merely clarified that if a benefit is in a State’s EHB-benchmark plan, the State does not need to defray its cost.¹⁰³ Whether a State can add a certain benefit to its EHB-benchmark plan remains subject to the requirements of § 156.111(b)(2)(ii), and if a State mandated a new benefit that was not in its benchmark plan, the State still would need to defray the cost.¹⁰⁴ Furthermore, any suggestion that States would exploit the 2025 Payment Notice defrayal policy to add unchecked numbers of new mandates as EHBs is

comment on finalizing the effective date as plan year 2028 instead of plan year 2027.

⁹⁸ 89 Fed. Reg. at 26265.

⁹⁹ “Under § 155.170, it is the State’s responsibility to identify which State-required benefits require defrayal. While States are encouraged to reach out to us concerning State defrayal questions in advance of passing and implementing benefit mandates, HHS does not provide determinations of whether the cost of a State-required benefit requires defrayal by the States.”

¹⁰⁰ See 42 U.S.C. § 18022(c)(1); *FAQ about Affordable Care Act Implementation Part 66*, U.S. Department of Labor (Apr. 2, 2024), <https://tinyurl.com/yr3pknd5>.

¹⁰¹ 91 Fed. Reg. at 6334.

¹⁰² 91 Fed. Reg. at 6334.

¹⁰³ 89 Fed. Reg. at 26397.

¹⁰⁴ The Department states that the adding of mandated benefits to State EHB-benchmark plans “could . . . undermine the purpose of section 1311(d)(3)(B),” but States would still have to defray non-EHB benefits, and the purpose of adding benefits to State benchmark plans is not only to better align benchmark plans with a State’s typical employer plan, as required, but also to provide EHB-style consumer protections for those benefits.

misguided. As the Department recognized in 2024, “States approach the provision of health benefits in good faith and with great consideration for ensuring balance between an appropriate scope of covered benefits with any corresponding increase in costs.”¹⁰⁵ The Department also recognized that the 2025 change will “make it simpler overall for States to address health equity concern in their states through mandates and EHB-benchmark plan updates.”¹⁰⁶

The Proposed Rule also neglects to substantiate its claim that the 2025 Payment Notice significantly increases premiums for unsubsidized enrollees “to the detriment of overall enrollment by this population.”¹⁰⁷ The Proposed Rule’s preamble is replete with the Department’s “concern[]” and belief that the 2025 change will incentivize States to produce an “accumulation” of new benefit mandates—for which the Department provides no support—that will raise costs for unsubsidized enrollees.¹⁰⁸ The Department “seeks to mitigate [a] risk” that it never authenticated.¹⁰⁹

2. The Proposed Rule’s Exclusion of Non-Pediatric Dental Services is Procedurally Invalid and Unjustified.

The Proposed Rule reverses the 2025 Payment Notice’s authorization for States to include non-pediatric dental services in their EHB-benchmark plans, purportedly to return to a “more precise interpretation” of section 1302(b)(2)(A) of the ACA.¹¹⁰ In doing so, however, the Department violates the ACA’s procedural requirements and advances a policy change that is not adequately justified.

The Department failed to abide by the procedural requirements in section 1302 of the ACA in promulgating the Proposed Rule. Section 1302 of the ACA requires that the Department ensure that the scope of EHBs “is equal to the scope of benefits provided under a typical employer plan.”¹¹¹ The statute instructs the Secretary of Labor to conduct a survey of employer-sponsored coverage to understand the scope of a typical employer plan.¹¹² After such a survey in 2011, the Department announced its commitment to “State flexibility” and indicated that assessing the contents of a “typical employer plan” was a State-specific inquiry.¹¹³

The ACA mandates that if the Department is to revise services included in EHBs, “the Secretary shall submit a report to the appropriate committees of Congress,” presumably premised on renewed reports by DOL based on “a survey of employer-sponsored coverage.”¹¹⁴ The Department failed to adhere to this statutorily mandated process in excluding non-pediatric dental services. In so doing, the Department has also deprived the States and other commenters of the ability to meaningfully comment on the data that would have been set forth in the statutorily required reports.

The Proposed Rule’s exclusion of non-pediatric dental services is also arbitrary and capricious. The 2025 Payment Notice allowed States to add non-pediatric dental services to their

¹⁰⁵ 89 Fed. Reg. at 26,268.

¹⁰⁶ 89 Fed. Reg. at 26,265.

¹⁰⁷ 91 Fed. Reg. at 6,334.

¹⁰⁸ 91 Fed. Reg. at 6,333.

¹⁰⁹ 91 Fed. Reg. at 6,333-34.

¹¹⁰ 91 Fed. Reg. at 6,369.

¹¹¹ 42 U.S.C. § 18022(b)(2)(A).

¹¹² *Id.*

¹¹³ *Essential Health Benefits Bulletin*, CMS: Center for Consumer Information and Insurance Oversight (Dec. 16, 2011), <https://tinyurl.com/6bs6eaxc>.

¹¹⁴ 42 U.S.C. § 18022(b)(2)(A)-(B).

EHB-benchmark plans for three central reasons: (i) the Department applied a “more natural” reading of the ACA, (ii) the Department found that more employer plans typically include adult dental services, and (iii) the Department acknowledged the importance of adult dental services to health equity.¹¹⁵ In the Proposed Rule, the Department does not sufficiently justify its departure from the 2025 Payment Notice’s considerations.

In the finalized 2025 Payment Notice, the Department recognized that previously, the agency believed that section 1302(b)(2)’s requirement that the Secretary of HHS make sure that EHBs are “equal in scope to the benefits provided by a typical employer plan” referred only to employer’s major medical plans.¹¹⁶ A more natural reading, the Department explained, would consider all benefits employers typically cover, “regardless of whether such benefit is historically considered a non-excepted ‘health benefit’ or whether such benefit is ‘typically covered’ by an employer’s major medical plan” because the statute does not specify whether the “typical employer plan” must be the typical employer *major medical* plan.¹¹⁷ Moreover, oral health is integral to overall health, and this change would align with the Department’s health equity goals.¹¹⁸ The Proposed Rule purports to correct the Department’s interpretation by pointing to section 1302(b)(1) of the ACA, which delineates the ten categories of EHBs.¹¹⁹ The final category, 1302(b)(1)(J), is “[p]ediatric services, including oral and vision care,” and the Department now takes the explicit inclusion of pediatric oral care as a sign that Congress intended to exclude *adult* oral care.¹²⁰ Such an interpretation might be correct if pediatric dental services were specifically included in another EHB category that also provided for adult health services—such as 1302(b)(1)(I), “Preventative and wellness services.” But the explicit mention of pediatric dental services only appears in the one category referencing pediatric services, which does not already carve out a wide range of “preventative and wellness services” that might include dental care. The Proposed Rule uses this illogical interpretation to support its conclusion that “typical employer plan” must only refer to major medical plans.¹²¹

The Proposed Rule then uses its unjustified insistence on substituting “typical employer plan” with “typical major medical employer plan” to avoid confronting the 2025 Payment Notice’s observation that an increased number of employer plans typically include adult dental services.¹²² Finally, the Proposed Rule does recognize that “oral health can have a significant impact on overall health and quality of life,” though it does not acknowledge the racial, geographic, and economic disparities in access to oral care.¹²³ Ultimately, however, the Department concludes that States can mandate oral care coverage and defray its cost if States care about health equity.¹²⁴

C. Other Provisions

The remainder of the provisions within the Proposed Rule propose a variety of changes to the Marketplace and plans. The undersigned States do not oppose every one of these proposals: for example, the States—which, as the Department recognizes, have not faced similar concerns about improper enrollment as the FFE—support protections against deceptive conduct by agents, brokers, and web-brokers, and they recommend reasonable methods for implementing H.R. 1’s

¹¹⁵ 89 Fed. Reg. at 26,342.

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ 89 Fed. Reg. at 26,342–44.

¹¹⁹ 91 Fed. Reg. at 6,293.

¹²⁰ 91 Fed. Reg. at 6,369.

¹²¹ *Id.*

¹²² *Id.*

¹²³ *Id.*

¹²⁴ 91 Fed. Reg. at 6,369–70.

pre-enrollment verification requirements. However, numerous other proposals seek to effectuate enormous changes in a rushed manner and based on flawed or incomplete data. The proposal to implement the State Exchange Improper Payment Measurement system within less than a year's time is misguided, as it would result in major unnecessary costs and is duplicative with existing systems, while the data the Department uses to justify its proposed Basic Health Program modifications are riddled with errors and inconsistencies. Meanwhile, the proposal allowing the Department to adjust the MLR in States that do not request it is directly contrary to the considerable State autonomy that the Department purports to respect, and it would usurp authority from those best positioned to make such adjustments. Finally, the Department's embrace of non-network plans will saddle consumers with an increased risk of high surprise medical bills and ultimately make healthcare less affordable.

1. Medical Loss Ratio (§§ 158.103, 158.120, 158.210, 158.220)

The ACA requires insurers to report the percentage of total expenditures made on clinical care and quality improvement, a measure known as Medical Loss Ratio, or MLR, and to issue rebates to enrollees if this percentage does not meet minimum standards, which is 80% for the individual market in a State.¹²⁵ A State may request an adjustment to its MLR under certain circumstances.¹²⁶ The Proposed Rule asks whether the Department should amend the regulations to enable the Department to adjust the MLR in the individual market in States that do not request such an adjustment. It should not.

The Department explains that it is considering this Proposed Rule due to “the instability in the individual market in recent years” and asks whether this proposal could “help stabilize the individual market, including potentially by lowering premiums for consumers.”¹²⁷ But the Department fails to provide any evidence or reasoning for why it believes this proposal might help stabilize the market or lower premiums for consumers. In fact, the likely outcome will be the opposite. As recognized by the Department, “States are often best positioned to evaluate local provider networks and market conditions.”¹²⁸ By taking away authority from States with expertise and knowledge of local market dynamics, the Department raises the risk of uninformed and misguided changes to the local MLR, injecting uncertainty into the individual market.

Should the Department adopt this proposed change, it is essential to retain the State's perspective and expertise on local marketplaces when determining whether to adjust the local MLR. The Department should be required to consult with the State first before any amendment, and it should continue to provide an opportunity for public comment on the potential MLR adjustment in the State. In the event of a disagreement with the State, the Department should defer to the State's expertise on its own local healthcare market. The States also stress that the Department is required by law to publish the data and analyses that lead to any determination that an MLR adjustment is needed.

The ACA's MLR requirement has raised consumer premiums not because of the 80% rate, but because it incentivizes vertical integration. Because MLR caps apply only to insurance entities, insurers that vertically consolidate with healthcare providers or pharmacies can dodge these caps. Vertical integration allows a parent company to be both the buyer (the insurance subsidiary) and the seller (the provider or pharmaceutical subsidiary) of health care. As both buyer and seller, the

¹²⁵ Centers for Medicare & Medicaid Services, Medical Loss Ratio (last modified Sept. 10, 2024), <https://tinyurl.com/2s4d2e88>.

¹²⁶ Centers for Medicare & Medicaid Services, State Requests for MLR Adjustment (last modified Sept. 10, 2024), <https://tinyurl.com/3bke86p2>.

¹²⁷ 91 Fed. Reg. at 6,422.

¹²⁸ 91 Fed. Reg. at 6,433.

parent company can determine how money flows from one arm of the company to another by setting prices, allowing insurers to game the MLR. The parent company can also set inflated prices for medical services or drugs that count as medical spending for MLR compliance purposes and then recoup that spending as profit on the provider side. Incentivizing vertical integration ultimately results in concentrated markets with less competition, higher premiums, and narrower networks, leading to fewer choices and longer wait times, particularly for rural areas with limited provider supply.

But the solution is not to undercut State authority and expertise. Rather, the Department should consider increasing transparency and requiring issuers to report payments to affiliated providers, pharmacy benefit managers, or pharmacies separately from payments to independent entities. The Department could require issuers to demonstrate that their medical spending towards affiliated entities reflects market-rate or below pricing. This is much more likely to succeed at stabilizing the market and lowering consumer premiums. The Department should withdraw this proposed change.

2. Basic Health Program Modifications (§ 600.5)

The Department proposed changes to the Basic Health Program (BHP) to bring the program in line with the requirements of certain provisions of H.R. 1. However, the Department presented inconsistent, unclear, and unverifiable data regarding the anticipated impact of those changes on federal spending and may have made mathematical errors in some of its calculations. Given these uncertainties, the States are unable to meaningfully comment on the proposed changes without the Department providing a proper impact analysis.

First, the Department claims that 1.6% of BHP enrollees would be affected by the change required by Section 71301 of H.R. 1.¹²⁹ It further claims this is an annual figure, yielding “about 2,000 individuals” affected by the Proposed Rule.¹³⁰ Table 24 provides baseline enrollment of 155,000 for 2027.¹³¹ Multiplying that figure by 1.6%, as the Department’s analysis seems to imply was done, yields 2,480 individuals, not 2,000, meaning the Department has underestimated the affected population by roughly 20%. The difference between 2,000 and 2,480 is not trivial, because the Department uses the artificially lower figure to calculate the anticipated decreases in federal funding that will flow to lawfully present noncitizen communities. Additionally, the Department fails to explain why the number of affected individuals is the same across each year from 2026-2030, even though Table 24 clearly shows total enrollment fluctuating between 144,000 and 155,000 for each of those years.¹³² Notably, 1.6% of 144,000 is different from 1.6% of 155,000, and neither number is 2,000.

Second, the text accompanying Table 23 states that the Department “multiplied the enrollment change by the projected average per member per year federal costs (see Table 25) to develop the expenditure amounts.”¹³³ This is likely a mistake, because Table 25 purports to show the outputs of this expenditure calculation, so it cannot simultaneously serve as the input to that calculation, and moreover, Table 25 contains data on enrollment and total spending, not per-

¹²⁹ 91 Fed. Reg. at 6,448.

¹³⁰ 91 Fed. Reg. at 6,449.

¹³¹ *Id.*

¹³² *Id.*

¹³³ *Id.*

member-per-year data.¹³⁴ Perhaps the Department meant that the figures in Table 24, not 25, served as the inputs—but that does not solve the problem. Substituting the per-member-per-month (PMPM) estimates provided in Table 24, the States are still unable to verify the Department’s calculation. For instance: Table 24 indicates that the 2027 average PMPM expenditure is \$670.¹³⁵ Multiplying that figure by the estimated static 2,000 loss of members discussed above, the result is $\$670 \times 2,000 \text{ members} \times 12 \text{ months} = \$16,080,000$, yet Table 23 says that the estimated loss for 2027 is \$17 million. Perhaps the Department used the corrected figure of 2,480 rather than 2,000? Not so. That calculation yields $\$670 \times 2,480 \times 12 \text{ months} = \$19,939,200$, or nearly \$20 million, not \$17 million.

The remaining numbers in Table 23 fare no better. The Department estimates in Table 23 that there will be a loss in federal funding of \$17 million in 2027 that then falls to \$16 million in 2028 and stays constant for the remaining years.¹³⁶ This is impossible if using the numbers in Table 24 because PMPM costs rise every year after 2027.¹³⁷ Nor does the Department ever explain whether this loss in federal funding presents losses relative to a pre-H.R. 1 counterfactual baseline or year-over-year changes, further making these estimated impacts unclear and unverifiable. The rule never discloses the underlying per-member cost figures that are actually used to produce Table 23 and 25, making these spending estimates unverifiable.

Given these errors and inconsistencies, the Department should refrain from implementing any changes to the BHP until it can provide a proper, clear, straightforward estimate of costs and impacts. In future rulemaking, the Department should provide more information on these calculations and estimates so that the public may offer meaningful feedback on this provision. As it is currently written, meaningful comments are impossible. This proposal should be withdrawn.

3. Certification of Non-network Plans as QHPs is Contrary to State Consumer Protection Policies and Will Harm Enrollees with Surprise Medical Bills.

In 2023, the Department required all Marketplace plans to use a network of providers in order to assure “that all plans certified as QHPs offer sufficient choice of providers in compliance with a consistent set of criteria for easier comparison across all QHPs and better ensure substantive consumer protections afforded by the ACA without undue barriers to access those protections.”¹³⁸ This was a wise decision, as non-network plans, rather than maintaining “a network of contracted providers who agree to accept the plan’s payment for services ... in full,” instead allow for balance billing: “if a provider wishes to be paid more than” what the plan determines it will pay, “the plan enrollee is financially responsible for paying that balance.”¹³⁹ This poses a significant risk of saddling enrollees with large surprise medical bills and undermines the aims of federal¹⁴⁰ and State

¹³⁴ 91 Fed. Reg. at 6,450.

¹³⁵ 91 Fed. Reg. at 6,449.

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ 88 Fed. Reg. at 25,873.

¹³⁹ Sabrina Corlette & Tara Straw, *Proposed Marketplace and Insurance Changes in the 2027 Notice of Benefit & Payment Parameters: Implications for States*, Princeton University: State Health & Value Strategies (Feb. 2026), <https://tinyurl.com/e7hyjmbj>.

¹⁴⁰ See 26 U.S.C. § 9816; 42 U.S.C. § 300gg-111 et seq.

laws¹⁴¹ that restrict or prohibit surprise billing. Critics of such plans have expressed concerns that enrollees would not “actually have access to medical care under plans without an established network,” and that non-network plans are ““not going to work as insurance as most people understand it.””¹⁴² Even the Department acknowledges that non-network health plans are quite rare and concedes that “the plan design may not be immediately intuitive to enrollees.”¹⁴³

The Department nevertheless reverses its 2023 determination and proposes allowing non-network plans to receive QHP certification starting in plan year 2027 if they “demonstrate[] a sufficient choice of providers in a manner consistent with ... the [ACA].”¹⁴⁴ Among its justifications for this reversal, the Department asserts that it now has “developed an effective, administrable approach”¹⁴⁵ for non-network plans to comply with the ACA’s network requirements by “requiring [S]tates to ensure that a sufficient number of providers in a given area would accept the non-network plan’s benefit amount as payment in full.”¹⁴⁶

We recommend that the Department not permit non-network plans to receive QHP certification due to the significant risks of deception and confusion they pose to potential purchasers, and because this change is contrary to the aim of State and federal laws protecting individuals from surprise costs. As the Department notes in the Proposed Rule, such plans do not include any “guarantee that the plan’s benefit amounts are actually sufficient to cover the provider’s full charges,” which “can leave enrollees with additional out-of-pocket costs that may disproportionately challenge low-income, medically underserved populations.”¹⁴⁷ In short, “[p]roviders have no obligation to accept the benefit amount as payment in full, which could leave consumers without access to a provider or with balanced bills and higher out-of-pocket costs.”¹⁴⁸

Because these plans cannot guarantee the same financial protections as network plans, non-network plans can be offered at a lower premium. The proliferation of non-network plans could have significant implications for most marketplace consumers—not just those who enroll in a non-network plan. This is because PTC eligibility is determined based on the second-lowest cost silver plan. If non-network plans serve as this benchmark, millions of consumers could see reduced PTCs and would, in turn, face higher net premiums for marketplace coverage with a true provider network. Aggressively low premiums could also lead to adverse selection for network plans, further raising premiums for traditional marketplace coverage.¹⁴⁹

¹⁴¹ See, e.g., N.J. Stat. Ann. § 26:2SS-9; Cal. Health & Safety Code § 1371.9; Mass. Gen. Laws. ch. 111, § 228. Overall, 33 States have enacted statutes protecting against surprise medical bills. See Jack Hoadley & Kevin Lucia, *Hybrid Approach to Resolving Payment Disputes Breaks Legislative Stalemates Over Balance Billing, How Will the No Surprises Act Affect These New State Laws?*, Georgetown University: Center on Health Insurance Reforms (Apr. 13, 2021), <https://tinyurl.com/mrrs23w5>.

¹⁴² See Reed Abelson, *New A.C.A. Plans Could Increase Family Deductibles to \$31,000*, N.Y. Times (Feb. 26, 2026), <https://tinyurl.com/yumsu4zr>; Maya Goldman, *Health plans with no providers may reshape Obamacare*, Axios (Mar. 11, 2026), <https://tinyurl.com/2wjb29ku>.

¹⁴³ 91 Fed. Reg. at 6,411.

¹⁴⁴ 91 Fed. Reg. at 6,407.

¹⁴⁵ 91 Fed. Reg. at 4,409.

¹⁴⁶ Katie Keith & Matthew Fiedler, *HHS Proposes Sweeping Changes For 2027 Marketplace Plans (Part 2)*, Health Affairs (Feb. 13, 2026), <https://tinyurl.com/muw8tzrt>; see 91 Fed. Reg. at 6,408, 6,410.

¹⁴⁷ 91 Fed. Reg. at 6,414-15.

¹⁴⁸ Keith & Fiedler, *supra* n. 146.

¹⁴⁹ Sherman, *supra* n. 13, at 9–10 (“States may also need to closely review issuer solvency.

Non-network plans would exacerbate a problem that already makes healthcare less transparent and less affordable. Balance billing and surprise bills are already present even in network plans, due to the prevalence of out-of-network charges: a 2020 study found that “[f]or people in large employer plans, 18% of all emergency visits and 16% of in-network hospital stays had at least one out-of-network charge associated with the care,”¹⁵⁰ with one third of respondents between the ages of 18-64 from another study that year reporting an unexpected medical bill.¹⁵¹ These unexpected costs are often substantial: the Department’s own 2022 reporting shows average costs between \$750 to \$2,600 for emergency room visits, elective surgeries, and giving birth in a hospital.¹⁵² Non-network plans allow for and encourage such surprise costs: by the Department’s own acknowledgment, it is a feature that is baked into their premise, as they offer “no guarantee” against balance billing and surprise costs.¹⁵³ As such, by expanding access to such plans, the Proposed Rule runs contrary to the intent of federal and State laws protecting against surprise bills¹⁵⁴ and undermines the ACA’s goal of “decreas[ing] the cost of health care.”¹⁵⁵

4. The Department’s proposed implementation of the State Exchange Improper Payment Measurement is Needlessly Rushed and Unduly Burdens States.

The Proposed Rule implements the State Exchange Improper Payment Measurement (SEIPM), an initiative through which the Department would collect data from State Exchanges to measure improper payments of APTC, with an applicability date of January 1, 2027. This would mean that State Exchanges “would be subject to improper payment measurement under the SEIPM beginning in 2027 for PY 2026.”¹⁵⁶ Especially given the delayed issuance of the Proposed Rule,¹⁵⁷ this applicability date does not allow States sufficient times to prepare for SEIPM. The Department has previously proposed and subsequently declined to adopt SEIPM reporting requirements.¹⁵⁸ The 2023 Payment Notice, published in January 2022, proposed SEIPM but would not have required reporting by States until 2025.¹⁵⁹ In contrast, the Proposed Rule would give States less than a year to interpret the Proposed Rule and any final rule, prepare the extensive data required by SEIPM, and send that data to the Department.

If non-network plans are priced aggressively low—as observed with Sidecar Health offerings off-exchange in 2022 and 2023—they could disproportionately attract healthier enrollees, resulting in substantial risk adjustment liabilities that may not outweigh the revenue from the new enrollees. Issuers offering these plans would therefore need sufficient reserves and financial capacity.”).

¹⁵⁰ Karen Pollitz et al., *An examination of surprise medical bills and proposals to protect consumers from them*, Peterson-KFF Health System Tracker (Feb. 10, 2020), <https://tinyurl.com/yfeh8tws>.

¹⁵¹ Lunna Lopes et al., *Data Note: Public Worries About And Experience With Surprise Medical Bills*, Kaiser Family Foundation (Feb. 28, 2020), <https://tinyurl.com/48my6bu6>.

¹⁵² *HHS Kicks Off New Year with New Protections from Surprise Medical Bills*, CMS.gov (Jan. 3, 2022), <https://tinyurl.com/y4tsxtjy>.

¹⁵³ See 91 Fed. Reg. at 6,408-09.

¹⁵⁴ See *supra* n. 140-141.

¹⁵⁵ *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012); see *King v. Burwell*, 576 U.S. 473, 498(2015) (“Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them.”).

¹⁵⁶ 91 Fed. Reg. at 6,358.

¹⁵⁷ See *supra* at 3–4.

¹⁵⁸ 91 Fed. Reg. at 6,356.

¹⁵⁹ 87 Fed. Reg. at 654–55.

The SEIPM initiative proposed in the 2023 Payment Notice was ultimately not adopted in light of the “significant volume of public comments stating that State Exchanges would need additional time and guidance to prepare for SEIPM.”¹⁶⁰ Instead, the Department established the Improper Payment Pre-Testing and Assessment (IPPTA) pilot program, which would allow State Exchanges to prepare for SEIPM. Nineteen States, including many of the undersigned, have participated or are currently participating in IPPTA, which will continue through the end of 2026. This means that important technical questions are unresolved. For example, the Department acknowledges that the “main challenge associated with IPPTA, which would carry through to SEIPM, relates to the quantity of data that the State Exchange must submit in order for [the Department] to accurately determine whether each payment of APTC was proper or improper”; in addition, “each State Exchange operates its own platform with a unique data architecture, making it challenging to develop a unified process by which State Exchanges could submit the requisite information.”¹⁶¹ And yet the Department now proposes imposing SEIPM, even though, as it concedes, “it is too early in the IPPTA cycle to determine if alternate means of collecting the data will be necessary” for those State Exchanges that have not yet completed IPPTA.¹⁶² The Department’s only solution to these conceded “challenges” is to offer State Exchanges unspecified “flexibility in data submissions,” and the Department does not meaningfully explain why it considered but rejected “extending the implementation timeline to 2028 or 2029,” even though it concedes that doing so “would have provided [the Department] the window to evaluate all of the results from IPPTA as well as afford State Exchanges with additional preparation time.”¹⁶³

The Department’s rushed implementation of SEIPM will not only impose needless recordkeeping costs on States, which the Department estimates as about \$1.1 million annually.¹⁶⁴ As many States and State Exchanges have commented in response to prior proposed iterations of SEIPM, the data collection and reporting procedures in the Proposed Rule seem generally duplicative of already existing reporting metrics and procedures and cost States additional money. New data reporting schemes, like SEIPM, that attempt to impose a universal standard on varied State systems would require technology adjustments, additional expense, and significant investment of time, resources, and labor to address the Department’s rules and supplementary guidance. Especially given that the IPPTA program has not yet taken its full course, the States remain skeptical that SEIPM (or any uniform reporting program across diverse State Exchange database programs) will not be any less complex, resource-intensive, or expensive than those previous tested, proposed, and rejected.

Should the Department nevertheless proceed with the SEIPM reporting requirements, the undersigned States recommend that it extend the lead time for SEIPM reporting to give the Department adequate time to evaluate pilot programs and prepare agency guidance and for States to examine what changes to the State Exchange systems may be required to fully comply with future reporting requirements. This is especially necessary since the consequences for substantial non-compliance, as proposed, would be severe, ranging from imposition of a corrective action plan to revocation of a State Exchange’s authority to operate.¹⁶⁵

¹⁶⁰ 91 Fed. Reg. at 6,356.

¹⁶¹ 91 Fed. Reg. at 6,357.

¹⁶² *Id.*

¹⁶³ 91 Fed. Reg. at 6,357, 6,466.

¹⁶⁴ Katie Keith & Matthew Fiedler, *HHS Proposes Sweeping Changes For 2027 Marketplace Plans (Part 3)*, Health Affairs (Feb. 17, 2026), <https://tinyurl.com/3v2eabwn>.

¹⁶⁵ 91 Fed. Reg. at 6,366.

5. **The Proposed Protections Against Deceptive Conduct by Agents, Brokers, and Web-brokers are Reasonable Measures that Align with our State Consumer Protection Laws.**

In its Proposed Rule, the Department sets forth “new standards of conduct” and “consumer protection standards” for agents, brokers, and web-brokers (collectively, brokers).¹⁶⁶ Generally, the Department proposes to “require[]” brokers “to provide consumers with correct information and refrain from marketing or conduct that is misleading.”¹⁶⁷ Among other things,¹⁶⁸ the Proposed Rule would require brokers to use a Department-created and approved consumer consent form for all Marketplace enrollments, as well as a document memorializing that consumers have reviewed and confirmed their application information as accurate.¹⁶⁹ The Proposed Rule would also limit the gifts that consumers could receive from brokers, unless certain restrictions were met.¹⁷⁰ The Department believes that “[m]any of these prohibitions on gifts associated with enrollments” are “also prohibited under State law” and the “proposals would not attempt to supersede State laws on these topics.”¹⁷¹ The Department also plans to inform State regulators about brokers who are terminated because they violate the proposed marketing and consumer restrictions.¹⁷²

The undersigned States are aligned with the Department on the pro-consumer, anti-fraud policies that underlie these proposed broker restrictions and our relevant State laws.¹⁷³ We further urge the Department to clarify in the final rule that our State laws would not be preempted by *any* of the proposed new standards of conduct for brokers and new marketing restrictions—including, but not limited to, the proposals relating to gifts.

6. **Solicitation of Comment – Pre-Enrollment Verification Procedures for 2028**

H.R. 1, passed last year, requires exchanges to conduct pre-enrollment eligibility verification beginning with plan year 2028, in order to be eligible for PTC. The Proposed Rule solicits comment on how the Department should implement that requirement.

The pre-enrollment verification process adopted for 2028 must be designed to minimize the burden on consumers and make re-enrollment with APTC as easy as possible. Even a “small hassle” creating a minor barrier to enrollment causes “about one-third of eligible individuals [to] simply fail to take up health insurance.”¹⁷⁴ Moreover, the Department already knows that pre-

¹⁶⁶ 91 Fed. Reg. at 6,335.

¹⁶⁷ *Id.*

¹⁶⁸ *See, e.g.*, 91 Fed. Reg. at 6,339 (explaining that brokers “may not provide cash, monetary rebates, gift cards, travel vouchers, or cash equivalents to induce consumers to enroll;” “miscommunicat[e] enrollment timelines and deadlines;” “misconstrue[e] ... legislation;” or use the image or likeness of a “notable figure” in an “advertisement claiming that the figure has endorsed the” broker).

¹⁶⁹ 91 Fed. Reg. at 6,335.

¹⁷⁰ 91 Fed. Reg. at 6,339.

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ *See, e.g.*, Cal. Ins. Code § 790.03 (prohibiting “unfair methods of competition and unfair and deceptive acts or practices in the business of insurance”); Mass. Gen. Laws ch. 176D, § 3 (same); N.J. Stat. Ann. § 17:29B-4 (same).

¹⁷⁴ Mark Shepard & Myles Wagner, *Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment*, 115 Am Econ. Rev. 772, 775 (March 2025),

enrollment verification creates significant hurdles, estimating 293,000 SEP verification issues in the SEP verification policy discussed above, and previously found that up to 14% of individuals facing such verification requirements might fail to clear them.¹⁷⁵ The Department must also keep in mind that enrollees who face enrollment verification requirements will not be able to obtain APTC and therefore will not be able to enroll in affordable health insurance coverage until they clear the review status; this consideration weighs strongly in favor of making the verification process as streamlined, straightforward, and minimally burdensome as reasonably possible.

Individuals with no change in life circumstances that would affect their APTC eligibility status or category should be permitted to re-enroll in continuing coverage with APTC with the click of a button—minimizing barriers to affirmatively continue enrollment. Such individuals would remain subject to other requirements that safeguard the federal government’s interest in avoiding improper payments to ineligible individuals, such as the FTR requirement. Any framework that subjects re-enrollees to new pre-enrollment verification requirements—particularly documentation requirements they were not previously required to satisfy—will produce substantial, needless coverage losses among a population that has already demonstrated eligibility.

Additionally, verification should be automated wherever possible, with conflicts between data sources resolved in the enrollee’s favor pending a manual re-check, and should not rely on documentation requirements that shift the burden onto consumers unless absolutely necessary. The Department should also, to the maximum extent allowed by law, permit enrollees to access coverage with conditional APTC while any verifications are pending.

Finally, the Department should allow State-based exchanges maximum flexibility to implement their own verification procedures. Covered California, for instance, has consistently maintained one of the lowest rates of improper enrollments in the country while maintaining widespread coverage and participation because it already implements industry-leading verification procedures that avoid needlessly burdening enrollees.

Respectfully submitted,



ROB BONTA
CALIFORNIA ATTORNEY GENERAL



ANDREA JOY CAMPBELL
MASSACHUSETTS ATTORNEY GENERAL

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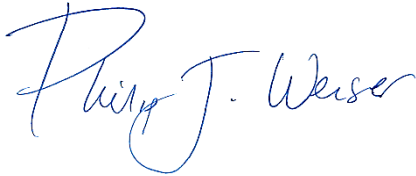
¹⁷⁵ 91 Fed. Reg. at 6,352.



JENNIFER DAVENPORT
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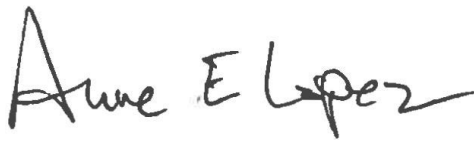
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NEW MEXICO ATTORNEY GENERAL

A handwritten signature in blue ink that reads "Letitia James". The signature is fluid and cursive, with the first name and last name clearly distinguishable.

LETITIA JAMES
NEW YORK ATTORNEY GENERAL

A handwritten signature in black ink that reads "Dan Rayfield". The signature is stylized, with the first letters of the first and last names being prominent.

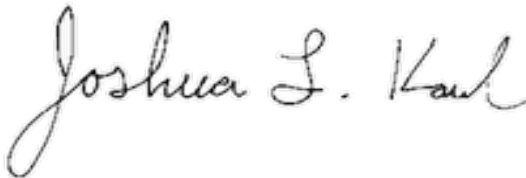
DAN RAYFIELD
OREGON ATTORNEY GENERAL

A handwritten signature in blue ink that reads "Peter Neronha". The signature is very fluid and cursive, with the first name and last name clearly distinguishable.

PETER NERONHA
RHODE ISLAND ATTORNEY GENERAL

A handwritten signature in black ink that reads "Nick Brown". The signature is fluid and cursive, with the first name and last name clearly distinguishable.

NICK BROWN
WASHINGTON ATTORNEY GENERAL

A handwritten signature in black ink that reads "Joshua L. Kaul". The signature is fluid and cursive, with the first name and last name clearly distinguishable.

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March 13, 2026

To: Centers for Medicare & Medicaid Services (CMS), the Department of Health and Human Services (HHS)

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

To Whom it May Concern:

The Center on Budget and Policy Priorities (CBPP) is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax, and programmatic issues affecting individuals and families with low or moderate incomes. We appreciate the opportunity to comment on the proposed rule by the Centers for Medicare and Medicaid Services (CMS) on the Notice of Benefit and Payment Parameters for 2027 (NBPP).

The U.S. has made significant progress toward universal health coverage. The uninsured rate was 8.2 percent in 2024, down from 15.5 percent in 2010, with low-income people, people of color, and people who are lawfully present immigrants among those seeing big gains. The Affordable Care Act (ACA) drove this progress. It established health insurance marketplaces, where people can qualify for tax credits that reduce their costs and compare comprehensive plan options; it also expanded Medicaid eligibility to millions of low-income adults. Health insurance reforms including guaranteed protections for people with pre-existing health conditions, minimum standards for benefits, limits on people's cost-sharing charges, and mechanisms to pool and spread risk all helped to ensure people without other health benefits were able to access quality, affordable health coverage. The law moved the country toward "no wrong door" eligibility and enrollment, with simplified and modernized processes to reduce burden on applicants and enrollees.

Now, federal policy is pushing in the opposite direction: from coverage gains to health care cuts, from prioritizing people with low incomes to penalizing them, from a streamlined system to a tangle of red tape, and from strengthening consumer protections to seeing how much cost and risk people

who rely on marketplace plans can take. Many aspects of this proposed regulation are attempting to add to this shift, sometimes in ways that conflict with the statute.

We are concerned about the changes in the proposed rule that would let insurers offer coverage that is less comprehensive than is currently allowed on the ACA marketplaces, making shopping for health coverage more complicated and exposing people to higher medical costs. The proposed rule also imposes multiple new documentation barriers that will make it harder for eligible people to enroll in and maintain marketplace coverage. Many of the proposals in this rule would result in people losing marketplace coverage, adding to projected health coverage losses from the expiration of the premium tax credit (PTC) enhancements, P.L. 119-21 (also known as the One Big Beautiful Bill Act), and the 2025 Marketplace Integrity and Affordability rule. We urge CMS to reconsider these proposals and instead take action to help people maintain their health coverage and afford their basic needs amid this upheaval.

Sincerely,

Claire Heyison, Senior Policy Analyst

Nicole Rapfogel, Senior Policy Analyst

Jennifer Sullivan, Director of Health Coverage Access

Gideon Lukens, Senior Fellow and Director of Research and Data Analysis

Sarah Lueck, Vice President for Health Policy

Part 154 – Health Insurance Issuer Rate Increases: Disclosure and Review Requirements

CMS proposes to greatly expand the information collected from marketplace insurers as part of annual rate filing justifications, saying this is needed to better understand cost-sharing reduction (CSR) loading practices. In the preamble, CMS indicates that it would use this information to help ensure that CSR loading practice is “calibrated on actual experience and...only accounts for the projected revenue loss of unreimbursed CSR payments without materially exceeding that amount.”

We are concerned that CMS’s preamble discussion about defining an actuarially justified CSR load factor as “one that is calibrated on actual experience” indicates a push for rating practices that would violate federal rules. The statute requires insurers to set rates based on a single risk pool that includes all of an insurer’s enrollees in a given market. The law identifies specific factors by which rates can vary (number of people plan covers, geographic rating area, age, and tobacco use) and generally prohibits insurers from considering the claims experience of only a plan’s covered population when setting rates for that plan. These changes were critical advances in consumer protection, promoting stability and access to comprehensive coverage in the individual insurance market and prohibiting insurer practices that were common prior to the ACA.

If CMS considers changes in this area, it should prioritize affordability of coverage for people who rely on the marketplace and avoid implementing policies that would reduce affordability and coverage. It is critical for the agency to avoid attempting to make changes to rating practices that conflict with federal law and also to transparently analyze the effect of potential policy change on people, including differential impacts on people in different states. For instance, ending or limiting silver loading would increase what many people would have to pay for marketplace coverage, worsening affordability and leading more people to become uninsured.

CMS estimates that the new reporting requirements for CSR loading would cost issuers \$440 million in the first year. These costs would be passed along in the form of higher premiums. The proposed data collection could be especially challenging because CMS would require insurer data from 2025 that may not be readily available. Should CMS choose to implement this proposal, we urge the agency to consider ways to make data collection less expensive and avoid related premium increases. We also encourage CMS to consider delaying implementation of this provision until at least 2029, after the marketplace-related provisions of PL 119-21 have gone into effect. This would reduce the data collection burden and avoid adding to what is already likely to be a time of significant turmoil in the insurance market.

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

CMS proposes discontinuing standardized plan option policies, including requirements for issuers to offer these plans, differential display of these plans, and requirements for plans to meaningfully differ from one another. We oppose these changes because they may make it more difficult for enrollees to consider plan options, find higher quality plans, and afford cost-sharing requirements.

Rising enrollment in standardized plans in recent years demonstrates enrollee desire for these offerings. In plan year 2023, 20 percent of people in the federally facilitated marketplace (FFM) and

state-based marketplaces on the federal platform (SBM-FPs) were enrolled in standardized plans. In 2024 and 2025, this rose to 33 percent. Notably, in 2024, limits on non-standardized options took effect, reducing choice overload.

We support the implementation of standardized plan designs as a strategy to address choice overload and reduce enrollees' out-of-pocket costs, but far more could be done via federal policy to strengthen standardized plans so that they help reduce people's out-of-pocket costs and advance health equity. Several jurisdictions, including Colorado and the District of Columbia, have employed standardized plan designs to reduce cost-sharing charges for services and medications that address health conditions disproportionately impacting people of color. For example, Colorado standardized plans offer lower cost sharing for services targeted to reduce racial health disparities and improve health equity, including primary care, pre/postnatal care, and mental health/substance use disorder visits and diabetic supplies with no cost sharing.¹ District of Columbia standardized plans waive cost sharing for insulin and other diabetes supplies.²

Standardized plans guarantee access to important services before someone has met their deductible (for example, emergency room services, primary care visits, and mental health and substance use disorder treatment); they also apply fixed-dollar copayments instead of coinsurance to certain services, making it easier for people to understand their charges. Instead of eliminating standardized plans altogether, CMS should improve standardized plan designs to include more pre-deductible services and fewer services with coinsurance. Marketplace enrollees identify high deductibles, coinsurance, and other cost sharing as major barriers to affording and accessing care.³ In one survey of marketplace enrollees, 61 percent reported difficulty affording out-of-pocket health costs.⁴ In addition, CMS should work with health care advocates, community-based organizations, and enrollment assisters to examine enrollees' experiences and preferences in the FFM and in state-based marketplaces (SBMs) that have adopted standardized plan designs.

The meaningful difference standard for standardized plans within the same product network type, metal level, and service area is an important consumer protection policy. It aligns with CMS's goal of

¹ R. Vincent Pohl, *et al.*, "Analysis of Colorado Option, pursuant to § 10-16-1310, C.R.S.," *Mathematica*, January 16, 2026, <https://doi.colorado.gov/sites/doi/files/documents/CO-Option-10-16-1304-Report.pdf>; Johanna Butler, "Improving Insurance Access, Affordability, and Equity: Updates on the Colorado Option," *National Academy for State Health Policy*, August 23, 2022, <https://nashp.org/improving-insurance-access-affordability-and-equity-updates-on-the-colorado-option/>.

² Karen Pollitz, Justin Lo, and Rayna Wallace, "Standardized Plans in the Health Care Marketplace: Changing Requirements," *KFF*, May 8, 2023, <https://www.kff.org/private-insurance/standardized-plans-in-the-health-care-marketplace-changing-requirements/>.

³ Center on Budget and Policy Priorities, "Building on the Affordable Care Act: Strategies to Address Marketplace Enrollees' Cost Challenges," April 10, 2024, <https://www.cbpp.org/research/health/building-on-the-affordable-care-act-strategies-to-address-marketplace-enrollees>.

⁴ Lunna Lopes, *et al.*, "2025 Marketplace Enrollees Survey," *KFF*, December 4, 2024, <https://www.kff.org/public-opinion/2025-kff-marketplace-enrollees-survey/>.

reducing choice overload and simplifying the plan selection process. Research has shown that too many plan choices can result in consumer confusion and suboptimal enrollment decisions.⁵

We oppose eliminating the meaningful difference standard, which may result in the proliferation of similar plans with subtle or indistinguishable differences, making it hard for people to make informed choices about their coverage. However, we acknowledge the current standard does not meet its full potential. Instead of eliminating the meaningful difference standard, CMS should build on it to make it more effective at reducing choice overload. We are concerned that the existing meaningful difference standard would still enable issuers to continue offering multiple plans that are, for consumers, indistinguishable from one another. We encourage the agency to continue the meaningful difference policy and provide more clarity on what constitutes a “meaningful difference” between health plans.

Approval of a State Exchange (§ 155.105)

We oppose rescinding the requirement for a state to operate as an SBM-FP at least one year, including its open enrollment period, prior to transitioning to operating an SBM. CMS claims that this requirement is not necessary because some states already perform plan management functions and because states are able to contract with third parties that have experience operating SBMs in other states. However, SBM functions are highly state specific and require coordination with other state agencies, as CMS acknowledged when it established this requirement: “[i]t is not possible for a State seeking to newly establish a State Exchange to identically apply development and implementation plans and other resources utilized for an eligibility platform in already-established State Exchanges, because in [HHS’s] experience, those exchanges may operate with partner State agencies, such as Medicaid and CHIP [Children’s Health Insurance Program], differently from the State that is seeking to newly establish a State Exchange.”⁶

The rationale CMS provides also ignores the benefit that an interim SBM-FP year has for other stakeholders, as CMS acknowledged when issuing this requirement. In the 2025 NBPP, CMS proposed this requirement in part so that states would have sufficient time to “establish relationships with interested parties critical to a State Exchange’s success in operating an Exchange, including standing up and operating a Navigator and consumer outreach program...and communicating effectively with consumers to support enrollment and avoid health care coverage gaps.” In our comments to the proposed rule, we agreed that operating an SBM-FP for one year before transitioning to an SBM would minimize disruption for applicants, enrollees, assisters, and

⁵ Rose C. Chu *et al.*, “Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces,” ASPE Office of Health Policy, December 28, 2021, <https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf>

⁶ Centers for Medicare & Medicaid Services, “Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program,” November 24, 2023, <https://www.federalregister.gov/documents/2023/11/24/2023-25576/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2025>.

other interested parties.⁷ This requirement also provides the state with sufficient time to alert these parties of changes to the website, application process, and assister training and certification process that may occur when the state transitions to an SBM. In the 2027 NBPP, CMS fails to address these considerations or the potential harm that rescinding this requirement would cause for consumers. For example, a shortened SBM transition might not leave sufficient time for navigators and brokers to understand, access, and provide feedback on the SBM website, resulting in longer application times for consumers.

Approval of a State Exchange (§ 155.106)

CBPP opposes the proposal to rescind the requirement for states transitioning to an SBM to provide supporting documentation demonstrating progress toward meeting State Exchange Blueprint requirements, or documentation that details a state's plans for how it intends to implement and meet the functional requirements laid out in the State Exchange Blueprint.

CMS claims that it is no longer necessary to require states to provide supporting documentation because historically, most states have done so voluntarily. However, requiring states to submit supporting documentation makes this process more transparent and predictable for states by specifying the types of documentation that will be required in advance. For example, when this requirement was proposed in the 2025 NBPP, CMS chose to highlight the potential need for states transitioning to an SBM to provide documentation demonstrating the state's capabilities for robust consumer assistance programs and targeted direct outreach. Requiring states to submit supporting documentation to demonstrate these capabilities could help CMS identify and prevent situations in which outreach to key stakeholders or communities are overlooked. Directives such as these provide insight into states' ability to operate their own marketplace beyond operational readiness considerations and allow states to better prepare for requests for supporting documentation.

We appreciate that CMS will continue to require states transitioning to an SBM to provide the public with notice and a copy of its State Exchange Blueprint application and conduct at least one public engagement. We also appreciate that CMS will continue to post State Exchange Blueprints to its public-facing website within 90 days of receipt. These actions increase transparency in the SBM transition process, facilitate stakeholder and community input, and enable third parties to monitor the impact of the transition. We encourage CMS to additionally require states transitioning to an SBM to solicit and respond to public comment, which would enable the state to incorporate community members' concerns and ideas.

Amending Requirements for State Exchanges to Operate a Centralized Eligibility and Enrollment Infrastructure (§§ 155.205(b) and 155.221(k))

We strongly oppose CMS's proposal to eliminate the requirement that SBMs must operate a centralized eligibility and enrollment platform that allows users to apply for Medicaid and the ACA

⁷ Centers for Medicare & Medicaid Services, "Comment on CMS-2023-0191-0003," January 9, 2024. <https://www.regulations.gov/comment/CMS-2023-0191-0089>.

marketplace. And we strongly oppose CMS's proposal to let SBMs deprive their residents of the option to enroll through a public marketplace and instead require them to enroll exclusively through private web brokers and insurers (referred to as the SBM-EDE option). This proposal is contrary to the statute, circumvents the statutory waiver process, and would expose more consumers to the flaws of enhanced direct enrollment (EDE), potentially leading to an increase in unauthorized enrollment activity.

The ACA created, through health insurance exchanges, a credible, transparent, and centralized source where people can buy coverage for themselves and their families. This change helped bring much-needed order to a chaotic and uneven individual insurance market and empowered people to make informed choices to protect their own health and finances. At the time the law was enacted, legal scholar Sara Rosenbaum wrote: "Exchanges are meant to simplify and ease health insurance purchasing by creating a one-stop shopping market for insurance products that qualify for federal tax subsidies and that meet federal and state standards."⁸ The statute requires an exchange that is a "governmental agency or nonprofit entity" to "make available qualified health plans to qualified individuals." Furthermore, a marketplace "facilitates the purchase of qualified health plans." The role of agents and brokers is restricted to assisting in enrollment when "the plan is offered through an Exchange in the State." Limiting the role of a state Exchange to the back end of a website and fully handing enrollment over to private entities is clearly contrary to the letter and spirit of the law and would pose serious risks to people who rely on the marketplace for their health insurance.

The proposed rule also attempts to establish the SBM-EDE pathway as a state option when a waiver should be required. In 2020, CMS approved Georgia's 1332 waiver proposal to use EDE processes in lieu of HealthCare.gov or a state marketplace – acknowledging that the state needed a waiver of Section 1311 of the ACA in order to do so. Among other problems, circumventing the waiver process is an end run around the statutory requirement for notice and comment to seek consumer input on wholesale changes in the way health insurance enrollment operates. Under the SBM-EDE option, CMS would require states to submit an implementation plan and timeline and demonstrate that at least one EDE entity meets federal accessibility requirements and is capable of enrolling all consumers in the state into all available qualified health plans (QHPs). First, it is problematic that CMS would only require one EDE entity in the state to meet the aforementioned standards, allowing all other EDE entities to limit QHP offerings and skirt accessibility requirements. Second, CMS conspicuously leaves out a requirement for any public input prior to approval of such an arrangement. And there are a lot of reasons to think the public would object: Georgia's 1332 waiver had eight supporters, out of 1,826 public comments.⁹

Moreover, EDE has numerous weaknesses. First, unscrupulous agents and brokers have used EDE platforms to enroll people in marketplace coverage or change their plan without the person's

⁸ Sara Rosenbaum, "The Patient Protection and Affordable Care Act: implications for public health policy and practice," Public Health Reports, Vol. 126, Iss. 1, Jan-Feb 2011, <https://pmc.ncbi.nlm.nih.gov/articles/PMC3001814/>.

⁹ Center on Budget and Policy Priorities, "Sabotage Watch: Tracking Efforts to Undermine the ACA," February 2, 2021, <https://www.cbpp.org/research/health/sabotage-watch-tracking-efforts-to-undermine-the-aca-0?item=28647>.

knowledge, in order to gain commissions.¹⁰ In the preamble to the rule, CMS acknowledges that “a notable driver of ... continued payment integrity concerns...is agent, broker, and web-broker behavior.” Of note, a recent class action lawsuit against a broker and call center alleged that EDE platforms were “the key” to the companies’ ability to fraudulently “enroll large numbers of customers in a short amount of time without scrutiny.”¹¹ Meanwhile, broker-initiated plan changes and agent-of-record switches on the FFM dropped precipitously after CMS took steps to prevent brokers from changing a person’s coverage through EDE channels.¹² Given this history, allowing states to operate their marketplaces solely using EDE seems counter to the agency’s goal of reducing unauthorized enrollment.

Web brokers’ commission-based compensation structure gives them incentives that often don’t align with the interests of people applying for and enrolled in marketplace plans. Web brokers are not required to display all marketplace plans available within a consumer’s rating area and may omit plans for which they receive no commission or that they are not licensed to sell. They are incentivized to steer consumers to coverage that is not ACA-compliant and carries significant consumer risks, as brokers are often more highly compensated for selling non-ACA-compliant products than they are for marketplace plans.¹³ Forcing consumers to rely solely on EDE without the backstop of a state-operated marketplace would increase the risk that they are steered toward products that do not meet their needs and expose them to high costs.

Requiring people to rely on brokers and direct enrollment websites presents new barriers for people who turn out to be eligible for Medicaid or CHIP, increases the complexity for people trying to get health coverage, and undermines the “no wrong door” policy of the ACA. Brokers and agents have no incentive to assist people with enrolling in Medicaid and CHIP, and in some instances they have ignored potential eligibility for these programs, screened people incorrectly, or steered people away from the single-streamlined application.¹⁴ As the “Find Local Help” page on HealthCare.gov says: while navigators and other enrollment assisters are trained and certified by the marketplace to

¹⁰ Julie Appleby, “Exclusive: Senator Urges Biden Administration To Thwart Fraudulent Obamacare Enrollments,” KFF Health News, March 21, 2024, <https://kffhealthnews.org/news/article/aca-enrollment-fraud-senator-ron-wyden-urges-biden-administration-crackdown/>.

¹¹ *Conswallo Turner, et al. v. Enhance Health, LLC, et al.* <https://litigationtracker.law.georgetown.edu/litigation/conswallo-turner-et-al-v-enhance-health-llc-et-al/>; Department of Justice, “President of Insurance Brokerage Firm and CEO of Marketing Company Sentenced in \$233M Affordable Care Act Enrollment Fraud Scheme that Preyed on Vulnerable Consumers,” February 18, 2026, <https://www.justice.gov/opa/pr/president-insurance-brokerage-firm-and-ceo-marketing-company-sentenced-233m-affordable-care>

¹² Centers for Medicare & Medicaid Services, “CMS Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity,” October 17, 2024, <https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity>.

¹³ U.S. Government Accountability Office, “Private Health Coverage: Results of Covert Testing for Selected Offerings,” August 24, 2020, <https://www.gao.gov/products/gao-20-634r>.

¹⁴ Tara Straw, “‘Direct Enrollment’ in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm,” Center on Budget and Policy Priorities, March 15, 2019, <https://www.cbpp.org/research/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes-them-to>.

help with marketplace, Medicaid, and CHIP enrollment, brokers and agents are only trained to help with marketplace enrollment.

CMS's own oversight of EDEs has exposed serious concerns about their operations. CMS recently terminated EDE agreements with two platforms after finding that their parent company illegally shared consumer data overseas and exposed personally identifying information.¹⁵ CMS suspended – and subsequently reinstated – the parent company four times between 2018 and 2024, despite concerns that the company submitted false Social Security Numbers, failed to verify consumers' identity, and shared consumers' sensitive information overseas.¹⁶ It is alarming that it took CMS seven years to resolve what it refers to as “intentional, serious, long-term, and repeated violations.” The process of holding bad actors accountable is likely to be more complex and drawn-out if federal regulators delegate oversight of EDE to states, as this proposal would do, because states have fewer resources to dedicate to oversight and enforcement.

CMS also requests comment on whether the FFM should abandon HealthCare.gov and shift to an all-EDE approach to eligibility and enrollment. CMS should reject this idea. It would only amplify the concerns noted above and expose many more people to potential harm, confusion, and wrong doors. In addition, it would eliminate consumer choice across the country, by forcing everyone to enroll through private insurers' and brokers' web sites.

Ability of States to Permit Agents and Brokers and Web-Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§155.220(j))

We support the proposal at § 155.220(j)(2) to mandate a standard eligibility application review form and consumer consent form for consumers using the FFM or enrolling through a an SBM-FP. We agree with the assessment that current consent documentation requirements allow for inconsistent and incomplete documentation and do not provide uniform consumer protections. Large numbers of consumers have been harmed by agent, broker, and web-broker activity that either enrolled people in a marketplace plan or switched their marketplace plan without the consumer's knowledge or consent. Implementing a standardized consent form will help ensure consumers are more consistently protected from agents, brokers, and web-brokers taking action on their behalf without their consent.

While we generally support the model consent form provided, we recommend adding language to the “CMS Model Eligibility Application Review Form for Marketplace Agents, Brokers, Web-

¹⁵ Centers for Medicare & Medicaid Services, “Re: Notice of Final Determination of Noncompliance and Denial of Right to Enter into Future Exchange Agreements,” November 24, 2025, <https://www.cms.gov/files/document/speridian-notice-final-determination.pdf>.

¹⁶ Stacey Pogue, Justin Giovannelli, and Sabrina Corlette, “Federal Efforts Ostensibly Aimed at Marketplace ‘Fraud’ Ignore Obvious Strategies to Counter Broker Misconduct,” Georgetown Center on Health Insurance Reforms, June 10, 2025, <https://chir.georgetown.edu/federal-efforts-ostensibly-aimed-at-marketplace-fraud-ignore-obvious-strategies-to-counter-broker-misconduct/>.

brokers, and Agencies”¹⁷ that states that the agent, broker, web-broker, or agency must provide login credentials used to create the consumer’s marketplace account to the consumer and notify the consumer that they may log into their account or request assistance with their account through the marketplace website or from the marketplace call center at any time. We believe this is important because consumers may not understand that they are not obligated to work with an agent or broker to enroll or re-enroll in a QHP, nor are they required to work with the *same* agent or broker every time they request assistance with their coverage or account. We believe this empowers consumers by informing them of their right to their own marketplace account information.

We also recommend that CMS test the new proposed consent form with consumers, including individuals with disabilities and individuals with limited English proficiency, and make changes based on testing results to ensure the form is as accessible and easy for consumers to understand as possible.

We support the proposal at 155.220(j)(3) to create new standards of conduct related to agent, broker, and web-broker marketing. We are aware of egregious marketing practices that some lead generation and other entities seeking to make a profit have used to mislead consumers—particularly vulnerable populations including people experiencing homelessness, people with mental health and substance use disorders, and people who are immigrants—into disclosing their personally identifiable information (PII), and subsequently using this information to enroll the individual in a QHP without their knowledge or consent.¹⁸

We support prohibiting agents, brokers, web-brokers and agencies from providing gifts or “cash, monetary rebates, gift cards, travel vouchers, or cash equivalents to induce consumers to enroll or for other purposes” as laid out in 155.220(j)(3)(iii). We encourage CMS to strengthen these protections by adding a new sub-paragraph 155.220(j)(3)(iii)(H) that prohibits agents and brokers from marketing coverage that is not a QHP in ways that could cause an individual to assume otherwise. QHPs convey specific federal consumer protections and are the only plans that can be purchased with PTCs and CSRs. It is important that consumers can distinguish whether marketing materials refer to QHPs or to other non-group private coverage (which may have lower premiums or other marketable features that make them more attractive than QHPs if compared as though the two were equal). We recommend adding the following subparagraph:

(H) Marketing health coverage that is not a qualified health plan in a manner that could be construed to conflate these products with comprehensive coverage.

¹⁷ Centers for Medicare & Medicaid Services, “CMS Model Consent Form for Marketplace Agents, Brokers, Web-brokers, and Agencies,” <https://www.cms.gov/marketplace/agents-brokers/files/cms-model-consent-form-marketplace-agents-brokers.pdf>.

¹⁸ U.S. Department of Justice, “Press Release: President of Insurance Brokerage Firm and CEO of Marketing Company Sentenced in \$233M Affordable Care Act Enrollment Fraud Scheme that Preyed on Vulnerable Consumers,” February 18, 2026, <https://www.justice.gov/opa/pr/president-insurance-brokerage-firm-and-ceo-marketing-company-sentenced-233m-affordable-care>.

We also encourage CMS to clarify that agents and brokers will be responsible for ensuring that the materials of any lead generators or field marketing organizations they work with also adhere to these marketing standards. This may be implied in 155.220(j)(3)(v), but more explicit clarification in guidance would be helpful.

We oppose the proposed revisions to the definition of “sex” that would remove “(which includes discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes)” from 155.220(j)(3)(ii). This change would be harmful to women, pregnant people, and transgender people, all of whom are legally protected from discrimination by Section 1557 of the ACA. The existing text of the regulation is needed to support meaningful enforcement of the nondiscrimination protections in Section 1557.

Without these protections, women, pregnant people, and transgender people could be subject to sex discrimination, discriminatory steering, misinformation, and hostile treatment while working with agents, brokers, and web-brokers to compare and select a QHP.

Transgender individuals, in particular, face significant discrimination in many dimensions of public life, including in employment, housing, and when seeking health coverage and care.¹⁹ Transgender individuals are also more likely to be uninsured or to have Medicaid or ACA marketplace coverage compared to the general population.²⁰ Therefore, we disagree with the assertion that changing the definition of “sex” in the regulation will not result in or facilitate discrimination against transgender individuals. These individuals are more likely than the overall population to rely on the marketplace for health insurance, or to be uninsured but potentially eligible for insurance through the marketplace. They should receive the same protections against discriminatory agent and broker marketing and conduct as other protected groups.

Limit APTC Eligibility to “Eligible Noncitizens” (45 CFR 155.20; 45 CFR 155.305(f)(1); 45 CFR 155.320(c)(3) and 42 CFR 600.5)

CMS proposes to modify the current marketplace regulations to add a new section 155.320(c)(3)(ix) related to verification of eligible non-citizen status. We oppose this proposal as an unnecessary change. The new P.L. 119-21 insurance affordability eligibility restrictions based off immigration status can be accommodated by modifying the verification regulation in § 155.315(c)(2) to include the new immigration-related eligibility standard for premium tax credits. The revised regulation could read:

Verification with the records of the Department of Homeland Security. For an applicant who has documentation that can be verified through the Department of Homeland Security and who

¹⁹ Jamie M. Grant, *et al.*, “Injustice at Every Turn: A Report of the National Transgender Discrimination Survey,” National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011, https://transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf.

²⁰ Ankit Rastogi, *et al.*, “Health and wellbeing: A report of the 2022 U.S. Transgender Survey. Advocates for Transgender Equality,” June 2025, <https://ustranssurvey.org/download-reports/>.

attests to lawful presence, **having an eligible noncitizen immigration status as defined at § 155.20**, or who attests to citizenship and for whom the Exchange cannot substantiate a claim of citizenship through the Social Security Administration, the Exchange must transmit information from the applicant's documentation and other identifying information to HHS, which will submit necessary information to the Department of Homeland Security for verification.

If CMS decides to move forward with this new redundant section, it should include the same language under § 155.315(c)(2) that directs HHS to submit only necessary information to the Department of Homeland Security (DHS) for verification. The ACA clearly articulates that this exchange of information at 1411(c)(2)(B)(ii)(I) must be from HHS to DHS and limits information submitted by HHS to DHS to: name, date of birth, immigration-related information, and attestation of eligibility based off status. Any new regulation should reiterate these provisions in the ACA.

Failure to File and Reconcile (FTR) Policy (§ 155.305)

The proposed rule would require all exchanges to find an individual ineligible for APTC if the individual has not reconciled their APTC for one year (referred to as “failure to reconcile” or FTR). CMS proposes implementing this one-year FTR in plan year (PY) 2027 for the FFM and would require SBMs to implement the requirement no later than PY 2028. We believe that implementing one-year FTR before PY 2028 (when it becomes a requirement for marketplace enrollees to receive APTC, pursuant to P.L. 119-21) is contrary to law. This requirement as promulgated in CMS’s Marketplace Integrity and Affordability final rule last year is currently being challenged in *City of Columbus et al. v. Kennedy et al.*, and the provision was stayed by the District Court for the District of Maryland. The court found no statutory basis for the provision in 2026. We do not believe CMS has the authority to put a near-identical one-year FTR requirement in place in any state in 2027.

In addition to the legal arguments, we believe implementing one-year FTR in 2027 poses added administrative burden on enrollees that outweigh any potential program integrity enhancements or protection from “tax liability” for APTC recipients. In previous rulemaking, CMS acknowledged that the FTR policy is burdensome both for enrollees and marketplaces and could result in enrollees losing access to affordable coverage due to inaccurate data or a misunderstanding of the requirement.²¹ Many people are flagged unnecessarily, in part because the data transferred to the marketplace by the Internal Revenue Service (IRS) are not fully up to date and may not capture people who filed their tax return late or by mail.

²¹ U.S. Department of Health and Human Services, “Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024,” December 21, 2022, <https://www.govinfo.gov/content/pkg/FR-2022-12-21/pdf/2022-27206.pdf>.

These tax data delays are likely to grow, based on findings from the Treasury Inspector General for Tax Administration's recent report on agency readiness for the 2026 tax filing season.²² The report finds that staffing levels at the IRS are below October 2021 levels following workforce reduction efforts in 2025; backlogs persist in processing amended tax returns and taxpayer correspondence; hiring and onboarding new staff has been delayed due to the government shutdown in fall 2025; and efforts to create new efficiencies in processing systems have lagged. CMS paused the FTR process in 2021 because of concerns that people would lose coverage due to IRS processing delays. Similar processing delays currently exist with little sign of being resolved in advance of PY 2027 when CMS proposes to implement one-year FTR in the federal marketplaces.

Even if the FTR resolution process were timelier and more streamlined, we believe it is inappropriate to withhold affordable coverage as a program integrity measure in advance of the requirement from P.L. 119-21 that links one-year FTR to APTC availability. ACA marketplaces already utilize several mechanisms to ensure program integrity, including identity verification, data matching, and internal financial controls, and CMS took additional actions beginning in 2024 to identify and thwart potential unauthorized enrollment.²³ The IRS also has its own mechanisms for recouping unpaid tax obligations. When a person who has claimed APTC submits their tax return without reconciling APTC, the IRS rejects the return and the taxpayer receives notice of their need to reconcile (a 12C letter).²⁴ The IRS can also reconcile the APTC by issuing a substitute return (an IRS-generated return prepared for non-filers with a filing requirement) or through the collections process, with standard financial penalties.

We also disagree with CMS's argument that exchanges should begin implementing one-year FTR in PY2027 to protect people from accumulating tax liabilities. The expiration of APTC repayment limits beginning in PY 2026 (as required by P.L. 119-21) will cause some enrollees to have higher repayment obligations going forward. But this is true for any individual whose income projection is lower than their actual income for a given year. There are ways to communicate this change more effectively than an isolated FTR process that affects a small proportion of total APTC recipients.²⁵ If one-year FTR were implemented in the FFM in PY 2027, we believe the administrative burden and loss of APTC among eligible individuals due to IRS backlogs would likely affect more people than

²² Treasury Inspector General for Tax Administration, "Memorandum for Commissioner of Internal Revenue: The Internal Revenue Service's Readiness for the 2026 Filing Season (Audit No.: 2026400002)," January 26, 2026, <https://www.tigta.gov/sites/default/files/reports/2026-01/2026400002-Readiness-Memo.pdf>.

²³ Centers for Medicare & Medicaid Services, "Press Release: CMS Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity," October 17, 2024, <https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-broker-marketplace-activity>.

²⁴ Internal Revenue Service, "How to correct an electronically filed return rejected for a missing Form 8962," updated November 9, 2025, <https://www.irs.gov/newsroom/how-to-correct-an-electronically-filed-return-rejected-for-a-missing-form-8962>.

²⁵ For example, as of August 2025, 199,165 individuals lost APTC in the FFM due to 2-year FTR. This represents approximately 1.3 percent of all FFM enrollees receiving APTCs. See CMS Effectuated Enrollment Data <https://www.cms.gov/files/document/first-five-months-effectuated-enrollment-tables.xlsx> and CMS 2025 FTR data <https://www.cms.gov/files/document/failure-file-and-reconcile-data-plan-year-2025.xlsx>

the number of people who would avoid accumulating tax liabilities as a result of one-year FTR. The number of people who would lose APTC, and thus would avoid a tax liability, would be 28,500 by CMS's own estimates. As explained above, there are many reasons why the relatively small number of marketplace enrollees with FTR status do not file and reconcile, and sufficient enforcement tools already exist for the IRS to recoup unpaid taxes from tax filers without CMS also withholding access to marketplace health insurance through an FTR process.

Comment Solicitation on Eligibility Verification Provisions of the WFTC legislation, Section 71303

We are concerned about the increased administrative burden and resulting delays in enrollment and coverage loss as well as the negative impact on the risk pool that will result from the implementation of Sec. 71303 of P.L. 119-21. This provision essentially eliminates provisional eligibility (the period after an individual has submitted their application but before they have resolved any data matching issues (DMIs) associated with the application) and automatic re-enrollment, which more than half of returning marketplace enrollees relied on for reenrollment in 2025.²⁶ These two longstanding features of the ACA marketplaces reduce friction for enrollees and promote continuity of coverage and of health care. External analyses have found that some 4.7 million APTC recipients could receive DMIs and be at risk of losing PTCs starting in 2028 due to these new verification requirements.²⁷ CMS should take steps to reduce APTC and coverage loss among eligible enrollees.

In its implementation-related rulemaking and other activities, we recommend CMS do the following:

- Increase funding for navigators serving the FFM. P.L. 119-21 calls for individuals to meet the new pre-enrollment verification requirements by August 1 of a given year. People will need assistance understanding and complying with these new verification requirements, yet CMS cut federal funding for navigators by 90 percent last year.²⁸ To cope with these cuts, navigator organizations have sharply reduced staff and subgrants to partner organizations. In some cases, funding cuts have been so severe that navigator organizations can no longer offer assistance outside of open enrollment or can only maintain one navigator on staff to provide assistance for the entire state. Providing additional funding will allow navigators to increase staffing to support both outreach and

²⁶ Centers for Medicare & Medicaid Services, "Marketplace Open Enrollment Period Public Use Files for 2025," May 12, 2025, <https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files>.

²⁷ Zachary Sherman, Michael Cohen, and Lina Rashid, "2027 Proposed NBPP: Analyzing State and Consumer Impacts New and Returned Trump Administration Policy Priorities," Health Management Associates, March 2026, <https://www.healthmanagement.com/insights/briefs-reports/2027-proposed-nbppanalyzing-state-andconsumer-impacts/>.

²⁸ Centers for Medicare & Medicaid Services, "CMS Announcement on Federal Navigator Program Funding," February 14, 2025, <https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding>.

education around these new requirements as well as individual appointments with enrollees to support their compliance with the new requirements.

- Issue guidance quickly to provide states and marketplaces with ample time to prepare systems, training, and outreach and communication strategies in advance of August 1, 2027.
- Maximize flexibility for SBMs, where there is little evidence of unauthorized enrollment.
- Provide a special enrollment period (SEP) for anyone denied APTC for any month as a result of the new verification requirements.

Income Verification Policy When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320 (c)(3)(iii))

In the 2025 Marketplace Integrity and Affordability Rule, CMS required all marketplaces to generate an income inconsistency for applicants who attest to household income between 100 and 400 percent of the federal poverty level (FPL) but for whom other data available to the marketplace indicate the individual has income less than 100 percent of FPL. This policy was scheduled to sunset at the end of 2026. This provision is being challenged as part of *City of Columbus et al. v. Kennedy et al.*, and the provision was stayed by the District Court for the District of Maryland; it is not currently being implemented. The proposed rule reintroduces this provision and removes its sunset date. We oppose this proposal.

CMS notes that on the FFM it has continued to detect instances of improper enrollments by agents, brokers, and web-brokers. But this proposal would make the enrollment process more difficult for *all* applicants (including applicants in states with SBMs, where unauthorized enrollment is virtually unheard of, and applicants in states that have expanded Medicaid, where there is no discernable coverage incentive to overstate income).²⁹ This would cause more people to go uninsured and harm the marketplace risk pool, while failing to target the entities responsible for unauthorized enrollments.

The United States District Court for the District of Maryland decided *City of Columbus, et al. v. Cochran*, No. 523 F. Supp. 3d 731 (D. Md. 2021) and vacated earlier CMS revisions to income verification, stating that “CMS’s decision to prioritize a hypothetical risk of fraud over the substantiated risk that its decision result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic.” We believe CMS continues to prioritize hypothetical risk over substantiated risk in ways that will harm individuals who are eligible for PTC but may be unable to receive PTC as a result of this proposal.

²⁹ Stacey Pogue, “Stakeholder Perspectives on CMS’ Proposed “Marketplace Integrity” Rule: State Insurance Departments and Marketplaces,” Georgetown Center for Health Insurance Reforms, May 12, 2025, <https://chir.georgetown.edu/stakeholder-perspectives-on-cms-proposed-marketplace-integrity-rule-state-insurance-departments-and-marketplaces/>.

CMS cites evidence from a 2025 Government Accountability Office (GAO) report, claiming that opportunities continue to exist for people to enroll through HealthCare.gov or an agent or broker without completing the DMI resolution process.³⁰ However, this report focuses on fictitious applicants and whether the fictitious applicants were required to resolve DMIs and whether or not they continued to receive APTC following such requests. This report does not suggest that increasing the number of individuals who *receive* DMIs—as this proposal would do—would enhance program integrity. The authors of the report also note that its results cannot be extrapolated to draw wider conclusions generalizable to the overall enrollment population. Nevertheless, that is precisely what CMS attempts to do in its explanation of the necessity for this provision.

This proposal would increase the number of marketplace applicants who must submit paperwork to resolve a DMI by more than half a million individuals per year according to CMS’s calculations, and external analyses suggest that the total number could be even higher.³¹ Increasing paperwork requirements poses an administrative barrier that makes it less likely that applicants will complete the process and maintain coverage, particularly healthy applicants without an immediate health care need, who are more likely to forgo enrollment altogether because of the time and hassle required to submit verification paperwork.³² This will be exacerbated when new verification requirements from P.L. 119-21 take effect for PY 2028, because coverage will not begin until after a person has resolved any DMIs.

Previously, CMS shared data suggesting that income DMIs have a negative impact on access to coverage, health equity, and the risk pool.³³ Data from PY 2022 demonstrate that income DMIs have a disproportionate impact on households with attested income less than \$25,000. CMS has also previously shared data showing that income DMI expirations are “higher than expected” among Black or African American consumers and that younger people (ages 25 to 35) were the age group most likely to lose their APTC eligibility because of an income DMI. A policy that presents barriers to coverage for people with low incomes, Black people, and younger people is problematic, as these groups have historically had disproportionately high uninsurance rates.

³⁰ U.S. Government Accountability Office, “Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist,” December 2025, <https://www.gao.gov/products/gao-26-108742>.

³¹ Zachary Sherman, Michael Cohen, and Lina Rashid, “2027 Proposed NBPP: Analyzing State and Consumer Impacts New and Returned Trump Administration Policy Priorities,” Health Management Associates, March 2026, <https://www.healthmanagement.com/insights/briefs-reports/2027-proposed-nbppanalyzing-state-andconsumer-impacts/>.

³² Centers for Medicare & Medicaid Services, “Fact Sheet: Strengthening the Marketplace – Actions to Improve the Risk Pool,” June 8, 2016, <https://www.cms.gov/newsroom/fact-sheets/strengthening-marketplace-actions-improve-risk-pool>.

³³ U.S. Department of Health and Human Services, “Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024,” December 21, 2022, <https://www.govinfo.gov/content/pkg/FR-2022-12-21/pdf/2022-27206.pdf>.

In 2025, approximately 45 percent of marketplace enrollees had income between 100 and 150 percent of poverty, and many likely had income that fell below the poverty level in certain months of the year.³⁴ It can be difficult for people with very low incomes to accurately project annual income and obtain written documentation of their income projections.³⁵ Many people with low incomes work part-time or in hourly positions, where an employer may be reluctant to certify anticipated year-end income. Many people rely on multiple part-time or part-year jobs, including people who depend on seasonal employment at the end of the year to make ends meet. Many work in cash industries, such as food service, where tip income makes up the largest portion of their earnings. In all these cases, income can be volatile and documentation from an employer may be hard to obtain, which could lead to loss of APTC and loss of insurance for working individuals. Having a volatile or difficult-to-document income should not be conflated with an intentional attempt to mischaracterize income.

Regardless of someone's ability to gather statements from employers to justify the income attestation, the process itself may be too confusing or daunting for people to pursue. This is particularly true of people with low literacy or numeracy; this policy is likely to have a disproportionate negative impact on these individuals.

CMS states that this policy is necessary on an ongoing basis to protect individuals from accumulating unnecessary tax liabilities given the elimination of APTC repayment caps under P.L. 119-21. However, in its Marketplace Integrity and Affordability Rule finalized last year, CMS took the opposite approach, arguing that increasing income verification requirements was necessary because the federal government could not recoup all excess premium payments from individuals. This inconsistent reasoning weakens an argument we already find lacking. People can experience income and household changes at any time during the year that could lead to higher tax liabilities now than in the past when APTC repayment caps were in place. This is not sufficient justification for making it harder for a specific subset of very low-income individuals to enroll.

Removal of the Requirement to Accept Attestations of Household Income When Tax Data is Unavailable
(§ 155.320(c)(5))

CMS proposes to permanently remove the requirement to accept attestations of household income when tax data are unavailable. Last year's Marketplace Integrity and Affordability Rule removed the requirement for 2026 only (although the provision is being challenged as part of *City of Columbus et al. v. Kennedy et al.*, and the provision was stayed by the District Court for the District of Maryland; it is not currently being implemented). The court found that CMS did not provide adequate evidence that income attestation in these circumstances contributed to fraud, explaining,

³⁴ Centers for Medicare & Medicaid Services, "2025 Marketplace Open Enrollment Period Public Use Files," May 12, 2025, <https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files>.

³⁵ Lauren Bauer, Chloe East, and Olivia Howard, "Low-income workers experience—by far—the most earnings and work hours instability," Brookings Institution, January 9, 2025, <https://www.brookings.edu/articles/low-income-workers-experience-by-far-the-most-earnings-and-work-hours-instability/>.

“if the agency cannot point to data showing that self-attestation meaningfully contributes to increased fraud, then the agency adopted an incongruent solution to the problem.” In its proposal to implement this policy in 2027 and beyond, CMS similarly fails to provide justification for this policy as a response to fraud.

CMS states that it has changed its position and now believes that the benefits of making this policy permanent outweigh the administrative burden on applicants, the potential negative risk pool impact, and the potential loss of coverage. We disagree and oppose this proposal to permanently require marketplaces to follow the full income verification and DMI resolution process when tax data are not available for an applicant.

As CMS has stated previously, there are many reasons that the IRS may not have tax return data for an individual including changes in family composition, changes in filing status, name changes, and an individual not having a filing requirement for the year in question. Processing delays at the IRS this year are likely to increase the number of people for whom data may be unavailable.³⁶ Triggering income DMIs for individuals in this situation (which CMS estimates will be nearly 2.8 million individuals per year) will add an administrative burden at the time of enrollment, which may deter the individual from completing the process and obtaining (or retaining) coverage.

CMS states that this policy is necessary on an ongoing basis to protect individuals from accumulating unnecessary tax liabilities given the elimination of APTC repayment caps under P.L. 119-21 and because unscrupulous agents, brokers, web-brokers, and other intermediaries may continue to intentionally misrepresent an individual’s income to get the individual the maximum APTC available. We disagree that adding documentation barriers to individuals for whom tax data are unavailable will protect them from unnecessary tax liabilities. Compared to when repayment caps were in place, the income and household changes people experience at any time during the year could lead to higher tax liabilities. This does not justify making it harder for people to enroll. If implemented as proposed, we believe the policy will reduce the number of eligible individuals who enroll and will negatively impact the marketplace risk pool because people with greater health care needs are more likely to complete the process and resolve any DMIs, whereas people who are healthier and expect to use less care are more likely to be deterred by administrative barriers.³⁷

We also question CMS’s reasoning that even with the expiration of PTC enhancements, many agents and brokers are misrepresenting people’s incomes to enroll them. CMS does not offer data from the most recent open enrollment period to support this assertion. Bad-actor agents, brokers, and web-brokers have no way to know whether IRS data are available for an individual and no

³⁶ Treasury Inspector General for Tax Administration, “Memorandum for Commissioner of Internal Revenue: The Internal Revenue Service’s Readiness for the 2026 Filing Season (Audit No.: 2026400002),” January 26, 2026, <https://www.tigta.gov/sites/default/files/reports/2026-01/2026400002-Readiness-Memo.pdf>.

³⁷ Mark Shepard and Myles Wagner, “Reducing Ordeals through Automatic Enrollment: Evidence from a Health Insurance Exchange,” Harvard Kennedy School Faculty Research Working Paper, January 2023, <https://www.hks.harvard.edu/publications/reducing-ordeals-through-automatic-enrollment-evidence-health-insurance-exchange>.

mechanism for targeting this group for unauthorized enrollment. And individuals who are victims of fraud would not be subject to increased tax liability; they can follow the steps CMS has outlined to get the situation corrected and receive an updated (or voided) 1095-A.³⁸ If CMS has evidence of agents and brokers misrepresenting income of consenting clients, it should use other enforcement tools at its disposal to hold these agents and brokers accountable rather than imposing new paperwork burdens on an entire group of applicants (whose tax data may be unavailable from the IRS through no fault of their own).

If finalized as proposed, this requirement would create significant burden for people attempting to enroll in marketplace coverage. When this provision was initially proposed in the 2025 Marketplace Integrity and Affordability Rule, CMS proposed to sunset it after one year, citing “the corresponding Exchange costs and consumer burden for additional income verification, potential negative risk pool impact, and potential loss of coverage for low-income consumers.” The 2027 proposed rule estimates that this provision would generate nearly 2.8 million additional DMIs annually, cost consumers more than \$69 million each year, and result in 407,000 people losing some or all of their APTC.³⁹ External estimates of the potential coverage loss that could result from this provision are significantly higher.⁴⁰ This could weaken the risk pool and result in fewer eligible individuals completing the enrollment process when they find the new obstacles insurmountable. And for some number of people with immediate health care needs, the proposed policy would reinstate a barrier to enrollment that these individuals would be more likely to resolve than individuals without immediate health care needs, which would result in fewer eligible individuals completing the enrollment process, contrary to the requirements of the law.

Comment Solicitation on Premium Payment Threshold (§ 155.400)

CMS seeks comment about whether to permanently disallow QHP issuers from implementing a fixed-dollar and gross percentage-based premium payment threshold for PY 2027 and beyond. We strongly believe that HHS should end its one-year moratorium that limits issuers to net percentage-based premium payment thresholds, set to expire at the end of PY 2026. If fixed-dollar and gross percentage-based premium payment thresholds remain unavailable on the FFM, state exchanges should have the flexibility to adopt these thresholds.

³⁸ Centers for Medicare & Medicaid Services, “Alert: Unauthorized Agent and Broker Activity on ACA Marketplace,” October 2024, <https://www.cms.gov/files/document/agent-broker-infographic-2024-final.pdf>.

³⁹ This may be an underestimate. When CMS initially proposed this provision in the 2025 Marketplace Integrity and Affordability Rule, it estimated that DMIs would increase by 2.1 million individuals and would cause 407,000 people to lose APTC. In the 2027 NBPP, it estimates that the proposal would generate 2.8 million DMIs (660,000 more DMIs than in the 2025 rule) and cause 407,000 people to lose APTC. It seems unlikely that a 30 percent increase in DMIs would lead to no increase in coverage loss.

⁴⁰ Zachary Sherman, Michael Cohen, and Lina Rashid, “2027 Proposed NBPP: Analyzing State and Consumer Impacts New and Returned Trump Administration Policy Priorities,” Health Management Associates, March 2026, <https://www.healthmanagement.com/insights/briefs-reports/2027-proposed-nbppanalyzing-state-andconsumer-impacts/>.

These new options were made available for PY 2026 and beyond but discontinued for PY 2026 by the 2025 Marketplace Integrity and Affordability Rule, meaning the new options never took effect. These options provide issuers with additional flexibility to help enrollees who miss nominal premium payments to remain covered. CMS stated limiting issuers to net percentage-based premium payment thresholds will reduce the number of people enrolled without their knowledge or consent by increasing the number of people whose coverage is terminated for nonpayment of premiums. CMS estimated that this change would result in more than 184,000 policy terminations among people who owe \$10 or less in PY 2026 alone.⁴¹ However, there is no evidence that these terminations would be for people improperly enrolled.

Reinstating the options for issuers to accept a percentage of gross premiums and fixed dollar amount premium payment thresholds would help protect people, particularly people with very low incomes, from losing coverage.

Robust evidence spanning decades in Medicaid and CHIP shows that premiums are a barrier to obtaining and maintaining coverage.⁴² And a growing body of evidence shows similar results in marketplace plans. One study showed that people who enrolled in zero-dollar premium plans (before those plans became more prevalent because of the enhanced PTC) stayed enrolled for 23 to 46 days longer compared to those with a premium; they were also more likely to be enrolled at 12 months.⁴³ In Massachusetts, observations of its pre-ACA marketplace found that one-quarter of its enrollees whose premiums increased from \$0 to \$3 per month did not pay, evidence pointing to the hassle costs of paying even a nominal premium.⁴⁴ As premiums rose to \$10 per month, enrollees showed more financial strain, as evidenced by additional plan switching.

The number of marketplace enrollees with *de minimis* premiums is not trivial. One study found that in 2022, 404,000 HealthCare.gov enrollees had small positive premiums of less than 0.5 percent of gross premium (an average of about \$3 per month).⁴⁵ This study estimates that eliminating this premium would increase enrollment by 48,000. CMS data corroborate the significant effect of small

⁴¹ Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, Proposed Rule, March 19, 2025, 45 CFR Parts 147, 155, and 156, <https://www.federalregister.gov/documents/2025/03/19/2025-04083/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability>.

⁴² Samantha Artiga, Petry Ubri, and Julia Zur, “The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings,” KFF, June 1, 2017, <https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-issue-brief>. (See footnotes 5 through 39.)

⁴³ Coleman Drake, *et al.*, “Financial Transaction Costs Reduce Benefit Take-Up: Evidence from Zero-Premium Health Plans in Colorado,” October 22, 2021, <https://ssrn.com/abstract=3743009> or <http://dx.doi.org/10.2139/ssrn.3743009>.

⁴⁴ Adrianna McIntyre, Mark Shepard, and Myles Wagner, “Can Automatic Retention Improve Health Insurance Market Outcomes?,” AEA Papers and Proceedings Vol. 111, 2021, https://scholar.harvard.edu/files/mshepard/files/automaticRetention_McIntyreShepardWagner_aeaPandP.pdf.

⁴⁵ Matthew Fiedler, “Eliminating small Marketplace premiums could meaningfully increase insurance coverage,” Brookings Institution, June 29, 2022, <https://www.brookings.edu/articles/eliminating-small-marketplace-premiums-could-meaningfully-increase-insurance-coverage/>.

premiums; in 2023, more than 81,000 total policies were terminated for nonpayment of less than \$5 and that another 103,000 individuals lost coverage for deficiencies between \$5 and \$10.⁴⁶ These data show that thousands of people suffer the harsh penalty of coverage loss for minimal unpaid premiums.

Eliminating issuers' option to use gross premium percentage or fixed-dollar premium payment thresholds result in loss of coverage, especially among those with low incomes. A few dollars each month is virtually meaningless to issuers, and CMS presents no evidence that people who would lose coverage due to nonpayment would be improperly enrolled. However, even nominal premium payments can lead people to lose coverage, primarily due to the hassle of payment or lack of awareness.

CMS asserts that allowing gross premium percentage or fixed-dollar premium payment thresholds would lead to situations in which an enrollee stops paying for coverage, but the coverage continues for several months and the person accumulates a large amount of debt over time. However, all premium payment threshold options consider the accumulated underpayment over time. If an issuer applies a more generous premium payment threshold, it may protect a consumer for a short period of time, but continued underpayment would result in termination of coverage before a large debt would accumulate.

Further, PTC enhancements expired at the end of 2025, meaning many more people will be enrolled in plans with low but nonzero premiums (rather than \$0 premiums) in future years, exacerbating the risk of disenrollment due to nonpayment of small premium amounts. While CMS argues that \$0 premiums raise fraud concerns and notes that an estimated 27 percent of enrollees can select a PY 2026 QHP with \$0 premiums, these plans are often lower metal tiers with high deductibles and other costs, meaning only a fraction of those with access would select them. Even so, agents and brokers are the primary perpetrators of fraud.⁴⁷ Eliminating policies that protect people who miss small premium payments is not an effective approach to addressing concerns about unauthorized marketplace enrollment.

CMS asserts that marketplace plans including those with no or low premiums and costs have high rates of enrollees with no claims and states that this is evidence of fraudulent or unauthorized

⁴⁶ Centers for Medicare & Medicaid Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program," Proposed Rule, 42 CFR Part 600, 45 CFR Parts 153, 155, 156, and 158, October 10, 2024, <https://www.federalregister.gov/documents/2024/10/10/2024-23103/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2026-and>.

⁴⁷ Kaye Pestaina, *et al.*, "Fraud in Marketplace Enrollment and Eligibility: Five Things to Know," KFF, June 30, 2025, <https://www.kff.org/patient-consumer-protections/fraud-in-marketplace-enrollment-and-eligibility-five-things-to-know/>; Georgetown University Center on Health Insurance Reforms, "Federal Efforts Ostensibly Aimed at Marketplace 'Fraud' Ignore Obvious Strategies to Counter Broker Conduct," June 10, 2025, <https://chir.georgetown.edu/federal-efforts-ostensibly-aimed-at-marketplace-fraud-ignore-obvious-strategies-to-counter-broker-misconduct/>; U.S. Government Accountability Office, "Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist," December 3, 2025, <https://www.gao.gov/assets/gao-26-108742.pdf>.

enrollments. However, it's not uncommon for healthy people to not use their insurance in a given year. CMS cites that 34 percent of on-exchange silver enrollments from PY 2023 through PY 2024 were associated with no claims. However, this rate of zero-claim enrollment is not unreasonable.⁴⁸ Comparatively, an average of 23 percent of people enrolled in employer-sponsored insurance had no claims each year from 2018 to 2022.⁴⁹ There are several reasons the rate of zero-claim enrollments may be higher for subsidized marketplace plans: the marketplace population skews younger (and younger enrollees may be less likely to use their insurance),⁵⁰ the duration of enrollment is shorter compared to employer-sponsored insurance;⁵¹ and subsidized coverage with lower net premiums may attract healthier enrollees who may not have enrolled at all if only offered a more expensive option.

CMS argues that limiting premium payment thresholds to net premium percentage-based calculations would reduce improper enrollments. In its 2025 Marketplace Integrity and Affordability Rule, CMS allowed its moratorium on additional premium payment threshold options (which were temporarily stayed by a federal court) to sunset at the end of 2026 to “address the urgent improper enrollment concerns without permanently dismantling these premium threshold options.” However, these additional premium payment threshold options never took effect and cannot be the reason for CMS's claims of previous instances of improper enrollment.

CMS argues elsewhere in this proposed rule that other policies are successfully reducing fraudulent enrollments, making the proposed limits on premium payment thresholds neither urgent nor necessary. Again, CMS is proposing to take actions that are punitive to eligible people who have low incomes, driving coverage losses without achieving the agency's purported goal of reducing fraud.

Extending the moratorium on new premium payment threshold options would also infringe on the authority of state regulators to set rules for their insurance markets. The best approach to uphold states' regulatory authority would be to permanently end the moratorium on new premium payment threshold options. Even if CMS prohibits issuers on the federal marketplace from applying fixed-dollar and gross-percentage based premium thresholds, issuers in SBMs should still be able to

⁴⁸ Victoria Knight, “GOP Talking Point Holds ACA Is Haunted by ‘Phantom’ Enrollees, but the Devil’s in the Data,” KFF Health News, <https://kffhealthnews.org/news/article/aca-marketplace-subsidies-tax-credits-insurance-federal-government-shutdown-fraud/>, October 24, 2025.

⁴⁹ Kelsey Burke and Jessica Chang, “One in Five People With Employer-Sponsored Insurance Do Not Use Any Health Care Services,” Health Care Cost Institute, September 16, 2024, <https://healthcostinstitute.org/all-hcci-reports/one-in-five-people-with-employer-sponsored-insurance-do-not-use-any-health-care-services/>.

⁵⁰ KFF, “Marketplace Plan Selections by Age,” Open Enrollment, 2024, <https://www.kff.org/affordable-care-act/state-indicator/marketplace-plan-selection-by-age/?currentTimeframe=1&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>; Matthew McCough, *et al.*, “How do health expenditures vary across the population?,” KFF, March 2, 2026, <https://www.healthsystemtracker.org/chart-collection/health-expenditures-vary-across-population/>.

⁵¹ Matthew Fielder, X, August 21, 2025, <https://x.com/MattAFiedler/status/1958581096439824693>; Barbara Rubino and Emory Wolf, “Covered California’s Data Tells A Fuller Story About ACA Marketplace Utilization,” Health Affairs Forefront, September 22, 2025, <https://www.healthaffairs.org/content/forefront/covered-california-s-data-tells-fuller-story-aca-marketplace-utilization>.

use these flexibilities, which we believe minimize harm to enrollees when they don't pay small premium amounts.

Extend the Removal of the 150 Percent FPL SEP Beyond Plan Year 2026 (§ 155.420(d)(16))

While we believe that this SEP provided an important, year-round path to coverage for people who are eligible for significant financial help purchasing coverage on the marketplace, P.L. 119-21 prohibits an individual who enrolls via an income-based SEP from receiving APTC. Preserving the option to offer a low-income SEP serves little purpose without the availability of APTCs to make coverage affordable for people with low incomes. We do not have comments on how CMS proposes to operationalize permanent removal of the low-income SEP option.

However, in its Regulatory Impact Analysis, CMS states that a projected 2 to 3 percent increase in marketplace premiums due to adverse selection (as a result of other proposals in this notice) will be offset by a 3 to 4 percent premium reduction as a result of the removal of this SEP. We believe this estimate is based on a flawed assumption that had the low-income SEP continued to be available, healthier people would have used it to enroll only when they need care. APTCs would not be available, so we find it highly unlikely that people with income at or below 150 percent FPL would enroll in full-cost marketplace coverage at all. People in this group have incomes that overlap with or are only a little higher than the incomes of people receiving Medicaid. We believe the estimated premium reduction as a result of permanently ending the option to offer a low-income SEP is vastly overstated.

Special Enrollment Period Verification (§ 155.420(g))

As noted in our comments to the 2025 Marketplace Integrity and Affordability rule,⁵² we oppose the proposal to require marketplaces to conduct pre-enrollment eligibility verification for at least 75 percent of special enrollments for people newly enrolling in marketplace coverage.

CMS also claims that additional SEP verification is needed because the continued existence of bronze plans with \$0 net premiums will entice unscrupulous agents and brokers to use SEPs to enroll people in coverage without their knowledge. This logic is strained. We note that SBMs allow people to self-attest to various SEPs, yet no SBM has reported any meaningful fraud in their markets.⁵³ This suggests that there are other, more targeted strategies that CMS could employ to limit agents' and brokers' ability to access people's marketplace application without authorization, without making it more difficult for people to enroll in coverage mid-year. These strategies include increasing oversight and accountability for misconduct by agents, brokers, and EDE platforms;

⁵² Centers for Medicare & Medicaid Services, "Comment on CMS-2023-0191-0003," January 9, 2024, <https://www.regulations.gov/comment/CMS-2023-0191-0089>.

⁵³ Stacey Pogue, "Stakeholder Perspectives on CMS' Proposed 'Marketplace Integrity' Rule: State Insurance Departments and Marketplaces," Georgetown Center on Health Insurance Reforms, May 12, 2025, <https://chir.georgetown.edu/stakeholder-perspectives-on-cms-proposed-marketplace-integrity-rule-state-insurance-departments-and-marketplaces/>.

improving information-sharing with state departments of insurance; and adopting best practices from SBMs.⁵⁴

CMS expects that SEP verification will impose “minimal burdens” on consumers and, as a result, would create “only a minimal impact on the risk pool and premiums.” But CMS’s own projections contradict this position. Firstly, the regulatory impact analysis for the proposed rule estimates that this provision will increase administrative burden for consumers by \$7.3 billion annually. This estimate does not include the burden from delays in coverage or gaps in care that would result if people fail to obtain or submit required paperwork within 30 days. Second, in its review of pre-enrollment verification policies in 2019, CMS found that 14 percent of people subject to pre-enrollment verification ultimately did not submit the paperwork required for enrollment. If the same rate were to apply to FFM states in 2026,⁵⁵ it would mean that approximately 2.2 million people would be shut out of marketplace coverage due to a failure to submit paperwork. As a result of P.L. 119-21, the burden for individuals would be even more severe beginning in 2028, when marketplace applicants will be denied APTC while their paperwork is pending.

CBPP’s experience working closely with navigators also suggests that SEP verification can be a lengthier and more time-consuming process than CMS estimates. Currently, the FFM requires people to submit documents to verify eligibility for the SEP for loss of minimum essential coverage. Navigators report that it can take weeks and multiple follow-up attempts to obtain these documents. It can be difficult to obtain proof of loss of employer-sponsored coverage, especially at companies that outsource their human resources services. People who are no longer eligible for Medicaid often do not receive termination notices in a timely fashion or at all, due to mail issues or outdated contact information. It can take weeks for people in this situation to obtain a termination notice, depending on the responsiveness of the Medicaid agency and the person’s availability to follow up or answer their phone during the workweek. These delays are likely to increase as states implement Medicaid work reporting requirements, biannual Medicaid redeterminations, and additional SEP verification for loss of Medicaid denial. Nor is this situation unique to Medicaid agencies – it can take weeks for copies of a marriage license or birth certificate to arrive electronically or by mail.

These additional documentation requirements will disproportionately impact people who lack reliable Internet access and those with low technological literacy, including people who live in rural areas and older adults. The burden will also be felt by groups that typically receive help from navigators, including people with lower incomes and those with limited English proficiency, due to CMS’s cuts to navigator funding. Conversely, allowing people to self-attest to experiencing a qualified life event allows people to gain health coverage without delay, particularly during stressful

⁵⁴ Stacey Pogue, Justin Giovannelli, and Sabrina Corlette, “Federal Efforts Ostensibly Aimed at Marketplace “Fraud” Ignore Obvious Strategies to Counter Broker Misconduct,” Georgetown Center on Health Insurance Reforms, June 10, 2025, <https://chir.georgetown.edu/federal-efforts-ostensibly-aimed-at-marketplace-fraud-ignore-obvious-strategies-to-counter-broker-misconduct/>.

⁵⁵ CMS, “Marketplace 2026 Open Enrollment Period Report: National Snapshot,” January 12, 2026, <https://www.cms.gov/newsroom/fact-sheets/marketplace-2026-open-enrollment-period-report-national-snapshot-0>.

times like a permanent move or welcoming a new child. Self-attestation is particularly important for people with low incomes and other marginalized groups; extensive research demonstrates that these groups are more likely to experience time and resource constraints that make it difficult to navigate administrative burdens.⁵⁶ Younger, healthier people are also less likely to complete administrative burdens in order to obtain health insurance, resulting in negative impacts to the individual market risk pool⁵⁷—a consideration that CMS dismisses without providing evidence to the contrary.

Before setting any SEP verification threshold for marketplaces, CMS should provide compelling information supporting the need for such a change and justification for the specific threshold it is proposing. To aid in this goal, we encourage CMS to publicly release data on SEP use, which it has not done since 2015.⁵⁸ CMS should also describe what it will do to increase enrollment among SEP-eligible people. CMS should also clarify that marketplaces can and should maximize the extent to which data sources are used for verification and minimize the extent to which people are asked to submit documentation.

Should CMS finalize this proposal, it should explicitly prohibit pre-enrollment verification for SEPs for survivors of domestic violence, abuse or spousal abandonment; people recently released from incarceration; and people impacted by emergencies declared by the Federal Emergency Management Agency and major disasters. Individuals in these circumstances are in vulnerable situations where they may need urgent access to medical care and their situations could make it difficult for them to access documentation in a timely manner.

Expansion of Hardship Exemption Eligibility (§155.605(d)(1))

CMS proposes codifying guidance released last year that allows people age 30 and older to qualify for a hardship exemption and enroll in catastrophic plans if they become ineligible for PTCs or cost-sharing reductions. We oppose this proposal, which is contrary to law and would harm consumers.

CMS states that this policy is warranted due to rising premium costs. However, broadening the hardship exemption for catastrophic plans would expose more people to astronomically high out-of-pocket costs while doing little to address high premiums. In 2026, the average lowest-cost catastrophic plan costs \$346/month. This amount is likely to be prohibitively expensive for people with income below 100 percent FPL and unaffordable for many people with income between 250-400 percent FPL, and people cannot use PTCs to reduce this cost. In comparison, bronze plans –

⁵⁶ Pamela Herd, , *et. al.*, “Introduction: Administrative Burden as a Mechanism of Inequality in Policy Implementation,” RSF: The Russell Sage Foundation Journal of the Social Sciences, Vol. 9, Iss. 5, Sep 2023, <https://www.rsfsjournal.org/content/9/5/1>.

⁵⁷ Adrianna McIntyre,, Mark Shepard, Myles Wagner, “Can Automatic Retention Improve Health Insurance Market Outcomes?,” AEA Papers and Procedures, Vol. 11, May 2021, <https://www.aeaweb.org/articles?id=10.1257/pandp.20211083>.

⁵⁸ Centers for Medicare & Medicaid Services, “2015 Special Enrollment Period Report – February 23 – June 30, 2015,” August 13, 2015, <https://www.cms.gov/newsroom/fact-sheets/2015-special-enrollment-period-report-february-23-june-30-2015>.

which offer more generous coverage – have similar (or lower) premiums than catastrophic plans in many areas. In 2026, monthly gross premiums for the average lowest-cost bronze plan were \$369/month – just \$23 more than catastrophic plans.⁵⁹ And expanding access to catastrophic plans to more people age 30 and older would likely increase catastrophic plan premiums even more, as people tend to need more medical care as they age.

More importantly, catastrophic plans are only able to offer relatively low premiums because they provide extremely limited coverage, leaving enrollees on the hook for very high out-of-pocket costs.⁶⁰ Catastrophic plans cannot cover any medical expenses – aside from preventive care and three primary care visits – before an enrollee or household reaches the annual maximum out-of-pocket (MOOP) limit. In 2026, the MOOP limit is \$10,600 for an individual or \$21,000 for a household of two or more people. In comparison, 37 percent of Americans report being unable to cover a \$400 expense with cash or its equivalent.⁶¹

Catastrophic plans are especially harmful for people with complex or chronic conditions who have higher health care utilization. Multiple studies have found that people with chronic conditions enrolled in high-deductible health plans – plans with deductibles between \$1,000-2,000 for an individual – are more likely to delay or forgo recommended medical care and are also more likely to have lower medication adherence.⁶² Expanding access to catastrophic plans would likely exacerbate these issues.

General Program Integrity and Oversight Requirements (§ 155.1200) and State Exchange Improper Payment Measurement (SEIPM) (§§ 155.1600 through 155.1650)

The proposed rule would establish a State Exchange Improper Payment Measurement (SEIPM) program to measure improper payments of APTC in SBMs and would allow SBMs to fulfill the requirement to conduct an annual independent external programmatic audit through this new program. CMS previously proposed this change in the 2023 NBPP but ultimately chose not to finalize it, citing commenters' concerns about additional burden for states and an infeasibly short implementation timeline. In reproposing the SEIPM program, CMS does not provide rationale for

⁵⁹ Michelle Long, *et al.*, “Policy Changes Bring Renewed Focus on High-Deductible Health Plans,” KFF, January 5, 2026, <https://www.kff.org/patient-consumer-protections/policy-changes-bring-renewed-focus-on-high-deductible-health-plans/>.

⁶⁰ Charlotte Huff, “Out-of-Pocket Pain From High-Deductible Plans Means Skimping on Care,” Kaiser Health News, December 9, 2025, <https://kffhealthnews.org/news/article/high-deductible-plans-out-of-pocket-diabetes-care/>.

⁶¹ Board of Governors of the Federal Reserve System, “Report on the Economic Well-Being of U.S. Households in 2024 - May 2025,” June 12, 2025, <https://www.federalreserve.gov/publications/2025-economic-well-being-of-us-households-in-2024-savings-and-investments.htm>.

⁶² Richa Gidwani, *et al.*, “High-Deductible Health Plans and Receipt of Guideline-Concordant Care for Adults With Chronic Illness,” *JAMA Network Open*, Vol. 8, No. 4, 2025, <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2833325>; Kenneth E. Thrope, *et al.*, “The Challenges Of High-Deductible Plans For Chronically Ill People,” *Health Affairs Forefront*, April 22, 2019, <https://www.healthaffairs.org/content/forefront/challenges-high-deductible-plans-chronically-ill-people>.

why these considerations no longer apply. In fact, the proposed rule estimates that this proposal would cost SBMs \$1.1 million annually. We note that compared to 2023, states will likely experience increased administrative burden in implementing the SEIPM since they will also be required to implement Medicaid work reporting requirements and additional verification for marketplace enrollees resulting from the Marketplace Integrity and Affordability rule, P.L. 119-21, and other sections of the 2027 NBPP. We also note that because the proposed 2027 NBPP was delayed, it is likely that states would have even less time to prepare for the SEIPM than in 2023, should this proposal be finalized. For those reasons, we recommend that CMS delay implementation of the SEIPM until at least 2029, after the marketplace-related provisions of PL 119-21 have gone into effect.

Permitting Plan-Level Adjustments for Multi-Year Catastrophic Plans (§ 156.80(d)(2)(ii))

CMS proposes to allow issuers to offer multi-year catastrophic plans with terms of up to 10 years and proposes a number of new features for multi-year plans. People who enroll in these plans would not need to verify their continued eligibility for marketplace plans during the plan term. Issuers would be allowed to apply the MOOP to the lifetime of the plan, so long as the plan satisfies the average MOOP across that period, and could vary the MOOP by disease. Issuers could also design multi-year, catastrophic plans with monthly, rather than annual, deductibles and introduce additional pre-deductible benefits (beyond preventive services defined in Section 2713(a) and three primary care visits). CBPP opposes these proposals, as they conflict with the statute, would be confusing to applicants and enrollees, and would expose people to very high out-of-pocket costs, while doing little to improve the affordability or value of coverage.

CMS's proposal for multi-year catastrophic plans violates several provisions of the ACA. Section 1302(e) repeatedly references single plan years; "plan year," is defined at 45 C.F.R. § 155.20 as a "consecutive 12-month period during which a health plan provides coverage for health benefits." Section 1302(c)(1) specifies that health plans must limit cost-sharing for essential health benefits (EHBs) to the annual MOOP limit. Section 1302(e)(1)(B) clearly limits pre-deductible coverage in catastrophic plans to preventive services defined in Section 2713(a) and three primary care visits. Moreover, the ACA's guaranteed availability provisions (Section 1311 and conforming amendments) require QHP issuers to accept all eligible individuals who apply for coverage during open enrollment or an SEP. Multi-year plans appear to preclude new people from enrolling in them during the plan's second year and beyond, which would violate these provisions.

The flexibilities that CMS proposes to allow for multi-year plans would harm consumers. Allowing issuers to vary a plan's MOOP based on diagnosis would enable plans to discriminate against people with pre-existing conditions. For example, an issuer could conceivably design a plan variation for people with high-cost medical conditions, such as cancer or hemophilia, that has a higher MOOP than the base plan, which still meets actuarial standards for a given metal level. And allowing issuers to apply the MOOP to the lifetime of the plan could result in issuers designing multi-year plans with very low MOOPs at the beginning of the plan to entice consumers, only to have the MOOP balloon in later years.

Meanwhile, it is not clear what goals multi-year plans would accomplish. CMS claims that allowing for multi-year catastrophic plans would enable issuers that effectively promote utilization of preventive services to experience the benefits of enrollees' improved health in later years. This ignores the fact that many marketplace enrollees transition to other coverage sources within a relatively short period of time; approximately 20 percent of marketplace enrollees transition to other coverage sources within two years, compared to 8.5 percent of employer-sponsored insurance (ESI) enrollees.⁶³ This is likely because changes in age, income, household size, and employment can make a person ineligible for marketplace coverage or PTCs. Marketplace enrollees may also wish to transition to a different QHP due to increased cost-sharing relative to other plans or changes in provider network, which would not be addressed by this proposal. CMS further asserts that multi-year plans could reduce issuers' spending on plan marketing and enrollment costs, thereby reducing premiums. However, issuers would still be required to comply with the ACA's individual market reform requirements – such as QHP certification and rate review – which apply on an annual basis, even for multi-year plans. To the extent that multi-year plans result in administrative savings, it seems unlikely that such spending reductions would have a meaningful impact on premiums, given that rate increases are primarily driven by rising health care costs and federal policies that make it more difficult to get and keep marketplace coverage⁶⁴ (See our comments to other sections of this proposed rule).

The proposed multi-year plans pose several crucial implementation and policy questions which challenge their viability. CMS does not attempt to answer these questions, instead asking commenters to fill in missing details. For example, it is not clear whether issuers would be required to provide applicants with details about each year of the plan's terms – such as cost-sharing amounts and formulary benefits – when the plan is sold. If so, how would plans account for design elements such as cost-sharing, considering that CMS only releases the annual MOOP limit two years in advance? If not, then could consumers reasonably be said to understand the product that they are purchasing?

As stated above, we believe that the proposal to institute multi-year catastrophic plans is contrary to law. But should CMS seek to finalize this proposal, more detail and consideration is needed, especially regarding potential negative impact on consumers.

State Selection of EHB-Benchmark Plan for Plan Years Beginning on or After January 1, 2020
(§ 156.111)

In the preamble to the proposed rule, CMS states its intent to pause review of previously submitted state applications to select EHB benchmark plans. We strongly disagree with this

⁶³ Liran Einav and Amy Finkelstein, “The risk of losing health insurance in the United States is large, and remained so after the Affordable Care Act,” Proceedings of the National Academy of Sciences Vol. 120, Iss. 18, April 24, 2023, <https://www.pnas.org/doi/10.1073/pnas.2222100120>.

⁶⁴ Jared Ortaliza, et. al., “How much and why ACA Marketplace premiums are going up in 2026,” Peterson-KFF Health System Tracker, August 6, 2025, <https://www.healthsystemtracker.org/brief/how-much-and-why-aca-marketplace-premiums-are-going-up-in-2026/>.

approach. CMS should promptly approve pending updates to states' EHB benchmarks provided that they comply with current regulations. States with pending EHB benchmark plan updates have already solicited public input, conducted hearings, commissioned actuarial analyses, and engaged in deliberative processes, including enacting legislation, all while relying on the EHB benchmarking framework established by HHS nearly fifteen years ago. These proposals are carefully designed to address coverage gaps and help address the health care needs of state residents. It is unconscionable that HHS would simply disregard these efforts.

Multi-Year Terms for Catastrophic Plans To Improve Health (§§ 156.130(c) and 156.155(a)(6))

As discussed in our comments above, CMS proposes to allow issuers to offer multi-year catastrophic plans with terms of up to 10 years. This proposal violates Section 1302(e) of the ACA, which repeatedly references single plan years and bases eligibility for catastrophic plans on exemptions to the individual mandate penalty (which are administered on an annual basis). CMS does not provide adequate information about how this proposal would be implemented and offers scant evidence supporting its potential positive impacts. We oppose this proposal.

Cost Sharing for Bronze and Catastrophic Plans (§§ 156.136 and 156.155)

CMS proposes increasing the MOOP limits for bronze and catastrophic plans. These proposed increases are contrary to statute and clearly unnecessary. They would lower affordability, reduce ACA financial protections, and shift risk onto enrollees. People with lower incomes or who develop illnesses or costly health conditions would be particularly harmed. CMS fails to consider these harms in its regulatory impact analysis.

CMS justifies an increase in bronze plan MOOPs as a “mathematical necessity” to keep bronze plans viable, but in fact, bronze plans could have significantly higher cost sharing and still fall within the required actuarial value (AV) range. Looking ahead, cost sharing in bronze plans will soon have even more room to grow while staying within the AV range because the MOOPs in 2026 and 2027 are increasing at rates far higher than ever before due to payment formula changes in the 2025 Marketplace Integrity and Affordability Rule. And CMS does not just change MOOP requirements for bronze plans; it fails to specify an upper bound, effectively ignoring the requirements.

CMS maintains that consumers desire more bronze plans with lower AVs but provides no evidence to support this claim. Roughly 7.3 million people – equivalent to 30 percent of enrollees – selected bronze plans in 2025.⁶⁵ Clearly, bronze plans are a popular choice. Further, the distribution of bronze plan AVs reflects consumer preferences. There is no evidence that consumers are constrained to bronze plans with the highest AVs. In any case, CMS' unsupported belief about consumer plan preferences is not adequate justification for ignoring MOOP requirements.

⁶⁵ Centers for Medicare & Medicaid Services, “2025 Marketplace Open Enrollment Period Public Use Files,” May 12, 2025, <https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files>.

If, in the long run, if it becomes necessary to take action to keep bronze plans viable, there are other ways to ensure AV compliance that don't harm consumers, such as updating the AV calculator's methodology and assumptions. Any such action would not need to be taken for years, if at all. There is no reason to violate MOOP statutory standards when both MOOP and AV standards can still easily be met.

Beyond bronze plans, CMS also proposes increasing the catastrophic plan MOOP by 30 percent. This proposal is contrary to the requirements of ACA section 1302(c) and would impose substantial harm on consumers. The proposed increase – which would entail a \$15,600 MOOP for an individual and \$31,200 MOOP for a family in 2027 – would leave enrollees exposed to extremely high out-of-pocket costs. For perspective, \$15,600 is about a third⁶⁶ of median personal income, and roughly the entire income⁶⁷ of a person at the federal poverty level.

CMS suggests that catastrophic plans must have substantially lower AVs than bronze plans to offer a “clear difference” between the two. Their reasoning is crystalized by the fact that they chose 30 percent as their proposed increase in MOOP so that catastrophic would have a “theoretical” AV of 55 percent. But catastrophic is not a metal tier and was never intended to have a specific AV. Catastrophic plans serve a purpose that is fundamentally different than metal level plans, and it is against the intent of Congress to implicitly assign catastrophic plans an AV and make them a widely available option – essentially creating a new metal tier with an AV below bronze.

Non-Standardized Plan Option Limits (§ 156.202)

CMS proposes to eliminate limits on non-standardized plan options in certain circumstances. Beginning in PY 2027, insurers would no longer be limited to two non-standardized plans per product network type, metal level, and inclusion of adult dental, pediatric dental, and adult vision benefit coverage, in any service area. We oppose this proposal because it may increase plan choice overload and make it more difficult for consumers to differentiate plans, despite CMS' purported goal of reducing plan choice overload.

Research has shown that too many plan choices can result in consumer confusion and suboptimal enrollment decisions.⁶⁸ An extensive body of research on health care plan selection shows that consumers prefer a more limited array of choices, and when faced with too many plans to choose from, they are more likely to be confused and to make suboptimal plan choices or to not enroll at

⁶⁶ U.S. Census Bureau, “Median Personal Income in the United States,” retrieved from FRED, Federal Reserve Bank of St. Louis, February 25, 2026, <https://fred.stlouisfed.org/series/MEPAINUSA646N>.

⁶⁷ U.S. Department of Health and Human Services, “2026 Poverty Guidelines: 48 Contiguous States,” <https://aspe.hhs.gov/sites/default/files/documents/b1bfa16b20ae9b89d525bc35de7c1643/detailed-guidelines-2026.pdf>.

⁶⁸ Rose C. Chu, *et al.*, “Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces,” ASPE Office of Health Policy, December 28, 2021, <https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf>; Erin A. Taylor, *et al.*, “Consumer Decisionmaking in the Health Care Marketplace,” RAND, June 28, 2016, https://www.rand.org/pubs/research_reports/RR1567.html.

all.⁶⁹ Plan choice overload has a specific, negative impact on low-income applicants, who face greater constraints on time and finances, as well as lower levels of health literacy. With more complex and confusing plan options, enrollees are more likely to require assistance from agents and brokers – some of whom perpetuate fraud or steer people toward high-premium off-marketplace plans⁷⁰. While CMS dismisses the effectiveness of limits on standardized plans as “marginal,” the average number of QHPs available to HealthCare.gov marketplace enrollees declined nearly 27 percent for bronze plans and nearly 20 percent for silver plans from PY 2022, before standardized plans and non-standardized plan limits were introduced, to PY 2025.⁷¹ Because the strictest limits on non-standardized plans only took effect in 2025, there has not been enough time to truly understand the impact.

In addition to making it more difficult for enrollees to determine which plans meet certain standards, removing limits on the number of non-standardized plans can enable issuers to manipulate the marketplace. Removing limits on the number of non-standardized plans is likely to lead to the proliferation of “look-alike” plans and “silver spamming” by carriers, in which a carrier introduces many underpriced silver and bronze plans so that it dominates the first few pages of plan options displayed to consumers in FFM states.⁷² These plans typically have only very slight differences in cost sharing structures and provider networks, making it especially hard for consumers to choose the best and most affordable plan for them. Silver spamming can potentially distort the market or create significant swings in carrier market share and risk year-to-year.

If CMS finalizes the proposal to eliminate standardized plan requirements, it’s important to continue to apply a meaningful difference standard to avoid flooding the marketplace with extremely similar plan offerings. Facing more plan options, enrollees may need additional support from

⁶⁹ Rose C. Chu, *et al.*, “Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces,” ASPE Office of Health Policy, December 28, 2021, <https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf>.

⁷⁰ Jeanne M. Lambrew and Christen Linke Young, “Lessons from the ACA: Simplifying Choices to Optimize Health Coverage,” The Commonwealth Fund, December 2, 2025, <https://www.commonwealthfund.org/publications/issue-briefs/2025/dec/lessons-aca-simplifying-choices-optimize-health-coverage>; Kaye Pestaina, *et al.*, “Fraud in Marketplace Enrollment and Eligibility: Five Things to Know,” KFF, June 30, 2025, <https://www.kff.org/patient-consumer-protections/fraud-in-marketplace-enrollment-and-eligibility-five-things-to-know/>; Julie Appleby, “Short-Term Health Plans Boost Profits For Brokers and Insurers,” KFF Health News, December 21, 2018,, <https://www.npr.org/sections/health-shots/2018/12/21/678605152/short-term-health-plans-boost-profits-for-brokers-and-insurers>.

⁷¹ Centers for Medicare & Medicaid Services, “Plan Year 2025 Qualified Health Plan Choice and Premiums in HealthCare.gov Marketplaces,” October 25, 2024, <https://www.cms.gov/files/document/2025-qhp-premiums-choice-report.pdf>.

⁷² Rose C. Chu, *et al.*, “Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces,” ASPE Office of Health Policy, December 28, 2021, <https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf>

navigators and assisters to choose plans that meet their needs. Boosting funding navigator and assister programs is especially critical.

Essential Community Provider Standards for Network Plans (§ 156.235) and Implementation of the Effective Essential Community Provider Review Program (§ 155.1051)

CMS proposes to reduce the essential community provider (ECP) minimum percentage requirement (or ECP threshold) for QHPs from 35 to 20 percent. The ECP threshold is the minimum percentage of ECPs in a service area that an issuer must include within its provider network. CMS also proposes reducing the minimum percentage of two types of ECPs, federally qualified health centers (FQHCs) and family planning providers, that must be in an issuer's network from 35 to 20 percent. We urge CMS not to reduce the ECP threshold and maintain the 35 percent threshold to preserve enrollee access to care (or increase the threshold advance improvements in health equity and access to care).

Requiring issuers to include adequate numbers of ECPs is critical for health equity. ECPs primarily serve low-income and medically underserved populations, many of whom would be unable to access or afford care without ECPs. Enabling issuers to narrow their networks and contract with fewer ECPs would have dire impacts on many people, especially people with low incomes, people who are Black or Latino, other people of color, people who need reproductive health care, and people living in rural areas.

ECPs are trusted providers for Black, Latino,⁷³ LGBTQ+⁷⁴, and disabled people⁷⁵ and all these communities struggle with limited access to care and worse health outcomes. Family planning providers deliver essential contraception, pregnancy, and abortion care and an extensive list of other important services, including cancer screenings, sexually transmitted infection testing and treatment, and other primary and preventive care.⁷⁶ ECPs also include Ryan White Program Providers who provide care for people living with HIV. Early detection and regular treatment are critical to survival for people with HIV.

Reducing ECP thresholds would be particularly harmful for people in rural communities, who face poorer health outcomes for certain conditions compared to urban residents.⁷⁷ People in rural communities already have limited access to health care providers, especially as rural hospitals close—

⁷³ Nambi Ndugga, *et al.*, “Race, Inequality, and Health,” KFF, October 8, 2025, <https://www.kff.org/racial-equity-and-health-policy/health-policy-101-race-inequality-and-health/>

⁷⁴ Lindsey Dawson, *et al.*, “LGBTQ+ Health Policy,” KFF, October 8, 2025, <https://www.kff.org/lgbtq/health-policy-101-lgbtq-health-policy/>.

⁷⁵ Monika Mitra, *et al.*, “Advancing Health Equity and Reducing Health Disparities For People With Disabilities In The United States,” *Health Affairs* Vol. 41, Iss. 10, <https://doi.org/10.1377/hlthaff.2022.00499>

⁷⁶ Office of Population Affairs, “What are Title X family planning clinics, and where can you find one?”, July 2024, <https://opa.hhs.gov/about/news/e-updates/what-are-title-x-family-planning-clinics-and-where-can-you-find-one>.

⁷⁷ Centers for Disease Control and Prevention, “About Rural Health,” May 16, 2024, <https://www.cdc.gov/rural-health/php/about/index.html>.

which are likely to be exacerbated by drastic cuts to Medicaid—and people lose timely access to services like labor and delivery.⁷⁸ CMS acknowledges this and cites limited access to care in rural areas as a reason to reduce the ECP threshold. However, limited access to rural providers makes a higher ECP threshold especially important.

This removes a critical safeguard without evidence that the current threshold is burdensome for issuers. CMS claims that reverting to the 20 percent threshold in place in 2014 and from 2018 through 2022 “would minimize disruptions for issuers in adjusting to meet the threshold requirements.” However, maintaining the current ECP threshold at 35 percent poses no new or unprecedented burdens for issuers to continue to comply. CMS estimated that in 2021, when the 20 percent ECP threshold was in place, 80 percent of medical FFM issuers “could have satisfied a 35 percent ECP threshold.”⁷⁹ CMS notes that every year “the majority of issuers on the FFE...exceed each of the minimum percentage requirements.” Reducing the ECP threshold would do little for CMS’ purported goal of reducing administrative burdens for issuers, while leaving enrollees exposed to significant reductions in access to care.

As detailed in the next section, we strongly oppose the proposal to certify non-network plans as QHPs. However, if finalized as proposed, the ECP threshold is the only explicit network adequacy requirement for non-network plans. While it remains unclear that non-network plans could demonstrate meeting the ECP threshold with only informal (non-contractual) agreements with providers to accept the benefit amount as payment in full, the requirement for non-network plan enrollees to have access to just 20 percent of ECPs is woefully inadequate.

We oppose CMS’s proposal to eliminate the requirement for issuers to provide a narrative justification when they do not meet the ECP threshold. Currently, if an issuer does not meet the ECP threshold, it must submit a justification explaining how its network ensures an adequate level of service for low-income enrollees and how the issuer plans to strengthen its network toward the ECP standard. Instead, issuers would only need to report the status of contract offers to ECPs available in the plan’s service area. The issuer receives “credit” for making a contract offer, even if that offer has unreasonably poor terms that the ECP can’t or won’t accept. Removing this requirement would make it easier for issuers to avoid compliance with the ECP threshold and enable issuers to avoid making network improvements in the next plan year. If the reduction in the ECP threshold is finalized as proposed, issuers who do not include just 20 percent of ECPs in their networks would not need to provide any justification for failing to provide minimal access to ECPs.

⁷⁸ Scott Hulver, *et al.*, “10 Things to Know About Rural Hospitals,” KFF, April 16, 2025, <https://www.kff.org/health-costs/10-things-to-know-about-rural-hospitals/>; Katy Backes Kozhimannil, *et al.*, “Obstetric Care Access Declined in Rural and Urban Hospitals Across US States, 2010-22,” *Health Affairs*, Vol. 44, Iss. 7, July 2025, <https://doi.org/10.1377/hlthaff.2024.01552>.

⁷⁹ U.S. Department of Health and Human Services, “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023,” 45 CFR Parts 144, 147, 153, 155, 156, and 158,

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

We strongly disagree with CMS’s proposal to allow non-network plans to receive QHP certification by demonstrating a sufficient choice of providers. The proposed rule lacks clarity about how non-network plans would operate and meet ACA standards for QHPs. From the information provided, we are very concerned that regulators would be unable to ensure non-network plans meet network adequacy standards, provide quality coverage, and abide by ACA consumer protections. We believe this proposed policy would be difficult for state and federal regulators to monitor and enforce, reduce patient access to care, and put enrollees at risk for high costs.

While the ACA does not explicitly require QHPs to have a network of contracted providers, several statutory provisions depend on networks to function.⁸⁰ In fact, in its proposed HHS Notice of Benefit and Payment Parameters of 2024, HHS expressed “doubt that a plan without a network can comply with the statutory requirement at section 1311(c)(1)(C) of the ACA,” which requires plans to include essential community providers (ECPs) in their networks.⁸¹ Additionally, it’s unclear how non-network plans could meet ACA standards, including prohibiting cost sharing for recommended preventive services (Public Health Service Act Section 2713), requiring individual market plans to cover essential health benefits (PHSA Section 2707), and requiring plans to limit cost sharing to maximum out-of-pocket (MOOP) costs (ACA Section 1302(c)). QHPs are subject to a MOOP for in-network services; without a network, issuers could attempt to consider all services out-of-network and therefore not apply cost sharing limits, eliminating a critical protection that the ACA requires to limit people’s exposure to very high costs and medical debt.

Non-network plans set specific benefit amounts for covered services but lack a network of providers that have agreed to accept negotiated rates. While the proposed rule states that non-network plans would have to demonstrate access to ECPs within their service area that accept the plan’s benefit amount as payment in full to comply with section 1311(c)(1)(C) of the Affordable Care Act, we do not believe the proposed policy adequately ensures patient access. We are concerned that the proposed 20 percent ECP threshold is too low and that CMS has not adequately explained how a non-network plan could accurately demonstrate that ECPs would continuously accept the benefit amount as payment in full. In addition, the proposed standard of “sufficient access to care” would leave far too much discretion to the issuer to define “sufficient” and includes no additional quantitative requirements.

There is no requirement for providers to accept the plan’s benefit amount, and providers who agree to non-network rates as payment in full have no obligation to hold up this agreement. In fact,

⁸⁰ For example, see ACA Section 1311(c)(1)(B) and Section 1311(c)(1)(C).

⁸¹ U.S. Department of Health and Human Services, “Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024,” 45 CFR Parts 153, 155, and 156, April 27, 2023, <https://www.federalregister.gov/documents/2023/04/27/2023-08368/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2024/>.

CMS acknowledges that there is “no guarantee that the plan’s benefit amounts are actually sufficient to cover the provider’s full charge.” We are concerned non-network plans could consider informal, unenforceable agreements with providers to constitute sufficient access, but in reality this would fall short of sufficient access to care for people. If enrollees are unable to access regular care at affordable prices, they may delay or forego needed care, resulting in worse health outcomes and increased use of expensive emergency services.⁸² Non-network plans without guaranteed access to providers over the course of the plan term would also be a bad deal; enrollees could find they pay premiums for coverage that is ultimately useless for accessing care.

CMS argues that non-network plans would empower enrollees to use price information to shop for lower prices and negotiate with providers directly. However, ample evidence demonstrates limited value and uptake of price transparency efforts to patients, as well as limited provider compliance, resulting in little progress at reducing health care costs, prices, and utilization, even when paired with cost sharing exposure.⁸³ Providers have reported they are unable to provide uninsured and self-pay patients with a “Good Faith Estimate” of their costs for services, despite the requirement to do so in the Consolidated Appropriations Act of 2021.⁸⁴ Even if enrollees had access to transparent health care prices — which is unlikely considering providers themselves struggle to estimate costs — and were empowered to use them, they’d have little negotiating power as an individual. Without an issuer’s promise of access to a large pool of potential patients, providers would have little incentive to negotiate down to a lower price for an individual patient.

⁸² Grace Sparks, *et al.*, “Americans’ Challenges with Health Care Costs,” KFF, January 29, 2026, <https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/>; Matthew A. Heard, *et al.*, “Poor Outcomes of Patients From Delayed Care After Ground Level Falls,” *The American Surgeon*, Vol. 89, Iss. 7, March 6, 2023, <https://doi.org/10.1177/00031348231161706>; Gregory Jasani, *et al.*, “Association Between Primary Care Availability and Emergency Medical Services Utilization,” *The Journal of Emergency Medicine*, Vol. 64, Iss. 4, April 2023, <https://doi.org/10.1016/j.jemermed.2023.01.002>.

⁸³ Niki Nourmohammadi and Gelareh Sadigh, “Patients, practice, and price transparency: The impact of disclosing healthcare costs on consumer decision-making,” *Clinical Imaging* 107, March 2024, <https://doi.org/10.1016/j.clinimag.2023.110064>; David Muhlesein and Yuvraj Pathak, “Improving Hospital Compliance With Price Transparency Rules,” *Health Affairs Forefront*, March 18, 2024, [Improving Hospital Compliance With Price Transparency Rules | Health Affairs](https://doi.org/10.1016/j.jclinimag.2023.110064); Sunita Desia, *et al.*, “Association Between Availability of a Price Transparency Tool and Outpatient Spending,” *JAMA* 315(17), May 3, 2016, <https://jamanetwork.com/journals/jama/fullarticle/2518264>; Michael Cohen, Daria Pelech, and Karen Stockley, “Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals’ and Physicians’ Services,” CBO, September 2022, [Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals’ and Physicians’ Services](https://www.cbo.gov/publications/2022/09/2022-09-20-policy-approaches-to-reduce-what-commercial-insurers-pay-for-hospitals-and-physicians-services); Ateev Mehrotra, *et al.*, “Americans Support Price Shopping For Health Care, But Few Actually Seek Out Price Information,” *Health Affairs* 36(8), August 2017, <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.1471?journalCode=hlthaff>;

⁸⁴ Centers for Medicare & Medicaid Services, “FAQs About Consolidated Appropriations Act, 2021, Implementation – Good Faith Estimates (GFEs) For Uninsured (Or Self-Pay) Individuals – Part 3,” December 2, 2022, <https://www.cms.gov/files/document/good-faith-estimate-uninsured-self-pay-part-3.pdf>.

Further, many health care services are not shoppable.⁸⁵ CMS suggests that non-network plan enrollees would negotiate rates for all services, despite a real possibility that an enrollee is facing an emergency and does not have time to negotiate or is incapacitated or too sick to bargain when presenting for care. Furthermore, even with plans that have clearly defined networks, patients struggle to determine which providers participate, especially in a hospital setting, where patients may see many providers and not all providers necessarily accept a plan's benefit amounts. In health care, too many situations exist where it is unreasonable to expect an enrollee to map out costs and make payment agreements for each provider and service they receive.

Even with access to a “sufficient” number of ECPs, enrollees may find themselves in need of urgent or specialty care from providers who do accept the non-network plan's rates as payment in full. CMS acknowledges that non-network plans can make “certain providers, as a practical matter, unavailable,” and this is particularly “problematic for services that an enrollee could not have anticipated in advance,” namely services that are not shoppable. While CMS suggests an exception process for patients unable to find care with providers willing to accept benefit amounts as payment in full, this may be a challenge in practice. Patients could be on the hook for extremely high bills, well above the non-network plan's rates. As CMS notes, this “can have a particular impact on low-income, medically underserved populations who may face disproportionate challenges in paying for large out-of-pocket costs.”

While we oppose the certification of non-network plans as QHPs altogether and think they are incompatible with statutory requirements, if CMS were not allow non-network plans to become available as a QHP, it must also set a true, effective ban on balance billing to avoid saddling enrollees with impossible costs. There must also be clear standards for coverage of essential health benefits and application of maximum out-of-pocket caps. The proposed rule states that non-network plans must demonstrate they provide the essential health benefits required by a state. However, it's unclear how or if non-network plans would have to demonstrate sufficient coverage of each EHB and how rates for EHBs with payments that don't go through providers, such as prescription drugs, some labs, or medical equipment, would relate to access and affordability. CMS must also explain, in the context of non-network plans, how it will ensure that reduced deductibles and other cost-sharing protections the statute requires for people with low incomes via cost-sharing reduction plans would be satisfied with a non-network plan.

CMS also argues that non-network plans are beneficial to issuers because they reduce administrative overhead. In reality, they shift administrative costs and burden to patients, who would have to do the work that insurers and health care providers are supposed to do, but without being paid. While non-network plans would have to demonstrate “continuous outreach” to providers, one of these administrative cost savings CMS cites is removal of provider “directory maintenance.” Given the proliferation of ghost networks within existing QHPs, if non-network plans do not

⁸⁵ Amanda Frost, David Newman, and Lynn Quincy, “Health Care Consumerism: Can The Tail Wag The Dog?”, Health Affairs Forefront, March 2, 2016, <https://www.healthaffairs.org/content/forefront/health-care-consumerism-can-tail-wag-dog>;

maintain an accurate and up-to-date list of providers willing to accept their rates as payment in full, patient access would be at risk.⁸⁶ Regulators would not have the information to determine if the plan complies with access to a sufficient number of providers. As CMS states, providers without network contracts can change rates at any time, and without frequent confirmation and updates to a provider directory, patients may be unable to find affordable care. If these listings are inaccurate, non-network plans may bypass requirements to maintain a sufficient number of willing providers.

Certifying non-network plans as QHPs may result in reduced access to other types of plans in the marketplace. Introducing a new, confusing product into the marketplace without clear labels on the marketplaces puts enrollees at risk of inadvertently enrolling in a plan that doesn't meet their needs. Non-network plans with lower premiums may be attractive for people who are healthier and don't anticipate using a lot of health care. Since non-network plans are not a fit for many marketplace enrollees, it's essential that their certification does not make network plans unaffordable. If non-network plans have lower premiums due to their lack of network coverage and are the second lowest cost silver plan in a given market, this could place more generous network plans out of individuals' financial reach.

Data indicate that non-network plans could indeed lower the benchmark substantially, which in turn would reduce premium tax credit amounts and raise out-of-pocket costs for enrollees in network plans. For example, in 2023, Sidecar Health offered three silver non-network plans in Ohio that were not offered through the marketplace. If those plans had instead been available on the marketplace, Sidecar's silver offerings for a typical 40-year-old individual would have been the three cheapest silver plans in every Ohio county, making Sidecar's second-lowest cost plan the benchmark plan across the state. The benchmark would have been \$100 per month less than the actual benchmark plan on average, equivalent to a 24 percent decrease, with reductions in benchmark plans ranging across counties from \$71 to \$193 (17 to 38 percent decreases).⁸⁷ It is likely that non-network plans would not only put more burden and risk on the people who would enroll in them, they would also increase costs and affordability challenges for people who do not.

Quality Standards: Quality Improvement Strategy (§ 156.1130)

The ACA requires all plans to have a quality improvement strategy (QIS) in order to be certified as a QHP. CMS proposes to allow QHP issuers to address any two of five QIS topic areas (improving health outcomes of plan enrollees, preventing hospital readmissions, improving patient safety and reducing medical errors, promoting wellness and health, and reducing health and health

⁸⁶ U.S. Government Accountability Office, "Private Health Insurance: State and Federal Oversight of Provider Networks Varies," December 2022, <https://www.gao.gov/assets/gao-23-105642.pdf>; Max Blau, "I Don't Want to Die: Needing Mental Health Care, He Got Trapped in His Insurer's Ghost Network," September 8, 2024, ProPublica, <https://www.propublica.org/article/ambetter-ghost-network-consequences>.

⁸⁷ CBPP analysis of premiums from the Robert Wood Johnson Foundation's HIX Compare files merged with county-level plan selections from CMS. The actual benchmark is based on the Essential Health Benefits (EHB) portion of the premium; no adjustments are made if the Sidecar plan covers any non-EHB benefits.

care disparities) rather than the current requirement that issuers address at least two of the five QIS topic areas, one of which must be health and health care disparities. We oppose this change.

Contrary to CMS's description, the current approach to QIS is not one-size-fits-all; issuers may opt to address any (or all) of the five QIS areas, but all are required to address health and health care disparities. This was a common QIS topic (60 percent of QHP issuers selected it) even in 2020 before the requirement⁸⁸ and is relevant to QHP issuers in all rating areas.

All QHPs serve diverse populations and would identify existing inequities if they focused their efforts on recognizing and eradicating them. The proposed change would allow QHPs to ignore health care disparities and the interventions that could address them, in favor of reporting on QIS topics that may be easier to report, or that may present their plan in the most positive way. Halting required reporting on health disparities does not halt their impact on enrollees' lives and health outcomes. Health disparities are responsible for higher rates of illness and death among those affected, and higher health care costs that ultimately affect everyone in the health care system.⁸⁹ We oppose this proposed change, which would allow for more health and health care discrimination to go unchecked, resulting in poorer health and economic outcomes for affected individuals, and a more expensive, less effective health care system for all.

Comment Solicitation on Potential Adjustment to the MLR for a State's Individual Market (Subpart C)

The Medical Loss Ratio (MLR) standard for individual market coverage requires that insurance carriers spend at least 80 percent of their premium revenue on clinical care or quality improvement, or else provide rebates to enrollees for amounts under 80 percent. This standard limits administrative costs while providing billions of dollars to enrollees (\$1.2 billion⁹⁰ in the individual market in 2024).

CMS doesn't provide a rationale for changing the MLR or even indicate whether it is considering increasing vs. decreasing the MLR. CMS mentions market consolidation and market stability but does not specify how it believes these pertain to the MLR. Increased industry consolidation has driven price increases across the entire health care system, and there are a number of policy actions that could directly address the fundamental drivers of harmful consolidation.⁹¹ Likewise, a variety of policies promote stability in the individual market, such as premium tax credits, cost-sharing

⁸⁸ Centers for Medicare & Medicaid Services, "HHS Proposed Notice of Benefit and Payment Parameters for 2023", January 5, 2022 <https://www.govinfo.gov/content/pkg/FR-2022-01-05/pdf/2021-28317.pdf>.

⁸⁹ Nambi Ndugga, *et al.*, "Inequality and Health," KFF, October 2025, <https://www.kff.org/health-policy-101-race-inequality-and-health/>.

⁹⁰ Centers for Medicare & Medicaid Services, "2024 MLR Rebates by State," <https://www.cms.gov/files/document/2024-rebates-state.pdf>.

⁹¹ Zachary Levinson et al., "Ten Things to Know About Consolidation in Health Care Provider Markets," KFF, April 219, 2024, <https://www.kff.org/health-costs/ten-things-to-know-about-consolidation-in-health-care-provider-markets/>.

subsidies, robust enrollment, a single risk pool, and regulatory predictability.⁹² While these factors have changed over time, along with market stability, the MLR threshold has remained constant in every state since its inception.

States already have a process to request adjustments to the MLR, and none have done so, indicating no demand for a federal-level adjustment. It is concerning that the administration specifically seeks comment on how the federal government can adjust the standard in states that do not request an adjustment, even without formulating a rationale as to why an adjustment might be needed in the first place.

⁹² American Academy of Actuaries, “Strategies to Achieve Market Stability in the Individual Health Insurance Market,” July 21, 2025, <https://actuary.org/resources/brief-strategies-to-achieve-market-stability-in-the-individual-health-insurance-market/>.

March 12, 2026

The Honorable Robert F. Kennedy, Jr.
Secretary
Department of Health and Human Services

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services

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

The Colorado Consumer Health Initiative (CCHI) and the undersigned organizations appreciate this opportunity to comment on the proposed 2027 Notice of Benefit and Payment Parameters rule. CCHI is a nonprofit, non-partisan, consumer-oriented, membership-based health advocacy organization that serves Coloradans whose access to health care and financial security are compromised by structural barriers, affordability, poor benefits, or unfair business practices of the health care industry.

The Affordable Care Act (ACA) made significant improvements to health coverage, consumer protections, and affordability. It is fundamental to how our health coverage and care systems now operate. The federal government and CMS should be doing everything possible to champion and improve the ACA. The NBPP rule should be a vehicle to bolster consumer protections, improve affordability both in seeking coverage and in meaningful out-of-pocket cost limits, and expand access and enrollment.

We are dismayed to see CMS using this rule as a mechanism to undermine fundamental ACA protections, make coverage and the ability to access care with that coverage less affordable, and ultimately lower enrollment in ACA coverage. The lateness of the publication of the rule and short comment period are deeply concerning given the depth and breadth of changes proposed. While there are some elements we agree with in the rule, such as ensuring greater accountability of brokers and agents, overwhelmingly provisions of the rule seem targeted to making coverage less affordable, more costly to use, and will likely make the ACA markets less stable and less healthy.

Indeed the number of provisions included in this proposed rule that are either currently subject to challenge in the courts from the earlier Marketplace Integrity Rule or build upon them are deeply troubling. This approach seems to be an effort to circumvent the legal process and court challenge to that rule. Several of the proposals contained within this Payment Rule seem questionable and may also raise legal challenges and additional uncertainty about ongoing regulation of ACA markets. This could create layers of uncertainty for consumers, insurers, regulators, states, and exchanges, and ultimately harm the insurance markets and consumers' access to coverage and care.

While we provide more direct comments and our rationale on elements of this proposed rule below, **we oppose an overwhelming majority of the proposed changes in this rule as the rule runs counter to the primary goals of the ACA and will harm consumers in various ways by undermining fundamental protections.**

Comments Regarding Analytical Claims and Assertions

The proposed rule includes a RIA and other analyses about the effects of the rule. The included analysis should provide meaningful information about what the rule will accomplish. However, much of the analysis seems implausible, ignores key facts, is inadequately explained, or leaves out information that is necessary to understand and justify the rule. Various estimates as to the rule's effects on health coverage and premiums are implausible and the rule fails to provide meaningful information regarding how the rule's proposals would address improper enrollment, which are a key justification for much of the rule. The analysis also fails to address certain proposals contained in the rule.

CMS asserts that the goal of the requirements laid out in the rule is “*providing quality, more affordable coverage to consumers while minimizing administrative burden and ensuring program integrity.*” However, CMS fails to define quality or establish a baseline or metrics for it in the rule, “more affordable” seems to only refer to premiums and fails to account for negative impacts of changes to out-of-pocket costs, the rule fails to provide adequate baseline data or projected premium impact for different provisions, and “minimizing administrative burden” is contradicted with several provisions clearly increasing administrative burden for enrollees, exchanges, and insurers.

The proposed rule and many of the changes therein repeat CMS's reliance on questionable analysis and proposed solutions by the Paragon Health Institute. For example, the proposed rule re-proposes the pre-enrollment SEP verification requirements that were stayed by *City of Columbus v. Kennedy*, explicitly noting “new supporting information since the original policy” but the underlying claims about improper enrollment are the same ones Paragon developed. In *City of Columbus v. Kennedy*, the court faulted CMS for relying heavily on a report from Paragon Health Institute while failing to meaningfully address commenters' concerns about the analysis, yet CMS continues to rely on said analysis and continues to provide deficient analysis of its own.

Based on the significant deficiencies and failures in the analysis, there is not a reasonable basis for the rule nor is there adequate information provided to adequately inform comments. CMS frequently relies on “belief” and speculation to reach its conclusions and supposed rationale to support theories for proposed changes. The proposed rule uses “believe” or “do not believe” nearly 200 times. Belief is not sufficient basis for rule changes. This unsound basis for rule changes is paired with the implausible, inadequate analysis that omits or ignores facts or

information. **CMS should withdraw the rule, perform new analysis, provide clear explanations and assumptions based on concrete, publicly provided evidence and data for future rule making.**

There are a few examples we want to highlight where the analysis is problematic, insufficient or implausible. First and foremost, CMS's baseline estimates of coverage absent the rule are implausible. Given the already documented decrease in coverage in 2026 and the anticipated further decline in 2027 and 2028 as H.R. 1 provisions are implemented, CMS's baseline projections of slight increases in coverage in 2026 and increase slightly or hold steady in 2027 are spurious. Indeed, there has already been a [decrease in enrollment documented for 2026](#) in Colorado and across the country, and as provisions of H.R. 1 are implemented, further declines in enrollment are anticipated. Only in 2028 does CMS estimate more loss in coverage, though again, it seems to be very likely underestimated.

These baseline estimates and how CMS arrived at them are unexplained in the rule, along with many rule-impact coverage estimates, when they seem implausible under reasonable assumptions.

The premium impact estimates used in the rule seem to greatly underestimate how much the rule would increase premiums and are also not explained. The rule's topline analysis claims that it would reduce premiums by 1.5% to 1.8% in 2027. However, these estimates are flawed in several ways; the rule would in fact likely increase premiums.

CMS's discussion of the premium impact estimates relies on the cited 3% to 4% reduction in premiums from elimination of the under 150% FPL SEP. That assertion is also likely implausible based on evidence that this SEP likely has a healthy effect on the risk pool as communicated in prior comments. However, even if we accept CMS's assertion, the removal of this SEP is a provision under H.R. 1 starting in 2026 and should be excluded from premium impact estimates. Removing this from the calculation, CMS's own estimates show the rule would *increase* gross premiums by 1.2% to 2.5%.

The rule also includes a number of provisions that create new administrative burdens or premium costs for enrollees, such as requiring additional paperwork for income verification, the proposal to deny APTC for people who fail to file a tax return, and the provision eliminating issuers' ability to continue coverage when there is a de minimis underpayment of premiums. These proposed changes are likely to increase adverse selection and increase premiums substantially more than CMS's "assumed" 2% to 3% increase. CMS does not provide explanation for its assumptions. The evidence is robust that increasing administrative burdens and higher premiums reduce enrollment particularly among lower-risk individuals.

For example:

- A [Mcintyre, Shepard, & Layton study](#) finds that states that implemented nominal monthly premiums saw enrollment fall by 14%.
- A [2025 study in the American Economic Review](#) finds that imposing administrative burdens to enrollment “differentially exclud[es] young, healthy, and economically disadvantaged people” and that adding one single additional step to the enrollment process prompted a 33% decline in enrollment, predominantly among young, healthy, and economically disadvantaged people.
- An [American Economic Association study on auto-retention](#) finds “that automatic retention has a sizable impact,...differentially retaining healthy, low-cost individuals.”
- A 2023 [Commonwealth Fund report \(Policy Innovations in the Affordable Care Act Marketplaces\)](#) details how numerous state policies which reduce administrative burden are effective at connecting consumers to coverage.
- A [KFF brief \(Key Facts about the Uninsured Population\)](#) describes how almost 20% of uninsured nonelderly adults cite the difficulty or complexity of signing up as a reason for their lack of health insurance coverage
- [National Bureau of Economic Research report \(Reducing Administrative Barriers Increases Take-up of Subsidized Health Insurance Coverage\)](#)
- A [2016 Urban Institute research report \(Helping Special Enrollment Periods Work under the Affordable Care Act\)](#) recommends reducing required documentation where possible for SEP enrollment as a way to combat slow uptick.

CMS should incorporate this research into its analysis and clearly explain its assumptions about how administrative burdens are felt and impact premiums prior to rule changes.

Ironically, CMS’s Regulatory Impact Analysis (RIA) recognizes that several of the rule’s provisions would lead to adverse selection: the section on the overall impact of the rule notes that “Many enrollees will lose coverage due to no longer being eligible for subsidies, and we believe it is likely that healthier enrollees are more likely to discontinue coverage.” Yet CMS’s estimate of the premium impact is inexplicably small. “We have assumed a 2 percent increase in premiums in the scenario where 1.2 million enrollees leave the market and a 3 percent premium increase if 2.0 million enrollees exit the market.” CMS offers no explanations for these assumptions. They are especially suspect given CMS’s approach in the Integrity Rule, where it conceded that it focused exclusively on the group it considered improperly enrolled and ignored the impact of administrative burdens on eligible enrollees, writing that “[the coverage loss estimates] may underestimate the actual number of individuals impacted, as eligible enrollees may lose coverage as a result of the administrative burdens imposed by the provisions of this rule.” While CMS’s approach in the proposed rule is not explained, the explanation from last year and the small premium impact estimate suggest that CMS is again understating the adverse selection effects.

CMS also seemingly overstates the premium benefit of its proposal to require more paperwork for individuals enrolling through a SEP, while failing to explain its methods. CMS assumes that provision will reduce premiums by 0.5 to 1.0%. CMS explains that the “positive impact on program integrity by verifying eligibility for SEPs” would decrease premiums. But [this assumption is inconsistent with available evidence](#) about those who enroll through a SEP, including data to show that the risk profile of SEP enrollees is lower than non-SEP enrollees.

For all of these estimates, CMS should release new analysis that accounts for relevant evidence and clearly explains CMS’s assumptions and methods and should re-issue a proposed rule that incorporates this analysis, to allow the public a meaningful opportunity to comment on the agency’s proposals.

CMS must provide separate estimates of the premium impact of each provision. CMS indicates the included analysis provides impact analyses and estimates for each proposal in the rule separately, with the intent for each provision to be severable from the rest. However, while CMS provides estimates for some provisions’ coverage impacts and overall premium impact of the rule, it fails to provide estimates of the premium impact of several key provisions, including several that are likely to more substantially increase premiums. For instance, CMS fails to include specific estimates regarding the proposed income verification provisions that impose new administrative burdens nor information for how this will harm the risk pool. Similarly, CMS’s RIA does not even acknowledge the proposal to allow plan-level adjustments to the index rate for multi-year catastrophic plans, which directly impacts how premiums are calculated.

In order to truly consider proceeding with the proposals in this rule, CMS must include more robust analysis, explanation, and recognize the rule’s impacts by increasing administrative burdens. CMS must provide the data it possesses on the coverage and risk impacts of these proposed changes.

The rule provides inadequate support indicating that several major proposals are justified based on the need to address improper enrollments. CMS provides only limited and often contradictory information about ongoing improper enrollment and concedes that they are primarily caused by broker malfeasance, are already being addressed, and are declining in number. And CMS offers no evidence that most of the proposals in the rule would address the causes of any unaddressed improper enrollments. CMS also fails to provide any estimate of the unaddressed improper enrollment it claims.

CMS has reported a significantly reduced, though still troublesome, number of reported improper enrollments in 2025, but also emphasizes multiple times that CMS is addressing these cases and that these figures are decreasing and expected to continue to decrease. CMS also provides no evidence that proposals in the rule would address causes of improper enrollment or address broker malfeasance that CMS itself cites and is known to be a [key source of the problem](#). Even if we accepted that some of the proposals in this rule had some effect on

improper enrollments, which we generally do not, CMS has acknowledged that fraud is concentrated in the FFM and fails to provide sufficient basis to extend the rule's provisions to SBMs. Colorado's SBM in prior comments to CMS has stated: "As a result of carefully considered design choices and a robust state regulatory framework, Colorado has not experienced reports of unauthorized or fraudulent enrollment."

CMS also seemingly ignores what SBMs do differently that reduces improper enrollment, namely not allowing or relying on EDE. CMS does not include proposals that would address the known FFM issues, such as strengthening the FFM actions already taken, bringing FFM practices in line with SBMs practices, ensuring adequate regulation and enforcement of regulations governing EDE entities, regulating lead generators, and [other options](#) that target the actual problem rather than imposing new burdens on consumers.

If a key goal of the rule is to respond to improper enrollment and fraudulent broker activity, CMS should take enforcement action against brokers, not burden consumers with additional administrative barriers to enrollment that will reduce enrollment and harm the risk pool and increase costs for states and exchanges.

Comments on Specific Sections and Proposed Changes

Comment Solicitation on Retaining Separate Risk Adjustment Transfer Calculations for Individual Catastrophic Plans and Individual Non-Catastrophic Plans Under the State Payment Transfer Formula - § 153

Regarding CMS's call for comments regarding whether risk adjustment transfer calculations for catastrophic and non-catastrophic plans should be combined or remain separate, **we urge HHS to keep them separate**. We generally oppose the expansion of exemptions for catastrophic coverage and saddling more consumers with very high cost-sharing/out-of-pocket costs they cannot afford. However, if these rules and changes for catastrophic plans are implemented, it is not prudent to alter the risk adjustment transfer calculation approach as doing so would be premature to fully understanding the impacts on the market and would likely harm the metal level risk pool, driving up premiums for metal level plans and further eroding affordability.

State exchanges ability to rely solely on web brokers - § 155.205

We oppose the proposed change to allow state-based marketplaces to rely on enhanced direct enrollment (EDE) through web brokers. State-based marketplaces create a single entry point for enrollment that can be easily identified and trusted by enrollees. SBMs have a responsibility to ensure consumers can access APTCs if eligible and have more substantial oversight than EDE web brokers. Unfortunately we've seen a few examples over the years in Colorado where websites purporting to offer ACA plans either do not provide any opportunity for enrollees to

understand if they're eligible for and enroll with APTCs or these websites steer enrollees into non-ACA/non-QHP plans that leave enrollees at significant unforeseen risks.

EDE has also been documented to substantially contribute to fraudulent enrollments perpetrated by unscrupulous brokers, agents, and web brokers.¹ CMS has clearly stated it wants to stop fraudulent enrollments. Allowing EDE facilitated by private web brokers will undermine this goal and leave consumers vulnerable to enrollment in non-ACA plans or losing access to APTCs for which they are eligible.

This change combined with allowing states to fast-track their transition from FFM or SBE-FP to a state-based marketplace will encourage rapid and potentially shoddy development of EDE web platforms by private entities as a potential way for states to quickly shift to being an SBM without sufficient infrastructure, robust eligibility platform development, or protections for enrollees to ensure they can access APTCs and CSRs if eligible.

EHBs & Required benefit/mandate defrayal - § 155.170 & 156.115

The proposed changes regarding state coverage mandates, EHBs, and defrayal are simultaneously confusing, alarming, and coercive of state policy. On the one hand, CMS indicates it is reverting to the policy prior to the 2025 NBPP rule, but the rule seems to propose a much more substantial change to the policy by requiring state defrayal even for state mandated benefits that have been incorporated into the state's EHB benchmark plan since Dec. 31, 2011, in some cases having been incorporated more than a decade ago into the state's benchmark plan. Such a change would effectively reverse how CMS has approached this issue for over 15 years and will force states to substantially alter their policy landscapes regarding coverage that have developed in that time. Most states will be heavily impacted by this and state budgets and policymakers will not be prepared for this change. This will effectively coerce states to undo state coverage mandates and likely coerce changes in state policy beyond the individual and small group markets, which CMS seems to acknowledge yet we question CMS's authority to do.

Essential Health Benefits are a key vehicle for states to respond to the needs of their population. All prior rulemaking on EHBs clearly acknowledged that states should be provided flexibility in determining coverage mandates and potential alignment through their EHB benchmark. The proposed change in approach to defrayal effectively undermines states' rights and the flexibility to update their EHB benchmark, whether through the EHB benchmark process or through other state policymaking. The combination of requiring defrayal for state coverage mandates and preventing states from updating their benchmark infringes on states' authority over their insurance markets and coverage landscape.

¹ Justin Giovannelli and Stacey Pogue, "Policymakers Can Protect Against Fraud in the ACA Marketplaces Without Hiking Premiums," To the Point (blog), Commonwealth Fund, Mar. 5, 2025. <https://doi.org/10.26099/nq57-4z21>

CMS has simultaneously indicated it may be considering broader rulemaking changes to EHBs by pausing benchmark updates that were already in progress. The proposed changes to defrayal tied with the pause in benchmark updates and potential additional rulemaking on EHBs raise substantive questions and concerns regarding CMS's ultimate intention regarding EHBs and make the proposed change in this rule potentially even more significant and alarming.

Additionally, the way this proposed rule has been crafted, it fails to acknowledge that state mandates could precede or follow updates to a state's benchmark plan. For instance, a state could update their benchmark with particular benefits not yet subject to a state coverage mandate, in which case defrayal would not be required, and if a state then codifies that benefit in the form of a state coverage mandate to potentially expand the benefit to other markets, the proposed rule would presumably require the defrayal of this benefit even though it would have been incorporated into the benchmark plan prior to a coverage mandate. This is yet another example of why altering the longstanding approach to defrayal when benefits from coverage mandates are integrated into a state's benchmark does not make sense.

The rationale CMS states for the change in approach to defrayal is to keep premiums lower for unsubsidized enrollees. This rationale disproportionately favors the needs of unsubsidized enrollees over those who receive APTCs. Even if we were to accept the assertion that this helps unsubsidized enrollees, which we do not, this change diminishes the quality of coverage for all enrollees regardless of APTC eligibility. Affordability is far more complex than just premiums, as noted elsewhere in these comments, and ensuring benefits coverage and more reasonable cost-sharing are substantial components to overall out-of-pocket affordability. The historic approach to defrayal provided sufficient guardrails and balance for all enrollees and we strongly urge CMS to revert to this balanced approach.

The proposed rule change also fails to address or provide guidance regarding other statutory and regulatory changes that impact EHBs, in particular mental and behavioral health parity.

The Affordable Care Act (ACA) requires Marketplace plans to cover EHBs, one of which is "mental health and substance use disorder services, including behavioral health treatment." State-required benefits adopted after 2011 are generally not considered EHB unless they are adopted "for purposes of complying with federal requirements." Although each state has some latitude in determining which benefits must be covered under each EHB category, the MH and SUD benefits must also "comply with the requirements under section 2726 of the Public Health Service Act and its implementing regulations." That is, coverage of MH and SUD benefits as an EHB must also comply with the Mental Health Parity and Addiction Equity Act (Parity Act) that was passed in 2008, as amended in 2020, and its implementing regulations. The 2013 implementing regulations included a "scope of services" requirement, such that if a plan covers a benefit for a SUD or MH condition in one classification (inpatient, outpatient, prescription drugs, emergency services), then the plan must cover benefits in all of the other classifications in which medical/surgical benefits are covered.

Given this timeline, it is important to realize that many MH and SUD benefits that have been added to benchmark plans to comply with the Parity Act were likely added after 2011. Indeed, many states did bolster their coverage of MH benefits in particular, which now may put these benefits in jeopardy under the proposed rule. Even as of 2017 though, most states offered ACA plans that did not comply with this requirement for coverage of SUD services.² In the 2020 NBPP final rule, the first Trump administration similarly acknowledged that “there is not comprehensive, nationwide coverage of the drugs used in MAT [medication and counseling treatment for opioid use disorders], at least among QHP issuers,” and encouraged “every health insurance plan to provide comprehensive coverage of MAT.”³ Since 2020, at least 11 states and D.C. have updated their EHB-benchmark under pathways through which they did not have to defray the costs of these services, most commonly adding benefits through this process for opioid use disorder-related prevention and treatment,⁴ as encouraged by CMS in a Frequently Asked Questions resource in 2018 under President Trump’s first term.⁵ CMS’s currently proposed rule would require these benefits added after 2011 to now be subject to defrayal in 2027. We have grave concerns that states will reduce their coverage of both MH and SUD benefits under this proposal, or at a minimum be deterred from adopting additional evidence-based lifesaving care for these conditions.

Ultimately, the substantial shift proposed in this rule to EHB and defrayal also creates substantial uncertainty that is unhealthy for insurers, the market, and consumers. CMS is substantially altering 13 years of policy at the federal and state levels with this change. In making this policy change, CMS would be exposing states to new financial liabilities, after those states made changes to their benchmark plans in reliance on CMS policy. This will create enormous confusion for consumers, administrative burden for states and insurers, and a substantial amount of coerced change in state policy. CMS should be continuing to improve EHBs and allowing states to innovate with different benchmark approaches and coverage models, not creating uncertainty and harm and likely exceeding its authority.

We strongly urge CMS not to finalize this proposal. If this proposal is finalized, at a minimum states should be provided with at least an additional two years (to plan year 2029) to undertake the extensive effort necessary to assess which mandates could be subject to defrayal, the costs

² “Uncovering Coverage Gaps II: A Review and Comparison of Addiction Benefits in ACA Plans,” Partnership to End Addiction (Mar. 2019), https://cdn-01.drugfree.org/web/prod/wp-content/uploads/2019/03/19202355/Uncovering%20Coverage%20Gaps%20II%20-FINAL%20%28040819%29.pdf?_gl=1*lg89snr*_gcl_aw*R0NMLjE3Njk1NDc0MjEuQ2owS0NRaUE0ZUhMQmhDekFSSXNBSjJOWm9LRkMxaC1Ub1FpX0sza1RRS3d4R1lVZEJTcnRWcWJkenZJWlkzYW5ZOGd6QTZtdjZWUnhpQWFBa1NxRUFMd193Y0I.*_gcl_au*NTAzMDIwNTczLjE3Njk1NDc0MDY.*_ga*MTA1NDQzNDczNS4xNzY5NTQ3NDA4*_ga_ECZGQ0GWSZ*_czE3NzE5NjgxODMkbzMKZzAkDDE3NzE5NjgxODgkajU1JGwwJGgw.

³ “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020,” 84 Fed. Reg. 17454, 17563 (Apr. 25, 2019).

⁴ Stacy Pogue, “Enhancing Essential Health Benefits: How States are Updating Benchmark Plans to Improve Coverage,” The Commonwealth Fund (Nov. 14, 2024), <https://www.healthaffairs.org/content/forefront/hhs-proposes-sweeping-changes-2027-marketplace-plans-part-2>.

⁵ “Frequently Asked Questions on Defrayal of State Additional Required Benefits,” Centers for Medicare & Medicaid Services (Oct. 23, 2018), <https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/downloads/faq-defrayal-state-benefits.pdf>.

associated with such defrayal, and to either repeal or amend relevant existing laws or regulations.

Prohibition on coverage of sex-trait modification and adult dental as EHBs - § 156.115

We oppose the proposed change to reinstate the prohibition on including adult dental in EHBs through a benchmark plan. Adult dental coverage is routinely and immediately brought up by consumers in community forums as a key priority in Colorado and consumers frequently ask why it is not included with health insurance. There is increasing and strong evidence that oral, physical, and mental health are [inextricably linked](#) and failure to treat one leads to detrimental, and sometimes devastating, effects on the others. It is precisely because oral health is so important that pediatric dental was included as a required EHB category, but evidence since the ACA's passage has further illuminated the importance for oral health throughout an individual's lifespan. CMS's about face after removing the prohibition is based on a reinterpretation that fails to acknowledge the evidence that supports integration of oral health into EHBs for all enrollees. Some states, including Colorado, have already invested time and resources investigating the opportunity to add adult dental to EHBs. Those efforts in Colorado show it would be significantly cheaper for adults to have dental coverage embedded in ACA regulated plans than purchase it separately. CMS is actively generating uncertainty and ignoring state investment and this important opportunity. Arguably, inclusion of dental coverage for some, but not other enrollees is discriminatory in nature. **We not only oppose the prohibition on adult dental in EHBs, but as in the past, urge CMS to actively require embedded dental coverage regardless of age.**

CMS also continues to include language to prohibit issuers from offering "sex-trait modification" as an essential health benefit (EHB). We reiterate the term "sex-trait modification" has no basis in law, policy, science, or medicine.

As we have communicated in other comments on this issue, we strongly oppose this discriminatory proposal. CMS's integration of this while this provision (among others) in the Marketplace Integrity Rule is subject to legal challenge seems an attempt to circumvent the legal process.

By excluding this care from state EHB requirements, this proposal will raise health care costs and encourage denials and other limits on medically necessary care, including hormone therapy and other medical interventions for persons diagnosed with gender dysphoria. Such limits are not only unlawful; they are unconscionable.

By targeting care for individuals with gender dysphoria—while expressly proposing to create exceptions to cover this care for other indications—this proposal exceeds CMS' authority to define EHBs.

Issuing a blanket nationwide rule that would prevent insurers from covering treatment for people with gender dysphoria as EHB is contrary to the requirement that EHBs be defined in a way that protects individuals from discriminatory benefit designs. It is also inconsistent with existing laws

and policies, including Section 1557 of the Affordable Care Act (ACA), the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act, that prohibit discrimination against people with gender dysphoria, as the courts have recognized.⁶

Second, the proposal goes beyond the limit imposed by the ACA that ties EHBs to coverage in typical employer plans. CMS claims, without evidence, that treatment for gender dysphoria is not typically covered in employer plans. This is false. In the 2025 Corporate Equality Index, the Human Rights Campaign Foundation found that 72% of Fortune 500 businesses (and 91% of businesses listed on the Corporate Equality Index) offer coverage of treatment for gender dysphoria.⁷ As a result, over 1,300 major employers nationwide cover this care, 28 times as many businesses as in 2009.⁸ Similarly, coverage for gender dysphoria is widespread among state employee plans (24 states and DC), Medicaid (27 states, Puerto Rico, and DC), the Health Insurance Marketplaces (55% of plans across all 50 states covered this care in plan year 2025), and state-regulated coverage (24 states and DC prohibit exclusions of coverage for gender dysphoria).⁹

Third, CMS's proposal risks disrupting coverage and access to care for all consumers, regardless of their diagnosis. CMS seeks to discriminatorily exclude from EHB items and services when administered or prescribed for the medically necessary treatment of gender dysphoria. However, the medical services associated with this treatment are not unique to transgender people and are frequently needed by non-transgender people for treatment of other conditions. Services that may be needed for the treatment of gender dysphoria are found across almost every category of EHB and, as the proposed rule itself recognizes, are routinely covered for a variety of indications.

This proposal would also disrupt the balance CMS has established between safeguarding access to a minimum level of services across the country and state flexibility to address the health care needs of their populations. Since CMS established the EHB benchmarking process, the agency has often used its authority to define EHBs to create national coverage standards as minimum requirements, but it has never utilized the EHB framework to force states to

⁶ Prescott v. Rady Children's Hosp. (S.D.C.A. 2016), Flack v. Wisconsin Dept. of Health Svcs. (W.D. Wis. 2018), Boyden v. Conlin (W.D. Wis. 2018), Tovar v. Essentia Health (D. Minn. 2018), Williams v. Kincaid, 45 F.4th 759, 766 (4th Cir. 2022)

⁷ See Human Rights Campaign, Corporate Equality Index 2025: Rating Workplaces on Lesbian, Gay, Bisexual, Transgender, and Queer Equality (Jan. 2025).

⁸ *Id.*

⁹ Out2Enroll, *Summary of Findings: 2025 Marketplace Plan Compliance with Section 1557 of the Affordable Care Act*,

<https://drive.google.com/file/d/1FpSNyaZVfC25o3zXnYBWUVaYRWokwbwg/view>; Comm. Ricardo Lara et al., Letter to Sec. Xavier Becerra, U.S. Depart. of Health & Human Svcs., *Re: Proposed rule Section 1557 of the Affordable Care Act RIN 0945-AA17*, Docket ID number HHS-OCR-2022-0012 (Sept. 30, 2022),

https://www.insurance.ca.gov/0400-news/0100-press-releases/2022/upload/joint-Letter-Final_ACA_SECTION_1557_NPRM_sign-on_letter_2022-2.pdf.

categorically exclude benefits that target populations with a particular condition. The existing approach, which this proposed rule would eviscerate, has been an essential tool that appropriately affords states the opportunity to use EHBs as a tool to ensure that coverage is nondiscriminatory and responsive to the needs of their populations.

CMS's proposed exclusion of "sex-trait modification" will inflict higher costs, limit access to care, and cause harm to transgender people, who already experience discrimination and coverage denials at an unprecedented level. This proposal is discriminatory and should be withdrawn.

Failure to reconcile (FTR) - § 155.305

We strongly encourage the CMS to maintain the existing two-year timeframe for APTC denial due to FTR status, as we believe it's essential to maintain the current notice requirements. Clear and timely notices remain a critical component for individuals to understand both their FTR status and steps necessary to come into compliance. The goal should be to support taxpayers with the tools needed to properly engage with the Marketplace and IRS systems. Systems must also take accountability for system driven errors and delays that might result in the incorrect FTR tags and thus, inappropriate APTC denials. Clear and timely notices empower applicants to understand their status and proactively address any issues or errors- allowing the systems to function more accurately and as intended. Given the IRS' backlogs and error rates for tax filing, any punitive action without reasonable timelines to identify and address issues is simply in service of denying affordable coverage to individuals and families rather than ensuring appropriate designation of APTCs.

Income verification requirements and removal of self attestation - 155-320

We oppose any barriers to enrollment, including additional verification processes when previous IRS data is inconsistent with projected future income. Data matching issues (DMI) leave many people to pay the full premiums to their issuer after the end of an inconsistency period and during an appeal process. For consumers initially determined eligible for APTCs, this can create an extreme financial hardship and puts these consumers in a bind of maintaining coverage with full premiums that they are paying out of pocket, versus losing coverage and potentially incurring medical debt, especially if coverage is allowed to lapse for an extended period of time.

We again emphasize that in general, state-based marketplaces have implemented appropriate systems for verification, and additional verification adds administrative burden and cost that is unnecessary.

We oppose any barriers to enrollment, including removing the option for self-attestation of projected income. This proposed policy would erect new barriers in coverage for people who are eligible. This would be especially harmful for people who are eligible for Marketplace coverage with very low incomes, but especially those who live in states that have not yet expanded Medicaid and have no other options for affordable coverage.

We reiterate earlier comments that it is normal for many enrollees to predict their income, and individuals know their situation best to be able to attest to the income they anticipate in the coming year. This proposed change will disproportionately impact people with lower incomes and those who engage in seasonal work, agriculture, the gig economy, are self-employed, or work in rural areas.

This proposed change also fails to offer alternative income verification methods to address data gaps that exist, such as for new labor market entrants or individuals transitioning from informal work. CMS does not provide data or evidence to support its assertion that this change will improve integrity without creating a coverage gap, effectively denying a pathway to certain populations to establish their eligibility.

Creating a DMI when IRS data shows income below 100% FPL or in the absence of IRS data will create substantial burden for eligible low-income people and those with variable income and generate a nonsensical barrier to receiving benefits for which they are eligible. Again, this will deter enrollment of healthier individuals and worsen the marketplace risk pool, raising premiums for unsubsidized enrollees. This imposes real, tangible harms with only speculative benefit that is unsupported in CMS's analysis. A similar version was struck down in court in 2019, with the court finding that CMS's decision to "prioritize a hypothetical risk of fraud over the substantiated risk that its decision [would] result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic." In staying the same provision in the Integrity rule, [the court](#) reiterated this reasoning.

According to CMS's own estimates, implementing this policy would deny APTCs to tens of thousands of people *eligible for this financial assistance*, who would be required to respond to (DMIs) by providing proof of income- documentation that may be hard for individuals to collect before they can enroll in coverage.¹⁰ In the preamble for this rule, CMS points to a substantial number of improper enrollments by agents, brokers, and web-brokers exploiting the recent changes in eligibility, potentially being facilitated by AI. As noted previously, CMS should pursue addressing improper enrollments by addressing the primary source, EDE and fraudulent enrollments perpetrated by unscrupulous brokers, rather than effectively deny eligible people access to care through unnecessary administrative burden.

While CMS may have authority to verify income under these circumstances, CMS must also consider the primary goal of the ACA to maintain coverage for eligible enrollees in devising the methods to verify income. It has fundamentally failed to do that.

Comment solicitation on Premium Payment Threshold - 155.400

¹⁰ "HHS Proposes To Restrict Marketplace Eligibility, Enrollment, And Affordability In First Major Rule Under Trump Administration (Part 2)", *Health Affairs Forefront*, March 13, 2025 . DOI: 10.1377/forefront.20250313.693035

We strongly oppose CMS’s consideration of permanently discontinuing regulatory options allowing QHP issuers to implement a premium payment threshold. Eliminating the flexibility of issuers to implement a premium payment threshold will lead to additional losses in coverage. CMS states its primary concern with this comment solicitation is unauthorized enrollments (UEs). UEs however are [rarely perpetrated by the individual consumer](#). As CMS has acknowledged elsewhere, brokers, agents, and web-brokers have been overwhelmingly responsible for UEs. If CMS were to eliminate the option to implement a premium payment threshold, it would effectively punish individual enrollees rather than the primary perpetrators of UEs.

We disagree with the assertion that optional gross premium and fixed-dollar payment thresholds contribute to improper enrollments and CMS fails to provide evidence thereof. Under current regulations, gross premium and fixed-dollar thresholds only apply for purposes of triggering grace periods and coverage loss, not to binder payments.¹¹ Therefore, individuals who owe a premium amount must still make an initial payment to effectuate coverage – owing a portion of their binder payment under a net premium percentage-based threshold, or the entire binder payment under a fixed-dollar or gross premium percentage-based threshold.

Once again, this policy also unnecessarily limits the ability of our state to manage our own unique health insurance market. We already see lower rates of fraud in states with State-based Marketplaces and we need the flexibility to establish premium payment thresholds that work best for the people of Colorado and our market.

Extend removal of SEP for below 150% FPL - § 155.420

We oppose any barriers to enrollment, including eliminating the special enrollment period (SEP) for households with projected incomes at or below 150% of the federal poverty level (FPL). The monthly low-income SEP is an effective tool for promoting access to health coverage, particularly for individuals who experience administrative challenges during other enrollment periods. Enrolling through an SEP is already challenging. Individuals must first recognize their eligibility, know to look at the marketplace for affordable plan options, seek enrollment assistance when necessary, and then typically apply within 60 days of qualifying event. Existing administrative hurdles already discourage many individuals from enrolling in coverage, particularly younger and healthier individuals who are crucial for a balanced risk pool and who benefit from comprehensive coverage during unexpected health issues.¹² Given the additional enrollment barriers proposed by CMS, eliminating this SEP places even greater burdens on low-income individuals who may need additional time to meet new documentation requirements or access enrollment assistance.

¹¹ 45 CFR 155.400(g)(2); 45 CFR 155.400(g)(3)

¹² Schwab, R. (2017, March 17). Stakeholders React to HHS’ Proposed Market Stabilization Regulations: Part 2 Consumer Advocates. *CHIRblog*. <https://chirblog.org/stakeholders-react-hhs-proposed-market-stabilization-regulations-part-2-consumer-advocates/>; Lucia, L. (2016). How Do We Make Special Enrollment Periods Work? *Health Affairs Blog*. <https://doi.org/10.1377/forefront.20160216.053180>

Without the low-income SEP, many eligible individuals - who are generally young and healthy - could be left uninsured simply because they are unable to navigate these challenges, harming all enrollees by upsetting the risk pool. Additionally, all states are continuing to work to support people who were disenrolled from Medicaid after the end of the public health emergency. This is of particular importance in Colorado given our high disenrollment rate. This SEP helps ensure Coloradans who have been disenrolled, which they may not know until the traditional 60 day period for an SEP has lapsed, can get covered and not be left exposed to crippling medical debt.

We would also note that SEPs have also generally proved beneficial for the risk pool without adverse selection. When people are able to receive significant financial assistance to lower their premiums, consumers are not an adverse selection risk, as they have a strong incentive to stay enrolled.¹³ What we have seen, however, is that some consumers are still unaware substantial financial assistance is available, or may believe the tax credits are less supportive than they are, especially after the termination of the enhanced tax credits. When some states provided an SEP during the COVID pandemic effectively re-opening enrollment, risk score decreases (-14.1%) and enrollment increases (3.9%) were larger than in states that did not.¹⁴ This demonstrates that SEPs are beneficial for the risk pool overall by lowering barriers to bring people who are generally healthier into the market.

Expansion of hardship exemption and Multi-year catastrophic plan (expansion of catastrophic plans) - § 155.605, 156.155, 156.130

We strongly oppose the expansion of catastrophic coverage as these plans do not adequately protect consumers.

The proposed rule would make catastrophic coverage much more widely available. CMS posits that this is to benefit consumers struggling with premium increases (for example, because of the termination of enhanced premium tax credits) to create more choices that trade the specter of more affordable premiums for unaffordable higher deductibles. This is combined with CMS's announced flexibility expanding availability of catastrophic plans beyond individuals under 30 years old, the proposed change to allow multi-year catastrophic plan terms as long as ten years, and significantly increasing out-of-pocket maximums for catastrophic (and bronze) plans.

Affordability is based on more than just premiums, and the out-of-pocket/cost-sharing allowed under these changes will sacrifice the ability to seek care with less fear of costs for lower premiums. CMS fails to account for or balance premiums with the corresponding financial protection needed in out-of-pocket cost limits to ensure affordability. Plan designs with high out-of-pocket maximum amounts and high deductibles leave people with complex or chronic conditions, who have higher health care utilization, with very high out-of-pocket costs and

¹³<https://www.cbpp.org/research/health/broadening-marketplace-enrollment-periods-would-boost-access-to-health-coverage>

¹⁴<https://www.commonwealthfund.org/blog/2022/does-making-health-insurance-enrollment-easier-cause-adverse-selection>

expose individuals who develop new health conditions or experience a substantial medical event to severe out-of-pocket cost burdens. This proposal will erode fundamental consumer protections that have limited these plans to a small segment of the population. The policy solution for premium affordability for unsubsidized consumers should not be to foist more cost sharing onto already struggling consumers.

CMS's proposal to expand the hardship exemption for consumers below 100% or above 250% FPL is contrary to the intent of the ACA and will harm consumers. Consumers who qualify for APTCs should be protected from sub-standard metal level coverage that leaves them at significantly greater financial risk. It is also simply baffling and fundamentally flawed logic that CMS believes catastrophic plans are affordable for people below 100% FPL in any respect, premiums or cost-sharing, and catastrophic plans will also not be affordable for consumers above 250% FPL. Even looking at an individual with income at 399% FPL, with an income around \$60,000 a yr, cannot afford a maximum out-of-pocket of more than \$15,000 that equates to a more than 25% of their annual income. Federal analysis shows 4 in 10 Americans would struggle to afford an unexpected medical bill of \$400 or more,¹⁵ or an unexpected medical bill that is nearly 40 times smaller than maximum deductible CMS plans to set for catastrophic plans.

These changes are also substantially likely to increase premiums in metal level plans as healthier people shift out of those plans and the risk pool deteriorates. This will result in the complete opposite of CMS's stated goal of improving affordability in the market as consumers will face higher premium increases for metal level plans and increasingly struggle to afford coverage that adequately protects their health and finances. CMS fails to adequately account for the impact to premiums in other metal tiers in this proposal.

It also seems that allowing a ten-year catastrophic plan is a policy solution to a problem that does not exist and allowing these plans to design a product with varying out-of-pocket maximum amounts yearly by disease or condition will most certainly allow for discriminatory plan designs. This combined with the significant expansion of the hardship exemption creates a pathway for a skimpy plan with very little consumer financial protections that will siphon off healthy enrollees from other metal levels while exposing consumers whose health needs change in a 10-year period to unpredictable higher out-of-pocket costs.

There is ultimately insufficient detail provided in the rule to even be able to fully understand the 10-year catastrophic plan proposal nor how it will operate for either consumers or insurers. The proposal has been presented without clarity on many aspects of the proposed multi-year plans, including whether the premium per year of the plan would be fixed for the duration of the plan contract, how issuers would calculate the index rate for both multi-year plans and other plans if at least one of its plans is a multi-year plan, whether consumers would be able to switch plans during Open Enrollment or enroll in an existing multi-year plan during a special enrollment period, or what happens if a plan is no longer offered or the insurer leaves the marketplace. These are key criteria of coverage and the lack of details regarding them indicates this

¹⁵ <https://www.federalreserve.gov/consumerscommunities/shed.htm>

proposal's detrimental impact for consumers may be substantially larger than those already listed above. We question whether this proposal is even allowable under the ACA, but regardless, the harm to consumers is clear enough that this proposal must be abandoned.

Amending network adequacy standards and "non-network" plans - § 155.1050, 156.230, 156.236

We strongly oppose the proposed changes to network adequacy requirements and the proposal to allow "non-network" plans. We are deeply concerned about the erosion of network adequacy protections in several respects. Removal of the requirement for SBM states to implement time and distance standards and allowing FFM states to do their own network adequacy review if they demonstrate to CMS their program is sufficient removes an important federal floor for protection. We know that states have an important role to play in network adequacy protections, and Colorado has done so. However, removal of this federal floor that ensures protections across the country is likely to lead to access challenges for consumers depending on their state and the state's ability or willingness to ensure adequate insurance networks. If consumers buy a plan under the ACA, they should have the peace of mind that those plans will ensure they have access to the spectrum of providers they may need.

We are alarmed at CMS's highly under-developed and harmful proposal to allow "non-network" plans and oppose this change. First and foremost, CMS has insufficiently articulated how certain key consumer protections will be maintained within these plans, such as limits on consumers' out-of-pocket spending, coverage of preventive services without cost sharing, and limits on maximum out-of-pocket spending. CMS fails to provide evidence to contradict the prior rule that found non-network plans were inadequate to ensure consumer access to care and relies on general assertions without evidentiary support.

Instead of the traditional requirement of plans to have a published network of providers with whom the plan contracts, "non-network" plans agree to pay providers a capped amount. This proposal seems to mirror models like fixed indemnity plans that do not provide comprehensive coverage and would fail in multiple respects to qualify as a QHP. CMS's proposal for "non-network" plans fails to address the key consumer protections necessary to meet QHP standards.

It is also unclear how insurers would be able to provide sufficient documentation or guarantee that enough providers are available in these "plans." This includes the proposal being entirely unclear how mental health parity will be protected in these "non-network" plans. In fact, it seems highly unlikely provider access can be guaranteed and mental health parity protections and standards can be maintained meaningfully without a traditional provider network. Again CMS fails to address or provide guidance on how these plans can comply with requirements like mental health parity rules, making this proposal that much more dubious.

Even assuming key consumer protections are met, which we fundamentally do not believe these plans capable of, these plans would put an exorbitant burden on consumers to do a lot of

work on the front end before seeing a provider to ensure the provider would accept their plan's payment as payment in full, and – since "non-network" providers would not be required to accept assignment – would likely be forced to deal with the bureaucracy of both the provider's billing system and the plan's claims systems. This will put consumers in the middle in a very similar way that surprise balance bills did prior to the No Surprises Act.

The NSA protections is yet another area in which we question how this proposal will work. Without an established provider network, it's highly likely almost all bills for healthcare services will result in balance bills. Even the most savvy consumers may not be able to prevent a balance bill, especially because they cannot rely on the protections available in network plans.

While this Administration has touted consumer transparency provisions, they are simply not yet available nor enforced at a scale that would allow any consumer to navigate this type of policy.¹⁶ CMS's proposal related to "non-network" plans assume both CMS and state regulators have access to information about providers' billed charges to assess issuers' statements that their reimbursement rates provide access to a sufficient choice of providers. This information simply is not available at the level needed for CMS and state regulators, much less consumers, and we question how issuers would be able to reasonably make such an assertion for these plans.

"Non-network" plans will also encourage providers to overcharge patients up front and put the onus on the consumer to closely track their cost-sharing and pursue refunds from providers in cases of overpayment, which increases burden and affordability barriers for consumers. This will make care less affordable up front and deter access to care under these plans. CCHI's consumer assistance program has seen numerous cases with traditional network QHP plans where providers overcharge patients up front (often consumers with HDHPs), and it can be extremely difficult for the patient to request and subsequently receive a refund in a timely manner after they receive services or treatment and their insurer processes their claim. This will only add to the burden and financial strain of being overcharged up front. To make this matter worse, we do not see a clear, viable mechanism for patients to receive documentation like an advanced explanation of benefits for "non-network" plans.

Because these "non-network" plans don't have traditional provider networks, there won't be provider lists available in advance, removing the ability to pick a plan based on the network for these plans. This is also a key protection for consumers to ensure they can continue to access the providers they need. There is no way they will be able to determine if a provider is accessible with the proposed "non-network" plans. This raises yet another area of consumer protection that CMS has failed to address regarding this proposal, continuity of care protections. Continuity of care protections rely on traditional provider networks to function and CMS has failed to articulate how these protections would be sustained in "non-network" plans.

¹⁶ Darius Tahir, KFF Health News, Trump Required Hospitals To Post Their Prices for Patients. Mostly It's the Industry Using the Data, February 7, 2026, <https://kffhealthnews.org/news/article/price-transparency-trump-hospitals-insurers-health-care-costs/>

We are also concerned that multiple proposed provisions in the NBPP could operate together to undermine core protections for marketplace coverage. For example, if a "non-network" plan design is paired with the flexibilities also proposed for catastrophic plans, that product would begin to mirror pre-ACA coverage with potential for significant financial exposure if someone actually uses their coverage. While attractive to young, healthy consumers, this type of plan design will not work well for people who have higher health care utilization. The combination of proposed changes are likely to substantially damage the risk pool, lead to premium spikes for traditional QHP non-catastrophic plans, exacerbate affordability challenges in the marketplaces, undermine other laws and protections like the No Surprises Act, and ultimately leave patients and consumers at much higher financial risk and unable to access the care they need with these plans. The combination of changes will substantially erode consumer protections that are required under the ACA and will ultimately add to the affordability crisis and drive up underlying healthcare costs.

Essential community provider standards for networks (reduction from 35 to 20% threshold) - § 156.235

Federal law generally defines ECPs as providers who serve predominately low-income, medically underserved individuals, and particularly providers described in section 340B of the Public Health Service (PHS) Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act (SSA). According to the CMS Office of Disease Prevention and Health Promotion, as well as research funded by the National Institutes of Health, Essential Community Providers (ECPs) often achieve better health outcomes for underserved populations, such as rural communities, inner city communities and various ethnic communities, by delivering high-quality, comprehensive care, resulting in, for example, better hypertension/diabetes management and lower mortality rates. They improve access to care, lower overall per-patient costs compared to other providers, and offer essential services in areas with limited resources.

As safety net clinics in Colorado worked to become parts of coverage networks, significant effort had to go into having carriers even pay attention to the fact that an ECP was trying to join the network. This meant engaging the state Division of Insurance to alert carriers to this effort.

Despite the current standard of 35%, there is no qualifier during the carrier's vetting process through application and/or credentialing that would assist the carrier in knowing whether or not they are meeting any required standards. This is suboptimal given the successes of ECPs relative to the rest of the providers in a network in improving the health of challenging patients.

When safety net clinics began the process of applying to be a part of carriers' networks, the ECPs that are safety net clinics presented to the carriers as just another small practice.....something in which the carriers appeared to have no interest. Special resources had to be applied to have the carrier even consider the application. The first few attempts, clinics received a polite, "no thank you, we are not expanding our network at this time." Once the Division of Insurance backed the effort, the clinics were considered and accepted, but only after significant engagement and documentation outside the regular application process.

According to the Peter G. Peterson Foundation's comparison of the US and European countries the US has as trading partners, the U.S. healthcare system spends significantly more per capita than other high-income nations, yet consistently underperforms in key health outcomes, including lower life expectancy, higher infant/maternal mortality, and higher rates of preventable, premature deaths. While the U.S. has high health system capacity and technology, it ranks last overall among similar countries due to poor access and inequity.

Thus, to regress in assuring that ECPs, providers naturally positioned to provide the culturally competent care necessary across the country, are included in insurance providers' networks increases the likelihood that the overall health outcomes of the United States will continue to decline. If anything, in order to turn this circumstance around, insurance networks should have a higher percentage of ECPs in their networks, not less.

ECPs are typically developed from their community, so they are better positioned to understand the unique circumstances and cultural needs of a rancher, a farmer, an immigrant or a specific neighborhood. Given the data showing the healthcare improvements for populations who normally are high cost and difficult to treat, CMS should be encouraging Essential Community Provider (ECP) contracting rather than discouraging it. Making America Healthy Again is possible with culturally competent care offered by ECPs, and this should be reinforced.

CMS again does not provide data, studies, or evidence to support the change of the threshold to 20%. It does not provide evidence to support the assertion that 20% will ensure "meaningful access" for low-income or medically underserved enrollees. **CMS should maintain the 35% threshold as it has not provided sufficient evidence or data to support lowering it.**

Maximum Out-of-pocket Limits and de Minimis Ranges - §156.130 & 156.140

We strongly oppose CMS's proposal to allow cost-sharing designs that exceed the maximum annual limit and question CMS's authority to do so.

CMS's proposal to allow plans, particularly bronze level plans, to offer cost-sharing designs that exceed the maximum annual limit defeats the purpose of such maximums as required under the ACA statute, and is yet another proposed change by CMS to expose consumers to increasing financial risk in this rule. Maximum out-of-pocket costs are already too high for a majority of consumers to be able to afford care, and this will only exacerbate the crisis. A major health event with bronze level coverage would put a large majority of Americans at extreme risk of financial hardship and instability.

The ACA clearly required maximum annual out-of-pocket limits to protect consumers from excessive medical costs and ensure consumers are better protected during a major health event. We question CMS's authority in this proposal to allow plans that exceed the maximum annual limits under the ACA. Doing so effectively undermines this fundamental guardrail of the ACA's protections.

We also reiterate earlier comments we have provided regarding CMS's allowing expanding the *de minimis* range in the negative, a change proposed in the Marketplace Integrity Rule that is again under court challenge. The definition of *de minimis* range for actuarial value (AV) requirements for individual and small group market plans was proposed to change from +/- 2 percentage points to +2/-4 percentage points, which is detrimental to consumer protections against higher out-of-pocket costs. The expanded negative range for *de minimis* undermines the ACA's established metal tiers and will make it more difficult for consumers to distinguish and compare plans and choose what best suits their needs. By lowering the AV for silver plans to 66 percent, only one point above certain bronze plans, plans across those metal tiers will become virtually indistinguishable to individuals. People who enroll in marketplace plans consistently demand higher value plans and cite barriers like cost-sharing affordability, deductibles, and other out-of-pocket costs¹⁷.

Premium tax credits are also based on the premium of the second-lowest cost silver plan where the consumer lives (the "benchmark"). Allowing plans with lower actuarial values to qualify as silver plans can result in lower benchmark plan premiums, and hence - lower premium tax credits *for all plans*. This fundamentally undermines affordability by reducing the premium tax credits for millions of individuals, driving up their costs while creating greater confusion for individuals during the plan selection process.

Combined with the substantial jump of 13% in the maximum annual out-of-pocket limit proposed for 2027 (second highest since the ACA's inception after the 15% increase for 2026), CMS is fundamentally undermining out-of-pocket limit protections for consumers. Prior to the 2026 and proposed increase for 2027, no increase in annual out-of-pocket limits exceeded 5% annually, more closely aligning those annual increases with the rates of medical inflation. CMS has proposed two consecutive increases that are roughly 3 times the rate of medical inflation. CMS indicates these changes are necessary to "catch up" to increasing costs and AV calculations. However, if CMS makes this argument, it indicates it is dedicating insufficient effort and capacity in the insurance rate review process and failing to push insurers to do more to control the underlying costs of healthcare.

Consumers should not be punished for the failures of insurers or regulators to leverage their power to control healthcare costs. If anything, this is an even stronger reason against such changes to protect consumers and to increase pressure on insurers. CMS should dedicate more capacity to effective rate review that helps control costs for consumers. It also indicates the federal AV calculator may be overstating medical inflation year to year, something we encourage CMS to address.

¹⁷ *Building on the Affordable Care Act: Strategies to Address Marketplace Enrollees' Cost Challenges*. Center on Budget and Policy Priorities. (2024, April 10). <https://www.cbpp.org/research/health/building-on-the-affordable-care-act-strategies-to-address-marketplace-enrollees>

We again oppose these changes to out-of-pocket annual limits that will make accessing care an extreme financial hazard for millions of Americans and reiterate our opposition to expanded de minimis ranges in the negative.

Removal of standardized plans for FFE/SBM-FE & Removal of limits on non-standardized plan options - § 155.20, 155.205, 155.220 156.201, 156.202, 156.265

While we understand the proposed removal of standardized plans and removal of limits on non-standardized plans do not affect state-based marketplaces like Colorado's, **we oppose these changes as they are detrimental to consumers across the country, remove key federal guardrails, and will create choice overload, silver-spamming, and other harmful effects.**

Standardized plans make plan selection easier for beneficiaries and provide upfront certainty and limits to patient cost-sharing for various services making the use of insurance more affordable. Removing them will make plan selection more difficult and subject beneficiaries to higher costs, depending on their health needs, and create choice overload that is detrimental for consumers. Research and consumer testing studies have consistently found that too many plan choices can impede the ability to make the best plan choice.¹⁸ Analyses have also found that standardized plans can help reduce discriminatory plan designs (e.g., by making it more difficult in plans to engage in “adverse tiering” where all or most drugs used to treat a particular condition are placed on the highest cost-sharing tier.¹⁹ Coupled with meaningful difference standards (which CMS could opt to reinstate here), reducing plan numerosity could not only help consumers, but could also reduce regulator burden.

CMS makes a conclusory statement that standardized plan options are “ineffective” in improving the consumer experience or understanding and that these changes are intended to improve “flexibility.” However, this claim is unsupported by CMS, fails to address evidence to the contrary from prior rulemaking and consumer decision-making research, and the experience in Colorado entirely contradicts this assertion. In 2023, Colorado introduced the standardized Colorado Option plans. Based on initial enrollment, Colorado Option plans now account for 50% of enrollment submissions through Connect for Health Colorado. This indicates that contrary to CMS’s claim, standardized plans can be a very effective tool to improve consumer experience and understanding. CMS also claims, without justification or providing evidentiary support, that it is necessary to remove standardized plan option for market stability.

¹⁸ Quincy L. What’s Behind the Door: Consumers’ Difficulties Selecting Health Plans. Consumers Union. Jan. 2012. https://advocacy.consumerreports.org/wpcontent/uploads/2013/03/Consumer_Difficulties_Selecting_Health_Plans_Jan2012.pdf.

¹⁹ HHS, ASPE, Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces, December 2021, <https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf>; Jacobs D.B. and Sommers B.D. Using drugs to discriminate--adverse selection in the insurance marketplace. N Engl J Med, vol 372, no. 5 (Jan. 2015): 399-402. <https://www.nejm.org/doi/10.1056/NEJMp1411376>.

CMS's proposal to end standardized plans, combined with the proposed removal of the limitation on non-standard plan options, will undermine meaningful consumer choice. Consumers would again be faced with an array of confusing choices and struggle to select the plan that will be best for their needs, and FFM states will be hamstrung in preventing this. It is also highly likely removing limits on non-standardized plans will lead to "silver-spamming" by carriers to attempt to monopolize the first page of plan options displayed to consumers in FFM states. If carriers are successful at "silver-spamming" it will distort the market and create significant swings in carrier market share and risk year to year. This will create more volatility and likely reduce affordability overall as the market will be less stable and predictable for carriers year to year. The evidence does not support this change and CMS should reverse course and sustain standardized plan options and limits on non-standard plans to ensure meaningful consumer choice.

Comment solicitation on potential adjustment to the MLR for a state's individual market (Part 158 Subpart C)

We are deeply concerned and opposed to the proposal to adjust the MLR in states that have not requested it and fundamentally question CMS's authority in considering this. It is alarming that comments regarding this concept are being solicited. State regulators are best positioned to understand markets under their purview and know if adjustments to MLR are needed and is not an area of rule in need of change.

CMS acknowledges that no states have requested adjustments to MLR under the existing rule that has been in place since the 2019 Payment Rule. This strongly indicates that CMS's solicitation for comments is baseless and the MLR standards are not creating market instability. This is not surprising as the MLR standard has been consistent since the ACA's implementation and has become a consistent element in how the individual market functions. The MLR should not be a significant factor in market stability in an effectively regulated market and we would generally find it dubious if a state, insurer, or CMS claimed otherwise. Insurers have a variety of tools and mechanisms in creation of their plans and rates to ensure plan viability. While there may be extreme scenarios that might warrant a temporary adjustment to MLR, the existing rule structure would allow a state to request such an adjustment.

CMS indicates there has been market "instability in recent years." In Colorado's case, the primary instability we have seen in the individual market is for the 2026 plan year from the termination of enhanced premium tax credits. Prior to that, Colorado's individual market has been largely stable with respect to premiums. While there have been shifts in carrier participation in the individual market, those have not been due to instability in the market, much less the MLR, but from business decisions made by carriers.

CMS's consideration of a broader change to MLR not driven by a state is deeply troubling and seems to be a fishing expedition to get input from carriers to justify lowering the MLR threshold in the name of reducing premiums and further reducing the value of ACA plans on top of the detrimental changes already proposed in this and prior rules. However, this ignores the fact that

no state has requested an MLR adjustment and fundamentally fails to acknowledge the protection the MLR provides for consumers. The ACA established the MLR for a clear purpose, to ensure carriers met a clear threshold of spending on actual health care from the premiums they bring in.

This is yet again an area where we are alarmed CMS is likely exceeding its authority and that rulemaking would go beyond what is allowed or intended under the ACA to fundamentally undermine the consumer protections required by law.

In conclusion, several proposals in this rule likely exceed CMS's authority, do not maintain the key protections required under the ACA, and are likely to be challenged. With many others, CMS fails to provide sufficient evidence or analysis to support the proposed changes or uses a rationale that fails to justify the change. **We strongly oppose many proposals in this rule and urge CMS to abandon changes as noted above that will make it harder for consumers to enroll, create administrative burden and barriers, increase premiums and out-of-pocket costs, and harm the individual market.**

If you have any questions regarding these comments, please contact Adam Fox, afox@cohealthinitiative.org.

Sincerely,

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SUBMITTED ELECTRONICALLY:

Date: March 13, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9883-P

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

Community Catalyst is pleased to submit these comments in response to the Department of Health and Human Services (“HHS”) and the Center for Medicare and Medicaid Services (“CMS”) Notice of Proposed Rulemaking (“proposed rule,”) CMS-9883-P.

Community Catalyst is a leading non-profit national health advocacy organization dedicated to advancing a movement for health equity and justice. We partner with local, state, and national advocates to leverage and build power so all people can influence decisions that affect their health. Health systems will not be accountable to people without a fully engaged and organized community voice. That’s why we work every day to ensure people’s interests are represented wherever important decisions about health and health care are made: in communities, state houses, and on Capitol Hill.

We appreciate HHS and CMS' long-standing dedication to improving the lives of individuals through affordable, accessible, high quality, and comprehensive health coverage. That said, we have significant concerns about this proposed rule, which is expected to decrease Marketplace enrollment by up to 2 million individuals for 2027, according to the agency’s own conservative and insufficiently explained analysis. We are grateful to be able to provide comments on this proposal, though we note that the comment period was unusually and unrealistically short given the complexity of policy changes proposed in this rule.

I. Additional Required Benefits, (§155.170)

Community Catalyst strongly opposes the proposed changes to § 155.170 and urges the Department to maintain the existing defrayal framework and not to finalize these proposals. Updating the essential health benefit (EHB)-benchmark plan is a valuable tool for states to ensure certain private insurance plans meet the needs of residents, reflect current clinical practices and scientific advancements, and align with the scope of benefits offered by a typical employer plan. Based on our work with health care advocates across the country, we continue to believe that restrictive defrayal requirements have stymied states in operationalizing EHB policies aimed at creating health plan designs that best address the needs of their states and communities.

Under the proposed rule, states would need to conduct a benefit-by-benefit analysis both immediately, in compliance with the updated policy, and again each time they seek to update their EHB-benchmark plan or enact a new state benefit mandate in the future. This additional administrative burden would create unnecessary complexity and thereby deter states from using either policy tool to regulate their insurance markets and improve coverage for individuals.

HHS justifies this proposal based on concerns that the current defrayal framework incentivizes states to enact state benefit mandates and subsequently incorporate those mandated benefits into their EHB-benchmark plans, thereby increasing premiums and federal contributions to advance premium tax credits. However, the proposed revisions would not materially change the scope of benefits states may include under existing federal EHB policy. As HHS noted in the [final 2025 NBPP](#), the current defrayal framework “does not increase the opportunity for states to increase the generosity of their EHB-benchmark plans more than is already theoretically possible, as states have been always permitted to add benefits to their EHB-benchmark plan, provided those additions comply with the scope of benefits requirements at [45 CFR 156.111\(b\)\(2\)](#).”

Furthermore, HHS noted in the [final 2025 NBPP](#) that, “based on experience providing technical assistance to states that are considering state-mandated benefits or changes to its EHB-benchmark plans, we believe that states appropriately balance the need for coverage of a specific benefit with the potential impact it may have on costs. This analysis typically includes a consideration of the impact on premiums and the corresponding impact on tax credits.” The proposed rule does not identify how, and to what degree, states have materially changed their approach to the EHB-benchmark selection process since the last update to the defrayal requirement. Without evidence of significant changes in state behavior, we do not believe the Department provided sufficient justification for revising the current defrayal framework.

The proposed framework eliminates the clarity established in the 2025 rule, creates great uncertainty for states and upends actions taken in reliance on current rules and regulations and puts individuals at risk of coverage gaps, financial burdens, and medical debt when they seek needed care. **We urge the Department not to finalize this provision. If the Department does finalize the proposed defrayal requirement, the implementation date should account for the time necessary to undertake the extensive analysis required to assess which, if any, mandates could be subject to defrayal, the costs associated with such defrayal, and state legislative cycles.** The comment period remains open until March 13, 2026. By that time, thirty states will have adjourned their regular sessions and/or passed deadlines to introduce new legislation. As a result, most states will not have an opportunity in 2026 to conduct the necessary benefit-by-benefit analyses between their EHB-benchmark plan and state mandate requirements, assess whether the state should maintain a state mandate or EHB policy, and enact legislation to repeal state mandates where appropriate. Given these constraints, if the Department moves forward with finalization, we urge the Department to implement the proposed defrayal requirement no earlier than the 2029 plan year.

II. Prohibiting Issuers from Including Routine Non-Pediatric Dental Services as an Essential Health Benefit, (§ 156.115(d))

Community Catalyst strongly opposes the proposal to prohibit issuers from including routine non-pediatric dental services as an essential health benefit (EHB). Community Catalyst strongly supported the policy finalized in the 2025 Notice of Benefit and Payment Parameters (NBPP) allowing states to include routine adult dental services as an EHB and agreed with CMS' determination at that time that this policy was aligned with CMS' commitment to whole person health and reflected the direct link between oral and overall health. We continue to agree with these determinations and with CMS' reinterpretation of the statutory requirements under section 1302(b)(2)(A) of the ACA included in the 2025 NBPP; namely, we continue to believe that all benefits typically covered by employers, whether they are embedded in medical plans or in a separate excepted benefits plan, should be considered as part of a "typical employer plan".

We continue to agree with CMS' assessment in the 2025 NBPP that routine adult dental care is a commonly covered benefit in employer sponsored insurance (ESI) arrangements and should be included per the typicality standard. While we understand that KFF Employer Health Benefits surveys from recent years show that most employers do not include dental benefits as part of their traditional medical plan, the [vast majority of people with dental insurance are covered by an employer-sponsored plan](#) or similar group program. Similarly, about [two-thirds of employers offer dental plans to their employees](#). While most of these are offered separately from a medical plan, data clearly show that dental benefits are typically covered by employers.

The reality of the dental plan market is that the vast majority of available dental plans are offered as standalone products. On average, about 5 insurers per state offer standalone dental plans compared to only [about 2 insurers per state that offer medical plans that embed dental](#) coverage. Only about [9% of health plans on the Marketplaces offer embedded adult dental plans](#). Thus, the low likelihood of employers offering dental benefits as part of a traditional medical plan is reflective of market availability and not employer choice. If employers wish to offer dental benefits to their employees at all, they are typically constrained to doing so via standalone plans. Considering most employers opt to offer dental benefits to their employees, we continue to believe that this arrangement should be reflected in EHB standards.

We appreciate CMS' reiteration that states would still be allowed to mandate coverage of routine adult dental services as a non-EHB, however, this would require states to defray the costs associated with those benefits. CMS' reversal of the policy finalized in the 2025 NBPP would leave only this cost prohibitive option available for states. Currently, no state includes adult dental as a state mandated benefit.

We also strongly disagree with CMS' assessment that the inclusion of "Pediatric services, including oral and vision care" in the 10 EHB categories included in section 1302(b)(1) of the Affordable Care Act suggests that Congress did not view routine adult dental care as an EHB. States are not prohibited from covering as EHBs other specific services that are not concretely defined in the 10 broad EHB categories. We do not believe that the specific inclusion of oral and vision care as an EHB for children is a statement of intent to *exclude* adult dental care from EHB status. But for the specific and unique prohibition on coverage of adult dental services, we believe specific adult dental services could be defined as EHBs under ambulatory and/or preventive services. Given no such prohibition exists for other specific services

that states may choose to cover under the 10 broad EHB categories, we strongly disagree with CMS' current interpretation.

As we have also previously commented, removal of the regulatory prohibition on coverage of non-pediatric dental services allows states the autonomy to address relevant access barriers and, as CMS noted in the 2025 NBPP, this change would not require states to add non-pediatric dental or any other services to its benchmark plan. Allowing states the option to add adult dental services as an EHB would offer greater flexibility and cause no harm to states that do not wish to make changes to their benchmark plans in this way.

We also understand that reinstating the prohibition on inclusion of routine non-pediatric dental services as an EHB would present fewer operational concerns for issuers. However, we maintain that any operational concerns would not constitute a substantial burden to issuers, given CMS' clarification in the 2025 NBPP that issuers could contract with standalone dental plans (SADPs) to administer those services. The removal of the regulatory prohibition *did*, however, offer substantial benefits to states and consumers, and we continue to believe these greatly outweigh any potential logistical concerns of issuers.

Finally, while plans would be required to embed routine non-pediatric dental EHB services into medical plans, we do not believe that requiring pre-deductible coverage would be the only available option for states to address potential impacts on cost sharing. States could instead opt to require separate dental and medical deductibles, which could address CMS' concerns with these plans' incompatibility with health savings accounts (HSAs).

We believe CMS' reinterpretation in the 2025 NBPP which allowed states the option to add non-pediatric dental services as an EHB, represents a more reasonable and less restrictive reading of the ACA, the intent of which was to ensure that the full scope of benefits typically provided by employer plans be included as EHBs to ensure that Marketplace plans align with employer-sponsored plans. **We urge CMS to return to this more natural reading of section 1302(b)(1) of the ACA and uphold the removal of the regulatory prohibition on issuers covering routine non-pediatric dental care as an EHB.**

III. Prohibiting Issuers from Including Gender Affirming Services as an Essential Health Benefit, (§ 156.115(d))

Community Catalyst continues to strongly oppose the prohibition of "specified sex-trait modification" as an essential health benefit (EHB). Although the term "sex-trait modification" has no basis in law, policy, science or medicine, HHS continues to specifically target health care services sought by many transgender people for the treatment of gender dysphoria.

Gender dysphoria is a serious medical condition characterized by clinically significant distress when a person's gender identity differs from the sex assigned to them at birth. This distress can limit a person's ability to fully participate in social situations, employment, or other areas of their life. Existing clinical guidelines, such as those maintained by the World Professional Association for Transgender Health and the Endocrine Society, outline an evidence-based standard of care to treat gender dysphoria. Every major medical association—including the American Medical Association, the American Psychiatric Association, and others—has held that these treatments for gender dysphoria are [medically necessary](#) and

are an [essential aspect](#) of health insurance coverage. On top of the intrinsic benefits of these treatment options, studies show they may improve several health disparities affecting transgender people, including unequal health outcomes related to [mental health](#), [SUD](#), and [HIV](#). For example, patients who receive treatment have less [depression and anxiety](#) and report better [mental health](#) and function. In one [study](#), people who did not get gender-affirming surgery were twice as likely to experience depression and four times more likely to experience anxiety than those who did. Additionally, a number of studies show a [reduction](#) in [suicidality](#) following gender-affirming treatment. According to one analysis, suicidality rates dropped from 30 percent pre-treatment to 8 percent post-treatment. In terms of behavioral health, emerging research also [suggests](#) that an unmet need for gender-affirming care is one factor associated with increased substance use among transgender women.

Health care services sought by transgender people to treat gender dysphoria are not a standalone category of EHB. Rather, they cut across a range of existing EHB categories including prescription medications, laboratory services, ambulatory patient care, and hospitalization for surgical procedures. The proposed rule seeks to prevent people with gender dysphoria from accessing these services, while maintaining access for others. CMS specifically notes in [previous rulemaking](#) that, “there are some medical conditions, such as precocious puberty, or therapy subsequent to a traumatic injury, where items and services that are also used for sex-trait modification may be appropriate.” CMS subsequently enacted an overtly discriminatory framework that allows certain individuals to access “sex-trait modification” while denying that same coverage and financial protection to transgender people. This approach violates numerous statutory and regulatory nondiscrimination requirements while contradicting EHB requirements.

Issuing a nationwide prohibition on treatment for gender dysphoria under EHBs contradicts the requirement that EHBs be defined in a way that protects individuals from discriminatory benefit designs and complies with all applicable nondiscrimination laws. Section 1557 of the Affordable Care Act, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act all prohibit discrimination against people with gender dysphoria, as the courts have recognized.

HHS has previously claimed, without evidence, that treatment for gender dysphoria is not typically covered in employer plans. This is false. In the 2025 [Corporate Equality Index](#), the Human Rights Campaign Foundation found that 72% of Fortune 500 businesses, and 91% of businesses listed on the Corporate Equality Index, offer coverage of treatment for gender dysphoria. As a result, over 1,300 major employers cover this care, 28 times as many businesses as in 2009. Similarly, coverage for gender dysphoria is widespread among state employee plans ([24 states and DC](#)), Medicaid ([26 states, Puerto Rico, and DC](#)), the Health Insurance Marketplaces ([55% of plans across all 50 states covered this care in plan year 2025](#)), and state-regulated coverage ([24 states and DC prohibit exclusions of coverage for gender dysphoria](#)).

Moreover, the interpretation by HHS that the scope of EHBs must be consistent with employer-sponsored plans is overly restrictive and inconsistent with the intent of EHB requirements. Although the ACA [does instruct](#) HHS to “ensure that the scope of EHB ... is equal to the scope of benefits provided under a typical employer plan” the statute sets additional factors that HHS must consider when defining EHBs. For instance, HHS must consider barriers related to coverage and cost, changes in medical evidence or scientific advancement, and the health needs of “diverse populations.” Strictly limiting the scope of EHBs to a typical employer plan would disregard these other factors expressly included by Congress. Under HHS’ interpretation of EHB requirements, no amount of evidence could compel the agency to change the scope of EHB if doing so would deviate from the current practices of employers, even if a majority of employer plans contradicted medical evidence or scientific advancement. The more plausible interpretation of the typical employer plan provision would permit the scope of EHBs to be either similar to or at least as comprehensive as that of a typical employer plan – neither of which would prohibit EHBs

from including treatment for gender dysphoria. Furthermore, statute may compel CMS to define EHB to include treatment for gender dysphoria upon careful review of the evidence.

Lastly, prohibiting states from including gender-affirming care in their EHB benchmark plan will exacerbate discriminatory denials and restrictions of coverage that lead to high out-of-pocket costs. For example, those who lack gender-affirming care coverage may have to pay up to \$400 per month for hormone therapy, \$8,500 for top surgery, and \$25,000 for bottom surgery. Excessive costs mean some people go without care. In fact, one-third of transgender people report avoiding needed health care due to costs. Inadequate insurance coverage and other financial barriers join a host of other factors that make it hard for transgender, nonbinary, and gender-diverse people to access care. Transgender people face high levels of mistreatment, harassment, and violence when seeking health care. And transgender people of color report the worst experiences in the health care setting.

This prohibition violates existing nondiscrimination protections, contradicts EHB requirements, and will cause significant harm to transgender people. **We urge HHS to remove this prohibition from the proposed rule and eliminate the prohibition against sex-trait modification services under the 2025 Marketplace Integrity and Affordability Final Rule in future rulemaking.**

IV. Verification Process Related to Eligibility for Insurance Affordability Programs (§ 155.320)

Community Catalyst strongly opposes the proposed changes to income verification processes as they will create significant barriers to enrollment for eligible people and generate more paperwork in response to a problem that CMS itself cannot identify. CMS proposes to generate data matching issues (DMI) where IRS data show income below 100% of the Federal Poverty Level (FPL) and generating DMI in the absence of IRS data. However, CMS has offered no evidence that improper enrollment is a substantial problem or that these proposals would address it. In fact, these proposals would make it more burdensome for low-income individuals and people with variable incomes to enroll in subsidized coverage when they are eligible.

These proposed changes would create disproportionate burdens for lower income individuals and deter healthy people from enrolling in coverage, consequently diminishing the risk pool and increasing premiums for unsubsidized enrollees. Similar proposals have been struck down by the courts because CMS was unable to substantiate the claims that erecting such enrollment barriers would reduce risk of fraud or justify the administrative burdens and coverage losses that would ensue.

CMS claims that the elimination of reconciliation caps on premium tax credits justifies these proposed changes and yet the agency made the opposite argument in the Marketplace Integrity Rule, arguing that, “[because] the statute does not allow the Federal Government to recover a substantial portion of excess APTC payments...it is critical to establish an accurate estimate of household income during the application and enrollment process to most accurately set APTC payment amounts before the APTC payments are made.” It is therefore contradictory for CMS to now claim that these proposed changes protect consumers against significant tax liabilities.

Simply put, these changes harm eligible individuals by removing their option to enroll and receive PTCs. These proposals would leave more people uninsured by eliminating their ability to enroll. Low-income

marketplace enrollees often experience high income volatility; as such relying on two-year-old tax data would provide little useful information about income for the upcoming plan year and would saddle an estimated 3.8 million low-income individuals and families with unnecessarily burdensome paperwork. CMS expects that, every year, dealing with these new paperwork requirements will require these already marginalized individuals to spend time worth approximately \$83 million.

Further, the under-100% DMI is unnecessary and creates confusion in states that have expanded Medicaid. If a Marketplace relies on tax data showing income under 100% rather than an attestation of income over 100%, it must generally consider that individual eligible for Medicaid even though the consumer is not attesting to being eligible for Medicaid. For a consumer without ready access to information documenting their current income, this would mean they could receive coverage only by misstating their income. This creates unanswered questions and administrative costs for both the consumer and the state administrative apparatus.

We therefore urge CMS not to finalize these provisions of the rule. If CMS moves forward with finalization, we urge that these policies not be extended to SBMs, which by CMS’s own admission, experience much lower rates of fraud than the FFM and therefore, extending these policies to SBMs cannot be justified by the potential for fraud.

V. CSR Reimbursement & Rate Filing Justifications Regarding CSRs (§ 154.215)

Community Catalyst strongly opposes the proposed changes to data reporting requirements. CMS proposes to greatly expand the information collected from Marketplace insurers as part of annual rate filing justifications, asserting that this information is needed to better understand CSR loading practices, how they relate to insurers’ costs under CSRs, and associated effects on PTC spending. This data collection alone is projected – by CMS – to come with an astronomical price tag: \$419 million in the first year and \$209 million per year after that. Insurers would be expected to pass this cost along as higher premiums to consumers and to the federal government in the form of higher PTC. At a minimum, CMS should delay this provision to reduce the data collection burden by requiring only the collection of prospective data. Starting with data from plan year 2027 (or later) would better enable insurers to build systems to tabulate this information as claims are processed.

CMS also notes in the proposal that they will use this information to ensure that CSR loading practices are “calibrated on actual experience and...only accounts for the projected revenue loss of unreimbursed CSR payments without materially exceeding that amount.” As CMS notes in the rule, CSR loading practices currently vary across states, with different practices leading to different levels of loading and thus different effects on consumer affordability. We hear frequently from our partners about the challenges that individuals and families face in affording out-of-pocket costs on Marketplace plans and how these costs limit access to needed care and increase medical debt. CSR-loading is one strategy states have used to contain these costs. As CMS implements a new policy, it should prioritize preserving and supporting affordability for consumers – and avoid locking states into inflexible market regulations that reduce state authority and market oversight.

In alignment with CMS’s longstanding respect for state authority over insurance markets, CMS should permit states to use any rules that permit premiums to reach an actuarially justified equilibrium. As recently as the 2026 NBPP, CMS “recognized states’ traditional role in regulating insurance and rating practices.” That NBPP finalized a rule modifying the single-risk-pool regulation to “codif[y] this deference to State regulators.” The rule’s preamble emphasized, “states may determine how to implement CSR loading in their state.” Now, the 2027 NBPP sharply reverses course, proposing to disallow many states’ current approaches to CSR-related silver premiums.

CMS should avoid rules that prohibit setting rates based on enrollee experience or single risk pool requirements, which would excessively reduce silver premiums and harm consumer affordability. CMS’s preamble language about calibrating CSR loading to “actual experience” raises concerns that CMS may be pushing for practices that violate federal rules against setting rates based on the claims experience of the covered population. Both the ACA’s rating rules and CMS’s regulations implementing them, and the single risk pool requirement prohibit insurers from considering the experience of the enrolled population in setting rates for a particular plan. Rather, rates must reflect the claims experience of the single risk pool overall.

Limiting silver loading would reduce overall consumer affordability and coverage. If CMS considers further action in this space, it should be clear and transparent about these tradeoffs and recognize that the primary effect on consumers of reining in silver loading would be to raise the premiums that people pay. **We urge CMS not to finalize the data reporting requirements nor changes to silver loading contemplated here.**

VI. Standardized Plan Options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, and 156.265(b)(3)(iv))

This proposal rolls back the requirement that states using the Federally Facilitated Marketplace (FFM) offer a set of standardized plans and removes the limitation on the number of non-standardized plan options an insurer can offer. This proposal will reduce Market competition, make it more difficult for individuals to compare and differentiate between plans and to choose the plan that best meets their health needs. We oppose this proposal and urge CMS to continue requiring standardized plans in all states and at all metal levels.

Standardized plans make plan selection easier for individuals and provide upfront certainty and limits to patient cost-sharing for various services, reducing out-of-pocket costs and downstream medical debt. In working with our network of 350+ state- and community-based advocacy organizations across the country, we frequently hear about the benefits of standardized plans in meeting individual health needs, clarifying consumer choice, and reducing out-of-pocket costs. [A 2026 Mathematica evaluation](#) of the Colorado Option standardized plans found that they made it easier for individuals to compare plans and, “enrollees paid about 15 percent less out of pocket on average—consistent with plan designs that replace coinsurance with copays and cover key services before reaching the deductible.” Moving plans away from standard copay amounts and allowing additional use of coinsurance will lead to individuals with

higher health needs experiencing unpredictable and higher out-of-pocket costs and can reduce consumer affordability across the board.

Even if FFM states continue to require standardized plans, without differential display on healthcare.gov, it will be extremely difficult for individuals in FFM states to discern which plans are standardized and which are not. Combined with the proposed removal of the limitation on non-standard plan options, consumers may again be faced with an array of confusing choices and struggle to pick the plan that will best meet their health needs.

Removing limits on non-standardized plans may also lead to “silver-spamming” by carriers to attempt to monopolize the first page of plan options displayed to consumers in FFM states, potentially distorting the market or creating significant swings in carrier market share and risk year to year. This would significantly increase workload for state regulators who would be faced with many more plans to review and approve, with questionable benefit to consumers or the market.

Research and consumer testing studies have consistently found that too many plan choices can impede the ability to make the best plan choice, and [reduce consumer satisfaction](#). Analyses have also found that standardized plans can help reduce discriminatory plan designs (e.g., by making it more difficult for plans to engage in “adverse tiering” where all or most drugs used to treat a particular condition are placed on the highest cost-sharing tier.) There is a long history of using standardized plans in health insurance markets, including Medicare’s Medigap program, as a mechanism to facilitate consumer choice. **We urge CMS to retain standardized plan requirements here across metal levels, and to maintain differential display on the federal Marketplace.**

VII. Removing Language on the Definition of “Sex,” (§ 155.220(j)(2)(i))

Community Catalyst strongly opposes the proposed change to § 155.220(j)(2)(i), which would weaken nondiscrimination requirements for individuals who assist with or facilitate health insurance enrollment. HHS proposes to strike regulatory language which clarifies that for purposes of this section, sex-based discrimination includes discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes. We urge HHS to maintain existing regulatory text, which protects people enrolling in coverage, and particularly women, pregnant people, and LGBTQI+ people from consequential barriers to health insurance.

Explicit nondiscrimination protections during the enrollment process are particularly important given the long history of systemic barriers that contribute to [higher uninsurance rates](#) for LGBTQ+ people. When LGBTQ+ people encounter discrimination, misinformation, or bias from brokers or other enrollment assisters, they may abandon the enrollment process altogether or avoid seeking enrollment assistance in the future. Even when individuals obtain coverage, experiencing discrimination during the enrollment process can undermine trust and discourage them from using that coverage to access care. Research consistently finds that [LGBTQ+ people avoid seeking care](#) or engaging with health systems due to concerns about mistreatment or bias, particularly LGBQ people of color and transgender people who are [more likely to have prior negative experiences](#) with the health care system. **We urge CMS not to finalize**

this change and to retain the parenthetical on prohibited sex-based discrimination in regulatory text is essential to notify covered entities of their obligations and support meaningful enforcement of § 1557 of the Affordable Care Act.

VIII. Cost-Sharing for Bronze and Catastrophic Plans (§§ 156.136 and 156.155)

Community Catalyst opposes the proposed increase in maximum out-of-pocket costs for bronze and catastrophic plans. Above all else, this proposal allows cost-sharing beyond the statutory limits set forth by the ACA and is therefore beyond the scope of this rule. In and of itself, this policy would increase medical debt and discourage people from obtaining needed care. Further, this change would increase the complexity of cost-sharing comparisons at a time when individuals are already struggling to understand coverage options.

CMS justifies this proposed change by claiming that “eventually the maximum annual limitation on cost sharing will be too low to allow for an AV calculation for the most basic bronze plan design.” We agree that this is a problem worth addressing, but it requires statutory change that only Congress can make. The solution is not to allow insurers to ignore the current statutory requirements on cost sharing limits for bronze and catastrophic plans, especially given that it is not currently impossible to offer bronze plans within the current requirements.

Health care costs are already unaffordable for many people, including those with insurance. High deductibles [reduce adherence](#) to recommended medical care and are [associated](#) with higher rates of cancer mortality. In [2026](#), the average deductible for a bronze plan was \$7,746, while catastrophic plans had deductibles of \$10,600 for an individual or \$21,200 for a family. These deductibles are already too high for the [59 percent](#) of U.S. adults who do not have enough in savings to cover an unexpected \$1,000 emergency expense. We urge CMS not to increase out-of-pocket health care costs when many are already unable to afford needed care.

Further, these changes will increase the complexity of plan comparisons and the financial risks for patients. Many people are currently struggling to understand different plan options. One [recent survey](#) found that 31% of Marketplace consumers had difficulty comparing cost-sharing features, and 25% had trouble comparing premiums when presented with different coverage options. **We urge CMS not to increase cost-sharing for bronze and catastrophic plans.**

IX. Expansion of Catastrophic Plans and Separated Risk Pools (§ 155.605(d)(1) [expansion of the hardship waiver], § 156.130 and 156.155 [multi-year terms for catastrophic plans])

For similar reasons, including the fact that the ACA does not provide authority to CMS to create the proposed hardship exemption in this rule, Community Catalyst opposes the encouragement of catastrophic plans through expanded hardship waivers and multi-year plan terms and the proposed increase in out-of-pocket costs for catastrophic plans. With limited exceptions for preventive and primary

care services, catastrophic health plans do not cover health care until the enrollee has paid the maximum out-of-pocket amount – which CMS proposes to increase to \$15,400 for an individual in 2027.

CMS is not responsible for ensuring catastrophic plans have high enrollment levels or increasing the popularity of these plans and is instead responsible for implementing and enforcing the law consistent with statutory requirements. We oppose the proposals to: (1) allow more individuals over age 30 to enroll in catastrophic plans; (2) allow catastrophic plans to exist for up to 10 consecutive years; and (3) increase the out-of-pocket costs for catastrophic plans.

As we've discussed, high out-of-pocket health costs result in enrollees incurring medical debt, avoiding needed medical care, and experiencing worse health outcomes. Further, health needs change over time, and it is not clear whether or not enrollees could switch plans over the course of 10 years under this proposal. We do not believe that locking enrollees into multi-year plans is allowable by law. The statutory framework of the ACA requires that individual market plans – including catastrophic plans – have a plan year equal to the calendar year; therefore, this proposal is not in alignment with either the statute or the decades-long history of implementing regulations. Finally, the proposed expansion of catastrophic coverage could further increase costs for enrollees across plan metal levels by distorting the risk pool, as healthier enrollees would be more likely to switch to catastrophic plans. **We urge CMS not to finalize these proposals.**

X. Added Paperwork for Consumers Using a Special Enrollment Period (§ 155.420(g))

Community Catalyst opposes adding additional paperwork that create barriers to enrollment. CMS also proposes to impose additional documentation requirements on consumers seeking to enroll in Marketplace coverage through a SEP. Specifically, the FFM would require consumers to submit documents for a broader range of SEP triggering events and would conduct SEP verification (SEPV) for at least 75% of new enrollments.

First, this is inconsistent with CMS's rationale for initially finalizing this change **on a temporary basis**, with a sunset in the Marketplace Integrity final rule. At the time, CMS was clear that this increased verification was needed only as a temporary measure. It is not clear from this proposal what has changed that would necessitate a need for this ongoing documentation.

The proposal would also impose new administrative burdens on consumers that would delay coverage during already stressful life events – such as a move or gaining a dependent – where coverage is critically important. CMS estimates that, if finalized, this expansion of SEPV will require an additional 293,073 people to submit documents proving their SEP eligibility, costing consumers an additional \$7,332,686 each year. It will also cost the FFM an additional \$14,602,615 each year to process, review, and decide on SEPV requests. This cost estimate does not take into account additional expenditures associated with consumer communications, outreach, and assister training. As with other changes proposed across this rule, the additional administrative burdens imposed would disproportionately reduce enrollment among young, healthy people and thus raise premiums across the board. Currently, many SBMs require

consumers seeking to enroll via SEPs to attest, upon penalty of perjury, that they qualify for the SEP in question. None of these SBMs have reported concerns about fraudulent enrollments via a SEP.

Given the lack of policy justification, the excessive costs, the increased burdens on individuals and families, and the negative effects on the risk pool, we urge CMS not to finalize this proposal.

XI. Implementing Provisions of H.R. 1 that affect Noncitizen Immigrants: ICRs Regarding Limiting APTC Eligibility to “Eligible Noncitizens” (§§ 155.20, 155.305(f)(1), and 155.320); ICRs Regarding the Prohibition of APTC for Individuals Who Are Ineligible for Medicaid Due to Their Immigration Status and Have Income Below 100 Percent of the Federal Poverty Level (FPL) (§ 155.305(f)(2))

Community Catalyst strongly opposes the eligibility changes for noncitizens from H.R. 1 in this proposal. Combined, the changes to immigrant eligibility would affect [1.5 million](#) lawfully present immigrants who would be left without a pathway to coverage. This includes 237,000 immigrants below the poverty line who were not eligible for Medicaid and lost their PTCs for FFM this year, and 1.23 million set to lose PTCs next year for the first time since the beginning of ACA.

We also strongly oppose the mechanisms in this proposal that go beyond H.R. 1, including limiting the Basic Health Plan (BHP) federal funding payment methodology that would newly exclude noncitizens. This change would penalize states who utilize BHPs to provide coverage to noncitizens who do not receive PTCs and disincentivize state level health coverage options for populations that have no other pathways to coverage. States that operate BHPs would see federal BHP [spending reduced by](#) more than \$100 million annually. If finalized, this proposal will reduce the security of coverage for another 10,000 lawfully present immigrants. States that currently provide or are considering providing BHP to their residents will then be forced to consider additional limitations of federal funding to this pool.

These eligibility changes and their implementation in BHPs threaten access to coverage for millions of lawfully present immigrants and will destabilize risk pools; therefore, we urge CMS not to implement these proposals.

a. Exchange Verification of Noncitizen Immigration Status (§ 155.305(f)(1)(ii)(C))

Additionally, Community Catalyst opposes the use of the SAVE program to verify eligible noncitizen immigration status. The U.S. Department of Homeland Security (DHS)’s Systematic Alien Verification for Entitlements (SAVE) program is consistently unreliable in verifying immigration status and may lead to delayed access to health coverage of eligible citizens and noncitizens. There is no national database of all US citizens. A [2018 report](#) from the US Commission on Civil Rights found that “SAVE itself doesn’t house comprehensive lists of US Citizens, is not updated to include naturalized citizens, and does not include derivative citizens born to US parents outside the country.” [As recently reported](#) by ProPublica and The Texas Tribune, SAVE’s expansion has led to bad data at voter polls resulting in confusion and people being turned away from voting which DHS later had to manually correct. In Denton County alone, SAVE had at least a 14% error rate in identifying potential noncitizens. These types of mistakes have

persisted in verification for public benefit for years, leading to erroneous denials of public benefits. In a 2017 US Government Accountability Office [report](#), after USCIS established mechanisms for correcting an individual person's information, GAO found these mechanisms were ineffective and unlikely to enable benefit applicants to make timely record corrections.

The consequential verification process when SAVE cannot confirm individual immigration status triggers a manual review of documents, which introduces additional red tape for eligible US citizens and lawfully present immigrants. This type of administrative barrier has long been [documented](#) to result in declines in enrollment among eligible individuals and increased administrative costs. **SAVE is not an effective nor efficient process for verifying immigration status and puts eligible people at risk of not completing health coverage enrollment; we urge CMS not to finalize this proposal.**

XII. State-Based Marketplaces (SBMs)

We oppose the changes to SBMs on the basis of fraud, for which CMS does not provide adequate justification. Although this proposal repeatedly uses claims of fraud, waste, and abuse to justify changes, there is little evidence that fraudulent activity is active in SBMs. In the preamble to this proposed rule, CMS even states “State Exchanges do not report the same problems with unauthorized enrollments as those currently facing the FFEs.” Yet CMS does not include proposals that would address the known FFM issues, such as strengthening the FFM actions already ongoing, including case evaluation and suspending or terminating agreements where appropriate, bringing FFM practices in line with SBMs practices, ensuring adequate regulation and enforcement of regulations governing enhanced-direct-enrollment (EDE) entities, regulating lead generators, and [other options](#) that target the actual problem rather than imposing new burdens on consumers. Instead, this proposal forces Marketplaces to make changes that lack a clear connection to the known problems while encouraging SBMs to embrace additional EDE.

There is no evidence of meaningful fraud in the SBMs, and CMS repeatedly notes this disparity. This difference is supported by evidence from SBM states in their comments on the Integrity Rule:

- California Marketplace [comment](#): “Covered California does not have any indication of widespread fraud and abuse occurring in our market. In fact, a robust review of consumer complaints and enrollment partner activity in recent years did not reveal a single identified case of a consumer being enrolled in Covered California without their knowledge. These outcomes are largely because we have implemented tailored approaches that make sense for California’s market and Covered California’s systems, ensuring the over 14,000 enrollment partners we work with abide by the highest standards with comprehensive support and oversight.”
- Colorado Marketplace [comment](#): “As a result of carefully considered design choices and a robust state regulatory framework, Colorado has not experienced reports of unauthorized or fraudulent enrollment.”
- Massachusetts Marketplace [comment](#): “To date, the Health Connector has not received complaints about any fraudulent or unauthorized activity by Assistors.”
- Rhode Island Marketplace [comment](#): “In contrast to the concerns raised in the proposed rule, HSRI has not observed any indication of “improper enrollments” in [the under 150% FPL] group.

Rhode Island does not have individual market brokers, agents, or web-brokers operating in our individual market. HSRI instead relies upon its 8 Navigator network and Certified Application Counselors, who are not individually compensated to support enrollment on our marketplace, to support customers in need of assistance enrolling in health coverage.”

CMS points to a December [GAO report](#) with preliminary results showing that applicants who are willing to lie can be fraudulently enrolled. But that report, which is based on only 20 fictitious applicants, is careful to note that its results cannot be extrapolated to draw wider conclusions or make estimates. The report states “The results of our covert testing, while illustrative of potential enrollment control weaknesses, cannot be generalized to the overall enrollment population.” It certainly provides no estimate suggesting substantial SBM fraud. **Community Catalyst opposes changes to SBMs resulting from vague and unsubstantiated claims of fraud or misuse.**

a. State-Based Exchange (SBE)-Enhanced Direct Enrollment (EDE) Option (§ 155.221(k))

We oppose the EDE changes to SBEs and urge CMS to not finalize this proposal. As noted in the preamble, an Exchange DE option was repealed in part 3 of the 2022 NBPP (86 FR 53429). CMS claims that since the repeal, many of the policy and operational priorities and then-new Federal laws to justify the repeal are no longer competing for agency resources. However, the combined impacts of H.R. 1, the Marketplace Program Integrity Rule, and this proposal introduce many destabilizing challenges to SBMs.

In this rule, CMS fails to consider the SBM features that support successful enrollment compared to the FFM. [Improper enrollments in the FFM](#) have been driven by agent and broker behavior on the FFM EDE, while SBMs who maintain and operate their own agent and broker portals for assisted enrollments have not experienced similar types or levels of improper enrollments. The use of EDE as the exclusive enrollment pathway raises [significant concerns](#) about the privacy and security of consumer information, the potential for fraud, and the possibility of consumers receiving inaccurate or misleading information about their eligibility and plan options that could lead them to make suboptimal plan choices. Rather than reducing fraud as other sections of this proposal claim to address, the use of EDE, especially without adequate regulation and enforcement, places people at increased risk of fraud. In addition, this proposed rule includes several provisions aimed at strengthening CMS’s authority to oversee and address fraud in SBMs. Yet a non-centralized eligibility system model that entirely delegates Marketplace enrollment to private, for-profit vendors will increase program integrity challenges, leading to the risk of inaccurate PTC payments to insurers and increased tax liability for consumers. Delegating Exchange functions to private brokers would require intensive and costly oversight, and states would have to conduct extensive, continuous oversight and compliance reviews of multiple for-profit EDE vendors. The administrative costs associated with the necessary procurement processes and required oversight, particularly given rapidly evolving federal and state insurance standards and operational rules, would be considerable and ultimately raise costs for consumers.

The proposed rule repeatedly notes that brokers are key drivers of improper enrollment. The [Paragon Institute](#) also notes this connection, finding that unscrupulous brokers are “driving fraudulent enrollments by exploiting the EDE feature of [HealthCare.gov](#), which allows third parties to enroll consumers without their direct interaction with the [Marketplace].” Although the authors of the Paragon study also point to

the influence of enhanced PTCs as a driver of fraud, notably, there has been almost zero fraud in any of the SBMs. Consumers in the SBM were also eligible for enhanced PTCs; the main differentiator between the SBMs and the FFM is that all but one of them have declined to use EDE to mediate enrollments.

Another critical concern is that many web-brokers sell more than just qualified Marketplace health plans to consumers; they also sell products that do not comply with ACA insurance standards or consumer protections. To the extent this is permitted under an SBM-EDE framework, it appears to violate section 1311(d)(2)(B)(i), which prohibits Marketplaces from making available any health plan that is not a qualified health plan. Further, web-brokers are often more [highly compensated](#) for selling non-ACA-compliant products than they are for Marketplace plans. If an SBM delegates all Marketplace enrollment functions to these web-brokers, consumers are likely to believe that these entities have the government's seal of approval, and that all the products on their site will provide comprehensive coverage and financial protection similar to Marketplace plans.

Today, all SBMs already have the option of working with web-brokers and insurers to enable consumers to enroll through EDE. Therefore, what CMS is proposing would not create any new options, but instead would eliminate the primary, state-based, trusted online portal for high quality, affordable insurance coverage. CMS also requests comment on whether the FFM should abandon [HealthCare.gov](#) and shift to an all-EDE approach to eligibility and enrollment. Doing so would create all the same concerns we raise above, only on a larger scale.

We urge CMS not to finalize this proposal. If CMS does finalize this proposal, they should prohibit EDE vendors from offering any non-QHP plan, to ensure compliance with ACA section 1311(d)(2)(B)(i). Further, CMS should ensure that SBM-EDEs will be subject to the same level of oversight and reporting as all other SBMs.

Thank you for the opportunity to provide comments on the proposed rule. If you have further questions, please contact Colin Reusch at creusch@communitycatalyst.org.

Respectfully submitted,

Community Catalyst



March 13, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9884-P
P.O. Box 8016
Baltimore, MD 21244-8016

Subject: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program (RIN 0938-AV62)

Dear Administrator Oz,

Covered California welcomes the opportunity to offer the following comments in response to the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), proposed Notice of Benefit and Payment Parameters for 2027.

Since Covered California launched in 2014, millions of Californians have gained coverage through the Marketplace, helping drive California's uninsured rate to historic lows and demonstrating the enduring strength of the Affordable Care Act (ACA). Today, Covered California connects more than 1.9 million¹ Californians to high-quality, affordable, and comprehensive coverage and administers federal financial assistance to eligible households. Covered California's active purchaser model continues to promote affordability, choice, and market stability by negotiating directly with qualified health plan issuers and holding plans accountable for delivering value to consumers.²

Covered California's success in making healthcare a reality for millions of Californians is rooted in state flexibility and our ability to implement innovative strategies tailored to the state's unique needs. By leveraging this flexibility and deep market expertise, we have expanded financial assistance through premium assistance and cost-sharing reduction programs, streamlined enrollment into more generous plans, and established robust fraud prevention and enforcement standards. These efforts have safeguarded consumers, held agents and brokers accountable, and delivered one of the healthiest

¹ Covered California, Press Release, [As Enhanced Federal Subsidies Expire, Covered California Ends Open Enrollment With State Subsidies Keeping Renewals Steady — for Now — and New Signups Down](#) (Feb. 26, 2026).

² Covered California, Press Release, [Covered California Rates and Plans for 2026: Consumer Affordability on the Line With Uncertainty Surrounding Federal Premium Tax Credit Extension](#) (Aug. 14, 2025).

risk mixes in the nation—all while reducing barriers to coverage for those who need it most.

Covered California appreciates that this proposed rule acknowledges the importance of preserving state flexibility in certain areas and that State-based Marketplaces (SBMs) are uniquely equipped to craft policies that address the specific needs of their populations, systems, and market dynamics. However, at the same time, **several provisions in the proposed rule reflect a broader federal shift that diminishes meaningful state discretion.** A central principle of the ACA is allowing states to operate Marketplaces that respond to their own unique circumstances. This proposed rule risks undermining that principle by limiting state authority in critical areas while introducing new flexibilities that could inadvertently harm consumers, affordability, and market stability. These shifts constrain states' ability to structure coverage solutions while opening pathways that may weaken access, quality, and risk pool stability.

Within this broader context, Covered California has utilized this flexibility to strike a critical balance between maintaining program integrity and enhancing consumer access and experience. **We strongly support the goals of program integrity and accurate eligibility determinations and share CMS's commitment to reducing fraud and preventing improper enrollments. However, program integrity measures must be carefully balanced to avoid creating barriers for eligible individuals seeking coverage or retaining it.** Proposals related to data matching issues (DMIs), failure to reconcile, and expanded verification requirements risk increasing administrative burden, coverage churn, and inadvertent terminations for consumers acting in good faith.

California's experience demonstrates that effective safeguards can mitigate fraud while simultaneously reducing consumer burden. For example, Covered California enforces rigorous standards through agent agreements, certification requirements, and a code of conduct, which together ensure strong oversight while facilitating enrollment assistance in a Marketplace where more than half of enrollments are supported by certified agents. We agree that strengthening agent and broker marketing standards is a critical opportunity to enhance program integrity while minimizing burdens on consumers. Covered California supports CMS's efforts to align Federally-Facilitated Marketplace (FFM) requirements with proven best practices, which would bolster consumer protections across all Marketplaces without creating unnecessary barriers for eligible individuals. Unfortunately, other provisions of this proposed rule—particularly those concerning Enhanced Direct Enrollment—move in the opposite direction by decentralizing critical Marketplace functions and weakening oversight, potentially granting unscrupulous brokers greater latitude to engage in fraudulent practices.

Covered California is also deeply concerned that certain provisions within this proposed rule risk undermining the quality, comparability, and financial protections of Marketplace coverage. Proposals to expand catastrophic coverage

through broader hardship exemptions, adjust catastrophic and bronze cost-sharing, permit multi-year catastrophic plans, allow non-network plans, and eliminate standardized plans on the FFM collectively raise the risk of steering consumers toward less protective products that are harder to compare and offer weaker financial safeguards. To address these concerns, Covered California welcomes collaboration with CMS to develop implementation strategies that ensure continuity of coverage, preserve consumer choice architecture, and sustain a balanced health risk mix that protects the integrity of the ACA Marketplaces.

Finally, **we are concerned that several provisions in this proposed rule—particularly when combined with policies implementing H.R. 1 and the Marketplace Integrity and Affordability Rule—further commit to restrictive eligibility requirements that will reduce enrollment and disproportionately impact low-income and immigrant communities.** Narrowing premium tax credit (PTC) eligibility for lawfully present immigrants, tightening income verification standards, and introducing pre-enrollment verification requirements risk creating significant enrollment barriers. These policies move further away from the ACA's core goals of expanding access to affordable, high-quality coverage, promoting equity, and fostering Marketplace stability.

Drawing on our experience and shared commitment to advancing the ACA's goals, we offer the following detailed comments on the specific provisions of the proposed rule to reduce eligibility and enrollment barriers, strengthen consumer protections, coverage quality, and Marketplace stability, and optimize Marketplace operations.

REDUCING ELIGIBILITY AND ENROLLMENT BARRIERS

Income Verification Requirements

Covered California is deeply committed to program integrity and supports CMS's efforts to address fraudulent activity on the FFM. However, **the proposed income verification changes fail to account for the proven systems and safeguards already in place within SBMs like Covered California. By applying a one-size-fits-all approach, CMS risks creating unnecessary burdens for consumers and states while undermining efficient and effective systems tailored to the unique needs of individual Marketplaces.**

Covered California has continually invested in robust fraud prevention systems and takes swift action if improper activity is identified. As a result, we have no indication of widespread fraud or abuse in our Marketplace, nor do we share the vulnerabilities specific to HealthCare.gov outlined in the Government Accountability Office's

preliminary report—findings that solely studied the FFM, not SBMs.³ This success stems from tailored approaches designed for California’s unique market and systems, ensuring the over 14,000 enrollment partners we work with adhere to the highest standards under comprehensive oversight. Covered California’s fraud prevention measures⁴ effectively ensure program integrity while minimizing barriers for eligible consumers, including:

- Consumers must affirmatively delegate access to enrollment partners before any application changes can be made, preventing unauthorized changes by brokers or agents.
- AI-driven identity verification systems proactively prevent fraud by identifying anomalies in real time and verifying consumer identities through biometric and document validation.
- Duplicate enrollments across programs, including Medi-Cal, are actively monitored and resolved to ensure financial assistance integrity.
- A dedicated fraud team investigates risks, collaborates with external partners, and hosts an annual Fraud Summit to share best practices.

Because California does not experience such widespread fraud, the proposed changes instead would only exacerbate existing challenges for both consumers and Marketplaces. Requiring additional documentation would significantly increase DMIs, delay income determinations, and prolong uncertainty for consumers. This is especially problematic given significant Internal Revenue Service (IRS) backlogs⁵ and longstanding data gaps. Income DMIs already take months to resolve, and under the proposed framework, consumers could face prolonged periods of uncertainty and higher premium liability while their cases are pending. Starting in 2028, when Marketplaces would be prohibited from providing advanced premium tax credit (APTC) during the verification period, the consequences would be even more severe. Eligible consumers could face unaffordable premiums and risk losing access to financial assistance altogether if they cannot meet documentation requirements on time.

These changes also impose substantial operational burdens on SBMs, particularly as they are already working to implement broader eligibility and enrollment changes. Accordingly, Covered California urges CMS to provide flexibility for SBMs to tailor income verification policies to their established systems and practices, recognizing that

³ U.S. Government Accountability Office, [Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist](#), GAO-26-108742 (Dec. 2025).

⁴ U.S. Government Accountability Office, [Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist](#), GAO-26-108742 (Dec. 2025).

⁵ Diana M. Tengesdal, Deputy Inspector Gen. for Audit, Dep’t of the Treasury, [Memorandum for Commissioner of Internal Revenue: The Internal Revenue Service’s Readiness for the 2026 Filing Season \(Audit No. 2026400002\)](#) (Jan. 26, 2026).

SBMs are best equipped to maintain program integrity without creating barriers for eligible consumers.

If CMS applies these requirements to all Marketplaces, Covered California strongly recommends delaying implementation to minimize further disruption.

The current timeline is operationally unfeasible due to system limitations, competing federal and state requirements, and the volume of changes already underway.

Restricting PTC Eligibility to Limited Immigrant Groups

Covered California recognizes that the proposed changes to PTC eligibility for certain lawfully present immigrant groups are driven by recent statutory amendments and that CMS cannot, through this rulemaking, alter those underlying legal requirements. Within those constraints, however, CMS retains important discretion in how it interprets, sequences, and operationalizes these provisions, especially through engaging and communicating with impacted consumers. **Covered California therefore strongly urges CMS to fully evaluate the far-reaching consequences of these statutory changes and minimize the impact on vulnerable communities as much as possible.** These changes, if not carefully implemented, will have significant negative impacts on enrollment, access to care, and the financial stability of affected populations.

In California alone, an estimated 123,000 lawfully present Covered California enrollees are projected to lose access to APTC and cost-sharing reductions by 2027 as a result of statutory changes affecting eligibility for financial assistance. These individuals—who include those with asylum or pending asylum status, work or student visas, refugees, and survivors of trafficking, domestic violence, and other serious crimes—are lawfully present in the United States and rely on Marketplace coverage to access necessary healthcare services. While the underlying statute may require changes to their eligibility status, CMS's implementation choices will materially affect the extent of coverage loss, the timing and magnitude of disruptions, and the availability of mitigations.

Pre-Enrollment Verification

We appreciate the opportunity to provide feedback on how CMS should implement this proposal, as the policy has the potential to cause significant harm to consumers and Marketplaces. These impacts could be mitigated with a flexible approach that prioritizes consumer needs and minimizes administrative burdens. Given the importance of this policy, we respectfully request a minimum 60-day public comment period for any subsequent proposed verification regulations.

Specifically, the requirement introduces new hurdles for consumers to retain coverage, and when combined with income verification provisions, could exacerbate denials of APTC for millions of eligible individuals awaiting paperwork processing. A study in the

American Economic Review⁶ found that adding even one extra administrative step reduces enrollment by 33 percent, disproportionately affecting healthy, younger, and low-income individuals. This adverse selection would destabilize the risk pool and raise premiums for unsubsidized enrollees.

Given the low incidence of fraud in SBMs, Covered California strongly supports the statutory provision allowing consumers to affirm electronically verified data for eligibility determinations. Current Marketplace processes have proven effective in simplifying enrollment and keeping eligible individuals covered. CMS should preserve these successful approaches and avoid replacing them with more cumbersome and disruptive processes. Further, CMS should recognize that SBMs have different systems and operational approaches for many core areas of eligibility and enrollment from the FFM. Regulations should allow for state flexibility and avoid unnecessarily rigid requirements that are designed around FFM operations without a full understanding of variation across SBMs.

Additionally, this proposal places a significant burden on Marketplaces, requiring costly and complex implementation. Covered California urges CMS to issue pre-enrollment verification regulations or guidance no later than July 2026 to ensure SBMs have sufficient time to design, build, test, and implement the required changes. Even with this timeline, implementation would remain highly challenging. CMS estimates that implementing new verification requirements would cost Marketplaces approximately \$198 million annually, diverting resources from other critical priorities, including broader eligibility changes under H.R. 1.

For states like California, which operate integrated eligibility systems coordinating Marketplace coverage and Medicaid, the difficulties are even greater. SBMs are already navigating packed implementation schedules, including major changes related to Medicaid work requirements and eligibility rules for noncitizens in both Medicaid and the Marketplaces. These efforts demand more than technical adjustments—they require new policies, procedures, and solutions, while simultaneously unwinding longstanding operational processes that have successfully supported enrollment and eligibility determinations for years.

If CMS proceeds with changes in this area, it must establish a timeline that allows SBMs to implement updates thoughtfully and effectively, without compromising the consumer experience or operational soundness.

⁶ Mark Shepard & Myles Wagner, [*Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment*](#), 115 Am. Econ. Rev. 772, 822 (2025).

STRENGTHENING CONSUMER PROTECTIONS, COVERAGE QUALITY, AND MARKETPLACE STABILITY

Expanded Eligibility for Catastrophic Plans

Covered California urges CMS to preserve state flexibility regarding expanded eligibility for catastrophic plans. A one-size-fits-all approach is not appropriate for states like California, which independently process hardship exemptions and have developed systems and standards tailored to their unique markets.

California's Legislature deliberately reinforced this approach when it enacted the Minimum Essential Coverage Individual Mandate and directed Covered California to establish a state-administered hardship exemption process tailored to California's individual market. In doing so, the Legislature made a careful, evidence-based judgment about how best to stabilize our market in the wake of the repeal of the federal mandate penalty, including allowing targeted access to catastrophic coverage where it would promote continuous coverage and affordability. Overly prescriptive federal catastrophic eligibility rules would undermine this state-specific statutory framework and limit California's ability to use the very tools the Legislature provided to protect consumers and keep our market stable. These measures were designed to stabilize the individual market, lower premiums, and increase coverage following the repeal of the ACA's mandate penalty, ensuring affordability and stability in California's individual market.

Against this backdrop, expanding access to catastrophic coverage raises significant concerns around market stability. In California, the premium differential between catastrophic and bronze plans varies widely across issuers and regions, with some differences being substantial. Broadening eligibility would likely lead to a meaningful migration of younger, healthier enrollees from bronze plans to catastrophic plans, disrupting Marketplace risk pools and introducing considerable uncertainty into rate-setting. As issuers adjust to new enrollment patterns, these shifts could strain plan financials and result in more conservative pricing, ultimately increasing premiums across all metal tiers. Furthermore, increased enrollment in catastrophic plans could adversely impact morbidity patterns within the remaining metal tiers. As healthier enrollees migrate out of bronze and silver plans, premiums for those tiers would likely rise, reducing the cross-subsidization that currently stabilizes the Marketplace.

Covered California is also concerned that encouraging migration to leaner benefit designs may undermine the ACA's goal of improving population health. Catastrophic plans offer limited coverage for non-preventive services, which may lead some consumers to delay or forgo necessary care due to higher cost exposure. While plan liability may be lower for catastrophic plans compared to bronze plans due to higher cost-sharing, the financial burden on consumers would increase. Many Marketplace enrollees already struggle to meet deductibles and out-of-pocket maximums under

bronze plans; catastrophic plans could exacerbate financial hardship and increase medical debt.

Additionally, the affordability advantage of catastrophic plans may erode over time. As enrollment patterns shift and premiums adjust to reflect evolving risk pools, catastrophic premiums may gradually approach current bronze plan pricing, diminishing affordability benefits while leaving consumers with less comprehensive coverage.

Finally, these dynamics raise important questions regarding how catastrophic plans should be integrated into the risk adjustment framework. Covered California urges CMS to carefully evaluate these potential consequences and maintain flexibility for states to address the needs of their unique markets.

Risk Adjustment Transfer Methodology for Catastrophic Plans

In response to CMS's request for comment on the treatment of catastrophic plans within the risk adjustment framework, **Covered California emphasizes the importance of ensuring that the methodology appropriately addresses the selection dynamics associated with these products, particularly as policies to expand access to catastrophic coverage are considered.**

Catastrophic plans tend to attract a distinct enrollment population, skewing younger and healthier compared to other metal tiers. Expanding eligibility for these plans could amplify these selection effects, as a larger share of lower-risk enrollees may migrate into catastrophic coverage. Under these circumstances, maintaining separate risk adjustment pools for catastrophic and non-catastrophic plans could meaningfully exacerbate adverse selection pressures across the individual market.

Significant enrollment shifts into catastrophic plans could weaken the current risk adjustment program's ability to balance risk effectively across plans. Specifically, segregating catastrophic plans from the broader metal tier pool may diminish the program's capacity to offset morbidity differences, as healthier enrollees increasingly select catastrophic coverage while higher-risk enrollees remain in other tiers.

Covered California recommends that CMS carefully evaluate whether the current risk adjustment structure for catastrophic plans remains appropriate if eligibility is expanded. Integrating catastrophic plans into the broader individual market risk pool could be a potential solution to mitigate selection pressures. However, implementing such structural changes would require thorough analysis and sufficient time for issuers and Marketplaces to adjust their rate-setting processes. As CMS considers these policy options, it is essential to ensure that the risk adjustment framework continues to promote balanced enrollment across coverage levels and supports stable premiums in the individual market.

Bronze and Catastrophic Plan Cost-Sharing

Covered California strongly urges CMS to withdraw its proposal to increase cost-sharing for bronze and catastrophic plans beyond the ACA's established maximum annual limitation on cost-sharing. First and foremost, the proposal is clearly contrary to the statutory requirements of section 1302(c) of the ACA. CMS has previously acknowledged that bronze plan designs can comply with actuarial value (AV) requirements and out-of-pocket maximum limits, leaving no legal or practical justification for adopting these changes.

In addition to legal concerns, the proposed policy undermines one of the ACA's core principles: providing meaningful financial protection for consumers. Increasing the maximum out-of-pocket limit in catastrophic plans to 130 percent of the ACA cap, while failing to set an upper limit for bronze plans, would significantly increase medical debt and weaken consumer protections. This could result in some enrollees paying nearly half of their annual income for non-preventive care before coverage becomes effective—a consequence fundamentally at odds with the promise of catastrophic coverage as a financial safeguard.

These changes would further erode the already limited protections of lean plan designs, exposing enrollees to substantial financial harm. Covered California urges CMS to reconsider this proposal and prioritize policies that enhance—not diminish—consumer protection.

Multi-Year Catastrophic Plans

Covered California strongly urges CMS to withdraw its proposal to allow issuers of catastrophic plans to enroll individuals for multiple terms lasting up to ten years. The proposal lacks sufficient clarity to enable meaningful feedback and raises significant unanswered questions regarding plan design, pricing, and integration into existing risk adjustment and rating structures. For instance, it is unclear whether CMS intends to apply a single plan-level catastrophic adjustment regardless of the term purchased or to vary adjustments based on the duration of coverage. Additionally, the proposal does not address how risk adjustment's zero-sum framework would account for differences between single-year and multi-year catastrophic products.

Operationally, implementing multi-year plan terms would require extensive and costly changes to claims adjudication systems, accumulators, enrollment operations, consumer notices, and other infrastructure, all of which are currently designed around annual benefit years. The administrative burden would be substantial and difficult to justify.

Furthermore, Covered California sees little consumer value in this proposal. Longer-term catastrophic plans are likely to have higher costs over time as the frequency of claims increase, thereby reducing affordability benefits. Additionally, market churn—typically driven by changes in Medicaid or employer-sponsored insurance eligibility—is unrelated to the annual terms of Marketplace plans. Multi-year catastrophic plans would therefore introduce unnecessary complexity and confusion without addressing the root causes of consumer churn.

Benefit Cost Defrayal

We urge CMS to reconsider its proposal on state benefit requirements and defrayal. Since 2018, CMS policy has provided states with flexibility to revise and update their essential health benefit (EHB) benchmark plans without triggering new defrayal obligations for benefits incorporated through the update process. This was reaffirmed in the 2025 Payment Notice, which explicitly finalized that benefits covered under a state's EHB benchmark plan are considered EHB and exempt from defrayal. These policies have offered essential clarity to states in determining which benefits qualify as federal EHB and are exempt from defrayal obligations.

Reversing this policy would expose states to new financial liabilities after they relied on CMS's prior guidance to make changes to their benchmark plans. Abrupt policy shifts risk undermining states' efforts, destabilizing markets, and reducing access to care for consumers. If states are required to repeal existing benefit mandates enacted in good faith reliance on CMS rules, consumers could face additional out-of-pocket costs and barriers to care.

Timing is also a critical concern. CMS proposes implementing this defrayal requirement in plan year 2027. However, the timing of this proposed rule, combined with the majority of state legislative calendars, makes it exceedingly difficult—if not impossible—for states to repeal or amend benefit mandates, or alternatively, to appropriate funds to satisfy new defrayal obligations. This proposal would place states in an untenable position, creating unnecessary financial and operational challenges.

If CMS moves forward with changes to defrayal requirements, those changes must be implemented with adequate notice and flexibility to allow states to fully assess the implications, coordinate with regulators and issuers, and avoid disrupting markets. Predictability is essential for states to maintain stable and effective benefit designs that serve consumers and preserve access to care.

Quality Improvement Strategy Standards

Covered California strongly urges CMS to preserve the health disparities reduction component from Quality Improvement Strategy requirements to ensure

issuers remain accountable for improving care for vulnerable and underserved populations. Equity is a cornerstone of meaningful quality improvement and is central to the ACA's commitment to expanding access and improving care for all populations.

Quality improvement efforts that fail to address disparities cannot fully achieve better access, affordability, or outcomes for those who face the greatest barriers to care. Eliminating this component would represent a step backward in federal policy, especially at a time when sustained focus on reducing disparities is critical to advancing equity and improving health outcomes nationwide.

Medical Loss Ratio (MLR)

Covered California recommends that CMS preserve independent state authority over adjustments to MLR requirements by ensuring coordination and collaboration with states, rather than granting CMS unilateral authority. In California, robust state oversight, including solvency regulation and Covered California's active purchaser model, has been instrumental in promoting market stability, ensuring issuer accountability, and maximizing consumer value, all without the need for unilateral federal intervention.

If CMS considers changes to MLR rules, such efforts should focus on targeted improvements that enhance issuer accountability and affordability for consumers. Specifically, CMS should review and refine the definitions of quality improvement activities and administrative expenses to ensure consistent treatment of activities that directly improve health outcomes and consumer value. Additionally, CMS should explore establishing clearer limits on administrative expenses to ensure premium dollars are closely aligned with care delivery and affordability, particularly in the individual market.

OPTIMIZING MARKETPLACE OVERSIGHT

State Exchange Improper Payment Measurement Program (SEIPM)

Covered California supports efforts to ensure the accuracy of APTC determinations and appreciates the collaborative work CMS has undertaken with SBMs through pilot programs and related testing. Covered California previously participated in CMS improper payment measurement efforts and values this ongoing partnership. However, Covered California has concerns about the proposed annual cadence for SEIPM reviews. Conducting reviews every year would place undue operational strain on SBMs and fail to allow adequate time for implementing remediation measures before subsequent reviews. Covered California recommends adopting a three-year review cycle for SEIPM, similar to the IRS's triennial safeguard review of Marketplace compliance with federal tax return information protections. The IRS's model provides

thorough evaluations of systems, platforms, applications, and sample case files, yielding actionable results that Marketplaces can address before the next review. A similar cadence for SEIPM would ensure an efficient and effective oversight process for both CMS and SBMs. Between review cycles, CMS could leverage existing audit and reporting frameworks to support continuous program improvement without duplicating oversight efforts.

Finally, Covered California urges CMS to continue working closely with SBMs to ensure any future measurement framework is appropriately calibrated, operationally feasible, and respectful of state systems and state-held data.

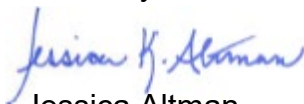
Civil Monetary Penalties Against Issuers

Covered California recommends that CMS collaborate closely with state regulators and SBMs in developing and implementing a civil monetary penalty framework for issuers. Effective oversight depends on coordination and partnership, rather than unilateral federal action that risks duplicating or conflicting with existing state authority and enforcement structures.

State regulators and SBMs bring extensive experience and expertise in issuer oversight, enabling them to assess market dynamics, operational challenges, and the most appropriate corrective actions. CMS should prioritize aligning any federal penalty framework with state oversight efforts to ensure it complements, rather than disrupts, the effective regulation of Marketplaces.

Thank you for the opportunity to provide feedback on this proposed rule. Covered California values CMS's continued partnership and its recognition of the essential role SBMs play in advancing the ACA's mission. We look forward to ongoing collaboration to ensure the ACA continues to evolve, strengthen its foundation, and expand access to high-quality, affordable healthcare for all Americans.

Sincerely,



Jessica Altman
Executive Director



March 13, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via regulations.gov

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

Dear Administrator Dr. Oz:

As the longtime national, non-partisan health care consumer advocacy organization, Families USA appreciates the opportunity to comment on the 2027 Notice of Benefit and Payment Parameters (NBPP) proposed rule.

For more than 40 years, Families USA has worked to improve the health and health care of the nation. We are committed to ensuring that consumers have access to high-quality, affordable coverage that protects their health and financial security.

Many of the policies proposed in the 2027 NBPP, individually and taken together, would substantially undermine coverage and the overall individual insurance marketplaces by weakening consumer protections, increasing plan design flexibility without adequate safeguards, and shifting oversight responsibilities away from federal standards. While these proposals are framed as reducing regulatory burden and increasing innovation, several of the changes would likely increase consumer confusion, weaken market transparency, and expose consumers and patients to greater financial risk at a time when our nation's families are begging lawmakers to lower their health care costs, not increase them. If finalized, this proposed rule would systemically destabilize many of the core components of the Affordable Care Act (ACA) marketplace which ensure its success including clear plan comparisons, strong consumer protections, and robust regulatory oversight.

Families USA therefore urges the Centers for Medicare & Medicaid Services (CMS) to reconsider many of the changes proposed in this rule. Specifically, CMS should withdraw or substantially revise several provisions that would undermine access to comprehensive, affordable coverage, and weaken consumer protections in the marketplaces.

Families USA offers comments on the following sections of the proposed rule:

- Discontinuation of Standardized Plan Options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, 156.202, and 156.265(b)(3)(iv))
- Comment Solicitation on Potential Adjustment to the MLR for a State's Individual Market (Subpart C)

- Submission of Rate Filing Justification (§ 154.215)
- Amending Requirements for State Exchanges to Operate a Centralized Eligibility and Enrollment Infrastructure (§§ 155.205(b) and 155.221(k))
- Proposals Related to Creating Standards of Conduct Related to Marketing (§ 155.220(j)(3))
- Provision of EHB (§ 156.115(d)) and Additional Required Benefits (§ 155.170)
- Network Adequacy Standards and Use of Non-network Plans (§§156.230, 156.235, 155.1050, 156.230, 156.235, and 156.236)
- Proposals and Comment Solicitation Regarding Catastrophic Plans (§§153.320, 155.605, 156.80, 156.130, 156.155, 156.605)
- Data Matching Issues (§§155.320 (c)(3)(iii) and 155.320(c)(5))

Discontinuation of Standardized Plan Options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, 156.202, and 156.265(b)(3)(iv))

CMS proposes to eliminate the requirement that Qualified Health Plan (QHP) issuers in the Federally Facilitated Exchanges (FFE) and State-Based Exchanges on the Federal Platform (SBE-FP) offer standardized plan options beginning in plan year 2027. CMS also proposes to remove limits on the number of non-standardized plans issuers may offer.

Families USA strongly opposes these proposals. Standardized plans are a key consumer protection that improves the ability of individuals and families to compare health coverage options and access needed services at predictable cost-sharing levels.¹

A central challenge facing consumers in the marketplace is the complexity of plan choice. Marketplace shoppers in many areas face dozens, and in some cases more than one hundred, plan options with varying deductibles, copayments, and coinsurance structures.² Research has consistently shown that excessive choice can lead to poorer decision-making, with consumers more likely to select plans that do not meet their health or financial needs. Standardized plans were developed to help address this problem by establishing consistent cost-sharing structures across insurers.³ By holding deductibles and copayment structures constant, standardized plans allow consumers to compare plans primarily based on premiums and provider networks, factors that allow consumers to more meaningfully evaluate plans.

Enrollment assisters and navigators consistently report that standardized plans significantly simplify plan comparisons and reduce confusion during the enrollment process.⁴ Marketplace enrollment data from 2025 indicates that more than 8 million consumers have selected these standardized plan options.⁵ Even consumers who ultimately enroll in non-standardized plans benefit from the availability of standardized plans because they provide a clear benchmark against which other plan designs can be compared.⁶

Standardized plans also improve access to care by requiring certain commonly used services—including primary care visits, specialist visits, mental health services, urgent care visits, and generic prescription drugs—to be covered with fixed copayments before the deductible.⁷ This plan and cost sharing structure is critical given that it is well established that high deductibles discourage patients from seeking necessary care, including critical preventive health and chronic disease management services.⁸ By reducing upfront cost barriers for routine services, standardized plans help ensure that consumers and patients can access care earlier, which can reduce downstream health costs.⁹

In its proposed rulemaking, CMS justifies its proposal to eliminate standardized plans on the basis that they may contribute to excessive numbers of plan offerings in the marketplaces.¹⁰ However, if that is the concern, CMS should instead withdraw its concurrent proposal to eliminate limits on non-standardized plan offerings, which would likely increase, not reduce, the number of plans available to consumers.¹¹ We agree with the academic research that shows limiting the number of plan choices can improve consumer decision-making, but we also emphasize that standardized plans provide help for consumers in making sense of a multiplicity of plans. As such, we strongly oppose CMS's proposal and its justification that focus on only eliminating the more comprehensive benefits promised through standardized plans while simultaneously allowing non-standardized plans to proliferate and create more complexity for consumers.

Eliminating standardized plans would only serve to increase consumer confusion, reduce transparency in plan comparisons, and weaken access to affordable routine care for our nation's families. As a result, **Families USA strongly opposes CMS's proposal to eliminate standardized plans and recommends that CMS maintain the requirement that issuers offer standardized plan options, and that CMS retain limits on non-standardized plans to preserve meaningful consumer choice and protect access to care.**

Comment Solicitation on Potential Adjustment to the MLR for a State's Individual Market (45 Part 158 Subpart C)

CMS requests comments on whether the federal Medical Loss Ratio (MLR) standard should be adjusted for individual markets in particular states and whether such adjustments should be allowed for longer periods of time.

Under Section 2718 of the Public Health Service Act, health insurers in the individual market must spend at least 80 percent of premium revenue on clinical services and activities that improve health care quality. If insurers fail to meet this threshold, they must provide commensurate rebates to consumers. The MLR standard plays a critical role in protecting consumers from excessive and inflated premiums and ensuring that premium dollars are used primarily for medical care rather than administrative expenses or profits.¹² **Families USA strongly opposes any reduction in the federal MLR standard for the individual market.** Lowering the MLR threshold would allow insurers to retain a greater share of premium revenue for administrative costs and profits, reducing the value consumers receive from their coverage.¹³

CMS accurately acknowledges in its proposed rule that no states have recently requested adjustments to the individual market MLR standard as a mechanism to stabilize their markets.¹⁴ This fact counters CMS's suggestion that the existing standard has posed a barrier to the stability of the individual market. Moreover, allowing lower MLR standards would only serve to weaken incentives for insurers to control administrative costs and would undermine consumer confidence in marketplace coverage. If states were permitted to lower the MLR threshold, consumers could pay higher premiums without receiving additional medical benefits, exposing them to higher cost care with less access to needed services.¹⁵

CMS also seeks comment on whether catastrophic plans, and specifically its new proposal under §§ 156.130(c) and 156.155(a)(6) of this rule for multi-year catastrophic plans, should be subject to different MLR requirements (see our detailed comments on these sections of the rule below). **Families USA strongly opposes any policy that would allow catastrophic plans to operate under lower MLR standards—especially since catastrophic plans already expose enrollees to very high deductibles and**

cost-sharing requirements. Further exposing consumers to any increased costs would only deepen their financial insecurity at a time when consumers and patients need greater protections from rising health care costs.¹⁶ Allowing insurers to spend an even smaller share of premiums on medical care would further weaken the value of these plans and expose consumers to greater financial risk.¹⁷ **We strongly recommend that CMS maintain the existing 80 percent MLR standard and not allow lower MLR thresholds for catastrophic or other marketplace plans.**

Submission of Rate Filing Justification (§ 154.215)

CMS proposes to collect additional information regarding how issuers calculate the “CSR load factor” used to account for the costs of unreimbursed cost-sharing reductions.

While Families USA supports efforts to improve transparency in rate filings and to ensure that pricing methodologies are actuarially justified, we urge CMS to ensure that any new requirements remain consistent with the ACA’s statutory requirement for insurers to treat all enrollees in the individual market as part of a single risk pool.

States have adopted a range of approaches to incorporate the cost of unreimbursed cost-sharing reductions into premiums including “silver loading” which concentrates CSR costs in silver-tier plans while allowing premium tax credits to increase accordingly.¹⁸ This approach has helped many consumers obtain lower premiums in bronze and gold plans and has improved affordability for millions of marketplace enrollees.¹⁹

As CMS notes, some issuers have priced silver level on-exchange plans based on the utilization they anticipate among silver plan enrollees alone, while others have priced the increased utilization across all metal levels in the individual market (a “single risk pool”). We anticipate that state loading policies may change further as consumers make different enrollment choices. We urge CMS to continue to allow states to consider the claims experience of all enrollees in all health plans and at all metal levels to be members of a single risk pool in setting metal-level plan rates, as this approach is consistent with the law and is advantageous for many states’ marketplace populations.

The Affordable Care Act at Section 1312(c) and Regulation § 156.80(a) explicitly states that an issuer must consider the claims experience of all enrollees in all health plans to be members of a single risk pool. It further states in § 156.80(d) that issuers may vary premium rates only by five listed factors, which do not include actual plan-level experience. Calibrating the CSR load factor on the actual claims experience of those enrolled in silver plans (the only plans eligible for CSRs) would create a separate risk pool. In practice, this approach results in mispriced silver plans relative to bronze and gold plans and can cause 97% of marketplace consumers to spend more for coverage.²⁰ **As a result, Families USA recommends that CMS allow states to continue using approaches that treat all individual market enrollees as part of a single risk pool and that support stable and affordable marketplace premiums.**

Amending Requirements for State Exchanges to Operate a Centralized Eligibility and Enrollment Infrastructure (§§ 155.205(b) and 155.221(k))

CMS proposes to remove the requirement that all State Exchanges operate a centralized, consumer-facing eligibility and enrollment platform. Under the proposal, states could instead rely entirely on privately operated web-broker platforms using an Enhanced Direct Enrollment (EDE) model. **Families**

USA strongly opposes this proposal to allow state marketplaces to rely entirely on private web brokers' platforms.

Maintenance of a state-run platform creates legitimacy, supports better oversight, and builds consumer trust. Allowing private companies to operate their own enrollment and eligibility platforms, with no option for consumers in the state to instead use a government-run platform, may cause confusion for prospective enrollees, lead to significant marketplace attrition and invite new opportunities for bad actors to engage in fraud and deceptive practices.

Such web brokers are unlikely to serve all the functions of a public platform. Unlike a state-operated platform, EDE platforms have no obligation or financial incentive to help direct prospective consumers who are eligible for other types of coverage to those programs.²¹ For example, when Georgia proposed to move to an EDE platform in 2022, researchers estimated losses of 4.4 to 8.3% in individual market enrollment in 2023, and continued enrollment losses of 8.4% annually from 2024 to 2027.²² Coverage losses in Medicaid could be particularly acute as web-brokers do little to support Medicaid enrollment since they are not compensated for directing Medicaid-eligible enrollees into Medicaid coverage.²³ Instead, some brokers might even direct Medicaid-eligible populations into non-marketplace coverage they offer.²⁴ Importantly, CMS's proposal does not address how states might mitigate coverage losses during a future transition away from operating a centralized, consumer-facing enrollment platform suggesting that coverage losses may in fact be the goal.

Of further concern, many operators of Direct Enrollment (DE) and EDE platforms have deeply problematic track records of anti-consumer behavior, with many engaging in deceptive if not illegal marketing practices that put consumers at risk.²⁵ Some DE platforms have used screening tools to direct consumers away from marketplace options or collect personal and health information to sell non-marketplace plans to consumers later.²⁶ Notably, web-brokers using DE and EDE platforms have been associated with significant marketplace fraud, including some of the more than 90,000 instances of unauthorized plan switches and more than 180,000 instances of unauthorized enrollment between January and August 2024.²⁷ This widespread fraud led to the suspension of 850 agents and brokers and two EDE enrollment websites by CMS in 2024,²⁸ though under the Trump administration, all 850 of these agents and brokers were reinstated.²⁹

Families USA has significant concerns that some agents and brokers using EDE platforms will continue to commit enrollment fraud or other types of deceptive marketing and enrollment practices, given the minimal punishment they have thus far faced amidst hundreds of thousands of cases of fraud and evidence of other practices harmful to consumers. **As a result, Families USA strongly opposes this proposal and recommends that CMS rescind this proposed change in order to protect consumers from falling prey to fraudulent actors.**

Proposals Related to Creating Standards of Conduct Related to Marketing (§ 155.220(j)(3))

CMS proposes to align the definition of "sex" with Executive Order 14168³⁰ by removing language from § 155.220(j)(2)(i) that defines the term "sex" to include sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes. CMS further states that they "do not believe this change would result in or facilitate any discrimination against consumers."

Families USA opposes this change. The removal of language related to sex characteristics, sexual orientation and gender identity from the definition of “sex” dehumanizes transgender, nonbinary, and intersex people and defies medical and scientific consensus on the understanding of sex and gender.³¹

Families USA strongly recommend CMS rescind this proposed change.

Proposals Related to Provision of EHB (§ 156.115) and Additional Required Benefits (§ 155.170)

CMS proposes to restrict pathways for states to update Essential Health Benefit (EHB) benchmark plans without being required to defray the costs, and to prohibit states from including routine adult dental services as EHB. **Families USA strongly opposes these proposals to limit the ability of states to update and improve essential benefits.**

The ACA established Essential Health Benefits to ensure that health insurance plans provide comprehensive coverage across ten core benefit categories. The EHB framework also allows states to update their benchmark plans to reflect evolving medical standards and changing health needs.³² In recent years, several states have used this flexibility to improve coverage for important services, including hearing aids, prosthetic devices, and treatment for substance use disorders.³³ As medical knowledge advances, patients, especially those with chronic conditions like diabetes, will need benefits to be revised and updated. These updates reflect advancements in clinical care and respond to longstanding gaps in coverage that can affect health outcomes.³⁴ If finalized, this proposal would prevent states from improving EHBs to be on par with other states or meet current clinical guidelines for services that are shown to improve health outcomes and reduce costs for patients—services like routine adult dental coverage.³⁵ Importantly, poor oral health is associated with a range of serious medical conditions, including cardiovascular disease, diabetes complications, and adverse pregnancy outcomes.³⁶ Expanding access to dental care is one of the best interventions states and policymakers have to improve population health while reducing long-term health care costs.³⁷

Further, the proposed changes would create confusion and uncertainty among states regarding how to clarify or improve EHBs to be equal in scope to benefits provided under employer-based plans and as to what requires defrayal of costs by the state. The lack of clarity around these issues will stifle action by states to improve EHBs. **As a result, Families USA strongly opposes this proposal and recommends that CMS preserve states’ flexibility to update EHB benchmark plans, and to specifically preserve coverage of routine adult dental services.**

Proposals Regarding Network Adequacy Standards (156.230, 156.235, 155.1050, 156.230, 156.235, and 156.236)

Scaling Back Federal Review and Deference to States for Network Adequacy

CMS proposes to defer network adequacy reviews to states and reduce federal requirements for quantitative network adequacy standards. **Families USA strongly opposes these proposals to scale back review requirements for network adequacy, a fundamental patient protection to ensure access to care.**

Network adequacy standards are critical to ensuring that insurance coverage translates into meaningful access to care. Without sufficient provider networks, enrollees may face long wait times, excessive travel distances, or an inability to obtain appointments with needed specialists.³⁸

Federal quantitative standards such as time and distance requirements and appointment wait time standards provide an objective framework for evaluating network adequacy. Eliminating these standards could result in inconsistent oversight across states and reduce accountability for plans that fail to maintain adequate networks.³⁹

Importantly, secret shopper surveys have proven to be an effective tool for verifying whether providers listed in plan directories are actually accepting new patients and participating in plan networks. These surveys have found significant inaccuracies in provider directories, particularly for mental health services.⁴⁰ For example, in a 2018 survey, about half of privately insured English-speaking people in health plans with provider networks reported inaccuracies in insurers' mental health provider directories; though they were unlikely to file grievances, those experiencing inaccuracies were four times as likely as other patients to receive surprise bills.⁴¹ More recently, the New York State Attorney General used a secret shopper survey to monitor ghost networks in 2023, and found that among 13 health plans surveyed, the number of mental health providers who accepted new patients ranged from 0 to 35 percent. As a result, the New York Office of the Attorney General recommended several changes to better support network adequacy including regular audits of provider networks including secret shopper surveys, robust appointment time wait standards, regular analysis of network adequacy indicators, vigorous enforcement, and a centralized provider directory among plans.⁴²

In fact, secret shopper surveys have been so effective they became a federal standard for Qualified Health Plan (QHP) certification in 2025.⁴³ Furthermore, secret shopper surveys are an important tool in ensuring compliance with the No Surprises Act, which requires that plans and providers regularly update information about providers that participate in a given plan. As a result, maintaining strong oversight tools such as secret shopper surveys is essential to ensuring that provider networks function as advertised. All Americans should have these basic patient protections to safeguard access to care, and to ensure that federal laws are followed, even if they live in states that don't have the capacity or commitment to do such reviews at the state level.

As such, **Families USA urges CMS to maintain quantitative measures, including the availability of in-network appointments as measured by secret shopper surveys, as a requirement for both federal and state exchanges' oversight of QHPs.**

- **Furthermore, criteria for an "effective provider access review program" under §155.1050 should include oversight of provider availability throughout the plan year.**
- **Rather than eliminating network adequacy requirements, we urge CMS to make plan network adequacy measures more transparent.** For example, since 2019, marketplaces have displayed some plan quality information to shoppers through a star rating system.⁴⁴ The quality rating system that CMS currently uses displays an overall rating of member satisfaction with "ease of getting appointments and services" that is based only on a telephone survey of enrollees.⁴⁵
- **Finally, we recommend that CMS incorporate the results of secret shopper surveys into public plan ratings as they are a much more thorough measure of appointment availability and network adequacy.**

Diminution of Essential Community Provider Standards (156.235)

CMS proposes to reduce the minimum percentage of Essential Community Providers (ECPs) with which plans must contract from 35 percent to 20 percent (including 20 percent of family planning providers, 20 percent of Federally Qualified Health Centers, and 20 percent of other available essential community

providers). **Families USA strongly opposes this change as it would threaten stability of key community providers and jeopardize patient access to care.**

Essential Community Providers including community health centers, family planning providers, rural clinics, and safety-net hospitals serve millions of low-income and medically underserved patients. They offer important services including hemophilia treatment, mental health and substance use disorder treatment, rural emergency care, family planning, and other care that is in short supply and/or that serves low-income enrollees.⁴⁶ Reducing contracts of essential community providers would further threaten access to care for underserved populations, harming health and driving health care costs in the long-term as patients without affordable access to timely treatment delay needed care until they are much sicker and forced to seek care in an emergency setting.⁴⁷ For example, Federal Qualified Health Centers (FQHCs) provide comprehensive primary care as well as ongoing medical, dental, and behavioral care to about 32 million patients. About 22% of Health Center patients have private insurance, including through the marketplaces.⁴⁸ If this rule is implemented, it would further diminish essential community providers' contracts and revenues, likely forcing some FQHCs to cut hours, eliminate services, or go out of business altogether.⁴⁹

Allowing Non-Network Plans in the Marketplace

Families USA strongly opposes CMS's proposal to allow plans without traditional provider networks to participate in the marketplaces.

Traditional insurance networks provide consumers with clear information about which providers participate in their plans and protect consumers from unexpected costs by establishing negotiated payment rates. Allowing non-network plans to participate in the marketplace would undermine these protections and expose consumers to unpredictable and unnecessary medical bills and financial risk.

Although the proposal attempts to establish guardrails requiring plans to demonstrate that some providers would accept the plan's payment rates, these safeguards do not guarantee that consumers will be able to access providers without additional charges throughout the plan year. Additionally, the interaction between non-network plans and existing consumer protections such as the No Surprises Act is unclear at best. Because many surprise billing protections rely on the distinction between participating and non-participating providers, introducing non-network plans could create gaps in consumer protections.^{50,51}

Unless and until comprehensive safeguards are established, CMS should not permit non-network plans to participate in the ACA marketplaces.

Proposals and Comment Solicitation Regarding Catastrophic Plans (153.320, 155.605, 156.80, 156.130, 156.155, 156.605)

CMS proposes to expand eligibility for catastrophic plans, increase allowable cost-sharing, and allow catastrophic plans to be sold with multi-year terms of up to ten years. **Families USA strongly opposes these proposals to allow for even more ultra-high deductible and skimpier catastrophic plans.**

Catastrophic plans are designed to provide limited coverage for very high-cost events and currently have extremely high deductibles. Because these plans provide little coverage for routine services, they offer

limited financial protection for most households. These health plans should be available in very limited circumstances given their high cost and lack of comprehensive coverage.

Most households do not have sufficient savings to pay the maximum out of pocket limit in private health plans – which is also the deductible that people must meet before a catastrophic plan pays for anything except preventive care.⁵² Further, even now, a significant number of insured adults go without needed care: 25% of insured adults say they delay or forgo some health or dental care due to cost and 10% of insured adults report difficulty paying medical bills.⁵³ Catastrophic plans by definition leave people more exposed to such cost barriers. Wisely, few people enroll – they prefer bronze plans that cover more care at a similar premium.⁵⁴ Expanding eligibility for catastrophic plans to people with incomes below poverty or above 250% of poverty will expose more people to unaffordable costs of care. Increasing the deductibles and out-of-pocket limits beyond what is currently allowed by regulations and statute will cause them further harm.

Allowing multi-year catastrophic plans would create new challenges for consumers whose health needs change over time. For example, individuals may wish to switch plans during open enrollment if they develop chronic conditions or require more comprehensive coverage. However, multi-year plan structures would create financial incentives that discourage consumers from switching plans even when their health needs change and would lock consumers into high-cost health plans that don't serve their health needs over many years. For example, consider a person who was believed to be in good health, until they suffered a stroke. As of 2024, the cost of an initial hospital stay for a stroke among people with spasticity was \$62,875 per patient; and beyond the hospital stay, these patients incurred about \$12,630 of care costs.⁵⁵ Such costs might be incurred over several policy years, depending on when the stroke occurred. Moreover, even if that person had to stop working as a result of their stroke, they would not be eligible for Social Security Disability until five months after the onset of their disability and then would need to wait another 24 months for Medicare.⁵⁶ If such a person was locked into a multi-year catastrophic plan or was enticed into such a plan due to its multi-year pricing structure, the proposed cost-sharing charges that average more than \$15,000 per plan year could be insurmountable.

CMS specifically seeks comments on whether multi-year catastrophic plans should receive additional adjustments in risk pools. **We strongly urge CMS against making such a change to encourage multi-year plans, especially if they lock consumers into certain prices and benefits even if their needs and the market change.** Also, expanding catastrophic plans, lengthening their terms of coverage, and giving them preferential treatment in risk pooling would likely weaken existing marketplace risk pools by drawing healthier people out of the single risk pool in violation of the statute.⁵⁷ This shift would increase premium costs for those that remain in more comprehensive coverage.⁵⁸ As a result, **we oppose establishing multiyear catastrophic plans and urge CMS to reject this proposal.**

Data Matching Issues (Section 155.320 (c)(3)(iii) and 155.320(c)(5))

CMS proposes to continue requiring states to generate data matching inconsistencies when consumers attest to incomes above the federal poverty level, but external data sources suggest lower incomes or tax data is unavailable - a change first proposed in the 2026 marketplace integrity rule. **Families USA commented on and opposed this issue in 2025⁵⁹ and reiterates our opposition here.**

CMS's policy will deny many enrollees access to subsidized coverage, afford little flexibility for consumers while imposing significant administrative burdens on federal and state-based exchanges, and disproportionately harm lower-income enrollees who experience high income volatility.⁶⁰ For these

individuals, income documentation may require collecting dozens of individual paystubs to substantiate their income projection. For these reasons, **Families USA continues to have serious concerns about this policy that would deny access to subsidized coverage for eligible Americans due to data matching inconsistencies, and we urge CMS to drop this proposal.**

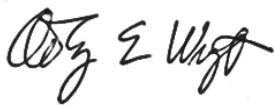
Conclusion

The Affordable Care Act marketplaces have achieved historic coverage gains over the past decade, bringing our nation's uninsured rate to record low levels. These gains have been driven by strong consumer protections, clear plan comparisons, and effective federal and state oversight that builds clarity and trust for many consumers. Many of the policies proposed in the 2027 NBPP would weaken these foundations. Eliminating standardized plans, reducing network adequacy standards, weakening oversight of enrollment platforms, and expanding high-deductible catastrophic plans would increase consumer confusion, reduce access to care, and expose families to greater financial risk.

Families USA urges CMS to withdraw or substantially revise these proposals and to continue strengthening the existing consumer protections that have helped make the ACA marketplaces a reliable source of affordable coverage for millions of Americans.

We appreciate the opportunity to submit these comments and look forward to continued engagement with CMS on policies that strengthen health coverage and improve health outcomes for all.

Sincerely,



Anthony Wright

Executive Director

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March 13, 2026

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Centers for Medicare and Medicaid Services
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 [CMS-9883-P]

Dear Administrator Oz:

Thank you for the opportunity to comment on the proposed 2027 Notice of Benefit and Payment Parameters issued by the Centers for Medicare and Medicaid Services (CMS).¹ My letter comments on several aspects of the proposed rule. I make three main points:

1. Combining the catastrophic and metal-tier risk pools for risk adjustment purposes, as CMS seeks comment on, would improve the risk adjustment system's ability to meet its goals.
2. CMS proposes to allow insurers to offer bronze plans with out-of-pocket maximums that exceed the statutory limit, with the stated goal of ensuring that it remains feasible to offer a plan with an actuarial value (AV) low enough to qualify for the bronze tier. However, this limit is not currently a barrier to offering bronze plans and it is unlikely to become a barrier for many years unless CMS changes the AV calculator methodology.

Moreover, the recent upward trend in the AV of a plan that provides no coverage below the required out-of-pocket maximum—which is what CMS expects to threaten the long-term viability of bronze plans—likely at least partly reflects the AV calculator's failure to account for prescription drug rebates. Fixing this issue would likely meaningfully reduce reported AVs and their tendency to rise over time; thus, it would offer CMS an alternative path to achieving its stated goal of ensuring the continued viability of bronze plans.

3. CMS proposes to allow insurers to offer plans without a provider network as long as the insurer can demonstrate that enough providers will accept its schedule of allowed amounts as payment in full. If this access requirement can be effectively enforced, it is doubtful that there is much scope for these plans to offer lower premiums than existing plans, in which case this proposal would likely have little effect on market outcomes. If, on the other hand, this requirement cannot be effectively enforced, as seems quite possible, then these plans likely would offer lower premiums and, in turn, reduce federal spending, but at the cost of meaningfully reducing access to care for enrollees who shift into non-network plans, increasing what enrollees who remain in traditional plans pay for their coverage, and

¹ The views expressed in this letter are my own and do not reflect the views of the Brookings Institution or anyone affiliated with the Brookings Institution other than myself. I thank Richard Frank for helpful comments on a draft of this letter, as well as Chloe Zilkha and Rasa Siniakovas for research and editorial assistance, respectively.

perhaps even threatening the continued viability of some traditional plans. In short, if the access requirements work as intended, then this proposal seems likely to be less impactful than CMS hopes, and if these requirements do not work as intended, then the proposal has potentially significant downsides that the proposed rule fails to grapple with.

The remainder of this letter examines these points in greater detail.

Treatment of catastrophic plans in risk adjustment

CMS currently treats catastrophic and metal-tier plans as separate risk pools for risk adjustment purposes. Concretely, CMS conducts separate transfer calculations for each type of plan and, thus, the risk adjustment system does not aim to offset differences in risk mix between catastrophic and metal-tier plans. In the proposed rule, CMS seeks comment on whether its proposed expansion of catastrophic plan eligibility merits combining these risk pools for risk adjustment purposes.

Such a change would likely improve the risk adjustment system's ability to meet its goals. The goal of risk adjustment is to break (or, at least, weaken) the link between who an insurer enrolls and the claims costs it incurs. By doing so, risk adjustment encourages insurers to set premiums for different plans that reflect differences in plan characteristics rather than differences in the enrolled population. That, in turn, encourages enrollees to select the plans that offer the best balance between the quality of the coverage they offer and the cost at which they can deliver that coverage, rather than gravitating toward plans that happen to attract healthier enrollees.

Segregating catastrophic plans means that risk adjustment fails to offset differences in enrollee characteristics between catastrophic and metal-tier plans. In practice, it is likely that catastrophic plans attract enrollees who have lower costs than those who select metal-tier plans since catastrophic plans require higher cost-sharing than non-bronze metal-tier plans, and healthier enrollees tend to gravitate toward less generous plans.² This likely results in higher premiums for metal-tier plans relative to catastrophic plans and, in turn, causes some enrollees who would be more efficiently served by metal-tier plans to select catastrophic plans instead.³

This distortion is likely modest in practice, as catastrophic plans attracted only around 69,000 life-years of enrollment in total in 2024.⁴ Nevertheless, there is little clear rationale for tolerating it. And while the fact that catastrophic enrollees are ineligible for premium tax credits will likely continue to limit how many people opt for catastrophic plans, CMS' proposals to expand eligibility for catastrophic plans and change the catastrophic benefit design in ways that increase the

² See, for example, Victoria R. Marone and Adrienne Sabety, "When Should There Be Vertical Choice in Health Insurance Markets?," *American Economic Review* 112, no. 1 (2022): 304–42, <https://doi.org/10.1257/aer.20201073>.

³ Importantly, while the current risk adjustment treatment of catastrophic plans likely reduces the *relative* premiums of catastrophic plans, it does not necessarily reduce their *absolute* premiums because the additional enrollees attracted by the catastrophic plans' lower relative premiums are likely more costly than other catastrophic enrollees. For more discussion of these types of enrollment dynamics, see Michael Geruso et al., "The Two-Margin Problem in Insurance Markets," *The Review of Economics and Statistics* 105, no. 2 (2023): 237–57, https://doi.org/10.1162/rest_a_01070.

⁴ This reflects my calculations based on CMS' risk adjustment summary report for 2024.

difference in generosity between catastrophic and metal-tier plans will likely magnify the existing distortion to some degree, strengthening the case for a risk adjustment change.

Out-of-pocket maximums for bronze plans

CMS proposes to permit insurers to offer bronze plans with out-of-pocket maximums that exceed the statutory limit in certain circumstances. While this proposal raises many questions (including about its substantive desirability and statutory basis), I limit my comments to the empirical claim that CMS uses to justify disregarding the statutory limit: namely, that this change is necessary to allow insurers to continue to offer plans with AVs low enough to qualify as bronze plans.

Viability of bronze plans in 2027

Setting aside the statutory limit is clearly unnecessary for 2027. Under the final AV calculator for 2027, a “MOOP-only” plan (i.e., a plan with an out-of-pocket maximum [“MOOP”] equal to the statutory limit that offers no coverage below that level) would have an AV of 57.7%.⁵ This AV falls well below the top of the de minimis range for standard bronze plans (62%) and even farther below the top of the de minimis range for expanded bronze plans (65%). Thus, insurers face no barriers to designing and offering bronze plans for the 2027 plan year under CMS’ current rules.

Potential future trends in bronze plan viability

CMS suggests that insurers could encounter greater difficulty in the future since the AV of a MOOP-only plan has tended to rise over time. This is certainly possible, but it is far from guaranteed. As CMS notes, the driver of the historical increase in the AV of a MOOP-only plan has been that the per enrollee spending reflected in the continuance tables underlying the AV calculator (which CMS constructs from health insurance claims databases) has grown faster than the maximum out-of-pocket limit (which is updated annually based on estimates of premium growth). Absent a clear understanding of why these two growth rates have differed, something that CMS does not offer in the proposed rule, it is hard to be confident whether this differential will persist and, thus, whether it poses a realistic threat to the viability of bronze plans.

While I examine one factor that may have contributed to the upward trend in AVs in the next subsection, it is worth noting that even if this trend persisted in full, it would be many years before it would become impossible to offer a bronze plan (unless CMS makes changes to the AV calculator that increase reported AVs). For 2014, the reported AV of a MOOP-only plan was 58.0%. If one removes the effect of changes CMS has made to the AV calculator methodology to exclude certain high-spending enrollees, that number would have risen to around 63% in 2027,⁶ a rate of increase of only around 0.4 percentage points per year. At that rate of increase, it would take around a decade for the AV of a MOOP-only plan to reach the top of the bronze de minimis range and many years more to reach the top of the expanded bronze de minimis range. It is thus hard to see how this trend could justify a near-term change like the one CMS proposes.

⁵ This and all other calculations using the AV calculator employ the bronze continuance tables.

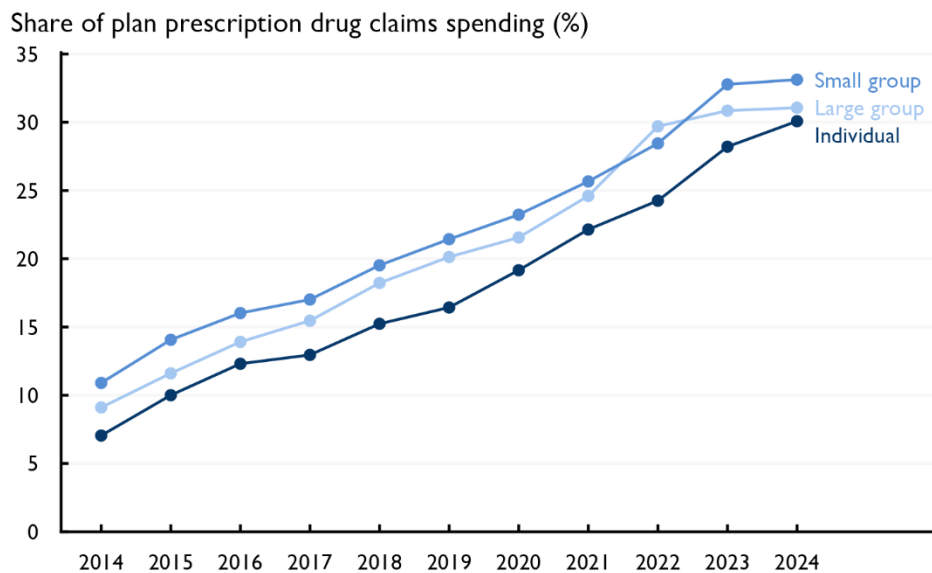
⁶ This estimate reflects the 57.7% AV for such a plan from the actual 2027 AV calculator, plus 5.5 percentage points, which is the midpoint of the range that CMS provides in the proposed rule for how excluding high-spending enrollees affects the reported AV of a plan in the bronze tier.

Prescription drug rebates and the AV calculator

In the remainder of this section, I briefly consider one factor that is likely distorting plan AVs and may help explain the upward trend in the AV of a MOOP-only plan: the AV calculator's failure to account for rebates paid by drug manufacturers after the point of sale. The core issue in this regard is that the continuance tables that underlie the AV calculator are based on claims data and, as such, do not reflect manufacturer rebates that are paid after the point of sale. Cost-sharing is based on point-of-sale prices, so this does not distort the AV calculator's estimates of enrollee cost-sharing liabilities. But failing to net out rebates does cause the calculator to overstate the total cost of the care enrollees receive and, correspondingly, to understate the share of total costs that are borne by enrollees. Equivalently, this causes the calculator to *overstate* plan AVs.

This distortion is likely sizeable and growing. Using data from insurers' medical loss ratio (MLR) filings, Figure 1 shows that rebates offset a large and growing fraction of what individual and small group market insurers spend on prescription drugs. While MLR data on drug rebates should be interpreted with some caution because they are not used to calculate an insurer's MLR, the levels and trends shown here are broadly consistent with those found in prior research.⁷

Figure 1. Prescription drug rebates by insurance market



Source: MLR public use files; author's calculations.

⁷ Inmaculada Hernandez et al., "Changes in List Prices, Net Prices, and Discounts for Branded Drugs in the US, 2007-2018," *JAMA* 323, no. 9 (2020): 854–62, <https://doi.org/10.1001/jama.2020.1012>; Elizabeth Plummer et al., "Trends of Prescription Drug Manufacturer Rebates in Commercial Health Insurance Plans, 2015-2019," *JAMA Health Forum* 3, no. 5 (2022): e220888, <https://doi.org/10.1001/jamahealthforum.2022.0888>; Justine Mallatt et al., "Consumer Out-Of-Pocket Drug Prices Grew Faster Than Prices Faced By Insurers After Accounting For Rebates, 2007–20," *Health Affairs* 43, no. 9 (2024): 1284–89, <https://doi.org/10.1377/hlthaff.2023.01344>; Andrew W. Mulcahy et al., *Prescription Drug Prices, Rebates, and Insurance Premiums* (2024), https://www.rand.org/pubs/research_reports/RRA1820-3.html; Adam J. Fein, "U.S. Brand-Name Drug Prices Fell in 2025 as the Net Pricing Drug Channel Emerges," *Drug Channels*, January 7, 2026, <https://www.drugchannels.net/2026/01/us-brand-name-drug-prices-fell-in-2025.html>.

Using methods detailed in the appendix to this letter, I use MLR and other data to estimate that the AV calculator's failure to account for rebates likely inflated the reported AV of a MOOP-only plan by 2.5 percentage points in 2024. In light of the upward trend in rebate percentages depicted in the figure, this distortion is likely growing over time. In particular, this distortion will likely be larger in 2027 than it was in 2024, and it would likely have been mostly absent as of 2014.

This has two key implications. First, trends in rebates can account for a substantial fraction of the underlying upward trend in the reported AVs of MOOP-only plans in recent years; importantly, while a rising rebate share does cause the distortion in reported AVs to grow over time, it likely does *not* affect trends in the maximum out-of-pocket limit since, as noted above, this limit is indexed to premiums, and premiums are likely to reflect net, rather than gross, claims spending. Second, CMS' concerns about the viability of bronze plans would be substantially ameliorated if it revised the AV calculator to more appropriately account for prescription drug rebates.

Implications of permitting non-network plans

CMS proposes to begin allowing insurers to offer plans that lack a provider network and instead specify a fixed schedule of payment rates for health care services, apparently in hopes of bringing lower-premium options into the market. Under the proposal, insurers would be required to "ensure access to a range of providers that accept the non-network plan's benefit amount as payment in full" instead of complying with network adequacy requirements. The effects of this proposal would likely hinge on whether these access requirements can be effectively enforced.

Effects with effective enforcement

If they can be effectively enforced (and crafted to ensure a level of access equivalent to existing plans), it is doubtful that non-network plans could offer meaningfully lower premiums. Importantly, non-network plans do not offer insurers useful new strategies for disciplining prices. Even under current rules, an insurer could publish a schedule of allowed amounts, permit any willing provider to sign a contract at those amounts, and base out-of-network payments on those amounts. A non-network plan presents providers and enrollees with exactly the same options and incentives except that it removes the option for providers to sign a network agreement and obtain the potentially improved access to the plan's enrollees that in-network status entails; if anything, this difference is likely to make it harder for the plan to induce providers to accept a given set of rates and thus necessitate higher, not lower prices. And if access to providers is comparable, enrollees would likely also use similar amounts of care as they do under existing plans.

Non-network plans would avoid administrative costs associated with contract negotiations. However, they would need to implement new processes to verify that their payment rates were accepted by enough providers. Claims processing might also become more cumbersome since providers and insurers would no longer have a venue in which to agree on claims submission protocols. Thus, it is unclear whether administrative costs would even fall on net. In any case, it is

doubtful that any administrative savings would allow large premium reductions, as insurer administrative spending of all kinds averages only around 10% of claims spending.⁸

Effects without effective enforcement

In practice, it seems likely that CMS would have trouble enforcing the access requirements it envisions. Unlike with network plans, it may not always be obvious whether enough providers are willing to accept the plan's rates. If this is the case, non-network plans likely would offer lower premiums, mainly by paying lower prices for care and making accessing care harder.

This outcome likely would reduce federal tax credit costs by reducing the benchmark premiums those credits are based on. But those savings would come at a cost. Enrollees who shifted into non-network plans would experience worse access to care but would generally not pay less since these plans' lower gross premiums would be offset by smaller tax credits. At the same time, enrollees who remained in traditional plans would pay more, for two reasons. First, as noted above, tax credits would shrink. Second, because non-network plans would offer more limited access to providers, they would likely differentially siphon off healthier enrollees, raising the gross premiums of traditional plans, perhaps substantially.⁹ In certain cases, these selection dynamics could even threaten the continued viability of some types of traditional plans. Regardless, it is likely that the migration of enrollees out of traditional plans would be inefficiently large since some enrollees would opt for non-network plans to gain the benefits of pooling with lower-risk enrollees rather than because non-network plans offered a better price-quality tradeoff.

In short, if CMS' proposed access requirements work as intended, then this proposal seems likely to be less impactful than CMS hopes. If, on the other hand, these requirements do not work as intended, then the proposal has potentially significant downsides that the proposed rule fails to grapple with. In either case, the proposal seems unlikely to function as CMS expects.

Thank you for the opportunity to comment on this proposed rule. I hope that this information is helpful to you. If I can provide any additional information, I would be happy to do so.

Sincerely,

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⁸ Matthew Fiedler, *Capping Prices or Creating a Public Option: How Would They Change What We Pay for Health Care?* (Brookings Institution, 2020), <https://www.brookings.edu/research/capping-prices-or-creating-a-public-option-how-would-they-change-what-we-pay-for-health-care/>.

⁹ See, for example, Geruso et al., "The Two-Margin Problem in Insurance Markets"; Mark Shepard, "Hospital Network Competition and Adverse Selection: Evidence from the Massachusetts Health Insurance Exchange," *American Economic Review* 112, no. 2 (2022): 578–615, <https://doi.org/10.1257/aer.20201453>.

Methodological Appendix

This appendix describes how I estimate how much the AV calculator's failure to account for the rebates paid by prescription drug manufacturers distorted reported plan AVs in 2024. To that end, I let G denote gross allowed spending under a plan, R denote the rebates received by that plan, and C denote enrollee cost-sharing. A plan's "true" AV, AV_t , is defined to be

$$AV_t = \frac{G - R - C}{G - R} = 1 - \frac{C}{G - R}.$$

Consistent with the discussion in the main text, the AV calculator computes the correct amount of cost-sharing for a given plan design but overstates the total cost of an enrollee's care because it fails to net out rebates. Formally, it delivers a "reported" AV, AV_r , given by

$$AV_r = \frac{G - C}{G} = 1 - \frac{C}{G}.$$

Combining these two definitions, we thus find that the distortion $AV_r - AV_t$ can be written as

$$AV_r - AV_t = (1 - AV_r) \left(\frac{G}{G - R} - 1 \right). \quad (1)$$

Equation (1) shows that estimating the distortion for a plan with a known AV_r only requires an estimate of the gross-to-net spending ratio $G / [G - R]$. In what follows, I use a market-wide aggregate version of this ratio, with the caveat that this ratio could, in principle, vary across different types of plans to some degree. Formally, for a variable X , I let $\bar{X}_m$ denote sum of the amounts X for each insurer across all insurers in market $m \in \{I, SG\}$, where I denotes individual and SG denotes small group. I then define $\bar{X} = \bar{X}_I + \bar{X}_{SG}$ and use the aggregate ratio $\bar{G} / [\bar{G} - \bar{R}]$.

I rely principally on data from 2024 MLR filings to estimate $\bar{G}$ and $\bar{R}$. The aggregate rebate amount $\bar{R}$ can be calculated directly by aggregating the corresponding amounts on MLR filings (part 1, line 2.3). Estimating $\bar{G}$ is more difficult because MLR filings report plan claims liability rather than the total allowed costs. To get around this issue, I note that $\bar{G}_m$ can be written as

$$\bar{G}_m = \frac{[\bar{G}_m - \bar{C}_m - \bar{R}_m] + \bar{R}_m}{[\bar{G}_m - \bar{C}_m] / \bar{G}_m}. \quad (2)$$

The two amounts in the numerator of equation (2) can be obtained from MLR filings: the rebate amounts $\bar{R}_m$ as described above; and the net plan liability amounts $\bar{G}_m - \bar{C}_m - \bar{R}_m$ by aggregating amounts on MLR filings (part 1, line 2.1). The denominator is an average reported actuarial value for market m . For the individual market, I estimate this using the 2024 Open Enrollment Public Use Files, which break down enrollment by income and metal level; I assign enrollees in non-silver plans the base actuarial value of their metal level, while I assign silver enrollees the appropriate actuarial value corresponding to their income level, and I then compute an enrollment-

weighted average of 78.4%.¹⁰ For the small group market, I compute an enrollment-weighted average AV of 77.2% using the 2024 risk adjustment summary report for that year.¹¹

Combining these AVs with the amounts from the MLR data generates a final ratio $\bar{G}/[\bar{G} - \bar{R}] = 1.063$. Because the 2024 AV calculator reports that the AV of a MOOP-only plan was 60.2% in that year, equation (1) then implies that the overall distortion is 2.5 percentage points.

¹⁰ This approach omits the relatively small number of enrollees in off-Marketplace plans.

¹¹ This approach is not feasible for the individual market because the actuarial value reported in risk adjustment data does not account for the existence of cost-sharing reductions.

March 13, 2026

Submitted via <https://www.regulations.gov/>

The Honorable Robert F. Kennedy, Jr.
Secretary
Department of Health and Human Services

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services

Attention: CMS-9883-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Secretary Kennedy and Dr. Oz:

Thank you for the opportunity to comment on the Notice of Benefit and Payment Parameters for 2027.¹ This proposed rule represents a substantial step backward in affordability and access to health coverage. It raises costs for consumers directly, for example by increasing deductibles, and indirectly, for example by destabilizing the market and creating a less favorable risk pool, which will raise premiums across the board. It imposes new red tape and confusion that will reduce coverage and discourage enrollment, especially by healthier people. It undermines key Affordable Care Act (ACA) protections and shifts consumers into insurance products that increase financial barriers to care and the risk of medical debt. This would harm not only those who lose insurance or turn to products offering only minimal value, but also the financial stability of [health care providers](#) in [rural and](#) low-income communities that rely heavily on the Marketplace. The community-wide effects of high uninsured rates is [well-documented](#). Yet the proposal neither addresses nor reflects this evidence.

¹ This comment, submitted by the signatories below, was prepared by Jason Levitis of the Urban Institute, Sabrina Corlette of Georgetown University's Center on Health Insurance Reforms, Lindsey Murtagh of Brown University School of Public Health's Center for Advancing Health Policy through Research, and Claire O'Brien of the Urban Institute. The opinions and conclusions expressed in this public comment are the authors' and signatories' alone and do not reflect those of their institutions or funders.

The rule also suffers from legal impairments. It disregards the statute and prior judicial decisions in numerous places. It is based on flawed and confusing analysis that makes it impossible to understand what the Centers for Medicare and Medicaid Services (CMS) believes the rule would do, let alone what it would actually do. Even to the extent that real problems exist under current policy (including evidence of fraud by brokers), the proposals generally bear no reasonable relationship to solutions that would address these problems. (A key exception is the proposal to strengthen oversight of brokers, which we support while suggesting further improvements.)

The rule also fails to provide a meaningful opportunity to comment, due to the short comment period, the lack of critical information about unprecedented and untested policy proposals, the confusing and incomplete impact estimates, and CMS's failure to make publicly available key data that the agency has access to.

Finally, the rule undermines state autonomy, imposing needless costs.

We urge CMS to withdraw the proposals discussed below (except the broker oversight proposal). To the extent CMS wants to advance these or similar proposals in the future, the agency must perform credible analysis, reconsider options in light of this analysis, provide a meaningful comment period to enable full consideration by the public and key stakeholders, and delay effective dates to allow for this process and a workable implementation timeline.

This comment is organized into three sections.

- [Comments on the rule's analytical claims and their connection to the rule](#)
- Comments on specific proposals of the rule
 - [Provisions that add to red tape and consumer confusion](#)
 - [Provisions that weaken consumer protections and expand junk coverage](#)
 - [Provisions that make coverage less affordable](#)
 - [Other provisions](#)
- [Comments about procedural issues under the rule](#)

The Rule's Analytical Claims and Their Connection to the Rule

The proposed rule includes a Regulatory Impact Analysis (RIA) and other analysis of the effects of the rule. CMS requests comments on all aspects of the analysis. This section responds to those requests. We also provide comments regarding proposal-specific analysis in our comments on specific proposals.

The included analysis is supposed to provide meaningful information about what the rule will accomplish. But much of it is implausible, ignores key facts, is inadequately explained, and omits information crucial to understanding or justifying the rule, including information that CMS has access to but has not disclosed. The analysis provides inadequately explained and implausible estimates of the rule's effects on health coverage and premiums. And it lacks any meaningful information about how the rule's proposals would address improper enrollment, which is a central policy justification for much of the rule. The RIA even fails to address certain proposals in the rule.

As a result, the analysis fails to provide either a reasonable basis for the rule or a meaningful opportunity to comment. Before deciding to pursue the policies in this rule, CMS should perform new analysis, release it with clear explanation, and provide a new opportunity to comment.

CMS's coverage estimates are implausible and not explained.

The rule includes year-by-year estimates of health coverage in the baseline and under the proposals. Table 26 shows CMS's lower-bound estimates of the impact of the rule, and Table 27 shows upper-bound estimates. In both cases, the baseline estimates and the impact estimates are implausible under any reasonable set of assumptions. And the agency does not explain the assumptions that guide its estimates. As a result, the estimates fail to provide a reasonable basis for the rule and deny meaningful opportunity to comment.

CMS's estimates of baseline coverage absent the rule are implausible. CMS's baseline projections show a slight increase in Marketplace coverage between 2026 and 2027 (from 17.71 million to 17.73 million), followed by a reduction of about 1.25 million in 2028 (to 16.48 million). See Exhibit 1. This trend is inconsistent with reasonable expectations about coverage in coming years: in both 2027 and 2028, Marketplace coverage is projected to decline as H.R. 1 provisions are implemented and the effects of the premium tax credit (PTC) enhancements expiring are [fully felt over time](#). One possible explanation would be that CMS is using a pre-statutory baseline, which [Office of Management and Budget rules](#) permit for a rule implementing statutory provisions. This could potentially explain the 2027 figure, though the small increase in coverage seems wrong even without H.R. 1's effects. But it's incompatible with the large projected enrollment drop in 2028. In short, given the policy changes expected under current law, there's no reasonable set of assumptions under which enrollment would rise slightly in 2027 but then fall substantially in 2028.

Exhibit 1: CMS's Baseline and Upper-Bound Impact Estimates from the Rule**TABLE 27: Overall Enrollment and APTC Impacts – Upper Bound Estimates**

2 Million Enrollment Decrease Scenario							
	Calendar Year	2026	2027	2028	2029	2030	2026-2030
Baseline	Total Enrollment (Millions)	17.710	17.729	16.484	16.527	16.532	84.981
	APTC Enrollment (Millions)	15.979	15.957	14.701	14.719	14.711	76.067
	Premium (\$Billions)	156.491	162.599	156.873	164.414	172.577	812.954
	APTC (\$Billions)	124.841	125.785	124.434	128.317	134.514	637.891
NBPP Rule	Total Enrollment (Millions)	17.710	15.729	15.367	15.407	15.412	79.626
	APTC Enrollment (Millions)	15.979	14.157	13.705	13.722	13.715	71.278
	Premium (\$Billions)	156.491	144.823	147.859	154.914	161.940	766.027
	APTC (\$Billions)	124.841	115.359	117.285	120.903	126.222	604.610
Changes	Total Enrollment (Millions)	0.000	-2.000	-1.117	-1.119	-1.120	-5.356
	APTC Enrollment (Millions)	0.000	-1.800	-0.996	-0.997	-0.996	-4.789
	Premium (\$Billions)	0.000	-17.776	-9.013	-9.500	-10.638	-46.927
	APTC (\$Billions)	0.000	-10.426	-7.149	-7.414	-8.292	-33.281

CMS's estimates of the coverage effects of the rule are also implausible. In Exhibit 1 above, CMS estimates that the rule would reduce coverage by 2.0 million relative to the baseline in 2027, and by just 1.1 million relative to the baseline in 2028 and later years. Again, these numbers are incompatible with expected policies. That's because, as explained in detail below, coverage losses under the rule are almost certain to increase starting in 2028 due to interactions between the provision creating additional data matching issues (DMIs) and the H.R. 1 provision effective 2028 that denies the advance premium tax credit (APTC) to people in a DMI. There's no reason to think coverage losses would instead decline in 2028 and later years.

Even for 2027, CMS's estimates for the impact of the DMI proposals are implausibly low, as explained in more detail below in the section on these proposals. CMS estimates that these provisions would reduce the number of people receiving APTC by about 488,000 people. But an analysis from the actuarial firm Wakely estimates that

enrollment would fall by up to [2.3 million](#) people. The reason for the disparity seems to be primarily that CMS assumes an attrition rate of about 10% among those with DMIs. Based on available evidence, Wakely estimates an attrition rate of about [25% to 50%](#).

In addition, CMS's estimates for the proposal to require a DMI when there is no applicant tax data seem inconsistent with its estimates for the same provision last year. CMS projects that the proposal creates approximately 660,000 more DMIs than it did in the 2025 Marketplace Integrity and Affordability rule (the Integrity Rule) (2.1 million versus 2.8 million). But it projects that the same number of people (407,000) will lose APTC. It is unclear how a 30% increase in DMIs would lead to no increase in coverage loss.

CMS's assumptions and methodology for its coverage estimates are not explained, making it impossible to understand what CMS is asserting. Even if one assumed that CMS's baseline and rule-impact coverage estimates were right, the lack of explanation makes it impossible to understand what CMS is asserting. What baseline is CMS using? Why does CMS think baseline coverage will hold steady in 2027 but fall in 2028? Does CMS have a different interpretation of how the rule will interact with the 2028 changes? None of these questions are answered. As a result, we don't know what CMS thinks its own proposals would do. Without that information, it's impossible to meaningfully comment on the proposals.

The premium impact estimates are not explained but seem to greatly understate how much the rule would increase premiums.

The rule's topline analysis claims that it would reduce premiums by 1.5% to 1.8% in 2027. These estimates are flawed in several ways; the rule would in fact likely increase premiums. Also, the premium impact estimates are not adequately explained and are missing for key provisions of the rule, making it impossible for commenters to understand CMS's assertions about the effects of the rule.

CMS's analysis takes credit for estimated premium reductions under an H.R. 1 provision that would take effect with or without the proposed rule. Without this H.R. 1 provision, the rule increases premiums, even by CMS's own math.

CMS's [discussion](#) of the premium impact of the rule estimates that several provisions in combination would increase premiums by between 2% and 3%. CMS claims that this increase will be offset by other provisions, most importantly by a 3–4% reduction from ending the special enrollment period (SEP) for people with incomes under 150% of the Federal Poverty Level (FPL). As a result, CMS estimates that the rule overall will reduce premiums by 1.5% to 1.8%. This appears to be the basis for Health and Human Services (HHS) Secretary Kennedy's claim in the associated [press release](#) that the "proposed rule lowers premiums."

But this calculation misstates the effects of the rule. Specifically, the rule should not get credit for the 3–4% premium reduction due to ending the under-150% SEP, since the SEP was eliminated by H.R. 1 starting in 2026 (and we understand that CMS told Marketplaces that the elimination is self-executing, so the SEP is already not available). In other words, the rule does not make this change. Removing the 3–4% from the calculation, CMS's own estimates show the rule would *increase* gross premiums by 1.2% to 2.5%. And this estimate is likely understated, for reasons addressed below. (In addition, the 3–4% estimate very likely overstates the risk pool impact of eliminating this SEP, as discussed in [comments](#) on the Integrity Rule.)

CMS’s analysis “assumes”—without explanation and contrary to available evidence—that key provisions creating adverse selection would increase premiums by only 2% to 3%.

The rule includes several provisions that would impose new administrative burdens or premium costs on enrollees, including two proposals requiring additional paperwork for income verification, a provision denying APTC for people who fail to file a tax return, and a request for comment on the elimination of insurer options to continue coverage when there is a de minimis underpayment of premiums. There is a wealth of evidence that administrative burdens and higher premiums reduce take-up among eligible people, and that this attrition disproportionately affects lower-risk individuals, since sicker people are more likely to fight through the burdens to stay covered. For example:

- A [2025 study in the American Economic Review](#) finds that imposing administrative burdens on enrollment “differentially exclud[es] young, healthy, and economically disadvantaged people” and that adding one step to the enrollment process prompted a 33% decline in enrollment.
- A [2021 study in the American Economic Review](#) finds that healthier individuals are more responsive to the removal of administrative frictions.
- A [2021 American Economic Association study on auto-retention](#) finds that “automatic retention has a sizable impact,...differentially retaining healthy, low-cost individuals.”
- A [2024 study in Health Affairs](#) finds that states that implemented nominal monthly premiums saw enrollment fall by 14%, with larger effects among younger individuals.
- A [National Bureau of Economic Research working paper](#) found that reducing administrative barriers increases take-up of subsidized health insurance coverage.
- A [KFF brief](#) describes how almost 20% of uninsured nonelderly adults cite the difficulty or complexity of signing up as a reason for their lack of health insurance coverage.

This evidence suggests that the large and widespread administrative burdens imposed by the rule would substantially increase premiums.

The RIA recognizes that several of the rule's provisions would lead to adverse selection: the section on the overall impact of the rule notes that "Many enrollees will lose coverage due to no longer being eligible for subsidies, and we believe it is likely that healthier enrollees are more likely to discontinue coverage." Yet CMS assumes that these changes would increase premiums by an implausibly small amount. "We have assumed a 2 percent increase in premiums in the scenario where 1.2 million enrollees leave the market and a 3 percent premium increase if 2.0 million enrollees exit the market." CMS offers no explanations for these assumptions. They are especially suspect given CMS's approach in the Integrity Rule, where it conceded that it focused exclusively on the group it considered improperly enrolled and ignored the impact of administrative burdens on eligible enrollees, writing that "[the coverage loss estimates] may underestimate the actual number of individuals impacted, as eligible enrollees may lose coverage as a result of the administrative burdens imposed by the provisions of this rule." While CMS's approach in the proposed NBPP is not explained, the explanation from last year and the small premium impact estimate suggest that CMS is again understating the adverse selection effects.

CMS also seems to disregard other factors that would increase premiums under the rule. For example, as with the coverage estimates, the premium impact estimates seemingly ignore the interaction of the proposed provisions creating DMIs with the onset in 2028 of the H.R. 1 provision denying APTC to those in a DMI. These interactions would especially raise premiums since sick people are [less price-sensitive](#) and thus more likely to be willing to pay the full premium out of pocket while the DMI is resolved.

CMS also seemingly ignores its own estimate that the proposal to require additional reporting on cost-sharing reductions (CSR) loading would cost insurers \$420 million in the first year. This cost would be passed along in the form of higher premiums. Yet neither the discussion of that provision nor the RIA's discussion of the effects of the rule overall discuss any such impact.

CMS also seemingly overstates the premium benefit of its proposal to require more paperwork for individuals enrolling through a SEP, while failing to explain its methods. CMS assumes that provision will reduce premiums by 0.5 to 1.0%. CMS explains that the "positive impact on program integrity by verifying eligibility for SEPs" would decrease premiums. But this assumption is inconsistent with available evidence about those who enroll through a SEP, including data that was put before CMS during the development of the Integrity Rule. For example, [actuarial data from the Massachusetts Connector](#) show that their population with the most SEP eligibility generally has lower

risk than other enrollees and that consumers enrolling through an SEP tend to be slightly younger than those enrolling through an open enrollment period.

For all these estimates, CMS should release new versions that account for relevant evidence and clearly explain CMS's assumptions and methods. CMS should then re-issue a proposed rule that incorporates this analysis, to allow the public a meaningful opportunity to comment on the agency's proposals.

CMS should provide separate estimates of the premium impact of each provision.

CMS's discussion of the included analysis claims that "the regulatory impact analysis [includes] impact analyses and estimates for each proposal separately, as we intend for each provision to be severable from the rest." But this is not the case. CMS provides estimates of many provisions' *coverage impacts* (or at least the APTC recipient impact, which is closely aligned). But it does not provide estimates of the premium impact of several key provisions that are likely to substantially increase premiums. For example, the income verification provisions would impose new administrative burdens on millions of people and (starting in 2028) increase the cost of coverage for millions of people, both of which are likely to cause adverse selection. Yet CMS provides no estimates for how much these provisions would hurt the risk pool. Similarly, CMS's RIA does not even mention the proposal to allow plan-level adjustments to the index rate for multi-year catastrophic plans, which directly impacts how premiums are calculated. This makes it impossible to understand the impact of these provisions or weigh their costs and benefits. If CMS wishes to proceed with these proposals, it should first share such estimates and provide a new opportunity to comment.

The analysis should recognize that the rule's proposals adding administrative burdens are likely to be especially harmful due to staffing cuts among those who provide consumer support. Imposing additional administrative hurdles leads to more consumers needing help in meeting requirements to avoid losing coverage. Recent reductions in CMS staffing, [Navigator funding](#), and [Internal Revenue Service \(IRS\) staff](#) likely mean less support for consumers trying to resolve DMIs, address failure to file and reconcile (FTR), and document SEP eligibility.

CMS should release the data it possesses on the coverage and risk effects of its proposals. The proposed rule repeatedly fails to provide directly relevant data about proposals that CMS has access to. For example, CMS could access data obtained from the experience with resolving DMIs, which could readily be used to calculate the risk profile of enrollees affected by DMIs—including, crucially, the differential risk profiles of enrollees who resolve DMIs versus those who don't. But CMS does not provide such data. Similarly, CMS could readily calculate the risk profile of individuals losing coverage due to FTR. In other instances, CMS fails to disclose even more basic data,

such as the number of people who enrolled in catastrophic plans for the 2026 plan year under the agency's expanded eligibility criteria announced in fall 2025.

This information is necessary to understand how the proposed rule—which seeks to codify and expand this policy—would impact enrollment, premiums, consumer costs, and the broader risk pool. That CMS withholds such information raises questions about whether available data support its case. CMS should release this information to permit a clearer understanding of the impacts of its proposals. Without these disclosures, the public lacks a fair opportunity to examine the assumptions underlying CMS's proposals.

The rule fails to establish that unaddressed improper enrollments are a significant problem or are tied to the proposals, even as the rule points to them as the primary justification for these proposals.

Several major proposals in the rule are justified primarily on the grounds that they are needed to address purported improper enrollment among APTC recipients. This includes two proposals requiring additional paperwork for income verification, the provision denying APTC for people who fail to file a tax return (FTR, discussed below), the provision requiring additional eligibility verification for SEPs in the Federally-facilitated Marketplace (FFM), the request for comments on eliminating insurer options to continue coverage when there is a de minimis underpayment of premiums, and new rules for brokers. CMS concedes that each of these proposals will impose costs on Marketplaces and consumers. Yet CMS provides only limited—and often conflicting—information about ongoing improper enrollments and concedes that they are primarily caused by broker malfeasance, are already being addressed, and are declining in number. And CMS offers no evidence that most proposals in the rule would address the causes of any unaddressed improper enrollments.

CMS provides no estimates of unaddressed improper enrollment or evidence that it is widespread. The rule repeatedly claims that its provisions are necessary to address improper enrollment and that the benefits of doing so outweigh the costs to consumers and Marketplaces of imposing new administrative burdens.² Yet the rule fails to establish that unaddressed improper enrollments are a significant problem—especially compared to the immense figures CMS cited in the Integrity Rule.

In the Integrity Rule, CMS presented deeply flawed estimates that several million people are improperly enrolled. The agency's reliance on these flawed estimates led to several

² For example, when discussing creating DMIs when income returned is under 100% FPL, CMS says “We believe that the long-term program integrity savings of this change outweigh the operational costs to the Exchanges.” And when discussing creating no-data DMIs, CMS says “We now believe that the tax liability changes for these consumers outweigh those concerns, and providing that protection is necessary even with the costs, burdens, and coverage impacts this policy could result in.” As we discuss later, the agency also points to tax liability concerns stemming from improper enrollments.

provisions of the Integrity Rule being stayed in *City of Columbus et al v Kennedy et al* (*City of Columbus*).

CMS now reports a much smaller—but still not insubstantial—number of reports of improper enrollments in 2025: 342,000 complaints overall. But CMS repeatedly emphasizes that these cases are largely attributable to actions by brokers, that the agency is addressing these cases, and that these figures are falling and expected to continue falling. CMS reports success in addressing these cases, including [terminating such coverage and taking action against the brokers responsible](#). CMS also notes that the expiration of the PTC enhancements is further reducing these cases. Overall, CMS reports that its “program integrity measures implemented over the past year, in addition to the expiration of enhanced APTCs that took effect on January 1 of this year, are likely to lead to a decrease in the number of UE [unauthorized enrollment] complaints received.” CMS reports that complaints fell by nearly half between January 2025 and January 2026, and that “this trend is likely to continue.”

In short, cases of improper enrollment are down significantly from their height in early 2024, a trend that began after CMS took a range of efforts to address these concerns beginning in [mid-2024](#). CMS, in the preamble of the rule, confirms as much by noting that cases are continuing to fall, which underscores that existing program integrity measures, put in place beginning in 2024, have been effective. None of this is indicative of an improper enrollment problem that justifies costly and harmful policy changes.

CMS provides no estimates of the number of cases that cannot be resolved with existing measures. Without such estimates, CMS is left justifying burdensome and costly changes based on the mere risk of improper enrollments. This approach was rejected by the [opinion](#) in *City of Columbus*: “As Judge Chasanow previously (and eloquently) explained, the agency’s ‘decision to prioritize a hypothetical risk of fraud over the substantiated risk that its decision result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic.’”

This order of operations—proceeding to propose policy changes without evidence to support them—indicates a rulemaking process that is, as [multiple courts](#) have now recognized, not grounded in careful analysis. CMS repeatedly asserts that changes are worth doing despite their downsides because of improper enrollments. But the lack of clear evidence about remaining improper enrollments undermines this central justification for the rule. It also denies the public a meaningful opportunity to comment, since they lack information about the scope and nature of the problem. And these concerns are exacerbated by the fact that CMS, less than a year ago in the final Integrity Rule, concluded that several of the same measures it proposes here would not be needed in 2027. CMS now reverses itself by asserting that these changes are newly necessary.

CMS provides no evidence that the proposals in the rule would address the causes of improper enrollment. Even if improper enrollments remain a problem, the proposals are justified only if those enrollments result from factors that would be addressed by the rule. CMS notes repeatedly that improper enrollments are tied to broker malfeasance.³ But it provides no evidence to tie their cause to most of the rule's provisions. This is not sufficient to create a reasonable basis for rulemaking, as the [opinion](#) in *City of Columbus* noted in staying the income verification proposals in the Integrity Rule:

The question for the Court is not simply whether Defendants have presented sufficient evidence of fraudulent enrollment, but also whether there is sufficient evidence of a nexus between fraudulent enrollment and self-attestation to tax data such that it justifies requiring heightened income verification. Put differently, if the agency cannot point to data showing that self-attestation meaningfully contributes to increased fraud, then the agency adopted an incongruent solution to the problem...The Court agrees with Plaintiffs that CMS "attempted to justify these burdens and these coverage losses simply by reciting that self-attestation 'may have played a role in weakening the Exchange eligibility system,' but it provided no support for this assertion.

Again in this rule, CMS provides no such evidence for this connection.

CMS provides even less basis to extend the rule's provisions to State-based Marketplace (SBMs), which CMS concedes have even less improper enrollment than the FFM. While CMS reports several hundred thousand cases of broker fraud in the FFM, it concedes that there is no such evidence in the SBMs, repeatedly noting that fraud is concentrated in the FFM.⁴ As a result, even if changes may be warranted in the FFM, nothing in the record justifies making nationwide changes that would impose burdens on SBMs and their consumers.

³ For example, CMS reports that "the Federal Exchange has received reports that agents, brokers, and web-brokers may be using artificial intelligence to impersonate consumers and falsely attest to household income that could potentially qualify the consumers for decreased APTC and CSR benefits now that the enhanced subsidies have expired, something that we were not aware of when we finalized the 2025 Marketplace Integrity and Affordability final rule." The justification is heavily focused on the role of brokers, finding that they are a "notable driver" of program integrity concerns, are "taking advantage of weaknesses in the Exchanges' eligibility framework to enroll consumers in coverage with APTC without their knowledge," and account for "nearly 80 percent of income DMIs," and that this experience "underscores that there continues to be broad miscalculations in household income attestation and resulting APTC assessment for applications assisted by agents, brokers, and web-brokers across Exchanges on the Federal platform."

⁴ For example, CMS notes that "State Exchanges do not report the same problems with unauthorized enrollments as those currently facing the FFEs."

CMS also seemingly fails to consider what SBMs are doing differently that the FFM might emulate. For example, while most SBMs maintain and operate their own agent and broker portals for assisted enrollments, the FFM allows enhanced direct enrollment (EDE) entities to provide a streamlined enrollment platform for agents and brokers. This pathway was a [key source of improper enrollment](#) in 2024, when only FFM states used EDE. The FFM has reported problems with agent and broker behavior in their use of EDE platforms.

Yet CMS does not include proposals that would address the known FFM issues, such as strengthening the FFM actions already taken, bringing FFM practices in line with SBMs practices, ensuring adequate regulation and enforcement of regulations governing EDE entities, regulating lead generators, and [other options](#) that target the actual problem rather than imposing new burdens on consumers. Instead, the agency forces Marketplaces to make changes that lack a clear connection to the known problems while encouraging SBMs to embrace additional EDE in this rule.

CMS should respond to fraudulent broker activity by taking enforcement action against brokers, not by burdening consumers who have done nothing wrong. As noted above, the rule repeatedly cites inappropriate actions by brokers as a central cause of improper enrollment. Fraudulent behavior should never be tolerated, and it is helpful that the rule includes measures to crack down on broker malfeasance. However, many provisions in the rule would instead harm consumers by imposing new paperwork burdens and making their coverage less affordable. This is unfair and counterproductive. Consumers (along with the federal fisc) are the victims of broker malfeasance. If brokers are committing fraud, go after the brokers; don't punish the victims.

The analysis miscalculates the revised maximum out-of-pocket cap (MOOP) for catastrophic plans. In addition to the problems discussed above, the analysis in the rule seems to make an elementary mathematical error that understates the harm from the rule. The proposal would increase the MOOP, and therefore the deductible, of catastrophic plans to 130% of their baseline values, which are \$12,000 for single individuals and \$24,000 for families. CMS calculates the revised values as \$15,400 and \$30,800. In fact, 130% of the baseline values are \$15,600 and \$31,200.

CMS should repropose the rule with corrected, complete, and adequately explained analysis. To summarize the discussion above, the analysis in the rule is repeatedly implausible, incomplete, and unexplained. It is inconsistent with credible analysis by Wakely and with reasonable expectations based on future policy changes. To create a reasonable basis for its proposals and provide a meaningful opportunity to comment, CMS should reconsider and repropose the rule with new analysis that is

credible, complete, clearly explained, and consistent with the facts on the ground, and that addresses any differences with Wakely's and other credible estimates.

Comments on Specific Proposals of the Rule

Provisions that Add to Red Tape and Consumer Confusion

Creating Additional Data Matching Issues (Section 155.320)

CMS proposes two policies that will generate more paperwork related to income verification, especially for low-income people: generating a DMI when IRS data show income below 100% of the Federal Poverty Level (FPL) and generating a DMI in the absence of IRS income data. As with other proposals in the rule, CMS justifies these on the grounds that they will reduce improper enrollment. But as with other provisions of this proposed rule, CMS provides no evidence that improper enrollment is a substantial unaddressed problem, let alone that these proposals would address it.

What is clear is that these changes would make it more burdensome for eligible low-income people and those with variable incomes or family circumstances (like small business owners and the self-employed) to receive tax credits to which they are entitled. Based on the evidence cited above, this will especially deter enrollment of healthy people, worsening the individual market risk pool and increasing premiums for unsubsidized enrollees, as discussed below. In other words, these proposals would impose real predictable harms with only speculative benefit. This is the same scenario that led the 2019 version of one of these policies to be struck down in court, with the Court finding that CMS's decision to "prioritize a hypothetical risk of fraud over the substantiated risk that its decision [would] result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic."⁵ In staying the same provision in the Integrity Rule, [the Court](#) reiterated this reasoning.

CMS offers both legal and policy justifications for these changes, but both are flawed. CMS also offers faulty analysis of the proposals, including minimizing the harms of the changes. CMS should retract both proposals.

⁵ *City of Columbus v. Cochran*, 523 F. Supp. 3d 731, 763 (2021).

CMS provides no meaningful justification for the DMI proposals.

CMS offers no evidence of substantial unaddressed improper enrollment. As discussed above, CMS's central policy justification for these changes is that they are necessary to address improper enrollment. Yet CMS provides no evidence that substantial improper enrollment is occurring that is not addressed by other measures. Without such evidence, there's no good reason for these burdensome and costly changes. CMS thus provides no reasonable basis for the rule.

CMS offers no evidence that whatever fraud is occurring would be addressed by imposing more DMIs. The rule's primary policy justification for imposing additional DMIs is that doing so would help to reduce fraudulent enrollments. Yet CMS provides no evidence suggesting that whatever improper enrollment is occurring is related to people misstating their income. As noted above, the [District Court's opinion](#) in the *City of Columbus* case made this a central point in staying these same provisions.

CMS provides no reasonable basis to extend the rules to SBMs, which CMS concedes have less fraud than the FFM. As explained above, there is no evidence of significant fraud in the SBMs, and CMS repeatedly notes this disparity. This difference is supported by evidence from SBM states in their comments on the Integrity Rule:

- California Marketplace [comment](#): "Covered California does not have any indication of widespread fraud and abuse occurring in our market. In fact, a robust review of consumer complaints and enrollment partner activity in recent years did not reveal a single identified case of a consumer being enrolled in Covered California without their knowledge. These outcomes are largely because we have implemented tailored approaches that make sense for California's market and Covered California's systems, ensuring the over 14,000 enrollment partners we work with abide by the highest standards with comprehensive support and oversight."
- Colorado Marketplace [comment](#): "As a result of carefully considered design choices and a robust state regulatory framework, Colorado has not experienced reports of unauthorized or fraudulent enrollment."
- Massachusetts Marketplace [comment](#): "To date, the Health Connector has not received complaints about any fraudulent or unauthorized activity by Assistors."
- Rhode Island Marketplace [comment](#): "In contrast to the concerns raised in the proposed rule, HSRI has not observed any indication of "improper enrollments" in [the under 150% FPL] group. Rhode Island does not have individual market brokers, agents or web-brokers operating in our individual market. HSRI instead relies upon its 8 Navigator network and Certified Application Counselors, who are not individually compensated to support enrollment on our marketplace, to support customers in need of assistance enrolling in health coverage."

CMS points to a December [Government Accountability Office \(GAO\) report](#) with preliminary results showing that applicants who are willing to lie can be fraudulently enrolled. But that report, which is based on only 20 fictitious applicants, is careful to note that its results cannot be extrapolated to draw wider conclusions or make estimates: it says, “The results of our covert testing, while illustrative of potential enrollment control weaknesses, cannot be generalized to the overall enrollment population.” It certainly provides no estimate suggesting substantial SBM fraud.

CMS claims that the elimination of the PTC reconciliation caps supports the changes, but in fact it cuts the other way, as CMS itself noted in the Integrity Rule. CMS claims that the elimination of the reconciliation caps in H.R. 1 makes it more important to deny APTC when tax data can’t verify income, asserting that “the removal of the repayment caps necessitates this policy becoming permanent to protect consumers from significant tax liabilities.” But CMS made the [opposite argument](#) in the Integrity Rule, arguing that “[because] the statute does not allow the Federal Government to recover a substantial portion of excess APTC payments..., it is critical to establish an accurate estimate of household income during the application and enrollment process to most accurately set APTC payment amounts before the APTC payments are made.”

Contrary to CMS’s current claim that the proposals protect consumers, the proposed changes would harm consumers by removing their option to enroll. Under current rules, applicants have the option to either obtain health insurance with APTC and risk a repayment or go uninsured and avoid that risk. The proposal simply takes away the option to get coverage, leaving consumers with the only option of going uninsured. Taking away options is not protective of consumers.

CMS also notes that this change prevents excess payments to those fraudulently enrolled by a broker. But in fact CMS [holds people harmless](#) who are fraudulently enrolled, including retroactively cancelling such coverage. Thus, consumers are clearly better off having the option to get coverage with the risk of repayment than not having this option and being left uninsured. As noted above, fraudulent broker behavior warrants action against brokers, not imposing punitive new burdens on consumers.

High income volatility at low incomes means the under-100% DMI proposal has little value and would be especially harmful to low-income people. One [detailed analysis of earnings variability among low-income workers](#) found that more than half experienced significant variability in income, a proportion that is greater than higher income workers. Moreover, the actual magnitude of this income variability is striking: workers in the lowest quintile have more than double the magnitude of variability of all other income groups. (For low-income workers, the standard deviation of monthly income was 85% of the mean—so someone who earned an average of \$1,000 per

month had so much monthly variation that a month where their income was anything from \$150 to \$1,850 would be within a single standard deviation.) [Multiple other analyses](#) find this same pattern. Against this factual backdrop, there is little reason to think that two-year-old tax data provide useful information about income for the coming year. Rather, relying on it means that the large share of low-income people who've experienced income changes will be needlessly subjected to burdensome paperwork requirements.

The under-100% DMI proposal serves no apparent purpose and creates administrative headaches in states that have expanded Medicaid. Both CMS's analysis in the Integrity Rule and the [Paragon Health Institute analysis](#) on which it was based found no substantial excess enrollment in states that have expanded Medicaid. This may be because, as Paragon notes, in these states, there isn't even a theoretical reason to overstate income.

In addition, these DMIs would create administrative headaches for state agencies. That's because, if a Marketplace relies on tax data showing income under 100% rather than an attestation of income over 100%, then it must generally consider that individual eligible for Medicaid even though the consumer is not attesting to being eligible. For a consumer without ready access to information documenting their current income, this would mean they could receive coverage only by misstating their income. This creates unanswered questions and administrative costs for both the consumer and state agencies.

CMS attempts a permanent change based on a weaker justification than it offered for the temporary change in the Integrity Rule. In the Integrity Rule, CMS attempted to justify the need for this rule for one year with enormous fraud estimates and with the possibility of the enhanced PTCs remaining in place. The case is now weaker on both fronts: CMS has abandoned its flawed fraud analysis, and Congress did not extend the enhanced PTCs. Yet, upon these much weaker grounds, CMS proposes to make it permanent. If the stronger asserted justification could support only one year—which it could not according to the Court in *City of Columbus*—the weaker case cannot support a permanent policy.

The DMI proposals would impose excessive harms on consumers and increase premiums across the board, effects that CMS understates and fails to adequately consider.

The proposed changes would significantly increase administrative burdens, imposing great costs on consumers. The DMI proposals would place substantial new administrative burdens on people and on state and federal Marketplaces. CMS estimates that, together, the proposals would generate 3.3 million new income DMIs (548,000 for tax data below 100% FPL and 2.8 million for missing tax data)—requiring

3.3 million people, many of whom live just above the Federal Poverty Level, to track down and submit paperwork in order to buy health insurance. CMS expects that, every year, dealing with these new paperwork requirements would require consumers to spend time worth approximately \$83 million. And these figures likely understate the costs: the actuarial firm Wakely estimates the provisions would lead to 4.7 million more DMIs, as discussed below.

Providing additional documentation would prove extremely onerous for some people, including those who are self-employed or have low incomes. As the Court [opined in the City of Columbus case](#), while Defendants argue that "the agency made the reasonable observation that applicants without tax return data will likely have documentation verifying their household income (e.g., pay stubs) 'readily available' to them and that the burden of submitting that documentation, by extension, would be relatively minimal," the agency provides no basis for this conclusory statement. In fact, this assertion is not even internally consistent with the rest of the rule, as CMS separately acknowledges in the Rule that 'income verification can be more challenging for lower-income tax filers due to less consistent employment.' To address this concern, CMS merely stated 'our experience with income verifications suggests the process does not impose a substantial burden.' The agency never explains what this history is or how it led to the conclusion it purportedly supports."

The provisions would reduce enrollment among eligible people, and by far more than CMS estimates. CMS estimates that the DMI proposals would cause 488,000 people to lose APTC in 2027, and thus likely health insurance, because they fail to successfully navigate the new administrative steps. [Most of this group is likely eligible.](#)

However, this estimate greatly understates the expected impact. The actuarial firm Wakely estimates that as many [2.3 million people](#) would lose coverage in 2027. (In addition, CMS coverage losses starting in 2028 would be even greater, for reasons explained below.) CMS seems to understate coverage losses in 2027 for two key reasons:

- **CMS understates the number of DMIs that would be created.** The rule estimates that the no-data DMI provision would create 2.8 million DMIs per year and the under-100% DMI provision would create about 550,000 DMI, for a total of about 3.3 million additional DMIs annually. Wakely estimates that this figure would be 4.7 million. CMS may be undercounting for at least two reasons. First, reports from SBMs indicate that about 40% of data requests to the IRS return no income data, and this rate holds even among those with relatively high incomes, who almost certainly file a return. The reason for the high no-data rate is not clear, but it means that many millions of people are at risk of a DMI through no fault of their own. CMS's lower DMI estimate may not reflect this high rate of

missing data. Second, CMS's estimate may be an undercount given that IRS processing backlogs are increasing due to recent staffing cuts. Larger processing delays would mean more no-data DMIs, contributing to higher coverage losses and, ultimately, higher overall premiums, neither of which is discussed in the proposed rule.

- **CMS understates the share of people with DMIs who would lose coverage.**

The rule estimates that the 3.3 million additional DMIs under the rule would result in about 488,000 people losing APTC in 2027. Given that the average Marketplace coverage unit includes about 1.4 people, this means that CMS assumes that about 10% of those with DMIs will lose coverage. This rate is implausibly low given the research cited above about the impact of administrative burdens on take-up. For example, a 2025 study finds that adding a single step to the enrollment process prompted a 33% decline in enrollment. Consistent with relevant research, Wakely has estimated that DMIs lead to enrollment attrition of between about 25% and 50%. Applying the high end of this range, Wakely estimates that the DMIs provisions could reduce enrollment in 2027 by 2.3 million.

CMS does not explain how it arrives at its much lower figures.

CMS seemingly ignores that DMIs' interactions with H.R. 1 would tremendously increase harm caused by the provisions starting in 2028. While the preamble section on the DMI proposals discusses H.R. 1's elimination of the PTC reconciliation caps, it makes no mention of an H.R. 1 change with far stronger interactions: beginning in 2028, H.R. 1 generally denies APTC to people in a DMI. This would greatly intensify the effects of the new DMIs, since it would impose higher premiums in addition to greater administrative burdens. Wakely estimates that, given this interaction, [coverage losses](#) due to the DMI provision could exceed 3 million people in 2028.

This interaction is central to the effects of these proposals. Not addressing it means that CMS has failed to meaningfully contend with the effects of these proposals and denies the public a meaningful opportunity to do so.

The provisions would greatly increase premiums across the board, which CMS does not adequately consider. The DMI changes would harm the risk pool, due to both the added administrative burdens and—starting in 2028—the interaction with the denial of APTC for people in a DMI.

As discussed above in the section on the rule's analysis, [administrative burdens create adverse selection by deterring enrollment of younger and healthier enrollees](#). An enrollee with heart disease who is taking multiple expensive medications is *far* more motivated to jump through the many hoops necessary to obtain the documents to prove their income than a healthy 30-year-old enrolling in coverage for the financial security it

provides. CMS has long underscored that [coverage losses associated with DMIs are concentrated among the young](#), a pattern that CMS [acknowledges](#) continues to this day. [Data from Massachusetts](#) document the same pattern.

As the American Academy of Actuaries has [explained](#), higher premiums also disproportionately [deter enrollment among healthier people](#), since they expect to use less health care. Deterring these younger and healthier people from enrolling worsens the risk pool and increases premiums—further deterring enrollment of healthy unsubsidized enrollees. This is exactly the kind of market instability that CMS purports to be trying to avoid in this rule.

CMS makes no mention of the effects of the loss of APTC on the risk pool. But even for the administrative burdens, CMS does not analyze and seems to largely ignore the risk pool effects. CMS acknowledges that it considered the “potential negative risk pool impact” in deciding to sunset the provision in the Integrity Rule. It now disregards those concerns without any analysis of the scale of the premium increases associated with this large new administrative burden and attendant losses of coverage. Without such analysis, CMS can neither justify this rule nor give commenters the information they need to respond to it.

The proposed changes would increase administrative costs for Marketplaces, largely by creating a windfall for entities that sell personal data. CMS estimates that these proposals would increase state and federal Marketplace spending to resolve DMIs by \$198 million per year. These changes would add administrative costs for Marketplaces and consumers while providing a windfall for companies that profit off personal information and are greatly increasing their prices. The [New York Times](#) recently highlighted that Equifax is likely to earn hundreds of millions of dollars in new revenue due to additional Medicaid verification requirements in H.R. 1. Creating millions more Marketplace DMIs would represent an additional windfall for these types of companies and an additional diversion of health care dollars to administrative costs.

Imposing these provisions would unfairly punish consumers for IRS data gaps and processing backlogs beyond their control; CMS should at a minimum delay these provisions until federal agencies resolve these issues. As discussed above, the IRS has long failed to return income information for a surprisingly large fraction (about 40%) of applicants, including those with relatively high incomes who have almost certainly filed a return. The reasons are not totally clear, though they likely relate to IRS privacy rules. These no-data rates are likely to grow even larger given [ongoing IRS processing backlogs](#) driven by recent staffing reductions, as documented by the IRS’s Inspector General. These are important issues for CMS and IRS to address so that information is available for income verification. But consumers should not be punished for the shortcomings of federal agencies. CMS should withdraw this proposal in its

entirety. But at a minimum, it should delay consideration of the no-data DMI proposal until the agencies can ensure that the IRS will return tax information for everyone who has filed.

There are no compelling legal arguments for the DMI proposals.

CMS's claim that the ACA requires imposing no-data DMIs ignores statutory language that clearly supports the current rules. CMS claims that the plain language of the ACA section governing eligibility verification requires DMIs in cases where income data is not available. But this analysis ignores a different part of the same statutory section that provides ready authority for the current rule. This omission is especially striking since the Integrity Rule's justification for requiring no-data DMIs focused extensively on this now-ignored provision.

The proposed rule's analysis focuses on ACA section 1411, entitled "Procedures For Determining Eligibility For Exchange Participation, Premium Tax Credits And Reduced Cost-Sharing, And Individual Responsibility Exemptions." Section 1411 provides for the establishment of a program to make APTC eligibility determinations, including information to be submitted by applicants, rules for verification using reliable data sources, and the submission of additional documentation. As CMS notes, section 1411 describes procedures under which the applicant submits additional documentation when third-party data can't verify attested information. CMS asserts that this approach is mandated. But CMS does not mention that section 1411 also provides clear authority to depart from this approach. Section 1411(c)(4)(B), entitled "Flexibility," provides in relevant part that "The Secretary may modify the methods used under the program established by this section [meaning section 1411] for the Exchange and verification of information if the Secretary determines such modifications would reduce the administrative costs and burdens on the applicant."⁶ In other words, CMS can adopt alternative rules to reduce administrative burdens.

Current procedures could scarcely fit more squarely into this authority, given the administrative burdens under the proposed rule, as discussed above. Indeed, CMS gave this precise justification in the [2024 NBPP](#), noting that the proposal to end no-data DMIs is "consistent with the flexibility under ACA section 1411(c)(4)(B) to modify methods for verification of the information where we determine such modifications would reduce the administrative costs and burdens on the applicant."

In its proposal to impose no-data DMIs in the Integrity Rule, CMS attempted to explain away this flexibility authority by claiming it did not apply. This effort was not convincing,

⁶ Section 1411(c)(4)(B) also includes an example of a permitted modification ("allowing an applicant to request the Secretary of the Treasury to provide the information described in paragraph (3) directly to the Exchange or to the Secretary") and clarifies that such modifications must meet the privacy requirements of Code section 6103. But neither of these addenda limits the authority to continue with current law.

since section 1411(c)(4)(B) so clearly authorizes the current approach.⁷ CMS now instead ignores that this provision exists. Its discussion of section 1411 and the no-data DMI proposal makes no mention of section 1411(c)(4)(B). This approach to statutory interpretation—which is at best uninformative and at worst misleading—provides no reasonable basis for the rule and undermines the opportunity for meaningful comment.

CMS concedes that under-100% DMIs are not required by the statute. As for the under-100% DMIs, CMS does not even attempt to claim that they are mandated by the statute, instead relying on policy arguments for why the additional burden must be imposed.

Thus, neither proposal to generate new DMIs can be justified with claims that they are required by the statute.

Denying APTC under Failure to File and Reconcile (FTR) Policy (Section 155.305)

The proposed rule moves to impose FTR rules in 2027, going against the Court opinion in *City of Columbus*, which found no statutory basis for such rules in 2026, when the statutory framework matches that in 2027. Instead of following the Court’s opinion, CMS proposes to require Marketplaces to choose between the “one-year” and “two-year” FTR rules in 2027, with the FFM choosing the more restrictive one-year rules. This approach both violates the statute and creates substantial policy concerns. (The rule also implements the H.R. 1 provision that effectively imposes the one-year rule in 2028 and beyond.)

Background on FTR Rules

Under the ACA, consumers receive APTC based on their projected income and then must file a tax return to reconcile APTC against the PTC they are ultimately due. Anyone who fails to reconcile is subject to all the IRS’s normal enforcement tools for failing to properly file a return. CMS regulations promulgated in 2012 added another penalty: individuals who failed to file and reconcile would be denied APTC in subsequent years. During the Biden administration, CMS modified the rule so individuals could be denied APTC only after two consecutive years of FTR status (referred to as the two-year FTR rule). In May 2025, the Integrity Rule restored the one-year rule, effective for 2026 only. But the District Court in the *City of Columbus* case found both versions of the FTR rules were likely unlawful in 2026, as they purport to impose an eligibility requirement without statutory authority. (H.R. 1 effectively codified the one-year rule for 2028 and beyond, mooted the statutory argument from then on.)

⁷ For a discussion of this effort, see the [comment letter](#) from Jason Levitis, Christen Linke Young, and Sabrina Corlette on the Integrity Rule.

CMS now attempts to revive FTR rules for 2027, notwithstanding the Court's view that they are inconsistent with the statute. CMS would permit each Marketplace to choose to enforce either the one-year or two-year FTR rule.

The proposed FTR rule for 2027 would impose excessive administrative burdens and unfairly deny APTC to eligible consumers while also raising premiums.

FTR rules have long raised concerns about administrative burdens and fairness—and about whether they are necessary.

IRS privacy rules mean FTR rules are burdensome for consumers and deny them due process. IRS privacy rules generally [prohibit](#) Marketplaces from providing applicants with information about their FTR status, even when denying them APTC on that basis. As a result, CMS regulations provide that the notices Marketplaces send to consumers at risk of losing APTC eligibility due to FTR status needn't specify that FTR status is the cause. And consumers who call the Marketplace after receiving these confusing notices still cannot be told why their APTC is in jeopardy. This is a Kafkaesque recipe for consumer confusion, frustration, and coverage loss. Crucially, it is also a violation of consumers' due process rights. Given these administrative burdens, FTR rules likely worsen the risk pool, since [sicker individuals are more motivated to overcome administrative burdens](#) to enroll in coverage than healthier ones.

Errors and processing delays lead FTR rules to unfairly deny APTC to eligible consumers. Another concern is that consumers can be incorrectly targeted for FTR denial due to delays or errors in processing tax returns. This is especially likely for individuals who file paper returns, which may disproportionately affect filers who are older and lower-income, as well as those who amend their returns. Delays and errors are also possible in the process the IRS must perform to share FTR information with Marketplaces through the federal data services Hub. And such delays and errors are increasingly likely given recent IRS staffing reductions and processing backlogs, as recent documented by [IRS Inspector General](#). And again, resolving such errors is complicated by the Marketplaces' inability to discuss the reason for the denial. Recent [cuts in Navigator funding](#) will also exacerbate such issues. More generally, completing the forms to properly reconcile APTC is a complex process that may frustrate taxpayers attempting to comply.

FTR rules are unnecessary given other protections in place. As noted above, individuals who receive APTC and then fail to reconcile are subject to IRS's long-standing enforcement mechanisms for individuals who fail to properly file a return or pay taxes that are due, which can include the withholding of tax refunds and liens and levies. In addition, the IRS recently made an administrative change that minimizes the risk that consumers could fail to reconcile in the first place. If a consumer receives

APTC and then attempts to e-file a return without reconciling, the IRS now [bounces back](#) that return. This policy increases the likelihood that any appearance of an FTR flag is due to IRS delay or error. CMS does not mention this policy and does not appear to have considered whether this policy sufficiently addresses purported concerns about improper enrollment.

CMS also fails to explain how the FTR policy helps address its concerns about improper enrollment. The agency notes that 29% of people are enrolled in fully subsidized plans in 2026 and suggests that this means there is an ongoing risk of improper enrollment. But CMS does not suggest that these individuals were improperly enrolled or otherwise allege any fraud or abuse. The fact that some people qualify for fully subsidized plans, which [has been true since the Marketplaces opened in 2014](#), is not a sufficient basis for imposing significant and unlawful administrative burdens on consumers in the name of program integrity.

In short, the FTR regime is an unnecessary morass of complex rules that frustrates consumers and denies coverage to those who are eligible, all made worse by recent staffing cuts.

CMS's FTR proposal is inconsistent with the statute, notwithstanding CMS's deeply flawed new statutory argument.

CMS has long argued that it could impose FTR rules as an eligibility requirement for receipt of APTC. But the Court in *City of Columbus* made clear—and CMS now seems to concede—that this is not permissible, since, in the Court's language, “the agency's decision to condition APTC eligibility on reconciling tax information reads an exception into the statutory formula that is simply not there.”

CMS now shifts to another argument: that the ACA's income verification rules require conditioning APTC on reconciliation. CMS's argument is difficult to follow, but essentially it suggests that the ACA's eligibility verification rules compel the FTR rules, since they rely on income tax data:

The statute requires APTC to be set on the basis of the individual's household income for the most recent taxable year for which information is available. Therefore, the income reported on the tax return for the most recent taxable year establishes the starting point for verifying whether an applicant's income meets the requirements to qualify for APTC. As discussed previously, when the IRS does not have tax return information to verify an applicant's income, section 1412 of the Affordable Care Act requires HHS to establish alternative procedures to determine APTC when there is a change in circumstances or “in cases where the taxpayer was not required to file a return...”. Because section 1412(b)(2)(B) only references cases where a tax filer was not required to file a return, we do not

believe an applicant who fails to meet the requirement to file a return qualifies for this alternative process for determining APTC. Therefore, to determine and verify household income, it is imperative that consumers file a Federal income tax return when they are required to do so.

This argument fails for several reasons.

The statute includes no language requiring tax filing as a condition of applying for APTC. The ACA lays out in great detail what applicants need to do to support the verification process. Section 1411(b) enumerates the information applicants must submit, including information on citizenship, access to affordable employer-sponsored insurance, and income. Neither this list nor anything else in the statute says that applying for coverage requires having filed a tax return.

CMS falsely suggests that application procedures not requiring tax data are limited to people who are not required to file, when in fact the statute says they apply in cases “including” situations where people are not required to file. CMS claims that “because section 1412(b)(2)(B) only references cases where a tax filer was *not required* to file a return, we do not believe an applicant who fails to meet the requirement to file a return qualifies for this alternative process for determining APTC.” In fact, section 1412(b)(2) says to look at alternative data in cases “including” where the taxpayer was not required to file. There’s no reason these rules wouldn’t also apply in cases where data are unavailable for other reasons.

CMS’s reading would deny APTC much more broadly. CMS’s focus on failing to file a return doesn’t match the rule CMS proposes, in two ways. First, CMS’s reading would require denying APTC to anyone who was supposed to file but didn’t, not just those who received APTC. But CMS’s proposed FTR rules are confined to those who received APTC and then failed to file. This inconsistency makes clear that CMS’s reading doesn’t work. Second, CMS’s reading provides no grounds to deny APTC to those who file a return but fail to reconcile APTC, as CMS’s rule would do. This is a substantial additional population.

CMS claims the statute requires filing in the most recent year, but the statute says to look at the most recent year for which information is available. CMS says that “the income reported on the tax return *for the most recent taxable year* establishes the starting point for verifying whether an applicant’s income meets the requirements to qualify for APTC,” which would match the year FTR looks to. But the statute doesn’t specify the most recent year. Section 1412(b)(1)(B) says to look at “the individual’s household income for the most recent taxable year for which the Secretary, after consultation with the Secretary of the Treasury, *determines information is available.*” In other words, other years will also do just fine. This provides no basis to deny APTC if a return isn’t filed only for one particular year.

For these reasons, we urge CMS not to finalize this proposal.

Added Paperwork for Consumers Using a Special Enrollment Period (Section 155.420(g))

CMS proposes to impose additional documentation requirements on consumers seeking to enroll in Marketplace coverage through a SEP. Specifically, the FFM would require consumers to submit documents for a broader range of SEP triggering events and would conduct SEP verification (SEPV) for at least 75% of new enrollments.

This change was initially adopted in the Integrity Rule, but on a temporary basis, to sunset by the end of plan year 2026. At the time, CMS argued that additional SEP verifications were necessary as an interim measure to reduce fraud by unscrupulous brokers, who were processing unauthorized enrollments and switching people into new plans without their consent. The agency further claimed that it could safely sunset the policy at the end of 2026, because without enhanced PTCs, the program integrity concerns would be lessened and the cost burden of performing SEPV would outweigh the benefits. The Federal District Court in *City of Columbus* [stayed](#) this provision, finding its imposition to be arbitrary and capricious because CMS has “not identified...any evidence in the Rule to corroborate Defendants' conclusory assertion that abuse of SEPs is currently contributing to the ‘program integrity concerns’ the agency seeks to address through this provision.”

In this proposed rule, CMS reverses itself, arguing now that expanded SEPV should be made permanent, despite the expiration of enhanced PTCs at the end of 2025 and the significant costs of SEPV to consumers and to the Marketplace.

The data CMS offers to support this change do not show a connection between SEP use and fraudulent enrollment and therefore provide no basis for this change. To justify its change of mind, the agency points to data showing that when the FFM resumed SEPV for the loss of minimum essential coverage (MEC) SEP after suspending it during the COVID-19 public health emergency, the use of non-MEC SEPs increased. CMS suggests that this shift is an indicator of fraudulent enrollment. However, as the agency itself acknowledges, many consumers qualify for multiple SEPs at the same time. If a consumer has a choice between two SEPs and chooses to apply via the SEP that requires the least paperwork, that is not fraud. It is simply common sense.

The proposal would impose new administrative burdens on consumers that would delay coverage. CMS's proposed expansion of SEPV would dramatically expand the amount of documentation people would be required to submit to prove their eligibility, requiring them to wait weeks before they can access coverage and critical health care services. Estimating that the proposal would only require consumers to

spend on average 1 hour to complete application questions and submit documentation, CMS appears to assume, without any basis, that providing pre-enrollment documentation is easy for consumers, and that consumers have access to the documents they need to prove their eligibility. In fact, CMS's own data show that, in 2019, when expanded SEPV was in place, over one-quarter of applicants required more than two weeks to gather and submit the necessary paperwork to prove their eligibility, during which time they were denied access to coverage. And these new burdens would be exacerbated by the large reductions in FFM Navigator funding.

CMS estimates that, if finalized, this expansion of SEPV would require an additional 293,073 people to submit documents proving their SEP eligibility, costing consumers an additional \$7,332,686 each year. It would also cost the FFM an additional \$14,602,615 each year to process, review, and decide on SEPV requests. This cost estimate does not take into account additional expenditures associated with consumer communications, outreach, and assister training.

The administrative burdens imposed by the proposal would disproportionately reduce enrollment among young, healthy people and thus raise premiums across the board. Although CMS acknowledges that the additional paperwork demands could deter young, healthy people from enrolling, it asserts, without evidence, that such deterrence would be “minimal.” It further asserts, also without evidence, that the net effect of expanded pre-enrollment verification would be to reduce premiums by 0.5–1.0%. A considerable body of research has found that paperwork and other administrative hurdles to enrollment in coverage programs are a strong deterrent among people who are otherwise eligible for the coverage. Younger, healthier individuals are more likely to be deterred from enrolling, leading to a less-healthy risk pool. For example, [a study published by the American Economic Association](#) found that adding one step to the enrollment process prompted a 33% decline in enrollment, predominantly among young, healthy, and economically disadvantaged people. Removing paperwork burdens, on the other hand, [has been found](#) to significantly increase enrollment and continuity of coverage among healthy, younger individuals. Currently, several SBMs require consumers seeking to enroll via many SEPs to attest, upon penalty of perjury, that they qualify for the SEP in question. None of these SBMs have reported concerns about fraudulent enrollments via a SEP.

Given these excessive costs, the increased burdens on consumers, and the likely negative effects on the risk pool, we urge CMS not to finalize this proposal.

Comment Solicitation on Eligibility Verification Provisions of H.R. 1 (Section 71303)

The rule requests comments on an H.R. 1 provision, discussed above, that takes effect in 2028 and could make enormous changes to long-standing eligibility and enrollment

rules. Most importantly, the provision prohibits Marketplaces from providing APTC until they have completed an eligibility determination based on information provided or confirmed by the applicant. This could abolish both automatic re-enrollment and provisional eligibility, which permits many applicants who are required to submit additional documentation to receive APTC while the Marketplace adjudicates their eligibility. This provision could cause substantial harm, but the harm can be mitigated to some extent with a flexible approach that recognizes the needs of consumers.

The provision creates several key risks. First, it could impose substantial new administrative burdens on consumers, while also reducing affordability. Second, as noted above, it could interact with the DMI provisions to deny APTC to millions of people waiting for their paperwork to be processed. Both of these factors will likely reduce premiums by disproportionately discouraging enrollment among healthier people. Finally, it could impose a large burden on Marketplaces, with substantial implementation costs and operational risks not seen since 2013.

To mitigate these concerns, CMS should:

- Seek ways to implement Section 71303 of H.R. 1 to mitigate administrative burdens and coverage loss.
- Provide guidance quickly to provide a sufficient implementation runway. If guidance is not finalized by this August, CMS should delay implementation.
- Maximize flexibility for SBMs. As discussed above, there's little evidence of fraud in SBMs. More flexibility will mean less cost given variation in SBM information technology (IT) capabilities and required build timelines.
- Provide a SEP for anyone denied APTC for any month.

Comment Solicitation on Premium Payment Threshold (Section 155.400)

CMS requests comments on whether to extend its moratorium, imposed in the Integrity Rule, on giving insurers additional options to avoid terminating coverage when enrollees underpay premiums by a de minimis amount. These options were created in the 2026 NBPP but have not taken effect due to a one-year moratorium in the Integrity Rule. CMS now requests comments on whether this moratorium should be extended or made permanent, thus eliminating these options before they ever become available.

Long-standing regulations permit insurers to set a minimum percentage of the consumer's premium share (a "net premium percentage threshold") that they will accept for purposes of effectuating enrollment (referred to as a "binder payment") or avoiding triggering a three-month grace period or termination. For example, if a consumer's full premium is \$400, of which APTC covers \$300, and the insurer permits a net premium

threshold of 95%, the consumer satisfies the threshold so long as they pay at least \$95 (95% of the \$100 net premium).

This threshold provides relief where a consumer makes a nearly complete payment. But it does not help if the consumer owes only a minimal amount and pays a somewhat smaller share. For example, if the full premium was \$500 per month, APTC was \$480, and the consumer paid \$15 of their \$20 share, a net premium threshold of 95% would not protect the consumer, since they would have paid only 75% of their \$20 net premium.

To address such situations, the 2026 payment notice created two additional threshold options. First, insurers could set a threshold of no less than 98% for the combined premium paid by APTC and the consumer (a “gross premium percentage threshold”). Second, insurers could set a dollar value for permissible non-payment (a “fixed-dollar threshold”), which could be no more than \$10.

Both these new options came with some significant limitations. First, both would apply for triggering grace periods and coverage loss, but not for binder payments to effectuate coverage. Second, insurers could offer only one percentage-based threshold. Finally, all options are based on the accumulated non-payment. For example, if the insurer has a dollar-value threshold of \$10 and a consumer underpays by \$6 for two consecutive months, the accumulated shortfall of \$12 is considered as exceeding the \$10 threshold.

Offering such thresholds is generally optional for insurers, and states also may limit them using their regulatory authority.

The Integrity Rule imposed a moratorium on the new threshold options before they took effect. This means insurers can offer only net premium percentage thresholds in 2026. As a result, de minimis non-payments continue to result in coverage losses.

Extending the moratorium on the new threshold options would needlessly infringe on the authority of state regulators, who are best positioned to set rules for their insurance markets. Extending the moratorium would preemptively reduce the flexibility afforded to states and insurers to meet consumers’ needs. There is no evidence that they would make imprudent decisions about what to permit. If they did so, CMS could reconsider the rule.

Extending the moratorium would reduce enrollment among eligible people. While the proposed rule does not provide estimates on the effects of eliminating these options would lead to coverage loss, the Integrity Rule estimated that this change would reduce APTC payments by about \$820 million in 2026.

The rule presents no evidence that premium payment thresholds contribute to improper enrollment. CMS raises the concern that permitting the new threshold

options could contribute to improper enrollment. But CMS provides no evidence for this connection, again creating the prospect of imposing concrete harms to address only hypothetical problems—an approach roundly condemned by the courts in both *City of Columbus* cases. And such a connection seems especially unlikely given that the new threshold options do not apply to binder payments.

The data offered by CMS about zero-claim coverage do not support the contention that substantial numbers of enrollees do not know they're covered.

CMS argues that consumers may be harmed by the more flexible premium thresholds because they may be unknowingly continuing coverage with a de minimis premium. But CMS offers no evidence for this claim. CMS provides data suggesting that subsidized enrollees are more likely than others to have no claims. CMS suggests that this shows that people don't know they're covered, which in turn would justify eliminating the threshold options.

However, in addition to erroneous and improper enrollment data, there is evidence that consumers in many instances are unaware that they remain in coverage. For example, in a recent internal analysis of claims data from 2019 through 2024, we found that among silver plans offered on- and off-Exchange, a significantly higher percentage (34 percent from PY 2023 through PY 2024) of on-Exchange silver enrollments were associated with no claims as compared to off-Exchange silver enrollments (18 to 23 percent from PY 2019 through PY 2024) across all years examined, with the greatest difference occurring in PY 2023 and 2024.

But this argument fails on several fronts. First, 34% is not a surprisingly large fraction of consumers to have no claims. As [KFF recently cited](#), “A [recent report](#) found that each year from 2018 to 2022, an average of 23% of enrollees in employer-sponsored plans didn't use their health insurance.” As Matt Fiedler, senior fellow at the Brookings Institution, explained in an [X thread](#), the rate with individual market coverage is expected to be higher, since the duration of enrollment is shorter. And as for the difference between subsidized and unsubsidized coverage, it's natural that this rate would be higher for subsidized coverage, since the lower net premiums attract healthier enrollees. Thus, these figures provide no evidence that subsidized consumers are more likely to be unaware that they are covered.

The rule seems to not understand that underpayments accumulate for purposes of the new options, leading to unfounded concerns about extended coverage leading to large liabilities. CMS expresses the concern that a fixed-dollar or gross percentage-based premium threshold could lead to situations where a consumer stops paying for coverage but “the coverage [continues] for several months..., with the additional risk that the enrollee has accumulated a large amount of debt if the issuer has

adopted a gross premium percentage-based threshold and the enrollee's gross premium is much higher than the de minimis \$10 fixed-dollar threshold.” But neither of these is a reasonable risk given that both these thresholds consider the accumulated underpayment over time. For example, if the monthly premium was \$1,000, and an insurer offered the most generous gross premium percentage-base threshold (allowing an accumulated underpayment of 2%), the consumer would lose the protection of the threshold once the liability exceeded \$20. This means that it’s impossible to accumulate a large liability and that there’s virtually no risk of the protection extending for a long period.

Loosening Standards for Establishing a State-Based Marketplace (Sections 155.105 and 155.106)

The proposed rule would reverse CMS policy on the requirements for states seeking to establish an SBM. Specifically, the rule would eliminate the requirement that a state seeking to transition to an SBM spend a year as an SBM on the federal platform (SBM-FP) in order to give the state sufficient time to create, staff, and structure an SBM.

We are concerned that, without the requirement to spend one year as an SBM-FP, some states may not have sufficient time to make the necessary changes to websites, application processes, and assister training, resulting in consumer confusion and disruption. We urge CMS not to finalize this change.

Promoting Broker-Operated Marketplace Websites and Placing Consumers at Increased Risk (Sections 155.205(b) and 155.221(k))

The ACA requires that SBMs operate a centralized eligibility and enrollment platform via the Marketplace website. Specifically, section 1311(d) provides that Marketplaces must:

- Be “a governmental agency or nonprofit entity that is established by a State;”
- “Make available qualified health plans to qualified individuals;”
- “Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;”
- “Utilize a standardized format for presenting health benefits plan options in the [Marketplace].”

The Marketplaces also at section 1311(d)(2)(B)(i) are prohibited from “mak[ing] available any health plan that is not a qualified health plan.” Further, section 1413(c)(1) of the ACA requires Marketplaces to maintain a secure electronic interface that enables consumers to safely submit private information via their online Marketplace applications,

and to electronically receive an eligibility determination from the Marketplace. Section 1401 of the ACA—which governs the availability of subsidies—further requires individuals to be enrolled in a Marketplace qualified health plan (QHP) “through an Exchange.”

Consistent with these statutory provisions, current regulations require that Marketplaces operate a centralized eligibility and enrollment platform via the Marketplace website, run by a government or non-profit entity. The proposed rule would reverse this long-standing policy, creating a pathway for privatization of the Marketplaces, a prospect counter to the plain text of the ACA. Specifically, CMS proposes allowing SBMs to forgo offering a centralized, consumer-facing eligibility and enrollment website and instead have enrollments exclusively occur through a diffuse system of for-profit web brokers.

The proposal runs counter to the ACA’s basic requirement of a Marketplace. The ACA requires a Marketplace to “make available” QHPs via a government or non-profit entity. While it is common for SBMs to contract with vendors for various services, including the design and maintenance of web-based eligibility and enrollment platforms, in all cases those vendors are under contract, accountable to, and acting on behalf of, the state agency or non-profit entity authorized under state law to operate the Marketplace. What CMS is proposing here is fundamentally different; instead, health plans would be made available exclusively through private, generally for-profit web-brokers who are not subject to the same level of Marketplace control and accountability as contracted vendors, and whose commission-based compensation structure gives them incentives that often don’t align with consumers’ interests. CMS asserts that enrollment through an insurer or web-broker would still satisfy the requirement to enroll “through an Exchange” even while repeatedly referring to web-brokers as “non-exchange entities.”

Under the proposal, the statutorily mandated SBM websites would be only informational to consumers and act as a back-end intermediary for certain functions, such as in transmitting Marketplace enrollment information to CMS and the IRS and conducting assessments or determinations of eligibility for Medicaid or the Children’s Health Insurance Program (CHIP). CMS is calling this new form of SBM a “State-Based Exchange-Enhanced Direct Enrollment” or “SBM-EDE.” It is notable that, when Georgia pursued a similar approach, it used a section 1332 waiver to [waive ACA section 1311](#), which requires each state to have a functioning Marketplace.

CMS’ proposal would likely result in gaps in coverage or even uninsurance for many consumers. HealthCare.gov facilitates Marketplace, Medicaid, and Children’s Health Insurance Plan (CHIP) enrollment with a “no-wrong-door” application that routes people to the program for which they’re eligible based on their family size, income, and other factors. On average, [6% of applicants](#) who apply through [HealthCare.gov](#) are

found to be Medicaid or CHIP eligible, or potentially eligible. Brokers and insurers have no incentive to assist people who turn out to be Medicaid or CHIP eligible, rather than eligible for APTCs. Neither are they trained to do so. Indeed, the “[Find Local Help](#)” page on [HealthCare.gov](#) makes this explicit: it informs consumers that, while Navigators are trained and certified by the Marketplace to help with Marketplace, Medicaid, and CHIP enrollment, brokers and agents are only trained to help with Marketplace enrollment. For people who are Medicaid- or CHIP-eligible, parceling out the Marketplace’s critical eligibility and enrollment responsibilities to web-brokers and insurers is likely to mean they will receive little to no help navigating the process, exacerbating consumer confusion and increasing the risk of coverage gaps and uninsurance.

Eligibility and enrollment rules are continually evolving, and delegating enrollment entirely to web-brokers raises the risk of incorrect eligibility determinations and inappropriate enrollments. Determining eligibility for government coverage programs such as Marketplace APTCs, Medicaid, and CHIP is best performed through a centralized, accountable platform to ensure uniform adherence to eligibility rules and consistent oversight. In addition, web brokers’ interests may conflict with those of consumers, as seen in recent episodes of broker fraud.

CMS does not provide meaningful analysis of the proposal. Despite these obvious concerns and new barriers, CMS made no attempt to estimate the burden that this proposal would place on consumers in states that take up the SBM-EDE option. For instance, CMS does not account for the burden on consumers of having to navigate a new process and enroll or re-enroll through a new platform. CMS also does not estimate how such changes might affect enrollment levels and thus premiums, noting only that the proposal “may have varied impacts” and that a higher number of enrollment websites “might impact consumers and consumer behavior.” If CMS wishes to proceed with this proposal—which would dramatically reshape enrollment in any state that takes up this option—it should first share such estimates and provide a new opportunity to comment. Notably, when CMS analyzed Georgia’s section 1332 waiver proposal to make a similar change, it found that [coverage losses were likely](#).

EDE as an exclusive enrollment pathway increases the risk of fraud and consumer confusion.

The use of EDE as the exclusive enrollment pathway also raises [significant questions](#) about the privacy and security of consumer information, the potential for fraud, and the possibility of consumers receiving inaccurate or misleading information about their eligibility and plan options that could lead them to make suboptimal plan choices, and even to inadvertently enroll in non-ACA compliant coverage, such as short-term plans or health care sharing ministries, that leave them exposed to significant financial risk and medical debt.

The use of EDE places consumers at increased risk of fraud. Notably, in this proposed rule CMS repeatedly expresses concerns about fraud as justification for imposing new paperwork requirements on consumers seeking to enroll in Marketplace coverage, but the agency raises few such concerns here. In addition, this proposed rule includes several proposals aimed at strengthening CMS’s authority to oversee and address fraud in SBMs. Yet a non-centralized eligibility system model that entirely delegates Marketplace enrollment to private, for-profit vendors would increase program integrity challenges, leading to the risk of inaccurate APTC payments to insurers and increased tax liability for consumers.

Indeed, the FFM’s expanded use of EDE in recent years is directly correlated to the rise of unauthorized enrollments and unauthorized plan switching. As discussed above, the proposed rule repeatedly notes that brokers are a key driver of improper enrollment. The [Paragon Institute](#) also notes this connection, finding that unscrupulous brokers are “driving fraudulent enrollments by exploiting the EDE feature of [HealthCare.gov](#), which allows third parties to enroll consumers without their direct interaction with the [Marketplace].” Although the authors of the Paragon study also point to the influence of enhanced PTCs as a driver of fraud, notably, there has been almost zero fraud in any of the SBMs. Consumers in the SBMs were also eligible for enhanced PTCs; the main differentiator between the SBMs and the FFM is that all but one of them have declined to use EDE to mediate enrollments.

Despite this overwhelming data—from SBMs, external entities such as Paragon, and CMS’s own data and experience with EDE—the agency ignores the fact that EDE has been associated with higher levels of improper enrollment via brokers. And, instead of applying robust oversight and program integrity mechanisms specific to this new model, CMS suggests (without evidence) that an annual attestation of compliance will be sufficient to address any potential program integrity risks associated with the SBE-EDE model.

Allowing SBMs to rely entirely on EDE vendors for enrollment would make it extremely difficult—if not impossible—for SBMs to act quickly if they discover an EDE vendor is acting inappropriately. Currently, if an EDE vendor is determined to be acting inappropriately, there are steps that a Marketplace can take to bring them back into compliance or terminate them. But these are time-intensive, legally fraught actions. While the procedural steps play out, improper enrollments may continue, sensitive consumer information may be compromised, and other harms to consumers or the federal fisc may continue. Under a model where an SBM has no other enrollment pathway, such oversight would be immeasurably more difficult. The state may not have the option to terminate the EDE vendor. CMS has not adequately addressed the risks to SBMs and consumers if the EDE vendors running the Marketplace fail to follow the

rules or proposed a solution for SBMs to immediately and effectively address such behavior.

Delegating Marketplace functions to private brokers would require intensive and costly oversight. Notwithstanding CMS's suggestion that a mere annual attestation would be sufficient to mitigate the program integrity risks, states would have to conduct extensive, continuous oversight and compliance reviews of multiple for-profit EDE vendors. The administrative costs associated with the necessary procurement processes and required oversight, particularly given rapidly evolving federal and state insurance standards and operational rules, would be considerable and ultimately drive up costs for consumers.

The fracturing of the eligibility and enrollment process would create consumer confusion and raise the risk of coverage loss. Americans are [frustrated with an increasingly byzantine](#) health care system. Purchasing health insurance is already needlessly time-consuming and overwhelming. In drafting the ACA, Congress [required centralized Marketplaces in each state](#) in order to help organize insurance markets, make it easier for consumers to compare their plan options, and to incentivize insurers to compete on premiums. Shifting to a system that requires consumers to choose among countless sellers before even beginning the process of applying for eligibility and selecting a plan, with no guarantee that the seller will allow consumers to see and compare all plans on equal terms, would at best increase consumer confusion and at worst result in fewer enrollments and more people uninsured.

Web brokers' receipt of commissions may put their interests in conflict with consumers' needs. Another concern is that many web-brokers sell more than just qualified health plans to consumers; they also sell products that do not comply with ACA insurance standards or consumer protections. To the extent this is permitted under an SBM-EDE framework, it appears to violate section 1311(d)(2)(B)(i), which prohibits Marketplaces from making available any health plan that is not a qualified health plan. Further, web-brokers are often more [highly compensated](#) for selling non-ACA-compliant products than they are for Marketplace plans, creating a risk that web-brokers may be more incentivized to encourage consumers to enroll in non-ACA plans. If an SBM delegates all Marketplace enrollment functions to these web-brokers, consumers are likely to believe that these entities have the government's seal of approval, and that all the products on their site will provide comprehensive coverage and financial protection similar to Marketplace plans. Nothing could be [further from the truth](#).

CMS premises its proposed reversal of current policy on the need for greater "innovation." However, most EDE providers offer services that, at best, duplicate [HealthCare.gov](#)'s sorting and selection functions. Many EDE providers are also biased by commission structures, creating incentives for them to display favorably plans from

insurers that offer the highest commissions. This can result in consumers not seeing, or not being able to compare, plan options that may be most optimal for them. Today, all SBMs already have the option of working with web-brokers and insurers to enable consumers to enroll through EDE. Therefore, what CMS is essentially proposing would be not to create any new options, but to take away the one option that, for millions of Americans, has become the primary, trusted portal for high-quality, affordable insurance coverage.

CMS also requests comment on whether the FFM should abandon [HealthCare.gov](https://www.healthcare.gov) and shift to an all-EDE approach to eligibility and enrollment. Doing so would create all the same concerns we raise above, only on a larger scale.

We urge CMS not to finalize this proposal. If CMS does finalize this proposal, it should prohibit through regulations EDE vendors from offering any non-QHP plan, to ensure compliance with ACA section 1311(d)(2)(B)(i). Further, CMS should ensure that SBM-EDEs will be subject to the same level of oversight and reporting as all other SBMs, clearly explain how State Exchange Improper Payment Measurement and other oversight measures would apply to SBM-EDEs, and set up a framework through which SBM-EDEs are authorized and required to take immediate action against EDEs that engage in bad behavior, while providing a back-up government-operated enrollment system for consumers.

Eliminating Standardized Plan Options for the FFM and Lifting Limits on Non-Standardized Plans (Sections 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, 156.202, and 156.265(b)(3)(iv))

CMS is proposing to discontinue the standardized plans currently available via the FFM, and end limits on the number of non-standardized plans that insurers can offer for each product type, metal level, inclusion of dental/vision benefits, and service area. States would continue to have the option to require standardized plans or limit the number of plan offerings, including those states that rely on the FFM. But the FFM would provide no preferential display of such plans, making them a far less useful tool for helping consumers choose a plan. We have strong concerns about removing the availability of standardized plan options in the FFM and allowing insurers to offer an unlimited number of plans.

Standardized plans can promote informed decision-making and improve access to high value services.

Standardized plans can be a highly effective method of helping consumers assess and compare plan options and a tool for ensuring access to high value services pre-

deductible. Removing standardized plan options from the Marketplace and ending their differential display would take away a tool that helps consumers be better-informed participants in the process of selecting a health plan.

Eliminating standardized plans would worsen consumer decision-making.

[Evidence indicates](#) that standardized plans can make it easier for consumers to compare plans on key variables such as provider networks, premiums, and quality, leading to [more optimal plan choices](#). By removing cost-sharing differences across plans within a given metal tier, standardized plans simplify consumers' decision-making process. CMS's own data show that consumers value standardized plans: for 2025, 33 percent of all FFM or SBM-FP enrollees had selected a standardized plan. CMS tries to characterize this as "comparatively low uptake," but standardized plans have captured a full-third of enrollment, despite having been an option through the FFM for only two plan years. If CMS finalizes this proposal and insurers choose not to maintain these policies, these consumers would be forced to review, select, and enroll in a new plan.

The proposal fails to consider concerns, which CMS raises elsewhere, that a lack of standardization creates consumer confusion and potential harm. It is notable that, in proposing at section 155.220(j) to require brokers, agents, and web-brokers to use a standardized, HHS-drafted consumer consent form, CMS expresses concern that the use of non-standardized forms is overly "complicated or difficult to follow for consumers, leading to potential consumer harm." In proposing to eliminate standardized health plans, however, CMS expresses no such concern, even though choosing among health plans, with their different premiums, cost-sharing, networks, and formularies, can be an even more complex task than reading a consent form.

Eliminating standardized plans would lead to plans that expose consumers to higher costs and make health care less affordable. Standardized plans can also be a mechanism to ensure that consumers have plan choices that reduce cost-sharing or provide pre-deductible coverage of high-value drugs and services. [Standardized plans on the FFM](#) have had to waive the deductible or charge a fixed dollar copayment for a core set of high-value services, including primary care, urgent care visits, behavioral health services, and generic drugs. Similarly, [DC Health Link's standardized plans](#) have eliminated cost-sharing for primary care visits, laboratory tests, and generic drugs for people with HIV; DC has also eliminated cost-sharing for diabetes-related and cardiovascular-related services, and limited co-payments to \$5 for pediatric behavioral health outpatient visits. Colorado Option plans offered via Colorado's Marketplace are required to offer services such as primary care and behavioral health office visits, and pre- and post-natal care, without cost-sharing. A [2026 Mathematica evaluation](#) of the Colorado Option plans finds that "standardized plans made it easier for consumers to understand what benefits they get from their plans, what they will pay out-of-pocket, and compare across plans— especially for common services."

CMS for the FFM and states like DC and Colorado that have developed standardized plans that incorporate value-based insurance design have done so precisely because, left to their own devices, insurers have little incentive to adopt benefit designs that reduce cost-sharing or provide pre-deductible coverage for services related to a range of high cost conditions such as HIV, mental illness, or substance use. Standardized plans can be an important tool to foster equitable benefit designs that improve the health and lives of people living with chronic conditions. We urge CMS not to finalize this proposal.

Ending limits on non-standardized plans will increase consumer frustration and suboptimal plan choices.

The number of plan offerings on display in many [HealthCare.gov](https://www.healthcare.gov) markets is overwhelming for applicants and complicates the plan selection process. Although CMS's imposition of plan limits brought the weighted average number of total plans available per enrollee down from 114 in plan year 2023 to 100 in plan year 2024, 100 plans per consumer is still too high. As CMS acknowledges, too many health plan choices [leads consumers to make poor decisions](#) and enroll in plans that are suboptimal for their health and financial condition. [Additional research](#) suggests that offering consumers more than 30 plans has a negative effect on enrollment. Yet for plan year 2025, CMS introduced an exceptions process for insurers, allowing them to exceed the limits on non-standardized plan offerings if they could demonstrate they had benefit designs that benefited people with high cost or chronic conditions.

We tend to agree with CMS that the introduction of an exceptions process in plan year 2025 likely blunted the effect of the non-standardized plan limits, hindering CMS's stated objectives of streamlining consumers' shopping experience and reducing plan choice overload. However, CMS's proposed solution to this problem of choice overload is to, bizarrely, eliminate the plan limits entirely, which could cause the number of plan options to increase (not decrease). Indeed, [research on health care plan selection](#) shows that consumers prefer a more limited array of choices, and when faced with too many plans to choose from, they are more likely to make suboptimal plan choices or to not enroll at all. Plan choice overload has a particularly negative impact on low-income applicants, many of whom have limited time to undertake the enrollment process, as well as lower levels of health insurance literacy.

The proposal would permit an even greater over-abundance of plan options, which worsens consumer decision-making. Consumers repeatedly [report considerable frustration](#) with a health care system that is too complex, with [one-third of consumers](#) reporting that they do not understand what their plan covers or what costs they owe. Insurance companies take advantage of consumer confusion by flooding the market with look-alike products that create the environment of [choice overload](#) and

result in many consumers [selecting plans that are sub-optimal](#) for their health and financial situation. This is likely to increase burdens on states in reviewing and approving plan filings.

In short, CMS’s proposed “solution”—to both eliminate standardized plan options and uncap the number of non-standardized plan options—does nothing to prevent the same number or even more plans from being certified for 2027. This presents a fundamental mismatch with the problem of choice overload that the agency says it is trying to address. Instead, CMS should retain standardized plan options for the FFM, further winnow down the number of plan offerings consumers are required to choose from, boost funding for Navigators who can help consumers make informed coverage choices, and engage in an ongoing and consistent cycle of consumer testing and user experience improvement for [HealthCare.gov](#). We urge CMS not to finalize this proposal.

Provisions that Weaken Consumer Protections and Expand Junk Coverage

Increasing MOOPs for Bronze and Catastrophic Plans (Sections 156.136 and 156.155)

In the proposed rule, CMS explains how the rates of change of the three components of the Actuarial Value (AV) calculation (the standard population, the maximum annual limitation on cost sharing (MOOP), and essential health benefits (EHB) costs) have limited insurers’ flexibility in designing plans that conform to the de minimis range for bronze plans, and made it harder to differentiate bronze and silver plans. CMS points out that “eventually the maximum annual limitation on cost sharing will be too low to allow for an AV calculation for the most basic bronze plan design.” We agree this is a problem, one that ideally Congress would fix.

For years, CMS has taken steps to delay the point in time at which designing a bronze plan becomes impossible. Most recently, CMS modified the calculation of premium adjustment percentage to incorporate 2013 individual market premiums. While we have concerns with the approach the Administration took, this change made it easier for insurers to design bronze plans, and delayed the date at which they no longer can.

CMS now proposes to allow insurers to ignore the statutory requirements around cost-sharing limits for bronze and catastrophic plans. For bronze plans, CMS proposes to allow an insurer to offer a bronze plan that fails to comply with the maximum annual limitation on cost sharing, if the insurer also offers a bronze plan that complies. In addition, CMS fails to specify an upper bound for non-compliant bronze

plan's annual limit on cost sharing, thereby not simply changing the upper limit of the MOOP, but effectively voiding the requirement.

CMS's proposal to permit bronze plans to have MOOPs that exceed statutory caps is not legally permissible. In trying to justify its proposal, CMS cites *Gustafson v. Alloyd Co.*, 513 U.S. 561 (1995) for the proposition that statutory provisions should not be interpreted in a manner that renders any part "superfluous," but then proceeds to do just that. CMS argues that maintaining the AV requirement over the generally applicable maximum annual limitation on cost-sharing is the most legally permissible approach. However, this is wrong, given that it is not currently impossible for a bronze plan to comply with both the rules regarding AV and MOOP limits. Indeed, the Integrity Rule's changes to the Premium Adjustment Percentage, by raising MOOPs, made it even easier. The statute requires insurers to comply with both statutory standards.

Even if we were to assume, counterfactually, that it is impossible for a bronze plan to meet both standards, the result would simply be that bronze plans couldn't be offered, not that CMS was suddenly free to start rewriting the statute or picking and choosing the standards that should (or should not) apply. It is not uncommon for Congress to enact rules with parameters tailored to immediate conditions. Congress can and often does include language providing for such parameters to be updated over time. But when Congress does not do so, agencies may not overrule Congress by adjusting these statutorily-prescribed parameters.

It is puzzling that CMS conditions offering a non-compliant plan on also offering a compliant plan. CMS claims this pre-condition is necessary to show the agency's good faith efforts to adhere to the statute, but instead, the pre-condition underscores that the proposed policy—which could expose consumers to thousands of dollars more in higher out-of-pocket costs—is unnecessary. It is still possible to offer a compliant bronze plan.

CMS's proposal to require catastrophic plans to provide no benefits for any plan year (with limited exceptions) until an amount equal to 130% of the MOOP is reached is contrary to the requirements of ACA section 1302(c). Section 1302(c)(1) of the ACA requires plans to comply with the annual limit on cost sharing. This requirement applies explicitly to catastrophic plans under section 1302(e)(1)(B), which requires catastrophic plans to provide no benefits "until the individual has incurred cost-sharing expenses *in an amount equal to* the annual limitation in effect under subsection (c)(1) for the plan year" (emphasis added). These requirements make clear that catastrophic plans must comply with the annual MOOP—not a multiple of the annual MOOP as CMS has proposed.

CMS's primary justification for sidestepping this clear requirement seems to be making catastrophic plans more appealing to the kinds of consumers that the Administration thinks should be enrolled in catastrophic plans. However, this is not a justification for

adopting a policy that is contrary to law. CMS is not responsible for ensuring catastrophic plans have high enrollment levels. This is especially true because Congress set narrow eligibility restrictions that were designed to limit, not promote or expand, enrollment in catastrophic plans. Rather, CMS is responsible for implementing and enforcing the law consistent with statutory requirements. It cannot abandon that responsibility to improve the popularity of catastrophic plans.⁸

By failing to consider the impact on consumers and other parties of allowing bronze plans or requiring catastrophic plans to include higher MOOPs, the RIA falls far short of that required by law. Already the MOOP [far exceeds](#) what most Americans [can afford](#) to pay for an unexpected medical bill. Individuals are likely to delay care when they cannot afford the treatment. And, when individuals cannot avoid care, they are likely to face medical bills that they [cannot pay](#), leading to worsening credit scores, and potentially medical bankruptcy. A [wide array of literature confirms](#) that this can be especially true amongst those enrolled in high-deductible health plans. Providers and hospitals who treat such patients are unlikely to get fully paid, increasing the already [high levels of uncompensated care burden](#). Allowing plans to use cost-sharing limits that exceed the statutory limit further exacerbates these problems, but CMS does not appear to have considered these costs.

In addition, as noted previously, the preamble to the rule makes elementary mathematical errors in calculating the higher deductibles proposed for catastrophic plans. CMS claims the new catastrophic deductible would be \$15,400 and \$30,800, when 130% of \$12,000 and \$24,000 are \$15,600 and \$31,200. This again shows a lack of fair and thorough consideration of the impact of the rule and impedes meaningful comments.

CMS should not finalize these proposals. However, if CMS finalizes either proposal it should delay the applicability date. At a minimum, these provisions should not go into effect until the tri-agencies have gone through the notice-and-comment rulemaking process to require such plans to state in the Summary of Benefits and Coverage that enrollees are subject to higher out-of-pocket limits than allowed under the ACA.

⁸ The rule is silent on how this proposal would apply to multi-year plans, but the preamble discussion for multi-year plans refers to the annual limitation on cost sharing, not 130% of the annual limitation. Therefore, we assume that CMS is not proposing the change for multi-year plans. CMS should provide additional clarity and more information, including on the estimated impact of these proposals, to enable an opportunity for meaningful comment on the proposed changes and their potential interactions.

Expanding Eligibility for Catastrophic Plans (Section 155.605(d)(1))

CMS proposes to expand eligibility for catastrophic plans in all states. Specifically, the rule would expand eligibility to everyone with income under 100% or over 250% of FPL. CMS argues that this change will improve access to affordable coverage based on a belief that there are a substantial number of consumers for whom purchasing a metal level QHP relative to a catastrophic plan could cause a financial hardship. CMS should not finalize this proposal because it is (a) contrary to law; and (b) fails to consider the potential harms to consumers. In addition, CMS should revoke the September 2025 guidance that initially introduced the change in eligibility.

The ACA does not provide authority for CMS to create the proposed hardship exemption. In creating catastrophic plans, Congress limited eligibility to three groups: individuals aged 30 or under, individuals who qualify for an “affordability exemption” under section 5000A(e)(1) of the Internal Revenue Code, and those who qualify for a hardship exemption under Code section 5000A(e)(2). Code section 5000A(e)(1) sets forth the specific rules and eligibility criteria under which individuals are permitted to receive the affordability exemption, based on the share of the income they would be required to pay for coverage. Section 5000A(e)(2) limits eligibility for a hardship exemption to individuals who have “suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.” Congress also stipulated that the eligibility criteria for the affordability exemption be indexed to reflect the excess rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

CMS now proposes to create a categorical hardship exemption—and thus provide far expanded eligibility for catastrophic plans—for a tremendous population of individuals based on income alone. Specifically, catastrophic plans would be available to everyone with income that would make them ineligible for either PTC or CSRs. This means everyone with income below 100% of FPL (\$15,650 for a single person) and also everyone with income above 250% of FPL (\$39,125 for a single person). This is a huge group, representing approximately 80% of the adults aged 18-64.⁹ In other words, CMS would replace the statutory affordability standard with its own much broader one, attempting to twist the ACA’s narrow “hardship” exemption criterion to create a parallel insurance market for catastrophic plans that would compete with the metal-level Marketplace plans.

To support the proposal, CMS cites the premium increases that have occurred since 2013, and the degree to which the average premium increase has outpaced inflation

⁹ Urban Institute analysis of the 2024 American Community Survey Data.

and average hourly earnings. But in creating rules for the updating of the affordability standard based on premium changes, Congress explicitly considered and addressed the divergence between premium growth rates and income growth that CMS points to as justification for its proposal.

Congress could have allowed expansive eligibility for catastrophic plans or given HHS the authority to modify the eligibility criteria for the affordability exemption in the ACA. But it did neither. And Congress, as recently as December 2025 considered, but did not enact, changes to broadly expand eligibility for catastrophic plans under the [Health Care Freedom for Patients Act](#) that failed to pass the U.S. Senate. The proposed rule unlawfully attempts to read such authority into CMS's authority to grant hardship exemptions as described in section 5000A(e)(5), and ignores the fact that Congress already narrowly defined who is eligible for an exemption on this basis.

CMS has not provided sufficient policy justification for its proposal, and ignores potential harm.

The affordability challenges in the individual market are real. However, CMS's reliance on the increase in premiums since 2013 is misguided, misleading, and fails to provide sufficient justification for the proposal. It should come as no surprise that premiums in the individual market have jumped significantly since 2013. In 2013, the ACA's core consumer protections were not in place. For instance, individual market plans did not need to cover the EHB or comply with the MOOP limit, and insurers could impose annual or lifetime caps on benefits and underwrite and exclude sick people from coverage. Congress knew a premium jump would occur when it set the eligibility criteria for the affordability exemption and adopted an approach that accounts for growing premiums. CMS also points to the more recent spike in premiums in 2026. There is something deeply ironic in the Administration pointing to this spike, after failing to support the extension of enhanced PTC, and adopting policy changes that have been [widely projected](#) to increase premiums. But, nevertheless, these too get reflected in the statutorily prescribed eligibility criteria for the affordability exemption.

CMS argues that the \$535 average increase in premium from 2013 to 2026 warrants a broad hardship exemption to enroll in catastrophic coverage. CMS assumes that expanding eligibility to enroll in catastrophic coverage will improve affordability for individuals with incomes above 250% FPL. However, CMS has not provided the evidence to support this assumption, and a [recent study](#) strongly suggests the exemption is too broad to achieve its stated goal. The study found that with extremely limited exceptions, the expanded hardship exemption guidance issued in September 2025 did not improve premium affordability for enrollees with incomes between 250 and 400% FPL. For these individuals, net premiums for bronze plans were more affordable than unsubsidized catastrophic plans.

CMS also assumes, without a basis, that the cost of metal-level coverage poses a hardship for everyone who is not eligible for PTC or CSRs based on income. But this is implausible. For example, individuals earning \$400,000 annually face no such hardship.

The proposed rule fails to take into consideration potential increased costs associated with the proposal, as well as consumer harm. Increased enrollment in catastrophic coverage would likely increase premiums¹⁰ for individual market plans of all metal levels. The increases would be substantial if enrollment levels increase by 3 million individuals (the number of additional people that the Council of Economic Advisers (CEA) [estimated](#) would enroll in catastrophic coverage as a result of the September 2025 guidance that this proposal would codify). Even if the CEA estimate is an overprojection (which we believe it is), increased enrollment in catastrophic plans could negatively impact the individual market risk pool and [result in higher premiums](#). Such a premium increase would negatively impact consumers purchasing coverage in the individual market, and it would be felt most acutely by unsubsidized individuals. For employers offering individual coverage health reimbursement arrangements (ICHRA), this policy could result in the employer needing to fund the ICHRA at higher levels for it to qualify as an offer of affordable coverage, and may reduce their employees' purchasing power. Finally, for the federal government, premium increases for metal level plans would increase the amount of federal PTC. Despite these broad implications for premiums and the Marketplace, CMS makes no attempt to project potential enrollment in catastrophic plans or otherwise account for these other predictable effects.

CMS also fails to consider potential negative impacts on consumers who enroll in catastrophic plans for which they are newly eligible. The deductibles on catastrophic plans make accessing benefits nearly impossible for most individuals. As proposed under this rule, catastrophic plans must not provide any benefits for a plan year (with limited exceptions) until the individual pays \$15,600 out of pocket—or \$31,200 for a family. These amounts dwarf the \$535 average increase in premium from 2013 to 2026 and far exceed what most Americans can afford to pay out-of-pocket on medical bills. About half of US adults would [not be able to pay](#) a \$500 out-of-pocket unexpected medical bill.

Being unable to pay out-of-pocket costs can have significant negative ramifications for individuals enrolled in catastrophic plans. About half of adults [enrolled in plans with high out-of-pocket costs](#) report skipping recommended treatments, or not filling prescriptions due to cost, which for many is followed by worsening health problems. In addition, [extensive research](#) has documented that increased cost sharing is associated with worse adherence or discontinuation of treatment. Others proceed with treatment and

¹⁰ Although catastrophic plans are part of the single risk pool, they are subject to a plan-level adjustment that applies only to catastrophic plans, and are separately risk adjusted.

face [medical debt](#) and [worsening credit scores](#). And, when consumers cannot pay, costs can end up being borne by providers and state and local governments in the form of [uncompensated care](#). The proposed rule fails to consider these potential costs.

Lastly, the RIA omits important information that could help stakeholders evaluate the proposal. CMS adopted the proposed approach outside of notice-and-comment rulemaking in states for which CMS processes exemptions at the end of 2025, yet CMS fails to evaluate the impact of this policy change. CMS presents no information regarding changes to enrollment, or other information that stakeholders could use to assess the cost and benefits associated with codifying and expanding the guidance.

Permitting Multi-Year Terms for Catastrophic Plans (Sections 156.130(c) and 156.155(a)(6))

Allowing multi-year catastrophic plans is contrary to law.

CMS proposes to allow insurers offering catastrophic plans to enroll individuals for multiple plan or policy year terms with periods of up to 10 years. CMS should not finalize this proposal, as it is contrary to law in multiple ways and has troubling policy impacts.

The proposal violates statutory requirements for *annual* plan participation and enrollment periods. The statutory framework of the ACA provides individual market plans—including catastrophic coverage—to have one-year coverage periods. Numerous ACA statutory requirements and implementing regulations applicable to individual market coverage function on a calendar year level. These include requirements related to guaranteed availability that mandate annual open enrollment periods; the annual limitation on cost sharing; the definition of plan year equaling a calendar year for all plans that have an annual limit; the medical loss ratio (MLR) rules; risk adjustment; rating rules; and the language creating catastrophic plans (which refers to the “plan year” six times). In addition, there are requirements that do not appear workable if some plans in the individual market are available on a multi-year basis and others are not. For example, how could an insurer comply with the single risk pool requirement that it consider the claims experience of all enrollees in all health plans in pricing its multi-year plans if most of the other plans won’t begin or even be designed until several years later?

The ACA’s requirements regarding eligibility to purchase catastrophic coverage and exemptions from the requirement to maintain MEC also reflect that individual market coverage is available on an annual basis. These provisions further demonstrate that the ACA requires that catastrophic plans are available on an annual, not multi-year basis. Section 1302(e)(2) defines eligibility for catastrophic plans on a plan year basis. Individuals who qualify on the basis of age are only eligible if they haven’t attained the

age of 30 by the *beginning of the plan year*. Similarly, individuals with an affordability exemption under either Internal Revenue Code section 5000A(e)(1) or a hardship exemption under section 5000A(e)(5) are eligible for the plan year in which they have the exemption. Furthermore, section 5000A(e) determines an individual's eligibility for an affordability exemption annually using the required contribution—which is also determined annually—and for a hardship exemption, on a monthly basis. CMS seems to suggest that an individual could enroll in and stay in a multi-year catastrophic plan if they satisfy the eligibility criteria at the beginning of the term, but this is contrary to the plain reading of the statute. Eligibility is established on a yearly basis.

The proposal is unclear, denying a meaningful opportunity to comment. CMS appears to acknowledge that multi-year catastrophic plans cannot legally be exempted from these generally applicable individual requirements in its proposed regulatory text stating that multi-year plans would be required to satisfy “all applicable requirements for health insurance coverage in the individual market.” But CMS entirely fails to explain how these requirements can be reconciled with the concept of multi-year plans. Instead, CMS seeks input from commenters, apparently asking the public to solve what CMS left unanswered.

The failure to address how multi-year plans could comply with statutory and regulatory requirements applicable to the individual market makes it unclear how multi-year plans would function, and it prevents stakeholders from having a meaningful opportunity to comment on the proposed multi-year plan. This information is critical for assessing the costs, benefits, and risks associated with the proposal, as well as for ensuring insurers have clarity regarding how requirements apply to a product that appears to be unlawful. Simply including a list of issues that the agency still needs to work through does not provide the basis for logical outgrowth. We urge CMS to abandon this proposal. If CMS is determined to move forward with the proposal, we strongly encourage CMS to re-propose the proposal with additional detail to satisfy the agency's obligations to offer an opportunity for public comment under the Administrative Procedure Act.

Proposals regarding the annual limitation on cost sharing for multi-year plans are also contrary to law.

Under the ACA's definition of catastrophic plans, such plans must provide no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation on cost-sharing (often referred to as the MOOP, as noted above) in effect for the plan year, with limited exceptions enumerated in statute. The statutory language is unambiguous, and yet the proposed rule offers multiple proposals regarding the application (or non-application) of the annual limitation on cost sharing that ignore the plain reading of the statute. These are contrary to law and should not be finalized.

CMS’s proposal to allow multi-year catastrophic plans to cover benefits that use value-based insurance design (VBID) before enrollees satisfy their deductible or annual cost-sharing limitation is contrary to law. ACA section 1302(e) generally prohibits catastrophic plans from providing coverage before the enrollee meets their deductible or MOOP, “except as provided for in section 2713,” which requires all plans to cover preventive services without cost-sharing. Section 2713(c), in turn, authorizes the Secretary to develop guidelines to permit group health plans and health insurance insurers offering coverage in the group or individual market to use VBID designs. CMS seems to rely on the reference to section 2713 in the language creating catastrophic plans in combination with the language in section 2713(c) to provide broad authority for the Secretary to overrule normal plan design rules and allow multi-year plans to cover VBID benefits pre-deductible. But this greatly overstates the authority conferred. Section 2713(c) cannot be interpreted to “provide for” pre-deductible coverage. CMS cannot use its authority to develop market-wide permissive standards to instead modify the statutory definition of catastrophic coverage.

CMS’s proposals regarding how multi-year plans may apply the annual limitation on cost sharing over the contract term are also contrary to law, for several reasons.

First, CMS proposes that multi-year catastrophic plans have the option to apply the annual limitation on cost sharing for each plan year of the contract on an annual basis, or, on average, over the life of the contract. Although it is not entirely clear from CMS’s proposal, we assume this would allow insurers to apply the aggregate amount of the annual limitation for the duration of the plan term, such that the enrollee would not receive any benefits (except for those specifically identified in the rules) before incurring cost sharing expenses equal to the annual limitation multiplied by the number of years in the contract term.

Exacerbating the lack of clarity provided by CMS, we note that the proposed rule is inconsistent in how it describes this proposal. Some passages indicate that the plan would need to take into account the annual limitation for each plan year the multi-year plan covers, but other passages and the proposed regulatory text suggest the insurer could apply the annual limitation applicable for the initial year for each year of the term. This lack of internal consistency makes it challenging to understand what CMS is proposing such that CMS should not finalize these proposals because the agency has not provided stakeholders with a reasonable opportunity for public comment. While we need additional information to offer robust comments on either proposal, we are concerned about both potential policy options.

Clearly, neither option is permitted under the ACA. ACA section 1302(c) sets forth the requirements for the “*annual* limitation on cost-sharing” (emphasis added). The plain

reading of the statute, indeed the only reading of the statute, is that these limits apply on an annual basis. Allowing an insurer to stack multiple annual limitations together clearly violates the ACA. By allowing insurers to apply cost sharing limits in ways that do not comport with ACA section 1302(c), the proposal would permit plans that do not provide EHB as provided for under section 1302(a), in violation of Public Health Service Act (PHS Act) section 2707(a).

In addition, section 1302(e) of the ACA provides that catastrophic plans must provide “no benefits *for any plan year* until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect...*for the plan year*” (emphasis added). Again, there is no ambiguity. The annual limitation must apply every plan year. Yet, under CMS’s proposal, if an enrollee in a 10-year plan with a front-loaded aggregate annual limitation incurs cost-sharing expenses equal to the aggregate annual limitation before the final year(s) of the contract, then the plan would provide benefits for the remaining year(s) without the individual needing to first satisfy an annual limit for those plan years. This is plainly not a viable read of the statute. CMS does not have discretion to allow insurers to apply the annual limitation on cost sharing for each plan year of the contract on average, over the life of the contract.

The version of the proposal that allows the insurer to use the annual limitation *for the initial year* contains the same legal flaws, as well as two additional legal problems. First, section 1302(e) requires the benefits only be covered after the individual has incurred cost sharing expenses equal to *that year’s* annual limitation. It does not permit the use of a different year’s annual limitation. Thus, using the initial year’s annual limitation is contrary to the statute. Second, because the MOOP grows each year, CMS’s proposal would permit multi-year plans to cover benefits before the MOOP is met for all years after the initial plan year. This, too, is contrary to the statutory requirements for catastrophic plans.

CMS also discusses the possibility that a plan, under its proposal, could require enrollees to meet one-twelfth the annual limitation per month, prior to the plan paying benefits. While we appreciate that this would make benefits more accessible to enrollees, it does not comport with the requirements of ACA section 1302(e), as it would allow insurers to cover benefits in a plan year prior to the enrollee incurring expenses equal to the annual limitation.

CMS also states that insurers would be able to vary the annual limitation “by disease...so long as the average over all plan participants and over years of the annual limitation on cost sharing equals the average [over the term of the contract] of the annual limitation on cost sharing.” This is blatantly inconsistent with the law. It would violate statutory prohibitions on discrimination on the basis of health status. Also, varying the annual limitation on cost sharing by plan participant is inconsistent with the

very definition of “plan” under section 144.103, as the cost-sharing structure would differ from enrollee to enrollee.

Furthermore, mathematically, there is no way that a plan could vary the annual limitation for cost-sharing for any given year by disease, participant, or other factor and achieve an average equal to the annual limitation on cost sharing, unless the plan applies a higher than permitted annual limitation on cost sharing in some years and a lower limit than the annual limitation on cost sharing for other years. Yet, this is inconsistent with the statutory requirements for catastrophic plans, as well as the requirements regarding annual limitation on cost sharing.

If the proposal were implemented, multi-year plans would harm enrollees and negatively impact the individual market and health care providers.

Apart from significant legal concerns with the multi-year proposal, we also have deep policy concerns.

The RIA falsely asserts that the proposal would maintain “the EHB and consumer protections required under the Affordable Care Act.” Consumers who enroll in multi-year catastrophic plans would be at increased financial risk due to the proposed application of annual limitations.

The risks and harms associated with enrolling in plans with increased cost-sharing liability are discussed at length in our comments related to hardship exemptions. However, here the potential negative harm to consumers would be magnified, given the illegal options offered to insurers in how they apply the MOOP. Consumers enrolled in coverage that applies cost sharing limits in excess of the statutorily allowed amount are more likely to be unable to pay medical bills, resulting in providers not being paid. This is likely to have a negative impact on providers at a time when providers are also facing [significant financial challenges](#) due to the passage of H.R. 1, and also on state and local governments, which both run many hospitals and also help pay for [uncompensated care](#). CMS fails to take these negative effects into consideration in the RIA.

CMS raises the possibility that consumers would be “locked into multi-year catastrophic plans.” This is alarming. The annual open enrollment period exists for a reason. Individuals should be free to shop for new coverage that reflects their needs and priorities each year. An annual enrollment opportunity is not unique to the individual market: people with job-based coverage and Medicare can also seek out different coverage options each year.

We also question the legality of forcing enrollees to stay in a multi-year plan. But, if individuals cannot be forced to stay in coverage—which we believe to be the case—it is entirely unclear how CMS can assume that insurers would have an incentive to invest

more in health promoting activities, nor is it clear why a multi-year plan offers more benefits that ensuring a smooth auto-reenrollment process.

CMS also appears to suggest that an insurer could discontinue a multi-year product, which could leave an individual with no coverage after having paid thousands towards the multi-year MOOP. Only in rare cases, such as bankruptcy, are insurers permitted to discontinue coverage mid-year. Regulators typically go to great lengths to avoid mid-term discontinuations due to the negative impact on enrollees, as well as the disruptive impact on the market. Such discontinuations are disruptive for enrollees too, who—if they are lucky enough to enroll in new coverage through an SEP—are faced with re-setting accumulators, changing networks, and other burdens to accessing care under their new plan. For a multi-year plan with a larger than legal MOOP, a plan discontinuation could leave the enrollees having paid enormous sums towards their MOOP, only to lose coverage as they near a point where the plan finally pays benefits. If CMS cannot guarantee that insurers can be required to honor multi-year contracts, CMS should take into account the negative impacts on consumers of mid-term discontinuations and not finalize the proposal.

Allowing plans to vary the annual limitation on cost sharing by disease and participant would open the door to exactly the types of discrimination and cherry picking that the ACA sought to end. It would allow insurers to design plans that are highly unattractive to sicker people, or people who the insurer otherwise sees as undesirable. This would in turn lead to adverse selection in the metal-level tiers and greater risk segmentation, which could increase premiums for enrollees purchasing metal-level tier coverage (including for individuals with ICHRAAs). If CMS is determined to finalize this proposal, CMS should make clear that insurers are prohibited from varying MOOP by disease or participant.

Even though CMS relies on section 2713(c) as the statutory basis of its proposal around VBID, the agency fails to provide insurers with guidance on how to utilize VBID. This lack of guidance would enable insurers to label as VBID benefits that are intended to cherry pick healthier individuals. To the extent that the allure of these so-called VBID benefits causes healthier enrollees to switch from metal-tier coverage, this could increase the premiums for metal-tier coverage and destabilize the market.

CMS's assumptions regarding administrative savings to insurers are flawed. As pointed out earlier in this letter, individual market requirements apply on an annual basis. Multi-year plans are not exempt from these requirements. Insurers would still need to comply with annual plan document preparation and filing, annual rating requirements, and annual enrollment activities. In addition, the insurers would have the additional burden of navigating how annual requirements apply to multi-year plans.

Although we agree with CMS that there is significant uncertainty regarding the impact of multi-year plans (in no small part due to the paucity of detail regarding how such plans would comply with individual market requirements), if such plans enter the market, they are likely to primarily attract healthy individuals. As discussed further in our comments regarding the proposed plan-level adjustments, we are concerned about the effect that this would have on the stability of the individual market, as well as the cost of premiums for metal-level plans.

Permitting Plan-Level Adjustments for Multi-Year Catastrophic Plans (Section 156.80(d)(2)(ii))

CMS proposes to amend the single risk pool rules to allow insurers of multi-year catastrophic plans to make plan-level adjustments to the index rate that reflect the length of the entire term. CMS further proposes that such plan-level adjustment would account for benefit design characteristics of such plans, such as their deductible and out-of-pocket cost structure, and would need to be actuarially justified. CMS seeks comment on whether a separate plan level adjustment based on term length should be permitted for multi-year catastrophic plans, and whether and the degree to which the risk profile of multi-year catastrophic plans that are otherwise identical to single year catastrophic plans would justify plan-level adjustments over and above those that would be made to account for the different features of such plans.

CMS should not finalize a plan-level adjustment for multi-year plans, for several reasons.

The change is unnecessary, for several reasons. First, the current rules already allow insurers to apply a plan-level adjustment that reflects the AV and cost-sharing design of a plan, which would already account for multi-year catastrophic plans' unusual deductible and MOOP structure.

Second, CMS has not articulated a reason why any other multi-year plans' benefit characteristics might justify a plan-level adjustment.

Third, insurers of multi-year plans will need to set premiums for multi-year plans on an annual basis to comply with statutory requirements, obviating the need for a plan level adjustment that accounts for the length of the term. We note that the rule seems to suggest that insurers *may*, but wouldn't be required, to change pricing each year for multi-year plans. However, this contradicts CMS's own rules that require insurers to calculate an index rate on an annual basis. The index rate must be based on the total combined claims costs for providing the EHB within the single risk pool of that State market and will therefore change every year. Thus, it cannot be correct that multi-year plans could set premiums for the full term length, unless insurers of multi-year plans are

presumed to be exempt from single risk pools rules. But that is not a supportable reading of the ACA's single risk pool requirements, nor one that CMS attempts to make.

Fourth, CMS should not allow insurers to use a plan-level adjustment that accounts for the risk profile of multi-year catastrophic plans. To do so would be contrary to the intent of the single risk pool rules in the ACA and would fundamentally undermine the community rating requirements. The ACA requires that insurers consider all enrollees in all health plans offered by such insurers in the individual market to be members of a single risk pool. Allowing a plan-level adjustment that reflects the risk-profile of multi-year plans would essentially allow an insurer to treat each multi-year catastrophic plan as its own risk pool. However, the statute is clear: individual market enrollees in all health plans must be part of the same risk pool. Lastly, we note that the single risk pool rules already allow a plan-level adjustment for catastrophic plans that reflects the expected impact of the specific eligibility categories for those plans.

The RIA is completely silent on the impact of the proposed plan-level adjustment.

The RIA for the proposed amendments to sections 156.130 and 156.155 state there is “uncertainty regarding how premiums would be structured for multi-year catastrophic plans,” but nowhere does the RIA discuss the impact of the proposed plan-level adjustment. We assume CMS proposed the plan-level adjustment in order to allow insurers to price multi-level catastrophic plans lower than the premium that would otherwise result under the single risk pool rules.

While the current plan level adjustment for catastrophic plans likely has minimal impacts on the premiums for plans at other metal levels due to the low level of enrollment in catastrophic plans, both the existing plan level adjustment and the proposed new plan level adjustment could lead to increased premiums for plans offered at other metal levels, particularly if enrollment in catastrophic plans increases to [3 million](#), as projected by the White House Council of Economic Advisors. The regulatory impact must consider the potential impact on consumers enrolling in all metal levels of coverage, as well as the potential for increased PTC payments, in the RIA. CMS's failure to address the impact of this proposal in the RIA prevents stakeholders from providing meaningful comment on this proposal.

For these reasons, CMS should not finalize this proposal.

Comment Solicitation on Risk Adjustment for Catastrophic Plans

In light of the proposal to codify expanded eligibility for catastrophic plans, CMS seeks comment on whether the agency should retain separate risk adjustment transfer calculations under the State payment transfer formula for individual catastrophic plans and individual non-catastrophic plans or whether state transfers should be calculated for all plans in the individual market together.

We believe more study of whether and how to combine risk adjustment for catastrophic and non-catastrophic plans is warranted. CMS proposes significant changes to the eligibility criteria for catastrophic plans, as well as design options. Yet the effects of these changes on the individual market, specifically the premiums of metal-plans sold in the individual market, is [unclear](#) given uncertainties about how risk adjustment would apply to catastrophic plans.

If enrollment in catastrophic plans grows at the levels anticipated by [The Council of Economic Advisers](#)—which doesn’t account for additional growth potentially arising out of the availability of multi-year plans—maintaining separate risk adjustment transfer calculations is likely to increase premiums for metal-level plans, and reveal distortionary impacts associated with having separate risk adjustment programs that may be less evident based on current enrollment numbers. CMS should model the effects of combining the risk adjustment transfer calculations and provide stakeholders with an opportunity to comment prior to making any changes.

If CMS finalizes its proposal for multi-year catastrophic plans, CMS should modify the risk adjustment program to account for such plans. The existing risk adjustment methodology is built on assumptions that would not or may not be true for multi-year plans. For example, it seems likely that the risk adjustment methodology’s assumptions regarding plan liability would not hold true for multi-year plans, particularly if the insurer has opted to aggregate the MOOP. In addition, the risk adjustment program is based on plans with a single year term, not multi-year. How would the transfer formula need to be adjusted if some plans are multi-year, of varying year durations? Currently the methodology takes into account partial year enrollees. Should it similarly account for enrollees who enroll in multi-year plans for less than the full plan duration? We urge CMS not to finalize this proposal. But if CMS finalizes the proposal, it should delay the applicability date of the changes until it has modified the risk adjustment program through notice and comment rulemaking to account for such plans.

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

CMS proposes to encourage the certification and sale of “non-network” health plans in the Marketplace. Such plans do not maintain a network of contracted providers that agree to accept the plan’s payment for services as payment in full. Instead, non-network plans determine what they will pay for services; if a provider wishes to be paid more than that amount, the plan enrollee is financially responsible for paying the balance.

Unfortunately, the proposed rule does not provide sufficient clarity about the standards for non-network plans to be certified, marketed, and sold on the Marketplace for us to fully evaluate or comment on the concept. However, from what we can discern, the certification of non-network plans appears to be contrary to law. In addition, based on

CMS's representations of how it would work, it appears that, if finalized, non-network plans would leave consumers facing unexpected and high charges for critical services and prescription drugs. These plans could also significantly destabilize the Marketplaces and leave millions of Marketplace enrollees with fewer, and more expensive, coverage options.

The ACA requires certified Marketplace plans to have a network.

While the ACA does not explicitly state that Marketplace plans must maintain a network of contracted providers, several provisions make clear that a network is required for the statutory structure to function:

- Section 1311(c)(1)(B) requires Marketplace plans to ensure a “sufficient choice of providers (in a manner consistent with applicable provisions under section 2702(c) of the PHS Act, which, in turn, provides rules for insured health plans that include a provider network). Section 1311(c)(1)(B) also requires Marketplace plans to “provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers.” This was a key basis for CMS regulations in the 2024 NBPP, which CMS now proposes to reverse, requiring all Marketplace plans to use a network of providers.
- Sections 1311(c)(1)(C) requires Marketplace plans to “include *within their provider networks* essential community providers (ECPs) that serve predominantly low income, medically underserved individuals.” (emphasis added) This clearly contemplates that enrollees’ access to ECPs must be through a provider network, which CMS accepted in its 2024 NBPP requiring all Marketplace plans to maintain provider networks.

Further, it is not clear that non-network plans can meet ACA marketwide standards, including:

- Section 2713 of the PHS Act, which prohibits insurers from imposing any cost-sharing for recommended preventive services;
- Section 2707 of the PHS Act, which requires individual market plans to cover the EHB; and
- Section 1302 of the ACA, which states that a plan does not cover the EHB package until the plan limits cost-sharing to the annual MOOP costs, as defined in section 1302(c).

The Departments of Health and Human Services, Labor and Treasury (the Departments) have never issued regulations addressing how non-network plans can comply with these standards. Given that non-network, reference-based plans cannot guarantee an individual’s out-of-network costs won’t exceed the MOOP or that an enrollee won’t face out-of-pocket costs when they receive preventive services, it is

questionable whether such plans remain legal, much less eligible to be certified as a QHP. At a minimum, CMS should delay finalizing the proposal, until the Departments have issued notice and comment rulemaking ensuring enrollees in non-network plans are assured the same consumer protections afforded under the ACA as consumers in other individual market plans.

CMS's proposed regulatory framework for non-network plans is unworkable

In reversing its stance here, CMS argues that it has now developed an “effective, administrable approach” to measure whether non-network plans can ensure a “sufficient choice of providers.” But this is simply not possible. Without a network, no plan can maintain a stable list of providers who accept their payment as payment in full, which makes it impossible either for the plan to guarantee or the regulator to ensure that enrollees would ever have a sufficient choice of providers, nor to determine whether the available choices meet any standard of sufficiency. Under CMS's proposed framework, non-network plan enrollees would inevitably be exposed to unexpected, unlimited balance bills for everything from preventive services to hospitalizations, rendering other statutory ACA protections useless.

Under this proposal, non-network plans would be allowed to participate in the Marketplaces simply by stating that they have identified an “assessed percentage” of available providers within the plan's service area that accept the plan's payment amount as payment in full. Notably, the proposed regulatory framework does not specify any minimum assessed percentage that would meet the ACA's requirement that Marketplace plans provide a “sufficient choice” of providers, nor does [CMS contemplate](#) that plans would have to report the actual percentage of providers that agree to accept their payment as payment in full. Under this proposed framework, then, it would be entirely up to the non-network plan insurer to determine how many providers would constitute a “sufficient choice” of providers needed to meet the ACA's certification requirements. On the other hand, CMS proposes to require non-network plan insurers to demonstrate that at least 20% of ECPs in their service area have agreed to accept their payment as payment in full.

The proposal also contemplates the barest minimum of regulator oversight, simply asking plans to attest, through “[yes or no](#)” statements, that they have processes and methodologies in place to:

- Conduct “continuous” outreach to available providers to determine whether they would accept the plan's benefit amount as payment in full;
- Make payment amounts available to the public, including plan enrollees, potential enrollees, and providers, in an easily accessible and understandable format;
- Determine benefit amounts;

- Provide consumer-facing information about potential balance billing scenarios and expected out-of-pocket costs;
- Offer an exceptions process for enrollees who cannot find providers willing to accept the payment amount as payment in full; and
- Provide a customer service or online provider directory assistance resource to help enrollees and potential enrollees to find providers who will accept the plan's payment amount as payment in full.

CMS estimates that certifying a plan's compliance with the above standards would demand 30 seconds to one minute for each question, for a total of 6 minutes per insurer. Such a minimalistic certification process cannot possibly give the Marketplace, or state regulators, sufficient information to adequately assess whether these plans can meet the minimum statutory criteria for Marketplace certification. A non-network plan simply cannot guarantee that any provider, including ECPs, will accept its payment as payment in full, without a written contract. Even if the plan can identify providers who provide such an assurance at a given point in time, they have no way to ensure, even through "continuous" outreach, that those providers will continue to honor it. Without a contract, a provider could agree to accept a plan's payment as payment in full on a Monday morning and decide by Monday afternoon they need a higher payment, leaving the patient with a large and impossible-to-plan-for balance bill.

Even if a state or Marketplace wanted to hold non-network plans to a stricter compliance standard by taking steps to verify that a "sufficient" number of providers accept the non-network plans rates, there is no good data source or source of truth for states or Marketplaces to consult to verify plans' statements. Comprehensive information on providers' billed charges is not publicly available. States and Marketplaces would be unable to verify that providers would accept the non-network plan's payment in full. Furthermore, it's implausible that the plan could (a) accurately determine the billed charges of providers; and (b) guarantee a sufficient number of providers with whom they have no contractual relationship will accept their payment as payment in full. Even if an insurer has previously paid claims for items or services billed by a provider, the insurer cannot be sure that the provider would accept that same rate as payment in full in the future.

The proposed rule also provides no framework for how a non-network plan would comply with the ACA's requirement that all Marketplace plans be accredited with respect to performance on "clinical quality measures, such as the Healthcare Effectiveness Data and Information Set [HEDIS]...as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access...." It is far from clear how a health plan without contracted providers would obtain the information necessary to assess performance on clinical quality, to ensure provider compliance with credentialing standards, or meet

accreditors' network adequacy and access standards. CMS acknowledges a similar concern with respect to risk adjustment data validation: without a contract with providers, how will plans obtain enrollee medical records from providers, as required to participate in this process? CMS provides no answer and instead asks for comment on this issue.

Under a plain reading of the statute, plans without a network simply cannot meet the ACA's minimum statutory criteria for Marketplace participation.

CMS's proposal to allow certification of non-network plans is too vague to provide meaningful comment.

In addition to proposing a framework for non-network plan certification that is completely unworkable, CMS's proposal provides no information on how, exactly, a non-network plan could ensure compliance with other important insurance standards and consumer protections under the ACA. For example, the proposal does not provide information on how non-network plans would comply with the ACA's mandate that they cover recommended preventive services, without enrollee cost-sharing, when such plans have no contracts with preventive services providers.

Further, the proposal does not explain how enrollees in non-network plans would access the protection of the ACA's required annual cap on MOOP. In the case of non-network plans, it appears that non-network plans could consider literally all services to be out-of-network, such that enrollees' potential spending to pay those balance bills would be unlimited. CMS's proposal does not explain how consumers would be able to ascertain, in advance of enrollment, that they would lose access to this critical financial protection if they sign up for a non-network plan.

CMS argues in this proposed rule that plan enrollees will be able to "negotiate prices among available providers to find a provider who will accept the plan's benefit amount as payment in full." Here, the agency leaves unaddressed such critical questions as how non-network plans would protect enrollees from balance billing for health care services that are not reasonably shoppable, such as non-elective procedures, non-emergent services that must be performed rapidly, or for services for which there is limited provider choice. Nor do they address how the insurers of non-network plans would protect patients who are very sick or otherwise unable to engage in one-on-one price negotiations with providers. Ironically, this is the same agency that has [delayed for over four years](#) implementation of the statutory mandate to provide plan enrollees by January 1, 2022 with an Advance Explanation of Benefits (AEOB), which, if ever implemented, has the potential to provide patients with a useful tool to assess their potential out-of-pocket financial liability prior to receiving a health care service.

The proposed rule also doesn't address the reality that care encounters often include multiple providers within a facility. For care provided in a facility such as a hospital, the patient cannot be expected to negotiate the price for their care not only with the hospital, but with each physician or billing health professional they encounter, for each health care service they receive. As CMS is well aware from its effort to implement the No Surprises Act good faith estimate requirements, it is extremely difficult to coordinate cost estimates amongst multiple providers. Recognizing the challenges that providers face in producing a cost estimate that includes all provider and facility fees an individual would face during a care encounter, CMS has issued [indefinite enforcement relief](#) to providers regarding its good faith estimate requirements. CMS couldn't possibly believe that it's reasonable to expect a patient to collect this information—much less negotiate after receiving the information—when providers working within the same system haven't been able to.

The proposed rule raises numerous additional, unanswered questions. Without provider contracts that “lock in” a negotiated price for the contract term, would enrollees be expected to negotiate prices each time they need a new or recurring service from the same provider? What if they are incapacitated or unconscious? Would enrollees have to negotiate prices for every item or service they receive? And, how likely is it that the same providers who accept the plan's payment as payment in full for one service, also accept it for the other services a patient would use in the same episode of care? Further, some non-network plans in the market today (i.e., Sidecar) provide enrollees with plan-issued credit cards. Would the Marketplace establish any limits on the interest rate on health care charges the plan doesn't pay or is slow to pay?

The proposed rule fails to take into account the realities of health care delivery in the U.S. CMS' proposal does not address the burden on providers, should enrollment in non-network plans grow. Most providers are staffed and equipped to negotiate prices with insurance companies, but not to engage in one-on-one price negotiations with individual patients. The likely result is not that providers will hire new staff to conduct those negotiations. Rather, most providers will either refuse to deliver non-emergency services to patients enrolled in a non-network plan or present them with a take-it-or-leave-it price that would result in many forgoing needed care.

This proposal further fails to recognize the unequal bargaining position between providers and patients. Some providers may be willing to negotiate with patients only over services for which the demand is elastic and refuse to negotiate when they know the service is necessary and the patient has no other option. In a country where the vast majority of provider markets are considered [highly concentrated](#), this latter scenario could be a common occurrence.

Non-network plans raise quality and population health concerns, to the extent enrollees must pick and choose the services they use, based on whether and to what extent they can successfully negotiate a price in advance rather than what is clinically appropriate or necessary. This will result in many patients failing to adhere to prescribed treatment plans, resulting in poorer health outcomes. Further, as noted above, due to non-network plans' inability to guarantee access to \$0 preventive services, enrollees will be disincentivized from seeking preventive care and engaging in health promotion activities, achieving exactly the opposite result of the goals expressed in [CMS' Strategic Direction](#).

The rule is also unclear about how consumers would know whether they are signing up for a non-network plan. Does CMS contemplate that these plans would be offered side-by-side with network plans? How would these plans be differentiated from network plans, such that consumers fully understand what they are purchasing? If a consumer enrolled in a non-network plan and wished to switch to a network plan due to the impossible-to-anticipate financial liability for health care services, would they be given a special enrollment opportunity to switch to a network plan? None of these issues is addressed.

If implemented, non-network plans would hurt consumers and destabilize the Marketplaces at a time when insurers are still assessing the full effect of dramatic federal policy changes.

Without a contracted provider network ensuring access to affordable care, non-network plans would likely have a lower cost structure than network-based plans, allowing them to set much lower premiums and undercut the pricing of network plans, a likelihood CMS acknowledges in its proposal. This would result in a lower premium for the silver benchmark plan in the markets where such plans are offered, which would, in turn, greatly reduce PTC generosity for all subsidized Marketplace enrollees.

A recent [analysis by Wakely Consulting](#) further raises the prospect that non-network plans could be at greater risk of insolvency than traditional Marketplace players. If non-network plans are priced aggressively low, as Sidecar's off-Marketplace offerings were in 2022 and 2023, they could generate significant risk adjustment liabilities that their revenue from new enrollees may not adequately account for. The offering of such plans would place new burdens on state regulators to monitor these plans to ensure they have sufficient reserves and financial capacity to pay their risk adjustment charges.

Because non-network plans will attract primarily young and healthy enrollees, plans with a network would be left with a sicker mix of enrollees. Although non-network plans would likely need to pay into the ACA's risk adjustment program as a result of their healthier mix of enrollees, the program is an imperfect one and cannot fully compensate network plans for the inevitable adverse selection. This would harm

consumers with pre-existing conditions, who could not safely gamble on a non-network plan and would be left paying more for a conventional plan.

More broadly, non-network plans would create market upheaval and instability at a time when Marketplace insurers are already grappling with the consequences of dramatic policy changes, such as the expiration of the enhanced PTCs and new limits on eligibility and enrollment as a result of H.R. 1. Marketplace insurers are quickly approaching state deadlines for determining whether and where they will participate, and how to set their prices. Injecting an entirely new product into the Marketplaces with unknown implications for enrollment and morbidity could result in significant premium increases by network-based plans, and potentially decisions by some carriers to pull back on their participation or even exit the market. Such actions would hurt not just Marketplace enrollees, but also unsubsidized individuals and individuals with ICHRAs shopping for coverage.

Reducing Oversight of Plan Network Adequacy (Sections 155.1050 and 156.230)

The ACA requires Marketplace insurers to ensure that their plan networks include “a sufficient choice of providers.” Under current CMS rules, this certification standard requires plans in the FFM to ensure that enrollees can access providers within a maximum period of time or distance, within their service areas. They must also ensure that enrollees do not have to wait more than a prescribed period of time before they can obtain covered health care services from any given provider. For SBMs and SBM-FPs, current rules require that they maintain quantitative time and distance standards that are at least as stringent as those prescribed by the FFM. They must also conduct reviews of each plan’s compliance with those standards, prior to certifying them for Marketplace participation.

In this proposed rule, CMS would eliminate the requirement that SBMs and SBM-FPs maintain standards at least as strong as the FFM’s. The agency would also allow FFM states to take on the responsibility of network adequacy review and oversight, rather than CMS, if they can demonstrate that they have an “Effective Provider Access Review Program.”

We are concerned that this proposal, if finalized, would weaken the standards, review, and oversight of Marketplace plans’ network adequacy. Many Marketplace plans come with narrow provider networks. According to [one analysis](#), 23% of Marketplace enrollees are in plans that include only 25% or fewer of the physicians in their area. While a narrow network plan does not necessarily mean that the plan has an inadequate provider network, a [recent survey](#) of Marketplace enrollees finds that one in five (20%) report that a provider they needed was not covered by their insurance and nearly one in four (23%) reported that a provider listed as part of their plan network did not have

appointments available. And indeed, [a GAO report](#) found that 243 of 375 plan insurers on the FFM didn't comply with network adequacy standards in place for the 2023 plan year.

Since 2023, CMS has attempted to improve the FFM's network adequacy standards by expanding its review of plan network adequacy and establishing quantitative time, distance, and wait time standards. It also required SBMs and SBM-FPs to establish quantitative time and distance standards at least as stringent as those required in the FFM, and to conduct quantitative network adequacy reviews to assess compliance, prior to certifying a plan for Marketplace participation. This proposed rule represents a reversal of CMS's efforts to improve enrollee access to in-network provider services, delegating primary responsibility for setting standards and compliance oversight to states.

Eliminating the federal floor would likely reduce network adequacy standards.

[Studies have found](#) that there is a wide diversity among states in their laws and processes for regulating network adequacy, and many state regulatory agencies lack authority and capacity to conduct effective pre-marketing compliance reviews. Although we strongly support the establishment of state-level standards and oversight processes that respond to the local topographical and health care needs of state residents, it is critical that the FFM provide a minimum floor of network adequacy protection. Although the proposed rule would require FFM states to maintain a network adequacy standard that is "consistent" with federal standards, the proposed regulatory language suggests states could meet that test without requiring plans to meet quantitative time or distance standards. We urge CMS to clarify that, at a minimum, FFM states must maintain quantitative time, distance, and wait time standards to facilitate the use of geomapping and other regulatory tools to meaningfully measure a plan's compliance, prior to certification. Without CMS establishing a minimum standard and conducting pre-certification oversight, the result in many states is likely to be lowered standards and reduced compliance, placing consumers at risk of reduced access to in-network providers. We urge CMS not to finalize this proposal.

A reduction in network adequacy standards is likely to impede ICHRA adoption.

In evaluating whether to adopt ICHRAs, employers consider the options their employees would have if purchasing coverage through the individual market, including through the Marketplace. For many employers, [a key deterrent to ICHRA adoption is the narrowness of network for Marketplace plans](#) compared to group plans. Loosening QHP certification network adequacy standards while also beginning to certify non-network plans would likely make it even harder for employees with ICHRAs to find plans with satisfactory networks, and further limit ICHRA uptake.

Any change in standards should be accompanied by transparency and public input. If the agency does move forward with its abdication of federal responsibility over Marketplace plan network adequacy, then we encourage the agency to require—and for itself to maintain—the strongest possible transparency and opportunity for public input into the determination of whether a state has and can maintain an Effective Provider Access Review Program. This should include, at a minimum:

- Public descriptions of, and an opportunity for, public comment on whether and how an FFM state’s provider network access standards are consistent with current federal time, distance, and wait time standards;
- Public-facing information about the insurers who have requested exceptions to any network adequacy standards and the state’s determination of whether or not to grant the exception;
- Public-facing information about consumer complaints about network access and inaccurate or out-of-date provider directories, as well as data on whether and how those complaints have been resolved;
- Public-facing information about state requests for exceptions to the standards for becoming an Effective Provider Access Review Program, as well as information about CMS’s determinations to grant such exceptions, and the proposed timeline for the state to demonstrate that it will meet the standards for becoming an Effective Provider Access Review program.

Relaxing Standards and Oversight for Access to Essential Community Providers (Sections 155.1051 and 156.235)

CMS proposes to scale back requirements that Marketplace plans contract with a minimum number of essential community providers (ECP) within their service areas. The ACA requires Marketplace plans to include ECPs in their provider networks in order to ensure that low-income and medically underserved enrollees have access to critical care, including preventive health screenings, family planning, immunizations, and behavioral health services. Under current rules, Marketplace plans must contract with at least 35% of available ECPs in their service areas, and separately, at least 35% of available federally qualified health centers (FQHCs) and at least 35% of available family planning providers within a plan’s service area. CMS would reduce those thresholds from 35% to 20% for both Marketplace plans and stand-alone dental plans in FFM states.

CMS would also weaken the oversight that ensures that insurers comply with even these lowered standards, proposing to remove requirements for insurers that cannot meet the threshold to provide justification for, and documentation of, their efforts to contract with ECPs in their service areas. It would further delegate the responsibility of

assessing compliance to regulators in the FFM states, if they can demonstrate that they maintain an “Effective Essential Community Provider Review Program.”

The proposal would harm consumers, especially vulnerable populations, and safety net providers. If finalized, this proposal would greatly reduce access to ECPs. This would disproportionately harm low-income and medically underserved individuals who would face reduced access to providers, longer wait times, and disruption in services as they lose access to providers they currently see. The reduction in access to ECPs would fall most hard on communities of color, which already face [significant barriers in access to care](#). For example, Black women experience higher rates of diabetes, hypertension, and sexually transmitted infections than white women. In 2022, [infant mortality rates were 4.9%](#) for Hispanic, 9.1% for American Indian/Native Alaskans, and 10.9% for non-Hispanic Blacks, compared to 4.5% for non-Hispanic whites. Reducing access to ECPs for these populations would likely exacerbate these disparities.

Enabling insurers to reduce the number of ECPs with whom they contract is likely to increase uncompensated care costs for these safety net providers. These providers are trusted by the communities they serve, and many patients would continue to seek care from them, even though the provider would no longer be reimbursed by the insurer. This would lead to higher uncompensated care costs to both states and providers, and narrower margins for these critical safety net providers.

The proposal would make it easier for insurers to avoid compliance. Consumers are [increasingly frustrated](#) with health insurance companies that prioritize profits over patient care. In this context, it is troubling to consider removing accountability measures that ensure that insurers comply with ECP standards. It is even more troubling that CMS has proposed to defer to states when CMS itself recognizes that these reviews are complex and require significant capacity and resources that “may not be readily available to states.”

For these reasons, we urge CMS not to finalize this proposal.

Provisions that Make Coverage Less Affordable

Reducing Access to Covered Benefits by Narrowing the Scope of Essential Health Benefits (Sections 155.170, 156.111, and 156.115(d))

The ACA requires non-grandfathered individual and small-group market plans to cover, at a minimum, a package of benefits referred to as the “essential health benefits” (EHB). If states require insurers to cover benefits “in addition to EHB,” then they must defray

the cost of these benefits. Additionally, ACA section 1302(b)(4)(G) requires that the HHS Secretary “periodically review” the EHB and assess whether benefits need modifications or updating based on whether “enrollees are facing any difficulty accessing needed services for reasons of coverage or cost” and to “account for changes in medical evidence or scientific advancement.” The Secretary must also inform Congress on how the EHB “will be modified to address any such gaps in access or changes in the evidence base.”

In implementing the ACA, the Secretary [established a regime](#) that largely delegates to states the responsibility to define and update what specifically constitutes EHB in the state. States were given the option to adopt an EHB-benchmark plan that all insurers must refer to in determining the scope of benefits covered for ACA-compliant individual and small-group market plans.

In [subsequent rulemaking for plan year 2019](#), CMS granted states greater flexibility to update benefits in their EHB-benchmark plans and laid out a process for states to seek CMS approval for such updates on an annual basis. So long as any added benefits meet two actuarial tests—(1) the scope of benefits is equal to a “typical” employer plan and (2) the scope of benefits falls under a “generosity” threshold—the state does not have to defray the cost of changes to its benchmark plan.

[CMS rulemaking for plan year 2025](#) provided further clarification of the 2019 policy. CMS affirmed that benefits in the EHB-benchmark plan, once approved by CMS, are considered EHB and there is no requirement for states to defray their cost. CMS provided that this would be the case even if the state had separately mandated coverage for the benefit.

CMS is now proposing to reverse this policy, eliminate this clarity, and require states to either repeal or defray the cost of certain state mandated benefits, even though the agency has previously approved many of those benefits as part of the state’s EHB benchmark plan. The language of the proposal is not entirely clear but, as we interpret it, it would repeal only the clarifications CMS provided to states beginning in 2025; the additional flexibility granted to states in the 2019 NBPP would remain in place. If CMS intends the proposed rule to apply more broadly and to be even more disruptive to long settled expectations about the rules that apply to EHB benchmark plans, we would need far more information in order to meaningfully comment. In any event, we have concerns about the proposed reversal of CMS’s 2025 policy. As drafted, it is likely to create significant confusion for states, upend actions taken in reliance on current rules and regulations, and place plan enrollees at risk of coverage gaps and increased financial risk when they seek needed services.

In reliance on CMS’s 2019 policy, [12 states](#) have sought, and CMS has approved, updates to their EHB benchmark plans. Although states had flexibility under the 2019

rules to reduce the benefits covered by their EHB benchmark plan, all states have used the benchmark updating process to expand or clarify the covered benefits. State [officials have reported](#) that these benefit changes were made, consistent with the ACA's section 1302(b)(4)(G), to address gaps in access and changes in medical evidence. Added benefits have included coverage for hearing aids and the treatment of diabetes, temporomandibular joint disorder, and periodontal disease. In addition, many states have used the benchmark update process to bolster their response to the nation's opioid epidemic, requiring coverage of medications that treat opioid use disorder and/or reverse overdose. Four states have added coverage of non-opioid pain treatments, such as acupuncture and nonopioid pain medications.

Under the proposed rule, CMS would require states to defray the cost of any benefit if it

- was mandated by the state after December 31, 2011, through a state action other than setting the EHB-benchmark plan;
- applies to the small-group and/or individual insurance markets;
- is specific to required care, treatment, or services; and
- is not required to comply with federal requirements.

CMS notes that states can avoid a defrayal obligation by either repealing the benefit mandate or by exempting Marketplace health plans from the mandate. If states are unable to make such a change, states may be forced to defray the cost of care even though it is considered part of their EHB benchmark plan.

In making this policy change, CMS would be exposing states to new financial liabilities, after those states made changes to their benchmark plans in reliance on CMS policy. Further, CMS is proposing to require states to undertake defrayal in plan year 2027. However, in [7 states, legislatures are not in session](#) in 2026; in 23 states, legislatures are scheduled to adjourn by April 30, 2026. Given that this rule is unlikely to be finalized much before then, it will be difficult or impossible for many states to avoid a new, unexpected defrayal obligation, if one exists, by repealing or amending benefit mandates—or in the alternative, to appropriate funds to satisfy a defrayal obligation. Finalizing the proposal would put states in an untenable position.

Further, requiring states to repeal existing benefit mandates, many of which were enacted in good faith reliance on CMS rules and regulations, would expose plan enrollees to additional financial liabilities and reduced access to care.

We urge CMS not to finalize this proposal. At a minimum, if this proposal is finalized, states should be provided with at least an additional two years (to plan year 2029) to undertake the extensive effort necessary to assess what, if any, mandates could be subject to defrayal, the costs associated with such defrayal, and to either repeal or amend relevant existing laws or regulations.

Requiring Additional Reporting Related to CSR Loading and Narrowing Flexibility on Loading Rules (Section 154.215)

CMS proposes to greatly expand the information collected from Marketplace insurers as part of annual rate filing justifications, asserting that this information is needed to better understand CSR loading practices, how they relate to insurers' costs under CSRs, and associated effects on PTC spending. CMS indicates that it would use this information to help ensure that CSR loading practice is "calibrated on actual experience and...only accounts for the projected revenue loss of unreimbursed CSR payments without materially exceeding that amount."

CMS should avoid implementing a rule that broadly reduces consumer affordability. The debate about CSR loading practices is a complicated one, with arguments traded about federal cost, state autonomy, and price equilibriums. In considering these factors, we urge CMS to prioritize consumer affordability as it implements new rules. As CMS notes in the rule, CSR loading practices currently vary across states, with different practices leading to different levels of loading and thus different effects on consumer affordability. As CMS implements a new policy, it should prioritize preserving and supporting affordability for consumers.

CMS should consider ways to make data collection less expensive. CMS concedes that collecting the data would be extremely costly for insurers: \$419 million in the first year and \$209 million per year after that. Insurers would be expected to pass this cost along as higher premiums to consumers and to the federal government in the form of higher PTC. CMS should consider ways to make it less costly.

CMS should delay the provision to give insurers time to prepare for the data collection and avoid piling on during a time of substantial market turmoil. While this proposal would be costly at any time, it would be especially costly—and may be infeasible—on the timeline that CMS proposes. The proposal requires insurers to submit, as part of their rate filing justifications for 2027, detailed information about claims in 2025, including how they were affected by CSRs. This will require pulling up and analyzing historical information that was not coded or stored with this requirement in mind. CMS claims that insurers can do this because their systems were set up to make this possible when CSR payments were being made. But there are new insurers in the Marketplace since 2017, and others may have changed their systems or no longer have staff trained on the historical systems. Thus, this reporting may be infeasible. Starting with data from plan year 2027 or 2028 would enable insurers to build systems to tabulate this information as claims are processed. Even a one-year delay, to start with 2026 data, might help mitigate some of the costs and burdens of this proposal.

In addition, this is an especially unsettled time for insurance markets given the recent expiration of the PTC enhancements, enormous changes enacted in H.R. 1, other

regulatory changes, and ongoing litigation. The disruption and uncertainty likely contributed to unusually high premium increases for 2026. Given the additional changes afoot and ongoing uncertainty, CMS should consider these burdensome new requirements at a later date.

CMS should avoid mandating loading rules that treat states differently based on their practices to date. As CMS notes in the rule, CSR loading practices currently vary across states, with different practices leading to different levels of loading and thus different premium differentials between silver plans and gold or bronze plans. State variation is not new: states have varied in their approaches since federal officials stopped making CSR payments to insurers in 2017. CMS asserts that its proposal would create more uniformity in these practices. Yet its proposed standard tied to experience with CSR costs in prior reference years could have the opposite effect, locking in different practices across states. That’s because the intensity of loading in the reference year (2025 under the proposal) affects enrollment choice in a way that’s self-reinforcing. If a state loaded intensively in the reference year, silver enrollment would be more heavily concentrated among high-CSR recipients, which means the experience would show higher CSR costs. If a state loaded less intensively in the reference year, more non-CSR recipients would enroll in silver, depressing the CSR cost. As a result, if loading is required to reflect historical CSR cost experience, then states that loaded intensively will generally be permitted to continue to do so, while states that didn’t won’t. This lock-in would be inequitable across states. And it would prevent the operation of market competition from determining new equilibrium price levels. To avoid these disparities and market distortions, CMS should permit states to use rules that permit premiums to reach an actuarially justified equilibrium.

CMS should avoid rules that violate the prohibition on setting rates based on enrollee experience. While it is unclear whether or not CMS is proposing a change to how it interprets its single risk pool regulations in 45 CFR 156.80, CMS’s preamble language about calibrating CSR loading to “actual experience” raises concerns that CMS may be pushing for practices that would set rates for silver plans based on the claims experience of the covered population, rather than all enrollees in the single risk pool. Both the ACA’s rating rules and CMS’s regulations implementing them and the single risk pool requirement generally prohibit insurers from considering the experience of the enrolled population in setting rates for a particular plan. Rather, rates must reflect the claims experience of the single risk pool overall. Requiring rates to be set based on the two-year-old experience in a specific plan would violate these rules. In addition, in applying 45 CFR 156.80, we urge CMS to recognize that using experience alone as the basis for projecting CSR costs for the future plan years would not be actuarially sound.

CMS should honestly analyze policies’ effects on consumer affordability and avoid the misleading focus on silver premiums. One unfortunate feature of ongoing

debates about CSR loading is misleading language about the effects of silver loading. Opponents of silver loading often boast that eliminating it would [reduce](#) silver [premiums](#). But this is quite misleading: ending silver loading would, in fact, broadly increase the premiums consumers pay. That's because reducing on-Marketplace silver premiums [reduces the PTC](#), which increases net prices for many consumers. And because off-Marketplace silver coverage is generally unloaded, reducing on-Marketplace silver premiums doesn't have a lot of benefit for unsubsidized consumers. As a result, limiting silver loading would reduce overall consumer affordability and [coverage](#). If CMS considers further action in this space, it should be clear and transparent about these tradeoffs and recognize that the primary effect on consumers of reining in silver loading would be to raise the premiums that people pay.

Other Provisions

Ensuring Consumer Consent to Enrollment and Limiting Improper Marketing (Section 155.220(j))

CMS proposes to require agents, brokers, and web-brokers (referred to here collectively as “brokers”) in the FFM to use a CMS-created and approved consumer consent form for all Marketplace enrollments. Further, the agency would require brokers to show that their clients have reviewed and approved their application information as accurate. The proposed rule also lists certain marketing practices that would be prohibited for brokers in the FFM, many of which are common misleading advertising types on social media platforms.

We support CMS's efforts to prevent unscrupulous brokers from enrolling consumers into Marketplace health plans without their consent, and to crack down on deceptive marketing practices. We believe that these actions, combined with CMS's [July 2024 action requiring a 3-way call](#) with the Marketplace before a new broker can change an enrollee's existing plan and recent clarifications of CMS's authority to pursue actions against fraud or misconduct [directed or facilitated by broker agencies](#) and the [standard of proof for assessing brokers' misconduct](#), are important steps forward in fraud prevention and broker accountability.

We do wish to flag, however, the internal inconsistency within this rule. In proposing to require that brokers use a standardized consumer consent form, CMS observes that the use of non-standardized consent forms unique to a specific broker “can sometimes be complicated or difficult to follow for consumers, leading to potential consumer harm.” CMS appears to have no such concern in its proposal to eliminate the use of standardized plans in the FFM, even though the myriad features of a health plan (i.e.,

premium, deductible, coinsurance, copayments, network, formulary, etc.) are arguably far more complicated and difficult to parse for consumers than a simple consent form.

We applaud CMS's proposal at section 155.220(j)(3)(v) to make brokers "responsible to ensure that all marketing-related materials" produced "on their behalf" adhere to the new marketing restrictions. However, it is not clear whether this responsibility extends to misleading ads or call center scripts used by lead generators and field marketing organizations that provide leads and consumer contact information to brokers. We urge CMS to clarify that brokers will be responsible for ensuring adherence to marketing standards not just for their own materials, but also, if they are relying on lead generators or field marketing organizations, to those entities as well.

In addition, we believe there is more CMS could do to fully protect consumers from unscrupulous broker activity. For example:

- CMS should provide an exceptional circumstances SEP, beginning when a consumer learns that he or she has been improperly switched to a new plan, to enroll in the plan of their choice.
- CMS should continue to ensure that consumers are held harmless for any APTCs paid towards a plan for which their consent to enroll cannot be documented.
- CMS should work with participating insurers to stop payment of broker commissions on enrollments where consumer consent cannot be adequately documented.
- CMS should share information about troubling patterns of broker behavior with state insurance regulators prior to the final adjudication of a case. While we recognize that the details of an investigation cannot be made public, state insurance regulators are responsible for the licensure of brokers within their states. Therefore, regulators can and should be important partners with CMS in protecting consumers from broker misconduct.
- CMS should conduct consumer testing on its consent form and scripts.

Additional Guidance Could Strengthen Impact of QHPs' Quality Improvement Strategies (Section 156.1130)

The ACA requires that plans must have a quality improvement strategy (QIS), as described in section 1311(g)(1), to be certified as a QHP. Quality improvement strategies are defined as payment structures that provide increased reimbursement or other incentives for implementing activities related to (1) improving health outcomes; (2) preventing hospital readmissions; (3) improving patient safety and reducing medical errors; (4) promoting wellness and health; and (5) reducing health and health care disparities. Under current guidance, CMS requires QHP insurers to report information

regarding their QIS strategies related to (5) and any one of the other four topics of their choosing. CMS now proposes to abandon the requirement to report on QIS strategies related to reducing health and health care disparities and to instead require QHP insurers to submit QISs addressing any two of the five areas. In addition, CMS explains that insurers have significant latitude in how they implement and report on QISs, including having the discretion to select what quality measure or performance targets to use.

CMS justifies this approach by arguing that the proposal empowers insurers to focus resources on areas with the greatest potential for meaningful improvement, that it supports innovative strategies for improving patient outcomes, that it encourages the adoption of best practices and helps ensure incentives are aligned with measurable progress on priority health outcomes. However, we are concerned that the flexibility instead makes it too easy for QHP insurers to manipulate this QHP certification requirement. Insurers are likely to report on QISs that present the QHP insurer in the best light. They are more likely to target the lowest hanging fruit, rather than systemic problems that warrant more attention. This will not further CMS's goals of encouraging the adoption of best practices, nor will it help with the identification of successful strategies. Requiring QHP insurers to report on health and health care disparities removed some of insurers' ability to pick and choose among QISs, and therefore we do not support the proposal to allow QHP insurers to report on any two categories of QIS. Instead, we urge CMS to continue to take steps to standardize the reporting requirements around QISs to minimize gaming by insurers.

Comment Solicitation on Adjustments to MLR Standards for a State's Individual Market (Part 158)

CMS solicits comments, but does not propose changes, regarding whether and how to amend the MLR regulations to adjust the federal MLR standard in the individual market, under the authority provided in section 2718(b) of the PHS Act, in states that do not request such an adjustment. Under section 2718(b)(1)(A), states may by regulation impose higher MLR standards than the default 80% in the individual and small group markets and 85% in the large group market. However, section 2718(b)(1)(A)(ii) permits the HHS Secretary to "adjust such percentage with respect to a State if the Secretary determines that the application of such 80% may destabilize the individual market in such State." Section 2718(d) clarifies that this Secretarial authority over the individual market extends to cases where volatility is due to the establishment of an SBM.

HHS's authority to unilaterally adjust the MLR threshold is statutorily limited. The comment solicitation appears to contemplate a policy that would give HHS significant discretion to adjust the MLR threshold. The proposed rule suggests that HHS could use the authority to stabilize the market, to lower premiums, and to address market

consolidation. Such wide latitude is not supported by PHS Act section 2718. The statute permits HHS to adjust the percentage in a given state only “if the Secretary determines that the application of such 80% may destabilize the individual market in such state.” While we applaud CMS’s efforts to promote market stability, adjusting the threshold is *only* permitted if the standard MLR threshold is itself destabilizing the market. Given that the same MLR threshold has been in place in every state since the introduction of the ACA’s MLR standard, including during periods of significant [market stability](#) and the establishment of the Marketplaces in 2014, it is unclear why CMS believes the MLR threshold could be destabilizing the market. Indeed, CMS has not presented any evidence of this. To the contrary, many of the policies CMS is considering in this proposed rule would themselves introduce market instability, as we have pointed out in this letter.

Authorizing HHS to unilaterally adjust MLR raises important federalism considerations that an actual proposal would need to address. If CMS decides to move forward with rulemaking in this area, CMS must ensure the agency complies with [Executive Order \(EO\) 13132](#) on Federalism, which requires agencies to consult with State and local officials before taking any action limiting the policymaking discretion of states. CMS should consult with the National Association of Insurance Commissioners (NAIC) prior to proposing amendments to Part 158.

EO 13132 also directs that “national action limiting the policymaking discretion of the States shall be taken only where...the national activity is appropriate in light of the presence of a problem of national significance. Where there are significant uncertainties as to whether national action is authorized or appropriate, agencies shall consult with appropriate State and local officials to determine whether Federal objectives can be attained by other means.” EO 13132 further directs that agencies “encourage States to develop their own policies...[and,] where possible, defer to the states to establish standards.” In direct contravention to EO 13132, CMS appears to be considering a policy that would give the agency the ability to unilaterally adjust the MLR in a specific state. This suggests (though CMS has not presented evidence for it) that CMS has identified a problem that exists in some states. Yet, a problem in some states does not equate to the presence of “problem of national significance.” In such a case, EO 13132 directs agencies to instead work with states to attain policy objectives through other, state-directed means.

Lastly, we note that it is unclear why CMS believes it is better positioned to adjust the MLR threshold in a particular state than the state itself. As CMS itself stated in the [original MLR rules](#), “only the State commissioner has knowledge of all insurers’ experience and market conduct in a state.” In the original rules, CMS stated its agreement with the NAIC that “the threshold consumer protection is ensuring a health insurance company is solvent.” But, CMS lacks visibility into the solvency of insurers in

a state's market, raising questions about how the agency could be better positioned to evaluate market stability than a state entity.

Interested parties need additional detail to provide meaningful comments.

We recognize that the discussion in the proposed rule is a comment solicitation and not intended to provide sufficient detail for the agency to have logical outgrowth to finalize regulations. Nevertheless, we note that there are key details missing from the discussion that would be necessary to ensure stakeholders are able to provide meaningful input. For example, it is unclear from the comment solicitation whether CMS is interested in raising or lowering (or both) the MLR threshold in certain states. It is also unclear whether CMS is also considering adjusting the MLR standard in all states that have not requested an adjustment. CMS should also provide additional detail on other details, such as factors CMS would look to in determining that the MLR threshold of 80% is contributing to market instability, how CMS would determine at what level to adjust the MLR threshold, the degree of state involvement, and the potential impact on premiums and consumers. Given recent concerns about the potential for [consolidated health care systems](#) to blunt the impact of the MLR program, we encourage CMS to specifically address how it would take into consideration market consolidation in a state market.

Comments on Procedural Issues under the Rule

The proposed rule suffers from several problems of administrative procedure and law that, individually and together, deny the public a meaningful opportunity to comment. These problems must be addressed before the rule can be finalized.

The rule fails to provide readily available information that is directly relevant to understanding the proposals. As noted above, the rule fails in numerous places to provide data that are clearly relevant to understanding the proposals and that CMS has access to. For example, CMS certainly has the data that would inform the public's understanding of the risk profile of individuals who lose coverage under DMI and FTR policies. Yet it does not reveal this information. Instead, it repeatedly claims generally that its proposals are supported by "analysis" without citing specific data, sometimes citing generally to "public use files." (Indeed, as noted above publicly available data and data from SBMs often indicate the opposite of what CMS claims.) Withholding this information on which CMS purports to rely denies the public a reasonable opportunity to comment.

The public comment period is too short to provide meaningful comments—especially given the request for detailed comments on analytical claims—and should be extended. CMS provides an unusually short comment period for the rule, despite its great complexity. The comment period is just 30 days from when the rule was published in the *Federal Register* (February 11, 2026) to the deadline on March 13. The short comment period is especially troubling because of CMS’s request for comments on the methods and results in the RIA. Such analysis requires detailed modeling work, which is impossible in the timeframe provided. CMS should extend the comment period, providing a minimum of 90 days from the announced extension. Some of the proposed changes would be difficult for Marketplaces, state insurance regulators, and insurance companies to comply with in the timespan contemplated, especially given the near certainty of litigation that will further delay clarity about the rule. To the extent the proposals in this rule are finalized, CMS should delay many of the proposed effective dates to provide a longer implementation runway.

Sincerely,

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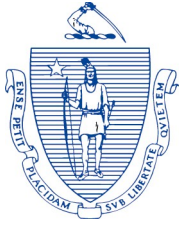
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March 13, 2026

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Re: Notice of Proposed Rulemaking, “Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program” (Published in Federal Register Volume 91, Number 28, page 6292 on February 11, 2026)

Dear Secretary Kennedy:

The Massachusetts Health Connector (“Health Connector”), a State-based Exchange (“Marketplace” or “SBM”) authorized under the Patient Protection and Affordable Care Act of 2010 (“ACA”), and the Massachusetts Division of Insurance appreciate the opportunity provided by the Department of Health and Human Services (HHS) to comment on the proposed Notice of Benefit and Payment Parameters (NBPP) for 2027.

Founded in 2006 as part of bipartisan state health reform, the Massachusetts Health Connector is the longest-running SBM in the country. The Health Connector is designed to connect Massachusetts residents and small businesses with high quality, affordable health coverage and to promote universal health coverage in the Commonwealth. Today, the Health Connector provides non-group health coverage to over 351,000 individuals and small group coverage to nearly 15,000 small business employees from more than 2,400 small businesses. In parallel, the Division of Insurance monitors health insurers across fully insured markets, working with stakeholders and agencies, to advance our goals of affordability. Our combined

efforts have contributed to the Commonwealth's status as one of the healthiest states in the nation,¹ with a nation-leading health insurance rate of 98 percent,² and average Marketplace premiums that are among the lowest-cost in the country in 2026.³

The Health Connector and the Massachusetts Division of Insurance share CMS's goals of providing quality coverage, minimizing administrative burdens, advancing program integrity, addressing affordability for all Massachusetts residents including the unsubsidized population, preserving state flexibility, and maintaining a stable and robust insurance market. However, several of the strategies CMS proposes would negatively impact these shared goals rather than advance them. We respectfully offer comments on the proposed rule sections that would have the greatest impact on enrollees, SBMs, and the Massachusetts merged commercial individual and small group insurance market.

These comments generally fall into three main categories:

1. **Supporting State Flexibility to Develop Solutions that Address the Unique Needs of their Residents and Markets:** We share CMS's goal of preserving and enhancing flexibility among SBMs to implement data-driven approaches to meet the unique needs of their local markets and residents. However, some of the proposed changes will eliminate that flexibility which has enabled Massachusetts to achieve historic rates of uninsurance, high value coverage, and stellar program integrity results.
2. **Impractical Timelines for Implementation, Increasing Risk of Adverse Outcomes:** The provisions detailed in this rule are impractical to implement according to the proposed effective dates, on top of an already full release schedule for our technical and operational systems, particularly given the late arrival of this annual NBPP and extensive implementation activities already underway as a result of the "Working Families and Tax Cut" (WFTC) Act, also referred to as the "One Big Beautiful Bill Act" (OBBBA).
3. **Harm to the Risk Pool and Increases in Premiums:** The proposed rule will cause harm to the Massachusetts merged market risk pool and result in premium increases for all market segments, including the unsubsidized population.

¹ See <https://wellbeingindex.sharecare.com/interactive-map/?defaultState=MA, State Rankings | 2025 Annual Report | AHR>

² Center for Health Information and Analysis (CHIA) 2025 Massachusetts Health Insurance Survey (MHIS), at <https://www.chiamass.gov/massachusetts-health-insurance-survey>.

³ Kaiser Family Foundation analysis of data from Healthcare.gov, state rate review websites, and state plan finder tools, at <https://www.kff.org/affordable-care-act/state-indicator/marketplace-average-benchmark-premiums/>

Supporting State Flexibility to Develop Solutions that Address the Unique Needs of their Residents and Markets

SBMs must be empowered to implement innovative, data-driven approaches to meet the unique needs of their residents and markets. This flexibility enables long-standing SBMs like the Massachusetts Health Connector to preserve historic achievements in providing affordable commercial market coverage to Massachusetts residents in partnership with the federal government, while ensuring program integrity, high-value plans for all market segments, and market stability. We thank and applaud CMS for recognizing these shared values of State flexibility and innovation in past rule making and in some sections of the proposed 2027 NBPP. States continue to be best suited to understand the unique aspects of their local markets and avoid the unintended consequences of policies that may be a good fit for the FFM given its unique policy and operational context but not necessarily for all SBMs.

Massachusetts does not experience the challenges that CMS describes within the FFM. In fact, the Health Connector's careful, long-standing approach to program integrity has affirmatively prevented those exact challenges from emerging in the first place. If such solutions are universally applied to SBMs in a one-size-fits-all fashion, it would worsen the Health Connector and Division of Insurance's ability to reach the shared goals of providing high-value plans to all, including the unsubsidized population; advancing program integrity; and protecting the stability of our merged market risk pool. We appreciate the instances in which CMS does provide SBMs with flexibility, for example, FTR implementation for 2027; the ability to not use agents, brokers, or web-brokers in the individual market; network adequacy standards; and the ability to set our own Medical Loss Ratio (MLR).

The Health Connector engages in robust program integrity activities to prevent improper enrollment and to ensure people meet eligibility requirements for the coverage in which they enroll. Massachusetts does not experience the same program integrity challenges that CMS describes as occurring within the FFM or via agents and brokers. Instead, many of CMS's proposals to address improper enrollments and fraud in the FFM would have the opposite of the intended impact here in Massachusetts. We agree with CMS's assertion that SBMs "do not all face the same problem in regard to unauthorized enrollments." In particular, the Health Connector does not use brokers or web-brokers for individual coverage or allow enhanced direct enrollment websites to enroll residents. We carefully considered and assessed how direct enrollment and enhanced direct enrollment would impact the market and proactively made the decision to not to pursue these options explicitly due to concerns about negative impacts to program integrity and the risk of misuse of taxpayer resources. Massachusetts residents looking to enroll in Health Connector coverage must apply directly through the Health Connector's portal and may access help from certified Assistors and Health Connector call center agents. Assistors and call center agents undergo robust and continuous training to assist individuals and only act with explicit individual consent. To date, out of the more than

1,266,000 people that have enrolled in Health Connector coverage since 2014, the Health Connector has received zero complaints or reports about fraudulent or unauthorized activity by Assistors, or that members were unaware of their coverage and suspected fraudulent enrollment.

We are deeply committed to preserving program integrity to ensure that member data is secure and that health insurance eligibility, including the allocation of premium tax credits and state subsidies, are awarded correctly. In Massachusetts, we offer additional state premium subsidies and cost sharing reductions as a part of our ConnectorCare program. To be eligible for ConnectorCare, one must first be eligible for federal premium tax credits. Thus, we share CMS's goal to safeguard program integrity related to eligibility, and depend upon confidence in the measures in place to ensure that eligibility is conducted accurately so that state dollars are used appropriately and efficiently to support access to affordable coverage to those who are eligible.

Our careful attention to program integrity has resulted in several years of no findings on financial audits, programmatic audits, and compliance reviews conducted by CMS and the IRS. Like other SBMs, the Health Connector regularly undergoes intense and comprehensive reviews, audits, and evaluations by different state and federal agencies and offices. In addition, our robust outreach to members through carefully designed education, notices, and public webinars ensures that members and applicants maximally understand the responsibilities associated with enrolling in Marketplace coverage, including keeping information up to date and reconciling tax credits received as part of their annual tax filing.

Impractical Timelines for Implementation, Increasing Risk of Adverse Outcomes

Many of CMS's proposals include impractical timelines for implementation, threatening program integrity and increasing risks associated with hasty implementation. The Massachusetts Health Connector shares an integrated eligibility system with MassHealth, our state's Medicaid program, which requires detailed and deliberate coordination between both agencies any time a new policy requiring system changes occurs. Any system changes require careful integration approximately a year in advance of planned technical releases. The Health Connector and MassHealth, the state Medicaid agency, are already engaged in significant systems changes as a result of the OBBBA legislation referenced in the proposed rule, with upcoming implementation dates for several provisions across Medicaid and Marketplace changes starting in August 2026, to prepare for Open Enrollment 2027. These changes include community engagement requirements and six-month renewals in Medicaid as well as eligible noncitizen changes that have different effective dates across Medicaid and Marketplaces. Adding modifications to income inconsistencies for 2027, in particular, would be challenging to add to an already full schedule.

The Health Connector takes very seriously applicant and enrollee experience, program integrity, and system accuracy. It generally takes about a year for a high priority item to be carefully planned and implemented into the integrated eligibility system, ensuring proper testing to avoid adverse outcomes. The current technical release schedule is already full as we seek to carefully implement provisions required by law from the OBBBA legislation. These provisions require extensive system changes. Adding new requirements on top of the already full technical release schedule will put the Commonwealth's integrated eligibility system at risk of adverse outcomes.

In addition, the late release of the proposed NBPP this year significantly adds to the operational burden and unworkable timeline of the proposed rule. Typically, the NBPP is issued in the fall and finalized in early spring to give insurers, states, and other stakeholders time to understand, adjust to, and implement the rules for the next year.

The late release of this proposed rule, coupled with eligibility system changes already well into development for Open Enrollment 2027, particularly at a time when Marketplaces (perhaps particularly those with integrated systems they share with Medicaid programs) are already managing extensive system changes in response to OBBBA, makes new implementation activities especially difficult to add to the queue without adding significant risk for adverse outcomes.

Harm to the Risk Pool and Increases in Premiums

Policies impeding and delaying enrollment in the Massachusetts merged market, especially those with the effect of reducing enrollment in the subsidized population, will have a negative impact on market stability, increase premiums for all market segments, including the unsubsidized market and the small group market, and increase federal per-enrollee spending. Since 2007, Massachusetts has maintained a merged market, a unique market structure that combines the individual and small group markets. In 2019, former Governor Baker authorized a Merged Market Advisory Council (MMAC)⁴ to analyze market stability and cost drivers in the merged market for individual and small employer health coverage in Massachusetts. The MMAC's final report provided data-driven insights on the health of the Massachusetts merged market based on independent actuarial analyses.⁵ Notably, one of the key findings of that report is that ConnectorCare, the Health Connector's flagship program in which qualifying low- and moderate-income residents up to 300 percent of the federal poverty level (FPL) can access coverage with state and federal subsidies, contributes positively to the risk pool.⁶

⁴ The Council was comprised of 13 members, chaired by Commissioner of Insurance, and included leaders, experts and stakeholders with experience in and knowledge of the health insurance industry, including carriers, brokers, actuaries, and individual purchaser representatives, as well as persons representing the business community, including representatives of employers and small businesses.

⁵ <https://www.mass.gov/merged-market-advisory-council>

⁶ Note, the 300 percent FPL eligibility for ConnectorCare was at the time of that report. ConnectorCare eligibility in 2026 is up to 400 percent FPL.

The independent actuarial analyses conducted as a part of the above-mentioned report found that the subsidized population in Massachusetts's ConnectorCare program plays a crucial role in stabilizing the Commonwealth's risk pool and in ensuring unsubsidized individuals have the opportunity to participate in a large, stable market with lower premiums than they otherwise would experience. Throughout this comment letter, our agencies detail how certain provisions in the proposed rule would worsen the risk pool by creating barriers to coverage for a large portion of the individual market, disproportionately impacting younger individuals and those who have historically had lower-than-average medical expenses. If lower cost enrollees lose coverage, thereby leaving the risk pool, it will likely increase premiums for *everyone*, including the unsubsidized population and small groups. Additionally, policies that destabilize the market will unnecessarily increase premiums and federal APTC dollars leading to an increase in per-enrollee costs for the federal government. These pressures will erode the Commonwealth's lowest-in-the-nation uninsured rate and raise costs for Massachusetts families and small businesses.

The Health Connector and Massachusetts Division of Insurance respectfully offer the following comments on specific provisions of CMS's proposed rule that would have the most significant impact on members, SBMs, and the state's insurance market.

GUIDANCE ON PRE-ENROLLMENT VERIFICATIONS

The pre-enrollment verification requirement of Section 71303 of the OBBBA will require significant systems and operational changes and will benefit from state flexibility in designing approaches to achieve its aims. The specific implementation requirements for this law remain unknown at this time, resulting in the Health Connector needing to consider a range of possible implementation approaches based on the language in the OBBBA. The new pre-enrollment verification policy touches multiple aspects of the process of applying for and enrolling in Marketplace coverage, will require significant investments of time and money to implement, and could result in considerable member abrasion and delayed and forgone care if not done thoughtfully, which could have broader implication for our health care system and the functioning of the insurance market. The Health Connector is pleased to provide CMS with some of the considerations that have arisen as staff have begun assessing an approach for pre-enrollment verification.

The requirement of pre-enrollment verification will significantly alter the flow of eligibility, shopping, payment, and enrollment functions in Massachusetts and nationwide, resulting in back-end systems changes to long-standing functionality to operationalize the new requirements. These back-end system changes will require additional Marketplace and vendor staff time to develop, review, and modify the updated requirements, to implement code changes and configuration changes, and to review test cases to ensure the system is functioning as intended. This requires many months of lead time, prior to these changes going

live in the system. The Health Connector is already considering the resource needs for this to be implemented by August 1, 2027, but has limited guidance at this time to appropriately scope the release and allocate staffing needs.

To ensure accurate implementation without risks, CMS guidance is needed now. Such guidance should be accompanied by appropriate flexibility for SBMs that promotes program integrity, while recognizing the value in SBM innovation and flexibility to build off decades of robust and secure eligibility and verification processes to ensure effective implementation and limit the risk of errors. We further ask that any comment period on pre-verification enrollment regulations be at least a typical 60-day long comment period and not the minimum 30-day period so that we can provide meaningful feedback and ensure implementation is feasible and accurate. According to Regulations.gov, the federal website facilitating regulatory publication and comment, “in a typical case, an agency will allow 60 days for public comment.”⁷ An agency typically tailors the comment period to reflect the breadth and depth of the substantive issues raised by the proposed rule. The complexities raised by the pre-verification enrollment process, independent of other proposals that might be issued along with it, necessitate a 60-day window to ensure CMS receives the thoughtful responses it aspires to obtain when putting a rule out for comment.

Pre-enrollment verification will add complexity and volume to downstream processes, including noticing and enrollment. The content and timing of member notices will need to be updated to accurately convey to members the new process to enroll in coverage. This will require additional Marketplace staff time to develop the updated content, additional vendor staff time to update the logic and text in the notices to reflect the reordered process, and corresponding testing to ensure the notices are generated as expected. These changes will include updates to notices related to eligibility sent during renewals, eligibility approval notices any time someone reports a change throughout the year, special enrollment period (SEP) verification notices, and data matching inconsistency (DMI) notices and reminders. These will require additional costs and time for notice translation to ensure members can receive these communications in their preferred language.

Delaying enrollment into a QHP with APTC will lead some people to drop out of coverage entirely, increasing premiums, and worsening the risk pool. Keeping as many people as possible covered in Massachusetts is critical to support a strong merged market risk pool and to prevent premium increases for everyone in the market. In Massachusetts, we have observed that people who auto-enroll and auto-renew and people who are in subsidized Health Connector coverage have lower risk scores. This helps to keep our merged market risk pool stable and premiums lower. If these individuals drop out of coverage due to administrative burdens, our risk pool will worsen and premiums will increase.

⁷ <https://www.regulations.gov/learn>

Analyses of total medical expenses of more than two million member months of 2024 claims data suggest that individuals who auto-renewed for Health Connector coverage and never subsequently shopped were lower cost than those who shopped for coverage during Open Enrollment 2025. In addition, the state's Merged Market Advisory Council (MMAC) found that enrollees in ConnectorCare, the state's flagship program that combines state and federal subsidies for people under 300 percent FPL, had the lowest proportion of members with claims over \$5,000.⁸ Additionally, the risk scores for non-ConnectorCare individual market members were over 30 percent higher than the risk scores for ConnectorCare members.

Given CMS's request for input on the "required timelines to comply with the law" and the clear complexity and cost of implementing this provision, we strongly recommend that CMS consider strategies for phased implementation of the pre-enrollment verification policy to enable Marketplaces sufficient time to implement these complex changes. We appreciate that CMS plans to issue regulations, guidance, technical assistance, and educational materials in the future to facilitate implementation of these provisions. However, we need that guidance now. Given the level of disruption associated with these changes, the complexity of processes that will result, and the lack of timely guidance, CMS should provide states with broad flexibility in designing and implementing these changes, including considering phased implementation and delayed enforcement.

CMS should identify and prioritize policies that enable consumers to easily access and maintain the coverage that they are eligible for. Such strategies should reduce the burden on consumers and streamline the application process to improve accurate program determinations, reduce the amount of time it takes to enroll in coverage, and eliminate unnecessary costs to individuals and the system. To reduce unnecessary delays in coverage effectuations, CMS should support state flexibility and encourage innovations in the approach to reliable verifications, particularly strategies that support positive outcomes among applicants and enrollees such as promoting continuous coverage. CMS should advocate for more data sources to be included in the federal data services hub to promote greater program integrity and enable more applicants and members to have their applications for coverage verified electronically by reliable data sources. We also recommend that CMS develop guidance that ensures members do not experience a reset of deductibles and maximum out of pockets if they enroll in a qualified health plan without subsidies for a short period of time and then later enroll in a plan with subsidies based on these new rules.

INCOME VERIFICATION RULES

The Health Connector opposes CMS's proposal to eliminate Marketplaces' acceptance of income attestation when the IRS cannot verify household income because this is an issue

⁸ Note, ConnectorCare is up to 400 percent FPL in 2026.

with IRS data. Individuals and families should not have to face extra administrative burdens because of issues with the IRS's data (§155.320(c)(5)). Individuals and families should not have to experience burdensome, unnecessary, and costly consequences to correct for IRS data challenges. The Health Connector experienced a 40 percent reduction in income inconsistencies after implementing changes to consider income verified in the event of a non-income response from the IRS, indicating that the IRS fails to return income data in a large number of cases, even when a return has been filed by the applicant/enrollee. CMS's proposal to reverse the ability to accept attestation of income when no IRS data is available would result in significantly more individuals receiving unnecessary requests to prove their income, significantly increasing administrative burdens for applicants and members, and leading to coverage erosion. Such coverage erosion would adversely impact the merged market risk pool and increase premiums for all in the market, as adult applicants under age 45 are slightly more likely to receive a non-income response from the IRS, at 41.5 percent compared to 38.5 percent of applicants over 45.

Recent federal reports emphasize the lack of adequate staffing at the IRS, impacting the ability of the agency to process tax returns in a timely way, which could in turn lead to lack of data received from the IRS as part of Marketplace eligibility processes. A January 26, 2026, memo from the Deputy Inspector General to the Commissioner of Internal Revenue echoed the deep concerns that the Taxpayer Advocate Service's 2025 Annual Report raised about the IRS's readiness for the 2026 Filing Season, taxpayer services, and tax processing.^{9,10} In 2025, the IRS saw a workforce reduction of 27 percent which spanned across all IRS functions. Significant staffing shortages and backlogs are expected to further worsen IRS data issues. The Health Connector often receives a response from the federal data services hub indicating that no tax return information was available to verify an applicant's attested income and has found that the receipt of a null income response from the IRS is not correlated with a particular income group or with a particular tax status. It is unclear why the IRS is unable to provide return information for these cases, but we do not support making it more difficult for individuals to obtain health insurance coverage as a result.

Maintaining continuous coverage is critical to a healthy risk pool. The Health Connector saw a significant decrease of about 33 percent in unnecessary subsidy loss due to unverified income during Open Enrollment 2025 as a direct result of accepting an individual's attestation of income when no income data was received from the IRS. Enabling eligible individuals to maintain their same level of coverage from one year to the next makes it more likely that people stay enrolled and supports a balanced, strong, and stable risk pool.

⁹ The Internal Revenue Service's Readiness for the 2026 Filing Season (Audit No.: 2026400002), at <https://www.tigta.gov/sites/default/files/reports/2026-01/2026400002-Readiness-Memo.pdf>

¹⁰ Taxpayer Advocate Service 2025 Annual Report to Congress, at <https://www.irs.gov/newsroom/national-taxpayer-advocate-delivers-annual-report-to-congress-finds-taxpayer-service-was-strong-in-2025-but-foresees-challenges-for-taxpayers-who-encounter-problems-in-2026>

The Health Connector opposes CMS's proposal to verify income when data sources indicate household income is less than 100 percent FPL because this policy would not help the Health Connector advance program integrity and would only create unnecessary and costly operational and administrative burdens (§ 155.320(c)(3)(iii)). CMS presents data within the proposed rule to support this proposal by highlighting FFM program integrity gaps related to unauthorized broker enrollments. In Massachusetts, where unauthorized broker enrollments literally do not exist due to our proactive decision to never allow them in the first place due to our concerns about the risks of misuse of taxpayer resources, this policy only serves to penalize low-income individuals with unpredictable incomes. Further, Massachusetts has an integrated Marketplace-Medicaid eligibility system, which more accurately helps residents qualify for the correct coverage. This means that individuals who apply for coverage will be considered eligible for Medicaid or eligible for Marketplace coverage with APTC simultaneously, depending on their income. Longstanding rules suggest that if an individual attests to an income that is higher than what the federal data services hub tells us, we should believe the attestation and adjust their eligibility accordingly so as to not provide more APTC than they are eligible for. This is often the case when someone secures a new job that may have changed their income relative to the previous year's tax return. It is irrational and inconsistent to apply this rule to applicants who report income above 100 percent FPL and have an electronic data source similarly report income above 100 percent, but a completely different rule to those who attest to income above 100 percent FPL but have an electronic data source report income below 100 percent FPL.

This proposed rule would turn this longstanding rule on its head. In a Medicaid-expansion state like Massachusetts, a person who attested to income above 100 percent FPL but received an electronic data report of income below 100 percent FPL would newly be issued a DMI. If that person takes no action to respond to the DMI, their eligibility would be redetermined based on the data provided by the hub, which would then provide them with Medicaid eligibility. It is unclear if this is the intended outcome of the proposed rule. Regardless, this inconsistent application of rules based on an applicant's income is unnecessary and does not solve any program integrity concerns for the Marketplace or Medicaid. Program integrity should be considered more holistically, as this does not make programmatic sense from a Medicaid perspective. **To resolve this inconsistency, this rule should not apply in Medicaid expansion states.**

In addition, it bears repeating that Massachusetts does not have and has never had agents, brokers, and web-brokers enrolling people in individual Marketplace coverage because we did not believe they would be able to uphold our high standards of program integrity, and we therefore do not experience the same issues that the FFM experiences related to these entities. As a result, applying this one-size-fits-all proposal to SBMs like Massachusetts—a Medicaid expansion state with an integrated eligibility system and without agents, brokers, or web-brokers involved in the Marketplace—would only create costly and unnecessary

administrative and operational burdens without any added benefit. We respectfully disagree with CMS' statement that long-term program integrity savings would outweigh the operational costs to Marketplaces and CMS provides no evidence to demonstrate that there are any such program integrity issues to solve for SBMs. For example, HHS states that nearly 80 percent of income data matching issues were generated for households who worked with an agent, broker, or web-broker. Massachusetts does not have any such agents involved in our SBM. Additionally, the new data CMS offers to support this proposal and highlight what they refer to as "obvious risk" is solely focused on unauthorized FFM enrollments and CMS does not specify whether these unauthorized enrollments on the FFM were linked to income verifications or to individuals whose income is below 100 percent FPL.¹¹

The Health Connector appreciates the flexibility to apply the two-year FTR policy for plan year 2027 because Massachusetts does not have the same issues with agent, broker, and web-broker improper enrollments that CMS describes the FFM having and is concerned about the impact of IRS data challenges (§155.305(f)(4)). CMS argues that one of the reasons to deny APTCs after one year instead of two is because agents, brokers, and web-brokers are improperly enrolling people in coverage with APTC without their knowledge. The Health Connector does not permit and has never permitted the use of agents, brokers, web-brokers, or private external entities, such as direct-enrollment entities, to enroll individuals and families in the individual market. Instead, the Health Connector relies on a network of qualified Assistants who receive robust training, especially around reconciliation rules. In addition, challenges with timely and reliable data from the IRS, as detailed by the Inspector General, may inadvertently lead to denial of APTC to individuals who have submitted taxes and reconciled, but the IRS has not processed them due to delays.¹² We thank CMS for proposing to give SBMs the flexibility to adopt the one-year or two-year policy for the 2027 plan year. Having a longer timeframe to implement system changes that significantly impact applicants and members in Massachusetts is greatly appreciated.

PLAN DESIGN, BENEFITS, AND REQUIREMENTS

The Health Connector has extensive experience in managing our insurance market successfully and responsibly in partnership with the Massachusetts Division of Insurance. Massachusetts is well positioned to continue to monitor cost-sharing reduction (CSR) loading in the absence of federal appropriation of CSRs. Additional federal reporting will increase costs and administrative burdens, potentially increasing premiums, without creating any clear value for Massachusetts (§ 154.215). As has long been recognized by CMS and other federal partners, states are and continue to be best suited to understand the unique aspects of their

¹¹ CMS Actions to Protect Consumers and Strengthen Exchange Program Integrity at, <https://www.cms.gov/newsroom/fact-sheets/cms-actions-protect-consumers-strengthen-exchange-program-integrity>

¹² The Internal Revenue Service's Readiness for the 2026 Filing Season (Audit No.: 2026400002), at <https://www.tigta.gov/sites/default/files/reports/2026-01/2026400002-Readiness-Memo.pdf>

local markets and to oversee them. In 2017, Massachusetts and other states began “silver loading” to make up the difference in unpaid CSR with increased APTC. Massachusetts has a robust Effective Rate Review Program and has responsibly and successfully overseen how insurers make up for unpaid federal CSRs. CMS states that this new reporting requirement would cost \$1.14 million per insurer in the first year in addition to annual costs of more than \$574,000 per insurer per year. Additionally, CMS states that it will cost the federal government more than \$2.4 million per year to review and evaluate the CSR-related information submitted by insurers. The Commonwealth has already proven that it is best suited to handle how insurers manage the CSR load and information; adding these costly and burdensome requirements on issuers and the federal government is unnecessary. Increased costs and burden for insurers could further increase premiums for all market segments at a time when people are already struggling to afford coverage due to recent federal policy changes. We recommend that CMS allow states and their Divisions of Insurance to continue to monitor their market’s CSR loading since they are best positioned to do this work. As the longest-running SBM in the country, Massachusetts’s unique policy context only amplifies the need for tailored, data-driven approaches to ensure shared goals and positive outcomes are achieved.

The Health Connector recommends that CMS not finalize their proposal to require states to defray state-mandated benefits included in the state’s EHB-benchmark plan for 2027 because it would be challenging for states to implement on such a short time frame and would erode important protections for consumers (§ 155.170). Considering the late release of the proposed 2027 NBPP, implementing this change for 2027 would create too many administrative and budgetary challenges on top of the many other changes already required. States just recently changed this policy at CMS’s direction under the 2025 NBPP—reverting back to the policy before the final 2025 NBPP will create significant waste and inefficiencies without a clear benefit to consumers or the market. In addition, this proposed policy would increase costs for consumers by treating more benefits as non-EHB. ACA consumer protections such as the ban on dollar limits and cap on annual out-of-pocket costs would no longer apply to benefits considered non-EHB, exposing individuals and families to higher premiums and out-of-pocket costs, on average. CMS acknowledges that states looking to reassess their current mandated benefits may need additional time, given legislative calendars, and we agree that additional time is needed for states to respond, should CMS finalize this reversal of its current policy.

The Health Connector urges CMS not to finalize proposals to allow Bronze plans with out-of-pocket maximums in excess of the annual limit or to require that Catastrophic plans offer no benefits until an amount equal to 130 percent of the out-of-pocket limit has been incurred. Allowing and/or requiring these plans to exceed the annual limit would cause financial harm to individuals and families (§§ 156.136 and 156.155). Out-of-pocket limits exist under the ACA to protect members from significant financial hardship when they need to access care.

While Bronze and Catastrophic plans expose individuals to extremely high out-of-pocket costs, allowing plans to exceed the annual limit would only exacerbate affordability challenges even further. Continuing to erode affordability will lead to increased medical debt and forgone care. According to the Health Connector's 2025 Member Experience Survey, 15 percent of members in Bronze or Catastrophic plans reported problems paying or were unable to pay medical bills in the last 6 months, and 34 percent of members in Bronze or Catastrophic plans reported delaying or forgoing health care due to cost in the past 6 months. Feedback from members suggests that the prevalence of Bronze plans closer to the high end of the allowable actuarial value range is not because plans are "mathematically impossible" to create at lower actuarial values, but because consumers do not find those plans valuable. Catastrophic plans are even less popular in Massachusetts, with only 0.19% of the Health Connector's more than 351,000 individual market enrollees choosing a catastrophic plan.¹³

While we recognize the challenges that the federal actuarial value calculator (FAVC) calculator creates in designing Bronze plans, we do not think that allowing plans to exceed the out-of-pocket limits is the answer. The text of Section 1302 of the ACA prescribes clear and specific limits on out-of-pocket limits and the proposed change to Bronze plans disregards those unqualified limits. Instead of focusing on increasing the out-of-pocket limits, CMS could explore other policy opportunities to address challenges with the FAVC or health care affordability more broadly. We welcome CMS' partnership in addressing the growing challenge of designing affordable, quality plans under the FAVC requirements and would support CMS convening stakeholders to discuss the growing challenge of designing ACA-compliant tier plans that feature reasonable cost-sharing levels.

The Health Connector and Division of Insurance have concerns about CMS's proposal to allow multi-year catastrophic plan contracts for up to ten years and generally advises CMS against focusing on increasing enrollment in Catastrophic plans as a response to the affordability challenges individuals and families face (§ 156.80(d)(2)(ii)). Multi-year plans may create issuer solvency issues and destabilize insurance markets. Such plans create uncertainty in whether set rates are sufficient to pay for the enrolled population long-term. As we all experienced with the Covid-19 pandemic, certain unforeseen circumstances may negatively impact a population's health and worsen their risk profile unexpectedly. The risk of unforeseen circumstances, whether a major public health event or unexpected individual health development, is exacerbated by a longer-term contract. While the population enrolling in catastrophic plans is "supposed to be" a healthier, lower risk group, when rates are set for multiple years, this assumption may not hold over time. No one plans to develop a chronic condition, have a life-altering physical accident, receive a cancer diagnosis, or have a family member develop a substance use disorder. In general, we recommend that CMS not rely on

¹³ Massachusetts Health Connector. (2026). February 2026 Health Connector Enrollment Report. Available at <https://www.mahealthconnector.org/about/data-and-reporting/health-connector-monthly-enrollment-dashboard>

enrollment in catastrophic coverage or multi-year contracts to address the significant affordability challenges Americans face today.

In addition, individuals who enroll in multi-year catastrophic coverage would not need to reassess or reverify their eligibility on an annual basis which conflicts with the arguments CMS makes about the importance of people re-verifying eligibility in other coverage. We strongly recommend that CMS not allow insurers to vary the maximum out-of-pocket limits by disease and ensure that ACA market reforms, including guaranteed issue and age rating, are fully preserved in any affordability policy options CMS considers.

The Health Connector and Division of Insurance support flexibility for states and SBMs to make important choices for their own markets, including whether to certify non-network plans, align with federal network adequacy standards, and to choose their own Medical Loss Ratios (MLR) (§ 156.236, 155.1050). States and SBMs are best positioned to make these decisions for their own markets, and we appreciate the ability to continue to make thoughtful choices for Massachusetts residents informed by our data and unique experience. Through a non-network plan, individuals and families may be responsible for paying a provider the full cost of a benefit or services or a much higher portion compared to a plan with a network, either leaving them with extremely high medical bills or rendering their coverage useless and causing people to forgo care. We are thankful for the option to not certify or sell these plans because these plans put individuals at greater risk of not fully understanding the financial and administrative burden associated with non-network plans and erode the robust standards offered by QHPs that offer them more predictable, robust coverage. The Health Connector also appreciates the ability to continue with our current approach to use the federal network adequacy standards, which required significant time and resources to implement. Moreover, we appreciate the opportunity to modify this approach if needed so we can continue to respond to the unique local needs of our market. Finally, we urge CMS to continue to allow states to choose their own Medical Loss Ratios (MLR) that works best for their own markets. Massachusetts has maintained a higher MLR than what is required under the ACA and continues to be among the states with the most affordable premiums along with a robust and competitive individual market.¹⁴ The Commonwealth's higher MLR works for our unique market, carriers, and consumers.

ELIGIBILITY FOR APTCs

We appreciate the guidance on required attestations for “eligible noncitizens” but is concerned about the short timeframe for implementation, and respectfully requests that CMS delay enforcement of the attestation requirement at (§§ 155.20, 155.305(f)(1), and

¹⁴ KFF. (2026) Average Monthly Marketplace Premiums by Tier. Available at <https://www.kff.org/affordable-care-act/state-indicator/average-marketplace-premiums-by-metal-tier>

155.320). At this point, the restriction of APTC eligibility for a subset of lawfully present non-citizens required by the One Big Beautiful Bill Act would likely result in about 30,000 currently enrolled individuals losing eligibility for APTC. We also expect that this eligibility change is going to worsen the risk pool among those who qualify for APTC, and due to the lack of affordability of coverage without APTC, we expect many of these individuals will drop out of Marketplace coverage all together.

We appreciate that CMS has provided updated guidance to require the option for individuals to attest to their status as an “eligible noncitizen” to be able to align that input with the updated guidance from the Verify Lawful Presence (VLP) service. We believe this is a valuable requirement for members so they can provide the Health Connector with accurate information about their immigration status. The Health Connector has already been engaged in several months of systems design conversations with our eligibility system vendor and our state Medicaid agency and is now having to completely rebuild the systems approach to incorporate these functional requirements. While the Connector is aiming for a timely implementation of both the attestation requirement and the use of updated VLP data, we respectfully request ongoing dialogue with CMS about the good-faith efforts states are making based on existing guidance to be ready for eligibility determinations for the 2027 plan year, which begin for the Health Connector in August 2026. This is another example of the importance of timely guidance from CMS. The Health Connector is essentially having to build these system changes twice due to the lack of timely guidance. This is a costly approach to systems design, leading to unnecessary staff time and increasing the likelihood of systems errors upon final execution.

While we strongly support the attestation approach detailed in the proposed rule and seek to implement it in time for plan year 2027, the timing of the guidance is problematic. We respectfully request that CMS delay enforcement of this provision, recognizing we are doing our due diligence to comply with the statute and implement systems changes as quickly as possible, while reducing the risk of errors or other adverse outcomes.

AGENTS, BROKERS, WEB-BROKERS, AND SBM-ENHANCED DIRECT ENROLLMENT

The Health Connector and Division of Insurance support any efforts to tighten standards for agents, brokers, and web-brokers in the Marketplaces that rely on them to ensure everyone can access high quality and accurate help, though the Health Connector does not have agents, brokers, or web-brokers associated with individual market applications due to program integrity concerns, instead relying on highly trained and qualified Assistors (§155.220(g)(2)). The Health Connector appreciates the ability to not allow agents, brokers, and web-brokers to assist individuals and families with applying for and enrolling in coverage and instead rely on qualified Assistors, such as Navigators and Certified Application Counselors (CACs). The Health Connector proactively chose not to allow these entities for the same program integrity concerns that CMS now identifies and highlights using FFM data. The extensive training

provided to the Health Connector's Assistants has greatly contributed to the strength of our program integrity. State flexibility to establish qualifications for trained assistants and our careful decision to not permit agents, brokers, web-brokers, or direct-enrollment entities to assist individuals with applying, shopping for, and enrolling in health insurance has resulted in robust consumer protection for Health Connector members. The Health Connector supports CMS's proposal to strengthen HHS' ability to hold agents, brokers, and web-brokers accountable. This change would improve transparency in the process for holding these entities accountable for compliance with applicable law, regulatory requirements, and their Marketplace Agreements and protect consumers from the impacts of potential noncompliance, including improper enrollments.

As the longest-running State-Based Marketplace in the country, the Health Connector has extensive experience in successfully operating an SBM with robust program integrity standards. The Health Connector has significant concerns related to expanding SBM-Enhanced Direct Enrollment (SBM-EDE) options due to the many risks such decentralized options pose to program integrity, consumer protection, value, and competition (§ 155.221(k)). The Health Connector supports CMS's goals of providing flexibility to States to respond to the unique local needs of markets and residents. However, the Health Connector also appreciates that such flexibility needs evidence-based guardrails to preserve program integrity. Thus, the Health Connector does not support the expanded use of direct enrollment entities because doing so would undermine the purchasing power and trusted brand of Marketplaces nationwide. CMS's direct enrollment proposals run counter to the intent and purpose of the ACA by reducing program integrity, consumer protections, interfering with transparency and competition, and providing no clear value over existing Marketplace pathways.

- **The SBM-EDE option worsens program integrity by relying exclusively on web-brokers to operate the consumer-facing websites that facilitate the applicant eligibility and enrollment process.** Expanded reliance on web-brokers will threaten our shared program integrity goals for all Marketplaces. In the proposed 2027 NBPP, CMS notes that they have observed agents, brokers, and web-brokers enrolling consumers with inaccurate information to conceal unauthorized enrollments and detailed these entities' potential for harming consumers. The extensive list of program integrity issues web-brokers present, as highlighted by CMS, cannot be fully rectified by new standards and requirements CMS proposes.
- **Decentralizing Marketplace enrollment functions erodes consumer protections.** Without a clear, consistent, and trustworthy pathway to enrollment, consumers are likely to struggle in finding the health coverage benefits they need and to which they are entitled. One common source of fraud that the Health Connector and Division of Insurance encounter across the insurance market is by residents who come across another entity falsely

claiming to provide Marketplace enrollment functions and instead end up enrolling in a product that is not certified by the Marketplace. Encouraging multiple entities to provide a pathway to Marketplace coverage will further confuse individuals, and make it even more difficult for an individual to tell the difference between a legitimate enrollment entity and a fraudulent actor. Consumers interacting with a direct enrollment entity may not be made aware of eligibility for certain programs and instead be directed to options that are less affordable and less generous than what they would have been determined eligible for through a centralized and streamlined application. Consumers left unaware of their eligibility may choose to forgo coverage altogether. Consumers are already confused by the actions of private companies with misleading and deceptive marketing practices. The expansion of direct enrollment entities exacerbates this problem and creates additional challenges for consumers trying to find their way to legitimate, comprehensive coverage.

- **Marketplaces encourage competition, allowing consumers to make “apples-to-apples” comparisons of available Qualified Health Plans by displaying all options available along with important comparative information such as premiums, cost-sharing information, and provider directories.** This impartial and complete display of certified plans promotes competition and informs consumers that all coverage options through a Marketplace are comprehensive and trustworthy. Direct enrollment entities complicate the shopping process for consumers and risk decreasing competition due to the differences in plan and information display requirements.
- **There is no clear or convincing evidence that SBM-EDE pathways provide more value than ACA exchanges.** A push towards a decentralized SBM-EDE when SBMs have a proven track record of success appears unsupported by evidence. Massachusetts’s 2006 landmark health care reform law demonstrated the value and effectiveness of establishing a centralized health insurance exchange. In the first two years of the Health Connector’s existence, nearly 440,000 Massachusetts residents became newly insured, half of which were enrolled in unsubsidized private plans.¹⁵ Establishing a centralized health insurance exchange helped to propel the Commonwealth from seventh place in the percentage of insured residents to first place, a ranking Massachusetts has maintained over time.¹⁶

Thank you for your careful consideration of our evidence-based perspectives, which are informed by nineteen years of serving as the Massachusetts health insurance marketplace, with the nation’s lowest rate of uninsured, the country’s healthiest population, and among the lowest Marketplace premiums in the nation.

¹⁵ Report to the Massachusetts Legislature Implementation of the Health Care Reform Law, Chapter 58 2006-2008

¹⁶ KFF, at <https://www.kff.org/wp-content/uploads/2013/01/8311.pdf>

The Health Connector and Division of Insurance are committed to protecting and advancing program integrity, addressing affordability for all Massachusetts residents, including the unsubsidized population, and maintaining a stable, robust merged market. Thank you for consideration of these comments in pursuit of the shared goal of a high-functioning Marketplace. Massachusetts has demonstrated the power of state-driven health policy with the Commonwealth's near universal health coverage rate and looks forward to building on its success in partnership with CMS.

Sincerely,

A handwritten signature in black ink, reading "Audrey Morse Gasteier". The signature is fluid and cursive, with a long horizontal stroke at the end.

Audrey Morse Gasteier
Executive Director

A handwritten signature in blue ink, reading "Michael T. Caljouw". The signature is cursive and stylized, with a prominent "M" and "C".

Michael T. Caljouw
Commissioner of Insurance



March 13, 2026

Centers for Medicare & Medicaid Services
 Department of Health and Human Services
 Attention: CMS-9883-P
 P.O. Box 8016
 Baltimore, MD 21244-8016

Via Regulations.gov

To Whom It May Concern:

On behalf of the members of the National Association of Insurance Commissioners (NAIC), we submit the following comments as well as the attached actuarial memo in response to the proposed Notice of Benefit and Payment Parameters for 2027 (Notice), as published in the Federal Register on February 11, 2026. NAIC represents the chief insurance regulators in the 50 states, the District of Columbia, and five United States territories.

Summary

While state insurance regulators support a number of the proposed regulatory changes included in the Notice, we highlight our concerns with four areas:

- The Notice's proposals impacting states' defrayal of the cost of benefits in addition to essential health benefits would force states to reevaluate past decisions and potentially bear new, unanticipated costs. We request alterations and clarifications to the proposal in our comments below.
- The proposals affecting catastrophic plans are not sufficiently developed and we urge delay in implementation while questions are answered.
- The proposal to allow non-network plans as qualified health plans could burden consumers' access to providers and complicate state enforcement of access standards. If this proposal is finalized, we strongly recommend maintaining state and marketplace authority to approve non-network plans and additional disclosures to consumers about how to use such plans.
- While we welcome discussion on the underlying methodology supporting medical loss ratio (MLR) requirements, we strongly oppose the idea of HHS imposing a lower MLR requirement on plans in states that have not requested an MLR adjustment.

Timing of Notice and Comment Period

As in some prior years, state regulators wish to express concern about the timing of this proposed Notice and urge the Department of Health and Human Services (HHS) to publish it much earlier in

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future years. Planning for plan year 2027 is already under way. The comment period ends with little time before state filing deadlines for 2027. HHS must review the comments and publish the final rules, then states must provide guidance for carriers that reflects the final rules, and carriers must modify and submit filings to comply with the final rule. State insurance regulators as well as state-based marketplaces (SBMs) need more time with the rules in place to prepare for the filing and rate review season. And health insurance carriers need more advance notice of the rules under which they will be operating to fully weigh their options and develop appropriate plans and rates.

In addition, the brief 30-day period allowed for comment on the Notice makes it challenging for state regulators to understand and analyze complex proposals, consult with stakeholders and colleagues in other states, and provide meaningful comments. We encourage the Administration to publish future proposed Notices by the end of November and then provide a longer comment period.

Requirements for State-Based Marketplaces (155.105-155.221), State Exchange Improper Payment Measurement, and Eligibility Verification Processes

State insurance regulators generally support regulatory changes that facilitate adoption of state-based marketplaces (SBMs) and reduce the burden associated with operating them. We support removal of the requirement for an SBM to operate for one year on the federal platform before becoming a full SBM. When an SBM can show its capacity to meet all applicable requirements it should be permitted to begin full operations. We also support removal of the requirement for SBMs to provide supporting documentation since such a requirement is duplicative with the State Exchange Blueprint.

State regulators appreciate the proposed flexibility offered to states by allowing SBMs to rely on enrollment through enhanced direct enrollment entities (EDEs) rather than the SBM's own website. We support maintaining "the flexibility to determine their own business controls" while complying with Federal web-broker and EDE requirements applicable to SBMs. However, we urge HHS to update federal EDE requirements to limit improper enrollment activity. In particular, limiting the use of national producer numbers (NPNs) to agents that are licensed by the state and appointed by the appropriate insurance carrier would help to combat improper enrollments. Broadening the use of EDE without limiting the use of shared NPNs introduces greater risk of improper enrollments.

State regulators recognize the need to measure and analyze improper payments of advance premium tax credits (APTC). The proposed State Exchange Improper Payment Measurement (SEIPM) program would complement existing measures of improper payments through federally-facilitated marketplaces (FFMs). However, SBMs are already subject to extensive reporting and oversight requirements which provide HHS with detailed information on their operations. We urge HHS to eliminate duplicative data collection between SEIPM and existing reporting by SBMs. We are also concerned that implementing SEIPM will introduce significant new administrative burdens for SBMs. We urge HHS to establish a longer transition period to full operation of SEIPM and to tailor the program to reduce the compliance effort by SBMs, providing technical assistance and other support as needed.

NAIC shared its concerns with eligibility verification changes with Congress as it considered the verification changes that HHS now seeks comment on before implementing. As we stated then, state insurance regulators agree that only eligible individuals should be allowed to purchase marketplace plans and only those who meet the income, immigration status, residence, and access to coverage

requirements for financial assistance should have their premiums reduced with an APTC. At the same time, all marketplaces must be open to eligible individuals and tax credits must be available in a timely manner for those who qualify. For many consumers, marketplace coverage is their only affordable option for health insurance and unnecessary barriers to coverage will leave them without access to coverage or needed care.

State regulators urge HHS to apply maximum flexibility as the marketplaces implement requirements to verify applicants' eligibility for special enrollment periods and APTC. If applied too broadly, new requirements could prevent many consumers from accessing coverage in a timely manner. The individuals most likely to drop coverage due to the new verification requirements and changes to automatic re-enrollment are younger and healthier people who expect to use their coverage the least. When healthy individuals leave the risk pool, insurance markets are less stable and more costly for those who remain. We believe HHS should carefully weigh the risks to coverage and market stability that added verification requirements are likely to introduce and new rules should not unnecessarily limit state authority to operate SBMs.

We urge HHS to implement new verification requirements for all marketplaces in a way that complies with the law while also preserving efficient access to coverage for eligible individuals. SBMs should retain the authority to set their own verification processes to the greatest extent possible. We note, SBMs have not experienced the same improper activity as the federal marketplace—any new verification rules should take this into account. HHS rules should maintain the ability of marketplaces to automatically re-enroll individuals as frequently as possible. Automatic re-enrollment is widely used and marketplaces already verify eligibility information against trusted data sources as part of automatic re-enrollment.

SBMs will need time to implement any changes to eligibility verification rules. We ask HHS to consider comments and establish new rules quickly. If they are to be in place for plan year 2028, we urge HHS to communicate new verification rules by July 2026.

State-Required Benefits in Addition to Essential Health Benefits (155.170)

State insurance regulators oppose regulatory changes that impose new obligations on states based on decisions states made in the past in reliance on then-existing rules and guidance. We request that any changes to HHS's standards for defraying the cost of mandates in addition to EHB be applied prospectively and only to state benefit mandates adopted in the future. We strongly support maintaining paragraph 155.170(a)(3) that recognizes states as the authority in identifying which benefits are in addition to EHB. We also request that any implementation date for changes to EHB identification and defrayal guidance be delayed until at least 2028. Several states have short or no legislative sessions in 2026, and this would give state legislatures a more meaningful opportunity to consider any changes in benefit mandates and, if necessary, appropriate funds for defrayal.

We understand the proposal to rescind the changes made in the 2025 Notice of Benefit and Payment Parameters that recognized benefits included in a state's EHB-benchmark plan as essential health benefits. The 2025 change remedied a situation in which some benefits were EHB (because of their inclusion in the benchmark plan) but could simultaneously be labelled "in addition to EHB" for defrayal purposes (because they were mandated by state action). We supported the 2025 change and we believe the reasons for making that change remain valid.

At the same time, we recognize the importance of limiting premium growth for unsubsidized consumers and of establishing in regulation a clear set of standards for when defrayal is due. We

understand the proposed Notice would give states that have enacted a benefit mandate after 2011 two choices: either 1) defray the cost of the benefit and render the benefit's EHB status null and void, forfeiting the consumer protections associated with EHB status or 2) avoid defrayal by repealing the benefit mandate.

In addition to requiring defrayal payments a state may not have planned for, option 1 has other effects that impact consumers across markets and may not be desirable for a state. State-required benefits in addition to the EHB under the proposed rule would no longer be subject to protections like the prohibition on discrimination, limitations on cost sharing, and restrictions on annual and lifetime dollar limits for these benefits. The benefits would lose these protections not only in the individual and small group markets, but also when they are included in large group health insurance and self-funded health plans.

Some states also have concerns with option 2. While a repealed mandate may, for the time being, remain an EHB, states lack clarity on how long this will be the case. HHS has paused review of state requests to update EHBs under existing rules. And state regulators are aware that HHS plans to update its EHB rule. Since EHBs and the process for selecting them may be subject to change under a new rule, any formerly-mandated benefits could cease to be EHB in the future, depending on yet-unknown rules.

States have valued their role in the EHB selection process since the original EHB rule in 2014. State policymakers have carefully considered new mandates since the passage of the Affordable Care Act, taking into account the requirement for defrayal and the regulations and guidance HHS has released to interpret it, including the 2025 NBPP. States have enacted mandates to respond to recognized needs in their states and have defrayed their cost when appropriate. This proposed change would expand the set of benefits that could trigger defrayal. While, under the proposal, new defrayal would only be required for benefits delivered in plan year 2027 and after, the obligation to defray would be triggered by decisions states made in the past, under previous regulatory regimes.

We also request that HHS revise the proposal to recognize that its previous rulemaking in the 2025 NBPP has influenced state decisions. Instead of only looking back to the 2011 deadline established in the original EHB rule, HHS should also set a future date beyond which inclusion in the EHB benchmark plan no longer eliminates the need for defrayal. Such a date should be after 2027 or after states have an opportunity to select an EHB benchmark under a new EHB rule, whichever is later. Under this approach, benefits mandated by state action before 2012 would not require defrayal. Consistent with the 2025 NBPP, benefits mandated by state action from 2012-2027 would not require defrayal if included in a state's EHB benchmark plan. State actions to mandate benefits that take place after 2027 (or after a new EHB rule's selection process) would trigger defrayal when the four elements outlined in the proposed 2027 Notice are satisfied. This approach would avoid changing the rules after states have already acted and provide clear notice of the choices confronting states when they consider new mandates.

Further, a final rule must clarify the application of the elements that require defrayal and the effects of changes in state mandates. HHS should explicitly clarify that state selection of an EHB benchmark plan does not constitute "state action" to mandate benefits. And the Department should make it clear that a state's EHBs remain in full effect under the new rule should a state repeal a benefit mandate that has already been made part of its EHB.

Marketing Practices (155.220)

State regulators support the proposed strengthening of marketing standards applicable to agents, brokers, and web-brokers. The proposal would explicitly ban misleading conduct and provide examples of prohibited conduct, including cash offers, false promises of zero-premium plans, the use of false celebrity endorsements, and other improper conduct we have observed in state markets. We strongly support the proposal to make agents, brokers, and web-brokers responsible for marketing content “created, written, released, or otherwise produced” by them or on their behalf. These provisions would provide more clear authority for both federal and state regulators to investigate and take action against improper marketers.

We urge HHS to take further steps to combat improper marketing by establishing a federal prohibition on sharing national producer numbers (NPNs). NPNs are unique identifiers assigned to individuals and business entities. Improper sharing of NPNs has contributed to harmful unauthorized plan transfers. A number of states have acted to limit the practice and it would be helpful for federal officials to take similar action.

State regulators also work to combat improper marketing activity using their own authorities. They can be more effective when they can leverage information from federal investigations and enforcement activity. We request HHS to continue to improve information sharing by providing timely and complete reports of its enforcement actions against any state-licensed entities. We seek detailed information including evidence, contact information for all parties, and other records held by federal agencies. We welcome continued conversation on how we can craft information sharing agreements that facilitate timely exchange of all case files.

Provider Access Review (155.1050 and 156.230)

State insurance regulators appreciate the proposed opportunity for states to demonstrate that they have Effective Provider Access and Essential Community Provider (ECP) Review Programs and take on greater responsibilities for provider access review. States can be better positioned than federal officials to evaluate provider availability and some states have invested in their capacity to examine provider access in recent years.

We recognize that adopting rigorous standards for qualifying as an Effective Provider Access Review Program helps HHS fulfill its own responsibility under the ACA to assure plans offer sufficient access to providers. Given these rigorous standards, states will benefit from technical assistance and shared data from HHS related to provider access. We support the proposal for HHS to continue to collect provider access data from issuers serving all FFE states and to share it with state regulators. We emphasize that all FFE states would benefit from access to this data, whether the state has an Effective Provider Access Review Program, is working to develop one, or continues to rely on HHS for provider access review.

We support the Notice’s proposed increases in flexibility for SBMs in their network adequacy or provider access reviews.

Catastrophic Plans (156.155, et al)

State regulators urge further consideration and consultation with stakeholders before HHS finalizes its proposed changes with regard to catastrophic plans. We believe the proposed changes raise many questions that are not answered in the Notice and will require additional analysis and further

refinement. These reforms should not be implemented until all questions have been resolved. With 2027 filing deadlines quickly approaching there simply is not enough time for market participants and regulators to adequately address all the unknowns for this cycle.

Additionally, the lack of effectuated enrollment data makes it impossible for states using FFM to understand the current state of their markets and the full effect of the 2025 federal changes. When combined with the short comment period for the Notice, state regulators have not had adequate opportunity to provide meaningful comments on the impact of any provision that alters the availability of catastrophic plans

The proposal would expand access to catastrophic plans, introduce multi-year plans, and increase maximum allowable out-of-pocket amounts for catastrophic plans. HHS seeks comment on whether it should maintain separate risk adjustment procedures for catastrophic plans and metal level plans. State regulators emphasize that changes to the accessibility of catastrophic plans may affect the risk pool and cost of metal level plans even if catastrophic risk adjustment remains separate. If catastrophic plans gain more enrollment due to all of the proposed changes, that enrollment is likely to be healthier as a group. Metal level plans could then see increased premiums due to a less healthy enrollment group. Because APTCs are calculated based on the cost of the "benchmark" silver plan, these premium hikes will trigger an increase in federal subsidies. Consequently, while the proposal aims to offer lower-cost options to some, it would create an upward pressure on federal spending to offset the rising costs for the majority of enrollees. Combining risk adjustment procedures could even out overall risk among catastrophic and metal level plans, eroding the premium advantage catastrophic plans have demonstrated in past years.

Please see the attached memo on Key Actuarial Issues for more comments on these proposals.

Cost Sharing for Bronze and Catastrophic Plans

State regulators believe the introduction of variable out-of-pocket (OOP) limits could create confusion for regulators and insurance companies. Should variable limits be allowed, we request the nominal OOP limit be qualified as only applying to Platinum, Gold, Silver, and at least one Bronze.

We strongly support limiting the expanded Bronze OOP to ensure distinction from the proposed OOP on Catastrophic plans. For example, a 58% Bronze plan could be devised with the same or higher OOP limit than what is proposed for the 55% Catastrophic plan. From testing of the actuarial value calculator, there is no constraint on how high a bronze OOP max can be set; it is easy to design plans with a \$2 million OOP max that fit within the bronze range. If the bronze OOP limit is to be expanded, it is essential that a cap be placed on it. However, there is concern with exceeding the statutory OOP limit to begin with. The increase from \$10,600 to \$12,000 is already significant to consumers, and our data shows that the sickest 5% of bronze members are reaching their OOP maximum.

Standardized Plan Options and Non-Standardized Plan Option Limits (156.201-202)

State insurance regulators support a flexible approach to standardized plan options that allows for variation based on market conditions in each state. The number of plan choices is more of a concern in some services areas and less in others. We support the removal of strict limits on the number of non-standardized plan options as well as the continued authority of SBMs to require standardized options.

In areas where the number of plan options is high, we support the application of a flexible meaningful difference standard. Under a flexible standard, state and federal regulators would collaborate to determine whether the number of plans submitted for certification is in the best interest of consumers. When regulators determine the number is unreasonably high, the flexible standard would require plans to be meaningfully different in cost-sharing levels, network type, or other relevant factors.

QHP Certification of Non-Network Plans (156.236)

State insurance regulators caution that the Notice's proposal to allow non-network plans to be certified as qualified health plans may challenge consumers' access to care, require significant additional disclosures before enrollment, and complicate state enforcement of provider access. If this proposal is finalized, we strongly support state and marketplace authority to determine whether non-network plans may be offered.

The proposal would create standards aimed at ensuring that non-network providers offer a benefit that a sufficient number of providers would accept as payment in full. However, state regulators are concerned that the real-world application of this benefit design will leave consumers without adequate access and/or increase consumer burden in identifying affordable providers. The preamble notes that, under this plan design, consumers would have the opportunity to negotiate on prices with providers. State regulators believe this is not a practical approach for most consumers and removes important protections. Consumers frequently lack information about what services they need before they see a provider and often do not have ready access to comparative prices for use in negotiations.

Ensuring ongoing access to a sufficient set of providers would also be a challenge, whether state or federal officials perform provider access reviews. As stated in the preamble, whether a provider will accept a certain amount as payment in full is "a moving target," subject to change by the provider at any time, for any reason. State regulators are concerned the proposal does not provide effective mechanisms for monitoring consumers' experiences with finding and using providers and the ultimate cost to the consumer.

If non-network plans are certified as QHPs, state regulators recommend that marketplaces be required to provide extensive information to potential enrollees about what to expect in using the plan. Potential enrollees should receive advice on how they are expected to interact with providers as well as access to a provider directory that lists the providers the plan has determined will accept the plan's benefits as payment in full and for which services.

Comments on Medical Loss Ratio

State insurance regulators appreciate HHS' interest in reforms to the ACA's medical loss ratio (MLR) requirements. We welcome discussion on the MLR's underlying methodology and whether it could be improved to meet the goals of ensuring that consumers and employers get value from their premium dollars. Nonetheless, we strongly oppose the idea of HHS imposing a lower MLR requirement on plans in states that have not requested an MLR adjustment. As contemplated in the ACA, states should retain the prerogative to explore MLR flexibility in collaboration with HHS, rather than HHS forcing MLR changes on states.

A broad lowering of MLRs could increase premiums and weaken consumer value protections in markets with limited competition. A lower minimum MLR could become a new pricing target rather than a mechanism to produce consumer savings.

State regulators recognize that the current approach to MLR may cause unintended consequences contrary to the statutory goals of the requirement. Issuers may meet the MLR requirement not by reducing administrative costs or profits, but instead by increasing provider payments or other claim costs or quality improvement payments. Sometimes these payments go to providers within the same vertically integrated ownership group as the issuer, subverting the purpose of MLR requirements.

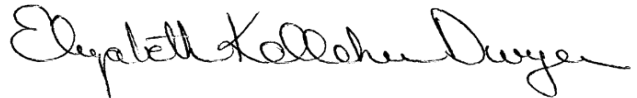
We welcome collaboration with HHS on ways to improve the underlying MLR methodology to prevent "gaming" and unintended consequences but oppose any HHS action to force states to adopt lower MLRs. The attached memo on Key Actuarial Issues provides further comments on this topic.

Thank you for your consideration of our comments in this letter and in the memo below. We look forward to continued collaboration between state and federal regulators to improve health insurance markets and better serve consumers.

Sincerely,



Scott White
NAIC President
Commissioner
Virginia Bureau of Insurance



Elizabeth Kelleher Dwyer
NAIC President-Elect
Director
Rhode Island Department of Business
Regulation



Jon Pike
NAIC Vice President
Commissioner
Utah Insurance Department



Michael Wise
NAIC Secretary-Treasurer
Director
South Carolina Department of Insurance

**Key Actuarial Issues
In the Proposed Notice of Benefit and Payment Parameters for 2027**

NAIC Memo - March 2026

Risk Adjustment Individual Market Risk Pools

We believe the individual catastrophic and non-catastrophic pools should be maintained separately unless combining calculations would improve market stability without material cross-subsidies or transfer volatility.

Because catastrophic and non-catastrophic plans differ in eligibility, benefit design, and enrollee behavior, combining calculations could shift transfers from reflecting relative morbidity toward reflecting structural plan differences unless supported by credible data and appropriate guardrails, including the potential impact on catastrophic enrollment and risk profile. Actuarial considerations for any change include comparability of plan liability, risk pool composition and selection dynamics, and interactions for states with merged markets.

Because the specific policy objective(s) were not identified, we recommend CMS provide a description of such objectives in order to properly evaluate the proposal.

Cost Sharing Reduction (CSR) Load in URRT

While we support greater transparency and CSR load reporting, we are concerned the proposal goes beyond standardized reporting and may establish a single acceptable CSR loading methodology, potentially preempting State-directed, actuarially-justified approaches permitted under State law. While we agree that plan-level adjustments to account for unreimbursed CSR amounts are permissible only if actuarially justified under 45 CFR § 156.80(d)(2)(i), in states with Effective Rate Review Programs, the State retains primary responsibility to review the actuarial justifications under 45 CFR § 156.80(d). Any changes to the Unified Rate Review instructions should not inadvertently preempt the State's responsibility.

We suggest CMS not provide a description of what constitutes "actuarially justified" or "actuarially sound." In actuarial practice, those phrases are commonly understood as actuarial opinions rendered by qualified actuaries under professional standards and supported by defined scope, relevant data, explicit assumptions/methods, and disclosures of limitations. The proposal's nationwide assertion of what is "actuarially justified" risks implying an actuarial certification that could be read as overriding state-specific actuarial determinations.

We further recommend that the new CSR-loading data elements be stored in a new URRT worksheet, allowing existing tabs to remain unchanged to minimize disruption and rework for states and issuers.

Plan-Level Adjustments for Multi-Year Catastrophic Plans

While states generally support flexibility in plan design, we encourage any approved term-length adjustment under 45 CFR § 156.80(d)(2)(ii) to consider single risk pool requirements, including interaction with pooling and uniformity concepts across an issuer's catastrophic plans. Additionally, it should be made clear how any such plan-level index rate adjustments differ from plan adjustments to AV and Cost Sharing Design of Plan factors for multi-year terms.

We understand the intent of the term-length factor in § 156.80(d)(2)(ii) is to adjust for multi-year contract and benefit characteristics. However, section III.E.2 mentions "risk profile" which may suggest morbidity/selection-based plan-level adjustments would be allowed. If CMS intends "risk profile" to support any morbidity/selection-based plan-level adjustment, we request clarification on how CMS would align (and, if needed, reassess) catastrophic risk adjustment so morbidity is not addressed twice. This is a key consideration of whether catastrophic transfers should remain calculated separately from non-catastrophic plans. Plan design expected cost differences (attributable to contract term and cost-sharing structure), including utilization differences associated with plan generosity, are distinct from morbidity/health-status differences driven by enrollee selection. Plan-level adjustments can be compatible within a single risk pool when they are limited to these plan design/contract features and applied consistently; adjustments that reflect morbidity/selection risk can function as indirect health-status rating and can overlap with (or counteract) the intended role of catastrophic risk adjustment.

Finally, we encourage adding a brief clarification describing the types of documentation that would generally support a term-length adjustment (for example, key assumptions, rationale, and how the adjustment avoids double counting and is applied consistently within a single risk pool), without prescribing a specific actuarial method.

Multi-Year Terms for Catastrophic Plans to Improve Health

Given the administrative barriers, potential solvency risks, and the complexity of pricing multi-year risk, states request multi-year terms for catastrophic plans remain strictly optional for states and issuers. And given the breadth of impacts and the clarifications and complexities involved, if the proposal is finalized without the optionality for states and issuers, we recommend delaying the implementation of multi-year terms for catastrophic plans.

Should these features be implemented, we request clarification on how guaranteed renewability and product discontinuation/ market exit rules are intended to apply to multi-year contracts and the associated consumer protections expected in that circumstance. Multi-year designs can create consumer expectations that value will accrue over time (for example, if cost sharing is structured to be less burdensome later in the term). If a product can be discontinued mid-term without an explicit run-off approach, enrollees may not be able to realize the benefit trajectory that was offered at enrollment. This risk is structural and is not fully addressed through general disclosures. This concern

is amplified if premiums are structured to effectively average premiums across the contract term (for example, level premiums) while meaningful cost-sharing value is backloaded to later years.

We further request specific guardrails and minimum disclosures that are clear, administrable, and reviewable by State regulators for “average-over-term” cost-sharing designs, specifically:

- Define the permitted unit of application (for example, whether “monthly” application is permitted and how it interacts with annual cost-sharing accounting and accumulation).
- Specify whether the MOOP and/or deductible may vary by contract year and, if so, define minimum boundaries that prevent extreme front-loading of cost-sharing exposure. Clarify whether the MOOP and deductible averaging approach must be the same or if the approaches can be chosen separately.
- Confirm nondiscrimination constraints that apply to any time-varying cost-sharing design and clarify whether designs that vary by disease/condition would be permissible in practice.
- Require standardized disclosure at enrollment of the full MOOP/deductible (and any other material cost-sharing features), including clear statements of what can change mid-term and under what conditions.

We also request clarification of what premium adjustment structures are intended to be permissible during a multi-year catastrophic contract term and what issuers should file (at a high level) so State rate reviewers can evaluate the product using existing rating/single risk pool frameworks.

Multi-year contracts can create incentives to front-load premiums or to adjust them later in ways that induce lapses before later-year value accrues. In addition, if a multi-year plan uses a premium structure that effectively averages premiums over the contract term (for example, a pre-specified level premium schedule), consumers may implicitly pre-fund later-year value, which heightens the importance of clear run-off/transition protections and transparent premium change rules. Even when individual-level health status rating is prohibited, product-level premium patterns can still undermine consumer expectations and market stability.

Multi-year plans also introduce complexities regarding risk adjustment and MLR reporting/rebates. We encourage specification of the operational approach for how multi-year catastrophic plan enrollment and claims will be treated under these programs. If these cannot be specified for PY2027 implementation, states would encourage delaying multi-year catastrophic plans until these program interactions are addressed. Without explicit program treatment, issuers and regulators could face avoidable uncertainty, and the policy could create unintended incentives that destabilize the catastrophic segment. For example, if a plan is designed with a higher MOOP in early years (lower claims) and a lower MOOP in later years (higher claims), an annual MLR calculation might trigger rebates in the early years, even though the issuer expects higher losses later. A multi-year aggregation method for MLR reporting for these specific blocks could be more appropriate.

Finally, we encourage resolution of other multi-year term plans concerning catastrophic plans, such as those related to issuer discontinuation, risk adjustment, proposed plan-level index rate

adjustments, multi-year cost shares, multi-year premium adjustments, rate review documentation, and MLR treatment prior to extending standards to metal level plans.

Cost Sharing for Bronze and Catastrophic Plans

States believe the introduction of variable out-of-pocket (OOP) limits could create confusion for regulators and companies. Should variable limits be allowed, we request the nominal OOP limit be qualified as only applying to Platinum, Gold, Silver, and at least one Bronze.

We agree limiting the expanded Bronze OOP would be appropriate to ensure distinction from the proposed OOP on Catastrophic plans. For example, a 58% Bronze plan could be devised with the same or higher OOP limit than what is proposed for the 55% Catastrophic plan.

The proposed flexibility for bronze and catastrophic plans, including multi-year catastrophic plan options and cost-sharing adjustments, may support enrollment stability and plan continuity. At the same time, the interaction with affordability standards and consumer cost exposure should be reviewed carefully to avoid unintended consequences. These considerations may be particularly relevant for smaller or geographically isolated markets where issuer participation is limited. CMS should consider revising the AV Calculator to use a single baseline continuance table with explicit, metal-level induced demand adjustments. This directly relates to CMS's cited drivers for the proposed bronze/catastrophic cost-sharing (MOOP-related) changes (year-over-year AV drift, AV Calculator constraints that force benefit redesigns, and reduced metal-tier comparability) by separating the common risk-pool cost distribution from tier-specific utilization effects. This approach could also improve transparency, stability, and alignment between AV certification and standard single-risk-pool pricing mechanics.

Adjustments to Minimum Medical Loss Ratios (MLR)

We believe states should initiate minimum MLR adjustments when the state determines it necessary to promote market stability. We do not support CMS initiating changes to minimum MLR standards without state involvement. States are most familiar with their markets and best suited to evaluate changes to minimum MLRs on issuer participation, competition, and solvency.

We note that broad lowering of the Federal individual market MLR standard, without guardrails, could create a material risk of higher premiums and weaker value protections, particularly in markets with:

- constrained issuer negotiating power due to provider consolidation or shortages,
- declining or volatile individual market enrollment,
- limited issuer competition, and/or
- rising medical prices (especially provider prices) that far outweigh what insurers could save by making small cuts to administrative expenses.

In such conditions, lowering the threshold can be priced into premiums: it increases the share of premium that can be retained for non-claims costs, and in markets with limited competitive pressure that allowance can become a new pricing target. This can raise premiums for the same underlying claims costs and weaken the MLR's role as a consumer value backstop.

Additionally, increasing the Federal individual market MLR standard above 80% could produce short-term premium pressure and/or higher rebates in some markets, but it also reduces the room for administrative costs and margin and may increase issuer exit risk, especially for smaller issuers or fragile/rural markets. If exit occurs, reduced plan availability and competition can offset any near-term gains and contribute to higher premiums over time.

Definition of "market stability"

We recommend CMS redefine "stability" for Subpart C to include one or more of the following:

- Premium stability and affordability, including gross premium growth (before subsidies) and net premium burden (after subsidies)),
- Prioritized access to and use of high-value care (including whether enrollees can get timely, in-network primary care, preventive services, and other evidence-based services expected to improve affordability and reduce morbidity over time), and
- Plan availability and competition (issuer participation, county-level plan availability/plan count, recognizing rural or geographically challenging counties often have fewer options, and market competition).

CMS should then calibrate evidentiary requirements based on which stability dimensions the State is addressing, rather than relying on a single narrow framework.

Streamlining the Waiver and Renewal Process

We support the change allowing States to request waivers for up to 5 instead of 3 MLR reporting years. We also recommend CMS add a streamlined renewal provision: if the State demonstrates meaningful progress on the metrics used to justify the adjustment (and no material consumer harm), renewal should be available for an additional 5 years with minimal disruption and without restarting the process from scratch.

We also support reducing the information required regarding the State's individual market and revising the criteria used to evaluate requests, such as:

- permitting States to cite existing rate review documentation, issuer MLR filings, and Exchange market data as primary evidence,
- allowing a standardized "core packet" with optional modules depending on the type of proposal, and

- establishing a CMS technical assistance process (pre-submission consultation) to reduce rework and uncertainty.

Regarding modifying the criteria in § 158.330, we recommend revising criteria so that States may support pilot proposals through:

- actuarially sound theory and prospective analysis,
- reasoned expert evaluation,
- identification of market failures and incentive misalignment, and
- a clear monitoring and fail-safe framework, even when historical data cannot fully demonstrate the outcome before the fact (which is often the case for innovation pilots).

Sequestration and Risk Adjustment Fee

Under Part 153, continuation of sequestration and the 5.7 percent rate applied to FY 2026 resources will continue to affect transfer amounts. For smaller or limited markets, this may have a more noticeable effect on issuer margins. Ongoing monitoring of solvency and market participation is advisable. The proposed risk adjustment user fee of \$0.20 PMPM for the 2027 benefit year appears aligned with administrative cost recovery. However, when viewed alongside other federal adjustments, cumulative impacts on premiums should be considered.



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Submitted online via Regulations.gov

March 12, 2026

Secretary Robert F. Kennedy, Jr.
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

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

Dear Secretary Kennedy:

The National Health Law Program (NHeLP) is a public interest law firm that works to advance equitable access to health care and protect the health rights of people with low incomes and underserved populations. For over fifty-five years, we have litigated, advocated, and educated at the federal and state levels to advance health and civil rights in the United States. Consistent with our mission, we strongly believe that health care is a human right. Every individual should have access to high quality, affordable, and comprehensive health care and be able to achieve their own highest attainable standard of health. Accordingly, we generally appreciate the opportunity to comment on the Department of Health and Human Services' (HHS) proposed rule, *Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program Proposed Rule* (hereinafter "Proposed Rule").

The Proposed Rule aims to enact sweeping changes to fundamental aspects of the Affordable Care Act, often in defiance of statutory requirements, without sufficient evidence, and in apparent disregard to the adverse impacts of proposed policies on individuals and families that rely on Marketplace coverage to access affordable health care.¹ Throughout the rule, HHS fails to support conclusory assertions with sufficient – or, in certain cases, any – data. In particular, we are concerned by the frequency with which HHS attempts to justify imposing burdensome, overly broad administrative barriers to enrollment by claiming that they are necessary to address fraud – without clearly demonstrating that improper enrollments represent a significant issue, much less that proposed policies will target improper enrollments effectively. Moreover, the rule relies on a foundation of flawed assumptions regarding enrollment and premium costs to overestimate its cost savings potential and underestimate likely negative coverage impacts. While it is not always clear whether these deficiencies spring from a lack of information on the part of the agency, or simply an unwillingness to share data that could undermine HHS's policy agenda, this persistent lack of adequate support and analysis robs the public of a meaningful opportunity to comment on virtually all of the proposals contained in the rule. For that reason, as well as others articulated throughout these comments, we urge HHS to withdraw the Proposed Rule except for proposals related to agent and broker standards of conduct, which we recommend be finalized with specific changes.

We also want to note our strong objection to the truncated, 30-day comment period, which is insufficient for a proposed rule with such far-reaching and potentially harmful effects. HHS should provide at least a 60-day comment period for such a wide-ranging rule. The truncated time is compounded by corrections to the rule that were published on March 6, just one week before the comments due date.

§§ 155.105(b)(4), 155.106(a)(2), 155.205(b), and 155.221(k) – Exchange Operations

NHeLP provides detailed comments in opposition to proposals related to State Exchange operations at §§ 155.105(b)(4), 155.106(a)(2), and 155.205(b) below.

As a preliminary matter, we find these proposals particularly ill-timed during the current period of ongoing massive coverage loss and system upheaval. Significant changes to Medicaid, Marketplace, and Basic Health Program eligibility mandated by the One Big Beautiful Bill Act and earlier HHS rulemaking will continue to heavily implicate Exchange operations over the next several plan years. These changes include the exclusion of millions of lawfully present non-citizens from Medicaid and insurance affordability programs, beginning in 2025 and accelerating through 2027; the implementation of work requirements

¹ U.S. Dep't. Health & Human Svcs., *Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program Proposed Rule*, 91 Fed. Reg. 6292 (proposed Feb. 11, 2026), <https://www.govinfo.gov/content/pkg/FR-2026-02-11/pdf/2026-02769.pdf> (hereinafter "Proposed Rule").

in Medicaid beginning in some states this year and expanding nationwide in 2027; and the implementation of extensive pre-verification requirements for applicants and enrollees to Marketplace coverage.² The Proposed Rule largely ignores the relationship between its proposals and these separate but deeply interrelated changes, failing to account for how its proposals would actually affect consumers if finalized. Coverage disruptions related to these and other policy changes are unfolding in tandem with the effects of the expiration of enhanced premium tax credits (PTCs), which is anticipated to drive millions of people to become uninsured or underinsured.³ During a period when households are already struggling to maintain access to affordable coverage, lowering standards for State Exchanges presents an unacceptable risk.

§ 155.105(b)(4) – Removing the requirement that a state seeking to operate a State Exchange must first operate as State Based Exchange on the Federal Platform for at least one plan year

NHeLP opposes the proposal to remove the requirement at § 155.105(b)(4) that a state that seeks to operate as a State Exchange first operate on the Federal platform for at least one plan year, including its first open enrollment period.

As HHS notes in the preamble to the Proposed Rule, every state that has elected to operate as a State Exchange after 2014 has operated as a State Based Exchange on the Federal Platform (SBE-FE) for at least one plan year before transitioning to independent State Exchange status.⁴ The current requirement therefore codifies best practices that reflect more than a decade of implementation of the Affordable Care Act (ACA).

HHS created the SBE-FP option to formalize an arrangement between a state and HHS that allows a State Exchange to maintain independent legal status and retain authority and primary responsibility for certain key Exchange functions (including plan management,

² See Pub. L. No. 119-21, §§ 71119, 71301, 71302, and 71303 (2025) (“OBBBA”) and U.S. Dept. of Health and Human Srvs., *Marketplace Integrity and Affordability Final Rule*, 90 Fed. Reg. (June 25, 2025), <https://www.govinfo.gov/content/pkg/FR-2025-06-25/pdf/2025-11606.pdf>.

³ The expiration of enhanced PTCs will drive significant coverage loss, although the full impact on consumers and Exchanges will likely unfold over months, if not years. See, e.g., Stacey Pogue, et al., Georgetown Ctr. on Health Ins. Reforms, *Clues in State Data Suggest Declines in Early Marketplace Enrollment Data May Be Just the Tip of the Iceberg* (Jan. 28, 2026), <https://chir.georgetown.edu/clues-in-state-data-suggest-declines-in-early-marketplace-enrollment-data-may-be-just-the-tip-of-the-iceberg>; Matthew Buettgens, et al, Urban Inst., *4.8 Million People Will Lose Coverage in 2026 if Enhanced Premium Tax Credits Expire* (Sept. 17, 2025), <https://www.urban.org/research/publication/48-million-people-will-lose-coverage-2026-if-enhanced-premium-tax-credits>; Ltr. from Philip Swagel, Director, Congressional Budget Office, to Hon. Ron Wyden, Hon. Richard Neal, Sen. Sheehan, and Rep. Underwood, *Re: The Effects of Not Extending the Expanded Premium Tax Credits for the Number of Uninsured People and the Growth in Premiums* (Dec. 5, 2024), <https://www.cbo.gov/system/files/2024-12/59230-ARPA.pdf> (estimating that the expiration of enhanced premium tax credits will increase the number of people without insurance by 2.2 million in 2026, 3.7 million in 2027, and 3.8 million, on average, in each year over the 2026-2034 period).

⁴ Proposed Rule at 6298.

consumer support, and Navigator operations), while continuing to rely on the Federally Facilitated Exchange (FFE) to perform eligibility and enrollment functions, including leveraging FFE consumer call center and casework resources and technology.⁵

Requiring one year of SBE-FP operations is a reasonable threshold that ensures that states have a minimum transition period to focus on developing the resources necessary to implement key SBE functions. As HHS explained in the 2025 Notice of Benefit and Payment Parameters, this includes establishing relationships with crucial formal and informal partners such as consumers, issuers, Navigators and other application assisters, providers, community-based organizations, and other entities whose partnership can bolster the eventual success of an independent State Exchange.⁶ Moreover, a minimum transition period provides states with a timeline for developing and launching eligibility and enrollment functions, which include not only the “back end” information technology, but a consumer-facing Exchange website and call center. Additionally, these functions must be carefully coordinated with relevant state agencies administering Medicaid, CHIP, and Basic Health Programs to ensure compliance with the requirement to provide a single, streamlined application for all applicable state health subsidy programs.⁷

HHS now claims that “requiring States to first operate as an SBE-FP for at least 1 plan year could potentially create unnecessary barriers for States that are well-prepared to implement a State Exchange more immediately” but fails to provide any evidence to explain how the current transition period has functioned as an “unnecessary barrier” to any states seeking to transition to State Exchange status. Moreover, states seeking State Exchange status must submit an Exchange Blueprint application for HHS approval no less than 15 months prior to the date on which the state proposes to begin open enrollment as an SBE.⁸ Therefore, a one-year transition period during which a state functions as a SBE-FP does not necessitate a burdensome or additional delay to the extent a state is “well-prepared to implement a State Exchange”, but rather provides a valuable opportunity for the state to demonstrate its capacity to carry out key Exchange functions quasi-independently of the FFE while HHS reviews its Blueprint submission.

This transition year is particularly valuable because State Exchange functions are highly state-specific. In the 2025 NBPP Final Rule, HHS acknowledged this reality, finalizing the current one-year SBE-FP requirement in part because: “[i]t is not possible for a State seeking to newly establish a State Exchange to identically apply development and implementation plans and other resources utilized for an eligibility platform in already-

⁵ 45 C.F.R. § 155.200(f); U.S. Dep’t of Health and Human Servs., *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017*, 81 Fed. Reg. 12204, 12244-12246 (March 8, 2016), <https://www.govinfo.gov/content/pkg/FR-2016-03-08/pdf/2016-04439.pdf>.

⁶ U.S. Dep’t of Health and Human Servs., *Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program*, 88 Fed. Reg. 82510, 82552 (Nov. 24, 2023), <https://www.govinfo.gov/content/pkg/FR-2023-11-24/pdf/2023-25576.pdf>.

⁷ 42 U.S.C. § 18083(b)(1)(B).

⁸ 45 C.F.R. § 155.106(a)(20).

established State Exchanges, because in [HHS's] experience, those exchanges may operate with partner State agencies, such as Medicaid and CHIP, differently from the State that is seeking to newly establish a State Exchange.”⁹ In the Proposed Rule, however, HHS claims that “the technology infrastructure available today to States for implementation of State Exchanges has become more compatible, such that technology used to support one State Exchange implementation could be leveraged by another State Exchange”.¹⁰ HHS does not identify specific technological advancements that support this reversal, nor does it provide evidence to counter the reasoning in recent prior rulemaking.

§ 155.106(a)(2) – Rescinding the requirement that state must provide supporting documentation demonstrating progress toward meeting or implementing State Exchange Blueprint requirements

We oppose the proposal to rescind the requirement that states must provide supporting documentation demonstrating progress toward meeting or implementing State Exchange Blueprint requirements to HHS upon request. In HHS's view, because states have provided such documentation both before and after the requirement was codified last year, a regulatory requirement is unnecessary.¹¹

This requirement was intended to clarify HHS's authority to request such documentation – authority which HHS does not appear to believe has changed.¹² HHS justifies its proposal as an effort to support the “overall goals” of Executive Order 14192, which aims to “promote prudent financial management and alleviate unnecessary regulatory burdens.”¹³ If HHS believes it retains the authority to request supplemental documentation as part of its Blueprint Application review and plans to continue to make such requests when appropriate, rescinding the regulation does little to reduce the practical burden on regulated entities. While rescinding the rule may allow HHS to check a deregulatory box, it will have little meaningful burden reduction effect on states. Rather, doing so is likely to promote confusion about HHS's authority to request documents or signal reduced rigor in the agency's approach to Blueprint Application review, which could in turn delay future provision of requested documentation and negatively affect Blueprint approvals.

§ 155.170(a) – Additional Required Benefits

HHS proposes to amend 45 C.F.R. § 155.170(a) to provide that any state-required benefit will be considered “in addition to EHB” and subject to defrayal if it is 1) required by state action taking place after December 31, 2011, 2) applicable to small group and/or individual markets, 3) specific to required care, treatment, or services, and 4) not required by state

⁹ 89 Fed. Reg. 26218, 26261 (“2025 NBPP Final Rule”).

¹⁰ Proposed Rule at 6327.

¹¹ Proposed Rule at 6328.

¹² Proposed Rule at 6327-6328.

¹³ 90 Fed. Reg. 9065 (Feb. 6, 2025), <https://www.govinfo.gov/content/pkg/FR-2025-02-06/pdf/2025-02345.pdf>.

action to comply with federal requirements.¹⁴ HHS claims that these changes “are only intended to codify longstanding elements of the defrayal analysis.”¹⁵ However, as proposed, many of the benefits added or improved via the EHB benchmarking process could be subject to defrayal. Moreover, states have relied on assurances from HHS that benefits which have been added or improved through the benchmarking process would not trigger defrayal.¹⁶ If finalized, the proposal will create confusion and uncertainty, impede state efforts to address health care needs of residents, and ultimately harm consumers.

We strongly object to this proposal, which stands to reverse years of progress in empowering states to establish benefits that best meet the needs of their residents. In the 2019 Notice of Benefit and Payment Parameters (NBPP), HHS acknowledged the importance of giving states “additional choices with respect to benefits, which may foster innovation in plan design and greater access to coverage[.]”¹⁷ HHS continued this trend toward increased state flexibility in the 2025 NBPP, clarifying that a covered benefit that is part of a state’s EHB benchmark plan will be considered an EHB and therefore not subject to defrayal, irrespective of whether the benefit was added as a state mandate.¹⁸ We supported that change, noting that it would “further incentivize states to seek modifications and improvements to their benchmark plans” without having to contend with ACA requirements concerning benefits in addition to EHB.¹⁹

This flexibility has served states well. The current version of the regulation has enabled states to, among other things, effectively address the needs of their residents, tailor responses to the opioid overdose crisis, expand access to fertility care, and strengthen preventive services.²⁰ The proposed amendment threatens these efforts and the viability of future efforts to improve EHB plans.

¹⁴ Proposed Rule at 6332.

¹⁵ *Id.* at 6333.

¹⁶ Ctrs. for Medicare & Medicaid Servs., *Frequently Asked Questions on Defrayal of State Additional Required Benefits* (Oct. 23, 2018), <https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/downloads/faq-defrayal-state-benefits.pdf> (hereinafter “CMS FAQ”).

¹⁷ U.S. Dep’t of Health and Human Servs., *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019*, 83 Fed. Reg. 16930, 17010 (April 17, 2018), <https://www.govinfo.gov/content/pkg/FR-2018-04-17/pdf/2018-07355.pdf>.

¹⁸ 2025 NBPP Final Rule at 26225.

¹⁹ Nat’l Health Law Prog., *Comments on RIN 0938-AV22; CMS-9895-P Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program*, 88 Fed. Reg. 82510 4 (Nov. 24, 2023), <https://www.regulations.gov/comment/TREAS-DO-2024-0001-0031>.

²⁰ See, e.g., Ctrs. for Medicare & Medicaid Servs., *North Dakota EHB Benchmark Plan (2025–2027)* (2023) (alternatives to opioids), *Washington, D.C. EHB Benchmark Plan (2026–2028)* (2024) (fertility services), *New Mexico EHB-Benchmark Plan (2025–2027)* (2020) (weight loss services and artery calcification testing).

A. The defrayal provision is vague and overly broad

Nearly a dozen states have updated their EHB benchmark plans by adding or improving benefits since the last time HHS modified the benchmarking process. These updates, pursuant to the EHB benchmarking framework and approved by CCIIO, could be subject to defrayal under this proposal. Benchmark updates meet the criteria for state action as described in the proposed regulatory text. EHB benchmark updates apply to the small group and individual market; are specific to required care, treatment, or services, and are typically not required for purposes of compliance with federal law. On their face, benefits added via benchmark updates would be subject to defrayal under this proposal.

In its 2018 FAQ on defrayal, HHS explicitly provided that benefits included in a new EHB benchmark plan would not be treated as state mandates and therefore would not be subject to defrayal under 45 C.F.R. § 155.170 unless they were mandated after December 31, 2011 “through legislative or regulatory action **separate from an EHB-benchmark plan selection process**” (emphasis added).²¹ Neither the preamble nor the proposed regulatory text address the distinction between benefits added through the benchmarking process and those considered state mandated benefits subject to defrayal.

HHS creates ambiguity about several crucial aspects of EHB standards and the benchmarking process. For instance, HHS “clarifies” that “a State that wants to avoid defrayal obligations for State-required benefits that are already in the State’s EHB-benchmark would be able to do so by repealing the applicable State requirement as being applicable to QHPs.”²² Seemingly, a state would need to repeal a state law, regulation, or other regulatory act adding a benefit to EHB to avoid defrayal, but would not need to change its benchmark accordingly. This circular reasoning only adds to the confusion and lack of clarity for states. As written, the Proposed Rule does not offer sufficient detail or evidence to provide a meaningful opportunity to comment, given lack of clarity about the nature of the proposal itself.

We urge HHS to withdraw this proposal. In the future, if the agency proposes changes to defrayal regulations, it should provide sufficient detail and evidence to ensure that the public has a meaningful opportunity to comment. HHS should include regulatory language making clear that benefits added or improved through the EHB benchmarking process are not subject to defrayal, reflecting the 2018 guidance.²³ Given the reliance interest for states, we do not believe that guidance documents or assurances in the preamble to the final rule are sufficient to clarify the applicability and the parameters of the proposal. Instead, we strongly urge HHS to re-propose any future clarifications as regulatory text.

²¹ See CMS FAQ, *supra* note 16.

²² Proposed Rule at 6334.

²³ See CMS FAQ, *supra* note 16.

B. Requiring defrayal harms states that have updated their EHB benchmark plans

Clarifying the meaning of “state action” is critical because states take a variety of approaches to updating their EHB benchmark plans. The following examples illustrate the diverse methods states undertake to update their EHB benchmark plans and the different reasons why states undertake such efforts.

North Dakota. North Dakota made wide-ranging changes to its EHB benchmark plan for plan year 2025 following a continuing resolution that “urged” the Insurance Commissioner to add the benefits that would ultimately be adopted in the updated plan.²⁴ The legislature’s resolution, the benchmarking update, and the subsequent codification into state law could all trigger defrayal under this proposal.²⁵

Oregon. Oregon updated its EHB benchmark plan for plan year 2022 to add benefits related to addressing effects of the opioid overdose crisis within the state, fashioning the changes after similar changes Illinois made for plan year 2020.²⁶ The state’s Department of Consumer and Business Services (DCBS) initiated the changes and they were codified into state regulation following approval of the new plan.²⁷

California. California’s benchmark plan has been codified into state law since 2014. Before the California Department of Managed Health Care (DMHC) submits any benchmark changes, the Legislature must enact and codify those changes (which only take effect upon federal approval). Following this process, in 2025, the California Legislature amended the state statute to add several new benefits to its EHB benchmark plan. In response, DMHC submitted an application to change the State’s benchmark plan for plan year 2027 reflecting those changes.²⁸

²⁴ See Ctrs. for Medicare & Medicaid Servs, *North Dakota EHB Benchmark Plan (2025-2027)* (2023); see also 2023 N.D. Laws (H.C.R. 3011), <https://legiscan.com/ND/bill/HCR3011/2023/>.

²⁵ See N.D. Cent. Code § 26.1-36-09.16 (2025) (insulin and insulin supplies).

²⁶ See Ctrs. for Medicare & Medicaid Servs, *Oregon EHB Benchmark Plan (2025-2027)* (2023).

²⁷ See *Essential Health Benefits (EHB) Rulemaking Advisory Committee*, Or. Dep’t of Consumer & Bus. Servs. (Apr. 23, 2020),

<https://web.archive.org/web/20250125222801/https://dfr.oregon.gov/help/committees-workgroups/pages/ehb-rulemaking-committee.aspx>, Or. Admin. R. 836-053-0017 (2021).

²⁸ See Cal. Dep’t of Managed Health Care, *DMHC Applies to Update California’s Benchmark Plan, Expand Essential Health Benefits to Include Fertility Services, Hearing Aids & Wheelchairs* (May 5, 2025), <https://dmhc.ca.gov/Resources/Newsroom/PressReleases/May5,2025.aspx>; see also, e.g., S.B. 1290, 2023-24 Reg. Sess. (Cal. 2023), A.B. 2914, 2023–24 Reg. Sess. (Cal. 2023); see also, e.g., Cal. Leg., *Joint Informational Hearing Assembly and Senate Health Committees 2027 Essential Health Benefits Benchmark Options* 6-8 (Feb. 11, 2025), <https://ahea.assembly.ca.gov/system/files/2025-02/ehb-background-feb-11-2025.pdf> (collecting examples of introduced coverage mandates). The coverage mandate is conditioned on HHS approval of California’s updated EHB benchmark plan. Cal. Ins. Code § 10112.27(a)(2)(E) (2026), Cal. Health & Safety Code § 1367.005 (2026).

Virginia. Virginia updated its EHB benchmark plan for plan year 2025, revising definitions related to coverage for medical formula and certain prosthetic devices.²⁹ The Virginia State Corporation Commission (SCC) Bureau of Insurance (BOI) selected the current benchmark plan following a directive from the Virginia General Assembly.³⁰

All of these states approached the process of updating their EHB benchmark plans in different ways. Some updates were the result of legislation. Others were the result of a state agency identifying an unmet health need within the state and addressing it. Some benefits were codified in statute or regulation following the approval of the updated plan. But they do all have something in common: it is impossible to tell, based on the proposed regulatory text, which of these approaches is “state action” that would render these new or expanded benefits subject to defrayal.

C. The defrayal proposal will increase health care costs and premiums while reducing coverage

The proposed defrayal requirement will increase health care costs, erode the value and comprehensiveness of ACA coverage, limit the reach of important consumer protections, and create significant burden for states. Imposing such onerous defrayal requirements on states will also prevent them from being flexible in addressing the health needs of their residents.

HHS claims that the current policy surrounding defrayal drives up premiums, increases federal spending on PTCs, and discourages enrollment by unsubsidized enrollees.³¹ Although HHS offers no evidence to support this specific assertion, it is true that the cost of health care is a matter of great public concern. A recent survey found that the cost of health care was the most significant of the public’s “economic anxieties,” ranking higher than other cost concerns such as food and housing by a wide margin.³² The expiration of enhanced premium tax credits has only exacerbated the problem for ACA enrollees, with premiums up over 20% in 2026.³³ In response, many ACA enrollees are opting for less comprehensive plans that may be cheaper upfront but carry much higher limits on out-of-

²⁹ See Ctrs. for Medicare & Medicaid Servs., *Virginia EHB Benchmark Plan (2025–2027)* (2023).

³⁰ 2023 Va. Acts 272 (directing the BOI to select a new benchmark plan that includes coverage for prosthetic devices and medical formula); see also Va. Code Ann. § 38.2-3418.18 (coverage for formula and enteral nutrition products as medicine), Va. Code Ann. § 38.2-3418.15 (coverage for prosthetic devices and components), Va. Code Ann. § 38.2-3418.15:1 (clarification of prosthetic coverage). Additionally, beginning in 2025, the Virginia Health Insurance Reform Commission (HIRC) and BOI must review the state’s benchmark plan every five years. Va. Code Ann. § 30-343.1.

³¹ 91 Fed. Reg. 6292, 6333.

³² Shannon Schumacher et al., Kaiser Fan. Found., *KFF Health Tracking Poll: Health Care Costs, Expiring ACA Tax Credits, and the 2026 Midterms*, KFF (Jan. 29, 2026), <https://www.kff.org/public-opinion/kff-health-tracking-poll-health-care-costs-expiring-aca-tax-credits-and-the-2026-midterms/>.

³³ John Holihan et al., *Understanding the Extraordinary Increase in ACA Premiums in 2026*, Urban Inst. (Dec. 2025), https://www.urban.org/sites/default/files/2025-12/Understanding%20the%20Extraordinary%20Increase%20in%20ACA%20Premiums%20in%202026_1217.pdf.

pocket spending, increasing their overall cost of care.³⁴ And in terms of discouraging enrollment, the expiration of enhanced ACA subsidies has resulted in widespread coverage loss, with ACA enrollment for 2026 down by over 1 million people from 2025 figures.³⁵

Implementing this new defrayal requirement is no way to address the public's legitimate affordability concerns. Widely designating benefits to be "in addition to EHB" as the proposed amendment contemplates will actually make coverage less affordable because many financial protections for Marketplace enrollees—such as bans on dollar limits, caps on annual out-of-pocket costs, and the use of premium tax credits—only apply to EHBs.³⁶ This proposed requirement will also render ACA coverage less valuable by limiting the benefits that QHPs must cover.

Moreover, if HHS is legitimately concerned about low enrollment among any group of people, the appropriate response is not to make coverage more expensive and less comprehensive. Instead, HHS should work to reinstate the enhanced PTCs that drove historically low numbers of uninsured and continue permitting states the flexibility to improve the value of ACA coverage.³⁷ Preserving this flexibility is particularly important to combat low enrollment in light of the fact that subsidy amounts are tied to the premium cost of EHBs and cannot be used to pay for benefits in addition to EHB.³⁸ If fewer benefits are considered EHB, it will diminish the amount of financial assistance available to Marketplace enrollees generally, risking depressing enrollment even further.

HHS's framing of current defrayal policy as one that "jeopardize[s] the affordability of premiums" for an "intangible improvement" in states' understanding of defrayal requirements is also disingenuous.³⁹ Even if it were true that the crux of the issue is the extent to which states "understand" defrayal requirements, ensuring that they *do* understand those requirements empowers states to establish benefits and develop coverage in a way that serves their residents—including increased access to care, lower costs (such as limits on cost-sharing and out-of-pocket spending), and nondiscrimination protections that do not apply to benefits in addition to EHB. These are just some of the reasons why NHeLP has long called for additional clarity on defrayal requirements.⁴⁰ However, the issue here is more fundamental: increased EHB flexibility allows states to offer better, more robust coverage, unhampered by the monetary cost of defrayal.

³⁴ Reed Abelson, *New A.C.A. Plans Could Increase Family Deductibles to \$31,000*, N.Y. Times (Feb. 26, 2026), <https://www.nytimes.com/2026/02/26/health/obamacare-health-insurance-rollbacks.html>.

³⁵ *Id.*

³⁶ 42 U.S.C. §§ 300gg-11, 18022(c); 45 C.F.R. § 147.126.

³⁷ HHS, *Health Coverage Under the Affordable Care Act: Current Enrollment Trends and State Estimates*, Off. of the Assistant Sec'y for Plan. & Evaluation (Mar. 22, 2024), <https://www.ncbi.nlm.nih.gov/books/NBK610896/>.

³⁸ 26 U.S.C. § 36B(b)(3)(D).

³⁹ 91 Fed. Reg. 6292, 6333.

⁴⁰ See, e.g., Nat'l Health Law Prog., *Comments on CMS-9930-P NPRM Notice of Benefit and Payment Parameters for 2019*, 82 Fed. Reg. 51052 4 (Nov. 27, 2017).

The cost to states of this proposed change also cannot be understated. More than a dozen states have updated their EHB benchmark plans since the promulgation of 45 C.F.R. § 156.111 in the 2019 NBPP, at great effort and significant cost.⁴¹ Forcing states to undo these changes to avoid defrayal will mean those resources were wasted. Additionally, states will have to expend additional effort to address existing coverage mandates that have been enshrined in law or regulation and deal with the confusion that this policy change would generate in terms of states' responsibilities. Finally, HHS has recognized in the past that making care less effective by weakening EHB standards will result in "spillover effects," which includes increased use of costly emergency services and additional burden on government-funded or safety-net providers.⁴²

For these reasons, we strongly urge HHS not to move forward with the proposed amendment to 45 C.F.R. § 155.170(a). However, if HHS does amend the regulation as proposed, we believe the amendment should be delayed to 2028 to allow states adequate time to adjust.⁴³

§§ 155.205(b) and 155.221(k) – State Based Exchange “Enhanced Direct Enrollment” (SBE-EDE) Option

NHeLP opposes the rescission of § 155.205(b) and the proposed new section § 155.221(k). These changes would permit SBEs to privatize consumer-facing eligibility and enrollment functions by opting into a new SBE-EDE model. This proposal is contrary to statute, imposes significant oversight burden on the state without improving access to coverage or consumer shopping experience, and raises serious program integrity concerns.

A. The SBE-EDE Option is contrary to law

If finalized, the Proposed Rule would allow a State Exchange to impermissibly outsource the inherent government functions of an Exchange to a private, non-Exchange entity in violation of multiple sections of the ACA. HHS's proposal is based on a selective and incomplete reading of the statute and fails to identify a source of authority for the agency to take regulatory action to undermine key statutory requirements.

⁴¹ For instance, Oregon spent more than \$164,000 on working with an actuarial firm for the required valuation report when the state updated its EHB benchmark plan for plan year 2022. *State Agency Contract and Procurement*, Or. Transparency, <https://www.oregon.gov/transparency/pages/contracts.aspx> (last visited Feb. 26, 2026).

⁴² 82 Fed. Reg. 51052, 51131.

⁴³ We note that 30 state legislatures are either not scheduled to convene in 2026 or will end regular sessions by April 30, 2026. Given the timing of the Proposed Rule, the majority of state legislatures will have inadequate opportunity to implement a finalized version of this proposal, either to rescind mandates through legislation or appropriate state dollars to defray benefits determined to be in addition to EHB.

First, the ACA clearly defines an Exchange as a “governmental agency or nonprofit entity that is established by a state”.⁴⁴ By allowing a “non-Exchange entity” to stand in the shoes of the Exchange for purposes of consumer-facing plan selection and enrollment functions, the SBE-EDE proposal substitutes a web broker for the Exchange in clear violation of the ACA. HHS claims that the elevated role of a web broker under the SBE-EDE option is similar to the relationship between SBEs and private contractors with whom a state may have engaged to support operations of an Exchange website today. But there is a fundamental difference between an Exchange that hires a contractor to carry out certain technical functions at the direction of the Exchange, and for which the Exchange is still ultimately accountable, and the SBE-EDE option that would permit the state to cede consumer-facing enrollment to private entities.

Second, the ACA is clear that an Exchange is required to, among other functions, actually *offer* QHPs to prospective enrollees; that is, provide individuals with an opportunity to enroll in coverage. HHS incorrectly asserts that an Exchange electing the SBE-DE option can meet this requirement by maintaining “a website listing basic QHP information for comparison, and a listing with links to approved partner websites for consumer shopping, plan selection, and enrollment activities.”⁴⁵ While the statute indeed requires an Exchange to maintain such an informational website with “standardized comparative information” on QHPs, this is just one of several statutory Exchange requirements.⁴⁶ Of particular relevance, 42 U.S.C. § 18031(d) establishes certain Exchange “Requirements.” Under the subheading “Offering of Coverage,” at § 13031(d)(1), these requirements include that the Exchange “shall *make available* qualified health plans (QHPs) to qualified individuals and qualified employers” (emphasis added). HHS aims to reinterpret this language as a mere suggestion – claiming that an Exchange that “minimally operates” an informational website that directs consumers to private sellers will meet statutory requirements. But that is simply not what it means to “offer insurance” or make coverage “available,” either elsewhere in the ACA, as previously interpreted by HHS or HHS of the Treasury, or in the common parlance of the insurance industry.⁴⁷

⁴⁴ 42 U.S.C. § 13031(d)(1).

⁴⁵ Proposed Rule at 6331.

⁴⁶ 42 U.S.C. § 13031(d)(4)(c).

⁴⁷ See, e.g., 42 U.S.C. 300gg-1 (“Guaranteed Availability of Coverage”) and numerous interpretive HHS guidance documents including *Frequently Asked Questions on Health Insurance Market Reforms and Marketplace Standards*, Question 5 (May 16, 2014), <https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/downloads/final-master-faqs-5-16-14.pdf>; *Frequently Asked Questions on Health Insurance Market Reforms and Marketplace Standards* (June 3, 2014), https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/downloads/fq_on_qhps_and_guaranteed_availability_6314.pdf; *Frequently Asked Questions on Agent/Broker Compensation and Guaranteed Availability of Coverage* (June 7, 2022), <https://www.cms.gov/files/document/agent-broker-compensation-and-guaranteed-availability-coverage.pdf>; 42 U.S.C §§ 13031(d)(2)(B)(ii) (“Offering of Stand-Alone Dental Benefits”) and 18053 (“Provisions Relating to Offering of Plans in More Than One State”) and 26 U.S.C. § 125(f)(3) (“Offering of Exchange-Participating Qualified Health Plans Through Cafeteria Plans”), which all use the phrase “offering of” plans to refer to making plans available for enrollment; Department of the Treasury, Internal Revenue Service, *Questions and answers on employer shared responsibility provisions under the Affordable Care Act*, Question 29, <https://www.irs.gov/affordable-care->

Additionally, 26 C.F.R. § 36B(b)(2)(A), as added by section 1401 of the ACA, requires individuals to enroll in coverage “through an Exchange” in order to be eligible for PTCs. HHS explains that it has previously interpreted this language to permit enrollment directly through a QHP issuer or agent, broker, or web broker provided the non-Exchange entity meets relevant regulatory guardrails. But these very guardrails are premised on the existence of an independent, trusted platform through which the Exchange itself offers coverage.⁴⁸ Enrolling in a plan through a web broker in a state where there is no Exchange enrollment option can never be “through an Exchange” as required by statute.

Thirdly, the SBE-EDE proposal is inconsistent with the ACA and would harm people who are eligible for other insurance affordability programs, including Medicaid. The ACA includes independent requirements for “no wrong door” application processes and other coordination standards that conflict with the privatized system proposed under the NBPP.⁴⁹ The SBE-EDE proposal would render it impossible for a State Exchange to meet its obligations under the ACA and the Social Security Act to effectuate a streamlined enrollment process into the full range of health subsidy programs, including Medicaid, CHIP, and the Basic Health Program along with Marketplace insurance affordability programs like PTCs and cost-sharing reductions.⁵⁰ In the preamble to the Proposed Rule, HHS sketches out a patchwork set-up through which a non-Exchange entity such as a private web broker could theoretically transfer information from its commercial website to the Exchange for eligibility determinations and referrals to the appropriate agency, such as the State Medicaid agency.⁵¹ But this approach fails to meet the requirements under the law to provide a streamlined application and enrollment experience. When people who are eligible for Medicaid or other programs initially seek coverage using a Direct Enrollment (DE) or Enhanced Direct Enrollment (EDE) pathway today, they do so in the context of

[act/employers/questions-and-answers-on-employer-shared-responsibility-provisions-under-the-affordable-care-act](#) (“In general, an [applicable large employer] makes an offer of coverage to an employee if it provides the employee an effective opportunity to enroll in the coverage (or to decline that coverage) at least once for each plan year.”); and Wellpoint, *The Health Insurance Exchange: Navigating on-exchange vs. off-exchange health plans*, <https://www.wellpoint.com/individual-family/learn/on-exchange-vs-off-exchange> (“On-exchange health insurance is coverage that you purchase through the Health Insurance Marketplace or your state-run exchange...Many insurers like Wellpoint often offer both on-exchange and off-exchange health plans”).

⁴⁸ See, e.g., 45 C.F.R. § 156.1230(a)(1)(iv) (requiring that a QHP issuer conducting DE inform “all applicants of the availability of other QHP products offered through the Exchange through an HHS-approved universal disclaimer and displa[y] the Web link to and describes how to access the Exchange Web site”; 45 C.F.R. § 155.220(c)(3)(i)(F) (requiring that if a web-broker’s own website is used to complete the QHP selection, the website must “[p]rovide consumers with the ability to withdraw from the process and use the Exchange Web site...at any time”).

⁴⁹ 42 U.S.C. § 18083. See also 42 U.S.C. § 1396w-3 and 42 C.F.R. § 435.1200.

⁵⁰ See 42 U.S.C. § 1396w-2(b)(1)(a) (requiring a state to establish procedures for “enabling individuals, through an Internet website that meets the requirements of paragraph (4)” to apply for and enroll in Medicaid; § 1396w-2(b)(4), “Enrollment Website Requirements,” requiring that the website referenced in (b)(1) must be “linked to any website of an Exchange established by a State under section 1311 of [the ACA]” that allows an individual to compare Medicaid and QHP coverage options (emphasis added).

⁵¹ Proposed Rule at 6329.

being able to default to a fully-functioning, compliant Exchange website. Even so, there have been reports of misleading or confusing practices by web brokers with respect to individuals who are determined eligible for Medicaid. While unacceptable, this behavior is hardly surprising in a profit-driven system, given that brokers affiliated with commercial insurance issuers have no financial incentive to appropriately direct eligible individuals to Medicaid coverage, which provides no revenue to the non-Exchange entities.⁵² Stripping the Exchange of its obligation to provide a single, streamlined enrollment experience for all consumers – whether they are eligible for Marketplace, Medicaid, CHIP, or BHP coverage – would exacerbate these effects. Allowing non-Exchange entities to serve as the exclusive pathway for Marketplace enrollment while maintaining a separate eligibility and enrollment pathway for Medicaid, CHIP, and other health programs clearly deprives consumers of the “streamlined” process required by the ACA. Such a system clearly fails to comply with the intent of the ACA to ensure that individuals seeking coverage can rely on an Exchange-supported “one stop shop”.

Finally, the SBE-EDE proposal appears to revive aspects of a policy initially finalized in the 2022 NBPP. Under that policy, HHS would have permitted both State Exchange and FFE states to replace the relevant Exchange with a decentralized system fully reliant on issuers, agents, and brokers. This so-called “Exchange Direct Enrollment” plan was never implemented and was ultimately reversed in subsequent rulemaking after HHS concluded that the program posed unacceptable risks to consumers and the strength of the ACA.⁵³ However, in response to the original proposal, NHeLP and other commenters noted that it closely mirrored a 1332 waiver to establish the Georgia Access Model, allowing Georgians to enroll in coverage through a decentralized system of private brokers and issuers.⁵⁴ In its waiver approval letter, HHS explicitly waived §§ 1311(b)-(e) and (i) of the ACA, suggesting that these are statutory requirements that Georgia was required to pursue a formal waiver to pursue. The 1332 waiver process, set out in statute, importantly includes multiple opportunities for public comment and individualized negotiation and approval between a state and HHS.⁵⁵ Not only does the current SBE-EDE proposal attempt an end-run around multiple statutory requirements, in conflict with the precedent set in the Georgia 1332 program, it would allow a state to effectively waive statutory requirements with no public

⁵² Tara Straw, “*Direct Enrollment*” in *Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm* (March 15, 2019), Center on Budget & Policy Priorities, <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>,

⁵³ 86 Fed. Reg. 53412, 53424-53429 (Sept. 27, 2021).

⁵⁴ See Nat’l Health Law Prog., *Comments to HHS re: “Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations,” Proposed Rule* (Dec. 23, 2020), <https://www.regulations.gov/comment/CMS-2020-0151-0114>; State of N.Y. Office of the Att’y Gen. and 22 other State Attorneys Gen’l, *Comments regarding Proposed Rule, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations*, 85 Fed. Reg. 78,572 (Dec. 4, 2020), RIN 1505-AC72 and RIN 0938-AU18 (Dec. 30, 2022), <https://www.regulations.gov/comment/CMS-2020-0151-0311>.

⁵⁵ 42 U.S.C. § 18052(a)(4).

input or transparent process. Consumers would essentially be forced to enroll in coverage through a fragmented and privatized system at the discretion of the state, with no opportunity to voice their concerns or review the state's proposal in advance.

B. The SBE-EDE Option would harm consumers and states

The SBE-EDE option prioritizes the business interests of private web brokers to the detriment of consumers and states.

The benefit of the SBE-EDE option to non-Exchange entities operating as web brokers is clear: by allowing a web broker to control the consumer-facing plan comparison, selection, and enrollment processes, these private entities can control the consumer “shopping” experience and steer individuals to products that are most profitable for the web broker, including non-QHP products.

By allowing non-Exchange entities to operate the consumer-facing enrollment experience, the SBE-EDE option selectively permits an Exchange to offload one key statutory function. But an Exchange operating in an SBE-EDE state would not only continue to be required to implement its other statutory functions, such as plan management; operating a centralized “back-end” eligibility and enrollment system; collecting and maintaining enrollment records and transmitting such enrollment information to HHS and the IRS; and providing consumer support services in the form of a call center and a Navigator program, it would also be required to take on burdensome new responsibilities. These responsibilities include developing and implementing standards for consumer-facing non-Exchange websites to “interface” appropriately with the Exchange-run eligibility and enrollment processes, maintaining a website with QHP comparison information and links to non-Exchange shopping and enrollment websites; and creating and implementing an oversight structure for ongoing monitoring of non-Exchange entities. These additional costs are likely to be extensive; HHS notes that the only state that has initiated a State Exchange while implementing an EDE option incurred \$25 million in startup costs.⁵⁶ While HHS optimistically claims that “any savings achieved through a decrease in call center volume or other consumer supports due to EDE partners assisting consumers with enrollment would offset any operational costs” it provides no evidence to support this assertion, or data to project ongoing maintenance and operations costs to the state.

Finally, the proposal would harm individuals and families seeking Marketplace coverage. Although HHS states that an aim of the SBE-EDE proposal is to “enhance the consumer enrollment experience,” replacing an Exchange consumer-facing website with one or more non-Exchange entities offers no meaningful benefit to consumers compared to the status quo. While HHS does not estimate the potential burden on consumers that would be forced to vet multiple non-Exchange entities to obtain coverage in a state that elects the SBE-EDE option, research shows that consumers find enrolling in coverage is time-consuming,

⁵⁶ Proposed Rule at 6446.

confusing, and frustrating, particularly for consumers with low health insurance literacy.⁵⁷ Removing the requirement that an Exchange provide a centralized enrollment experience that allows individuals to compare, select, and enroll in coverage in one verified location will only exacerbate the time burdens associated with selecting Marketplace coverage.

Additionally, private web brokers have little incentive to support consumers with greater needs whose cases are likely to require more resources with no guarantee of providing greater compensation – for example, low-income and rural households who do not have reliable Internet access and require in-person assistance, those with limited English proficiency, people with disabilities, or households with complex or mixed program eligibility such as families where some members are eligible for Medicaid. Navigating multiple EDE websites is likely to be particularly challenging for these households. Unlike Navigators, web brokers are not required to provide targeted assistance to underserved populations, offer unbiased information such as recommending a plan that does not financially benefit them even when it is in the best interest of an individual seeking coverage, or acknowledge other health programs like Medicaid.⁵⁸ Permitting an SBE-EDE option will make the process of comparing and enrolling coverage options more difficult for these households, increasing the risk that are unable to enroll in the most appropriate and affordable health coverage for which they are eligible.

C. The SBE-EDE Option raises significant program integrity concerns

Outsourcing consumer-facing plan selection and enrollment to non-Exchange entities as proposed raises significant program integrity concerns. First, web brokers have no fiduciary duty under the Proposed Rule to ensure that a household enroll in the plan option that is best for them. As noted above, these entities have no financial incentive to ensure that an enrollee who is eligible for Medicaid, CHIP, or a BHP is successfully connected to that type of coverage. Rather, these entities are motivated by profit to steer as many consumers as possible to the products that represent the biggest commission or other compensation for them. Often, the most lucrative products for issuers and brokers alike are not QHPs at all, but short-term plans and other junk insurance that offer few consumer protections and weaken the individual market risk pool, but offer broker commissions up to ten times higher than those for comprehensive coverage.⁵⁹ If finalized in any form, the SBE-EDE option

⁵⁷ See Kakar, R., *Health Insurance Literacy Perceptions and the Needs of a Working-Class Community*, HEALTH LITERACY RES. AND PRAC. (March 31, 2022), <https://pmc.ncbi.nlm.nih.gov/articles/PMC8973763>; Faugano, E., et al., “Pick a Plan and Roll the Dice”: A qualitative study of consumer experiences selecting a health plan in the non-group market, HEALTH POLICY OPEN (Dec. 15, 20203), <https://doi.org/10.1016/j.hopen.2023.100112>; Hero, J., et al., *Decision-Making Experiences of Consumers Choosing Individual Market Health Insurance Plans*, HEALTH AFF., Vol. 30, No. 3 (March 4, 2019), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05036>.

⁵⁸ See 45 C.F.R. § 155.210(e).

⁵⁹ See, e.g., Government Accountability Office, *Private Health Coverage: Results of Covert Testing for Selected Offerings* (Aug. 24, 2020), <https://www.gao.gov/assets/gao-20-634r.pdf>; Katie Keith, *New Congressional Investigation of Short-Term Plans*, HEALTH AFF. (June 26, 2020), <https://www.healthaffairs.org/doi/10.1377/forefront.20200626.227261/full/>.

should prohibit web brokers from offering QHPs and non-QHPs on the same platform and require EDEs to clearly notify consumers if they are directed to a platform that offers non-QHP products for sale in a manner that clearly distinguishes between comprehensive and non-comprehensive coverage. Although we appreciate that HHS would require an SBE-EDE to ensure that at least one EDE entity meets requirements under §§ 155.220(c)(3)(i)(A) and (D) to ensure consumers have at least one option through which to view detailed QHP information for all available QHPs and meets accessibility requirements under § 155.205(c), these requirements should apply to all EDEs offering QHPs under an SBE-EDE option, as the current proposal would not prevent other EDEs from presenting a more limited selection and does not guarantee that any EDE would display plans offered by issuers with whom they have financial ties on equal footing with those with whom they have no relationship.

In addition to the direct risks that consumers will face when deprived of a centralized, Exchange-operated option for enrolling in coverage, the SBE-EDE option weakens oversight over web brokers in a way that appears strikingly at odds with HHS's stated program integrity concerns elsewhere in the rule. According to HHS, "a notable driver of ... continued payment integrity concerns...is agent, broker, and web-broker behavior" and cites to both a 2025 GAO study on improper payments and "recently identified internal data" that nearly 80% of income-related data matching issues (DMIs) in 2024 were triggered for households working with agents, brokers, or web brokers.⁶⁰ From June 2024 to October 2024, the Centers for Medicare & Medicaid services suspended over 850 agents and brokers' Marketplace Agreements for reasonable suspicion of fraudulent or abusive conduct related to unauthorized enrollments or plan switches.⁶¹ These issues are of such "urgent" concern to HHS that it has re-proposed burdensome income verification requirements that are currently stayed by a federal court and that, if finalized, would generate 3.3 million data matching issues (DMIs) per year at a cost of over \$122 million to the FFE, \$75 million to State Exchanges, and \$83 million to consumers.⁶² And yet, HHS is poised to allow states to hand the keys to consumer enrollment to the same entities that it believes are driving significant fraud. Moreover, it would do so without any significant changes to monitoring and oversight, despite the novelty of the SBE-EDE option, stating that any additional oversight costs to the federal government would be "nominal" because it would largely rely on states to act as primary overseers of EDE entities while HHS "leverage[s] its existing State Exchange oversight mechanisms"⁶³ – identified in the preamble as annual SMART submissions, some unspecified technical assistance, and "ongoing informal communication" with states implementing the new option. This approach appears unwise and contradictory if HHS is urgently concerned about fraud perpetuated by

⁶⁰ Proposed Rule at 6348.

⁶¹ Ctrs. for Medicare & Medicaid Svcs., *Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity* (Oct. 17, 2024), <https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity>. See *supra* page 23 for a detailed discussion of these pre-verification proposals, which NHeLP opposes.

⁶² *City of Columbus v. Kennedy*, 796 F. Supp. 3d 123, 168-170 (D. Md. 2025); Proposed Rule. at 6431-6432.

⁶³ *Id.* at 6447.

agents, brokers, and web brokers. Merely continuing the same oversight approach while vastly expending the power of these entities to control the consumer enrollment experience would place consumers in an even more vulnerable position, particularly individuals with low health insurance literacy, limited English proficiency, or those living with disabilities.⁶⁴

If HHS is committed to reducing fraud, which the agency admits is largely tied to unscrupulous agents and brokers, the agency should look to current State Exchange oversight of DE entities. Most State Exchanges operate their own agent and broker portals and report few, if any, improper enrollments, as HHS acknowledges in the Proposed Rule.⁶⁵ The FFE was the sole Exchange that operated an EDE in 2024. We are puzzled by HHS's interest in encouraging State Exchanges to adopt a risky approach to enrollment from the FFE. Indeed, we would recommend the reverse: EDE on the FFE should be limited until the agency's concerns regarding improper enrollments have been resolved.

As noted elsewhere in these comments, we do not believe that the SBE-EDE option is legally permissible, nor is it in the best interest of consumers or states. Given HHS's concerns related to web brokers, we also strongly recommend against finalizing the SBE-EDE proposal on program integrity grounds. If HHS finalizes the proposal despite these concerns, we would strongly recommend delaying the effective date until January 1, 2029, at the earliest, rather than the proposed January 1, 2028, effective date.

HHS solicits comments on expanding the SBE-EDE option to *Healthcare.gov*. For the reasons set forth in our comments opposing the SBE-EDE option, we would also strongly oppose any future proposal to expand the SBE-EDE model to other Exchange options.

⁶⁴ HHS states that "the State Exchange, along with its EDE partners, would continue to be responsible for meeting Federal accessibility standards under § 155.205(c) for individuals living with disabilities and for individuals who have limited English proficiency," but its citation to support this statement includes an inaccurate statement of the scope of the application of § 1557 of the ACA. In fn. 78, HHS states that "[C]overed entities such as States, recipients of Federal financial assistance from HHS, programs or activities administered by HHS under title I of the Affordable Care Act (such as the FFE), and programs or activities administered by any entity established under Title I (such as State Exchanges) must comply with applicable Federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, sex, age, and disability. These laws include section 1557 of Affordable Care Act (42 U.S.C. 18116) (Section 1557), Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) (Title VI), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) (Section 504), and the Americans with Disabilities Act of 1990 (29 U.S.C. 12101 et seq.) (ADA)" (emphasis added). The italicized portion of this statement vastly understates the scope of the application of section 1557 of the ACA, which applies to *all* health programs and activities administered by HHS, not just those programs and activities established under title I of the ACA. 42 U.S.C. 18116(a); and see 89 Fed. Reg. at 37528. NHeLP urges HHS to correct this inaccurate statement of the scope of § 1557 in the final rule.

⁶⁵ J. Giovanelli and S. Pogue, The Commonwealth Fund, *Policymakers Can Protect Against Fraud in the ACA Marketplaces Without Hiking Premiums* (March 5, 2025), <https://www.commonwealthfund.org/blog/2025/policymakers-can-protect-against-fraud-aca-marketplaces-without-hiking-premiums>; Proposed Rule at 6345 ("State Exchanges do not report the same problems with unauthorized enrollments as those currently facing the FFEs...").

§ 155.220(j) – Revised Federally-Facilitated Exchange Agent and Broker Standards of Conduct

A. § 155.220(j)(2)(i) Removal of non-discrimination language

NHeLP strongly opposes HHS's proposed amendment to § 155.220(j)(2)(i), which articulates nondiscrimination requirements among the standards of conduct that individuals who assist with or facilitate health insurance enrollment must meet. HHS proposes to strike a parenthetical clarifying that prohibited sex discrimination includes discrimination based on sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes, erroneously claiming the text at issue addresses "ancillary issues of gender ideology." We urge HHS to maintain this regulatory text, which protects consumers, and particularly women, pregnant people, and LGBTQI+ people, from consequential barriers to health insurance.

Brokers, agents, and web-brokers exercise significant gatekeeping power in plan selection, benefit design, and access to enrollment assistance. Without explicit regulatory language clarifying prohibited grounds of sex discrimination, discriminatory steering, misinformation, and hostile treatment can persist under the guise of professional discretion or market practice, widening sex-related health inequities. The parenthetical at issue provides covered entities with notice of prohibited grounds of sex discrimination. For example, without this clarification, brokers or agents may steer men to more generous plans and women to less generous ones due to sex stereotypes about costs. An agent or broker may discriminatorily steer women to plans with the most robust pregnancy-related coverage without regard to whether they wish to have more children or want to prioritize other services based on the stereotype that a woman's most important societal role is to have children. They may refuse to answer questions about pregnancy-related coverage for people who are in same-sex marriages. They may turn people away based on gender identity, gender-affirming care needs, or past reproductive decisions. If brokers advise employers, they may recommend plan designs that limit pregnancy-related coverage to discourage the retention of staff who wish to become pregnant. In short, retaining the parenthetical on prohibited sex discrimination grounds in the regulatory text is essential both to place covered entities on notice regarding their obligations and to support meaningful enforcement of § 1557 of the Affordable Care Act in a health insurance context.

B. § 155.220(j)(2)(ii)-(iii) Standardizing forms used by agents, brokers, and web-brokers to meet certain compliance requirements

NHeLP supports the proposal to amend §§ 155.220(j)(2)(A) and (j)(3)(A) to require agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form ("HHS consent form") to meet eligibility application review documentation criteria and consent document requirements. We urge HHS to accept our recommendations to ensure that the standardized consent form is accessible to all consumers, including people with disabilities and those with limited English proficiency.

Agents, brokers, and web-brokers facilitate a significant percentage of Marketplace enrollments, but have been identified as a primary source of fraudulent enrollments and plan switches made without enrollee consent.⁶⁶ HHS requires agents and brokers facilitating enrollment on the FFE to document that an applicant for coverage has reviewed an application and consented to its submission by the agent, broker, or web-broker.⁶⁷ However, HHS permits this consent to be obtained and documented in a wide range of formats, including in person via unique paper forms, electronically, by telephone including by recorded telephone messages, and by text. In the Proposed Rule, HHS describes documentation reviews that identified widespread instances of noncompliance, such as documents with missing information, as well as consent forms that were unclear.⁶⁸ It is reasonable for HHS to standardize a single form that can be provided in person or electronically to obtain and document compliance with these requirements to facilitate consistent recordkeeping and audits. NHeLP also supports the clarifications proposed at § 155.220(j)(2)(iii)(C) which would codify 2024 guidance and require agents and brokers demonstrate consumer consent using clear and verifiable means, beyond simply a typed signature or filled-in check box.⁶⁹

However, the current model form falls short of being accessible to all consumers. A form that is overly complex, inaccessible to a person with a disability, or illegible because it is provided in a language in which the applicant is not fluent, can result in direct consumer harm. For example, a consumer could unknowingly consent to the submission of inaccurate household income information that results in under- or over-payment of APTC, resulting in a higher premium payment than necessary or a significant tax liability in the following year.

To ensure that the mandatory consent form is accessible to all consumers, NHeLP recommends that HHS should conduct consumer focus testing, including testing by people with disabilities and limited English proficiency. Language in the form should be revised to reflect the results of this focus testing as well as in consideration of low literacy levels. HHS should translate the form into at least the top 15 languages in each state and make all translations freely accessible online so that agents, brokers, and web-brokers can immediately access the appropriate form as needed for a particular consumer. HHS should also ensure that forms provide standardized but state-specific consumer support

⁶⁶ Jalen Brown, *CCIIO Chief Says Fraud Crackdown Removed 1.5M From Subsidies, Saved Nearly \$10B*, INSIDE HEALTH POL'Y (Feb. 23, 2025) (quoting CCIIO official statement that over 75% of enrollments were completed by an agent or broker during the 2026 Open Enrollment Period); Ctrs. for Medicare & Medicaid Svcs., Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity (Oct. 17, 2024), <https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity>; GAO, Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist (Dec. 3, 2025), <https://www.gao.gov/products/gao-26-108742>; Ctrs. for Medicare & Medicaid Svcs., Marketplace Compliance for Agents and Brokers (Aug. 28 2025), <https://www.cms.gov/files/document/marketplace-compliance-agents-and-brokers.pdf>.

⁶⁷ 45 C.F.R § 155.220(j)(2)(ii).

⁶⁸ Proposed Rule at 6336.

⁶⁹ See Ctrs. for Medicare & Medicaid Svcs., Frequently Asked Questions: Consumer Consent & Application Review Requirements, Q. 8 (June 12, 2024), <https://www.cms.gov/marketplace/agents-brokers/files/frequently-asked-questions-consumer-consent-application-review-requirements.pdf>.

information. Each form should provide information alerting consumers to free, unbiased enrollment assistance through Navigators and prominently display the State Exchange website URL and the telephone number for the Exchange consumer call center. Finally, the form should include contact information for state's Department of Insurance or equivalent regulator of agents, brokers, and web-brokers to report questions or concerns.

C. § 155.220(j)(3) Agent and broker marketing standards

NHeLP broadly supports the proposed restrictions on misleading or fraudulent marketing by agents, brokers, and web-brokers. We appreciate the codification of marketing standards of conduct, including a non-exhaustive list of prohibited practices, and agree that it is necessary for HHS to increase its monitoring of social media sites and other sources to address misleading marketing by agents, brokers, and web-brokers.

In addition to the examples of misleading marketing proposed at § 155.220(j)(3)(iii), we recommend adding language that would clearly prohibit agents and brokers from marketing health coverage that is not a QHP in a manner that could be construed to conflate these products with comprehensive coverage. It is vital that consumers can distinguish between QHPs, which are subject to federal consumer protections and are eligible for insurance affordability programs, and other forms of coverage, such as catastrophic health plans, fixed indemnity coverage, and short-term, limited duration insurance. Agents and brokers should be prohibited from marketing non-comprehensive coverage in a manner that could mislead a consumer into thinking that such coverage is a QHP or offers coverage that is equivalent to a QHP.

RECOMMENDATION: Amend § 155.220(j)(3)(iii) by adding the following language as a new sub-paragraph (j)(3)(iii)(H):

(H): Failing to clearly distinguish between QHP and non-QHP products, including marketing non-comprehensive coverage without clearly labeling such coverage as a non-QHP.

§ 155.305(f)(4) – Failure to File Taxes and Reconcile APTC Process

HHS does not have authority to require any failure to reconcile (FTR) process until the 2028 plan year.⁷⁰ *City of Columbus v. Kennedy* held that the FTR process generally was contrary to statute because eligibility for APTCs is not conditioned on reconciling tax information and HHS cannot add conditions to the express statutory formula for APTCs.⁷¹ While the reconciliation of tax credits is required, the only current statutorily required

⁷⁰ *City of Columbus v. Kennedy*, 796 F. Supp. 3d 123, 160-63 (D. Md. 2025), *appeal pending* (4th Cir. 2025) (No. 25-2012). The court found that “[t]he statute does not contemplate that the existence of a prior tax debt affects an applicant’s eligibility for APTCs in any way”; that Congress knew how to condition issuance of coverage on payment of premiums, but did not do so; and that HHS general rule making authority did not allow it to re-write the statutory formula for APTCs. *Id.* at 162-63.

⁷¹ *Id.*

outcome is that the individual will face increased taxes for that year.⁷² Although OBBBA puts the 1-tax year policy from the 2025 Marketplace Integrity and Affordability Final Rule as a condition of a “coverage month”, the use of a 1-year tax FTR policy does not begin until the 2028 tax year. *City of Columbus* stayed the effective date of not only the 2025 1-tax year FTR policy, but the failure to reconcile policy generally under 45 C.F.R. § 155.305(f)(4).⁷³ Therefore, although NHeLP offers comment on the 1- versus 2-tax year FTR policy below, we strongly recommend that HHS stay consequences from a consumer’s failure to reconcile their taxes until the 2028 tax year, given the analysis in *City of Columbus*.

The Proposed Rule allows an option to use either a 1- or 2-tax year FTR policy for Plan Year (PY) 2027 and the 1-tax year policy for PY 2028 and beyond. NHeLP reiterates the concerns we have raised in prior comments that the 1-tax year policy is harmful to those who rely on APTCs for health coverage.⁷⁴ These concerns are exacerbated by a recent Inspector General report highlighting major management challenges facing the IRS in 2026 in the wake of significant staffing and funding reductions as well as major tax law changes required under OBBBA.⁷⁵ HHS relies on the policy position that “the overriding policy need for the Federal Exchange is to be able to remove unauthorized enrollments from the Marketplace” and therefore the 1-tax year FTR policy is the appropriate choice.⁷⁶ But this declaration of the policy need ignores that the purpose of the underlying statute is to provide health coverage and that there is significant risk to people being denied coverage under the 1-tax year FTR policy due to tax filing and process delays, confusion, and other concerns that have been well-documented in prior NBPP rulemakings and comment periods.⁷⁷ The FTR process that ensures individuals receive the appropriate APTCs based

⁷² 26 U.S.C. §26B(f)(2).

⁷³ *City of Columbus*, 706 F. Supp. 3d at 177.

⁷⁴ NHeLP has consistently commented on this process to ensure that people are not denied the APTCs for which they are eligible and that HHS follows all due process requirements in any action that denies or terminates this benefit. We incorporate the following prior comments into these current comments by reference: Nat’l Health Law Prog., 2025 *Marketplace Integrity and Affordability Rule Comments* (Apr. 10, 2025), <https://healthlaw.org/wp-content/uploads/2025/04/Marketplace-Integrity-and-Affordability-Rule-Comments-April-2025.pdf>; Nat’l Health Law Prog., 2025 *NBPP Proposed Rule Comments*, 9-13 (Jan. 8, 2024), <https://healthlaw.org/resource/comments-on-the-notice-of-benefit-and-payment-parameters-for-2025/>; Nat’l Health Law Prog., 2024 *NBPP Proposed Rule Comments*, 6-8 (Jan. 30, 2023), <https://healthlaw.org/resource/nhelp-comments-on-patient-protection-and-affordable-care-act/>.

⁷⁵ Treasury Inspector General for Tax Administration, *Major Management Challenges Facing the IRS in FY 2026* (Oct. 2025), [https://www.tigta.gov/sites/default/files/reports/2025-10/FY 2026 MMC \(Final\).pdf](https://www.tigta.gov/sites/default/files/reports/2025-10/FY%2026%20MMC%20(Final).pdf).

⁷⁶ Proposed Rule at 6344.

⁷⁷ *Supra* note 74. Specifically, the 2-tax year proposal was based on HHS’s experience with a 1-tax year FTR process, under which there were significant delays in tax return processing, consumer and tax-preparer confusion, and significant costs associated with FTR-related appeals that could have been avoided with the two-year FTR status process. In addition, the process and notices of the existing FTR procedure would help protect against arbitrary actions by the government that affected benefits provided to individuals, as required by the Constitution. See 88 Fed. Reg. 25740, 25814-18 (Apr. 27, 2023); see generally Treasury Inspector Gen. for Tax Admin., 2024-406-020, *The IRS Continues to Reduce Backlog Inventories in the Tax Processing Centers Report* (2024),

on their tax filings has been an evolving process since 2017 as the relevant departments dealt with the intricacies of delayed tax data, privacy requirements of tax filers and providing notice to APTC recipients; notice requirements that comply with due process; and consumer confusion. The 2-tax year FTR policy was based on reliable information about tax filing issues and a careful balance of the need to ensure those who are eligible for APTCs have access to them, limiting the tax liability individuals could accumulate, and limiting abuse of the policy by unscrupulous brokers or others. The correct balance is to prioritize access to coverage as those who need APTCs cannot reasonably purchase coverage without that assistance and later have tax credits apply after delays in tax filings or other issues that prevent coverage under the 1-tax year FTR policy are worked out. While allowing State Exchanges to use the 2-tax year FTR policy helps those who rely on APTCs, and NHeLP supports this option, we strongly recommend that the 2-tax year FTR policy apply across both State Exchanges and the FFE so that everyone is under the same policy if the courts do not completely overturn FTR. Having separate policies across the country generates significant consumer confusion.

§ 155.320 – Verification Process Related to Eligibility for Insurance Affordability Programs

HHS proposes to add new verification regulations at 45 C.F.R. § 155.320(c)(3)(ix). However, these are duplicative and unnecessary. Existing regulations at 45 C.F.R. § 155.315(c)(2) already govern verification of immigration status for purposes of QHP eligibility.⁷⁸ Further, the statute requires that if information regarding immigration status “is verified” under the current procedures . . . “the individual’s eligibility . . . to apply for premium tax credits and cost-sharing reductions shall be satisfied.”⁷⁹ Thus, the agency cannot require an additional round of verification. The final rule should clarify that an individual’s immigration status need only be verified once.

Furthermore, the proposed verification regulations cross-reference the existing inconsistency process at 45 C.F.R. § 155.315(f)(1)-(4), but do not cross-reference § 155.315(c)(3), which modifies the inconsistency process when the inconsistency relates to citizenship or immigration status. Under subsection (c)(3), the individual may *either* “provide satisfactory documentary evidence or resolve the inconsistency with the Social Security Administration or the Department of Homeland Security.” The inconsistency procedures at (f)(1)-(4) require that the individual supply satisfactory documentary evidence and do not give the individual the option to resolve the inconsistency with DHS or SSA. There are additional discrepancies between the two verification procedures: the current procedures require Exchanges to submit information to HHS, which in turn submits

<https://www.tigta.gov/sites/default/files/reports/2024-03/2024406020fr.pdf> (describing significant delays in tax processing).

⁷⁸ See also Ctrs. for Medicare & Medicaid Servs., *Marketplace Verification of Citizenship and Immigration Status* (Nov. 2021), <https://www.cms.gov/marketplace/agents-brokers/files/marketplace-verification-citizenship-immigration-status-webinar-s.pdf> (describing use of SAVE for current verification).

⁷⁹ 42 U.S.C. § 18081(e)(2)(A)(i).

necessary information to DHS.⁸⁰ The Proposed Rule states that the Exchange must transmit the documentation to DHS directly and does not include the limitation to only transmitting “necessary” information.⁸¹ It is unnecessary and burdensome to require states to establish new data connections when existing procedures are sufficient to verify immigration status. Moreover, requiring new data sharing will further exacerbate concerns and chilling effect resulting from ongoing data sharing with immigration enforcement.

HHS should withdraw this proposal. However, if HHS insists on maintaining separate verification regulations, it should modify them so that they are identical.

§ 155.420(g) – Pre-enrollment Verification for Special Enrollment Period

HHS proposes to amend 45 C.F.R § 155.420(g) to reinstate pre-enrollment verification requirements for individuals and families to enroll in special enrollment periods (SEPs). Specifically, HHS proposes to require individuals and families to verify eligibility for several SEPs (marriage, adoption, moving to a new coverage area, loss of minimum essential coverage [MEC], and Medicaid/CHIP denials) in the FFE. The Proposed Rule would require the FFE to conduct these pre-enrollment verifications for at least 75% of new enrollees.

HHS included similar policies in the 2025 Marketplace Integrity and Affordability Rule.⁸² However, that rule included a provision that would have required these policies to sunset on December 31, 2026.⁸³ The agency explained that the expiration of enhanced PTCs would “obviate the need for ongoing higher levels of program integrity policies” such that the burdens of continuing heightened SEP verification would outweigh its benefits.⁸⁴ These provisions were stayed by a federal court in the *City of Columbus v. Kennedy*, where the Court cited a lack of evidence to justify these policies.⁸⁵ As a result, these policies never took effect. HHS is now re-proposing the same policies, but without the sunset provision. We strongly oppose these proposals and recommend that HHS withdraw this portion of the rule.

First, HHS simply fails to demonstrate a connection between improper enrollment and enrollment via a SEP. HHS states that when the FFE resumed verifying eligibility for the MEC SEP after the end of the COVID-19 Public Health Emergency, the use of non-MEC SEPs increased. This statement may be true. But it offers no proof that enrollments through non-MEC SEPs were invalid. As HHS itself observes, individuals are often eligible for multiple SEPs. As paperwork requirements for one SEP increased, consumers likely gravitated toward SEPs with less burdensome red tape.⁸⁶

⁸⁰ 45 C.F.R § 155.315(c)(2).

⁸¹ See § 45 C.F.R. 155.320(c)(3)(ix).

⁸² 90 Fed. Reg. 27074, 27223 (May 6, 2025).

⁸³ *Id.*

⁸⁴ *Id.* at 27151.

⁸⁵ *City of Columbus v. Kennedy*, 796 F.Supp.3d 123, 157-160 (2025).

⁸⁶ *Id.* at 6353.

Second, the burden of imposing pre-enrollment verification requirements on individuals and families seeking Marketplace coverage outweighs HHS's concern about fraudulent enrollment and program integrity. SEP proof, like paperwork confirming an adoption or marriage, is often difficult to track down from government agencies. Paperwork requests from government agencies and county offices also take time to process and mail to the consumer. Once the individual submits their proof to their marketplace, incorrect information and errors in processing documents can cause delays in proving eligibility for the SEP. Multiple studies have shown that administrative burdens deter individuals from signing up for health coverage.⁸⁷ These administrative barriers could delay or deter enrollment altogether.

It is well documented that SEPs are grossly underutilized, and the additional administrative burden of pre-enrollment verifications will only further hinder Marketplace enrollment. One study which relied on CMS data found that fewer than 15% of uninsured SEP-eligible individuals enroll in coverage.⁸⁸ Consumers may not be enrolling due to factors including lack of awareness, affordability concerns, or because of the difficulty of the enrollment and SEP verification process.⁸⁹ Regardless, the underutilization of SEPs contributes to annual enrollment declines, which ultimately result in a higher uninsured rate. Individuals and families will only be more deterred from enrolling in Marketplace coverage through SEPs if pre-enrollment verifications are mandated.

Further, requiring SEP pre-enrollment verifications will likely deter healthy individuals and families from enrolling when they are eligible for a SEP. Multiple studies have shown that administrative burdens disproportionately discourage younger, healthier people from signing up for health coverage.⁹⁰ In the 2023 Notice of Benefit and Payment Parameters final rule, CMS noted that younger, healthier consumers submit SEP verification requirements at much lower rates than older consumers.⁹¹ This is in part why the 2023 final regulations removed SEP verification requirements for all SEPs except loss of minimum

⁸⁷ See e.g., Jennifer Tolbert et al., KFF., *Key Facts About the Uninsured Population* (Dec. 18, 2024), <https://www.kff.org/uninsured/key-facts-about-the-uninsured-population/> (noting that over 20% of nonelderly adults listed difficulty and confusion in signing up for coverage as the reason they were uninsured) [hereinafter Tolbert, *Key Facts*]; Pamela Herd & Daniel Moynihan, *Administrative Burdens in Health Policy* 43 J. HEALTH & HUMAN SERVS. ADMIN. 3, 3-16 (2020) (particularly noting that those who are "least advantaged" are the most likely to face barriers in accessing coverage); Stan Dorn, Urban Inst., *Helping Enrollment Work Under the Affordable Care Act* (June 2016), <https://www.urban.org/sites/default/files/publication/81806/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf>.

⁸⁸ Matthew Buettgens et al., *More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods*, Urban Inst. (Nov. 20, 2015), <https://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf>.

⁸⁹ *Id.*

⁹⁰ See, e.g., Mark Shepard and Myles Wagner, Nat'l Bureau Econ. Research, *Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment* (Working Paper No. 30781) (Dec. 2022), <https://www.nber.org/papers/w30781>; Tolbert, *Key Facts*, *supra* note 87 (noting that over 20% of nonelderly adults listed difficulty and confusion in signing up for coverage as the reason they were uninsured).

⁹¹ 87 Fed. Reg. 27208, 27278 (May 6, 2022).

essential coverage (MEC) for new consumers.⁹² HHS also acknowledges in the preamble to the Proposed Rule that this “policy may deter enrollments among younger people at higher rates, which could worsen the risk pool.”⁹³ Overall, imposing pre-verification requirements for more SEPs will negatively impact the risk pool and adversely impact premium rates.

These provisions also carry significant costs, both to consumers and to the FFE. HHS states that they expect these policies will generate more than 293,000 SEP verification issues which will cost consumers more than \$7.3 million in 2027.⁹⁴ HHS bases this calculation on an assumption consumers would spend “approximately 1 hour of time ... to complete associated questions in the application or submit supporting documentation.”⁹⁵ The agency does not provide any basis for this assumption, which appears to conflict with its own data that 47% of consumers were unable to resolve a SEP verification issue within 14 days and that 14% of consumers in 2019 were never able to resolve the issue.⁹⁶ HHS also estimates that the processing costs associated with these provisions would be \$11.7 million annually in the FFE, and that labor costs would be close to \$3 million annually.⁹⁷

As noted earlier, we oppose these proposed changes and suggest that HHS withdraw this proposal. If HHS proceeds with requiring more extensive pre-enrollment verifications across marketplaces, we urge HHS to track and make publicly available data on how many individuals and families have incomplete enrollment applications because of a problem with their SEP verification. Prior CMS data indicates that implementing a pre-enrollment verification process decreases the already low enrollment numbers through SEPs, and we anticipate that this proposed provision will negatively impact enrollment numbers.⁹⁸

§ 155.605(d)(1) – Expanding Access to Catastrophic Health Plans

NHeLP strongly opposes the proposal at 45 C.F.R. § 155.605(d)(1) to expand hardship exemption eligibility for catastrophic health plans. This proposal exceeds HHS’s regulatory authority and attempts to implement a broad new eligibility category based on income levels that conflicts with the statutory framework for catastrophic health plan eligibility.⁹⁹ Moreover, if implemented, this proposal would weaken the individual market risk pool while exposing potentially millions of enrollees to the documented financial and health risks of these bare-bones plans. Finally, HHS is acting with unwarranted haste, codifying guidance implemented in September 2025, without a complete understanding of the effects of the

⁹² *Id.*

⁹³ 91 Fed. Reg. at 6452.

⁹⁴ *Id.*

⁹⁵ Proposed Rule at 6432.

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ U.S. Dept. of Health & Human Servs., *FAQs Regarding Verifications of SEPs* (Sept. 6, 2016), <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/FAQ-Regarding-Verification-of-SEPs.pdf>.

⁹⁹ 42 U.S.C. § 18022(e).

guidance on enrollees, given that full data on 2026 Open Enrollment will not be released for months.

A. HHS's Proposal is a vast expansion of eligibility for catastrophic coverage that conflicts with the language and intent of the ACA

Congress established catastrophic health plans in the ACA to provide a source of comprehensive coverage to specific groups who were otherwise unlikely or unwilling to purchase a metal-tier plan. The statute creates two distinct pathways to eligibility: age and certified exemptions. The age criterion is broad and straightforward, allowing any individual under 30 to enroll in a catastrophic health plan.¹⁰⁰ The exemption pathway is narrower and more nuanced. In order to be eligible to enroll in a catastrophic health plan, an individual must be certified exempt from the requirement to maintain minimum essential coverage on the basis of affordability or hardship.¹⁰¹ The affordability prong of the exemption pathway is available only to individuals for whom coverage is not affordable under the Internal Revenue Code.¹⁰² The hardship exemption is available to those who are determined by the Secretary of HHS to have suffered a hardship with respect to the capability to obtain coverage under a QHP.¹⁰³

HHS claims that the proposed eligibility expansion will address an affordability crisis in the individual market. NHeLP agrees that the accelerating cost of health coverage is harmful to households that rely on Marketplace coverage, particularly in light of the expiration of enhanced premium tax credits (ePTCs) that drove the 26% premium increase between 2025 and 2026.¹⁰⁴ While the intent of the proposal to reduce consumer cost burden is laudable, HHS fails to explain why its proposal would achieve its goal. Moreover, this proposal runs roughshod over the clear statutory language and intent of the ACA. First, HHS is attempting to bootstrap its statutory authority to define hardship criteria to rewrite the separate affordability exemption.¹⁰⁵ Congress created an affordability exemption to limit eligibility for catastrophic plan enrollment to individuals whose required contribution exceeds an annually-indexed required contribution percentage, with respect to either employer-sponsored coverage or the cost of a bronze plan reduced by eligible PTCs.¹⁰⁶

¹⁰⁰ 42 U.S.C. § 18022(e)(2)(A).

¹⁰¹ 42 U.S.C. § 18022(e)(2)(B), referencing section 5000A of the Internal Revenue Code, which requires individuals who are not eligible for an exemption to maintain minimum essential health coverage.

¹⁰² 26 U.S.C. § 5000A(e)(1), defining an “individual who cannot afford coverage” as “any applicable individual for any month if the applicable individual’s required contribution ... for coverage for the month exceeds 8 percent of such individual’s household income for the taxable year,” indexed annually. In 2027, the Secretary set the required contribution percentage at 8.5%; see CMS, *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2027 Benefit Year* (Jan. 29, 2026), <https://www.cms.gov/files/document/2027-papi-parameters-guidance-2026-01-29.pdf>.

¹⁰³ 42 U.S.C. § 18022(e)(2)(B)(ii).

¹⁰⁴ Proposed Rule at 6354.

¹⁰⁵ 42 U.S.C. §§ 18022(e)(2)(B)(i) and (ii),

¹⁰⁶ 36B(e)(1)(D) of the Code; see *supra* n. 102.

This percentage is set at 8.5% of household income in 2027.¹⁰⁷ This new proposal attempts to justify creating what is essentially a second, more expansive affordability-related eligibility category by claiming that premium increases have created “affordability challenges even for consumers who may not qualify for financial assistance.”¹⁰⁸ If finalized, this exemption would essentially use HHS’s hardship exemption authority to swallow up the distinct affordability exemption. Doing so would clearly override Congressional intent to limit catastrophic health plan eligibility related to the cost of coverage to those who were exempt from the individual mandate because they met the narrow statutory definition of “individuals who cannot afford coverage.”

Secondly, HHS cannot shoehorn its authority to determine when an individual has experienced a qualifying hardship. This action effectively legislates a third, new category under which millions of people would be newly eligible for catastrophic health plan coverage. Congress created a broad, national eligibility category with respect to age, permitting anyone under 30 to enroll in a catastrophic plan. In contrast, lawmakers explicitly chose narrower paths for both the affordability and hardship exemptions, both of which require individualized certifications of exemption eligibility.¹⁰⁹ HHS’s proposal ignores these clearly different approaches. If finalized, HHS’s proposal would invert Congressional intent with respect to catastrophic health plans by expanding eligibility to millions more people than would be excluded from a plan type that was clearly designed to cover a narrow subset of the population.¹¹⁰

Lastly, HHS provides no explanation for how an income-based eligibility category with no upper limit meets the statutory requirement to individually certify that a household has “suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.”¹¹¹ The HHS proposal would allow any household earning over 250% FPL – theoretically ranging from an individual making less than \$40,000 per year to a multi-millionaire – to enroll in a catastrophic health plan on the basis that premium costs represent an insurmountable “hardship” to that specific household. The proposal purports to address accelerating premium costs by expanding eligibility to individuals with incomes under 100% FPL, or \$15,960 for an individual in 2026. Given that the out-of-pocket limit for catastrophic plans is \$12,000 this year, before accounting for monthly premium costs, it is highly unlikely that the eligibility expansion provides any meaningful coverage alternative for individuals living in poverty. Rather than applying its legitimate authority to tailor hardship exemptions to promote access to affordable coverage, HHS has crafted a broad new eligibility category that conflicts with the Congressional intent and statutory eligibility

¹⁰⁷ *Supra* note 102.

¹⁰⁸ Proposed Rule at 6354.

¹⁰⁹ *Supra* note 105.

¹¹⁰ See KFF, *Distribution of Total Population by Federal Poverty Level: 2024*, <https://www.kff.org/state-health-policy-data/state-indicator/distribution-by-fpl>; Statista, *Share of households in the United States in 2024, by income group*, <https://www.statista.com/statistics/203183/percentage-distribution-of-household-income-in-the-us>.

¹¹¹ 26 U.S.C. § 5000A(e)(5).

categories for catastrophic health plan coverage and is likely to provide little relief to most low- and middle-income households.

B. Permanently expanding catastrophic coverage as proposed would increase financial and health risks for consumers, health care providers, and the overall risk pool

Vastly expanding eligibility for catastrophic health plans would harm enrollees, health care providers, and the individual market risk pool. Fewer than 1% of those who selected a plan during 2025 Marketplace Open Enrollment chose a catastrophic plan.¹¹² These plans are unpopular because of their limited eligibility, as mandated by Congress, but also because they offer minimal protection from risk compared to metal-tier QHPs. As explained above, catastrophic plans impose deductibles equivalent to the annual cost sharing limit under the ACA, which in 2027 will reach \$12,000 for self-only coverage and \$24,000 for coverage for two or more people. While catastrophic plans must cover EHB after the deductible is met, the ACA does not mandate any actuarial value threshold or range for these plans. Finally, catastrophic health plans do not qualify for PTCs, which means enrollees must bear the full cost of monthly premiums regardless of their household income level.¹¹³ In short, these plans were intended to provide young, healthy individuals and those without other coverage options an alternative to being fully uninsured. Congress did not design them as a robust coverage option for a majority of the population.

HHS does not provide any meaningful data to estimate the effects of this proposal on plan costs, consumer financial risks or health outcomes, providers, or the individual market risk pool generally. In the Regulatory Impact Analysis, HHS estimates that the four State Exchanges that currently process their own hardship exemptions would collectively process 1,072 applications annually under the expanded hardship eligibility criteria, noting that they represent 10% of total Exchange enrollment. This could suggest that HHS believes that nationwide catastrophic coverage could increase by close to 11,000 enrollees.¹¹⁴ However, the White House Council of Economic Advisors estimated that the guidance issued in September 2025, which closely mirrors HHS proposal in this rule, would increase enrollment in catastrophic coverage by “several million” people.¹¹⁵ The strikingly different

¹¹² Ctrs. for Medicare & Medicaid Svcs., *Health Insurance Exchanges 2025 Open Enrollment Report*, <https://www.cms.gov/files/document/health-insurance-exchanges-2025-open-enrollment-report.pdf>. Note that while the Proposed Rule states that “only about 20,000 people enrolled in catastrophic plans in 2025,” this estimate conflicts with the data reported elsewhere by CMS that roughly 54,000 people were enrolled in catastrophic plans in 2025. See Proposed Rule at 6382; but see also, *2025 Marketplace Open Enrollment Period Public Use Files*, <https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files>. NHeLP urges HHS to address this discrepancy in the final rule.

¹¹³ 42 U.S.C. § 18022(e); 26 U.S.C. § 36B(c)(3)(A).

¹¹⁴ Proposed Rule at 6452-6453.

¹¹⁵ White House Council of Economic Advisors, *Expansion of HSA Eligibility Under OBBA Act to Improve Marketplace Coverage, Affordability, and Access* (Sept. 2025), <https://www.whitehouse.gov/wp-content/uploads/2025/09/Expansion-of-HSA-Eligibility-Under-OBBA-1.pdf> (note that the authors do not provide an explanation for the “baseline projection” that 3

estimates from HHS and the White House raise further questions about the evidence underpinning both the guidance and the regulatory proposal.

Even the smaller increased enrollment contemplated by HHS in the preamble to the Proposed Rule would expose thousands of households to higher deductibles and cost-sharing required under catastrophic plans. Research shows that when people are underinsured, including having a deductible that exceeds 5% of their income, they are more likely to delay filling prescriptions, avoid seeking treatment for medical problems, and incur medical debt than those with affordable coverage.¹¹⁶ In 2027, given the \$24,000 deductible for a family catastrophic health plan, these risks would apply to households earning less than \$480,000 per year. These risks also extend to health care providers, who will be forced to shoulder a larger burden of uncompensated care, which presents particular risk to safety net and rural providers.¹¹⁷ A significantly higher shift to catastrophic coverage, such as that anticipated by the White House, could also weaken the individual market risk pool. Catastrophic plans that combine the risk of significant out-of-pocket costs with minimal benefits are more likely to attract wealthier, healthier, and younger enrollees who may anticipate using fewer health care services throughout a plan year. To the extent these plans siphon relatively low-risk households from metal-tier plans, it could result in a smaller, sicker individual market risk pool, increasing premium costs for people who remain in metal-tier coverage. Over time, this would result in a bifurcation of the overall individual market risk pool between healthy individuals with sufficient financial resources to accept the risk of a catastrophic plan, who could enjoy relatively cheaper premiums; and the remainder of the population, who would be forced to contend with ever-higher premiums. This outcome is incompatible with the single risk pool concept that is fundamental to the ACA.¹¹⁸

C. HHS lacks the necessary evidence to support codifying recent 2025 guidance

HHS is rushing to codify guidance that was implemented in September 2025, without any evidence of its effects on consumers or other interested parties. HHS attempts to justify a vast eligibility expansion by pointing to the indisputably high cost of individual health insurance premiums. However, HHS fails to provide any evidence that explains why significantly expanding access to catastrophic health plans, with their high deductibles and

million people would enroll in catastrophic coverage, including in states where such coverage is not being offered in 2026).

¹¹⁶ See Sara R. Collins and Avni Gupta, Commonwealth Fund, *The State of Health Insurance in the U.S.: 2024 Biennial Survey* (Nov. 21, 2024), <https://www.commonwealthfund.org/publications/surveys/2024/nov/state-health-insurance-coverage-us-2024-biennial-survey>.

¹¹⁷ See Sharita Thomas, et al., NC Rural Health Research Program, *Health System Challenges for Critical Access Hospitals: Findings from a National Survey of CAH Executives* (Feb. 2021), <https://www.shepscenter.unc.edu/product/health-system-challenges-for-critical-access-hospitals-findings-from-a-national-survey-of-cah-executives>; Emmaline Keesey, et al., *Uncompensated Care is Highest for Rural Hospitals, Particularly in Non-Expansion States* (Nov. 18, 2023) MED CARE RES. REV., <https://pmc.ncbi.nlm.nih.gov/articles/PMC10924546/#bibr17-10775587231211366>.

¹¹⁸ 42 U.S.C § 18032(c); 45 C.F.R. § 156.80.

limited coverage, would address this problem. Rather, HHS simply states that it “believe[s] that there are substantial number of consumers for whom purchasing a QHP relative to a catastrophic plan could cause a financial hardship” and cites to data showing the QHPs premium costs have risen significantly since 2013, the year before the ACA’s insurance market reforms were fully implemented.¹¹⁹ Notably, HHS fails to provide any meaningful comparison between catastrophic and QHP plan costs.

HHS implies that QHP premiums present a major barrier to coverage. However, catastrophic plans are not necessarily a lower-premium option than unsubsidized bronze coverage. On average, national data show that the lowest-cost catastrophic plans available for a 27-year old individual are just \$23 per month cheaper than the lowest-cost unsubsidized bronze plan.¹²⁰ National data obscure significant local price variation; in some regions of the country, catastrophic plan premiums may be up to \$200 more costly than the lowest-cost bronze plan, while in other counties, catastrophic plan premiums are \$200 less than the lowest-cost bronze plan.¹²¹ While premium rates may vary, out-of-pocket costs are significantly higher for catastrophic plan enrollees. The national average bronze plan deductible this year is just under \$7,500, more than \$3,000 less per year than the catastrophic health plan deductible for 2026.¹²² Given that catastrophic plan deductibles will rise to \$12,000 for self-only coverage in 2027 — or up to \$15,600 if a separate proposal is finalized — expanded access to such plans offers little relief to low- and middle-income households who would shoulder the full cost of health care plus premiums comparable to unsubsidized bronze coverage. In particular, the proposal’s extension of catastrophic coverage to households with incomes under 100% FPL feels particularly nonsensical, given that an individual would certainly be liable for more than their entire annual income between premium and deductible costs in the event of a medical emergency, costly diagnosis, or lengthy hospital stay.

HHS is proposing to enshrine into regulation a months-old guidance whose impacts have yet to be assessed and fails to provide compelling data that explains how and why expanding eligibility for catastrophic coverage would benefit consumers or other stakeholders.¹²³ To the extent HHS has data on the effects of the guidance on 2026 Open

¹¹⁹ Proposed Rule at 6354.

¹²⁰ Note that national data obscure significant regional variation in premium costs. In some regions of the country, catastrophic plan options have higher premiums than unsubsidized bronze plans, while the opposite is true elsewhere. See Michelle Long, et al., KFF, *Policy Changes Bring Renewed Focus on High-Deductible Health Plans* (Jan. 5, 2026), <https://www.kff.org/patient-consumer-protections/policy-changes-bring-renewed-focus-on-high-deductible-health-plans>, <https://www.kff.org/patient-consumer-protections/policy-changes-bring-renewed-focus-on-high-deductible-health-plans>. (“For example, unsubsidized bronze plans offered in more than half of the counties in Oklahoma are over \$200 cheaper per month than the cheapest catastrophic plan for a 27-year-old individual. Conversely, all counties in Connecticut have catastrophic plans around \$200 a month cheaper than the lowest-cost unsubsidized bronze plan for a 27-year-old individual.”)

¹²¹ *Id.*

¹²² *Id.*

¹²³ Ctrs. for Medicare & Medicaid Svcs., *Guidance on Hardship Exemptions for Individuals Ineligible for Advance Payment of the Premium Tax Credit or Cost-sharing Reductions Due to Income, and*

Enrollment, it has not provided it in the Proposed Rule. Based on past experience, HHS will not release its analysis of 2026 Open Enrollment data until months after the Proposed Rule is finalized. This gives the public no opportunity to understand the effects of the guidance before commenting on its proposed codification. Further, since the September 2025 guidance was issued after regulators had approved 2026 plans for the current plan year, including premium rates, the potential effects of the guidance on plan costs and enrollment trends was likely muted compared to the current proposal. A permanent expansion of the guidance will be more consequential than will be reflected in 2026 Open Enrollment trends. Prematurely finalizing expanded eligibility for catastrophic plans as proposed is unsupported by evidence and places consumers and other stakeholders at considerable risk.

§§ 155.1050 and 156.230 – Network adequacy standards

We oppose the proposal to eliminate the requirement for all exchanges to at least meet time and distance standards and to allow some states on the FFE to establish their own standards and conduct reviews of network adequacy with federal approval. The proposal will exacerbate existing challenges with network adequacy in Marketplace plans.

Narrow networks and consumers' inability to find available in-network providers have for years been one of the most visible problems in Marketplace coverage.¹²⁴ One investigation in Georgia found that 600,000 of the state's 846,000 Marketplace enrollees lacked access to care due to inadequate plan provider networks. In some rural counties, upwards of 90% of enrollees faced access issues due to poor plan networks, particularly for allergists and OB/GYN services.¹²⁵ Inadequate mental health care networks have led to documented hospitalizations, emergency department visits, and worse outcomes in Arizona, New York, and other states.¹²⁶ Marketplace secret shopper surveys have already documented persistent provider directory inaccuracies, which only compound the difficulties of finding a provider when needed.¹²⁷ Such deficiencies lead to unacceptable wait times for appointments and can cause negative health outcomes from delayed care. These examples of persistent shortcomings in network adequacy standards and provider directory

Streamlining Exemption Pathways to Coverage (Sept. 4, 2025), <https://www.cms.gov/files/document/guidance-hardship-exemptions.pdf>.

¹²⁴ Karen Pollitz, KFF, *Network Adequacy Standards and Enforcement* (Feb. 4, 2022), <https://www.kff.org/affordable-care-act/network-adequacy-standards-and-enforcement/>.

¹²⁵ Sofi Gratas, *Georgians with Marketplace Insurance Aren't Guaranteed Good Access to Care*, Georgia Public Radio (2023), <https://www.gpb.org/news/2023/02/08/georgians-marketplace-insurance-arent-guaranteed-good-access-care>.

¹²⁶ Max Blau, ProPublica, *"I Don't Want to Die": Needing Mental Health Care, He Got Trapped in His Insurer's Ghost Network* (Sept. 8, 2024), <https://www.propublica.org/article/ambetter-ghost-network-consequences>; *Inaccurate and Inadequate: Health Plans' Mental Health Provider Network Directories*, Off. of the NY State Attorney General (Dec. 7, 2023), https://ag.ny.gov/sites/default/files/reports/mental-health-report_0.pdf.

¹²⁷ Simon F. Haeder, Dept. Health Pol'y & Management, Texas A&M University, *Assessing the Persistence of Provider Directory Inaccuracies in Pennsylvania ACA Marketplace Plans Using Repeated Secret Shopper Surveys* (Oct. 29, 2024), <https://www.insurance.pa.gov/Coverage/health-insurance/Documents/networkadequacystudy-providerdirectoryinaccuracies-brief.pdf>.

accuracy led HHS to create new requirements that all states networks meet tiered time and distance standards and, more recently, appointment wait time standards that are annually audited by secret shopper surveys.

Yet just a year after implementation of new federal standards for Marketplace wait times and asking states to meet basic federal minimum requirements, HHS proposes to walk it back. This Proposed Rule would allow states that use the FFE to set their own standards for network adequacy, including ignoring federal wait time standards, if they demonstrate to HHS's satisfaction that they have Effective Provider Access Review programs. These ill-advised changes appear based not on evidence that states have shown improved access to providers through alternative, stronger network adequacy standards. Rather, evidence has pointed in the opposite direction – that generalized network adequacy standards and enforcement have proven consistently insufficient to ensure timely access to needed services. Results from the first year of required secret shopper surveys “exposed weaknesses in provider directories.”¹²⁸ In the preamble, HHS acknowledges that plans have struggled to meet the network adequacy time and distance standards, particularly in some rural areas for some services. But instead of exploring the reasons for these shortages and potential solutions, the approach seems to be that states should be allowed to simply lower their standards – such as shifting to a time *or* distance standard – to meet the current reality of plan network breadth.¹²⁹

The Proposed Rule preamble describes a Maryland court case that determined HHS's prior attempt to defer network adequacy review to the states was “arbitrary and capricious” due to HHS's failure to meaningfully respond to abundant evidence in the administrative record that states were not doing an adequate job of ensuring access to care through their own regulations and enforcement actions.¹³⁰ The preamble goes as far as summarizing how the decision:

raised concerns about HHS' position that States' network adequacy review procedures are adequate simply because States have State-specific regulations without explaining what these entail or why they are comparable to review under Federal standards.¹³¹

The court further pointed to comments and evidence that state review procedures were often inadequate and that complaint-driven oversight was inadequate. Yet HHS does not show that anything has changed in the intervening years. Rather, more recent analyses have continued to find that state enforcement of network adequacy provisions in private insurance plans has been “severely underwhelming,” with most state insurance regulators reporting an average of one to zero enforcement actions related to network adequacy

¹²⁸ Sutherland, *Year One Reflections: Key Lessons from CMS Secret Shopper Surveys for Health Plans* (Oct. 17, 2025), <https://www.sutherlandglobal.com/insights/blog/healthcare-plan-secret-shopper-survey>.

¹²⁹ 91 Fed. Reg. 6396.

¹³⁰ 91 Fed. Reg. 6394-95 (citing *City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021)).

¹³¹ *Id.*

annually.¹³² The preamble provides no clear evidence – aside from vague anecdotes about some issuers reporting various “challenges” with finding certain specialists in some rural regions – that state capacity to conduct these reviews has improved. There is simply no justification for weakening the current federal standards by devolving standard setting back to states, particularly without showing results from the first year of mandatory secret shopper surveys that evaluated how well FFE QHPs met appointment wait time standards.¹³³

HHS simply has not demonstrated that it is now appropriate to allow states to jettison the important new tools that were only implemented last year. Rather than requiring Marketplace issuers to maintain better networks and more accurate provider directories through improved oversight and enforcement, this rule proposes to water down the standards to support the status quo, even as it shifts administrative burden and responsibility onto states.

We oppose HHS finalizing the proposal to eliminate the requirement for all exchanges to at least meet time and distance standards and to allow some states on the FFE to establish their own standards and conduct reviews of network adequacy with federal approval. We especially oppose the changes that would allow some FFE states to evade mandatory federal appointment wait time standards without any evidence or argument to support abandoning this requirement.

§ 156.111 – State selection of EHB-benchmark plan for plan years beginning on or after January 1, 2020

While HHS did not propose changes to this section in the Proposed Rule, the discussion in the Preamble led us to submit our comments about potential revisions.

HHS acknowledges that it is pausing review of states’ applications to update their EHB benchmark plans and is considering future rulemaking to revise § 156.111 and EHB more broadly.¹³⁴ We strongly disagree with this approach. HHS should refrain from making any changes to the current EHB structure and, instead, should promptly evaluate pending EHB benchmark proposals and approve those selections that meet all procedural and actuarial requirements under the current regulations.

We are aware of several states that have been actively working to update their EHB benchmark plans. Nevada is seeking to add all FDA-approved HIV and hepatitis C treatments, as well as drugs approved for the treatment of, and withdrawal from, opioid use

¹³² Abigail Burman, *Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories*, 40 YALE LAW & POL’Y REV. 78, 122 (2021); see also, e.g., Shawna Read-Richards & Teresa Keller, *The Marketplace Illusion: Coverage Without Care*, HEALTH AFF. (Feb. 26, 2026), <https://www.healthaffairs.org/content/forefront/marketplace-illusion-coverage-without-care>.

¹³³ Moreover, one year of survey data is unlikely sufficient to draw firm conclusions.

¹³⁴ 91 Fed. Reg. 6302.

disorders.¹³⁵ California submitted an application to expand access to fertility services and improve coverage of hearing aids and durable medical equipment, including wheelchairs.¹³⁶ Kentucky considered adding routine adult dental services, as well as biomarker testing, infertility treatment, and expanded coverage of speech therapy and cancer screenings.¹³⁷

These states invested considerable time and resources developing their EHB benchmark proposals. They solicited public input, conducted hearings, commissioned actuarial analyses, and engaged in deliberative processes, including enacting legislation, all while relying on the EHB benchmarking framework established by HHS nearly fifteen years ago.¹³⁸ These carefully developed proposals are designed to address coverage gaps and help address the most serious health care needs of state residents. It is unconscionable that HHS would simply disregard these efforts without explanation.

More states were pursuing EHB benchmark updates, but HHS quashed those efforts by rescinding, without explanation, the EHB-Benchmark Plan Modernization Grant for States with a Federally-Facilitated Exchange, and the Expanding Access to Women's Health Grant last year.¹³⁹ The current benchmarking rules, which were finalized by the first Trump administration, welcomed state flexibility in EHB and allowed states to address ongoing health care needs within actuarially sound parameters. By refusing to even consider state proposals, HHS is now suppressing state innovation to meet the needs of their populations.

HHS should refrain from making any substantive changes to EHB and the current benchmarking structure. Over the past 14 months, HHS has engaged in an unprecedented weaponization of the U.S. health care system to denigrate and persecute trans and non-binary people.¹⁴⁰ This administration has engaged in numerous legislative and regulatory

¹³⁵ Nevada Div. of Insurance, *Plan Year 2027 Benchmark Plan Change Actuarial Report* (Feb. 11, 2025), [https://doi.nv.gov/uploadedFiles/doi.nv.gov/Content/Healthcare Reform/Individuals and Families/Essential Health Benefits/NV457-2302%20DRAFT%20Nevada%20EHB%20actuarial%20report\(1\).pdf](https://doi.nv.gov/uploadedFiles/doi.nv.gov/Content/Healthcare%20Reform/Individuals%20and%20Families/Essential%20Health%20Benefits/NV457-2302%20DRAFT%20Nevada%20EHB%20actuarial%20report(1).pdf).

¹³⁶ California Dept. of Managed Health Care, *DMHC Applies to Update California's Benchmark Plan, Expand Essential Health Benefits to Include Fertility Services, Hearing Aids & Wheelchairs* (May 5, 2025), <https://dmhc.ca.gov/Resources/Newsroom/PressReleases/May5,2025.aspx>.

¹³⁷ Kentucky Dept. of Insurance, *Kentucky Plan Year 2027 Benchmark Plan Change Actuarial Report* (April 28, 2025), <https://insurance.ky.gov/ppc/Documents/KY%20PY2027%20Benchmark%20Plan%20Change%20Actuarial%20FINAL%20Report%2020250428.pdf>. It is not clear whether Kentucky submitted its EHB benchmark proposal.

¹³⁸ U.S. Dept. of Health and Human Srvs., Ctr. for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin* (Dec. 16, 2011), https://www.cms.gov/ccio/resources/files/downloads/essential_health_benefits_bulletin.pdf.

¹³⁹ U.S. Dept. of Health and Human Srvs., Ctr for Medicare & Medicaid Srvs., *EHB-Benchmark Plan Modernization Grant for States with a Federally-Facilitated Exchange*, CMS-2U2-25-001 (Feb. 14, 2025), <https://www.grants.gov/search-results-detail/356740>; U.S. Dept. of Health and Human Srvs., Ctr for Medicare & Medicaid Srvs., *Expanding Access to Women's Health Grant*, CMS-2R2-24-001 (Sep. 6, 2024), <https://www.grants.gov/search-results-detail/354660>.

¹⁴⁰ See, e.g., U.S. Dept. of Health and Human Srvs., *Marketplace Integrity and Affordability Final Rule*, 90 Fed. Reg. 27074 – 27224 (June 25, 2025), <https://www.govinfo.gov/content/pkg/FR-2025->

efforts that have made health care coverage more expensive, less comprehensive, and continue to seriously undermine and destabilize the health insurance market.¹⁴¹ It must stop.

§ 156.115(d) – Provision of EHB

HHS proposes to reinstate an Obama-era regulatory prohibition on routine non-pediatric oral health services as EHB. We strongly oppose this proposal. This, and other EHB prohibitions currently codified in § 156.115(d) are not supported by law and, are, in fact, directly contrary to the plain language of the ACA. Moreover, a federal EHB prohibition on routine non-pediatric oral health services is bad policy and unduly restricts state flexibility to address unmet health care needs and advance health equity.

A. The ten categories of EHB are only a minimum and HHS can include other benefits as EHBs

HHS offers several revised interpretations of the ACA to justify its proposed prohibition of routine non-pediatric oral health services as EHB. First, HHS observes that Congress did not include routine non-pediatric oral health services when it established the list of ten minimum EHB categories.¹⁴² Indeed, in the ACA, Congress provided for pediatric oral care as part of EHB but made no mention of oral health services for adults.

However, nothing in the ACA bars HHS from adding adult oral health services pursuant to its EHB defining, reviewing, and updating authority. Yet HHS somehow now infers this omission as justification for a regulatory ban. If Congress had intended to prohibit non-pediatric oral health services as EHB, it would have done so. For example, Congress expressly excluded coverage for most dental services in Medicare but included no such language in the ACA.¹⁴³

Moreover, the EHB ban is contrary to other provisions in the EHB statutory provisions. In the ACA, Congress established that EHB must include, “at least,” coverage of the 10 listed

[06-25/pdf/2025-11606.pdf](https://www.govinfo.gov/content/pkg/FR-2025-12-19/pdf/2025-23464.pdf) (codifying at 42 C.F.R. § 156.115(d) a ban on “specified sex-trait modification procedures” as EHB); U.S. Dept. of Health and Human Svcs., *Prohibition on Federal Medicaid and Children’s Health Insurance Program Funding for Sex Rejecting Procedures Furnished to Children*, 90 Fed. Reg. 59441 – 59463 (Dec. 19, 2025), <https://www.govinfo.gov/content/pkg/FR-2025-12-19/pdf/2025-23464.pdf>; U.S. Dept. of Health and Human Svcs., *Hospital Condition of Participation: Prohibiting Sex-Rejecting Procedures for Children*, 90 Fed. Reg. 59463-59478 (Dec. 19, 2025), <https://www.govinfo.gov/content/pkg/FR-2025-12-19/pdf/2025-23465.pdf>.

¹⁴¹ Christen Linke Young, *New CBO Estimates Show 2025 Reconciliation Bill Would Have Impacts Similar in Magnitude to 2017 ACA Repeal Bills*, Brookings blog (Jun. 4, 2025), <https://www.brookings.edu/articles/new-cbo-estimates-show-2025-reconciliation-bill-would-have-impacts-similar-in-magnitude-to-2017-aca-repeal-bills/>.

¹⁴² 90 Fed. Reg. 6369.

¹⁴³ See 42 U.S.C. § 1395y(a)(12). A discussion by the Centers for Medicare & Medicaid Services (CMS) of the narrow cases where the Medicare program covers oral health services is available at www.cms.gov/Medicare/Coverage/MedicareDentalCoverage/index.html.

categories of benefits.¹⁴⁴ The fact that Congress did not include routine non-pediatric oral health services among the 10 categories does not mean that they could never be EHB. HHS does not have authority to rewrite a duly enacted statute by eliminating the words “at least.” Indeed, after claiming that the omission from the 10 listed EHB categories supports banning of routine non-pediatric oral health services as EHB, HHS seems to then abandon argument, conceding that “the 10 EHB categories set the floor for what constitutes EHB and that routine nonpediatric dental services could theoretically be added on top of this minimum set of EHBs.”¹⁴⁵

Congress also placed additional requirements and limits on HHS’s EHB authority. For example, HHS must take into account the health care needs of diverse segments of the population.¹⁴⁶ Congress also requires HHS to periodically review and update EHB to address:

- difficulty in accessing needed services for reasons of coverage or cost;
- changes in medical evidence or scientific advancement;
- gaps in access or changes in the evidence base;
- interactions between *the addition* or expansion of benefits and reductions in existing benefits to meet actuarial limitations.¹⁴⁷

Congress clearly envisioned adding benefits as EHB. Banning benefits as EHB, including those listed in § 156.115(d), is directly contrary to the plain language of the statute.

B. The ACA does not link EHB coverage to excepted benefits

When it originally promulgated § 156.115(d), HHS provided a one sentence explanation that “[i]n contrast with the benefits covered by a typical employer health plan, [routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, and non-medically necessary orthodontia] often qualify as excepted benefits.”¹⁴⁸ However, the ACA did not tie EHB to excepted benefits.

“Excepted benefits” is a term introduced in the Health Insurance Portability and Accountability Act (HIPAA) to exempt certain plans from the statute’s obligations. In its definition of excepted benefits, HIPAA and implementing regulations include limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits “if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not

¹⁴⁴ 42 U.S.C. § 18022(b)(1).

¹⁴⁵ 91 Fed. Reg. 6369.

¹⁴⁶ 42 U.S.C. § 18022(b)(4)(C).

¹⁴⁷ *Id.* at (b)(4)(G), (H) (emphasis added).

¹⁴⁸ See U.S. Dept. of Health and Human Svcs., *Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Proposed Rule*, 77 Fed. Reg. 70644, 70651 (Nov. 26, 2012), <https://www.govinfo.gov/content/pkg/FR-2012-11-26/pdf/2012-28362.pdf>; 78 Fed. Reg. 12845.

an integral part of a group health plan...”¹⁴⁹ The ACA did not change the definition of excepted benefits nor did it explicitly state that already defined excepted benefits were to be excluded from the definition of EHBs. As a result, a plain reading of the EHB statute and other provisions related to QHPs lends no support to the notion that under no circumstance could routine non-pediatric oral health services, or other services listed in § 156.115(d), be considered EHBs.

Even if Congress intended to apply the HIPAA excepted benefits provision to the EHB requirement, the original definition of excepted benefits is more specific than the HHS regulation in § 156.115(d). The HIPAA excepted benefits provision extends to benefits that are not an integral part of a group plan. Benefits are not considered an integral part of a group plan if either 1) enrollees may decline coverage for the specific services; or 2) if “claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan.”¹⁵⁰ However, § 156.115(d) bans coverage of these excepted benefits as EHBs regardless of whether these requirements are met, exceeding the limitations on excepted benefits added by the HIPAA statute. Therefore § 156.115(d) is simply not supported by the statutory language in the ACA or HIPAA.

HHS should read the HIPAA excepted benefits provision as written, applying to specific types of *plans* rather than types of benefits. While the HIPAA statutory provision in question talks about “benefits,” Congress’ unambiguous intention was to exclude limited-benefit *plans* (such as stand-alone dental and stand-alone vision plans) from HIPAA requirements, not the benefits themselves.

C. HHS offers wildly differing and at-times erroneous interpretations of the “typical employer plan” provision

HHS seeks to justify the EHB prohibition of routine non-pediatric oral health services by offering a new interpretation of the “typical employer plan” (TEP) provision. HHS now claims that TEP refers to an employers’ major medical plan.¹⁵¹ By contrast, in the 2025 NBPP, HHS recognized that routine non-pediatric oral health services are widely covered by employers.¹⁵² HHS underscored that “EHB should be equal in scope to the benefits provided under a typical employer plan, regardless of whether such benefit is historically considered a non-excepted “health benefit” or whether such benefit is “typically covered” by an employer’s major medical plan.”¹⁵³ HHS makes no effort to reconcile the two differing positions or to explain why the agency has suddenly changed its position. That is

¹⁴⁹ 26 U.S.C. § 9832(c)(2)(A); 29 C.F.R. § 2590.732(c)(3).

¹⁵⁰ 45 C.F.R. § 146.145(b)(3)(ii).

¹⁵¹ 91 Fed. Reg. 6369.

¹⁵² U.S. Dept. of Health and Human Srvs., *HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program*, 89 Fed. Reg. 26218-26426 (Apr. 15, 2025).

¹⁵³ *Id.* at 26342.

because the shift has no basis in law and only responds to an impetus of curtailing states' ability to expand access to care. As discussed above, the ACA distinguishes EHB and excepted benefits plans, but not the benefits provided in those plans.

Even when services are widely covered by major medical employer plans, HHS selectively disregards that fact in its TEP analysis. In the 2025 Marketplace Integrity and Affordability Final Rule, HHS excluded gender affirming care (GAC) as an EHB.¹⁵⁴ HHS conceded that 72% of Fortune 500 businesses, and 91% of businesses listed on the Corporate Equality Index, as well as a majority of state employee plans, Medicaid programs, and QHPs offer coverage of treatment for gender dysphoria.¹⁵⁵ Yet HHS dismissed this evidence because, somehow, an overwhelming majority of large employers "likely do not represent the typical employer."¹⁵⁶

Moreover, HHS's malleable and inconsistent application of TEP has led to EHB additions of benefits sometimes excluded from employer coverage. For example, in 2025, the District of Columbia added in vitro fertilization (IVF) and other fertility treatments to its EHB benchmark plan; while Washington added artificial insemination to its Washington's EHB benchmark plan.¹⁵⁷ Yet only 27% of employers cover IVF, and 26% cover artificial insemination, according to the KFF Employer Health Benefits Survey.¹⁵⁸ Alaska, Vermont, and Washington added hearing aid coverage to their EHB benchmark plans.¹⁵⁹ Yet a recent survey found that only one in ten employees reported being offered a hearing solution by their employer.¹⁶⁰ It would be nonsensical and completely disconnected from the goals of the ACA for HHS to define typicality in a way that would restrict states' ability to incorporate any of these basic services to their EHB benchmark plans. HHS offers no explanation as to why some benefits that are not typically covered by employers can be considered EHB, and added to state EHB benchmark plans, while other benefits that are not typically covered by employers, or covered outside a major medical plan, are prohibited as EHB.

Simply put, the TEP provision cannot be read to require a benefit-to-benefit analysis justifying broad categorical exclusions of important, medically necessary health services as EHB. We believe such a narrow reading of the ACA's typical employer plan provision

¹⁵⁴ U.S. Dept. of Health and Human Svcs. *2025 Marketplace Integrity and Affordability Final Rule*, 90 Fed. Reg. 27074-27227 (June 25, 2025), (prohibiting "specified sex-trait modification procedures" as EHB), <https://www.govinfo.gov/content/pkg/FR-2025-06-25/pdf/2025-11606.pdf>.

¹⁵⁵ 90 Fed. Reg. 27254.

¹⁵⁶ 90 Fed. Reg. 27255.

¹⁵⁷ See U.S. Dept. of Health and Human Svcs., Ctr. for Consumer Information and Insurance Oversight (CCIIO), *Information on Essential Health Benefit (EHB) Benchmark Plans*, <https://www.cms.gov/marketplace/resources/data/essential-health-benefits>.

¹⁵⁸ KFF, *2024 Employer Health Benefits Survey* (Oct. 9, 2024), at 17, <https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2024-Annual-Survey.pdf>.

¹⁵⁹ See CCIIO, *supra* note 157.

¹⁶⁰ TruHearing, *Hearing Loss in the Workplace Survey* (2024), at 11, <https://www.truhearing.com/wp-content/uploads/2025/03/560650-HLWP-ebook-2024-0924-A2-1.pdf>.

is not in line with the purpose of the law. When the ACA was enacted, it was common for private plans, including employer plans, to exclude certain services that are now considered essential from coverage.¹⁶¹ The ACA's EHB requirement was adopted precisely to close those gaps in coverage. It would make little sense for the ACA to require a benefit-by-benefit TEP equivalence if the goal of the law is to ensure and improve access to a broad range of minimum essential benefits.

Instead, the most appropriate reading of the TEP provision is that EHB plans should fall with the general range, and certainly no less than the scope of coverage in typical employer plans. Such an interpretation is consistent with the plain text of the TEP and EHB provisions. This understanding of the TEP provision is reflected in HHS's recent clarification of 45 C.F.R. § 156.111 that "the typicality standard functions as both a ceiling and floor."¹⁶² Specifically, the 2025 NBPP Final Rule established that state's EHB benchmark selection should be "equal to the scope of benefit in a typical employer plan," which means a scope of benefits that is at least or more generous as the least generous of comparator plans within a state, and as generous, or less, than the most generous of comparator plans within a state.¹⁶³

In the Proposed Rule, HHS adds that states may include the value of routine non-pediatric oral health services, as well as other EHB-prohibited services listed in § 156.115(d), when conducting their actuarial analyses of comparator plans.¹⁶⁴ Under this scheme, the cost of the services is included in the TEP analysis, but the services themselves must be excluded. This discrepancy makes no sense.

The actual statute provides needed clarity. Under the subheading "Limitations," the ACA requires the Secretary to "ensure the scope of EHB is equal to the scope of benefits provided under a typical employer plan."¹⁶⁵ The TEP analysis must be actuarially certified, by the Chief Actuary of the Centers for Medicare & Medicaid Services.¹⁶⁶ But there is more. Any additions or expansions of benefits, or reductions in existing benefits, must meet actuarial limitations, as described in the TEP provision.¹⁶⁷ The statute does not envision a benefit-by-benefit analysis.

¹⁶¹ ASPE, Essential Health Benefits: Individual Market Coverage (Dec. 16, 2011), <https://aspe.hhs.gov/sites/default/files/private/pdf/76356/ib.pdf> (finding that 62% of enrollees did not have coverage of maternity services).

¹⁶² U.S. Dept. of Health and Human Svcs., *HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program*, 89 Fed. Reg. 26218, 26268 (Apr. 15, 2024), <https://www.govinfo.gov/content/pkg/FR-2024-04-15/pdf/2024-07274.pdf>.

¹⁶³ *Id.* at 26424 (codified at § 156.111(b)(2)(ii)).

¹⁶⁴ See 91 Fed. Reg. 6370 ("if a typical employer plan used in the typicality comparison includes any of these services, the actuarial value of those services may be included when calculating that employer plan's overall value for purposes of the typicality test. This does not mean, however, that these services may be covered as EHBs in the State's EHB-benchmark plan itself.").

¹⁶⁵ 42 U.S.C. § 18022(b)(2)(A).

¹⁶⁶ 42 U.S.C. § 18022(b)(2)(B).

¹⁶⁷ 42 U.S.C. § 18022(b)(4)(G)(iv).

Instead, Congress set a general range and established an EHB minimum so that plans cannot be any less generous than a typical employer plan. The TEP and other provisions of the ACA do not provide for EHB prohibitions. HHS needs to follow the law.

D. EHB prohibitions stifle state flexibility to address urgent unmet health care needs

In addition, § 156.115(d), unnecessarily disrupts the carefully crafted balance that has been established between the need to ensure access to a minimum set of benefits for enrollees across the country and the objective that, as HHS expressed when it adopted the current EHB benchmarking framework in 2018, “states should have additional choices with respect to benefits, which may foster innovation in plan design and greater access to coverage...”¹⁶⁸

We have long advocated for improved access to quality and affordable oral health services for adults, underscoring its vital importance to overall health, in comments and public correspondence with HHS.¹⁶⁹ Several states have been considering adding adult dental services to their EHB benchmarks, including California, Maine, and Virginia.¹⁷⁰ Kentucky found that adding a comprehensive adult dental benefit could impact premiums by approximately \$15 per member, per month, falling well within the EHB generosity limits of state comparator plans.¹⁷¹ States have not yet had the opportunity to assess a more

¹⁶⁸ 83 Fed. Reg. 17010 (April 17, 2018).

¹⁶⁹ Mara Youdelman et al., Nat’l Health Law Prog., *Comments on the Notice of Benefit and Payment Parameters for 2025* (Jan. 8, 2024), <https://healthlaw.org/resource/comments-on-the-notice-of-benefit-and-payment-parameters-for-2025/>; Héctor Hernández-Delgado & Wayne Turner, Nat’l Health Law Prog., *NHeLP Comments on Essential Health Benefits (EHB) Request for Information (RFI)* (Jan. 31, 2023), <https://healthlaw.org/resource/nhelp-comments-on-essential-health-benefits-ehb-request-for-information-rfi/>; Wayne Turner, Héctor Hernández-Delgado & Alexis Robles-Fradet, Nat’l Health Law Prog., *NHeLP Letter to CCIIO Director, Ellen Montz - Re: Request for Modifications to the Federal Prescription Drug and Maternity Care Essential Health Benefit Standards* (Aug. 15, 2022), <https://healthlaw.org/resource/nhelp-letter-to-cciio-director-ellen-montz-re-request-for-modifications-to-the-federal-prescription-drug-and-maternity-care-essential-health-benefit-standards/>.

¹⁷⁰ California Dept. of Managed Health Care, *DMHC Applies to Update California’s Benchmark Plan, Expand Essential Health Benefits to Include Fertility Services, Hearing Aids & Wheelchairs* (May 5, 2025), <https://dmhc.ca.gov/Resources/Newsroom/PressReleases/May5,2025.aspx>; Virginia State Corporation Commission, *Virginia’s Essential Health Benefits Benchmark Plan, 2025 Review for Potential 2028 New EHB Benchmark Plan*, <https://www.scc.virginia.gov/consumers/insurance/health-insurance-consumer/about-the-affordable-care-act/essential-health-benefits-benchmark-plan/#> (last visited March 3, 2026); Maine Bureau of Insurance, *Essential Health Benefits (EHB) Benchmark Plan Update*, 132 Maine Legislature, Health Coverage, Insurance, and Financial Services Committee (Jan. 2025), https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/EHB%20Benchmark%20Plan%20Initiative%20HCIS%202025_0.pdf. See also Nat’l Health Law Prog., et al., *Letter to California Department of Managed Health Care, Re: California’s Essential Health Benefits and Updating the Benchmark Plan* (July 11, 2024), <https://healthlaw.org/wp-content/uploads/2024/07/DMHC-EHB-Coalition-Comments.pdf>.

¹⁷¹ Kentucky Dept. of Insurance, *Kentucky Plan Year 2027 Benchmark Plan Change Actuarial Report* (April 28, 2025),

targeted benefit, such as including routine oral health services as part of the maternity benefit. The Health Resources & Services Administration has well-documented the harm of poor oral health during pregnancy, including premature birth, low birthweight of the infant, preeclampsia, gestational diabetes, and other serious conditions.¹⁷² In all likelihood, oral health services as part of the maternity benefit, and even for all adults, could lead to lower health care costs, and ultimately lower premiums, due to improved health care outcomes.

HHS should not foreclose the opportunity for states to add routine non-pediatric oral health services to the EHB benefits package available to residents.

§§ 156.130 and 156.155 – Multi-Year Catastrophic Health Plans

NHeLP strongly opposes HHS’s proposal to permit issuers to offer catastrophic health plans with multiple consecutive years up to 10 years (“multi-year catastrophic plans”). The proposal violates the plain text of the ACA. It would reduce access to care and expose consumers to financial harm and discrimination. Lastly, HHS’s proposal fails to provide the public with a meaningful opportunity to comment, given major design gaps and the lack of evidence proving its effectiveness.

A. The multi-year plan proposal is contrary to statute

42 U.S.C § 18022(e)(2) establishes eligibility, coverage, and cost-sharing requirements for catastrophic health plans in terms of individual plan years. A “plan year,” as defined at 45 C.F.R. § 155.20, is a “consecutive 12-month period during which a health plan provides coverage for health benefits.” This proposal permits catastrophic health plans to be offered for multiple consecutive years in direct conflict with statutory language that such plans be offered on a “plan year” basis. For example, the ACA requires a catastrophic health plan to provide no benefits unless an individual has incurred “cost-sharing expenses in an amount equal to the annual limitation in effect ... for *the plan year*” (emphasis added); permits an individual to enroll in a catastrophic health plan only if they have “not attained the age of 30 before the beginning of *the plan year*” (emphasis added); and permits an individual to enroll in a catastrophic health plan on the basis of being exempt from the requirement to maintain minimum essential coverage only if the individual “has a certification in effect for any *plan year* under this title”.¹⁷³ Indeed, these and other statutory requirements mandating that

<https://insurance.ky.gov/ppc/Documents/KY%20PY2027%20Benchmark%20Plan%20Change%20Actuarial%20FINAL%20Report%2020250428.pdf> (it is not clear if Kentucky submitted its EHB benchmark update).

¹⁷² HRSA, *Oral Health and Pregnancy*, <https://www.hrsa.gov/oral-health/pregnancy> (last visited March 2, 2026).

¹⁷³ 42 U.S.C. §§ 18022(e)(1)(B); 42 U.S.C. § 18022(e)(2)(A); 18022(e)(2)(B).

catastrophic health plans operate on a plan-year basis are just a few of the numerous requirements reflecting the 12-month plan year as a foundational premise of the ACA.¹⁷⁴

Moreover, HHS appears to base its multi-year plan proposal on its largely unrelated authority to develop guidelines on how issuers can utilize value-based insurance design (VBID) with respect to preventive services.¹⁷⁵ Other than the fact that issuers of catastrophic plans are subject to the market-wide requirement to provide coverage of certain specified preventive services without cost sharing, there is no clear nexus between the multi-year catastrophic plan proposal and the authority to develop VBID guidance on preventive services.¹⁷⁶ Simply extending the term of a catastrophic health plan does not constitute VBID. Although VBID is not defined by the ACA or its implementing regulations, HHS has defined it in guidance as “health plan designs that provide incentives for enrollees to utilize higher-value and/or higher-quality services or venues of care.”¹⁷⁷ The University of Michigan Center for Value-Based Insurance Design, whose work HHS has cited in past rulemaking, defines VBID as “a potential solution built on the principle of lowering or removing financial barriers to essential, high-value clinical services.”¹⁷⁸ Permitting issuers to offer plans with extremely high cost-sharing and low actuarial value for multi-year plan terms would fail to achieve these aims, especially because such plans will cause greater financial and health risks for consumers. Finalizing this proposal would stretch HHS’s authority to issue guidance on VBID for preventive care past its breaking point and create a dangerous precedent that issuers could evade statutory requirements for any plan that is subject to the preventive services requirements under the guise of implementing VBID.

B. The multi-year plan proposal would harm consumers

HHS claims that its proposal to permit the sale of multi-year catastrophic plans would benefit consumers and issuers in multiple ways: first, as a mechanism for offering less expensive coverage options; second, as an alternative to single-year plan terms that HHS believes promote churn and fail to incentivize issuers to invest in the health of enrollees; and finally, HHS claims that multi-year plans may decrease issuers’ administrative costs associated with marketing and enrollment and “encourage alternative pricing structures” that could ultimately improve plan affordability. We disagree in all respects.

Overall, HHS does not offer any qualitative or quantitative data to support these claims. While HHS identifies legitimate challenges with affordability and access to preventive services in the present individual market landscape, the proposal fails to provide evidence

¹⁷⁴ See, e.g., requirements establishing an annual Open Enrollment Period (§ 42 U.S.C. 13033(c)(6)(B)); prohibiting annual cost sharing limits on a plan-year basis (§ 42 U.S.C. 300gg–11(a)(2)); imposing cost-sharing limitations on a plan-year basis (42 U.S.C § 18022(c)), etc.

¹⁷⁵ 42 U.S.C. § 300gg-13(c).

¹⁷⁶ 42 U.S.C § 18022(e)(1)(b)(i).

¹⁷⁷ See *FAQs about Affordable Care Act Implementation Part V, Q1*, https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/aca_implementation_faqs5. University of Michigan Value-Based Insurance Design, *Frequently Asked Questions, What is V-BID?*, <https://vbidcenter.org/frequently-asked-questions>.

¹⁷⁸ See 85 Fed. Reg. 7088, 7137 (Feb 6, 2020) (“2021 NBPP NPRM”).

to support its conclusion that permitting issuers to offer multi-year catastrophic plans would address these issues. In fact, HHS's proposal presents major risks for consumers with respect to each of its stated justifications, because it promotes high-cost, low-value plans and permits issuers to impose cost sharing in excess of statutory limits.

1. The multi-year plan proposal will not offer consumers less expensive options

First, HHS claims that multi-year catastrophic plans would offer consumers “less expensive options.”¹⁷⁹ Although the preamble does not clearly articulate the more costly comparator that forms the basis of this justification, we presume that HHS believes that catastrophic health plans offer less costly coverage than metal-tier QHPs. As discussed throughout these comments, catastrophic health plan premiums are not uniformly lower than unsubsidized bronze plan premiums. However, catastrophic health plans uniformly require much higher deductibles than most bronze plans. While the national average bronze plan deductible is roughly \$7,500 for an individual, self-only catastrophic plans are prohibited from providing benefits until the enrollee reaches the maximum annual cost-sharing limit.¹⁸⁰ In 2026, this translates to a \$10,600 deductible for a catastrophic health plan, which is set to increase to \$12,000 in 2027 — unless a separate proposal in the Proposed Rule is finalized to impose cost-sharing limitations 130% above statutory limits, or \$15,600 for an individual.¹⁸¹ While premiums may vary at the local level, catastrophic health plans generally represent a significant financial risk compared to QHP coverage for many people. Low- or middle-income households that would be unable to absorb a five-figure deductible, people with incomes between 100-400% FPL who qualify for PTCs to reduce the cost of metal-tier QHP premiums, and those with chronic health conditions would all likely be exposed to higher premium and/or out-of-pocket costs if enrolled in a catastrophic health plan compared to a QHP. Enrollees with substantial financial resources and who have few anticipated health costs may find that the risk inherent in catastrophic health plan coverage is a reasonable trade-off if they reside in a location where catastrophic health plan premiums are lower than a bronze plan premium, but it is unclear whether or why such consumers would benefit from multi-year contract commitments. In HHS's own words: “There is uncertainty regarding consumer demand for multi-year catastrophic plans.”¹⁸²

Further, HHS's proposal at 45 C.F.R. § 156.130(c) would permit issuers of multi-year plans to alter cost-sharing limitations across the life of a plan in ways that not only violate statutory cost-sharing requirements in the ACA, but could place enrollees at even greater financial risk than single plan-year catastrophic coverage.¹⁸³ For example, HHS describes a scenario in which an enrollee suffering from a disease that requires multiple years of treatment, like cancer, could be subjected to higher cost-sharing during earlier years of a

¹⁷⁹ Proposed Rule at 6371.

¹⁸⁰ Michelle Long, et al., KFF, *Policy Changes Bring Renewed Focus on High-Deductible Health Plans* (Jan. 5, 2026), <https://www.kff.org/patient-consumer-protections/policy-changes-bring-renewed-focus-on-high-deductible-health-plans>.

¹⁸¹ Proposed Rule at 6382-6383.

¹⁸² *Id.* at 6454.

¹⁸³ 42 U.S.C. §§ 18022(c)(1)(B) and (e)(B)(1).

multi-year contract in order to “entice” them to remain in the plan during later years when cost-sharing could theoretically be reduced to achieve expected actuarial value, “as long as the average over all plan participants and over years of the annual limitation on cost sharing equals the average” over the length of the contract term of the annual statutory cost sharing limit.

As noted above, the ACA requires catastrophic plans to adhere to annual cost sharing limitations.¹⁸⁴ HHS does not have the authority to alter these statutory limits. Even if this type of plan design did not conflict with the statute, it raises serious affordability and access concerns for consumers. Most households cannot simply float deductible costs that exceed the already extremely high cost-sharing limits permitted for single-year catastrophic health plans. This is likely to be particularly true during a period of intensive medical treatment that could impact the ability of multiple family members to earn wages due to illness or caregiving obligations. HHS also fails to explain how this front-loaded cost sharing design would effectively drive down overall plan costs, even for enrollees that can absorb higher cost sharing in early contract years and maintain coverage in the same plan long enough to access relatively lower cost sharing in later contract years. Research proves that higher cost sharing reduces access and discourages individuals from using high-value and medically necessary services.¹⁸⁵ Front-loaded cost sharing would simply encourage individuals to delay and defer access to care until they can access lower cost-sharing limits in later contract years.¹⁸⁶ Such delays often translate into worse health outcomes and higher costs for enrollees, especially for enrollees with higher health risks, like older adults, people with disabilities, and people battling cancer.¹⁸⁷ Delays to care will also translate to higher costs for issuers, since delay and deferment in care will ultimately drive up costs across a sicker risk pool.

2. The multi-year plan proposal would neither resolve churn nor encourage issuers to offer more robust preventive services

Second, HHS claims that single-year health plans on the individual market promote churn and fail to incentivize issuers to cover preventive services. NHeLP agrees that a profit-driven system that financially rewards issuers who delay or deny care does not promote positive health outcomes or protect consumers from financial distress. But HHS fails to explain why a multi-year catastrophic plan operating in essentially the same system would

¹⁸⁴ § 18022(e)(B)(1), applying annual cost-sharing limitations at § 18022(c)(B).

¹⁸⁵ Emmett B. Keeler, *Effects of Cost Sharing on Use of Medical Services and Health*, 8 MED. PRAC. MGMT. 317 (1992), <https://www.rand.org/pubs/reprints/RP1114.html>; Rajender Agarwal et al., *High Deductible Health Plans Reduce Health Care Cost and Utilization, Including Use of Needed Preventive Services*, 36 HEALTH AFF. 1762 (2017), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0610>.

¹⁸⁶ Sujha Subramanian, *Impact of Medicaid Copayments on Patients with Cancer*, 49 MED. CARE 842 (2011), https://journals.lww.com/lww-medicalcare/Abstract/2011/09000/Impact_of_Medicaid_Copayments_on_Patients_With.9.aspx; Amitabh Chandra et al., *Patient Cost-Sharing and Hospitalization Offsets in the Elderly*, 100 AM. ECON. REV. 193 (2010), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2982192/>.

¹⁸⁷ *Id.*

yield better results. HHS compares the different incentives between individual market issuers and large employers, stating that large employers have an incentive to invest in long-term employees through health promotion activities with a goal of reducing costs associated with a sicker work force and promoting overall health.¹⁸⁸ However, HHS does not provide evidence to support its statement that benefits provided by large-group employers result in better health outcomes among their employees compared to individual market enrollees. Even if this statement were true, it fails to acknowledge that the individual market tends to be much older and significantly sicker than the large group market.¹⁸⁹ Moreover, large employers have a relationship with their employees that goes beyond simply that between an insurer and a covered enrollee. Employers invest significant resources in their workforce and provide health insurance coverage as a fringe benefit to compete for and retain talent and to gain tax advantages. Similarly, workers have reasons other than retaining a specific health plan to remain employed. Merely extending the potential term of an individual market insurance contract does not convert the relationship between the two parties into that between an employer and employee or convert individual market coverage into employer-sponsored insurance.

Particularly given that enrollees could still terminate their enrollment in a multi-year plan for any reason, including to select a different plan during annual Open Enrollment or if eligible for a Special Enrollment Period, it is unclear how a multi-year plan truly differs from single plan-year coverage, except providing issuers the flexibility to impose cost sharing in excess of statutory limitation during early contract years.¹⁹⁰ Far from incentivizing issuers to offer richer preventive services benefits, the proposed multi-year catastrophic plans are more likely to place enrollees at greater financial and health risk. Ultimately, this approach to coverage will push enrollees that actually need health care to leave a multi-year catastrophic plan quickly for more affordable coverage, rather than remaining in a plan for the potential that cost sharing will be reduced in some future year.

3. HHS lacks evidence proving the multi-year plan proposal would decrease issuers' administrative costs

Finally, HHS states that issuers of multi-year catastrophic plans would benefit from reduced administrative costs related to marketing and enrollment but provides no support for this conclusory statement. As noted above, the proposal does not override the annual cadence

¹⁸⁸ Proposed Rule at 6371.

¹⁸⁹ Cotter, L., et al., Petersen-KFF Health Tracker, *How ACA Marketplace costs compare to employer-sponsored health insurance* (Nov. 2025), <https://www.healthsystemtracker.org/brief/how-aca-marketplace-costs-compare-to-employer-sponsored-health-insurance> (comparing the mean, median, and mode ages in Marketplace coverage [40, 41, and 64] to that of employer-sponsored coverage [33, 34, and 40]; Brett Lissenden and Marc Horvath, RTI International, *The ACA Individual Market Enrollees are Relatively Sick, but also Relatively Cheap, to Insure* (May 28, 2021), <https://www.rti.org/insights/aca-individual-market-enrollees> (finding that ACA individual market enrollees had 20% higher health risk than enrollees in the large employer market, but 27% lower health care costs than enrollees in the large employer market, due to higher cost-sharing and narrower networks in individual market plans).

¹⁹⁰ Proposed Rule at 6372.

of coverage subject to the ACA; issuers would still be required to participate in annual rate filing and enrollment activities. It is unclear whether simply offering the option for a multi-year plan would result in less churn, since enrollees could end the contract at any time¹⁹¹. Particularly given the stated uncertainty regarding consumer demand for these products, HHS's assertion that multi-year catastrophic plans would allow issuers to reduce marketing and enrollment costs is unsupported by evidence. Separately, the proposal appears to allow enrollees to remain eligible for catastrophic coverage for up to a ten-year plan term on the basis of the enrollee's eligibility at the start of the contract, although the language in the preamble is unclear.¹⁹² While allowing an individual to remain enrolled in the same plan for up to a decade regardless of eligibility may reduce churn, it conflicts with statutory eligibility requirements for catastrophic health plans, which are based on an enrollee's eligibility in each plan year.¹⁹³ Further, it raises the risk that the enrollee will remain in a plan that does not meet their evolving needs.

Further, the proposal would permit individuals to remain in a plan without re-verifying eligibility, which appears out of step with requirements in § 71303 of the One Big, Beautiful Bill Act to be implemented for QHPs beginning in 2028.¹⁹⁴ Given that HHS appears to be considering a future proposal to allow issuers to offer multi-year plans for other metal tiers, we note that the pre-verification requirements in § 71303 present a legal barrier to offering PTC-eligible metal-tier plans for multi-year terms in the future.¹⁹⁵ NHeLP would oppose a future proposal to offer multi-year plans in other types of plans for this and the other legal and practical concerns set forth in these comments with respect to catastrophic health plans.

C. The multi-year plan proposal increases the risk of discrimination against people with disabilities

HHS would allow issuers of multi-year catastrophic plans to impose greater cost sharing on the basis of disease. Specifically, HHS states that an issuer of a multi-year catastrophic plan with a five-year term “could opt to vary the annual limitation on cost sharing in the plan by disease, for example, cancer, if that disease requires treatment that spans multiple years, so long as the average over all plan participants and over years of the annual limitation on cost sharing equals the average over 5 years of the annual limitation on cost sharing as required by statute.” HHS justifies this as a form of VBID, authorized under 42 U.S.C. § 300gg-13(c). But this type of plan design could easily be manipulated to allow issuers to screen out people with disabilities. Charging higher cost sharing for people with conditions that “span[] multiple years” is an effective way to discourage people with chronic

¹⁹¹ *Id.*

¹⁹² This sentence in the preamble appears to be missing key language: “We propose that an individual who satisfies the requirements for a catastrophic plan at the time of enrollment in the plan under section 1302(e)(2) of the Affordable Care Act at the time of enrollment in the multi-year plan.” *Id.* at 6371.

¹⁹³ 42 U.S.C. § 18022(e)(2)

¹⁹⁴ Pub. L. No. 119-21 (2025).

¹⁹⁵ Proposed Rule at 6371.

conditions and disabilities from selecting such a plan at all. Nor does the proposal foreclose the possibility that an issuer could increase cost sharing requirements for a current enrollee who receives a new diagnosis during the term of coverage. Raising cost-sharing on the basis of a new condition would not only increase financial burden and reduce access to care when that individual needed it most but would also be likely to push the enrollee to seek a different plan at the next enrollment opportunity. HHS's proposal appears ripe for abuse by issuers of multi-year catastrophic plans who could adjust cost-sharing to discriminate against individuals with disabilities.

D. The multi-year plan proposal does not provide sufficient detail to allow public comment on key design features

Finally, HHS has simply failed to provide sufficient detail on the Multi-Year Plan proposal to permit the public to submit comments without significant speculation. The gaps in the design of the proposal are numerous and raise fundamental questions about implementation of multi-year plans. For example, the proposal does not clearly address whether and how issuers and regulators would be expected to develop and approve actuarially sound premium rates for plans that could theoretically provide coverage for up to a decade, or under what circumstances issuers would be permitted to alter cost-sharing, premiums, and other plan design features to keep a product viable and actuarially sound over the entire term of the contract. These elements of the proposal are not merely ancillary details. To the extent issuers can adjust these plan characteristics throughout the life of the contract, the value of a multi-year contract seems entirely weighted to benefit issuers, who HHS would permit to impose cost-sharing limitations that exceed the statutory requirements and discriminate on the basis of disability, chronic condition, and/or disease. But without clarity on the fundamental boundaries of the proposal, we are left to speculate about its potential effects on consumers, providers, and other stakeholders.

Further, a number of internal inconsistencies within the preamble and between the preamble and regulatory text raise questions about the very nature of the proposal. For example, HHS states at page 6372 of the preamble that “an enrollee could terminate their enrollment in a multi-year catastrophic plan at any time and for any reason, without a penalty or being liable for the premium for the remainder of the multi-year term,” but on page 6456 references risks to consumers “locked into multi-year catastrophic plans.” While we have based our comments on the assumption that enrollees in such plans would have the opportunity to disenroll or switch plans as needed, the preamble text suggests the troubling possibility that multi-year catastrophic plan enrollees could be trapped into coverage for up to a decade. These types of inconsistencies cast doubt on the specifics of HHS's proposals, rendering it impossible for commenters to provide a meaningful response.

While HHS seeks public comment on a lengthy list of issues related to the implementation of these plans — including how offering such plans would affect an issuer's costs and MLR, how they interact with tax-preferred accounts such as Health Savings Accounts and Individual Coverage Health Reimbursement Accounts, market-wide premium and PTC

impacts, and consumer impacts including how such coverage would affect a consumer whose health status changed during the term of a multi-year plan — simply requesting public feedback and data does not provide logical outgrowth to finalize design elements that are entirely lacking in the Proposed Rule. HHS even admits that there is currently no available evidence on these potential effects and data that could help understand the potential unintended consequences of the proposal.¹⁹⁶ Given that lack of evidence, as well as the clear statutory authority issues and likelihood of negative impacts on consumers and the individual market risk pool, HHS should withdraw this proposal.

§ 156.136 – Cost Sharing Requirements and
§ 156.155(a)(3) – Enrollment in Catastrophic Plans

HHS proposes to allow issuers that offer at least one bronze plan that meets the ACA's actuarial requirements and cost-sharing limits to also offer, in the same geographic area, a bronze plan that exceeds the established maximum out-of-pocket (MOOP) by an amount in increments of \$50.¹⁹⁷ Similarly, HHS proposes to require catastrophic plans to only begin covering services when a consumer reaches 130% of the MOOP in order to effectuate distinctions between bronze plans and catastrophic plans and make the latter more appealing for healthier individuals.¹⁹⁸ HHS justifies these proposals by arguing that several factors (mainly the cost of covering EHBs and the increasing costs associated with enrolled populations) are making it difficult for insurers to comply with statutory actuarial requirements related to cost-sharing and levels of coverage even after taking into account actuarial value calculation adjustments.¹⁹⁹ While we acknowledge the mathematical difficulties that HHS and insurers face given the increasing costs of health care, we urge HHS to withdraw this proposal. As the agency repeatedly recognizes in the preamble to the Proposed Rule, the proposal would be contrary to the unambiguous terms of the ACA and, therefore, HHS has no authority to finalize it.

The ACA requires all metal-tier plans to subject coverage of all EHBs to cost-sharing limits or MOOP.²⁰⁰ This statutory requirement is not waivable. The agency does not have statutory authority to make exceptions or increase the cost-sharing limit in certain situations or for certain plans simply because not following the law would make it more feasible for plans to comply with other parts of the law. While HHS recognizes the statutory obligation throughout the preamble to the Proposed Rule, the agency nonetheless claims that the proposal is in line with Congressional intent because otherwise it would be essentially

¹⁹⁶ Proposed Rule at 6455.

¹⁹⁷ 91 Fed. Reg. 6373–6382.

¹⁹⁸ *Id.* at 6382–6383.

¹⁹⁹ *Id.* at 6374–6386.

²⁰⁰ 42 U.S.C. § 18022(c)(1)(B) (“In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall— (i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and (ii) in the case of other coverage, twice the amount in effect under clause (i). If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50”).

impossible to meet other actuarial requirements.²⁰¹ This statutory interpretation is erroneous. We see no need to decipher further Congressional intent when the statute unambiguously indicates its intent: to not allow bronze and catastrophic plans from subjecting EHBs to cost-sharing beyond the MOOP. HHS must simply follow the law.

We also question why HHS is proposing to allow certain exceptions to the cost-sharing limits for bronze plans now when, as the agency acknowledges, plans are still able to meet their actuarial requirements despite the mathematical difficulties. As long as that is the case, HHS cannot claim that the different “statutory requirements cannot reasonably be satisfied simultaneously.”²⁰² As the Proposed Rule states, HHS could have proposed to allow bronze plans with higher MOOP “only when bronze plans would otherwise be non-viable (that is, impossible to design).”²⁰³ While even that scenario goes beyond the ACA’s unambiguous directive, it would at least indicate that HHS is only proposing to deviate from the law when it is absolutely necessary in order to comply with other actuarial requirements and harmonize the overall implementation of the law. Instead, HHS carelessly disregards the statutory text in anticipation of a potential future conundrum. In fact, the proposal undercuts its own justification by requiring issuers to offer at least one compliant plan as a pre-condition to offering a non-compliant plan. In other words, only issuers that can demonstrate the viability of bronze plans under the statute will be permitted to offer plans that violate the statute.

Likewise, HHS has no authority to deviate from the ACA requirements regarding catastrophic plans. The statute unambiguously establishes that, for a product to be considered a catastrophic plan, the plan must only cover services when the MOOP has been reached.²⁰⁴ The only exception to this rule, per the ACA, is to permit catastrophic plans to cover certain preventive services before the MOOP is reached. In fact, prohibiting catastrophic plan coverage before reaching a higher MOOP than contemplated in the law is directly contrary to the obvious and unambiguous intent of the statute to permit coverage after a lower MOOP level. There is no scenario where HHS is allowed or should unilaterally introduce exceptions to the statutory requirement.

While tied to the mathematical difficulties with the actuarial calculation HHS uses to justify the proposed cost-sharing changes for bronze plans, HHS also justifies the proposed changes to the MOOP limits for catastrophic plan coverage by arguing that, increasingly, consumers are selecting bronze plans over catastrophic plans. We disagree with HHS’s assessment that such a result contradicts Congress’s intent. The ACA’s Marketplace reforms sought, primarily, to ensure that individuals who were previously unable to

²⁰¹ 91 Fed. Reg. 6379.

²⁰² *Id.*

²⁰³ *Id.* at 6381.

²⁰⁴ 42 U.S.C. § 18022(e)(1)(B)(i) (“the plan provides – except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713)”).

participate would now be able to join the market. The market is stronger when more people, including young and healthy individuals, select metal-tier plans rather than catastrophic plans.²⁰⁵ Indeed, as addressed in detail in our comments regarding the proposal to expand eligibility for catastrophic health plans, Congress intentionally limited eligibility for these plans. Therefore, while catastrophic plans are nonetheless important for specific situations, lower enrollment levels do not justify ignoring the plan language of the statute.

§§ 156.201 and 156.202– Standardized Plan Options and Non-Standardized Plan Option Limits

NHeLP strongly opposes HHS’s proposal to discontinue all requirements pertaining to standardized plan options.²⁰⁶ Standardized plans are essential in improving consumer choice by simplifying and streamlining plan comparisons and serve as a tool to improve affordability and address health disparities in the Marketplace. Removal of standardized plans will disrupt consumer enrollment by removing consumers’ ability to make apples-to-apples comparisons of plans and benefits and increase financial burdens on consumers.

A. Standardized plans improve consumer choice

Standardized plans that share a common benefits structure, including tiering and cost-sharing, allow consumers to make apples-to-apples comparisons of plans and benefits. The ACA generally achieved a common benefit structure across plans through the requirement that Marketplace plans cover essential health benefits (EHB), but lack of cost-sharing standardization previously allowed issuers to offer an unlimited number of plans. Standardized plans allow consumers to compare plans without regards to cost-sharing requirements, allowing individuals to focus on other factors, such as premiums, provider network, and quality of services.

HHS claims that discontinuing the full suite of standardized plan options policies will reduce consumer choice overload. NHeLP does agree that choice overload can be an issue for consumers choosing a plan. An Assistant Secretary for Planning and Evaluation (ASPE) issue brief indicates that “almost three quarters of *HealthCare.gov* consumers have *more than 60 plan options* to choose from, and the average number of plans is *over 100*”

²⁰⁵ See, e.g., Am. Acad. of Actuaries, *Step Towards a More Sustainable Individual Health Insurance Market* (2017), <https://actuary.org/steps-toward-a-more-sustainable-individual-health-insurance-market/>.

²⁰⁶ Specifically, we oppose the proposals to remove the following requirements: the requirement that issuers of qualified health plans (QHPs) that offer individual market coverage in the Federally Facilitated Exchange (FFE) and State based Exchanges on the Federal Platform (SBE-FP) offer standardized plan options; the definition of “standardized options”; the requirement for these plans to meaningfully differ from one another; the authority to differentially display standardized plan options on *HealthCare.gov*; and the corresponding standardized plan option differential display requirements for approved web-broker and QHP issuer enrollment partners using a direct enrollment (DE) pathway to facilitate consumer enrollment through an FFE or SBE-FP.

(emphasis added).²⁰⁷ Because health care is not a typical consumer good, the usual understanding that more is better for the consumer does not hold true in the Marketplace. On the contrary, the high number of plan options often leads to confusion among shoppers, which in turn gives way to consumer errors during plan selection. As the ASPE report finds, a higher number of plan options runs counter to the central premise of the ACA, which relies on plan competition to increase the value of health care and requires informed consumers to “select among competing plans to realize that value.”²⁰⁸ Choice overload, on the other hand, often leads consumers to make selections without regard to value and discourages consumers from switching from lower-value plans to higher-value plans.

However, NHeLP does not agree with HHS’s proposal to resolve its concern of choice overload. Instead of implementing regulations that would help manage choice overload, HHS proposes discontinuing standardization requirements and leaving issuers with the option to keep or discontinue their existing standardized plan option while removing the differential display and designation of standardized plans. This proposal will disrupt consumer enrollment by waiting for issuers to make that determination, and if an issuer decides to discontinue, enrollees of that standardized plan would have to transition into a different plan that may not fit the health care needs that was covered in the enrollee’s previous plan. Additionally, HHS removing the differential display will limit the information available to consumers to make an informed decision on the plan they would be enrolled in, causing more confusion and financial stress. As we note below, HHS’s separate proposal to rescind limits on non-standardized plan options will contribute to choice overload.

Furthermore, HHS mischaracterizes the popularity of standardized plans. Standardized plan options account for a full third of enrollment after only a few years on the market, with total FFE and SBE-FP enrollment of 20% for 2023, 33% for 2024, and 33% for 2025.²⁰⁹ These percentages are aligned with the growing but still relatively modest share of standardized plan offerings on Healthcare.gov, which accounted for 25%, 28%, and 31% of plans in 2023-2025, respectively.²¹⁰ HHS’s characterization of standardized plan uptake as being “comparatively low” conflicts with data that reveal a steady increase in consumer interest in standardized plans in alignment with their availability.

²⁰⁷ U.S. Dept. of Health & Human Servs., Assistant Sec’y for Plan. and Evaluation (“ASPE”), *Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces* 1 (2021), <https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf>.

²⁰⁸ *Id.* at 4.

²⁰⁹ Katie Keith et al., *HHS Proposes Sweeping Changes For 2027 Marketplace Plans (Part 2)*, HEALTH AFF. (Feb. 13, 2026), <https://www.healthaffairs.org/content/forefront/hhs-proposes-sweeping-changes-2027-marketplace-plans-part-2>.

²¹⁰ Proposed Rule at 6387.

B. Standardization serves as a tool to improve affordability and address health disparities in the Marketplace

Standardized plans ensure that consumers always have access to at least one plan that exempts certain essential services – including emergency room services, primary care visits, and mental health and substance use disorder treatment – from deductibles. Because Black, Indigenous, and other people of color and other underserved populations often lack access to such services that are key to prevent further health complications, exempting these services from the deductible in certain standardized plans made it easier for these communities to receive the care they needed and helped close gaps in access to care.²¹¹

The effectiveness of standardization in improving access and affordability is made evident by the experience of the 9 states and the District of Columbia that have already adopted standardization in their State Exchanges. Our experience as consumer advocates in California, the only state that requires *all* plans in the Marketplace to be standardized, solidifies our disapproval of HHS' standardization proposal. California has required all plans to be standardized since Covered California's inception in 2014.²¹² The result of this policy has been that consumers are able to navigate the Marketplace and shop without having to worry about price variation within particular tiers and service areas. In turn, this ease of access has led to robust coverage across all counties in California alongside significant, albeit incomplete, improvements in the quality of care provided due to competition being based on plans' overall value instead of cost.

Evidence from states also shows that standardized plans can be designed to reduce cost-sharing and provide better coverage for high-cost drugs and services. For example, DC Health Link's standardized plans have eliminated cost sharing for primary care visits, laboratory tests, and generic drugs for people with HIV. DC also limited cost-sharing for diabetes and cardiovascular related services and limited pediatric outpatient visits to a \$5 copay.²¹³ Eliminating standardized plans removes the framework for innovative benefit designs aimed at improving consumer access to care.

We do agree that some of the cost-sharing in standardized plans on the FFE still remains too high for beneficiaries with high health needs. For people with chronic health conditions, who need certain drugs to help treat their health condition, high deductible requirements

²¹¹ For a discussion about how issuers use benefit manipulation and “adverse tiering” to discriminate against individuals with high-cost needs and how standardization helps fix this problem, see Douglas Jacobs, *CMS' Standardized Plan Option Could Reduce Discrimination*, HEALTH AFF. (Jan. 6, 2016), <https://www.healthaffairs.org/doi/10.1377/forefront.20160106.052546>.

²¹² Justin Giovannelli et al., *State Efforts to Standardize Marketplace Health Plans Show How the Biden Administration Could Improve Value and Reduce Disparities*, THE COMMONWEALTH FUND (July 28, 2021), <https://www.commonwealthfund.org/blog/2021/state-efforts-standardize-marketplace-health-plans>.

²¹³ Executive Board of the District of Columbia Health Benefit Exchange, Resolution (November 19, 2024), https://hbx.dc.gov/sites/default/files/dc/sites/hbx/event_content/attachments/Resolution%20-%20PY2026%20Standard%20Plans%20AMENDED%20FINAL_20241119.pdf.

can also be a barrier. Instead of eliminating standardized plans, HHS should exempt them from deductible requirements across sliver plans, which represent the bulk of enrollment in the marketplace. HHS should also evaluate the possibility of lowering copayments for specialty drugs without the need to increase cost-sharing for other services pursuant to the AV calculator.

Lastly, HHS should limit or prohibit coinsurance, which is inherently discriminatory and unduly shifts the costs of care to persons with high health needs. Coinsurance also increases confusion among consumers because even more experienced consumers may fail to understand that a lower coinsurance percentage may nonetheless represent a higher out-of-pocket amount than copayments. Coinsurance is particularly invidious for prescription drugs, for which actual prices vary considerably. Consumers are ill-equipped to consider these price variations and plans do not provide information on the dollar amount of coinsurance a consumer can expect to be charged. Eliminating standardized plans will only cause more confusion, instead of resolving these major issues that impact enrollee's access to affordable, non-discriminatory health care coverage.

§ 156.202 – Non-Standardized Plan Option Limits

NHeLP strongly opposes HHS's proposal to discontinue non-standardized plan option limits and exceptions. Choice overload and the complexity of comparing plans in the ACA Marketplace has been a challenge for many consumers. A 2023 Kaiser Family Foundation Study found that at least 35% of Marketplace enrollees cited difficulties in choosing a plan; 41% of enrollees found it difficult to compare doctors, hospitals, and health care providers across plans; 31% had difficulty in comparing copays and premiums; and 25% reported challenges in comparing premiums.²¹⁴ Evidence has shown that choice overload can lead to poor outcomes for enrollees. A recent RAND Corporation study shows that when consumers are given too many plan choices, there is the greater potential to make poor enrollment decisions. Multiple factors result in less than optimal plan choice decision making, including but not limited to the challenge of processing complex health plan information, inadequate decision support tools, and low health literacy and numeracy.²¹⁵ Consumers may incorrectly calculate costs, or focus on premiums without even considering total out-of-pocket costs. When there are too many options, consumers may also be susceptible to how choices are presented on the website. For example, someone might select a plan merely because it is presented first on the website. Of most concern, consumers may experience decision fatigue and not enroll in health insurance at all.

HHS also claims that part of the rationale for discontinuing non-standardized plan option limits and exceptions is that these policies are “an ineffective strategy in counteracting plan

²¹⁴ Kaye Pestaina et al., Kaiser Family Found., *Signing Up for Marketplace Coverage Remains a Challenge for Many Consumers* (Oct. 30, 2023), <https://www.kff.org/affordable-care-act/signing-up-for-marketplace-coverage-remains-a-challenge-for-many-consumers/>.

²¹⁵ Erin Audrey Taylor et al., *Consumer Decisionmaking in the Health Care Marketplace*, RAND Corp. (2016), https://www.rand.org/pubs/research_reports/RR1567.html.

proliferation.²¹⁶ The agency repeatedly references its “4 plan years” of experience administering standardized plans as justification for its proposal to eliminate non-standardized plan option limits. But this overstates the agency’s experience and any possible data it could have to support a policy reversal, because current rules limiting non-standardized plan options have only been in place for plan year 2025 and HHS has had only one year to observe the effects of the “full suite” of standardized plan options. One year is simply not enough time to measure the impact of this policy.

In addition to limiting plan selection, the evidence shows that outreach efforts help optimize plan selection and help consumers avoid choice errors. A Covered California analysis found that nearly 20,000 Covered California consumers selected more expensive gold and platinum plans in 2019 despite being eligible for a less expensive enhanced silver plan with richer benefits.²¹⁷ Covered California sent additional emails and letters to these consumers describing the financial savings if they switched to the silver product, and as a result, roughly 20% of these individuals switched to a silver plan with a lower premium and cost-sharing savings.²¹⁸ This analysis clarifies that consumers make suboptimal plan selections simply because of the sheer number of plans to choose from, and the complexity of information on Marketplace platforms. HHS should require Marketplaces to implement a multi-pronged approach to helping consumers navigate the platforms to make sound plan selections. Further, if HHS truly wants to improve consumer experience in navigating and selecting the best health plan, they should restore Federal Navigator funding to its previous levels of \$100 million, adjusted for inflation.²¹⁹ Federal Navigators are unbiased representatives trained to help consumers search for an optimal plan to meet their individual needs.

§ 156.235 – Essential Community Providers

A. Reduction of the minimum percentage (or threshold) requirement From 35% to 20%

HHS proposes, beginning in plan year 2027, to lower the Essential Community Provider (ECP) participation standard from 35% to 20% for both medical QHP and SADP issuers. HHS also proposes to reduce the separate minimum thresholds for Federally Qualified Health Centers (FQHCs) and Family Planning Providers that qualify as ECPs from 35% to 20%. We strongly oppose reducing these minimum percentage requirements. The current

²¹⁶ 91 Fed. Reg. at 6391.

²¹⁷ Andrew Feher & Isaac Menashe, *Using Email and Letters To Reduce Choice Errors Among ACA Marketplace Enrollees*, HEALTH AFF. 812, 814 (May 2021), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.02099>.

²¹⁸ *Id.* at 815.

²¹⁹ U.S. Dept. of Health & Human Servs., *CMS Announcement on Federal Navigator Program Funding* (Feb. 14, 2025), <https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding> (noting that funding for Federal Navigators was cut by 90% from \$100 million to \$10 million.)

threshold or higher percentage is necessary to facilitate access to these providers among QHP enrollees.

Including adequate levels of ECPs – including FQHCs and Family Planning Providers – in QHP networks is essential to improving health outcomes and advancing health equity.²²⁰ ECPs serve predominantly low-income and medically underserved populations. ECPs function as a lifeline for patients who would otherwise struggle to access or afford care. Lowering the thresholds from 35% to 20% would narrow provider networks and significantly impede access to essential services, particularly for people capable of becoming pregnant; Black, Indigenous, and other people of color (BIPOC); young people; LGBTQIA+ individuals; people with disabilities; and individuals living in rural communities.

QHPs serve large numbers of people capable of becoming pregnant, making it critically important that networks include sufficient family planning providers and other ECPs equipped to meet their reproductive and preventive health needs.²²¹ Access to quality family planning services is associated with improved maternal and infant health outcomes by enabling individuals to plan, delay, and space pregnancies.²²² Access to family planning providers has become increasingly difficult due to the defunding of clinics, stagnant Title X funding, low reimbursement rates, and other attacks on sexual and reproductive health care.²²³ Reducing the minimum participation thresholds for Family Planning Providers that qualify as ECPs from 35% to 20% would further limit QHP enrollees' ability to access timely and adequate family planning services.

Ensuring meaningful access to these providers is particularly urgent given the nation's maternal mortality crisis, which disproportionately affects BIPOC communities.²²⁴ Black

²²⁰ Cristina Jade Peña *et al.*, KFF, *Federal and State Standards for “Essential Community Providers” Under the ACA and Implications for Women’s Health* (2015), <https://www.kff.org/womens-health-policy/federal-and-state-standards-for-essential-community-providers-under-the-aca-and-implications-for-womens-health/>.

²²¹ Jennifer J. Frost *et al.*, Guttmacher Inst., *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Use, 2020*, <https://www.guttmacher.org/report/publicly-supported-FP-services-US-2020>.

²²² See Laurel W. Rice *et al.*, *Universal Access to Contraception: Women, Families, and Communities Benefit*, 222 AM. J. OBSTET. GYNECOL. 2 (2020), <https://www.sciencedirect.com/science/article/abs/pii/S0002937819311214>; Megan L. Kavanaugh & Ragnar M. Anderson, Guttmacher Inst., *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers* (2013), https://www.guttmacher.org/sites/default/files/report_pdf/health-benefits.pdf; Off. of Disease Prevention and Health Promotion, *Healthy People 2020, Family Planning*, <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/family-planning> (highlighting some of the negative health outcomes associated with unintended pregnancy).

²²³ Céline Gounder, KFF Health News, *The Quiet Collapse of America’s Reproductive Health Safety Net* (Oct. 2025), <https://kffhealthnews.org/news/article/title-x-family-planning-hhs-opa-trump-cuts-reproductive-health-maine/>.

²²⁴ The United States has the highest maternal mortality rates among well-resourced nations with Black birthing people experiencing significantly higher rates than other demographics. Latoya Hill *et al.*, KFF, *Racial Disparities in Maternal and Infant Health: Current Status and Key Issues* (Dec. 2025), <https://www.kff.org/racial-equity-and-health-policy/racial-disparities-in-maternal-and-infant->

birthing people experience higher rates of preterm birth and are more likely to have chronic conditions such as anemia, heart disease, diabetes, and hypertension that increase the risk of severe maternal morbidity and poor birth outcomes if left unmanaged prior to pregnancy.²²⁵ Additionally, they face a higher risk of developing life-threatening heart failure during the late stages of pregnancy and postpartum.²²⁶ Robust ECP participation standards are necessary to support access to preventive care and chronic disease management services that are critical to addressing these disparities.

ECPs – including Community Health Centers, Ryan White providers, and STD clinics – also deliver essential preventive and treatment services. Early detection and treatment of sexually transmitted infections can prevent chronic pelvic pain, infertility, miscarriage, neonatal complications, increased HIV risk, cancer, neurological consequences, and death.²²⁷ Early HIV diagnosis is key to successful treatment outcomes.²²⁸ Likewise, routine screenings for breast and cervical cancer improves survival by facilitating early detection and timely care.²²⁹ Weakening ECP participation standards would jeopardize access to these life-saving services.

ECPs are trusted providers within BIPOC, LGBTQIA+, and disability communities. These populations frequently encounter discrimination, bias, and culturally incongruent care in other health settings. Robust participation standards are necessary to guarantee that QHP networks meaningfully include the providers these communities rely upon. Reducing the thresholds risks destabilizing safety-net providers, including Family Planning Providers, and diminishing access to critical services in historically underserved areas.

HHS seeks comment on whether the proposed 20% threshold would maintain access to ECPs for enrollees in rural areas and reduce barriers to issuer participation in rural areas.

[health-current-status-and-key-issues/#:~:text=Pregnancy%2Drelated%20mortality%20rates%20among,14.9%20per%20100%2C00.](#)

²²⁵ Jasmine D. Johnson *et al.*, *Racial Disparities in Prematurity Persist Among Women of High Socioeconomic Status*, AM. J. OBSTET. GYNECOL. (Aug. 2020), <https://pmc.ncbi.nlm.nih.gov/articles/PMC7654959/>.

²²⁶ Black Birthing People are also more likely to be diagnosed later and less likely to recover. Olga Corazón Irizarry *et al.*, *Comparison of Clinical Characteristics and Outcomes of Peripartum Cardiomyopathy Between African American and non-African American Women*, JAMA CARDIOL. 2:1256–1260 (2017), <https://pubmed.ncbi.nlm.nih.gov/29049825/>.

²²⁷ Jeffrey S. Crowley *et al.*, *Sexually Transmitted Infections: Adopting a Sexual Health Paradigm*, Nat'l Acads. of Sciences, Engineering, and Med. (2021), <https://pubmed.ncbi.nlm.nih.gov/34432397/>.

²²⁸ Margaret T. May, *Better to Know: The Importance of Early HIV Diagnosis*, 2 THE LANCET PUBLIC HEALTH e6 (2017), [https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(16\)30038-X/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(16)30038-X/fulltext).

²²⁹ Am. Cancer Soc'y Recommendations for the Early Detection of Breast Cancer, <https://www.cancer.org/cancer/types/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html>; Am. Cancer Soc'y Guidelines for the Prevention and Early Detection of Cervical Cancer, <https://www.cancer.org/cancer/types/cervical-cancer/detection-diagnosis-staging/cervical-cancer-screening-guidelines.html>.

We believe the proposal would diminish rural residents' access to ECPs. Rural residents already face reduced access to care and poorer health outcomes compared to urban and suburban populations.²³⁰ These disparities have been exacerbated by rural hospital closures and the loss of obstetric services.²³¹

In regions such as Appalachia, life expectancy lags significantly behind the national average, and residents experience elevated rates of disability, diabetes, preterm birth, low birthweight, maternal diabetes, maternal hypertension, and maternal mortality.²³² At the same time, these communities face persistent provider shortages.²³³ Lowering ECP thresholds would further narrow already limited rural networks. Rural communities need more ECP participation, not less.

HHS suggests that lowering the thresholds would reduce administrative burden for QHP issuers, particularly in rural states which have fewer ECPs. However, 42 U.S.C §13031(c)(1)(C) requires that a QHP's network include ECPs, *where available*.²³⁴ Additionally, issuers are required to contract with a percentage of available ECPs in a service area, not a fixed number. Moreover, the regulatory history demonstrates that issuers are capable of meeting the current standards.

HHS suggests that reducing the overall threshold, FQHC threshold, and Family Planning Provider threshold requirements from 35% to 20% would provide additional flexibility for QHP issuers to build provider networks and minimize disruptions for issuers in adjusting to meet the threshold requirements. However, from 2015 through 2017, issuers were required to contract with at least 30% of available ECPs. That threshold was reduced to 20% beginning in 2018 and then raised to 35% beginning in PY 2023. At the time, many stakeholders including providers, provider associations, and consumer advocacy groups

²³⁰ CDC, *About Rural Health* (2024), <https://www.cdc.gov/rural-health/php/about/index.html#:~:text=People%20who%20live%20in%20rural,exposure%20to%20specific%20environmental%20hazards>.

²³¹ During the past two decades, rural counties experienced persistent losses of hospital-based obstetric services, with losses disproportionately affecting the most remote, rural areas of the United States. Katy Backes Kozhimannil *et al.*, Health AFF., *Obstetric Care Access Declined In Rural And Urban Hospitals Across US States, 2010–22* (July 2025), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2024.01552>. See also Christine Durrance *et al.*, *The Effect of Rural Hospital Closures on Maternal and Infant Health*, Health SERV. RES. (April 2024), <https://pmc.ncbi.nlm.nih.gov/articles/PMC10915477/>; Paula Chatterjee, *Causes & Consequences of Rural Hospital Closures*, 17 J. HOSP MED. 938-939 (Nov. 2022), <https://pmc.ncbi.nlm.nih.gov/articles/PMC9633454/>.

²³² David L Driscoll *et al.*, *Assessing and Addressing the Determinants of Appalachian Population Health: A Scoping Review*, 5 J. APPALACHIAN HEALTH 85-102 (Dec 2023), <https://pmc.ncbi.nlm.nih.gov/articles/PMC11110904/>; Gopal K. Singh *et al.*, 36 Health AFF. 1423-32 (Aug. 2017) *Widening Disparities In Infant Mortality And Life Expectancy Between Appalachia And The Rest Of The United States, 1990–2013*.

²³³ Kaitlyn Palmer *et al.* *Unique Health Care Delivery Considerations in Rural America*, INT. J. MS CARE (Feb. 2025), <https://pubmed.ncbi.nlm.nih.gov/40045977/>.

²³⁴ Patient Protection and Affordable Care Act § 1311(c)(1)(C), Pub. L. No. 111-148, 124 Stat. 119 (2010).

supported raising the threshold from 20% to 35% to strengthen access to care.²³⁵ The 2024 NBPP Final further strengthened standards by adding separate 35% thresholds for FQHCs and Family Planning Providers.²³⁶

Data confirms issuers' capacity to comply. For PY 2021, 80% of medical FFE issuers would have satisfied a 35% threshold.²³⁷ In 2017, only 6% of issuers failed to meet the 30% threshold and were required to submit a narrative justification.²³⁸ HHS now claims, based on an analysis of PY 2025 FFE plan data, only a small additional number of issuers would newly satisfy the reduced thresholds.

These data demonstrate that most issuers have not struggled to meet the current ECP standards and likely have the capacity to maintain broader networks. Maintaining the current 35% threshold would not impose new or unprecedented obligations, as issuers have complied with this requirement since PY 2023.

B. Modifications to narrative justification requirements at §§ 156.235(a)(3) and 156.235(b)(3)

HHS proposes to revise §§ 156.235(a)(3) and (b)(3) to eliminate the requirement that issuers provide a narrative justification when they do not meet the ECP participation standard, describing how their network ensures an adequate level of service for low-income enrollees and how the plan's provider network will be strengthened toward satisfaction of the ECP standard prior to the start of the benefit year. Instead, issuers would only need to report the status of contract offers to qualified ECPs available in the plan's service area as part of its QHP application. We oppose this proposal.

This provision has the potential to become the exception that swallows the rule. Without meaningful enforcement of ECP participation standards, individuals who depend on ECPs will have diminished access to the care they need. Given the importance of including ECPs in QHP networks, HHS should not provide issuers with leeway to avoid meeting its ECP standards.

Given the central role ECPs play in advancing health equity and ensuring access to care, HHS should preserve and strengthen existing participation requirements rather than weaken them.

²³⁵ U.S. Dep't. Health & Human Srvs., *Notice of Benefit and Payment Parameters for 2023 Final Rule*, 87 Fed. Reg. 27208 (2022), <https://www.federalregister.gov/d/2022-09438/p-1623>.

²³⁶ 88 Fed. Reg. 25740, 25747 (April 27, 2023).

²³⁷ *Id.*

²³⁸ 82 Fed. Reg. 10980 (2017), *Market Stabilization Proposed Rule 2017* <https://www.federalregister.gov/documents/2017/02/17/2017-03027/patient-protection-and-affordable-care-act-market-stabilization>.

§ 156.236 – Provider access and essential community providers standards for non-network plans

NHeLP opposes the unjustified policy reversal to allow issuers to administer so-called non-network plans as QHPs. HHS fails to provide sufficient detail to allow the public to meaningfully comment on the effects of the proposal. Based on the information sketched out in the Proposed Rule, the proposal not only conflicts with multiple statutory requirements but would incentivize the sale of policies that are all but guaranteed to impose significant burdens on consumers. The proposed guardrails would be insufficient to prevent widespread confusion and virtually ensure a major spike in rates of medical debt if non-network plans are allowed to proliferate.

HHS does not address how non-network plans offered on the Marketplace could adhere to statutory requirements throughout the ACA that clearly assume the availability of a fixed and identifiable network of providers. These requirements include network adequacy standards, references to in- and out-of-network providers that are incompatible with non-network plans, essential health benefits requirements, and cost-sharing limitations.²³⁹ Plans that do not utilize a provider network have no means of tracking, much less guaranteeing, that an individual will truly have access to sufficient providers as required by law, will not be charged for preventive services, or that out-of-pocket costs will remain below annual limits. The Proposed Rule fails to address how such non-network plans can comply with the statute or how the agency or state regulators could hope to enforce these fundamental consumer protections. Without this information, we do not have sufficient information to provide meaningful comment and HHS should not finalize the proposal.

Non-network plans will also harm consumers. NHeLP has previously raised concerns about people's ability to access care and control their health care costs in non-network plan models.²⁴⁰ This defined-benefit plan structure is a recipe for medical debt disaster. The Administration justifies its proposal to allow non-network plans based on two assumptions that these plans will lower health care costs:

- (1) empowering enrollees to utilize price transparency information to shop for lower prices and negotiate directly with providers, thus fostering increased competition, and (2) eliminating substantial administrative overhead

²³⁹ See, e.g., 42 U.S.C. § 13031(c)(1)(B)-(C) and (D)(1) (requiring the Secretary of HHS establish criteria that ensure that plans provide a “sufficient choice of providers (in a manner consistent with applicable network adequacy requirements under section 2702(c) of the Public Health Service Act) and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers”, “include [essential community providers] within health plan networks); and 42 U.S.C. § 18022 (requiring QHPs cover essential health benefits, which must be subject to cost-sharing limitations as defined at (c); and “); and meet clinical quality standards including with respect to provider credentialing and network adequacy; 42 U.S.C. §300gg-13(a) (mandating coverage of recommended preventive services without cost sharing);

²⁴⁰ See, e.g., Nat'l Health L. Prog., *Comments on RIN 0938-AU97; CMS-9899-P Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024*, (Jan. 30, 2023), <https://healthlaw.org/resource/nhelp-comments-on-patient-protection-and-affordable-care-act>.

associated with traditional network management, potentially resulting in lower premiums.²⁴¹

The first assumption glosses over the realities of how and when people access health care services and ignores the complexities and ongoing lack of transparency of health care costs. Despite some recent regulation changes affecting hospitals and ambulatory surgical centers, efforts to improve transparency in health care pricing remain in their infancy. Health care is not a grocery store. Different prices are commonly negotiated with different payers, so even if hospitals report their actual standard charges, those may show up to a consumer as a range of rates.²⁴² Other types of providers may not be subject to even these rudimentary transparency requirements. Recent reports provide ample details on the multiple, on-going challenges of achieving effective price transparency in health care.²⁴³ The fact is consumers still have extremely limited capacity to find out ahead of time what a given health service might cost, or how different potential charges might adhere to a given procedure.

Even if health care consumers were able to quickly and reliably price out services needed during a health care episode, the reality is that people who need health care often do not have the luxury of comparing or negotiating prices across a range of providers. While the No Surprises Act protects enrollees in non-network plans from surprise bills for emergency care and air ambulance services, consumers are vulnerable in all other circumstances.²⁴⁴ An older adult with shingles may be in too much pain to haggle over how much a provider charges for an exam and recommended course of treatment. A person needing a mammogram may not realize they have to comparison shop for their annual screening, since it is a recommended preventive service under the ACA when offered by an in-network provider – a designation that simply does not exist in a non-network plan. A parent seeking care for a child’s medically necessary but non-emergent condition may not have a wide choice of providers when seeking pediatric specialty care. Under HHS’s proposal, all of these individuals would be subject to balance billing at the discretion of the provider.

Even when a health care service is not time-dependent and could allow for cross-provider price comparisons, the individual has extremely limited power to negotiate prices with

²⁴¹ CMS, *Fact Sheet: HHS Notice of Benefit and Payment Parameters for 2027 Proposed Rule* (Feb. 9, 2026), <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-payment-parameters-2027-proposed-rule>.

²⁴² See, CMS, *Fact Sheet: CY 2026 OPPS and Ambulatory Surgical Center Final Rule - Hospital Price Transparency Policy Changes* (Nov. 21, 2025), <https://www.cms.gov/newsroom/fact-sheets/cy-2026-opps-ambulatory-surgical-center-final-rule-hospital-price-transparency-policy-changes> (requiring hospitals and ambulatory surgical centers to disclose real median prices along with the 10th and 90th percentile charges, for common services).

²⁴³ Gary Claxton et al., Peterson-KFF, *Challenges with Effective Price Transparency Analyses* (Feb. 25, 2025), <https://www.healthsystemtracker.org/brief/challenges-with-effective-price-transparency-analyses/>.

²⁴⁴ See Departments of Labor, the Treasury, and HHS, *FAQs About Affordable Care Act And Consolidated Appropriations Act, 2021 Implementation Part 55*, Q2 (Aug. 19, 2022), <https://www.cms.gov/files/document/faqs-part-55.pdf>.

providers. One of the main sources of leverage that payers bring to the table with health care provider price negotiations is the number of potential patients they bring to the table. No individual has that kind of leverage. They will instead be largely at the mercy of providers who are under no contractual obligation to accept the benefit offered by the non-network plan as full payment. Even if the provider first attests that they would accept the payment, there is little to hold them accountable to stick to their promise. This is the case even when a treatment is relatively straightforward and provided by a single practitioner; the complexity increases exponentially even for a routine outpatient procedure that involves multiple provider and facility fees.²⁴⁵ The end result under this policy is that consumers lose. Contractual obligations govern more than just price, they also incorporate elements of care quality, coordination across providers, and other consumer protections that would be lost under this proposed non-network structure.

The second assertion HHS makes is that non-network plans may save on the administrative cost of managing and maintaining a provider network, which could lead to lower premiums. This is a largely meaningless assumption, however, when considering the full cost of health care. These plans will no doubt be designed to look inexpensive with low front-end premiums, because they have no apparent obligation to cover the full cost of services should those costs exceed the defined benefit amount. Moreover, these plans present a threat to the stability of the individual market risk pool. Because non-network plans would not be guaranteed to cover the cost of non-emergency care, they are likely to function like catastrophic health plan coverage and attract young and healthy enrollees willing to risk the likelihood of non-payment for a lower premium. As a result, network plans will be left with a smaller and more costly pool of lives, driving premiums up further and bifurcating the market along network vs. non-network lines.

In short, most of the cost risks in proposed non-network plans appear to accrue to individual enrollee who purchases the plan, and the Proposed Rule includes little analysis on how key consumer protections would be maintained.

In addition, HHS's proposal to ensure that non-network plans provide adequate access to care is insufficient and ultimately unenforceable. While it claims that non-network QHPs will be required to "ensure access to a range of providers that accept the non-network plan's benefit amount as payment in full," the reality is that it implements a check-box system that would allow a plan to escape all but the most minimal regulation. Under this regime, a plan could self-attest that it has processes in place to, among other requirements, conduct provider outreach, make payments publicly available, develop benefit amounts, offer an

²⁴⁵ We note that CMS has acknowledged the complexity of coordinating health care prices across multiple providers when the obligation would adhere to a provider or facility. Patients should not be held to a higher standard. See Departments of Labor, the Treasury, and HHS, *FAQs About Consolidated Appropriations Act, 2021 Implementation - Good Faith Estimates (GFEs) for Uninsured (or Self-Pay) Patients Part 3*, Q1 (Dec. 2, 2022), <https://www.cms.gov/files/document/good-faith-estimate-uninsured-self-pay-part-3.pdf> (announcing non-enforcement of statutory requirements that providers provide patients with cost estimates that include co-providers and co-facilities).

exceptions process, and provide consumer assistance to identify providers who accept the plan's payment in full. It is revealing that HHS estimates that a non-network plan could complete these attestations in "a maximum of six minutes".

HHS previously expressed "doubt that a plan without a network can comply with the statutory requirement at section 1311(c)(1)(C) of the ACA."²⁴⁶ We are not aware of any regulatory standards that evaluate whether a non-network plan offers a sufficient selection of providers without excessive burden on its members.²⁴⁷ It is not at all clear how HHS's proposal to ensure that non-network plans provide adequate access to care would be implemented, or what recourse non-network plan members would have if they are unable to access necessary care. We agree with HHS's previous conclusion that this type of plan is not consistent with the ACA's statutory mandate and should not be permitted.

We oppose the reintroduction of the option to certify non-network plans as QHPs. The proposed "assurances" in this NPRM simply do too little to allow individuals to reasonably evaluate the true risks and costs associated with this plan structure.

§ 156.1130 – Quality Standards: Quality Improvement Strategy

HHS seeks comment on proposed changes to the Quality Improvement Strategy (QIS). We oppose HHS's proposal to eliminate a guideline that QHP issuers address health and health care disparities as a specific topic area within their QIS. As recognized in the 2023 Payment Notice, addressing persistent inequities in health care outcomes is critically important.²⁴⁸

HHS rationalizes this proposal saying it would allow QHP issuers to select the two topic areas most relevant to their population and operational context. However, all QHPs should be enrolling diverse populations and would identify existing inequities if they focused their efforts on recognizing and eradicating them. Instead, the proposed change would allow QHPs, and HHS itself, to ignore health care disparities and the interventions that could address them.

Overt discrimination remains prevalent but does not explain the full range of health disparities. Implicit bias — unconscious attitudes or stereotypes that affect our actions and decisions — and structural racism and discrimination reproduce disparate outcomes. Structural discrimination refers to the systems, public policies, institutional practices,

²⁴⁶ U.S. Dep't. Health & Human Srvs., *Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024*, 87 Fed. Reg. 78206, 78286 (Dec. 21, 2022).

²⁴⁷ We note that California's Department of Insurance has issued adequacy and access standards that apply across licensed health care products, including both network plans (such as PPOs) and traditional indemnity plans. See Cal. Dep't Ins., Provider Network Adequacy, <http://www.insurance.ca.gov/01-consumers/110-health/10-basics/pna.cfm> (last visited Mar. 3, 2026). While these standards account for the selection of providers, they do not measure the burden on members, and thus we cannot recommend them.

²⁴⁸ U.S. Dep't. Health & Human Srvs., *Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2023*, 87 Fed. Reg. 27208 (May 6, 2022).

cultural representations, and other norms that generate and reinforce inequities among specific groups, such as racial and ethnic groups.

A few examples of health inequities, outlined in NHeLP's Equity Stance,²⁴⁹ identify the importance of having health inequity as a specific requirement of QIS:

- As a result of racial and gender discrimination, the United States has the highest maternal mortality and morbidity in the developed world. Black and Indigenous women are more likely to die or experience serious health complications from childbirth than whites. These disparities persist irrespective of income. For instance, a study in New York City found that Black, college educated-women who gave birth in local hospitals were more likely to suffer life-threatening complications than non-Black women with less than a high school education. Such disparities demonstrate that structural racism as well as implicit bias still play a significant role in health care access. Systemic barriers also exist in other aspects of sexual and reproductive health care like abortion and family planning, reinforcing sexual and reproductive health stigma and limiting access.
- Individuals with disabilities, substance use disorders, and chronic conditions also experience numerous barriers to achieving health equity. Disability discrimination shows up in many places including the prevalence of physical and equipment barriers; obstacles to accessing employment; reduced availability of medical providers, particularly in rural communities; inappropriate application of criminal penalties and collateral consequences; restrictions on autonomy and freedoms; and difficulty accessing comprehensive health coverage. As the population ages and the number of people with disabilities increases, shortages of qualified caregivers and limited access to community-based, long-term care services threaten people with disabilities' right to live independently in integrated home and community-based settings.
- Structural and overt discrimination against Lesbian Gay Bisexual Transgender Queer (LGBTQ) individuals, including ongoing discrimination in coverage and access to health care services, creates health disparities. For instance, LGBTQ people have higher rates of certain chronic conditions and mental illnesses such as depression. Rates of attempted suicide are also higher among LGBTQ people, especially transgender individuals. Currently, several state Medicaid programs improperly deny coverage for gender-affirming services, leaving low-income individuals without access to these services. Gay and bisexual men and transgender individuals, especially those who are also Black and Latinx, are disproportionately affected by the HIV epidemic. But gay and bisexual men in the U.S. are also more likely to receive poor treatment from medical professionals due to their sexual orientation and are often uncomfortable discussing their sexual behavior with health care providers due to discrimination and bias.

²⁴⁹ Nat'l Health Law Prog., *Equity Stance*, <https://healthlaw.org/equity-stance/>.

- Individuals who have a limited ability to read, speak, write, or understand English experience health disparities because they encounter more challenges accessing information they can understand. In the U.S., many Latinx and Asian-Americans speak a language other than English, and may not be able to access health care information in their preferred language. In addition, people who are Deaf or hard of hearing and communicate using American Sign Language (ASL); who have speech impairments; or who are blind or have visual impairments often face challenges accessing health care information. Overall, people who encounter communication barriers are less satisfied with their care, have less access to and use less health care, and face higher costs and lower quality of care.

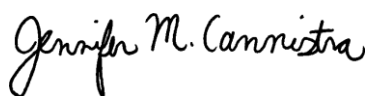
We recognize, as HHS noted in the preamble, that improving health care quality and outcomes for all is important. Yet ample evidence documents health care inequities. Ignoring the evidence and eliminating a focus on health and health care inequities will only serve to whitewash QIS and allow these inequities to continue unabated. Further, interventions to address the inequities often improve health care quality for everyone. We strongly oppose the elimination of the existing guideline that QHP issuers address health and health care disparities in their QIS.

Conclusion

We have included numerous citations to supporting research, including direct links to the research. We direct HHS to each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If HHS is not planning to consider these materials part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies and articles into the record.

Thank you for your attention to our comments. If you have any questions or need further information, please reach out to Mara Youdelman, Managing Director of Federal Advocacy, at youdelman@healthlaw.org.

Sincerely,



Jennifer Cannistra
Executive Director



**National
Nurses
United**

OUR PATIENTS. OUR UNION. OUR VOICE.

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March 10, 2026

Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

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:

National Nurses United (NNU), on behalf of more than 225,000 members who provide direct care to patients nationwide, submits these comments in opposition to the proposed rule from the Centers for Medicare & Medicaid Services (CMS) “Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program,” CMS-9883-P. **CMS should not move forward with proposals that would expand use of catastrophic coverage plans, permit higher cost-sharing, reduce reliability or understandability of exchanges, or increase the administrative burden for patients.**

CMS should not expand use of catastrophic coverage. The proposed rule would encourage insurance companies to take advantage of low-income families by charging them for insurance without paying for any care. The proposed rule would allow a significantly broader set of individuals to receive exemptions that allow them to enroll in catastrophic coverage plans, including anyone ineligible for tax credits because their income is below the federal poverty level or above 250% of the poverty level. Under the proposed rule, these plans would not cover any costs, aside from very limited preventative care, until out-of-pocket costs for health care reached \$15,600 for an individual or \$31,200 for a family.

These plans do not cover catastrophes: they create them.¹ First, they create financial catastrophes in the large number of working-class families who do not have \$31,200 on hand for medical costs. Half of U.S. adults do not even have cash to cover an expected \$500 health care bill.² More than 100 million people in the U.S., including 41% of adults, already have medical debt.³ Increasing catastrophic coverage would make the medical debt crisis worse.

Second, they create health catastrophes by forcing families to skip treatment for health conditions for financial reasons until their condition becomes an emergency. Two-thirds of

¹ See Noam Levey. Dec 9, 2025. Trump’s Idea for Health Accounts Has Been Tried. Millions of Patients Have Ended Up in Debt. KFF Health News. <https://kffhealthnews.org/news/article/trump-health-accounts-hsa-cash-patient-debt-high-deductible-insurance>.

² Noam Levey. June 16, 2022. 100 Million People in America Are Saddled With Health Care Debt. KFF Health News. <https://kffhealthnews.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/>.

³*Id.*

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people with medical debt said they have put off care they or a family member need because of cost.⁴ While these plans do cover up to three primary care visits, they do not cover treatment for whatever conditions are discovered in those visits. Many health conditions that are relatively simple to treat if discovered promptly will degrade into much more painful, disruptive, and expensive conditions if they are not treated.

Similarly, **CMS should not raise the amount of cost-sharing that can be required of patients enrolled in bronze plans** in the final rule. As explained above, increasing cost-sharing will cause patients to delay needed care and increase medical debt burden.

Further, **CMS should not move forward with the proposal to end standardized plan designs on the ACA marketplace.** Health insurance plans are incredibly difficult for patients to understand. Standardized plans help patients understand and compare different options. Standardized plans were implemented because the proliferation of Marketplace plans made it difficult for customers to assess their options based on quality.⁵ So-called innovation in plan design harms patients when they discover that the insurance company's "innovation" was not to cover the care the patient needs.

CMS should not reduce provider thresholds for network adequacy nor eliminate federal network adequacy standards. Federal law requires that the Secretary establish criteria to require that certified health plans "ensure a sufficient choice of providers."⁶ Network adequacy standards are designed to avoid a situation where a patient pays for insurance only to discover that they cannot access the care they need because there are not enough providers in the insurance network in their area. The thresholds requiring that a sufficient percentage of providers are included in an insurer's network are necessary to enable enrollees to access care. Lowering these thresholds will undermine network adequacy. Similarly, leaving standards up to states will lead to inconsistency in network adequacy across the country. CMS is responsible for network adequacy and should not let states set lower standards.

CMS should not permit states to rely on private web-brokers instead of running their own consumer-facing enrollment website. Private brokers frequently mislead consumers to sell them "junk plans" that do not comply with Affordable Care Act requirements.⁷ Letting states stop running consumer-facing enrollment websites leaves consumers vulnerable to manipulation and misleading sales tactics by the operators of private enrollment websites.

⁴ *Id.*

⁵ See Chu R.C. et al. Dec 28, 2021. Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Issue Brief: Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces. HP-2021-29.

⁶ 42 U.S. Code § 18031.

⁷ Georgetown University Center on Health Insurance Reforms. Feb 27, 2026. The Peddling Of "Junk Plans" To Consumers Facing Higher Insurance Premiums. <https://chir.georgetown.edu/the-peddling-of-junk-plans-to-consumers-facing-higher-insurance-premiums/>.

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Nurses urge CMS to make the pre-enrollment verification process, the income verification process, and any other administrative steps as simple as possible for enrollees. Excessive paperwork burden prevents people from enrolling in health insurance, thereby increasing the number of uninsured patients with severe consequences for patients' health, their family finances, and the health system as a whole.

It is well-established that individuals without health insurance coverage are more likely to delay or forgo necessary care out of cost concerns, often causing their condition to worsen and ultimately become more difficult and expensive to treat. This, in turn, causes many individuals to go into debt when care can no longer be delayed, making them less able to afford insurance, and creating a vicious, self-perpetuating cycle of illness and poverty. Moreover, fewer people receiving necessary health care may also result in worse health outcomes for those individuals lucky enough to still be able to afford coverage. By causing younger, healthier people with lower incomes to drop coverage, the proposed rule will degrade qualified health plans' risk pools, making premiums more expensive for those still receiving coverage.

Nurses oppose changes to block immigrants from accessing insurance coverage. CMS should design their final rule to maximize access to health insurance for immigrants. Nurses opposed the statutory changes limiting immigrants' access to premium tax credits, thereby reducing their access to health insurance and increasing the uninsured population, with the same negative consequences described above.

The ultimate solution to the complexity and expense of our health system is Medicare for All. In the meantime, CMS should help as many patients as possible access the health care they need without incurring medical debt. **Nurses urge CMS to preserve access to health care for our patients by limiting catastrophic coverage plans, keeping out-of-pocket costs low, ensuring plans have adequate networks, retaining standardized plans, retaining consumer-facing state-run enrollment websites, and avoiding increasing the administrative complexity of choosing a plan or proving eligibility for tax credits.**

Sincerely,



Michelle Grisat
National Director of Health and Regulatory Policy
National Nurses United



American Heart Association.

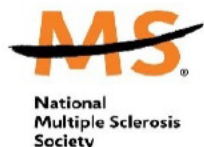


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WOMENHEART
THE NATIONAL COALITION FOR WOMEN WITH HEART DISEASE

March 13, 2026

The Honorable Robert Kennedy, Jr.
Secretary
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

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

Dear Secretary Kennedy:

Thank you for the opportunity to submit comments on the Notice of Benefit and Payment Parameters (NBPP) for 2027 Proposed Rule, issued by the Department of Health and Human Services (herein "Department" or "HHS").

The undersigned organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country, including individuals who rely on the patient protections provided under the Affordable Care Act (ACA). Our organizations have a unique perspective on what patients need to prevent disease, cure illness and manage chronic health conditions. Our breadth enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion.

In March of 2017, our organizations came together to form the Partnership to Protect Coverage. Together, we agreed upon three overarching principles¹ to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefit (EHB) package.

The Department's proposals would, if finalized, substantially undermine each of these principles. The 2027 NBPP would create new coverage products with sky-high deductibles in excess of legal limits, which, according to the Department, consumers could be "locked into" for multiple years. It would authorize insurers to sell products where all doctors are out-of-network and consumers would be expected to bargain with providers for all services and prescriptions, or else face near-total exposure to a surprise medical bill. The Department would allow states to offload all marketplace enrollment responsibilities to private companies – even though these companies have been the source of consumer confusion and, in some cases, outright fraud. And it would try again to erect burdensome administrative barriers for consumers seeking to enroll in marketplace coverage — barriers that a federal court just last fall set aside.

Many of the ideas offered in the NBPP are lacking in supporting detail and analysis. If finalized, these underdeveloped proposals will create confusion and uncertainty in insurance markets already navigating significant shifts in federal policy. The Department's own best estimate is that the rule would cut marketplace enrollment by up to 2 million people while also raising premiums.² These effects will hit the same people already facing massive cost increases due to the expiration of the enhanced marketplace premium tax credits. Simply put, the proposals would make coverage more complicated and less affordable.

We provide additional comments and recommendations regarding specific provisions of the rulemaking below.

Catastrophic Plans

Catastrophic plans provide the skimpiest coverage available in the marketplaces. In 2026, they carry a deductible of \$10,600 for an individual (\$21,200 for a family) and, with the exception of three primary care visits and specified preventive services, cover no services until the enrollee meets this deductible. These plans provide basic financial protection against catastrophic costs. They offer little value to consumers with anticipated care needs, even less to the patients we represent who would have to bear the full cost of treatment for serious, often chronic medical conditions up to that high deductible.

¹ <https://www.protectcoverage.org/ppc-consensus-healthcare-reform-principles>

² We address more fully the Department's assertions regarding the premium impact of its proposals, below.

The value of these plans is limited by statutory design, and the ACA narrowly circumscribes who is eligible to enroll in them. Under the law, catastrophic plan eligibility is restricted to people under age 30 and those who are, for specific reasons defined in statute, exempt from having to pay the ACA's (now defunct) individual mandate penalty. The relevant scenario is this: if an individual "suffered a hardship with respect to the capability to obtain [metal tier marketplace] coverage," they would be excused from paying the tax penalty and could enroll, as a last resort, in a catastrophic plan.

The Department offers a cluster of proposals to transform catastrophic plans in ways neither intended nor authorized by federal law. These proposals would launch a new, multi-year coverage product that would feature a \$31,200 deductible or higher, as the Department suggests insurers could impose a much higher deductible if the deductible averages to \$31,200 over the life of the product. The Department would offer consumers the opportunity to be locked into such a plan for multiple years, perhaps as many as ten. And it introduces new risks: private actors eager to exploit this novel and poorly defined regulatory option could end up destabilizing the market, and harming all consumers, including those who avoided these products entirely.

Catastrophic Plans: Expansion of Hardship Exemption (§ 155.605(d)(1))

As observed above, eligibility for catastrophic plans is restricted by statute, in a manner that reinforces other elements of the ACA framework and that is consistent with the law's purpose. These limited plans, which cannot be paid for with premium tax credits, were not intended to be available broadly to marketplace consumers. Rather, they were designed as a "better than nothing" option for young and healthy people and individuals with extenuating circumstances (who "suffered a hardship") such that imposing a tax penalty on them would be unfair.

As it stands in 2026, there is no federal tax penalty for anyone. The original rationale for making available a hardship exemption no longer exists. There is no practical reason to obtain a hardship exemption, other than to enable the purchase of an unsubsidized catastrophic plan to which Congress has otherwise restricted access.

The Department proposes to disregard this framework and codify a "broad nationwide hardship exemption" for all people who are ineligible for premium tax credits or cost-sharing reductions due to their income. We note that many of the individuals now ineligible for premium tax credits are in that position because Congress and the Administration did not maintain enhancements to the premium tax credits.

Department regulations currently interpret the hardship exemption to apply to individuals 1) who experienced circumstances, such as a natural or human-made disaster, that caused the individual to have a significant unexpected increase in essential expenses; 2) for whom the expense of purchasing marketplace coverage would have caused them to experience serious deprivation of food, shelter, clothing, or other necessities; or 3) who experienced other circumstances that "prevented" them from obtaining coverage. Whatever flexibility may exist under the ACA to expand eligibility for a hardship exemption and catastrophic coverage beyond these traditional bases, the Department has clearly exceeded it in this proposal. The proposed rule casts so broadly as to include individuals (from 250%-400% FPL) who remain eligible for premium tax credits. These consumers can continue to use financial assistance to purchase more robust metal tier coverage. Indeed, analysis suggests they can enroll in this

more protective marketplace coverage while spending less on premiums than they would for a catastrophic plan.³

We urge that the Department to tailor its exemption to low-income individuals ineligible for premium tax credits.

Catastrophic Plans: Multi-Year Plans (§§ 156.130(c) and 156.155(a)(6))

The Department’s planned expansion of eligibility for catastrophic plans is paired with proposals that would create a new catastrophic insurance product that individuals could enroll in for up to 10 years at a time. Health coverage with a policy term of more than one year does not exist in the individual market, nor anywhere else as we understand it. (Certainly, the proposal identifies no precedent for its this approach.)⁴ Numerous ACA provisions are premised on plans having an annual term. Catastrophic plans, specifically, are defined through criteria they must satisfy in the given “plan year.” These plans are, for example, subject to the “annual” limitation on cost-sharing that is in effect “for the plan year” — a requirement that makes sense, given that this annual limitation is required by statute to be recalculated on an annual basis. HHS attempts to resolve the mismatch by ignoring the word “annual”: the proposal would allow insurers to sell plans that exceed the annual statutory cap, so long as their cost-sharing limits average to the statutory threshold over the duration of the plan.

The legal and operational challenges of making the Department’s multi-year plan concept work are evident in the many questions the proposal leaves unanswered. How would these new plans “interact[]” with the ACA’s statutory consumer protections? How would they interact with federal tax policy; would these plans create conflicts with those federal laws? How would multi-year plans be treated for purposes of Medical Loss Ratio (MLR) requirements? How should risk adjustment work; what data should the Department use? What coverage terms will an insurer be allowed to change over the life of the policy, and at what intervals? Here, it seems at least some changes to cost-sharing parameters are on the table, but we are not told more.

These are not minor implementation details. They are foundational policy questions whose answers will determine how multi-year plans are priced and regulated. The Department is creating a situation where there will be a new coverage product with which no one has any experience and for which insurers may be afforded extraordinary latitude to fill in the blanks, creating the potential for abuse and instability.

The Department tells insurers they should market a multi-year product with a deductible above the statutory limit in the early years and more consumer-favorable limits in the later years, to “entice” consumers to remain enrolled for the duration of the plan. Yet insurers could offer this enticement and then terminate the plan mid-term, after benefiting from the low-exposure years but before the enrollee reaches the more consumer-friendly later years. Insurers could cause significant harm to enrollees and the broader market by discontinuing these plans mid-term, even once.

^{3 3} David M Anderson, et al., Will expanding catastrophic coverage eligibility increase marketplace premium affordability in 2026?, Health Affairs Scholar, Volume 3, Issue 11. November 2025. <https://doi.org/10.1093/haschl/qxaf202>

⁴ While we understand that employers or plan sponsors may sometimes enter into multiyear purchasing contracts with insurers or administrators, these arrangements are fundamentally different than one in which the actual coverage instrument is locked for years at a time.

The proposed rule lacks clarity and consistency regarding an enrollee's option for switching coverage under a multi-year plan. While HHS clarifies, in one part of the preamble, that it is not proposing to revoke statutory guaranteed availability and renewability rights, it elsewhere observes that its multi-year product may "reduc[e] consumer flexibility to switch plans in response to changing health needs or life circumstances" and says it is uncertain how consumers will respond when they are "locked into" a multi-year catastrophic plan and then get sick.

In fact, this is one element of the proposal that is certain: a consumer who develops cancer, is diagnosed with multiple sclerosis, or experiences a serious mental health crisis while enrolled in a catastrophic plan will face enormous out-of-pocket costs with no meaningful pre-deductible coverage beyond three primary care visits and preventive services. A consumer "locked into" that plan for years is a consumer locked into inadequate coverage during the period they need care the most.

We strongly oppose any policy that would lock consumers into a multi-year plan, or that would penalize enrollees who would choose a different plan during open enrollment or a special enrollment period for which they are otherwise eligible. Health needs change. Financial circumstances change. A consumer who enrolls in a 10-year catastrophic plan at age 35 may, by age 40, have developed a condition that makes catastrophic coverage wholly inadequate, or may have experienced a change in income that makes them eligible for subsidized metal tier coverage. A consumer may become eligible for employer-sponsored coverage or may need to relocate — scenarios the Department itself identifies. Policies that create barriers to exiting multi-year plans will trap consumers in coverage that no longer serves them, and the Department should not pursue them.

Bronze Plans: Disregard of Statutory Limitation on Consumer Cost-Sharing (§ 156.136)

The Department proposes to disregard the statutory limitation on annual consumer cost-sharing so that insurers can sell bronze plans that expose consumers to spending in excess of the statutory cap. We oppose the proposal.

By the Department's own admission, the proposal to allow insurers to sell bronze plans that exceed the annual limit on cost-sharing violates the law. The Department suggests its approach is nonetheless permissible because it is as limited as possible in order to still implement the statutory requirements as Congress intended.

But this is clearly not the case. Compliance is very much possible today (and in 2027). Indeed, the Department proposes that insurers must offer a legally compliant bronze plan if they want the opportunity to sell plans that are noncompliant.

There is an insufficient basis for the Department to preemptively excuse insurers from their statutory obligations and we urge that this proposal not be finalized.

Catastrophic Plans: Disregard of Statutory Limitation on Consumer Cost-Sharing (§ 156.155)

The discussion above also applies to the Department's proposal to require catastrophic plans to use a cost-sharing limit and deductible that exceeds the statutory limit – that is equal to 130 percent of that limit, \$31,200 for family coverage in 2027. And there are additional reasons why this proposal is unlawful and should not be finalized.

As the Department acknowledges, catastrophic plans do not have prescribed actuarial value (AV) requirements. The tension between statutory provisions that, it argues, justify disregarding the annual limit on cost-sharing for bronze plans simply does not exist for catastrophic plans. Still, HHS asserts that catastrophic plans may be unappealing to consumers, when compared to bronze plans, unless there is a “clear difference” between the two. When there is a clear difference between them, says the Department, healthier consumers will generally choose catastrophic plans instead of bronze plans, as Congress “plainly” intended for them to do. But, the Department worries, such differences may become obscured if catastrophic plans must continue to adhere to the statutory cost-sharing limit.

There is no statutory requirement for there to be a “clear difference” between the pricing of catastrophic and bronze plans. Congress did not design catastrophic plans to sit on the AV continuum and compete for enrollees among the general population of marketplace consumers. As observed above, what Congress intended was to offer a carefully circumscribed subset of consumers a last-ditch option for ACA-compliant coverage outside the metal tiers. That is why catastrophic plans are not subject to AV rules; why they can’t be used with premium tax credits; and why eligibility is limited by the statute to young adults and people exempt from the individual mandate’s tax penalty. These are the clear differences that set these plans apart. There is no need to increase the cost-sharing limit and deductible for catastrophic plans at such an affordable level for consumers.

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

The Department proposes to rescind regulations prohibiting health plans that do not use a provider network (“non-network plans”) from being sold through the marketplaces. The proposal would allow the sale of non-network plans beginning as early as next year and establish new standards and review processes for the purpose of determining whether such products satisfy statutory provisions requiring them to ensure enrollees have access to a sufficient choice of providers.

Our patients, and consumers broadly, face real and persistent challenges obtaining timely access to care and budgeting and paying for its costs. These challenges are often made worse when forced to navigate restrictive provider networks and inaccurate provider directories.

The proposed rule would compound these challenges. The Department proposes to allow products where all health care providers are out-of-network and provider directories, by definition, cannot be relied upon. The non-network plans it would authorize are premised on the unrealistic expectation that consumers, regardless of their circumstances or health needs, will negotiate the price of all of their care in advance of receiving it. People who do not or cannot manage to do this will be nearly completely exposed to additional medical bills (“balance” or “surprise” bills) of the kind that Congress intended to do away with in recently enacted legislation. The Department’s proposed oversight standards are inadequate and unworkable. The Department’s justification for reversing its judgment that non-network plans has clear deficiencies and lack key details. These proposals should not move forward.

Non-Network Plans: Consumer Price Negotiations

The Department’s case for non-network plans rests on the premise that consumers will “shop” for their care — all of their care.

The Department would require non-network plans to publicize the amounts it will pay for each covered benefit. Armed with this information, HHS anticipates enrollees will be able to compare prices among

providers and negotiate payment amounts directly. The Department acknowledges that these plans — which are entirely absent from the individual and small group markets and, tellingly, exist as non-comprehensive excepted benefits in the large group market — “may not be immediately intuitive” and could create “different pricing dynamics” for consumers. Nevertheless, it is confident that if consumers behave more proactively, they can get the best value for medically necessary services.

This vision is fundamentally at odds with how health care is actually delivered and consumed, particularly for the populations our organizations represent.

Patients managing cancer, autoimmune diseases, bleeding disorders, organ transplants, or other serious conditions require care from specialized providers. They often may have limited choice of doctors and facilities, particularly in rural or medically underserved areas, and little to zero practical leverage to bargain over the costs of treating complex or rare conditions or emergent needs. Expecting a patient about to begin chemotherapy to negotiate the price of each infusion, each lab test, and each imaging study (or even, for that matter, some bundled price for certain of these services) is not reasonable. Expecting a parent of a child with a rare disease to comparison-shop among the handful of specialists in the country who treat the condition is not reasonable. These patients need their plan to work, not a “reference price” they must then attempt to convince a provider to accept.

While non-network plans offered as excepted benefits are not obligated to pay for prescription drugs, these plans would be; prescription drugs are an EHB. Yet it is not clear how this would work. Does the Department expect enrollees to negotiate the prices of their prescriptions with pharmacies prior to each refill? Or does it assume that the plans’ payment amounts will always be sufficient to ensure patients can continue to access the medications they need, whether generic or of the range of specialty medications on which our patients rely?

The Department acknowledges that non-network plans “can have a particular impact on low-income, medically underserved populations who may face disproportionate challenges in paying for large out-of-pocket costs.” This is true. And indeed, marketplace consumers in particular are disproportionately lower-income individuals for whom unexpected medical bills can be financially devastating. These consumers are the least likely to have the time, resources, health literacy, and bargaining power to negotiate effectively with providers.

Non-Network Plans: Exposure to Surprise Medical Bills

The defining feature of a non-network plan is that no provider has a contractual obligation to accept the plan’s benefit amount as payment in full. Unlike a network plan, where in-network providers are bound to accept negotiated rates and are prohibited from balance billing enrollees for covered services, a non-network plan simply sets a benefit amount and shifts the negotiation and cost exposure to the enrollee. The Department sometimes shies from this distinction, referring to the non-network plan’s “de facto” network. But as the Department elsewhere acknowledges, “there is no guarantee that the plan’s benefit amounts are actually sufficient to cover the provider’s full charges, and there is no requirement imposed by the non-network plan on providers to accept the plan’s benefit amount as payment in full.”

Nearly every service, provider encounter, and claim under a non-network plan carries the risk that the patient will receive an additional surprise (or balance) bill from the provider.⁵ The enrollee's exposure is not limited to a discrete set of out-of-network scenarios, as in a network plan; it is the baseline condition of the coverage. In effect, every provider is out-of-network, because no provider has agreed to the plan's terms.

Congress recognized the serious harms caused by surprise medical bills and passed a law to prevent them. The No Surprises Act (NSA), which our coalition strongly supported, protects consumers from unexpected costs when they receive care from out-of-network providers in certain settings. It's the Department's job to implement and enforce the NSA and we deeply appreciate its work to do so. We are, in turn, deeply disappointed that it now proposes to execute an end run around these protections by sanctioning a product for which exposure to surprise bills is inherent.

The proposal expresses confidence that empowered consumers will be able to negotiate for all of their care and instructs the plans to come up with a strategy for telling the public about "potential balance billing scenarios." But information about the risk of balance billing is not a substitute for protection against it. The fact is, for enrollees in a non-network plan, nearly every single interaction with a provider is a potential balance billing scenario. Given the increased risk of surprise or balance billing, we urge HHS not to finalize this proposal.

Non-Network Plans: Inadequate and Unworkable Oversight Standards

The Department proposes new standards for non-network plans to demonstrate that they provide access to a sufficient choice of providers, including essential community providers (ECPs). On paper, these standards are inadequate to the task; in practice, they are unworkable and likely to be rendered effectively meaningless.

The Department's first standard requires the non-network plan to assess the percentage of available providers in its service area that accept the plan's benefit amount as payment in full. The Department will consider this standard to be met if the non-network plan attests that it has done the work.⁶

It is telling that the core regulatory requirement for non-network plans is, in effect, that they attest to having a de facto network. (Or a quote-in-quote "network," as the Department says.⁷) But there really is a difference between a network and a "network." Because no provider is under contract to accept the non-network plan's benefit amount, the "assessed percentage" is, at best, a point-in-time estimate that is out-of-date and, by definition, unreliable, the moment the communication between the non-network plan and each provider ends. A provider who indicates they would accept the plan's benefit amount as payment in full today is under no obligation whatsoever to do so tomorrow. Indeed, one member of a

⁵ While non-network plans expose enrollees to balance billing in nearly every circumstance, we interpret the No Surprises Act to prohibit balance billing for emergencies services even in the case of a non-network plan. Unfortunately, the proposal is silent on this issue.

⁶ Non-networks plans will demonstrate compliance by answering "Yes" or "No" on form that asks whether they meet each requirement. The Department estimates it will take plans between 30 seconds and a minute to answer each question.

⁷ According to the Department: a "non-network plan's 'network' consists of the providers in the applicable area that would accept the plan's benefit amount as payment in full."

provider's staff might tell a plan it will accept the benefit amount as payment in full, *at the exact same time* another staff member charges an enrollee a higher price.

The Department acknowledges that providers “may choose to change their charges for their services based on any multitude of factors, including changes in their operating expenses, changes in medical advancement, competitive pressure, or for no particular reason at all. And, they may choose to change this amount at any time.”

In an effort to address challenges, the Department proposes that non-network plans to have a “strategy for conducting continuous outreach” to providers. Plans must simply attest that they have a strategy. It is unclear what would constitute adequate outreach, how frequently it must occur, what documentation the plan must maintain, or how regulators would evaluate the effectiveness of these efforts: none of these issues is addressed. This lack of detail puts the patients we represent at serious risk.

Non-Network Plans: Legal Deficiencies and Unanswered Questions

In the 2024 NBPP, the Department concluded, after extensive discussion, that non-network plans cannot receive marketplace certification because they are inherently unable to comply with section 1311(c)(1)(C) of the ACA (which requires, as a condition of certification, that a plan “include [specified essential community providers] within health insurance plan networks”). The Department provided lengthy analysis even though, as it noted, the conclusion that plans must include ECPs within network in order to be certified was a “straightforward” reading of the statute.

Although this provision remains in statute and its meaning continues to be straightforward, the Department now embraces a different interpretation. The Department now says that section 1311(c)(1)(C) offers “broad flexibility governing the status of a contractual relationship between a plan and provider” and, asserts that non-network plans can be certified without any discussion explaining this significant shift.

The proposal is deficient in its treatment of other applicable federal provisions that are defined in terms of in-network benefits. For example, the ACA's limitation on annual cost-sharing applies to spending on EHB provided in-network. It does not cap consumer costs for, among things, balance billing. As proposed in the context of a non-network plan, what costs count towards the cap, what costs do not and how would the cap be administered? Further questions arise: a plan's AV is calculated based on in-network claims and utilization; how would AV be calculated, how would AV requirements apply, to a plan where all enrollee spending is out-of-network? All of these questions have significant implications for the patients we represent and must be answered before this proposal can move forward.

Non-Network Plans: Market Risks

By shifting responsibility for provider negotiation and contracting to consumers, non-network plans are likely to offer a lower — perhaps significantly lower — premium than their competitors that use a network. This is likely to have several detrimental effects for consumers who rely on the marketplaces.

First, it is likely to reduce the buying power of marketplace consumers, making it harder for people who want to enroll in a plan with a network to afford it. Because they can undercut their network-based competitors, non-network plans are likely to become the benchmark silver plan in the rating areas where they are sold. This means consumers' premium tax credits will be lower than they would be in the

absence of these plans. A consumer may have no interest whatsoever in this new product the Department is proposing, but they will still feel its impact in the form of a higher premium.

Second, these plans are likely to create risk selection issues that, together with the pricing advantage non-network plans benefit from, may destabilize markets. The Department notes non-network plans “may typically attract healthier enrollees who are generally more willing and able to engage” in price negotiations with providers. By contrast, consumers who are relatively less healthy will be less “willing and able” to bargain for their care and will remain, if they can afford it, in a network plan.

We are concerned that these plans could introduce significant uncertainty in the markets they enter, at a time when participating insurers are already dealing with substantial policy changes that will affect pricing and participation decisions. For all of the reasons described above, we strongly urge the Department not to finalize its non-network plan proposals.

Network Adequacy Standards and Review Processes (§§ 156.230 and 155.1050)

Federal law contains protections designed to ensure that all marketplace enrollees have timely, meaningful access to the care and services they need, as well as accurate information sufficient to enable them to understand plans’ networks and identify the plans and providers most likely to meet their needs. These protections apply to all marketplace plans and safeguard all consumers, no matter the state in which they live.

In recent years, the Department established quantitative measures of network adequacy and regulatory processes to review insurer compliance that have served as a federal baseline for marketplace coverage. Health plans sold through the federal marketplace have been subject to this federal minimum. State-based marketplaces (SBMs), meanwhile, have been required to implement a network oversight regime that is “at least as stringent as” the federal approach.

The use of a federal regulatory floor is not unique to network adequacy. It’s how most ACA consumer protections have been implemented and allows states flexibility to regulate in ways that meet or exceed the baseline federal safeguard. Our organizations strongly supported the adoption of this approach.

The Department proposes to erode these minimum standards. It would remove the requirement that SBMs regulate network adequacy at least as stringently as the federal approach, and would create a new process through which states on the FFM could opt out of the federal network adequacy framework. We oppose these proposals.

Marketplace network adequacy is a federal obligation, and a marketplace consumer’s ability to access an adequate network of providers should not depend on where they live. We continue to believe that having a robust federal regulatory floor in this area strikes the best balance wherein states have flexibility to regulate while enrollees remain protected by baseline federal standards.

Network Adequacy: Effective Provider Access Review Program

Although our organizations urge the Department not to finalize its network adequacy proposals, we offer three suggestions we think are important to help the proposed effective provider access review program operate as intended.

The proposed review program includes various criteria that states seeking to apply their own network standards and oversight processes must satisfy. If the Department does move forward with such a review program, we urge, first, that it follow through with its asserted commitment to the program as proposed. The program should include, at minimum, the six criteria proposed to be codified at §155.1050(d)(4); none should be removed. HHS says it intends to “thoroughly investigate” states’ processes to determine whether they satisfy the proposed criteria and offers to work in partnership with states, and offer extensive resources to them, so they may further develop and enhance their network adequacy review capabilities. We thank the Department for these statements and we believe it is strongly in the interest of consumers for the Department to follow through with them.

Second, we ask the Department to modify its first criterion to require states to establish provider access standards that are consistent with those set forth in §156.230(a)(1)(ii), (iii), *and* (a)(2). We understand that the Department does not believe it necessary for all states to implement the same specific criteria for assessing network adequacy. The Department identifies situations where, for example, the federally specified time/distance standards have posed challenges for states. Given these concerns, we believe states could be relieved of the requirement to use the specific standards set forth in federal guidance, giving them significantly greater flexibility and room to innovate than they now enjoy, while ensuring they enforce the same kinds of standards. In particular, we believe consumers are better served when plans are required to demonstrate compliance with quantitative measures of network adequacy, including time/distance and appointment wait time standards. Under our proposed modification, states would be free to depart from the federally specified metrics and construct quantitative standards appropriate for their circumstances. Their obligation, consistent with §156.230(a)(2), would be to ensure plans demonstrate compliance with time/distance and wait time standards that they, the states themselves, establish.

Third, the Department seeks comment on what level of transparency is necessary and appropriate for the review program. Information provided in connection with this program, and the Department’s decisions, are likely to have a significant impact on consumers’ ability to access care in a manner consistent with federal law and are of public interest. We urge that the default approach be full public disclosure of 1) all information submitted by the state to demonstrate it satisfies the criteria for having an effective provider access review program; 2) the Department’s written determination pursuant to proposed §155.1050(d)(7); 3) any decision to evaluate whether a state’s circumstances have changed such that it has begun to or has ceased to satisfy the criteria for having an effective provider access review program; and 4) any determinations, and their factual bases, made as a result of such evaluations.

Essential Community Providers: Effective ECP Review Program (§ 155.1051)

The ACA requires marketplace plans to include within their networks ECPs that serve predominately low-income, medically underserved individuals. While the Department currently reviews prospective marketplace plans for compliance with ECP standards, it proposes to allow states on the FFM to conduct their own ECP certification reviews if they satisfy proposed criteria intended to demonstrate their authority and capacity to do so. We ask the Department to refrain from finalizing this proposal until it can obtain more information regarding state approaches to ECP regulation.

In the proposal, the Department offers the view that it “should continue to primarily conduct ECP certification reviews as the default approach.” It observes, first, that “centralized Federal ECP certification reviews are continuously valuable to perform complex analyses that aim to protect [the]

more vulnerable populations [served by ECPs] and decrease potential disparities in access across States.” The Department recognizes that ECPs predominately serve individuals who are relatively sicker and less equipped to face high out-of-pocket costs, and the services ECPs provide are often more highly specialized, with greater levels of acuity and expense. Against this backdrop, federal experience and resources are critical to ensuring compliance with the statute.

Second, the Department acknowledges that it has only a limited understanding of state ECP rules and capacity to regulate. It says that “less is known” about whether states maintain standalone ECP requirements, that “it is unknown” how many states could develop and maintain a qualified ECP list, and that state tools and methodologies for assessing ECP data are similarly unclear. The Department is aware, it says, that some states have “limited resources and bandwidth to conduct ECP certification reviews, which are highly complex and data intensive.”

Given both what is unknown at this time (state authority and capacity) and what is known (that ECP review is critically important and challenging to execute), we urge the Department to continue to collect the information it lacks and, based on that information, revisit its proposal for an Effective ECP Review Program in subsequent rulemaking if warranted. With a clearer picture of where states stand, the Department will be equipped to establish approval criteria that safeguard low-income, medically underserved individuals’ access to these essential providers.

State-Based Marketplaces: Enhanced Direct Enrollment Option (§ 155.221)

We strongly oppose the proposal to eliminate the requirement for SBMs to maintain a centralized, consumer-facing eligibility and enrollment website and to allow marketplace enrollment to occur exclusively through private entities.

Enhanced direct enrollment (EDE) is already an option for all marketplaces. Indeed, it’s ubiquitous, and millions of people use it to sign up for coverage. At the same time, millions of other people decide differently, and choose to enroll through a trusted, government-run marketplace website. What the Department proposes to do is take away the option of a state-run enrollment site and require purchases through private sellers.

A core goal of the ACA marketplaces was to reduce the burden of enrolling in a health plan by giving consumers a one-stop shop for coverage: a single place to view their coverage options, the tools to understand and compare them, the opportunity to apply for federal financial assistance to help pay for such coverage, and finally, the ability to enroll. An ACA marketplace that does not actually allow consumers to enroll in the marketplace is one at odds with section 1311 of the statute.⁸

The Department’s proposal appears to rely on the assumption that it will promote “flexibility and innovation.” However, it does not explain how permitting a marketplace to fully delegate enrollment onto private entities that it is free to contract with today is innovative, or how such change would advance the interest of the consumers the marketplace is designed to serve.

⁸ The Department attempts to read statutory provisions that plainly contemplate a government-run enrollment portal in a manner it suggests does not technically require one. But [“\[a\] fair reading of legislation demands a fair understanding of the legislative plan.”](#) *King v. Burwell*, 576 U.S. 473, 498 (2015). Section 1311(d)(2)(A) requires marketplaces to “make available” marketplace plans to eligible individuals by enabling them to enroll in such coverage in the marketplace itself.

The FFM currently relies heavily on EDE. States that want to rely heavily on it can do so. There have been substantial developments in how plans are marketed and sold, both via government-run sites and EDE, over the years, with no indication that the mere existence of the government portals is inhibiting these changes. Indeed, evidence suggests that “innovation” among some private sellers is what poses the biggest risk to consumers and to program integrity. As the Department knows — as it details elsewhere in this proposed rule — misconduct by bad actor agents and brokers has caused significant harm to consumers, and the dangers of misleading marketing, confusion, and improper steering remain.

We urge the Department not to finalize this proposal and to retain the requirement that SBMs operate a centralized, consumer-facing eligibility and enrollment website.

Eliminating Standardized Plans and Non-Standardized Plan Limits (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, 156.265(b)(3)(iv), and 156.202)

The Department proposes to eliminate the requirement that insurers in FFM and SBM-FPs offer standardized plan options, remove the differential display of these plans, and repeal the limit on the number of non-standardized plan options insurers may offer. Our organizations oppose these proposals and urge that they not be finalized.

Standardized plan options serve important functions for consumers with serious, acute, and chronic conditions. By establishing uniform cost-sharing, including pre-deductible coverage of primary care, specialist visits, mental health and substance use services, and some prescription drugs, they reduce barriers to essential care. Flat copayments rather than coinsurance for key services enhance cost predictability and reduce unexpected financial harm. These features are particularly valuable for the patients our organizations represent. Standardized plans also enable meaningful comparison across insurers on premiums, networks, formularies, and quality—attributes that matter most but are hardest to evaluate when cost-sharing structures vary widely across plan options.

The Department’s primary rationale for discontinuing standardized plan requirements is that it believes the policy led to an increase in the total number of plan offerings. It’s true that plan offerings increased from 2022 (before standard plans returned) to 2023 (the first year of the policy); as the Department recognizes, its complementary rule limiting non-standardized plans was not in effect in 2023. A weak version of that limit became effective in 2024, and a somewhat stronger version kicked in in 2025, such that by 2025, plan offerings were lower, albeit marginally, compared to the baseline. This data shows that a non-standardized limit is an important component of addressing choice overload and a more robust limit would have a greater impact. However, the Department appears not to have even considered strengthening the limit on non-standardized plans as an alternative regulatory approach to address the problem it identifies.

The Department has other complementary tools it could use to support effective choice architecture. For it is not solely the total number of plan offerings that matters, but also how those options are presented. The Department has numerous tools at its disposal related to plan display that could facilitate consumer understanding and decision-making. We urge HHS to explore and utilize these tools that already exist.

The Department argues that standardized plan requirements constrain issuer innovation. To support this claim, it identifies a few plan types that it asserts that insurers are constrained in offering. But it

presents no evidence that insurers cannot use these designs as their non-standard offerings; they just can't offer them in unlimited fashion.⁹ It also provides no basis to conclude that there is unmet consumer demand for these designs, no reason to think that these plans are even desirable.

In the 2019 NBPP, the Department eliminated the first iteration of standardized plans on the grounds that they hampered innovation. That decision was challenged in federal court and ultimately vacated as arbitrary and capricious. The current proposal is no better substantiated. Our organizations urge the Department to retain the standardized plan option requirements and non-standardized plan option limits, and to strengthen the framework for supporting informed consumer choice.

Essential Health Benefits

The Essential Health Benefits (EHB) benchmark is a core protection for patients, including those with chronic, acute or high-cost conditions, and a key component of our organizations' guiding principles. It anchors other key protections, including the annual limit on out-of-pocket costs and the measure of a plan's generosity.

Since 2020, at least 11 states and the District of Columbia¹⁰ have updated their benchmark plans to address gaps in covered benefits. Five additional states have already undertaken the work and cost of preparing updates for the 2027 plan year. We believe more states should consider doing the same to keep their benchmark plans current with medical advances and sufficiently robust to meet the needs of consumers, as the statute intended.

With this proposed rule, the Department announces that it has paused review of the benchmark update applications of the five states seeking improvements for 2027 and indicates it plans to conduct a "comprehensive review" of Section 1302. This review has significant ramifications not just for states but ultimately for the patients our organizations represent. We ask the Department not to consider changes to the benchmark selection rules that would undermine states' existing EHB packages or otherwise reduce their ability to update their benchmarks to address gaps in access or changes in medical evidence or scientific advancement.

Beyond this, the Department proposes changes to the treatment of state-mandated benefits and would rescind the state option to require coverage of adult dental care, both of which would constrain states' ability to set benefits standards that work best for their states. We oppose those proposals.

Essential Health Benefits: State Mandated Benefits (§155.170)

Under a provision enacted in the 2025 Payment Notice, a benefit already covered in a state's EHB benchmark plan is treated as EHB, and therefore not subject to state defrayal. Our organizations supported this approach, which makes it easier for everyone to understand what benefits constitute EHB, helps state regulators ensure that patients and consumers receive the protections that attach to benefits designated as EHB, and facilitates decision-making by state policymakers seeking to ensure a robust benefit package for marketplace consumers.

⁹ We note that insurers should be in the clear for at least one of these "constrained" plan types. A provision of the One Big Beautiful Bill Act requires all bronze tier plans to be considered HSA-eligible by default, so insurers will not be limited in their ability to offer these designs.

¹⁰ [Enhancing Essential Health Benefits States Update Benchmark Plans | Commonwealth Fund](#)

The Department has proposed changing this approach, though the preamble is at times unclear and raises several questions. We are commenting on what we understand to be the proposed change – to rescind the 2025 provision – and its effects. To the extent the Department contemplates changes that will have a broader reach, we ask that you provide additional information and clarification so that we may fully evaluate such a proposed change.

We concurred with the arguments the Department made in putting forth and finalizing the 2025 update to the EHB benchmark rules and the treatment of state mandated benefits. That rule made states' options clearer and easier to navigate and reduced burdens on states seeking to undertake an EHB-benchmark plan selection. It helped to clarify state policy options and made the benchmark selection process more accessible, which we believe can help promote greater public engagement.

In support of the proposal to rescind the 2025 rule, the Department offers a misleading argument, saying, "over time, the accumulation of new State-required benefits that are EHB could substantially increase Federal [advanced premium tax credit] (APTC) costs." In fact, states' ability to add covered benefits to their benchmark plan is bounded by the requirement that it be equal in scope to the "typical" employer plan and no more generous than the most generous plan among a set of comparison plans. Within those boundaries, though, states have significant authority to tailor their benefit standards to reflect state priorities. The Department's proposal will no doubt stifle state action and limit their options. We oppose this proposed change. At a minimum, if finalized as proposed, it should take effect no sooner than 2028.

For the states that have updated their benchmark plans under the regulations in effect at the time of their undertaking, this proposed rule pulls the rug out from under them, potentially imposing substantial consequences for a decision already made and implemented. A delay in the effective date is needed to allow states time to consider any needed changes. The proposed rule even recognizes that additional time may be necessary for states to react to this change and we encourage HHS to provide that time.

Essential Health Benefits: Adult Dental Services (§156.155(d)):

The Department proposes to reinstate the prohibition on states requiring coverage of adult dental services, which we supported removing in the 2025 rule. Our organizations believed the restriction was not well-supported by the statute and, as a policy matter, did not well serve patients and consumers. The prohibition helped perpetuate a false distinction between oral health and the health of the rest of the person and between the oral health of children and adults, which can lead adult patients to forgo needed services and potentially experience worse health outcomes.

Furthermore, in removing the prohibition, the Department offered a clear rationale and helpfully noted considerations for states seeking to update their benchmark plans to require this coverage, including the need to establish adequate networks for the newly covered services. Though no state moved forward with an update that would add adult dental services, some had considered it, designing the benefits and estimating the cost. We urge the Department not to finalize this proposal.¹¹

¹¹ [State Flexibility To Add Adult Dental Care to Essential Health Benefits: An Update on State Action | Center on Health Insurance Reforms](#)

Premium payment thresholds (§155.400)

In the past, the Department gave issuers flexibility to effectuate a consumer's coverage, or allow an enrollee to remain in coverage, if their premium payment met or exceeded an insurer-determined threshold (among threshold types stipulated in regulation). We supported that consumer-friendly policy, which promotes continuity of comprehensive coverage. In a reversal last year, HHS limited insurer discretion to determine the threshold from August 2025 through 2026, with a return to granting insurers greater flexibility in 2027.

Now, the Department seeks comments on whether to extend the one-year ban on insurers' ability to set a more consumer-friendly threshold, and whether to impose that ban on all marketplaces. We strongly oppose the more restrictive policy. Consumers who intend to obtain and maintain health insurance may, due to other financial pressures or simple error, fall behind on owed premium by a de minimis amount. Issuers should not be required to deny or terminate coverage in these cases.

In establishing the temporary ban, HHS pointed to concern about fraud by bad-actor agents and brokers. There is no evidence that agent and broker fraud had anything to do with premium payment thresholds, and by the Department's own admission in this proposed rule, it lacks data from issuers on whether they have implemented a premium payment threshold policy let alone what threshold type they may have applied. The Department should allow the return to the premium payment threshold flexibilities previously in effect, monitor for abuse, and modify the policy if supported by evidence.

Implementing the Provisions of Public Law 119-21

We strongly opposed enactment of Public Law 119-21 for the many harms it will impose on individuals who rely on the marketplace or Medicaid to obtain affordable, comprehensive coverage. In addition to the estimated coverage losses from that law, the expiration of the enhanced premium tax credits means people who cannot afford to go without coverage, including the patients we represent, will find they can only afford a basic marketplace plan that comes with higher premiums and much higher cost-sharing. Thanks to these two policy developments, those seeking coverage will have to pay more to get less.

The Department has proposed rules to implement two particularly harmful provisions of Public Law 119-21 – stricter limits on APTC eligibility based on immigration status and the elimination of the low-income SEP. Beyond that, HHS seeks comment on how to effectively roll out communications and the necessary timelines to establish a pre-enrollment verification process by August 1, 2027, without offering any indication of what the Department may propose in these areas. We are very much interested in the opportunity to comment on specific proposals well in advance of their effective dates. We also urge the Department to conduct consumer testing on how best to communicate the many upcoming changes to eligibility and enrollment requirements, particularly given the drastic consequences of failure to fully and timely comply, including loss of coverage and APTCs. Our organizations further hope and expect HHS will make every effort to mitigate the coverage losses associated with Public Law 119-21 as you develop specific implementation proposals.

Income Verification Policy to Determine Eligibility for APTCs (§155.320)

In rulemaking last year, the Department finalized a policy to deny APTCs to certain low-income consumers whose projection of annual household income cannot be immediately verified with old tax return data. This latter policy would apply to (1) people who, according to old tax data, had income

below the poverty line, but who project that they will earn more than that amount in the coming year; and (2) people for whom Internal Revenue Services (IRS) systems cannot find a tax return match. As we noted in our comments on that proposed rule, this happens for a host of reasons, including changes in family size or filing status, name changes, or other mismatches in demographic information. The Department pursued that policy even though it acknowledged that making it harder for people to enroll in coverage may deter some people from enrolling. Its own research shows the burdens are likely to deter young and healthy people (but not individuals with immediate coverage and care needs), thereby leading to a sicker and more expensive insurance market.

In this proposed rule, HHS would continue this harmful policy, noting continued concern about fraud and improper enrollment. We continue to strongly oppose this policy. The Department is taking steps in this proposed rule to target the source of improper enrollments by imposing stricter standards for agents, brokers, and web-brokers (and we applaud those efforts). As the Department notes, 80 percent of income data-matching issues were generated by households who worked with an agent, broker, or web-broker to enroll.

In this proposed rule, the Department continues to base its improper enrollment argument on the assumption that low-income individuals below the poverty line who expect to earn more next year are program integrity risks. Furthermore, HHS claimed last year that the availability of \$0 premium plans made possible by the enhanced PTCs was driving fraud. Now, acknowledging the expiration of that enhanced assistance, the Department claims its concerns remain, along with concerns about the greater financial exposure for consumers no longer protected by a cap on repayment of excess PTCs (a change in law supported by the administration). This contradicts extensive research regarding the impact of administrative burden and application complexities, which demonstrate both that the Department's approach will reduce enrollment and (by discouraging healthy people from signing up) weaken the risk pool.¹²

Failure to Reconcile (§155.305)

Marketplace enrollees who receive APTCs must file a federal income tax return to reconcile the APTC they received with the premium tax credit they are entitled to based on their actual annual income. Previously, individuals who have failed to reconcile (FTR) their APTCs for two years may be denied APTCs until they comply with the obligation to reconcile their past-year APTCs. Last year, HHS finalized a rule change that would deny APTCs based on an individual's failure to reconcile their APTCs for a single year. However, this rule was struck down by a federal court that concluded it was contrary to law.

Now, the Department proposes to reimpose the 1-year FTR policy for 2027, with the option for SBMs to implement either a one-year or two-year FTR policy for plan year 2027. Public Law 119-21 requires a 1-year FTR policy beginning in 2028, even in SBMs.

We oppose the Department's proposal. This policy runs contrary to the court ruling that HHS does not have the authority to limit APTC eligibility based on a prior tax debt. Individuals who fail to reconcile their APTC remain subject to the Internal Revenue Service's normal enforcement measures. We oppose HHS adding an additional financial penalty not based in statute that hinders access to affordable

¹²American Academy of Actuaries, Response to Senate Budget Reconciliation of H.R.1, One Big Beautiful Bill Act. June 3, 2025. <https://actuary.org/wp-content/uploads/2025/06/Academy-Senate-Budget-Reconciliation-Comments.pdf>

coverage. At a minimum, notices sent to taxpayers who have failed to reconcile their APTCs should have clear, actionable information, so taxpayers can easily understand the risk of losing their APTC eligibility and the steps they must take to rectify that. In addition, we are concerned that even with clear information, serious understaffing¹³ at the IRS will mean taxpayers will be unable to timely resolve their past FTR and will be locked out of affordable coverage without an APTC.

Approval of a State Marketplace (§§155.105 and 155.106)

We oppose the Department’s proposals to lower standards for states transitioning to an SBM. Operating for at least one year as an SBM on the federal platform provides states time for careful planning before assuming full responsibility for their marketplace.

We also oppose the proposal to eliminate the requirement that transitioning states provide documentation demonstrating progress toward meeting or implementing state Marketplace Blueprint requirements and rely on states providing that information only upon request. Although the Department claims states generally make this information available when needed, requiring this information to be made available in all cases should be a baseline obligation of states seeking to operate their own marketplace.

Furthermore, as states move from the federal Marketplace to a state-based Marketplace, we urge HHS to extend minimum federal standards to all marketplaces and incorporate additional standards that consumers are not made worse off than they would have been if the state continued to use the federally facilitated Marketplace.

Quality Standards: Quality Improvement Strategy (§156.1130)

An insurer that participates in an ACA marketplace for two or more consecutive years must implement and report on a quality improvement strategy (QIS) that provides increased reimbursement or other incentives for activities designed to improve health care for enrollees. The insurer must implement 1) a strategy for improving performance in at least one of four key categories: health outcomes, hospital readmissions, patient safety and medical errors, and the promotion of wellness and health; and 2) a strategy dedicated to reducing disparities among people of color, LGBTQ+ people, people with disabilities, people who live in rural areas, or people otherwise adversely affected by poverty and inequality in health and health care.

We oppose CMS’s proposal to remove the requirement that insurers address “activities to reduce health and health care disparities” as one of the two required QIS. Requiring insurers to submit QIS for reducing health disparities is a step toward ensuring that health insurance coverage works equitably for all enrollees, including those who have historically experienced systemic barriers to care.

Pre-Enrollment SEP Verification (§155.420(g))

We strongly oppose the Department’s proposals to once again add administrative barriers for individuals attempting to enroll in health insurance coverage through a special enrollment period (SEP). The Department proposes to require applicants to submit additional paperwork before they can enroll through five different SEPs (marriage, adoption, moving to a new coverage area, loss of minimum

¹³ [https://www.tigta.gov/sites/default/files/reports/2025-10/FY%202026%20MMC%20\(Final\).pdf](https://www.tigta.gov/sites/default/files/reports/2025-10/FY%202026%20MMC%20(Final).pdf)

essential coverage, and Medicaid/CHIP denial) and for at least 75 percent of new SEP enrollments. The Department proposed these same restrictions last year but claimed they would be temporary and no longer necessary in 2027. Now, the Department says differently, and would impose the restrictions in 2027 and beyond.

Administrative hurdles tied to enrolling in public programs can significantly reduce participation among people who are otherwise eligible.¹⁴ The Department recognizes that requiring additional paperwork makes enrollment more difficult, particularly for younger and healthier adults. The departure of healthy enrollees from the risk pool is, in turn, likely to raise premiums for consumers. We strongly oppose the proposal to reinstate and make permanent these burdensome and harmful requirements.

Marketing Rules for Agents, Brokers and Web-Brokers (§155.220)

Drawing on findings from the Department's oversight of agents, brokers, and web-brokers, the proposal observes that technical assistance and enforcement of current rules are not sufficient to prevent these actors from fraudulently enrolling consumers into marketplace coverage. Accordingly, the Department proposes new limitations on the marketing practices of these entities. Furthermore, the Department proposes to require agents, brokers and web-brokers to use an HHS-created consumer consent form to obtain consumer consent and to clarify what types of consumer actions are adequate to demonstrate that they have, in fact, consented.

We strongly support these actions and believe greater clarification of prohibited marketing practices, use of a standardized consumer consent form, and continued oversight of agents, brokers and web-brokers will help protect consumers from the harms associated with being enrolled in coverage without their knowledge or consent. We believe the Department should also take steps to promote greater awareness of the consumer complaint line that has informed some of the Department's oversight and enforcement actions.

Beyond these common-sense changes to standards for agents, brokers and web-brokers, the Department has included a proposal to eliminate "gender identity" from prohibited discrimination based on sex in regulation governing the activities of state-licensed agents, brokers and web-brokers. The Department offers no justification for this proposal, nor any explanation of how it has any relationship with any of the reasons that motivate the many proposals in this rule, including addressing fraud and higher premiums. We strongly oppose this proposal.

Medical Loss Ratio

The Department seeks comment on multiple questions regarding the definition and application of the ACA's medical loss ratio (MLR) requirements, including its impact on market stability; the potential to adjust the MLR to lower premiums or to reduce incentives for consolidation; whether the Department should adjust the standard; whether it should adjust the process for states to request an adjustment; and how to resolve potential disagreements between the Department and states on whether an adjustment would help stabilize the market.

¹⁴Jalisa Clark, Justin Giovannelli, and Christine H. Monahan, "Congress and the Administration Are Using Paperwork to Discourage Enrollment in Marketplace Insurance," *To the Point* (blog), Commonwealth Fund, Sept. 4, 2025. (collecting literature). <https://doi.org/10.26099/773n-d085>

The MLR is an essential protection that ensures consumers get some minimum level of benefit from their insurance in return for the premiums they pay. It is unclear what motivates the interest in potential changes in the name of market stability. If no state has asked to adjust the MLR as a necessary measure to stabilize their market, it would seem there's not a problem here to solve. We do not see any reasonable basis for the Department to assert the authority to override a state and impose a lower MLR, where a state has determined it is not needed or appropriate.

Exchange User Fee

The Department proposes to maintain the current user fee for the FFM as well as SBMs. We have long supported that fees be sufficient to support robust consumer outreach and education, including a strong network of Navigator programs. This will be particularly important given drastically reduced funding for these functions and the many changes underway that will affect eligibility for coverage, available plan options, and restrictive enrollment requirements. These policy changes will require the user fee to adjust to maintain sufficient funding. We therefore strongly urge the Department to raise the user fee to keep pace with declining enrollment and the increased burdens on consumers seeking to enroll in marketplace coverage.

Impact of Proposed Rule on Premiums

In its regulatory impact analysis, the Department concludes that its proposals will increase premiums by about 2 percent. However, it claims that its housekeeping regulation formally removing regulatory text related to the special enrollment period for people with incomes below 150 percent of the federal poverty level (the low-income SEP) is an offset, reducing premiums by 3 to 4 percent. This (3-4 percent reduction) is the same premium effect the Department anticipated when it proposed to end the low-income SEP last year; after reincorporating the same estimate this year, the Department concludes that its rule, as a whole, will reduce premiums.

This estimate is the product of deeply flawed analysis and is contrary to evidence submitted to the Department in connection with the 2025 rulemaking. Furthermore, whatever the effect of ending the low-income SEP – the SEP has already been eliminated. Section 71304 of Public Law 119-21 bars consumers from receiving premium tax credits for any enrollment through an income-based SEP as of January 1, 2026. Whatever the effect of ending the low-income SEP, it is attributable to the statute. The Department's proposals will raise consumer premiums. It should not obscure that point by invoking a statutory policy that is already in effect, and that will remain in effect with or without this rulemaking.

Thank you for the opportunity to provide these comments. If you have any questions, please contact Theresa Alban at the Cystic Fibrosis Foundation (talban@cff.org).

Sincerely,

AiArthritis
ALS Association
American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund

American Lung Association
Arthritis Foundation
Autoimmune Association
Blood Cancer United (formerly The Leukemia & Lymphoma Society)
Cancer Nation
CancerCare
Coalition for Hemophilia B
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Diabetes Patient Advocacy Coalition
Epilepsy Foundation of America
EveryLife Foundation for Rare Diseases
Family Voices National
Foundation for Sarcoidosis Research
Hemophilia Federation of America
Immune Deficiency Foundation
Legal Action Center
Lupus Foundation of America
Lutheran Services in America
Muscular Dystrophy Association
National Alliance on Mental Illness
National Bleeding Disorders Foundation
National Kidney Foundation
National Multiple Sclerosis Society
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute
WomenHeart: The National Coalition for Women with Heart Disease
ZERO Prostate Cancer



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Submitted online via Regulations.gov

March 13, 2026

Secretary Robert F. Kennedy, Jr.
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

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

Dear Secretary Kennedy:

UnidosUS is the nation's largest Latino civil rights and advocacy organization. Through our combination of expert research, advocacy programs, and an Affiliate network of nearly 300 community-based organizations across the United States and Puerto Rico, UnidosUS simultaneously challenges the social, economic, and political barriers that affect Latinos at the national and local levels.

Health care coverage and affordability is a top priority for the Latino community. An estimated 6.5 million Latinos purchase coverage in the Affordable Care Act (ACA) Marketplace¹ and are thus directly affected by changes in federal policy that reshape Marketplace coverage. Accordingly, we appreciate the opportunity to comment on the Department of Health and Human Services' (HHS) proposed rule, *Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program* (hereinafter "Proposed Rule," "NBPP," and "Notice of Proposed Rulemaking," or "NPRM").²

While we appreciate the opportunity to comment, we object to the truncated, 30-day comment period, which is insufficient for a proposal with such far-reaching and potentially harmful effects. HHS should provide at least a 60-day comment period for such a wide-ranging

¹ UnidosUS, Health care costs are about to skyrocket for Americans in marginalized communities, December 16, 2025, <https://unidosus.org/blog/2025/12/16/health-care-costs-are-about-to-skyrocket-for-americans-marginalized-communities/>.

² U.S. Dep't. Health & Human Svcs., *Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program*, 91 Fed. Reg. 6292 (proposed Feb. 11, 2026), <https://www.govinfo.gov/content/pkg/FR-2026-02-11/pdf/2026-02769.pdf> (hereinafter "Proposed Rule").

rule. The truncated time is compounded by the correction to the rule that was not published until March 6, just one week before comments were due.

§§ 155.20, 155.205, 155.220, 156.201, 156.265 – Standardized Plan Options

We oppose the proposal to discontinue all requirements pertaining to the full suite of standardized plan options. This discontinuance includes removing the requirements for FFE and SBE-FP QHP issuers in the individual marketplace that offer these plans and removing the requirement for these plans to meaningfully differ from one another; removing the definition of “standardized option;” removing the differential display of standardized plan options on HealthCare.gov; and removing the corresponding standardized plan option differential display requirements for approved web-broker- and QHP-issuer- enrollment partners using a DE (Direct Enrollment) pathway to facilitate consumer enrollment through an FFE or SBE-FP. Standardized plans are essential in improving consumer choice by simplifying and streamlining plan comparisons. Such standardization helps improve affordability and address health disparities in the Marketplace. Removal of standardized plans will disrupt consumer enrollment by making it harder for consumers to make apples-to-apples comparisons of plans and benefits. The proposal will also increase financial burdens on consumers.

Standardized plans that share a common benefits structure, including tiering and cost-sharing, allow consumers to make apples-to-apples comparisons of plans and benefits. The ACA generally achieved a common benefit structure across plans through the requirement that Marketplace plans cover EHB, but lack of cost-sharing standardization has allowed issuers to offer a virtually unlimited number of plans. Through standardized plans, consumers are now able to compare plans without regards to cost-sharing requirements, allowing individuals to focus on other factors that are better indicators of the plan’s value and that are more crucial to consumers’ health, such as premiums, provider network, and quality of services.

HHS claims that discontinuing the full suite of standardized plan options policies will reduce consumer choice overload. It is true that choice overload can be an issue for consumers choosing a plan. A recent Assistant Secretary for Planning and Evaluation (ASPE) issue brief indicates that “almost three quarters of *HealthCare.gov* consumers have *more than 60 plan options* to choose from, and the average number of plans is *over 100*” (emphasis added).³ Because health care is not a typical consumer good, the usual understanding that more is

³ U.S. Dept. of Health & Human Servs., Assistant Sec’y for Plan. and Evaluation (“ASPE”), *Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces 1* (2021), <https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf>.

better for the consumer does not hold true in the Marketplace. On the contrary, the high number of plan options often leads to confusion among shoppers, which in turn gives way to consumer errors during plan selection. As the ASPE report finds, a higher number of plan options runs counter to the central premise of the ACA, which relies on plan competition to increase the value of health care and requires informed consumers to “select among competing plans to realize that value.”⁴ Choice overload, on the other hand, often leads consumers to make selections without regard to value and discourages consumers from switching from lower-value plans to higher-value plans.

However, we do not agree with HHS’s proposal to resolve its concern about choice overload. Instead of implementing regulations that would help manage choice overload, HHS proposes discontinuing standardization requirements and leaving issuers with the option to keep or discontinue their existing standardized plan option while removing the differential display and designation of standardized plans. This proposal will disrupt consumer enrollment by waiting for issuers to make that determination, and if an issuer decides to discontinue, enrollees in standardized plans would have to transition into different plans that may not meet the health care needs that were effectively addressed by enrollees’ previous plans. Additionally, HHS removing the differential display will limit the information available to consumers to make an informed decision on the plan they would be enrolled in, causing more confusion and financial stress.

Furthermore, standardized plan options account for a full-third of enrollment after only a few years on the market with total FFE and SBE-FP enrollment of 20% for 2023, 33% for 2024, and 33% for 2025.⁵ HHS misleadingly characterized this enrollment data as “comparatively low uptake.” In truth, this steady increase shows that consumers are attracted to these plans amongst the numerous other plans that are offered in the Marketplace.

Standardized plans ensure that consumers always have access to at least one plan that exempts certain essential services – including emergency room services, primary care visits, and mental health and substance use disorder treatment – from deductibles. Latinos and other underserved populations often lack access to such services that are key to prevent further health complications, so exempting these services from the deductible in certain standardized

⁴ *Id.* at 4.

⁵ Katie Keith et al., HHS Proposes Sweeping Changes For 2027 Marketplace Plans (Part 2), HEALTH AFF. (Feb. 13, 2026), <https://www.healthaffairs.org/content/forefront/hhs-proposes-sweeping-changes-2027-marketplace-plans-part-2>.

plans made it easier for these communities to receive the care they needed and helped close gaps in access to care.⁶

The effectiveness of standardization in improving access and affordability is evident in the experience of the 9 states and the District of Columbia that have already adopted standardization in their state-run Marketplaces. California has required all plans to be standardized since Covered California's inception in 2014.⁷ The result of this policy has been that consumers are able to navigate the Marketplace and shop without having to worry about price variation within particular tiers and service areas. In turn, this ease of access has led to robust coverage across all counties in California alongside significant, albeit incomplete, improvements in the quality of care provided due to competition being based on plans' overall value instead of cost alone.

Furthermore, discontinuing standardized plans does not resolve some of the other pertinent issues that still arise with implementation of these plans. In fact, this proposal may exacerbate them. For example, some of the cost-sharing in standardized plans still remains too high and unaffordable for beneficiaries with high needs. People with disabilities and those with chronic conditions, who need certain drugs to help treat their conditions, are enrolled in standardized plans that subject them to high deductible requirements. Instead of eliminating standardized plans, HHS should exempt them from deductible requirements across silver plans. In addition, copays for specialty drugs remain too high and unaffordable for most individuals. As such, HHS should evaluate the possibility of lowering copayments for "specialty" drugs without the need to increase cost-sharing for other services pursuant to the AV calculator.

Lastly, HHS should limit or prohibit coinsurance, which is inherently discriminatory and unduly shifts the costs of care to persons with high health needs. Coinsurance also increases confusion among consumers because even more experienced consumers may fail to understand that a lower coinsurance percentage may nonetheless represent a higher out-of-pocket amount than copayments. Coinsurance is particularly invidious for prescription drugs, for which actual prices vary considerably. Consumers are ill-equipped to consider these price variations and plans do not provide information on the dollar amount of coinsurance a consumer can expect to be charged. Eliminating standardized plans will only cause more confusion, instead of resolving

⁶ For a discussion about how issuers use benefit manipulation and "adverse tiering" to discriminate against individuals with high-cost needs and how standardization helps fix this problem, see Douglas Jacobs, *CMS' Standardized Plan Option Could Reduce Discrimination*, HEALTH AFF. (2016), <https://www.healthaffairs.org/doi/10.1377/forefront.20160106.052546>.

⁷ Justin Giovannelli et al., *State Efforts to Standardize Marketplace Health Plans Show How the Biden Administration Could Improve Value and Reduce Disparities*, THE COMMONWEALTH FUND (July 28, 2021), <https://www.commonwealthfund.org/blog/2021/state-efforts-standardize-marketplace-health-plans>.

these major issues that impact enrollees' access to affordable, non-discriminatory health care coverage.

§§ 155.105(b)(4), 155.106(b)(2), and 155.205(b) – Exchange Operations

We provide detailed comments in opposition to proposals related to State Exchange operations at §§ 155.105(b)(4), 155.106(b)(2), and 155.205(b). As a preliminary matter, we find these proposals particularly ill-timed during the current period of ongoing massive coverage loss and system upheaval. Significant changes to Medicaid, Marketplace, and Basic Health Program eligibility mandated by the “One Big Beautiful Bill Act” and earlier HHS rulemaking will continue to heavily implicate Exchange operations over the next several plan years. These changes include the exclusion of millions of lawfully present non-citizens from Medicaid, Medicare, Marketplace coverage, and the Basic Health Program, beginning in 2025 and accelerating through 2027; the implementation of work documentation requirements in Medicaid beginning in some states this year and expanding nationwide in 2027; and the implementation of extensive pre-verification requirements for Marketplace applicants and enrollees, necessitating major operational changes no later than August 2027.⁸ Coverage disruptions related to these and other policy changes are unfolding in tandem with the effects of the expiration of EPTCs, which is anticipated to drive millions of people to become uninsured or underinsured.⁹ During a period when households are already struggling to maintain access to affordable coverage, lowering standards for State Exchanges presents an unacceptable risk.

§ 155.105(b)(4) – Removing the requirement that a state seeking to operate an SBE must first operate as an SBE-FP for at least one plan year. We oppose the proposal to remove the requirement at § 155.105(b)(4) that a state that seeks to operate as a State Exchange first

⁸ See Pub. L. No. 119-21, §§ 71119, 71301, 71302, and 71303 (2025) (“OBBBA”).

⁹ The expiration of enhanced PTCs will drive significant coverage loss, although the full impact on consumers and Exchanges will likely unfold over months, if not years. See, e.g., Stacey Pogue, et al., Georgetown Ctr. on Health Ins. Reforms, *Clues in State Data Suggest Declines in Early Marketplace Enrollment Data May Be Just the Tip of the Iceberg* (Jan. 28, 2026), <https://chir.georgetown.edu/clues-in-state-data-suggest-declines-in-early-marketplace-enrollment-data-may-be-just-the-tip-of-the-iceberg>; Matthew Buettgens, et al, Urban Inst., *4.8 Million People Will Lose Coverage in 2026 if Enhanced Premium Tax Credits Expire* (Sept. 17, 2025), <https://www.urban.org/research/publication/48-million-people-will-lose-coverage-2026-if-enhanced-premium-tax-credits>; Ltr. from Philip Swagel, Director, Congressional Budget Office, to Hon. Ron Wyden, Hon. Richard Neal, Sen. Sheehan, and Rep. Underwood, *Re: The Effects of Not Extending the Expanded Premium Tax Credits for the Number of Uninsured People and the Growth in Premiums* (Dec. 5, 2024), <https://www.cbo.gov/system/files/2024-12/59230-ARPA.pdf> (estimating that the expiration of enhanced premium tax credits will increase the number of people without insurance by 2.2 million in 2026, 3.7 million in 2027, and 3.8 million, on average, in each year over the 2026-2034 period).

operate on the Federal platform for at least one plan year, including its first open enrollment period.

As HHS notes in the preamble to the 2027 NBPP NPRM, every state that has elected to operate as a State Exchange after 2014 has operated as a State Based Exchange on the Federal Platform (SBE-FE) for at least one plan year before transitioning to independent State Based Exchange (SBE) status.¹⁰ The current requirement therefore codifies best practices that reflect more than a decade of implementation of the Affordable Care Act (ACA).

HHS created the SBE-FP option to formalize an arrangement between a state and HHS that allows a State Exchange to maintain independent legal status and retain authority and primary responsibility for certain key Exchange functions (including plan management, consumer support, and Navigator operations), while continuing to rely on the Federally-facilitated Exchange (FFE) to perform eligibility and enrollment functions, including leveraging FFE consumer call center and casework resources and technology.¹¹

Requiring one year of SBE-FP operations is a reasonable threshold that ensures that states have a minimum transition period to focus on developing the resources necessary to implement key SBE functions. As HHS explained in the 2025 Notice of Benefit and Payment Parameters, this includes establishing relationships with crucial formal and informal partners such as consumers, issuers, Navigators and other application assisters, providers, community-based organizations, and other entities whose partnership can bolster the eventual success of an independent SBE.¹² Moreover, a minimum transition period provides states with a timeline for developing and launching eligibility and enrollment functions, which include not only the “back end” information technology, but a consumer-facing Exchange website and call center. Additionally, these functions must be carefully coordinated with relevant state agencies administering Medicaid, CHIP, and Basic Health Programs to ensure compliance with the requirement to provide a single, streamlined application for all applicable state health subsidy programs.¹³

HHS now claims that “requiring States to first operate as an SBE-FP for at least 1 plan year could potentially create unnecessary barriers for States that are well-prepared to implement a State Exchange more immediately” but fails to provide any evidence to explain how the current transition period has functioned as an “unnecessary barrier” to any states seeking to transition to SBE status. Moreover, states seeking SBE status must submit an Exchange Blueprint

¹⁰ 91 Fed. Reg. 6292, 6298 (Feb. 11, 2026) (“2027 NBPP NPRM”).

¹¹ 45 C.F.R. § 155.200(f); 81 Fed. Reg. 12204, 12244-12246 (March 8, 2016).

¹² 88 Fed. Reg. 82510, 82552 (Nov. 24, 2023).

¹³ 42 U.S.C. § 18083(b)(1)(B).

application for HHS approval no less than 15 months prior to the date on which the state proposes to begin open enrollment as an SBE.¹⁴ Therefore, a one-year transition period during which a state functions as a SBE-FP does not necessitate a burdensome or additional delay to the extent a state is “well-prepared to implement a State Exchange”, but rather provides a valuable opportunity for the state to demonstrate its capacity to carry out key Exchange functions quasi-independently of the FFE while HHS reviews its Blueprint submission.

This transition year is particularly valuable because SBE functions are highly state-specific. In the 2025 NBPP Final Rule, HHS acknowledged this reality, finalizing the current one-year SBE-FP requirement in part because: “[i]t is not possible for a State seeking to newly establish a State Exchange to identically apply development and implementation plans and other resources utilized for an eligibility platform in already-established State Exchanges, because in [HHS’s] experience, those exchanges may operate with partner State agencies, such as Medicaid and CHIP, differently from the State that is seeking to newly establish a State Exchange.”¹⁵ In the 2027 NBPP NPRM, however, HHS claims that “the technology infrastructure available today to States for implementation of State Exchanges has become more compatible, such that technology used to support one State Exchange implementation could be leveraged by another State Exchange”.¹⁶ HHS does not identify specific technological advancements that support this reversal, nor does it provide evidence to counter its own reasoning in recent prior rulemaking.

§ 155.106(a)(2) – Rescind requirement that state must provide supporting documentation demonstrating progress toward meeting or implementing State Exchange Blueprint requirements. We oppose the proposal to rescind the requirement that states must provide supporting documentation demonstrating progress toward meeting or implementing State Exchange Blueprint requirements to HHS upon request. In HHS’s view, because states have provided such documentation both before and after the requirement was codified last year, a regulatory requirement is unnecessary.¹⁷

This requirement was intended to clarify HHS’s authority to request such documentation – authority which HHS does not appear to believe has changed.¹⁸ HHS justifies its proposal as an effort to support the “overall goals” of Executive Order 14192, which aims to “promote prudent financial management and alleviate unnecessary regulatory burdens.”¹⁹ If HHS believes it retains

¹⁴ 45 C.F.R. § 155.106(a)(20).

¹⁵ 89 Fed. Reg. 26218, 26261 (“2025 NBPP Final Rule”).

¹⁶ 2027 NBPP NPRM at 6327.

¹⁷ 2027 NBPP NPRM at 6328.

¹⁸ 2025 NBPP Final Rule at 6327-6328.

¹⁹ 90 Fed. Reg. 9065 (Feb. 6, 2025).

the authority to request supplemental documentation as part of its Blueprint Application review and plans to continue to make such requests when appropriate, and HHS anticipates that in fact states will continue providing the same information without the proposed regulatory change, rescinding the regulation does little to reduce the practical burden on regulated entities. While rescinding the rule may allow HHS to check a deregulatory box, it will have little meaningful burden reduction effect on states. Rather, doing so is likely to promote confusion about HHS's authority to request documents or signal reduced rigor in the agency's approach to Blueprint Application review, which could in turn delay future provision of requested documentation and negatively affect Blueprint approvals.

§ 155.170(a) – Additional Required Benefits.

HHS proposes to amend 45 C.F.R. § 155.170(a) to provide that any state-required benefit will be considered “in addition to EHB” and subject to defrayal if it is 1) required by state action taking place after December 31, 2011, 2) applicable to small group and/or individual markets, 3) specific to required care, treatment, or services, and 4) not required by state action to comply with federal requirements.²⁰ HHS claims that these changes “are only intended to codify longstanding elements of the defrayal analysis.”²¹ However, as proposed, many of the benefits added or improved via the EHB benchmarking process could be subject to defrayal. If finalized, and the proposal will create confusion and uncertainty, impede state efforts to address health care needs of residents, and ultimately harm consumers.

We strongly object to this proposal, which stands to reverse years of progress in empowering states to establish benefits that best meet the needs of their residents. In the 2019 NBPP, HHS acknowledged the importance of giving states “additional choices with respect to benefits, which may foster innovation in plan design and greater access to coverage[.]”²² HHS continued this trend toward increased state flexibility in the 2025 NBPP, clarifying that a covered benefit that is part of a state's EHB benchmark plan will be considered an EHB and therefore not subject to defrayal, irrespective of whether the benefit was added as a state mandate.²³

This flexibility has served states well. The current version of the regulation has enabled states to, among other things, effectively address the needs of their residents, tailor responses to the

²⁰ 91 Fed. Reg. 6292, 6332.

²¹ 91 Fed. Reg. 6333.

²² 83 Fed. Reg. 16930, 17010.

²³ 89 Fed. Reg. 26218, 26225.

opioid overdose crisis, expand access to fertility care, and strengthen preventive services.²⁴ The proposed amendment threatens these efforts and the viability of future efforts to improve EHB plans.

Nearly a dozen states have updated their EHB benchmark plans by adding or improving benefits since the last time HHS modified the benchmarking process. These updates, pursuant to the EHB benchmarking framework and approved by CCIIO, could be subject to defrayal under this proposal. Benchmark updates meet the criteria for state action as described in the proposed regulatory text. EHB benchmark updates apply to the small group and individual market; are specific to required care, treatment, or services; and are typically not required for purposes of compliance with federal law. On their face, benefits added via benchmark updates would be subject to defrayal under this proposal.

In its 2018 FAQ on defrayal, HHS explicitly provided that benefits included in a new EHB benchmark plan would not be treated as state mandates and therefore would not be subject to defrayal under 45 C.F.R. § 155.170 unless they were mandated after December 31, 2011 “through legislative or regulatory action *separate from an EHB-benchmark plan selection process* (emphasis added).”²⁵ Neither the preamble nor the proposed regulatory text address the distinction between benefits added through the benchmarking process and those considered state mandated benefits subject to defrayal.

HHS creates ambiguity about several crucial aspects of EHB standards and the benchmarking process. For instance, HHS “clarifies” that “a State that wants to avoid defrayal obligations for State-required benefits that are already in the State’s EHB-benchmark would be able to do so by repealing the applicable State requirement as being applicable to QHPs.”²⁶ Seemingly, a state would need to repeal a state law, regulation, or other regulatory act adding a benefit to EHB to avoid defrayal, but would not need to change its benchmark accordingly. This reasoning only adds to the confusion and lack of clarity for states.

At a minimum, HHS should include regulatory language making clear that benefits added or improved through the EHB benchmarking process are not subject to defrayal, reflecting the

²⁴ See, e.g., CMS, North Dakota EHB Benchmark Plan (2025–2027) (2023) (alternatives to opioids), CMS, Washington, D.C. EHB Benchmark Plan (2026–2028) (2024) (fertility services), CMS, New Mexico EHB-Benchmark Plan (2025–2027) (2020) (weight loss services and artery calcification testing).

²⁵ CMS, *Frequently Asked Questions on Defrayal of State Additional Required Benefits* (Oct. 23, 2018), <https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/downloads/faq-defrayal-state-benefits.pdf> (hereinafter “CMS FAQ”).

²⁶ 91 Fed. Reg. 6334.

2018 guidance.²⁷ Given states' reliance interests, we do not believe that guidance documents or assurances in the preamble to the final rule are sufficient to clarify the applicability and the parameters of the proposal. Instead, we strongly urge HHS to embed the necessary clarifications to this new requirement directly into the regulatory text.

Clarifying the meaning of "state action" is critical because states take a variety of approaches to updating their EHB benchmark plans. The following examples illustrate the diverse methods states undertake to update their EHB benchmark plans and the different reasons why states undertake such efforts.

North Dakota made wide-ranging changes to its EHB benchmark plan for plan year 2025 following a continuing resolution that "urged" the Insurance Commissioner to add the benefits that would ultimately be adopted in the updated plan.²⁸ The legislature's resolution, the benchmarking update, and the subsequent codification into state law could all trigger deferral under this proposal.²⁹

Oregon updated its EHB benchmark plan for plan year 2022 to add benefits related to addressing effects of the opioid overdose crisis within the state, fashioning the changes after similar changes Illinois made for plan year 2020.³⁰ The state's Department of Consumer and Business Services (DCBS) initiated the changes and they were codified into state regulation following approval of the new plan.³¹

California's benchmark plan has been codified into state law since 2014. Before the California Department of Managed Health Care (DMHC) submits any benchmark changes, the Legislature must enact and codify those changes (which only take effect upon federal approval). Following this process, in 2025, the California Legislature amended the state statute to add several new benefits to its EHB benchmark plan. In response, DMHC submitted an application to change the State's benchmark plan for plan year 2027 reflecting those changes.³²

²⁷ See CMS FAQ, *supra*.

²⁸ See CMS, *North Dakota EHB Benchmark Plan (2025-2027)* (2023); see also 2023 N.D. Laws (H.C.R. 3011), <https://legiscan.com/ND/bill/HCR3011/2023/>.

²⁹ See N.D. Cent. Code § 26.1-36-09.16 (2025) (insulin and insulin supplies).

³⁰ See CMS, *Oregon Dakota EHB Benchmark Plan (2025-2027)* (2023).

³¹ See *Essential Health Benefits (EHB) Rulemaking Advisory Committee*, Or. Dep't of Consumer & Bus. Servs. (Apr. 23, 2020), <https://web.archive.org/web/20250125222801/https://dfr.oregon.gov/help/committees-workgroups/pages/ehb-rulemaking-committee.aspx>, Or. Admin. R. 836-053-0017 (2021).

³² See Cal. Dep't of Managed Health Care, *DMHC Applies to Update California's Benchmark Plan, Expand Essential Health Benefits to Include Fertility Services, Hearing Aids & Wheelchairs* (May 5, 2025), <https://dmhc.ca.gov/Resources/Newsroom/PressReleases/May5,2025.aspx>; see also, e.g., S.B. 1290, 2023-24 Reg. Sess. (Cal. 2023), A.B. 2914, 2023-24 Reg. Sess. (Cal. 2023); see also, e.g., Cal. Leg., Joint Informational

Virginia updated its EHB benchmark plan for plan year 2025, revising definitions related to coverage for medical formula and certain prosthetic devices.³³ The Virginia State Corporation Commission (SCC) Bureau of Insurance (BOI) selected the current benchmark plan following a directive from the Virginia General Assembly.³⁴

All of these states approached the process of updating their EHB benchmark plans in different ways. Some updates were the result of legislation. Others were the result of a state agency identifying an unmet health need within the state and addressing it. Some benefits were codified in statute or regulation following the approval of the updated plan. But they all have something in common: it is impossible to tell, based on the proposed regulatory text, which of these approaches is “state action” that would render these new or expanded benefits subject to defrayal. It is therefore imperative that HHS clarify the meaning of “state action” in any adopted regulatory text.

The proposed defrayal requirement will increase health care costs, erode the value and comprehensiveness of ACA coverage, limit the reach of important consumer protections, and create significant burden for states. Imposing such onerous defrayal requirements on states will also prevent them from being flexible in addressing the health needs of their residents.

HHS claims that the current policy surrounding defrayal drives up premiums, increases federal spending on APTCs, and discourages enrollment by unsubsidized enrollees.³⁵ Although HHS offers no evidence to support this specific assertion, it is true that the cost of health care is a matter of great public concern. A recent survey found that the cost of health care was the most significant of the public’s “economic anxieties,” ranking higher than other cost concerns such as

Hearing Assembly and Senate Health Committees 2027 Essential Health Benefits Benchmark Options 6-8 (Feb. 11, 2025), <https://ahea.assembly.ca.gov/system/files/2025-02/ehb-background-feb-11-2025.pdf> (collecting examples of introduced coverage mandates). The coverage mandate is conditioned on HHS approval of California’s updated EHB benchmark plan. Cal. Ins. Code § 10112.27(a)(2)(E) (2026), Cal. Health & Safety Code § 1367.005 (2026).

³³ See CMS, Virginia EHB Benchmark Plan (2025–2027) (2023).

³⁴ 2023 Va. Acts 272 (directing the BOI to select a new benchmark plan that includes coverage for prosthetic devices and medical formula); *see also* Va. Code Ann. § 38.2-3418.18 (coverage for formula and enteral nutrition products as medicine), Va. Code Ann. § 38.2-3418.15 (coverage for prosthetic devices and components), Va. Code Ann. § 38.2-3418.15:1 (clarification of prosthetic coverage). Additionally, beginning in 2025, the Virginia Health Insurance Reform Commission (HIRC) and BOI must review the state’s benchmark plan every five years. Va. Code Ann. § 30-343.1.

³⁵ 91 Fed. Reg. 6292, 6333.

food and housing by a wide margin.³⁶ The expiration of enhanced premium tax credits (EPTCs) has only exacerbated the problem for ACA enrollees, with premiums up over 20 percent in 2026³⁷ and increases in net premium costs exceeding \$1,000 per year, on average.³⁸ In response, many ACA enrollees are opting for less comprehensive plans that may be cheaper upfront but carry much higher limits on out-of-pocket spending, increasing their overall cost of care.³⁹ And in terms of discouraging enrollment, the expiration of enhanced ACA subsidies has resulted in widespread coverage loss, with ACA enrollment for 2026 down by over 1 million people from 2025 figures.⁴⁰

Implementing this new defrayal requirement is no way to address the public's legitimate affordability concerns. Widely designating benefits to be "in addition to EHB" as the proposed amendment contemplates will actually make coverage less affordable because many financial protections for Marketplace enrollees—such as bans on dollar limits, caps on annual out-of-pocket costs, and the use of premium tax credits—only apply to EHBs.⁴¹ This proposed requirement will also render ACA coverage less valuable by limiting the benefits that QHPs must cover.

Moreover, if HHS is legitimately concerned about low enrollment among any group of people, the appropriate response is not to make coverage more expensive and less comprehensive. Instead, HHS should work to reinstate the enhanced subsidies that drove historically low numbers of uninsured and continue permitting states the flexibility to improve the value of ACA coverage.⁴² Preserving this flexibility is particularly important to combat low enrollment in light of the fact that subsidy amounts are tied to the premium cost of EHBs and cannot be used to pay for benefits in addition to EHB.⁴³ If fewer benefits are considered EHB, it will diminish the

³⁶ Shannon Schumacher et al., Kaiser Fan. Found., *KFF Health Tracking Poll: Health Care Costs, Expiring ACA Tax Credits, and the 2026 Midterms*, KFF (Jan. 29, 2026), <https://www.kff.org/public-opinion/kff-health-tracking-poll-health-care-costs-expiring-aca-tax-credits-and-the-2026-midterms/>.

³⁷ John Holihan et al., *Understanding the Extraordinary Increase in ACA Premiums in 2026*, Urban Inst. (Dec. 2025), https://www.urban.org/sites/default/files/2025-12/Understanding%20the%20Extraordinary%20Increase%20in%20ACA%20Premiums%20in%202026_1217.pdf.

³⁸ Justin Lo, et al., *Premium Payments if Enhanced Premium Tax Credits Expire* (KFF Sept. 19, 2025), <https://www.kff.org/affordable-care-act/premium-payments-if-enhanced-premium-tax-credits-expire/>.

³⁹ Reed Abelson, *New A.C.A. Plans Could Increase Family Deductibles to \$31,000*, N.Y. Times (Feb. 26, 2026), <https://www.nytimes.com/2026/02/26/health/obamacare-health-insurance-rollbacks.html>.

⁴⁰ Abelson, *supra*.

⁴¹ 42 U.S.C. §§ 300gg-11, 18022(c); 45 C.F.R. § 147.126.

⁴² HHS, *Health Coverage Under the Affordable Care Act: Current Enrollment Trends and State Estimates*, Off. of the Assistant Sec'y for Plan. & Evaluation (Mar. 22, 2024), <https://www.ncbi.nlm.nih.gov/books/NBK610896/>.

⁴³ 26 U.S.C. § 36B(b)(3)(D).

amount of financial assistance available to Marketplace enrollees generally, risking depressing enrollment even further.

HHS’s framing of current defrayal policy as one that “jeopardize[s] the affordability of premiums” for an “intangible improvement” in states’ understanding of defrayal requirements is also misleading.⁴⁴ Even if it was true that the crux of the issue is the extent to which states “understand” defrayal requirements, ensuring that they *do* understand those requirements empowers states to establish benefits and develop coverage in a way that serves their residents—including increased access to care, lower costs (such as limits on cost-sharing and out-of-pocket spending), and nondiscrimination protections that do not apply to benefits in addition to EHB. However, the issue here is more fundamental: increased EHB flexibility allows states to offer better, more robust coverage, unhampered by the monetary cost of defrayal.

The cost to states of this proposed change also cannot be understated. More than a dozen states have updated their EHB benchmark plans since the promulgation of 45 C.F.R. § 156.111 in the 2019 NBPP, at great effort and significant cost.⁴⁵ Forcing states to undo these changes to avoid defrayal will mean those resources were wasted. Additionally, states will have to expend additional effort to address existing coverage mandates that have been enshrined in law or regulation and deal with the confusion that this policy change would generate in terms of states’ responsibilities. Finally, HHS has recognized in the past that making care less effective by weakening EHB standards will result in “spillover effects,” which includes increased use of costly emergency services and additional burden on government-funded or safety-net providers.⁴⁶

For these reasons, we strongly urge HHS not to move forward with the proposed amendment to 45 C.F.R. § 155.170(a). However, if HHS does amend the regulation as proposed, we believe the amendment should 1) include further clarification in the regulatory text regarding what constitutes “state action,” and 2) be delayed to 2028 to allow states adequate time to adjust.

§§ 155.205(b) and 155.221(k) – State Based Exchange “Enhanced Direct Enrollment” (SBE-EDE) Option

⁴⁴ 91 Fed. Reg. 6292, 6333.

⁴⁵ For instance, Oregon spent more than \$164,000 on working with an actuarial firm for the required valuation report when the state updated its EHB benchmark plan for plan year 2022. *State Agency Contract and Procurement*, Or. Transparency, <https://www.oregon.gov/transparency/pages/contracts.aspx> (last visited Feb. 26, 2026).

⁴⁶ 82 Fed. Reg. 51052, 51131.

We oppose the rescission of § 155.205(b) and the proposed new section § 155.221(k). These changes would permit SBEs to privatize consumer-facing eligibility and enrollment functions by opting into a new SBE-EDE model. This proposal is contrary to statute, imposes significant oversight burden on the state without improving access to coverage or consumer shopping experience, and raises serious program integrity concerns.

The SBE-EDE option is contrary to law. If finalized, the proposed rule would allow an SBE to impermissibly outsource the inherently government functions of an Exchange to a private, non-Exchange entity in violation of multiple sections of the ACA. HHS's proposal is based on a selective and incomplete reading of the statute and fails to identify a source of authority for the agency to take regulatory action to undermine key statutory requirements.

The ACA clearly defines an Exchange as a "governmental agency or nonprofit entity that is established by a state".⁴⁷ By allowing a "non-Exchange entity" to stand in the shoes of the Exchange for purposes of consumer-facing plan selection and enrollment functions, the SBE-EDE proposal substitutes a web broker for the Exchange in clear violation of the ACA. HHS claims that the elevated role of a web broker under the SBE-EDE option is similar to the relationship between SBEs and private contractors that a state may have engaged to support operations of an Exchange website today. But there is a fundamental difference between an Exchange that hires a contractor to carry out certain technical functions at the direction of the Exchange, and for which the Exchange is still ultimately accountable, and the SBE-EDE option that would permit the state to cede consumer-facing enrollment to private entities.

The ACA is clear that an Exchange is required to, among other functions, actually *offer* qualified health plans to prospective enrollees; that is, provide individuals with an opportunity to enroll in coverage. HHS incorrectly asserts that an Exchange electing the SBE-DE option can meet this requirement by maintaining "a website listing basic QHP information for comparison, and a listing with links to approved partner websites for consumer shopping, plan selection, and enrollment activities."⁴⁸ While the statute indeed requires an Exchange to maintain such an informational website with "standardized comparative information" on QHPs, this is just one of several statutory Exchange requirements.⁴⁹ Of particular relevance, 42 U.S.C. § 13031(d) establishes certain Exchange "Requirements." Under the subheading "Offering of Coverage," at § 13031(d)(1), these requirements include that the Exchange "shall *make available* qualified health plans to qualified individuals and qualified employers" (emphasis added). HHS aims to reinterpret this language as a mere suggestion – claiming that an Exchange that "minimally

⁴⁷ 42 U.S.C. § 13031(d)(1).

⁴⁸ 2027 NBPP NPRM at 6331.

⁴⁹ 42 U.S.C. § 13031(d)(4)(c).

operates” an informational website that directs consumers to private sellers will meet statutory requirements. But that is simply not what it means to “offer insurance” or make coverage “available,” either elsewhere in the ACA, as previously interpreted by HHS or HHS of the Treasury, or in the common parlance of the insurance industry.⁵⁰

Section 36B(b)(2)(A) of the Internal Revenue Code, as added by section 1401 of the ACA, requires individuals to enroll in coverage “through an Exchange” in order to be eligible for PTCs. HHS explains that it has previously interpreted this language to permit enrollment directly through a QHP issuer or agent, broker, or web broker provided the non-Exchange entity meets relevant regulatory guardrails. But these very guardrails are premised on the existence of an independent, trusted platform through which the Exchange itself offers coverage.⁵¹ Enrolling in a plan through a web broker in a state where there is no Exchange enrollment option can never be “through an Exchange” as required by statute.

The SBE-EDE proposal is inconsistent with Medicaid law and would harm people who are eligible for Medicaid. Medicaid includes independent requirements for “no wrong door” application processes and other coordination standards that conflict with the privatized system

⁵⁰ See, e.g., 42 U.S.C. 300gg-1 (“Guaranteed Availability of Coverage”) and numerous interpretive HHS guidance documents including *Frequently Asked Questions on Health Insurance Market Reforms and Marketplace Standards*, Question 5 (May 16, 2014), <https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/downloads/final-master-faqs-5-16-14.pdf>; *Frequently Asked Questions on Health Insurance Market Reforms and Marketplace Standards* (June 3, 2014), https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/downloads/faq_on_qhps_and_guaranteed_availability_6314.pdf; *Frequently Asked Questions on Agent/Broker Compensation and Guaranteed Availability of Coverage* (June 7, 2022), <https://www.cms.gov/files/document/agent-broker-compensation-and-guaranteed-availability-coverage.pdf>; 42 U.S.C. §§ 13031(d)(2)(B)(ii) (“Offering of Stand-Alone Dental Benefits”) and 18053 (“Provisions Relating to Offering of Plans in More Than One State”) and 26 U.S.C. § 125(f)(3) (“Offering of Exchange-Participating Qualified Health Plans Through Cafeteria Plans”), which all use the phrase “offering of” plans to refer to making plans available for enrollment; Department of the Treasury, Internal Revenue Service, *Questions and answers on employer shared responsibility provisions under the Affordable Care Act*, Question 29, <https://www.irs.gov/affordable-care-act/employers/questions-and-answers-on-employer-shared-responsibility-provisions-under-the-affordable-care-act> (“In general, an [applicable large employer] makes an offer of coverage to an employee if it provides the employee an effective opportunity to enroll in the coverage (or to decline that coverage) at least once for each plan year.”); and Wellpoint, *The Health Insurance Exchange: Navigating on-exchange vs. off-exchange health plans*, <https://www.wellpoint.com/individual-family/learn/on-exchange-vs-off-exchange> (“On-exchange health insurance is coverage that you purchase through the Health Insurance Marketplace or your state-run exchange...Many insurers like Wellpoint often offer both on-exchange and off-exchange health plans”).

⁵¹ See, e.g., 45 C.F.R. § 156.1230(a)(1)(iv) (requiring that a QHP issuer conducting direct enrollment inform “all applicants of the availability of other QHP products offered through the Exchange through an HHS-approved universal disclaimer and displa[y] the Web link to and describes how to access the Exchange Web site”; 45 C.F.R. § 155.220(c)(3)(i)(F) (requiring that if a web-broker’s own website is used to complete the QHP selection, the website must “[p]rovide consumers with the ability to withdraw from the process and use the Exchange Web site...at any time”).

proposed under the NBPP.⁵² The SBE-EDE proposal would render it impossible for a State Exchange to meet its obligations under the ACA and the Social Security Act to effectuate a streamlined enrollment process into the full range of health subsidy programs, including Medicaid, CHIP, and the Basic Health Program along with Marketplace insurance affordability programs like Premium Tax Credits and Cost-Sharing Reductions.⁵³ In the preamble to the 2027 NBPP NPRM, HHS sketches out a patchwork set-up through which a non-Exchange entity such as a private web broker could theoretically transfer information from its commercial website to the Exchange for eligibility determinations and referrals to the appropriate agency, such as the State Medicaid agency.⁵⁴ But this approach fails to meet the requirements under the law to provide a streamlined application and enrollment experience. When people who are eligible for Medicaid or other programs initially seek coverage using a Direct Enrollment or Enhanced Direct Enrollment pathway today, they do so in the context of being able to default to a fully-functioning, compliant Exchange website. Even so, there have been reports of misleading or confusing practices by web brokers with respect to individuals who are determined eligible for Medicaid. While unacceptable, this behavior is hardly surprising, given that brokers affiliated with commercial insurance issuers have no financial incentive to appropriately direct eligible individuals to Medicaid coverage, which provides no revenue to the non-Exchange entities.⁵⁵ Stripping the Exchange of its obligation to provide a single, streamlined enrollment experience for all consumers – whether they are eligible for Marketplace, Medicaid, CHIP, or BHP coverage – would exacerbate these effects. Allowing non-Exchange entities to serve as the exclusive pathway for Marketplace enrollment while maintaining a separate eligibility and enrollment pathway for Medicaid, CHIP, and other health programs clearly deprives consumers of the “streamlined” process required by the ACA. Such a system clearly fails to comply with the intent of the ACA to ensure that individuals seeking coverage can rely on an Exchange-supported “one stop shop”.

The SBE-EDE proposal appears to revive aspects of a policy initially finalized in the 2022 NBPP. Under that policy, HHS would have permitted both SBE and FFE states to replace the relevant Exchange with a decentralized system fully reliant on issuers, agents, and brokers. This so-called

⁵² See 42 U.S.C. § 1396w-3 and 42 C.F.R. § 435.1200.

⁵³ See 42 U.S.C. § 1396w-2(b)(1)(a) (requiring a state to establish procedures for “enabling individuals, through an Internet website that meets the requirements of paragraph (4)” to apply for and enroll in Medicaid; § 1396w-2(b)(4), “Enrollment Website Requirements,” requiring that the website referenced in (b)(1) must be “linked to any website of an Exchange established by a State under section 1311 of [the ACA]” that allows an individual to compare Medicaid and QHP coverage options (emphasis added).

⁵⁴ 2027 NBPP NPRM at 6329.

⁵⁵ Tara Straw, “Direct Enrollment” in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm (March 15, 2019), Center on Budget & Policy Priorities, <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>,

“Exchange Direct Enrollment” plan was never implemented and was ultimately reversed in subsequent rulemaking after HHS concluded that the program posed unacceptable risks to consumers and the strength of the ACA.⁵⁶ This proposal closely mirrored a 1332 waiver to establish the Georgia Access Model, allowing Georgians to enroll in coverage through a decentralized system of private brokers and issuers.⁵⁷ In its waiver approval letter, HHS explicitly waived §§ 1311(b)-(e) and (i) of the ACA, suggesting that these are statutory requirements that Georgia was required to pursue a formal waiver to pursue. The 1332 waiver process, set out in statute, importantly includes multiple opportunities for public comment and individualized negotiation and approval between a state and HHS.⁵⁸ Not only does the current SBE-EDE proposal attempt an end-run around multiple statutory requirements, in conflict with the precedent set in the Georgia 1332 program, it would allow a state to effectively waive statutory requirements with no public input or transparent process. Consumers would essentially be forced to enroll in coverage through a fragmented and privatized system at the discretion of the state, with no opportunity to voice their concerns or review the state’s proposal in advance.

The SBE-EDE option prioritizes the business interests of private web brokers to the detriment of consumers and states. The benefit of the SBE-EDE option to non-Exchange entities operating as web brokers is clear: by allowing a web broker to control the consumer-facing plan comparison, selection, and enrollment processes, these private entities can control the consumer “shopping” experience and steer individuals to products that are most profitable for the web broker, including non-QHP products.

By allowing non-Exchange entities to operate the consumer-facing enrollment experience, the SBE-EDE option selectively permits an Exchange to offload one key statutory function. But an Exchange operating in an SBE-EDE state would not only continue to be required to implement its other statutory functions, such as plan management; operating a centralized “back-end” eligibility and enrollment system; collecting and maintaining enrollment records and transmitting such enrollment information to HHS and the IRS; and providing consumer support services in the form of a call center and a Navigator program, it would also be required to take on burdensome new responsibilities. These responsibilities include developing and implementing standards for consumer-facing non-Exchange websites to “interface”

⁵⁶ 86 Fed. Reg. 53412, 53424-53429 (Sept. 27, 2021).

⁵⁷ See State of N.Y. Office of the Att’y Gen. and 22 other State Attorneys Gen’l, Comments regarding Proposed Rule, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations, 85 Fed. Reg. 78,572 (Dec. 4, 2020), RIN 1505-AC72 and RIN 0938-AU18 (Dec. 30, 2022), <https://www.regulations.gov/comment/CMS-2020-0151-0311>.

⁵⁸ 42 U.S.C. § 18052(a)(4).

appropriately with the Exchange-run eligibility and enrollment processes, maintaining a website with QHP comparison information and links to non-Exchange shopping and enrollment websites; and creating and implementing an oversight structure for ongoing monitoring of non-Exchange entities. These additional costs are likely to be extensive; HHS notes that the only state that has initiated an SBE while implementing an EDE option incurred \$25 million in startup costs.⁵⁹ While HHS optimistically claims that “any savings achieved through a decrease in call center volume or other consumer supports due to EDE partners assisting consumers with enrollment would offset any operational costs” it provides no evidence to support this assertion, or data to project ongoing maintenance and operations costs to the state.

The proposal would harm individuals and families seeking Marketplace coverage. Although HHS states that an aim of the SBE-EDE proposal is to “enhance the consumer enrollment experience,” replacing an Exchange consumer-facing website with one or more non-Exchange entities offers no meaningful benefit to consumers compared to the status quo. While HHS does not estimate the potential burden on consumers that would be forced to vet multiple non-Exchange entities to obtain coverage in a state that elects the SBE-EDE option, research shows that consumers find enrolling in coverage is time-consuming, confusing, and frustrating, particularly for consumers with low health insurance literacy or limited English proficiency.⁶⁰ Removing the requirement that an Exchange provide a centralized, vetted enrollment experience that allows individuals to compare, select, and enroll in coverage in one verified location will only exacerbate the time burdens associated with selecting Marketplace coverage.

Additionally, private web brokers have little incentive to support consumers with greater needs whose cases are likely to require more resources with no guarantee of providing greater compensation – for example, low-income and rural households who do not have reliable Internet access and require in-person assistance, those with limited English proficiency, people with disabilities, or households with complex or mixed program eligibility such as families where some members are eligible for Medicaid. Navigating multiple EDE websites is likely to be particularly challenging for these households. Unlike Navigators, web brokers are not required to provide targeted assistance to underserved populations, offer unbiased information such as recommending a plan that does not financially benefit them even when it is in the best interest

⁵⁹ 2027 NBPP NPRM at 6446.

⁶⁰ See Kakar, R., *Health Insurance Literacy Perceptions and the Needs of a Working-Class Community*, HEALTH LITERACY RES. AND PRAC. (March 31, 2022), <https://pmc.ncbi.nlm.nih.gov/articles/PMC8973763>; Faugano, E., et al., “Pick a Plan and Roll the Dice”: A qualitative study of consumer experiences selecting a health plan in the non-group market, HEALTH POLICY OPEN (Dec. 15, 20203), <https://doi.org/10.1016/j.hpopen.2023.100112>; Hero, J., et al., *Decision-Making Experiences of Consumers Choosing Individual Market Health Insurance Plans*, HEALTH AFF., Vol. 30, No. 3 (March 4, 2019), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05036>.

of an individual seeking coverage, or acknowledge other health programs like Medicaid.⁶¹ Permitting an SBE-EDE option will make the process of comparing and enrolling coverage options more difficult for these households, increasing the risk that are unable to enroll in the most appropriate and affordable health coverage for which they are eligible.

Outsourcing consumer-facing plan selection and enrollment to non-Exchange entities as proposed in the 2027 NBPP NPRM raises significant program integrity concerns. First, web brokers have no fiduciary duty under the proposed rule to ensure that a household can enroll in the plan option that is best for them. As noted above, these entities have no financial incentive to ensure that an enrollee who is eligible for Medicaid, CHIP, or a BHP is successfully connected to that type of coverage. Rather, these entities are motivated by profit to steer as many consumers as possible to the products that represent the biggest commission or other compensation for them. Often, the most lucrative products for issuers and brokers alike are not QHPs at all, but short-term plans and other junk insurance that offer few consumer protections, weaken the individual market risk pool, but offer broker commissions up to ten times higher than those for comprehensive coverage.⁶² Although we appreciate that HHS would require an SBE-EDE to ensure that at least one EDE entity meets requirements under §§ 155.220(c)(3)(i)(A) and (D) to ensure consumers have at least one option through which to view detailed QHP information for all available QHPs and meets accessibility requirements under § 155.205(c), these requirements should apply to all EDEs offering QHPs under an SBE-EDE option, as the current proposal would not prevent other EDEs from presenting a more limited selection and does not guarantee that any EDE would display plans offered by issuers with whom they have financial ties on equal footing with those with whom they have no relationship.

In addition to the direct risks that consumers will face when deprived of a centralized, Exchange-operated option for enrolling in coverage, the SBE-EDE option weakens oversight over web brokers in a way that appears strikingly at odds with HHS's stated program integrity concerns elsewhere in the rule. According to HHS, "a notable driver of ... continued payment integrity concerns...is agent, broker, and web-broker behavior" and cites to both a 2025 GAO study on improper payments and "recently identified internal data" that nearly 80% of income-related data matching issues (DMIs) in 2024 were triggered for households working with agents, brokers, or web brokers.⁶³ From June 2024 to October 2024, the Centers for Medicare

⁶¹ See 45 C.F.R. § 155.210(e).

⁶² See, e.g., Government Accountability Office, *Private Health Coverage: Results of Covert Testing for Selected Offerings* (Aug. 24, 2020), <https://www.gao.gov/assets/gao-20-634r.pdf>; Katie Keith, HEALTH AFF., *New Congressional Investigation of Short-Term Plans* (June 26, 2020), <https://www.healthaffairs.org/doi/10.1377/forefront.20200626.227261/full/>.

⁶³ 2027 NBPP NPRM at 6348.

& Medicaid services suspended over 850 agents and brokers' Marketplace Agreements for reasonable suspicion of fraudulent or abusive conduct related to unauthorized enrollments or plan switches.⁶⁴ These issues are of such "urgent" concern to HHS that it has re-proposed burdensome income verification requirements that are currently stayed by a federal court and that, if finalized, would generate 3.3 million data matching issues (DMIs) per year at a cost of over \$122 million to the FFE, \$75 million to State Exchanges, and \$83 million to consumers.⁶⁵ And yet, HHS is poised to allow states to hand the keys to consumer enrollment to the same entities that it believes are driving significant fraud. Moreover, it would do so without any significant changes to monitoring and oversight, despite the novelty of the SBE-EDE option, stating that any additional oversight costs to the federal government would be "nominal" because it would largely rely on states to act as primary overseers of EDE entities while HHS "leverage[s] its existing State Exchange oversight mechanisms"⁶⁶ – identified in the preamble as annual SMART submissions, some unspecified technical assistance, and "ongoing informal communication" with states implementing the new option. This approach appears unwise and contradictory if HHS is urgently concerned about fraud perpetuated by agents, brokers, and web brokers. Merely continuing the same oversight approach while vastly expending the power of these entities to control the consumer enrollment experience would place consumers in an even more vulnerable position, particularly individuals with low health insurance literacy, limited English proficiency, or those living with disabilities.⁶⁷

As noted elsewhere in these comments, we do not believe that the SBE-EDE option is legally permissible, nor is it in the best interest of consumers or states. Given HHS's concerns related

⁶⁴ Ctrs. for Medicare & Medicaid Svcs., Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity (Oct. 17, 2024), <https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity>.

⁶⁵ *City of Columbus v. Kennedy*, 796 F. Supp. 3d 123, 168-170 (D. Md. 2025); 2027 NBPP NPRM. at 6431-6432.

⁶⁶ *Id.* at 6447.

⁶⁷ HHS states that "the State Exchange, along with its EDE partners, would continue to be responsible for meeting Federal accessibility standards under § 155.205(c) for individuals living with disabilities and for individuals who have limited English proficiency," but its citation to support this statement includes an inaccurate statement of the scope of the application of § 1557 of the ACA. In fn. 78, HHS states that "[C]overed entities such as States, recipients of Federal financial assistance from HHS, programs *or activities administered by HHS under title I of the Affordable Care Act (such as the FFE)*, and programs or activities administered by any entity established under Title I (such as State Exchanges) must comply with applicable Federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, sex, age, and disability. These laws include section 1557 of Affordable Care Act (42 U.S.C. 18116) (Section 1557), Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) (Title VI), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) (Section 504), and the Americans with Disabilities Act of 1990 (29 U.S.C. 12101 et seq.) (ADA)" (emphasis added). The italicized portion of this statement vastly understates the scope of the application of section 1557 of the ACA, which applies to *all* health programs and activities administered by HHS, not just those programs and activities established under title I of the ACA. 42 U.S.C. 18116(a); and see 89 Fed. Reg. 37522, 37528 (May 6, 2024). we urge HHS to correct this inaccurate statement of the scope of § 1557 in the final rule.

to web brokers, we also strongly recommend against finalizing the SBE-EDE proposal on program integrity grounds. If HHS finalizes the proposal despite these concerns, we would strongly recommend delaying the effective date until January 1, 2029, rather than the proposed January 1, 2028, effective date.

§ 155.220(j) – Revised Federally-Facilitated Exchange standards of conduct

We oppose HHS’s proposed amendment to § 155.220(j)(2)(i), which articulates nondiscrimination requirements among the standards of conduct that individuals who assist with or facilitate health insurance enrollment must meet. HHS proposes to strike a parenthetical clarifying that prohibited sex discrimination includes discrimination based on sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes, erroneously claiming the text at issue addresses “ancillary issues of gender ideology.” We urge HHS to maintain this regulatory text, which protects consumers, and particularly women (including those who are pregnant) and LGBTQI+ people, from consequential barriers to health insurance.

Brokers, agents, and web-brokers exercise significant gatekeeping power in plan selection, benefit design, and access to enrollment assistance. Without explicit regulatory language clarifying prohibited grounds of sex discrimination, discriminatory steering, misinformation, and hostile treatment can persist under the guise of professional discretion or market practice, widening sex-related health inequities. The parenthetical at issue provides covered entities with notice of prohibited grounds of sex discrimination. For example, without this clarification, brokers or agents may steer men to more generous plans and women to less generous ones due to sex stereotypes about costs. An agent or broker may discriminatorily steer women to plans with the most robust pregnancy-related coverage without whether they wish to have more children or want to prioritize other services based on the stereotype that a woman’s most important societal role is to have children. They may refuse to answer questions about pregnancy-related coverage for people who are in same-sex marriages. They may turn people away based on gender identity, gender-affirming care needs, or past reproductive decisions. If brokers advise employers, they may recommend plan designs that limit pregnancy-related coverage to discourage the retention of staff who wish to become pregnant. In short, retaining the parenthetical on prohibited sex discrimination grounds in the regulatory text is essential both to place covered entities on notice regarding their obligations and to support meaningful enforcement of § 1557 of the Affordable Care Act in a health insurance context.

The proposal to amend §§ 155.220(j)(2)(A) and (j)(3)(A) to require agents, brokers, and web-brokers to use the HHS-approved and -created consumer consent form (“HHS consent form”) to

meet eligibility application review documentation criteria and consent document requirements has significant advantages. We urge HHS to ensure that the standardized consent form is accessible to all consumers, including people with disabilities, limited literacy, or limited English proficiency.

Agents, brokers, and web-brokers facilitate a significant percentage of Marketplace enrollments, but have been identified as a primary source of fraudulent enrollments and plan switches made without enrollee consent.⁶⁸ HHS requires agents and brokers facilitating enrollment on the FFE to document that an applicant for coverage has reviewed an application and consented to its submission by the agent, broker, or web-broker.⁶⁹ However, HHS permits this consent to be obtained and documented in a wide range of formats, including in person via unique paper forms, electronically, by telephone including by recorded telephone messages, and by text. In the 2027 NBPP NPRM, HHS describes documentation reviews that identified widespread instances of noncompliance, such as documents with missing information, as well as consent forms that were unclear.⁷⁰ It is reasonable for HHS to standardize a single form that can be provided in person or electronically to obtain and document compliance with these requirements to facilitate consistent recordkeeping and audits.

However, the current model form falls short of being accessible to all consumers. A form that is overly complex, inaccessible to a person with a disability, or illegible because it is provided in a language in which the applicant is not fluent, can result in direct consumer harm. For example, a consumer could unknowingly consent to the submission of inaccurate household income information that results in under- or over-payment of APTC, resulting in a higher premium payment than necessary or a significant tax liability in the following year.

To ensure that the mandatory consent form is accessible to all consumers, it is essential for HHS to conduct consumer focus testing, including testing by people with disabilities and limited English proficiency. Language in the form should be revised to reflect the results of this focus

⁶⁸ Jalen Brown, *CCIIO Chief Says Fraud Crackdown Removed 1.5M From Subsidies, Saved Nearly \$10B*, INSIDE HEALTH POL'Y (Feb. 23, 2025) (quoting CCIIO official statement that over 75% of enrollments were completed by an agent or broker during the 2026 Open Enrollment Period); Ctrs. for Medicare & Medicaid Svcs., Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity (Oct. 17, 2024), <https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity>; GAO, Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist (Dec. 3, 2025), <https://www.gao.gov/products/gao-26-108742>; Ctrs. for Medicare & Medicaid Svcs., Marketplace Compliance for Agents and Brokers (Aug. 28 2025), <https://www.cms.gov/files/document/marketplace-compliance-agents-and-brokers.pdf>.

⁶⁹ 45 C.F.R. § 155.220(j)(2)(ii).

⁷⁰ 2027 NBPP NPRM at 6336.

testing as well as in consideration of low literacy levels. HHS should translate the form into at least the top 15 languages in each state and make all translations freely accessible online so that agents, brokers, and web-brokers can immediately access the appropriate form as needed for a particular consumer. HHS should also ensure that forms provide standardized but state-specific consumer support information. Each form should provide information alerting consumers to free, unbiased enrollment assistance through Navigators and prominently display the state Exchange website URL and the telephone number for the Exchange consumer call center. Finally, the form should include contact information for state's Department of Insurance or equivalent regulator of agents, brokers, and web-brokers to report questions or concerns.

In §255.220(j)(3), we broadly support the proposed restrictions on misleading or fraudulent marketing by agents, brokers, and web-brokers. We appreciate the codification of marketing standards of conduct, including a non-exhaustive list of prohibited practices, and agree that it is necessary for HHS to increase its monitoring of social media sites and other sources to address misleading marketing by agents, brokers, and web-brokers.

In addition to the examples of misleading marketing proposed at § 155.220(j)(3)(iii), we recommend adding language that would clearly prohibit agents and brokers from marketing health coverage that is not a QHP in a manner that could be construed to conflate these products with comprehensive coverage. It is vital that consumers can distinguish between QHPs, which are subject to federal consumer protections and are eligible PTCs and cost-sharing reductions, and other forms of coverage, such as catastrophic health plans, fixed indemnity coverage, and short-term, limited duration insurance. Agents and brokers should be prohibited from marketing non-comprehensive coverage in a manner that could mislead a consumer into thinking that such coverage is a qualified health plan or offers coverage that is equivalent to a qualified health plan. We recommend amending § 155.220(j)(3)(iii) by adding the following language as a new sub-paragraph (j)(3)(iii)(H): “(H): Marketing health coverage that is not a qualified health plan in a manner that could be construed to conflate these products with comprehensive coverage.”

§ 155.305(f)(4) – Failure to File Taxes and Reconcile APTC Process

HHS does not have authority to require any failure to reconcile (FTR) process until the 2028 plan year.⁷¹ *City of Columbus v. Kennedy* held that the FTR process generally was contrary to

⁷¹ *City of Columbus v. Kennedy*, 796 F. Supp. 3d 123, 160-63 (D. Md. 2025), *appeal pending* (4th Cir. 2025) (No. 25-2012). The court found that “[t]he statute does not contemplate that the existence of a prior tax debt affects an applicant’s eligibility for APTCs in any way”; that Congress knew how to condition issuance of coverage on payment

statute because eligibility for APTCs is not conditioned on reconciling tax information and HHS cannot add conditions to the express statutory formula for APTCs.⁷² While the reconciliation of tax credits is required, the only current statutorily required outcome is that the individual will face increased taxes for that year.⁷³ Although OBBA puts the 1-tax year policy from the 2025 Marketplace Integrity and Affordability Final Rule as a condition of a “coverage month”, the use of a 1-year tax FTR policy does not begin until 2028 tax year. *City of Columbus* stayed the effective date of not only the 2025 1-tax year FTR policy, but also the failure to reconcile policy generally under 45 C.F.R. 155.305(f)(4).⁷⁴ Therefore, although we comment on the 1- versus 2-tax year FTR policy below, we strongly recommend that HHS stay consequences from a consumer’s failure to reconcile their taxes until the 2028 tax year, given the analysis in *City of Columbus*.

The proposed rule allows an option to use either a 1- or 2-tax year FTR policy for Plan Year (PY) 2027 and the 1-tax year policy for PY2028 and beyond. The one tax year policy is harmful to those who rely on APTCs for health coverage. HHS relies on the policy position that “the overriding policy need for the Federal Exchange is to be able to remove unauthorized enrollments from the Marketplace” and therefore the 1-tax year FTR policy is the appropriate choice.⁷⁵ But this declaration of the policy need ignores that the purpose of the underlying statute is to provide health coverage and that there is significant risk to people being denied coverage under the 1-tax year FTR policy due to tax filing and process delays, confusion, and other concerns that have been well-documented in prior NBPP rulemakings and comment periods.⁷⁶ The failure to reconcile (FTR) process that ensures individuals receive the appropriate APTCs based on their tax filings has been an evolving process since 2017 as the relevant departments dealt with the intricacies of delayed tax data; privacy requirements of tax filers and providing notice to APTC recipients; notice requirements that comply with due process; and consumer confusion. The 2-tax year FTR policy was based on reliable information about tax

of premiums, but did not do so; and that HHS general rule making authority did not allow it to re-write the statutory formula for APTCs. *Id.* at 162-63.

⁷² *Id.*

⁷³ 26 U.S.C. §26B(f)(2).

⁷⁴ *City of Columbus*, 706 F. Supp. 3d at 177.

⁷⁵ 2027 NBPP NPRM, *supra*, at 6344.

⁷⁶ Specifically, the 2-tax year proposal was based on HHS’s experience with a 1-tax year FTR process, under which there were significant delays in tax return processing, consumer and tax-preparer confusion, and significant costs associated with FTR-related appeals that could have been avoided with the two-year FTR status process. In addition, the process and notices of the existing FTR procedure would help protect against arbitrary actions by the government that affected benefits provided to individuals, as required by the Constitution. *See* 88 Fed. Reg. 25740, 25814-18 (Apr. 27, 2023); *see generally* TREASURY INSPECTOR GEN. FOR TAX ADMIN., 2024-406-020, THE IRS CONTINUES TO REDUCE BACKLOG INVENTORIES IN THE TAX PROCESSING CENTERS REPORT (2024), <https://www.tigta.gov/sites/default/files/reports/2024-03/2024406020fr.pdf> (describing significant delays in tax processing).

filing issues and a careful balance of the need to ensure those who are eligible for APTCs have access to them, limiting the tax liability individuals could accumulate, and limiting abuse of the policy by unscrupulous brokers or others. The correct balance is to prioritize access to coverage as those who need APTCs cannot reasonably purchase coverage without that assistance and later have tax credits apply after delays in tax filings or other issues that prevent coverage under the 1-tax year FTR policy are worked out. While allowing state-based exchanges to use the 2-tax year FTR policy helps those who rely on APTCs, we strongly recommend that the 2-tax year FTR policy apply across both state-based exchanges and the Federal Exchange so that everyone is under the same policy if the courts do not completely overturn FTR. Having separate policies across the country can generate significant consumer confusion.

§ 155.320 – Verification process related to eligibility for insurance affordability programs

HHS proposes to add new verification regulations at 42 C.F.R. § 155.320(c)(3)(ix). However, these appear to be duplicative and unnecessary. Existing regulations at 42 C.F.R. § 155.315(c)(2) already govern verification of immigration status for purposes of QHP eligibility.⁷⁷ Further, the statute requires that if information regarding immigration status “is verified” under the current procedures . . . “the individual’s eligibility . . . to apply for premium tax credits and cost-sharing reductions shall be satisfied.” 42 U.S.C. § 18081(e)(2)(A)(i). Thus, the agency cannot require an additional round of verification. The final rule should clarify that an individual’s immigration status need only be verified once.

Furthermore, the proposed verification regulations cross-reference the existing inconsistency process in § 155.315(f)(1)-(4), but do not cross-reference § 155.315(c)(3), which modifies the inconsistency process when the inconsistency relates to citizenship or immigration status. Under subsection (c)(3), the individual may *either* “provide satisfactory documentary evidence or resolve the inconsistency with the Social Security Administration or the Department of Homeland Security.” The inconsistency procedures at (f)(1)-(4) require that the individual supply satisfactory documentary evidence and do not give the individual the option to resolve the inconsistency with DHS or SSA. There are additional discrepancies between the two verification procedures: the current procedures require Exchanges to submit information to HHS, which in turn submits necessary information to DHS. *See* § 155.315(c)(2). The new proposed rule states that the Exchange must transmit the documentation to DHS directly and does not include the limitation to only transmitting “necessary” information. *See* § 155.320(c)(3)(ix). It is unnecessary and burdensome to require states to establish new data

⁷⁷ *See also* Ctrs. for Medicare & Medicaid Servs., Marketplace Verification of Citizenship and Immigration Status (Nov. 2021), <https://www.cms.gov/marketplace/agents-brokers/files/marketplace-verification-citizenship-immigration-status-webinar-s.pdf> (describing use of SAVE for current verification).

connections when existing procedures are sufficient to verify immigration status. Moreover, requiring new data sharing will further exacerbate concerns and chilling effect resulting from ongoing data sharing with immigration enforcement.

In short, if HHS insists on maintaining separate verification regulations, it should modify them so that they are identical.

§ 155.420(g) – Pre-enrollment Verification for Special Enrollment Periods

HHS proposes to amend § 155.420(g) to reinstate pre-enrollment verification requirements for individuals and families to enroll in special enrollment periods (SEPs). Specifically, HHS proposes to require individuals and families to verify eligibility for several SEPs (marriage, adoption, moving to a new coverage area, loss of MEC, and Medicaid/CHIP denials) in the federal marketplaces. The proposed rule would require federal marketplaces to conduct these pre-enrollment verifications for at least 75% of new enrollees.

HHS included similar policies in the 2025 Marketplace Integrity and Affordability Rule.⁷⁸ However, that rule included a provision that would have required these policies to sunset on December 31, 2026.⁷⁹ These provisions were stayed by a federal court in the *City of Columbus v. Kennedy* where the Court cited a lack of evidence to justify these policies.⁸⁰ As a result, these policies never took effect. HHS is now re-proposing the same policies, but without the sunset provision. We strongly disagree with these proposals and recommend that HHS withdraw this portion of the rule.

The burden of imposing pre-enrollment verification requirements on individuals and families seeking marketplace coverage outweighs HHS's concern about fraudulent enrollment and program integrity. SEP proof, like paperwork confirming an adoption or marriage, is often difficult to track down from government agencies. Paperwork requests from government agencies and county offices also take time to process and mail to the consumer. Once the individual submits their proof to their marketplace, incorrect information and errors in processing documents can cause delays in proving eligibility for the SEP. Multiple studies have shown that administrative burdens deter individuals from signing up for health coverage.⁸¹ These administrative barriers could delay or deter enrollment altogether.

⁷⁸ 90 Fed. Reg. 27074, 27223 (May 6, 2025).

⁷⁹ *Id.*

⁸⁰ *City of Columbus v. Kennedy*, 796 F.Supp.3d 123, 157-160 (2025).

⁸¹ See e.g., Jennifer Tolbert et al., Kaiser Family Found., *Key Facts About the Uninsured Population* (Dec. 18, 2024), <https://www.kff.org/uninsured/key-facts-about-the-uninsured-population/> (noting that over 20% of

Administrative burdens take a particularly heavy toll on Latinos and people in other historically marginalized communities. More frequent address changes mean notices are more often sent to the wrong place. Limited English proficiency and limited general literacy make notices harder to understand. Limited broadband access and internet fluency make it harder to provide information online. Long delays at call centers, which are sometimes particularly great when people call in languages other than English, make it hard to provide information and resolve challenges telephonically. And employment at low-wage jobs that do not allow time off for potentially lengthy visits to social services offices makes it harder to provide information and resolve challenges in person. Illustrating the impact of those factors, HHS found that, with Medicaid redeterminations from 2015-2016, 52% of Latino beneficiaries terminated from Medicaid were in fact eligible, compared to 40% of non-Hispanic whites, 44% of Asian Americans and Pacific Islanders, and 48% of African Americans.⁸²

It is well documented that the use of SEPs is grossly underutilized, so the additional administrative burden of pre-enrollment verifications will only further hinder marketplace enrollment. One study which relied on CMS data found that fewer than 15% of uninsured SEP eligible individuals enroll in coverage.⁸³ Consumers may not be enrolling due to factors including lack of awareness, affordability concerns, or because of the difficulty of the enrollment and SEP verification process.⁸⁴ Regardless, the underutilization of SEPs contributes to annual enrollment declines, which ultimately results in a higher uninsured rate. Individuals and families will only be more deterred from enrolling in marketplace coverage through SEPs if pre-enrollment verifications are mandated.

Further, requiring SEP pre-enrollment verifications will likely deter healthy individuals and families from enrolling when they are eligible for a SEP. Multiple studies have shown that

nonelderly adults listed difficulty and confusion in signing up for coverage as the reason they were uninsured) [hereinafter Tolbert, *Key Facts*]; Pamela Herd & Daniel Moynihan, Administrative Burdens in Health Policy 43 J. HEALTH & HUMAN SERVS. ADMIN. 3, 3-16 (2020) (particularly noting that those who are “least advantaged” are the most likely to face barriers in accessing coverage); Stan Dorn, Urban Inst., *Helping Enrollment Work Under the Affordable Care Act* (June 2016), <https://www.urban.org/sites/default/files/publication/81806/2000834-Helping-Special-Enrollment-Periods-Work-Under-the-Affordable-Care-Act.pdf>.

⁸² ASPE, Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches, August 19, 2022, <https://aspe.hhs.gov/sites/default/files/documents/dc73e82abf7fc26b6a8e5cc52ae42d48/aspe-end-mcaid-continuous-coverage.pdf>.

⁸³ Matthew Buettgens et al., *More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods*, Urban Inst. (Nov. 20, 2015), <https://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf>.

⁸⁴ Id.

administrative burdens disproportionately discourage younger, healthier people from signing up for health coverage.⁸⁵ In the 2023 Notice of Benefit and Payment Parameters final rule, CMS noted that younger, healthier consumers submit SEP verification requirements at much lower rates than older consumers.⁸⁶ This is in part why the 2023 final regulations removed SEP verification requirements for all SEPs except loss of minimum essential coverage (MEC) for new consumers.⁸⁷ HHS also acknowledges in the preamble to this proposed rule that this “policy may deter enrollments among younger people at higher rates, which could worsen the risk pool.”⁸⁸ Overall, imposing pre-verification requirements for more SEPs will negatively impact the risk pool and adversely impact premium rates.

These provisions also carry significant costs, both to consumers, and to the federal marketplaces. HHS states that the Department expects these policies will generate more than 293,000 SEP verification issues that will cost consumers more than \$7.3 million in 2027.⁸⁹ HHS also estimates that the processing costs associated with these provisions would be \$11.7 million annually in the federal marketplaces, and that labor costs would be close to \$3 million annually.⁹⁰

As noted earlier, we oppose these proposed changes and suggest that HHS withdraw this section. If HHS proceeds with requiring more extensive pre-enrollment verifications across marketplaces, we urge HHS to track and make publicly available data on how many individuals and families have incomplete enrollment applications because of a problem with their SEP verification. Prior CMS data indicates that implementing a pre-enrollment verification process decreases the already low enrollment numbers through SEPs, and we anticipate that this proposed provision will negatively impact enrollment numbers.⁹¹

§ 155.605(d)(1) – Expanding Access to Catastrophic Health Plans

⁸⁵ See, e.g., Mark Shepard and Myles Wagner, Nat’l Bureau Econ. Research, *Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment* (Working Paper No. 30781) (Dec.2022), <https://www.nber.org/papers/w30781>; Tolbert, Key Facts, *supra* (noting that over 20% of nonelderly adults listed difficulty and confusion in signing up for coverage as the reason they were uninsured).

⁸⁶ 87 Fed. Reg. 27208, 27278 (May 6, 2022).

⁸⁷ *Id.*

⁸⁸ 91 Fed. Reg. at 6452.

⁸⁹ 91 Fed. Reg. at 6452.

⁹⁰ *Id.*

⁹¹ U.S. Dept. of Health & Human Servs., *FAQs Regarding Verifications of SEPs* (Sept. 6, 2016), <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/FAQ-Regarding-Verification-of-SEPs.pdf>.

We oppose the proposal at 45 C.F.R. § 155.605(d)(1) to expand hardship exemption eligibility for catastrophic health plans. This proposal exceeds HHS's regulatory authority and attempts to implement a broad new eligibility category based on income levels that conflicts with the statutory framework for catastrophic health plan eligibility.⁹² Moreover, if implemented, this proposal would weaken the individual market risk pool while exposing potentially millions of enrollees to the documented financial and health risks of these bare-bones plans. Finally, HHS is acting with unwarranted haste, codifying guidance implemented in September 2025, without a complete understanding of the effects of the guidance on enrollees, given that full data on 2026 Open Enrollment will not be released for months.

HHS's proposal is a vast expansion of eligibility for catastrophic coverage that conflicts with the language and intent of the ACA. Congress established catastrophic health plans in the ACA to provide a source of comprehensive coverage to specific groups who were otherwise unlikely or unwilling to purchase a metal-tier plan. The statute creates two distinct pathways to eligibility: age and certified exemptions. The age criterion is broad and straightforward, allowing any individual under 30 to enroll in a catastrophic health plan.⁹³ The exemption pathway is narrower and more nuanced. In order to be eligible to enroll in a catastrophic health plan, an individual must be certified exempt from the requirement to maintain minimum essential coverage on the basis of affordability or hardship.⁹⁴ The affordability prong of the exemption pathway is available only to individuals for whom coverage is not affordable under the Internal Revenue Code.⁹⁵ The hardship exemption is available to those who are determined by the Secretary of HHS to have suffered a hardship with respect to the capability to obtain coverage under a QHP.⁹⁶

HHS claims that the proposed eligibility expansion will address an affordability crisis in the individual market. Of course, the accelerating cost of health coverage is harmful to households that rely on Marketplace coverage, particularly in light of the expiration of EPTCs that drove the

⁹² 42 U.S.C. § 18022(e).

⁹³ 42 U.S.C. § 18022(e)(2)(A).

⁹⁴ 42 U.S.C. § 18022(e)(2)(B), referencing section 5000A of the Internal Revenue Code, which requires individuals who are not eligible for an exemption to maintain minimum essential health coverage.

⁹⁵ 26 U.S.C. § 5000A(e)(1), defining an "individual who cannot afford coverage" as "any applicable individual for any month if the applicable individual's required contribution ... for coverage for the month exceeds 8 percent of such individual's household income for the taxable year," indexed annually. In 2027, the Secretary set the required contribution percentage at 8.5%; see CMS, *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2027 Benefit Year* (Jan. 29, 2026), <https://www.cms.gov/files/document/2027-papi-parameters-guidance-2026-01-29.pdf>.

⁹⁶ 42 U.S.C. § 18022(e)(2)(B)(ii).

26% premium increase between 2025 and 2026.⁹⁷ While the intent of the proposal to reduce consumer cost burden is laudable, HHS fails to explain why its proposal would achieve its goal. Moreover, this proposal runs roughshod over the clear statutory language and intent of the ACA.

HHS is attempting to bootstrap its statutory authority to define hardship criteria to rewrite the separate affordability exemption.⁹⁸ Congress created an affordability exemption to limit eligibility for catastrophic plan enrollment to individuals whose required contribution exceeds an annually-indexed required contribution percentage, with respect to either employer-sponsored coverage or the cost of a bronze plan reduced by eligible PTCs.⁹⁹ This percentage is set at 8.5% of household income in 2027.¹⁰⁰ This new proposal attempts to justify creating what is essentially a second, more expansive affordability-related eligibility category by claiming that premium increases have created “affordability challenges even for consumers who may not qualify for financial assistance.”¹⁰¹ If finalized, this exemption would essentially use HHS’s hardship exemption authority to swallow up the distinct affordability exemption. Doing so would clearly override Congressional intent to limit catastrophic health plan eligibility related to the cost of coverage to those who were exempt from the individual mandate because they met the narrow statutory definition of “individuals who cannot afford coverage.”

HHS cannot shoehorn its authority to determine when an individual has experienced a qualifying hardship. This action effectively legislates a third, new category under which millions of people would be newly eligible for catastrophic health plan coverage. Congress created a broad, national eligibility category with respect to age, permitting anyone under 30 to enroll in a catastrophic plan. In contrast, lawmakers explicitly chose narrower paths for both the affordability and hardship exemptions, both of which require individualized certifications of exemption eligibility.¹⁰² HHS’s proposal ignores these clearly different approaches. If finalized, HHS’s proposal would invert Congressional intent with respect to catastrophic health plans by expanding eligibility to millions more people than would be excluded from a plan type that was clearly designed to cover a narrow sub-set of the population.¹⁰³

⁹⁷ 2027 NBPP NPRM at 6354.

⁹⁸ 42 U.S.C. §§ 18022(e)(2)(B)(i) and (ii),

⁹⁹ 36B(e)(1)(D) of the Code; *see supra*.

¹⁰⁰ *Supra*.

¹⁰¹ 2027 NBPP NPRM at 6354.

¹⁰² *Supra*.

¹⁰³ *See* KFF, Distribution of Total Population by Federal Poverty Level: 2024, <https://www.kff.org/state-health-policy-data/state-indicator/distribution-by-fpl>; Statista, *Share of households in the United States in 2024, by income group*, <https://www.statista.com/statistics/203183/percentage-distribution-of-household-income-in-the-us>.

HHS provides no explanation for how an income-based eligibility category with no upper limit meets the statutory requirement to individually certify that a household has “suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.”¹⁰⁴ The HHS proposal would allow any household earning over 250% FPL – theoretically ranging from an individual making less than \$40,000 per year to a multi-millionaire – to enroll in a catastrophic health plan on the basis that premium costs necessarily represent an insurmountable “hardship” to that specific household. The proposal purports to address accelerating premium costs by expanding eligibility to individuals with incomes under 100% FPL, or \$15,960 for an individual in 2026. Given that the out-of-pocket limit for catastrophic plans is \$12,000 this year, before accounting for monthly premium costs, it is highly unlikely that the eligibility expansion provides any meaningful alternative coverage for individuals living in poverty. Rather than applying its legitimate authority to tailor hardship exemptions to promote access to affordable coverage, HHS has crafted a broad new eligibility category that conflicts with the Congressional intent and statutory eligibility categories for catastrophic health plan coverage and is likely to provide little relief to most low- and middle-income households.

Permanently expanding catastrophic coverage as proposed would increase financial and health risks for consumers and the overall risk pool. Vastly expanding eligibility for catastrophic health plans would harm enrollees, health care providers, and the individual market risk pool. Fewer than 1% of those who selected a plan during 2025 Marketplace Open Enrollment chose a catastrophic plan.¹⁰⁵ These plans are unpopular because of their limited eligibility, as mandated by Congress, but also because they offer minimal protection from risk compared to metal-tier QHPs. As explained above, catastrophic plans impose deductibles equivalent to the annual cost sharing limit under the ACA, which in 2027 will reach \$12,000 for self-only coverage and \$24,000 for coverage for two or more people. While catastrophic plans must cover EHB after the deductible is met, the ACA does not mandate any actuarial value threshold or range for these plans. Finally, catastrophic health plans do not qualify for PTCs, which means enrollees must bear the full cost of monthly premiums regardless of their household income level.¹⁰⁶ In short, these plans were intended to provide young, healthy individuals and those without other

¹⁰⁴ 26 U.S.C. § 5000A(e)(5).

¹⁰⁵ Ctrs. for Medicare & Medicaid Svcs., *Health Insurance Exchanges 2025 Open Enrollment Report*, <https://www.cms.gov/files/document/health-insurance-exchanges-2025-open-enrollment-report.pdf>. Note that while the 2027 NBPP NPRM states that “only about 20,000 people enrolled in catastrophic plans in 2025,” this estimate conflicts with the data reported elsewhere by CMS that roughly 54,000 people were enrolled in catastrophic plans in 2025. See 2027 NBPP NPRM at 6382; but see also, *2025 Marketplace Open Enrollment Period Public Use Files*, <https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files>. We urge HHS to address this discrepancy in the final rule.

¹⁰⁶ 42 U.S.C. § 18022(e); 26 U.S.C. § 36B(c)(3)(A).

coverage options an alternative to being fully uninsured. Congress did not design them as a robust coverage option for a majority of the population.

HHS does not provide any meaningful data to estimate the effects of this proposal on plan costs, consumer financial risks or health outcomes, providers, or the individual market risk pool generally. In the Regulatory Impact Analysis, HHS estimates that the four state Exchanges that currently process their own hardship exemptions would collectively process 1,072 applications annually under the expanded hardship eligibility criteria, noting that they represent 10% of total Exchange enrollment. This could suggest that HHS believes that nationwide catastrophic coverage could increase by close to 11,000 enrollees.¹⁰⁷ However, the White House Council of Economic Advisors estimated that the guidance issued in September 2025, which closely mirrors HHS proposal in this rule, would increase enrollment in catastrophic coverage by “several million” people.¹⁰⁸ The strikingly different estimates from HHS and the White House raise further questions about the evidence underpinning both the guidance and the regulatory proposal.

Even the smaller increased enrollment contemplated by HHS in the preamble to this proposed rule would expose thousands of households to higher deductibles and cost-sharing required under catastrophic plans. Research shows that when people are underinsured, including having a deductible that exceeds 5% of their income, they are more likely to delay filling prescriptions, avoid seeking treatment for medical problems, and incur medical debt than those with affordable coverage.¹⁰⁹ In 2027, given the \$24,000 deductible for a family catastrophic health plan, these risks would apply to households earning less than \$480,000 per year. A significantly higher shift to catastrophic coverage, such as that anticipated by the White House, could harm enrollees both financially and physically and also weaken the individual market risk pool. Catastrophic plans that combine significant costs with minimal benefits are more likely to attract wealthier, healthier, and younger enrollees who may anticipate using fewer health care services throughout a plan year. To the extent these plans siphon relatively low-risk households from metal-tier plans, it could result in a smaller, sicker individual market risk pool, increasing

¹⁰⁷ 2027 NBPP NPRM at 6452-6453.

¹⁰⁸ White House Council of Economic Advisors, Expansion of HSA Eligibility Under OBBA Act to Improve Marketplace Coverage, Affordability, and Access (Sept. 2025), <https://www.whitehouse.gov/wp-content/uploads/2025/09/Expansion-of-HSA-Eligibility-Under-OBBA-1.pdf> (note that the authors do not provide an explanation for the “baseline projection” that 3 million people would enroll in catastrophic coverage, including in states where such coverage is not being offered in 2026).

¹⁰⁹ See Sara R. Collins and Avni Gupta, Commonwealth Fund, *The State of Health Insurance in the U.S.: 2024 Biennial Survey* (Nov. 21, 2024), <https://www.commonwealthfund.org/publications/surveys/2024/nov/state-health-insurance-coverage-us-2024-biennial-survey>.

premium costs for people who remain in metal-tier coverage. Over time, this would result in a bifurcation of the overall individual market risk pool between healthy individuals with sufficient financial resources to accept the risk of a catastrophic plan, who could enjoy relatively cheaper premiums; and the remainder of the population, who would be forced to contend with ever-higher premiums. This outcome is incompatible with the single risk pool concept that is fundamental to the ACA.¹¹⁰

HHS lacks the necessary evidence to support codifying recent 2025 guidance. HHS is rushing to codify guidance that was implemented in September 2025, without any evidence of its effects on consumers or other interested parties. HHS attempts to justify a vast eligibility expansion by pointing to the indisputably high cost of individual health insurance premiums. However, HHS fails to provide any evidence that explains why significantly expanding access to catastrophic health plans, with their high deductibles and limited coverage, would address this problem. Rather, HHS simply states that it “believe[s] that there are substantial number of consumers for whom purchasing a QHP relative to a catastrophic plan could cause a financial hardship” and cites to data showing the QHPs premium costs have risen significantly since 2013, the year before the ACA’s insurance market reforms were fully implemented.¹¹¹ Notably, HHS fails to provide any meaningful comparison between catastrophic and QHP plan costs. And by worsening the individual market risk pool, the proposal ironically worsens the problem—namely, unaffordable gross premiums—that it purports to solve.

HHS implies that QHP premiums present a major barrier to coverage. However, catastrophic plans are not necessarily a lower-premium option than unsubsidized bronze coverage. On average, national data show that the lowest-cost catastrophic plans available for a 27-year old individual are just \$23 per month cheaper than the lowest-cost unsubsidized bronze plan.¹¹² National data obscure significant local price variation; in some regions of the country, catastrophic plan premiums may be up to \$200 more costly than the lowest-cost bronze plan, while in other counties, catastrophic plan premiums are \$200 less than the lowest-cost bronze

¹¹⁰ 42 U.S.C § 18032(c); 45 C.F.R. § 156.80.

¹¹¹ 2027 NBPP NPRM at 6354.

¹¹² Note that national data obscure significant regional variation in premium costs. In some regions of the country, catastrophic plan options have higher premiums than unsubsidized bronze plans, while the opposite is true elsewhere. See Michelle Long, et al., *KFF, Policy Changes Bring Renewed Focus on High-Deductible Health Plans* (Jan. 5, 2026), <https://www.kff.org/patient-consumer-protections/policy-changes-bring-renewed-focus-on-high-deductible-health-plans>, <https://www.kff.org/patient-consumer-protections/policy-changes-bring-renewed-focus-on-high-deductible-health-plans>. (“For example, unsubsidized bronze plans offered in more than half of the counties in Oklahoma are over \$200 cheaper per month than the cheapest catastrophic plan for a 27-year-old individual. Conversely, all counties in Connecticut have catastrophic plans around \$200 a month cheaper than the lowest-cost unsubsidized bronze plan for a 27-year-old individual.”)

plan.¹¹³ While premium rates may vary, out-of-pocket costs are significantly higher for catastrophic plan enrollees. The national average bronze plan deductible this year is just under \$7,500, more than \$3,000 less per year than the catastrophic health plan deductible for 2026.¹¹⁴ Given that catastrophic plan deductibles will rise to \$12,000 for self-only coverage in 2027 — or up to \$15,600 if a separate proposal is finalized — expanded access to such plans offers little relief to low- and middle-income households who would shoulder the full cost of health care plus premiums comparable to unsubsidized bronze coverage. In particular, the proposal's extension of catastrophic coverage to households with incomes under 100% FPL feels particularly nonsensical, given that an individual would certainly be liable for more than their entire annual income between premium and deductible costs in the event of a medical emergency, costly diagnosis, or lengthy hospital stay.

HHS is proposing to enshrine into regulation a months-old guidance whose impacts have yet to be assessed and fails to provide compelling data that explains how and why expanding eligibility for catastrophic coverage would benefit consumers or other stakeholders.¹¹⁵ Based on past experience, HHS will not release its analysis of 2026 Open Enrollment data until months after the 2027 NBPP NPRM is finalized. This gives the public no opportunity to understand the effects of the guidance before commenting on its proposed codification. Further, since the September 2025 guidance was issued after regulators had approved 2026 plans for the current plan year, including premium rates, the potential effects of the guidance on plan costs and enrollment trends was likely muted compared to the current proposal. A permanent expansion of the guidance will be more consequential than will be reflected in 2026 Open Enrollment trends. Prematurely finalizing expanded eligibility for catastrophic plans as proposed is unsupported by evidence and places consumers and other stakeholders at considerable risk.

§§ 155.1050 and 156.230 Network adequacy standards

We oppose the NBPP NPRM proposed regulations to eliminate the requirement for all exchanges to at least meet time and distance standards and to allow some states on the FFE to establish their own standards and conduct reviews of network adequacy with federal approval. The proposal will exacerbate existing challenges with network adequacy in Marketplace plans.

¹¹³ Id.

¹¹⁴ Id.

¹¹⁵ Ctrs. for Medicare & Medicaid Svcs., Guidance on Hardship Exemptions for Individuals Ineligible for Advance Payment of the Premium Tax Credit or Cost-sharing Reductions Due to Income, and Streamlining Exemption Pathways to Coverage (Sept. 4, 2025), <https://www.cms.gov/files/document/guidance-hardship-exemptions.pdf>.

Narrow networks and consumers' inability to find available in-network providers have for years been one of the most visible problems in Marketplace coverage.¹¹⁶ One investigation in Georgia found that 600,000 of the state's 846,000 Marketplace enrollees lacked access to care due to inadequate plan provider networks. In some rural counties, upwards of 90% of enrollees faced access issues due to poor plan networks, particularly for allergists and OB/GYN services.¹¹⁷ Inadequate mental health care networks have led to documented hospitalizations, emergency department visits, and worse outcomes in Arizona, New York, and other states.¹¹⁸ Marketplace secret shopper surveys have already documented persistent provider directory inaccuracies, which only compound the difficulties of finding a provider when needed.¹¹⁹ Such deficiencies lead to unacceptable wait times for appointments and can cause negative health outcomes from delayed care. These examples of persistent shortcomings in network adequacy standards and provider directory accuracy led HHS to create new requirements that all states networks meet tiered time and distance standards and, more recently, appointment wait time standards that are annually audited by secret shopper surveys.

Yet just a year after implementation of new federal standards for Marketplace wait times and asking states to meet basic federal minimum requirements, HHS proposes to walk it back. This proposed rule would allow states that use the FFE to set their own standards for network adequacy, including ignoring federal wait time standards, if they demonstrate to HHS's satisfaction that they have Effective Provider Access Review programs. These ill-advised changes appear based not on evidence that states have shown improved access to providers through alternative, stronger network adequacy standards. Rather, evidence has pointed in the opposite direction – that generalized network adequacy standards and enforcement have proven consistently insufficient to ensure timely access to needed services. Results from the first year of required secret shopper surveys “exposed weaknesses in provider directories.”¹²⁰

¹¹⁶ Karen Pollitz, KFF, *Network Adequacy Standards and Enforcement* (Feb. 4, 2022), <https://www.kff.org/affordable-care-act/network-adequacy-standards-and-enforcement/>.

¹¹⁷ Sofi Gratas, *Georgians with Marketplace Insurance Aren't Guaranteed Good Access to Care*, Georgia Public Radio (2023), <https://www.gpb.org/news/2023/02/08/georgians-marketplace-insurance-arent-guaranteed-good-access-care>.

¹¹⁸ Max Blau, ProPublica, *“I Don't Want to Die”: Needing Mental Health Care, He Got Trapped in His Insurer's Ghost Network* (Sept. 8, 2024), <https://www.propublica.org/article/ambetter-ghost-network-consequences>; Inaccurate and Inadequate: Health Plans' Mental Health Provider Network Directories, Off. of the NY State Attorney General (Dec. 7, 2023), https://ag.ny.gov/sites/default/files/reports/mental-health-report_0.pdf.

¹¹⁹ Simon F. Haeder, Dept. Health Pol'y & Management, Texas A&M University, *Assessing the Persistence of Provider Directory Inaccuracies in Pennsylvania ACA Marketplace Plans Using Repeated Secret Shopper Surveys* (Oct. 29, 2024), <https://www.insurance.pa.gov/Coverage/health-insurance/Documents/networkadequacystudy-providerdirectoryinaccuracies-brief.pdf>.

¹²⁰ Sutherland, *Year One Reflections: Key Lessons from CMS Secret Shopper Surveys for Health Plans* (Oct. 17, 2025), <https://www.sutherlandglobal.com/insights/blog/healthcare-plan-secret-shopper-survey>.

In the preamble, HHS acknowledges that plans have struggled to meet the network adequacy time and distance standards, particularly in some rural areas for some services. But instead of exploring the reasons for these shortages and potential solutions, the approach seems to be that states should be allowed to simply lower their standards – such as shifting to a time *or* distance standard – to meet the current reality of plan network breadth.¹²¹

The proposed rule preamble describes a Maryland court case that determined HHS’s prior attempt to defer network adequacy review to the states was “arbitrary and capricious” due to HHS’s failure to meaningfully respond to abundant evidence in the administrative record that states were not doing an adequate job of ensuring access to care through their own regulations and enforcement actions.¹²² The preamble goes as far as summarizing how the decision: “raised concerns about HHS’ position that States’ network adequacy review procedures are adequate simply because States have State-specific regulations without explaining what these entail or why they are comparable to review under Federal standards.”¹²³

The court further pointed to comments and evidence that state review procedures were often inadequate and that complaint-driven oversight was inadequate. Yet HHS does not show that anything has changed in the intervening years. Rather, more recent analyses have continued to find that state enforcement of network adequacy provisions in private insurance plans has been “severely underwhelming,” with most state insurance regulators reporting an average of one to zero enforcement actions related to network adequacy annually.¹²⁴ The preamble provides no clear evidence – aside from vague anecdotes about some issuers reporting various “challenges” with finding certain specialists in some rural regions – that state capacity to conduct these reviews has improved. There is simply no justification for weakening the current federal standards by devolving standard setting back to states, particularly without showing results from the first year of mandatory secret shopper surveys that evaluated how well FFE QHPs met appointment wait time standards.¹²⁵

HHS simply has not demonstrated that it is now appropriate to allow states to jettison the important new tools that were only implemented last year. Rather than requiring Marketplace issuers to maintain better networks and more accurate provider directories through improved

¹²¹ 91 Fed. Reg. 6396.

¹²² 91 Fed. Reg. 6394-95 (citing *City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021)).

¹²³ *Id.*

¹²⁴ Abigail Burman, Laying Ghost Networks to Rest: Combatting Deceptive Health Plan Provider Directories, 40 YALE LAW & POL’Y REV. 78, 122 (2021); see also, e.g., Shannna Read-Richards & Teresa Keller, The Marketplace Illusion: Coverage Without Care, HEALTH AFF. (Feb. 26, 2026), <https://www.healthaffairs.org/content/forefront/marketplace-illusion-coverage-without-care>.

¹²⁵ Moreover, one year of survey data is unlikely sufficient to draw firm conclusions.

oversight and enforcement, this rule proposes to water down the standards to support the status quo, even as it shifts administrative burden and responsibility onto states.

We oppose HHS finalizing the NBPP NPRM proposed regulations to eliminate the requirement for all exchanges to at least meet time and distance standards and to allow some states on the FFE to establish their own standards and conduct reviews of network adequacy with federal approval. We especially oppose the changes that would allow some FFE states to evade mandatory federal appointment wait time standards without any evidence or argument to support abandoning this requirement.

§§ 156.80 and 154.215 – Rate filing justification

HHS proposes a new interpretation of the requirement in §156.80(d) that plan-specific rates must be “actuarially justified.” As to the portion of silver-tier premiums that pays for cost-sharing reductions (CSRs), HHS proposes that “an actuarially justified CSR load factor is one that is calibrated on actual experience and that only accounts for the projected revenue loss of unreimbursed CSR payments, without materially exceeding that amount.”¹²⁶ To ensure that this new interpretation is fully implemented, HHS proposes collecting significant amounts of additional data from each issuer: “paid CSRs, additional revenue collected from the previously applied CSR load, CSRs expected to be paid, the CSR load factor and expected resultant additional revenue for the upcoming plan year, the underlying methodology for determining the CSR load factor ..., and an explanation of how the expected additional revenue compares to the amount of CSRs expected to be paid.”¹²⁷

This new definition of actuarial justification means that, as to the CSR-related portion of silver premiums, premiums must reflect anticipated utilization by a risk pool consisting exclusively of CSR-eligible enrollees. That utilization is much lower than the utilization that would result from enrollment of insurers’ entire individual-market risk pool. As noted by the American Academy of Actuaries, ““In general, lower-income individuals have ... a significantly higher threshold for determining when a service is sufficiently valuable to be utilized. As such, we would generally

¹²⁶ 91 Fed. Reg. 6326. This is another way of stating the new requirement that CSR-related silver premiums must be experience rated, based on a risk pool consisting solely of CSR enrollees into silver coverage. The “revenue loss of unreimbursed CSR payments” involves the additional paid claims a carrier incurs for actual CSR enrollees, based on the plan’s coverage of a higher proportion of costs than it pays for silver-tier enrollees not qualifying for CSRs. The “unreimbursed CSR payments,” referenced in the NBPP, are those formerly paid by the federal grant program that ended in late 2017, which paid carriers based on actual CSR enrollees’ costs. See 45 C.F.R. §156.430.

¹²⁷ 91 Fed. Reg. 6326.

anticipate much lower utilization among low-income enrollees...”¹²⁸ Past HHS research has found that low-income beneficiaries qualifying for CSRs receive fewer services in 94%- and 87%-AV silver coverage than do somewhat higher-income people enrolled in silver plans with 70% AV.¹²⁹ Based on 2025 enrollment data for healthcare.gov enrollees, more than 90% of all silver-tier purchasers have incomes at or below 200% of the federal poverty level (FPL) and thus qualify for 94%- or 87%-AV coverage, reinforcing the widespread impact of low income in depressing CSR-related silver premium costs.

This new definition of actuarial justification, which requires experience rating for a portion of silver-tier premiums, violates 42 U.S.C. §300g(a)(1), added by ACA §1201. This statute, mandating modified community rating, provides, “With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual ... market— (A) such rate shall vary with respect to the particular plan ... only by—(i) whether such plan or coverage covers an individual or family; (ii) rating area...; (iii) age ... ; and (iv) tobacco use...; and (B) such rate shall not vary with respect to the particular plan ... by any other factor not described in subparagraph (A).” The greatly reduced utilization associated with low-income CSR enrollees is a “factor not described in subparagraph (A)” and thus may not lawfully affect plan premiums.

This new policy also violates ACA §1312(c)(1) (42 U.S.C. §18032(c)(1)). This statute requires each insurer to consider all its individual-market enrollees, regardless of plan, to be “members of a single risk pool”— in other words, to base premiums for each plan on projected utilization by the insurer’s total individual-market risk pool, rather than just the people expected to enroll in the specific plan.

When it first promulgated 42 C.F.R. 156.80(d), the regulation implementing the single risk pool statutory requirement, HHS explained that the “statutory requirement that an issuer consider all of its enrollees in all plans ... offered by the issuer to be members of a single risk pool in the individual market ... prevents issuers from creating separate pools in order to segment high risk and low risk enrollees. Without a single risk pool rule, [the ACA’s] prohibitions against traditional underwriting could incentivize issuers to ... segment the market into separate risk pools and charge differentiated premiums based on segmented risk, a de facto mechanism for

¹²⁸ American Academy of Actuaries, Comments on 2021 Risk Adjustment Model Update Technical Paper, November 24, 2021, [https://www.actuary.org/wp-content/uploads/2021/11/Academy Comment Letter CCIIO RA Technical Paper 11.24.21.pdf](https://www.actuary.org/wp-content/uploads/2021/11/Academy%20Comment%20Letter%20CCIIO%20RA%20Technical%20Paper%2011.24.21.pdf).

¹²⁹ Center for Consumer Information and Insurance Oversight (CCIIO), HHS-Operated Risk Adjustment Technical Paper on Possible Model Changes, October 26, 2021, <https://www.cms.gov/files/document/2021-ra-technical-paper.pdf>.

underwriting. As a result, this statutory requirement ... protects consumers by requiring issuers to consider the risk of all enrollees when developing and pricing unique plans.”¹³⁰ By mandating all insurers to consider only the costs of CSR enrollees in determining the portion of silver premiums that reflects CSR costs, HHS’s new proposed policy “segments the market into separate risk pools and charge[s] differentiated premiums based on segmented risk,” thus creating the problem that the single-risk-pool requirement was intended to prevent.

Within 45 C.F.R. §156.80, “actuarial justification” requirement is placed in (d)(2). As a result, it governs all permitted plan-level adjustments listed in (d)(2)(i) through (v). Put differently, the “actuarial justification” requirement applies to every factor that an insurer can use in setting premiums for specific plans, not just to (d)(2)(i)’s adjustment of silver premiums to account for CSRs. Accordingly, HHS’s new interpretation of this requirement is untenable, as it conflicts with the core ACA objective of enabling people with preexisting conditions to purchase coverage that meets their needs. For example, consider what would happen if a particular plan’s provider network included numerous physicians highly skilled in treating people with a particular chronic disease. Under the NBPP NPRM, the premiums charged for that plan, if varied based on plan network as provided under (d)(2)(ii), would need to reflect the anticipated costs of enrolling a much higher proportion of people who have that disease than is the case in the overall individual market. The result would be unaffordable premiums for plans that are structured to meet the needs of people with preexisting conditions.

The phrase, “actuarial justification,” should be construed, instead, to mean that a licensed actuary must correctly apply the principles of actuarial science to estimate the claims an insurer would pay if its entire individual-market risk pool was enrolled in a plan with the characteristics listed in §156.80(d)(2). This interpretation supports rather than undermines statutory requirements for modified community rating and protections for people with preexisting conditions. A plan that expects to enroll numerous chronically ill people, whose utilization is above average, and a plan that expects to enroll numerous CSR-eligible consumers, whose utilization is below average, would each base premiums on the claims that would be paid if the plans’ enrollees had “the average demographic characteristics of the single risk pool,” in the words of HHS’s longstanding Unified Rate Review Instructions.¹³¹ Unlike the interpretation

¹³⁰ 77 Fed. Reg. 70584, 70601 (November 26, 2012).

¹³¹ CMS, “2023 Unified Rate Review Instructions, Rate Filing Justification: Parts I, II, and III,” <https://www.cms.gov/files/document/urr-py23-instructions.pdf>, cited in CCIO, 2027 Draft Letter to Issuers in the Federally-facilitated Exchanges,” Feb. 25, 2026, <https://www.cms.gov/files/document/draft-2027-letter-issuers.pdf>. Our proposed interpretation of “actuarial justification,” centering on the appropriate application of actuarial science by a licensed actuary, fits the broader scope of actuarial justification requirements, which touch on many issues, in addition to the conversion of market-wide index rates to plan-specific premiums. As HHS observed in first proposing regulations implementing ACA market reforms, “the index rate, the market-wide

advanced in the NPRM, this interpretation fits all permitted plan-specific variations to which the actuarial justification requirement applies and helps achieve rather than undermine the accomplishment of core ACA's objectives.

HHS cannot plausibly claim that, by outlawing current state practices that base CSR-related silver premiums on the individual market risk pool, the Department is merely implementing the 2026 NBPP's change to §156.80(d)(2)(i). The latter regulatory change did not disallow any existing state practices, according to the 2026 NBPP, and thus had no economic effect: "While we anticipate that codifying the permissibility of CSR loading will provide greater clarity and generally promote market stability, we do not expect that it will have a substantive economic impact, as it will continue to allow States' existing actuarially justified practices of determining whether and how CSR loading occurs."¹³²

The proposed NBPP for 2027 recognizes the variety of current state approaches to determining the CSR-related portion of silver premiums: "There are several ways that issuers have determined the CSR load factor. For example, issuers have loaded silver plans offered on-Exchange to recover expected lost CSRs based on experience, they have loaded silver plans on-Exchange based on an assumed distribution of enrollment and enrollee utilization (sometimes a set amount mandated by the State), or they have loaded all plans at all metal levels by the same amount."¹³³ HHS made clear that, among those current approaches, the ones disallowed by the 2027 NBPP NPRM raise silver premium amounts and thus PTCs: "These differing

adjustment based on total expected payments and charges for the risk adjustment and reinsurance programs, and the variations for individual plans would have to be actuarially justified." 77 Fed. Reg. 70584, 70601 (Nov. 26, 2012).

¹³² 90 Fed Reg 4533. The regulatory language, "accounting for cost-sharing reduction amounts provided to eligible enrollees under §156.410," does not support the current HHS proposal. The "amounts" of cost-sharing reduction, referenced in the language added by the 2026 NBPP, are those "provided ... under §156.410." The latter regulation makes clear that such amounts are increments of increased coverage generosity: from 70% AV to 73% AV, from 70% AV to 87% AV, or from 70% AV to 94% AV. 45 C.F.R. §156.410(b) states that an insurer provides the applicable cost-sharing reduction by "assign[ing] the individual to the silver plan variation" with an AV of 73%, 87%, or 94%, depending on the individual's income. The referenced regulatory language addresses the increased comprehensiveness of coverage, not the actual claims costs paid by insurers. This reading fits the definition of "cost-sharing reductions" found in 45 C.F.R. 155.20, which governs all ACA individual market regulations. This definition references the term, "cost sharing," which the regulation further defines as "*any expenditure required by ... an enrollee with respect to essential health benefits*; such term includes deductibles, coinsurance, copayments, or similar charges (emphasis added)." In other words, cost-sharing is a feature of the insurance plan. It references the costs the plan would require of an enrollee if that enrollee used essential health benefits, not the amount actually spent by enrollees or the amounts actually spent by an insurer. The "cost-sharing reduction amounts provided to eligible enrollees under Section 156.510" are thus the increments of higher-value coverage provided to eligible, low-income consumers, not the consumers' drop in spending (or the insurer's corresponding increase in paid claims). Similar language has a comparable meaning under other insurance market regulations. See, e.g., 45 C.F.R. §§147.138(b)(3)(i) and 147.140(g)(1)(iv), which respectively define a "copayment amount" and a "fixed-amount copayment" as features of coverage, not the actual amounts paid by consumers.

¹³³ 91 Fed. Reg. 6325.

approaches may result in loads that exceed the expected amount of unreimbursed CSRs by assuming an enrollment and claims distribution that significantly diverges from what actually occurs.” The 2027 NBPP NPRM proposal would thus have a substantive economic impact, making it inconsistent with HHS’s analysis of the effect of the regulatory change made by the 2026 NBPP. We set out below additional language in the NPRM showing HHS’s expectation that its proposal would lower silver tier premiums and federal PTC costs by forbidding current state practices—an outcome inconsistent with preamble language for the final 2026 NBPP.

In promulgating new regulatory language in §156.80(d)(2)(i), the 2026 NBPP repeatedly emphasized that the language did not limit the permissibility of different approaches states had previously used in defining the portion of silver premiums that covers CSRs. Responding to a commenter who asked “whether HHS intends to impose a test of ... actuarial justification that may override existing CSR loading practices permitted by States,” the agency made clear that no such override was contemplated: “Recognizing States’ traditional role in regulating insurance and rating practices, this final rule codifies longstanding statements that ... given States’ well-established role as the primary regulators of insurance, the ACA permits States’ rating practices for CSR loading, as long as the resulting rate adjustments are actuarially justifiable and otherwise comply with the requirements in § 156.80. The final rule codifies this deference to State regulators to determine if and how CSR loading practices exist in their State by permitting CSR loading ‘if permitted by the applicable State authority.’”¹³⁴ This recognition of state authority encompassed the state’s ability to define the actuarial justification required for CSR loading to meet regulatory requirements: “States may determine how to implement CSR loading in their State.... Likewise, ... the State has the responsibility to determine whether an issuer’s adjustments ... for plan specific factors (including accounting for CSR amounts) are actuarially justified.” Another commenter argued that “the proposed rule could be read to require the portion of silver premiums associated with CSRs to be experience rated.” The agency rejected this comment as unfounded, explaining that the relevant regulation, as revised, “does not require States or issuers to follow a specific methodology when accounting for unpaid CSRs, so long as any such adjustments are actuarially justified.”

Put simply, the current HHS proposal departs radically from HHS’s longstanding respect for state authority over insurance markets, which the agency repeatedly incorporated into its promulgation of the precise regulatory provision on which HHS purports to base its new policy of prohibiting many states’ previously accepted rating practices. In the past, HHS acknowledged

¹³⁴ 90 Fed. Reg. 4424, 4489 (Jan. 15, 2025).

that “the McCarran-Ferguson Act of 1945 establishes states as the primary regulators of insurance.”¹³⁵ This new proposal involves a potential violation of that longstanding statute.

In violating federal law and intruding into states’ authority to regulate insurance markets, the proposal would significantly increase consumers’ health insurance costs in states that currently require insurers to price all metal-tier coverage based on the costs that would be incurred by each issuer’s entire individual-market risk pool, rather than basing part of silver premiums on projected utilization exclusively by low-income, CSR-eligible consumers. Diverse states, including Arkansas, Colorado, Illinois, Maryland, New Mexico, Pennsylvania, Texas, Vermont, and Washington, have acted, by regulation or statute, to prohibit insurers from basing CSR-related silver premiums on the costs incurred by CSR consumers, rather than projected utilization by the entire individual market risk pool. HHS’s observation that these policies have increased PTC costs has a flip side: they have lowered costs for consumers, increasing the value and affordability of insurance. For example, when in 2022 New Mexico first implemented new regulations to rigorously enforce the single risk pool requirement, the proportion of ACA enrollees with high-deductible coverage in bronze or low-AV silver plans fell from 49% to 23%.¹³⁶ This substantially lowered consumers’ out-of-pocket costs, while, in many cases, simultaneously cutting premiums. In 2023, when Texas first implemented a similar policy passed unanimously by the state legislature, the proportion of ACA enrollees offered zero-net-premium gold coverage rose from 43% to 73%. In a year when ACA enrollment nationally rose by 13%, ACA coverage in Texas became so much more appealing to consumers that enrollment rose by 31%—more than in any other state.¹³⁷ In 2026, Illinois’s implementation of a similar policy led nearly 80,000 people to change from high-deductible bronze and silver plans to much lower-deductible gold coverage.¹³⁸

In 2025, 12 states based metal-tier premiums on the generosity of coverage, rather than the characteristics of plan enrollees. Average silver premiums in each of these states were higher than average gold premiums, reflecting that overall AV in silver plans, including CSR variants,

¹³⁵ 84 Fed. Reg. 8657, 8658 (March 11, 2019).

¹³⁶ Stan Dorn and Timothy Jost, ACA Metal-Tier Mispricing: Improving Affordability By Solving An Actuarial Mystery, *Health Affairs Forefront*, January 27, 2023, <https://www.healthaffairs.org/content/forefront/aca-metal-tier-mispricing-improving-affordability-solving-actuarial-mystery>.

¹³⁷ KFF, Marketplace Enrollment, 2014-2025, *State Health Facts*, <https://www.kff.org/affordable-care-act/state-indicator/marketplace-enrollment/?activeTab=graph&currentTimeframe=2&startTimeframe=3&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

¹³⁸ Get Covered Illinois, Illinois Health Benefits Exchange Advisory Committee Meeting, March 9, 2026, <https://doi.illinois.gov/content/dam/soi/en/web/insurance/about-us/documents/lhbeac-march-2026-final.pdf>.

exceeded the 80% AV provided by gold plans.¹³⁹ Altogether, 5.8 million residents of these states purchased ACA coverage healthcare.gov or state-based marketplaces (SBMs).¹⁴⁰ If premiums at all metal tiers had been recalibrated to fit the policy articulated in the NBPP NPRM, then 3.2 million residents of these states, or 55% of all Marketplace participants, would have seen their premium costs rise by an average of \$779 per person; these people purchased gold or bronze coverage, with gross premiums that would rise in response to a drop in silver premiums. Among those 3.2 million people, 2.8 million, or 47% of all Marketplace participants, would have seen their costs rise by even more—\$859, on average. These people purchased bronze or gold plans with the aid of PTCs, the value of which would fall under the policy now proposed by HHS. Just 141,000 residents, or 2% of the people in these states enrolled in Marketplace plans, would have saved money under the proposed HHS policy. Without PTCs, they purchased silver Marketplace coverage and so would have paid less in premiums under the NBPP NPRM. On average, they are estimated to save \$359—less than half the \$779 average increase paid by the far more numerous consumers whose costs are estimated to rise. Premiums would have been generally unaffected for 2.5 million people, or 42% of these states' Marketplace enrollees. These people bought silver plans using PTCs. Their savings from lower gross silver premiums would have been offset by cuts to their PTCs. Altogether, consumers' net premium costs would have risen by an estimated \$2.5 billion in these states, if the NBPP NPRM's proposed new requirement for experience-rating CSR-related silver premiums had been in effect.¹⁴¹

¹³⁹ KFF, Average Monthly Marketplace Premiums by Metal Tier, *State Health Facts*, <https://www.kff.org/affordable-care-act/state-indicator/average-marketplace-premiums-by-metal-tier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (KFF Premium Data).

¹⁴⁰ HHS, 2025 Marketplace Open Enrollment Period Public Use Files (2025 OEP PUF), last modified 5/12/25, <https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files>. (2025 OEP PUF)

¹⁴¹ To develop these estimates, we began by calculating how the lowest-cost average bronze, silver, and gold premiums in 2025, as estimated by KFF for 40-year-old non-smokers (KFF Premium Data), would have changed in each of these states if the CSR-loading proposal in the NBPP was in effect. To estimate the average lowest-cost premiums for a 40-year-old non-smoker at each metal level under the NBPP proposal, we calculated what those premiums would be if (a) the relationships between them had been the same as if the state was implementing policies like those in the many states that do not rigorously enforce the single-risk-pool requirement and so have average gold premiums that exceed average silver premiums, despite the greater overall generosity of coverage in silver; and (b) the premiums charged for enrollees produced the same amount of total revenue as under the KFF premium estimates. We based the relationships in condition (a) on rates in the median state where, based on KFF estimates for 2025, average lowest-cost gold premiums exceeded average lowest-cost silver premiums. We then adjusted those premium estimates, as well as those for benchmark premiums, based on the average age of enrollees at each metal level. To estimate the average age of each state's enrollees at each metal tier in 2025, we used the mid-point of each age range specified in the 2025 OEP PUF. For adults age 65 and older, we assumed an age of 65, which had the effect of underestimating the increased costs that would result from the HHS proposal. We then modified the average premiums, both currently and as estimated under the scenario in which CSR-related silver premiums were experience-rated, to reflect the difference in pricing that would result from changing the average age of enrollees at each metal level from the 40-year-old figure used by KFF to the estimated average age

In 2026, an additional six states, including Illinois, based metal-tier premiums on the generosity of coverage, rather than the characteristics of plan enrollees. Average silver premiums in each of these states were higher than average gold premiums.¹⁴² In these states, consumers enrolled in bronze and gold plans would likely face increased costs under the NBPP proposal; those buying silver coverage without PTCs would save money; and costs would be generally unchanged for people using PTCs to buy silver plans. Based on all of those states' most recent available detailed enrollment data, from 2025,¹⁴³ 2.5 million Marketplace enrollees in these states would likely have paid more in premiums under the NBPP proposal, because they were already enrolled in bronze or gold plans. They include 2.1 million people whose costs would have risen by especially large amounts, because they relied on PTCs to help pay premiums. Just 51,000 of these states' residents would have saved money because they purchased silver marketplace coverage without PTCs; and premium costs would have been generally stable for 4.1 million residents, for whom lower PTCs would have offset reduced silver premiums.

The regulatory impact assessment with respect to this new policy is seriously flawed. It fails to quantify the reduction in federal payment of PTCs that would result from this new policy. It merely notes the qualitative finding that there could be "potential adjustments to PTCs as a result of silver plan premium changes due to CSR load calculations."¹⁴⁴ The absence of quantification is indefensible, given that, elsewhere in the proposed rule, HHS frequently notes that one of the goals of this policy change is to reduce federal PTC costs;¹⁴⁵ and that the NPRM

of people in that metal tier in that state. We calculated that difference using the default premium ratio for age curve variations allowed by the ACA. CMS, State Specific Age Curve Variations, <https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-market-reforms/downloads/statespecagecrv053117.pdf>. We also used that default premium ratio to estimate how average benchmark premiums would change for people at every metal level, assuming the same proportionate change in benchmark premiums in each state as we estimated for the lowest-cost silver plan. To account for the January 2026 expiration of EPTCs, we assumed that no enrollee with income above 400% FPL qualified for PTCs. In healthcare.gov states, the federal government reports the number of beneficiaries, at each metal tier, who did not use PTCs to purchase coverage. We used that number in the relatively few cases when it exceeded that number of metal tier enrollees who had incomes above 400% FPL. Under §156.80, rating begins with a market-wide index rate, incorporating all of a carrier's projected claims in the individual market. If the share of those costs allotted to silver premiums drops, the share allotted to premiums at other metal level must rise. In some states, we found that either gold or bronze premiums would fall rather than rise, in order to match relative metal-tier premiums for the median state where gold premiums exceeded silver premiums, signaling that metal-tier premiums were not aligned to relative coverage generosity. In the states where bronze or gold premiums are estimated to fall under the NBPP proposal, people buying that coverage without PTCs would have realized savings. Those buying with PTCs may have spent more or less under the NBPP NPRM, depending on the relative increase to bronze or gold gross premiums compared to the drop in the consumer's PTC amount. All those effects are included in our estimates.

¹⁴² KFF Premium Data.

¹⁴³ 2025 OEP PUF.

¹⁴⁴ 91 Fed. Reg. 6443.

¹⁴⁵ 91 Fed. Reg. 6445.

quantifies, sometimes to the dollar, the estimated impact of reduced federal APTC payments resulting from many other policy changes, but not this particular policy change.¹⁴⁶

The absence of quantification is compounded by the misleadingly ambiguous nature of the impact assessment's qualitative finding. The impact is not just "potential adjustments to PTCs," to use the NPRM's anodyne language. The impact of the NPRM's proposal will include a significant drop in PTCs, both those for the 19 states that currently align metal-tier premiums with coverage generosity as well as those that would have been sent other states that would have adopted similar premium alignment requirements in the future, but for the policy articulated in the NBPP NPRM. At another point, the NBPP NPRM disingenuously professes ignorance of the directional change to silver premiums that would result from experience-rating the portion of silver premiums that relates to CSR costs: "If issuers have been overestimating actual CSR costs, they may decrease load factors and premiums, which could result in lower out-of-pocket costs for enrollees through decreased premiums. Conversely, if issuers have been underestimating CSR costs, load factors and premiums could increase."¹⁴⁷ Mandating the experience-rating of CSR-related silver premiums would lower those premiums, given HHS's own findings, cited above, about the very low utilization of covered services by low-income CSR enrollees. Moreover, to justify the cost of collecting and processing significant amounts of new information, HHS makes clear that one reason for implementing this new policy is that it would lower federal PTC spending: "[G]iven the significant impact of CSR loading on Federal expenditures through additional ... PTC... spending, we believe collection of this information is an important program integrity measure that will help ensure that CSR loads are appropriate to recover lost CSR payments and are not inappropriately inflating Federal expenditures..."¹⁴⁸ HHS specifies that the practices struck down by their new proposal have increased PTC costs, which means that the proposal would lower them: "Based on our review of actuarial memoranda submitted by issuers for PY 2026, HHS believes these excessive loads on silver plans in particular (and in some cases as mandated by State law) lead to inflated premiums for silver plans ... and significantly increase the cost of the second lowest cost silver plan available to a consumer, which in turn increases PTC amounts and Federal expenditures."¹⁴⁹

¹⁴⁶ The Notice's Accounting Table estimates, starting in 2027, annual reductions in APTC transfers of \$213 million due to reinstatement of DMIs where data sources show income below 100% FPL, \$1.069 billion for reinstatement of DMIs when IRS data are unavailable, \$179 million for denials based on failing to file and reconcile for one rather than two consecutive tax years, \$105.4 million for pre-enrollment verification requirements for Special Enrollment Periods, \$9,672,048,360 due to new immigration status limits imposed by budget reconciliation legislation, \$3.8 billion from ending the 150% FPL SEP, and starting in 2026, \$1,869,180,495 due to prohibitions of APTCs to people with incomes below 100% FPL whose immigration status makes them ineligible for Medicaid. 92 Fed. Reg. 6442.

¹⁴⁷ 91 Fed. Reg. 6445.

¹⁴⁸ 91 Fed. Reg. 6326.

¹⁴⁹ 91 Fed. Reg. 6325.

The regulatory impact assessment is also misleading when it suggests that “decrease[d] load factors and [silver] premiums” will “result in lower out-of-pocket costs for enrollees through decreased premiums.” A drop in silver premiums yields two results: PTCs fall, since their value is based on the second-lowest-cost silver premium; and premiums at other metal levels rise, to offset the drop in silver premium revenue.¹⁵⁰ The only people who experience clear reductions in net premium payments are purchasers of silver coverage who do not use PTCs. Based on 2025 OEP PUF data, just 1% of all enrollees in healthcare.gov plans¹⁵¹ purchase silver coverage without PTCs and so save money when silver premiums fall; 54% purchase silver coverage with PTCs and so see their savings in gross premiums offset by a drop in PTCs;¹⁵² while 45% purchase bronze or gold plans and so pay increased gross premiums when silver premiums fall. For the 91% of bronze and gold purchasers who use PTCs to buy those plans, the impact of a higher gross premium in bronze or gold would be compounded by a drop in PTCs. In sum, the lower silver premiums that would result from the NBPP NPRM would increase rather than reduce overall consumer costs.

§ 156.111 – State selection of EHB-benchmark plan for plan years beginning on or after January 1, 2020

While HHS did not propose changes to this section in the proposed rule, the discussion in the Preamble led us to submit our comments about potential revisions.

HHS acknowledges that it is pausing review of states’ applications to update their EHB benchmark plans and is considering future rulemaking to revise § 156.111 and EHB more broadly.¹⁵³ We strongly disagree with this approach. HHS should refrain from making any changes to the current EHB structure and, instead, should promptly evaluate pending EHB benchmark proposals and approve those selections that meet all procedural and actuarial requirements under the current regulations.

¹⁵⁰ As explained earlier, the rate setting process begins with a carrier estimating its total paid claims for covered EHBs throughout the individual market. It then divides that sum among plans, varying premiums by plan if allowed by §156.80(d). If less of that market-wide sum is paid by silver premiums, more must be paid by premiums at other metal levels.

¹⁵¹ This PUF provides detailed information about PTC participation among enrollees at various metal-tier levels only as to healthcare.gov states, hence the limitation in the text to those states.

¹⁵² This results in net premium costs that are unchanged, if the consumer is enrolled in a plan with the second-highest silver premium, or that could rise or fall by small amounts, if the consumer is enrolled in a different silver plan.

¹⁵³ 91 Fed. Reg. 6302.

We are aware of several states that have been actively working to update their EHB benchmark plans. Nevada is seeking to add all FDA-approved HIV and hepatitis C treatments, as well as drugs approved for the treatment of, and withdrawal from, opioid use disorders.¹⁵⁴ California submitted an application to expand access to fertility services and improve coverage of hearing aids and durable medical equipment, including wheelchairs.¹⁵⁵ Kentucky considered adding routine adult dental services, as well as biomarker testing, infertility treatment, and expanded coverage of speech therapy and cancer screenings.¹⁵⁶

These states invested considerable time and resources developing their EHB benchmark proposals. They solicited public input, conducted hearings, commissioned actuarial analyses, and engaged in deliberative processes, including enacting legislation, all while relying on the EHB benchmarking framework established by HHS nearly fifteen years ago.¹⁵⁷ These carefully developed proposals are designed to address coverage gaps and help address the most serious health care needs of state residents. It is unconscionable that HHS would simply disregard these efforts without explanation.

More states were pursuing EHB benchmark updates, but HHS quashed those efforts by rescinding, without explanation, the EHB-Benchmark Plan Modernization Grant for States with a Federally-Facilitated Exchange, and the Expanding Access to Women's Health Grant last year.¹⁵⁸ The current benchmarking rules, which were finalized by the first Trump administration, welcomed state flexibility in EHBs and allowed states to address ongoing health care needs within actuarially sound parameters. By refusing even to consider state proposals, HHS is now suppressing state innovation to meet the needs of their populations.

¹⁵⁴ Nevada Div. of Insurance, Plan Year 2027 Benchmark Plan Change Actuarial Report (Feb. 11, 2025), [https://doi.nv.gov/uploadedFiles/doi.nv.gov/Content/Healthcare_Reform/Individuals_and_Families/Essential_Health_Benefits/NV457-2302%20DRAFT%20Nevada%20EHB%20actuarial%20report\(1\).pdf](https://doi.nv.gov/uploadedFiles/doi.nv.gov/Content/Healthcare_Reform/Individuals_and_Families/Essential_Health_Benefits/NV457-2302%20DRAFT%20Nevada%20EHB%20actuarial%20report(1).pdf).

¹⁵⁵ California Dept. of Managed Health Care, DMHC Applies to Update California's Benchmark Plan, Expand Essential Health Benefits to Include Fertility Services, Hearing Aids & Wheelchairs (May 5, 2025), <https://dmhc.ca.gov/Resources/Newsroom/PressReleases/May5,2025.aspx>.

¹⁵⁶ Kentucky Dept. of Insurance, Kentucky Plan Year 2027 Benchmark Plan Change Actuarial Report (April 28, 2025), <https://insurance.ky.gov/ppc/Documents/KY%20PY2027%20Benchmark%20Plan%20Change%20Actuarial%20FINAL%20Report%2020250428.pdf>. It is not clear whether Kentucky submitted its EHB benchmark proposal.

¹⁵⁷ Dept. of Health and Human Svcs., Ctr. for Consumer Information and Insurance Oversight, Essential Health Benefits Bulletin (Dec. 16, 2011), https://www.cms.gov/ccio/resources/files/downloads/essential_health_benefits_bulletin.pdf.

¹⁵⁸ Dept. of Health and Human Svcs., Ctr for Medicare & Medicaid Svcs., *EHB-Benchmark Plan Modernization Grant for States with a Federally-Facilitated Exchange*, CMS-2U2-25-001 (Feb. 14, 2025), <https://www.grants.gov/search-results-detail/356740>; Dept. of Health and Human Svcs., Ctr for Medicare & Medicaid Svcs., *Expanding Access to Women's Health Grant*, CMS-2R2-24-001 (Sep. 6, 2024), <https://www.grants.gov/search-results-detail/354660>.

HHS should refrain from making any substantive changes to EHB and the current benchmarking structure. Over the past 14 months, HHS has engaged in an unprecedented weaponization of the U.S. health care system to denigrate and persecute trans and non-binary people.¹⁵⁹ This administration has engaged in numerous legislative and regulatory efforts that have made health care coverage more expensive, less comprehensive, and continue to seriously undermine and destabilize the health insurance market.¹⁶⁰ The proposed rule would continue down this harmful path.

§ 156.115(d) – Provision of EHB

HHS proposes to reinstate an Obama-era regulatory prohibition on routine non-pediatric oral health services as EHB. We strongly oppose this proposal. This, and other EHB prohibitions currently codified in § 156.115(d), are not supported by law and, are, in fact, directly contrary to the plain language of the ACA. Moreover, a federal EHB prohibition on routine non-pediatric oral health services is bad policy and unduly restricts state flexibility to address unmet health care needs and advance health equity.

The ten categories of EHB are only a minimum and HHS can add other benefits as EHBs. HHS offers several revised interpretations of the ACA to justify its proposed prohibition of routine non-pediatric oral health services as EHB. First, HHS observes that Congress did not include routine non-pediatric oral health services when it established the list of ten minimum EHB categories.¹⁶¹ Indeed, in the ACA, Congress provided for pediatric oral care as part of EHB, but made no mention of oral health services for adults.

However, nothing in the ACA bars HHS from adding adult oral health services pursuant to its EHB defining, reviewing, and updating authority. Yet HHS somehow now infers this omission as

¹⁵⁹ See, e.g., Dept. of Health and Human Svcs., Marketplace Integrity and Affordability Final Rule, 90 Fed. Reg. 27074 – 27224 (June 25, 2025), <https://www.govinfo.gov/content/pkg/FR-2025-06-25/pdf/2025-11606.pdf> (codifying at 42 C.F.R. § 156.115(d) a ban on “specified sex-trait modification procedures” as EHB); Dept. of Health and Human Svcs., *Prohibition on Federal Medicaid and Children’s Health Insurance Program Funding for Sex Rejecting Procedures Furnished to Children*, 90 Fed. Reg. 59441 – 59463 (Dec. 19, 2025), <https://www.govinfo.gov/content/pkg/FR-2025-12-19/pdf/2025-23464.pdf>; Dept. of Health and Human Svcs., *Hospital Condition of Participation: Prohibiting Sex-Rejecting Procedures for Children*, 90 Fed. Reg. 59463–59478 (Dec. 19, 2025), <https://www.govinfo.gov/content/pkg/FR-2025-12-19/pdf/2025-23465.pdf>.

¹⁶⁰ Christen Linke Young, *New CBO Estimates Show 2025 Reconciliation Bill Would Have Impacts Similar in Magnitude to 2017 ACA Repeal Bills*, Brookings blog (Jun. 4, 2025), <https://www.brookings.edu/articles/new-cbo-estimates-show-2025-reconciliation-bill-would-have-impacts-similar-in-magnitude-to-2017-aca-repeal-bills/>.

¹⁶¹ 90 Fed. Reg. 6369.

justification for a regulatory ban. If Congress had intended to prohibit non-pediatric oral health services as EHB, it would have done so. For example, Congress expressly excluded coverage for most dental services in Medicare but included no such language in the ACA.¹⁶²

Moreover, the EHB ban is contrary to other provisions in the EHB statutory provisions. In the ACA, Congress established that EHB must include, “at least,” coverage of the 10 listed categories of benefits.¹⁶³ The fact that Congress did not include routine non-pediatric oral health services among the 10 categories does not mean that they could never be EHB. HHS does not have authority to rewrite a duly enacted statute by eliminating the word “at least.” Indeed, after claiming that the omission from the 10 listed EHB categories supports banning of routine non-pediatric oral health services as EHB, HHS seems to then abandon argument, conceding that “the 10 EHB categories set the floor for what constitutes EHB and that routine non-pediatric dental services could theoretically be added on top of this minimum set of EHBs.”¹⁶⁴

Congress also placed additional requirements and limits on HHS’s EHB authority. For example, HHS must take into account the health care needs of diverse segments of the population.¹⁶⁵ Congress also requires HHS to periodically review and update EHB to address difficulty in accessing needed services for reasons of coverage or cost; changes in medical evidence or scientific advancement; gaps in access or changes in the evidence base; interactions between *the addition* or expansion of benefits and reductions in existing benefits to meet actuarial limitations.¹⁶⁶

Congress clearly envisioned that states have the option to add benefits as EHB. Banning benefits as EHB, including those listed in § 156.115(d), is directly contrary to the plain language of the statute.

The ACA does not link EHB coverage to excepted benefits. When it originally promulgated § 156.115(d), HHS provided a one sentence explanation that “[i]n contrast with the benefits covered by a typical employer health plan, [routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, and non-

¹⁶² See 42 U.S.C. § 1395y(a)(12). A discussion by the Centers for Medicare & Medicaid Services (CMS) of the narrow cases where the Medicare program covers oral health services is available at www.cms.gov/Medicare/Coverage/MedicareDentalCoverage/index.html.

¹⁶³ 42 U.S.C. § 18022(b)(1).

¹⁶⁴ 91 Fed. Reg. 6369.

¹⁶⁵ 42 U.S.C. § 18022(b)(4)(C).

¹⁶⁶ *Id.* at (b)(4)(G), (H) (emphasis added).

medically necessary orthodontia] often qualify as excepted benefits.”¹⁶⁷ However, the ACA did not tie EHB to excepted benefits.

“Excepted benefits” is a term introduced in the Health Insurance Portability and Accountability Act (HIPAA) to exempt certain plans from the statute’s obligations. In its definition of excepted benefits, HIPAA and implementing regulations include limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits “if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan...”¹⁶⁸ The ACA did not change the definition of excepted benefits nor did it explicitly state that already defined excepted benefits were to be excluded from the definition of EHBs. As a result, a plain reading of the EHB statute and other provisions related to QHPs lends no support to the notion that under no circumstance could routine non-pediatric oral health services, or other services listed in § 156.115(d), be considered EHBs.

Even if Congress intended to apply the HIPAA excepted benefits provision to the EHB requirement, the original definition of excepted benefits is more specific than the HHS regulation in § 156.115(d). The HIPAA excepted benefits provision extends to benefits that are not an integral part of a group plan. Benefits are not considered an integral part of a group plan if either 1) enrollees may decline coverage for the specific services; or 2) if “claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan.”¹⁶⁹ However, § 156.115(d) bans coverage of these excepted benefits as EHBs regardless of whether these requirements are met, exceeding the limitations on excepted benefits added by the HIPAA statute. Therefore § 156.115(d) is simply not supported by the statutory language in the ACA or HIPAA.

HHS should read the HIPAA excepted benefits provision as written, applying to specific types of *plans* rather than types of benefits. While the HIPAA statutory provision in question talks about “benefits,” Congress’ unambiguous intention was to exclude limited-benefit *plans* (such as stand-alone dental and stand-alone vision plans) from HIPAA requirements, not the benefits themselves.

HHS offers wildly differing and at-times erroneous interpretations of the “typical employer plan” provision. HHS seeks to justify the EHB prohibition of routine non-pediatric oral health

¹⁶⁷ See Dept. of Health and Human Svcs., Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Proposed Rule, 77 Fed. Reg. 70644, 70651 (Nov. 26, 2012), <https://www.govinfo.gov/content/pkg/FR-2012-11-26/pdf/2012-28362.pdf>; 78 Fed. Reg. 12845.

¹⁶⁸ 26 U.S.C. § 9832(c)(2)(A); 29 C.F.R. § 2590.732(c)(3).

¹⁶⁹ 45 C.F.R. § 146.145(b)(3)(ii).

services by offering a new interpretation of the “typical employer plan” (TEP) provision. HHS now claims that TEP refers to an employers’ major medical plan.¹⁷⁰ By contrast, in the 2025 NBPP, HHS recognized that routine non-pediatric oral health services are widely covered by employers.¹⁷¹ HHS underscored that “EHB should be equal in scope to the benefits provided under a typical employer plan, regardless of whether such benefit is historically considered a non-excepted “health benefit” or whether such benefit is “typically covered” by an employer’s major medical plan.”¹⁷² HHS makes no effort to reconcile the two differing positions or to explain why the agency has suddenly changed its position. That is because the shift has no basis in law and only responds to an impetus of curtailing states’ ability to expand access to care. As discussed above, the ACA distinguishes EHB and excepted benefits plans, but not the benefits provided in those plans.

Even when services are widely covered by major medical employer plans, HHS selectively disregards that fact in its TEP analysis. In the 2025 Marketplace Integrity and Affordability Final Rule, HHS excluded gender affirming care (GAC) as an EHB.¹⁷³ HHS conceded that 72% of Fortune 500 businesses, and 91% of businesses listed on the Corporate Equality Index, as well as a majority of state employee plans, Medicaid programs, and Qualified Health Plans (QHPs) offer coverage of treatment for gender dysphoria.¹⁷⁴ Yet HHS dismissed this evidence because, somehow, an overwhelming majority of large employers “likely do not represent the typical employer.”¹⁷⁵

Moreover, HHS’s malleable and inconsistent application of TEP has led to EHB additions of benefits sometimes excluded from employer coverage. For example, in 2025, the District of Columbia added in vitro fertilization (IVF) and other fertility treatments to its EHB benchmark plan; while Washington added artificial insemination to its Washington’s EHB benchmark plan.¹⁷⁶ Yet only 27% of employers cover IVF, and 26% cover artificial insemination, according

¹⁷⁰ 91 Fed. Reg. 6369.

¹⁷¹ Dept. of Health and Human Svcs., HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program, 89 Fed. Reg. 26218-26426 (Apr. 15, 2025).

¹⁷² 89 Fed. Reg. 26342.

¹⁷³ Dept. of Health and Human Svcs. *2025 Marketplace Integrity and Affordability Final Rule*, 90 Fed. Reg. 27074-27227 (June 25, 2025), (prohibiting “specified sex-trait modification procedures” as EHB), <https://www.govinfo.gov/content/pkg/FR-2025-06-25/pdf/2025-11606.pdf>.

¹⁷⁴ 90 Fed. Reg. 27254.

¹⁷⁵ 90 Fed. Reg. 27255.

¹⁷⁶ See Ctr. for Consumer Information and Insurance Oversight (CCIIO), <https://www.cms.gov/marketplace/resources/data/essential-health-benefits>.

to the KFF Employer Health Benefits Survey.¹⁷⁷ Alaska, Vermont, and Washington added hearing aid coverage to their EHB benchmark plans.¹⁷⁸ Yet a recent survey found that only one in ten employees reported being offered a hearing solution by their employer.¹⁷⁹ It would be nonsensical and completely disconnected from the goals of the ACA for HHS to define typicality in a way that would restrict states' ability to incorporate any of these basic services to their EHB benchmark plans. HHS offers no explanation as to why some benefits that are not typically covered by employers can be considered EHB, and added to state EHB benchmark plans, while other benefits that are not typically covered by employers, or covered outside a major medical plan, are prohibited as EHB.

Simply put, the TEP provision cannot be read to require a benefit-to-benefit analysis justifying broad categorical exclusions of important, medically necessary health services as EHB. We believe such a narrow reading of the ACA's typical employer plan provision is not in line with the purpose of the law. When the ACA was enacted, it was common for private plans, including employer plans, to exclude certain services that are now considered essential from coverage.¹⁸⁰ The ACA's EHB requirement was adopted precisely to close those gaps in coverage. It would make little sense for the ACA to require a benefit-by-benefit TEP equivalence if the goal of the law is to ensure and improve access to a broad range of minimum essential benefits.

Instead, the most appropriate reading of the TEP provision is that EHB plans should fall with the general range and certainly be no less than the scope of coverage in typical employer plans. Such an interpretation is consistent with the plain text of the TEP and EHB provisions. This understanding of the TEP provision is reflected in HHS's recent clarification of 45 C.F.R. § 156.111 that "the typicality standard functions as both a ceiling and floor."¹⁸¹ Specifically, the 2025 NBPP Final Rule established that state's EHB benchmark selection should be "equal to the scope of benefit in a typical employer plan," which means a scope of benefits that is at least or

¹⁷⁷ KFF, *2024 Employer Health Benefits Survey* (Oct. 9, 2024), at 17, <https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2024-Annual-Survey.pdf>.

¹⁷⁸ See CCIIO, *supra*.

¹⁷⁹ TruHearing, *Hearing Loss in the Workplace Survey* (2024), at 11, <https://www.truhearing.com/wp-content/uploads/2025/03/560650-HLWP-ebook-2024-0924-A2-1.pdf>.

¹⁸⁰ ASPE, *Essential Health Benefits: Individual Market Coverage* (Dec. 16, 2011), <https://aspe.hhs.gov/sites/default/files/private/pdf/76356/ib.pdf> (finding that 62% of enrollees did not have coverage of maternity services).

¹⁸¹ Dept. of Health and Human Srvs., *HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program*, 89 Fed. Reg. 26218, 26268 (Apr. 15, 2024), <https://www.govinfo.gov/content/pkg/FR-2024-04-15/pdf/2024-07274.pdf>.

more generous as the least generous” of comparator plans within a state, and as generous, or less, than the most generous of comparator plans with a state the 2025 NBPP.¹⁸²

In this NBPP 2027 Proposed Rule, HHS adds that states may include the value of routine non-pediatric oral health services, as well as other EHB-prohibited services listed in § 156.115(d), when conducting their actuarial analyses of comparator plans.¹⁸³ Under this scheme, the cost of the services is included in the TEP analysis, but the services themselves must be excluded. This discrepancy makes no sense.

The actual statute provides needed clarity. Under the subheading “Limitations,” the ACA requires the Secretary to “ensure the scope of EHB is equal to the scope of benefits provided under a typical employer plan.”¹⁸⁴ The TEP analysis must be actuarially certified, by the Chief Actuary of the Centers for Medicare & Medicaid Services.¹⁸⁵ But there is more. Any additions or expansions of benefits, or reductions in existing benefits, must meet actuarial limitations, as described in the TEP provision.¹⁸⁶ The statute does not envision a benefit-by-benefit analysis.

Instead, Congress set a general range and established an EHB minimum so that plans cannot be any less generous than a typical employer plan. The TEP and other provisions of the ACA do not provide for EHB prohibitions. HHS needs to follow the law.

EHB prohibitions stifle state flexibility to address urgent unmet health care needs. Section 156.115(d) unnecessarily disrupts the carefully crafted balance that has been established between the need to ensure access to a minimum set of benefits for enrollees across the country and the objective that, as HHS expressed when it adopted the current EHB benchmarking framework in 2018, “states should have additional choices with respect to benefits, which may foster innovation in plan design and greater access to coverage...”¹⁸⁷

Access to quality and affordable oral health services for adults is vitally import to overall health. Several states have been considering adding adult dental services to their EHB benchmarks,

¹⁸² Id. at 26424 (codified at § 156.111(b)(2)(ii).

¹⁸³ See 91 Fed. Reg. 6370 (“if a typical employer plan used in the typicality comparison includes any of these services, the actuarial value of those services may be included when calculating that employer plan’s overall value for purposes of the typicality test. This does not mean, however, that these services may be covered as EHBs in the State’s EHB-benchmark plan itself.”).

¹⁸⁴ 42 U.S.C. § 18022(b)(2)(A).

¹⁸⁵ 42 U.S.C. § 18022(b)(2)(B).

¹⁸⁶ 42 U.S.C. § 18022(b)(4)(G)(iv).

¹⁸⁷ 83 Fed. Reg. 17010 (April 17, 2018).

including California, Maine, and Virginia.¹⁸⁸ Kentucky found that adding a comprehensive adult dental benefit could impact premiums by approximately \$15 per member, per month, falling well within the EHB generosity limits of state comparator plans.¹⁸⁹ States have not yet had the opportunity to assess a more targeted benefit, such as including routine oral health services as part of the maternity benefit. The Health Resources & Services Administration has documented the harm of poor oral health during pregnancy, including increased risk of premature birth, low birthweight, preeclampsia, gestational diabetes, and other serious conditions.¹⁹⁰ Including oral health services as part of the maternity benefit, and even for all adults, would generate offsetting reductions to overall health care costs and lead to improved health care outcomes. HHS should not foreclose the opportunity for states to add routine non-pediatric oral health services to the EHB benefits package available to residents.

§§ 156.130 and 156.155 – Multi-Year Catastrophic Health Plans

We oppose HHS’s proposal to permit issuers to offer catastrophic health plans with multiple consecutive years up to 10 years (“multi-year catastrophic plans”). The proposal violates the plain text of the ACA. It would reduce access to care and expose consumers to financial harm and discrimination. Lastly, it would be unworkable as proposed, given major design gaps and the lack of evidence proving its effectiveness.

The multi-year plan proposal is contrary to statute. 42 U.S.C § 18022(e)(2) defines eligibility, coverage, and cost-sharing requirements for catastrophic health plans in terms of individual plan years. A “plan year,” as defined at 45 C.F.R. § 155.20, is a “consecutive 12-month period during which a health plan provides coverage for health benefits.” This proposal permits catastrophic health plans to be offered for multiple consecutive years in direct conflict with statutory language that such plans be offered on a “plan year” basis. For example, the ACA

¹⁸⁸ California Dept. of Managed Health Care, DMHC Applies to Update California’s Benchmark Plan, Expand Essential Health Benefits to Include Fertility Services, Hearing Aids & Wheelchairs (May 5, 2025), <https://dmhc.ca.gov/Resources/Newsroom/PressReleases/May5,2025.aspx>; Virginia State Corporation Commission, Virginia’s Essential Health Benefits Benchmark Plan, 2025 Review for Potential 2028 New EHB Benchmark Plan, <https://www.scc.virginia.gov/consumers/insurance/health-insurance-consumer/about-the-affordable-care-act/essential-health-benefits-benchmark-plan/#> (last visited March 3, 2026); Maine Bureau of Insurance, Essential Health Benefits (EHB) Benchmark Plan Update, 132 Maine Legislature, Health Coverage, Insurance, and Financial Services Committee (Jan. 2025), https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr/insurance/files/inline-files/EHB%20Benchmark%20Plan%20Initiative%20HCIS%202025_0.pdf.

¹⁸⁹ Kentucky Dept. of Insurance, *Kentucky Plan Year 2027 Benchmark Plan Change Actuarial Report* (April 28, 2025), <https://insurance.ky.gov/ppc/Documents/KY%20PY2027%20Benchmark%20Plan%20Change%20Actuarial%20FINAL%20Report%2020250428.pdf> (it is not clear if Kentucky submitted its EHB benchmark update).

¹⁹⁰ HRSA, Oral Health and Pregnancy, <https://www.hrsa.gov/oral-health/pregnancy> (last visited March 2, 2026).

requires a catastrophic health plan to provide no benefits unless an individual has incurred “cost-sharing expenses in an amount equal to the annual limitation in effect ... for *the plan year*” (emphasis added); permits an individual to enroll in a catastrophic health plan only if they have “not attained the age of 30 before the beginning of *the plan year*” (emphasis added); and permits an individual to enroll in a catastrophic health plan on the basis of being exempt from the requirement to maintain minimum essential coverage only if the individual “has a certification in effect for any *plan year* under this title (emphasis added)”.¹⁹¹

Moreover, HHS appears to base its multi-year plan proposal on its largely unrelated authority to develop guidelines on how issuers can utilize value-based insurance design (VBID) with respect to preventive services.¹⁹² Other than the fact that issuers of catastrophic plans are subject to the market-wide requirement to provide coverage of certain specified preventive services without cost sharing, there is no clear nexus between the multi-year catastrophic plan proposal and the authority to develop VBID guidance on preventive services.¹⁹³ Simply extending the term of a catastrophic health plan does not constitute VBID. Although VBID is not defined by the ACA or its implementing regulations, HHS has defined it in guidance as “health plan designs that provide incentives for enrollees to utilize higher-value and/or higher-quality services or venues of care.”¹⁹⁴ The University of Michigan Center for Value-Based Insurance Design, whose work HHS has cited in past rulemaking, defines VBID as “a potential solution built on the principle of lowering or removing financial barriers to essential, high-value clinical services.”¹⁹⁵ Permitting issuers to offer plans with extremely high cost-sharing and low actuarial value for multi-year plan terms would fail to achieve these aims, especially because such plans will cause greater financial and health risks for consumers. Finalizing this proposal would stretch HHS’s authority to issue guidance on VBID for preventive care past its breaking point and create a dangerous precedent that issuers could use to evade statutory requirements for preventive services requirements under the guide of implementing VBID.

The multi-year plan proposal would harm consumers. HHS claims that its proposal to permit the sale of multi-year catastrophic plans would benefit consumers and issuers in multiple ways: first, as a mechanism for offering less expensive coverage options; second, as an alternative to single-year plan terms that HHS believes promote churn and fail to incentivize issuers to invest in the health of enrollees; and finally, HHS claims that multi-year plans may decrease issuers’

¹⁹¹ 42 U.S.C. §§ 18022(e)(1)(B); 42 U.S.C. § 18022(e)(2)(A); 18022(e)(2)(B).

¹⁹² 42 U.S.C. § 300gg-13(c).

¹⁹³ 42 U.S.C. § 18022(e)(1)(b)(i).

¹⁹⁴ See FAQs about Affordable Care Act Implementation Part V, Q1, http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html. Frequently Asked Questions, *What is VBID?*, <https://vbidcenter.org/frequently-asked-questions>.

¹⁹⁵ See 85 Fed. Reg. 7088, 7137 (Feb 6, 2020) (“2021 NBPP NPRM”).

administrative costs associated with marketing and enrollment and “encourage alternative pricing structures” that could ultimately improve plan affordability. We support those goals but do not believe the current proposal is a good way to achieve them.

Overall, HHS does not offer any qualitative or quantitative data to support these claims. While HHS identifies legitimate challenges with affordability and access to preventive services in the present individual market landscape, the proposal fails to provide evidence to support its conclusion that permitting issuers to offer multi-year catastrophic plans would address these issues. In fact, HHS’s proposal presents major risks for consumers with respect to each of its stated justifications, because it promotes high-cost, low-value plans and permits issuers to impose cost sharing in excess of statutory limits.

HHS claims that multi-year catastrophic plans would offer consumers “less expensive options.”¹⁹⁶ Although the preamble does not clearly articulate the more costly comparator that forms the basis of this justification, we presume that HHS believes that catastrophic health plans offer less costly coverage than metal-tier QHPs. As discussed throughout these comments, catastrophic health plan premiums are not uniformly lower than unsubsidized bronze plan premiums. However, catastrophic health plans uniformly require much higher deductibles than most bronze plans. While the national average bronze plan deductible is roughly \$7,500 for an individual, self-only catastrophic plans are prohibited from providing benefits until the enrollee reaches the maximum annual cost-sharing limit.¹⁹⁷ In 2026, this translates to a \$10,600 deductible for a catastrophic health plan, which is set to increase to \$12,000 in 2027 — unless a separate proposal in the 2027 NBPP NPRM is finalized to impose cost-sharing limitations 130% above statutory limits, or \$15,600 for an individual.¹⁹⁸ While premiums may vary at the local level, catastrophic health plans generally represent a significant financial risk compared to QHP coverage for many people. Low- or middle-income households that would be unable to absorb a five-figure deductible, people with incomes between 100-400% FPL who qualify for PTCs to reduce the cost of metal-tier QHP premiums, and those with chronic health conditions would all likely be exposed to higher premium and/or out-of-pocket costs if enrolled in a catastrophic health plan compared to a QHP. Enrollees with substantial financial resources and who have few anticipated health costs may find that the risk inherent in catastrophic health plan coverage is a reasonable trade-off, but it is unclear whether or why

¹⁹⁶ 2027 NBPP NPRM at 6371.

¹⁹⁷ Michelle Long, et al., KFF, *Policy Changes Bring Renewed Focus on High-Deductible Health Plans* (Jan. 5, 2026), <https://www.kff.org/patient-consumer-protections/policy-changes-bring-renewed-focus-on-high-deductible-health-plans>.

¹⁹⁸ 2027 NBPP NPRM at 6382-6383.

such consumers would benefit from multi-year contract commitments. In HHS's own words: "There is uncertainty regarding consumer demand for multi-year catastrophic plans."¹⁹⁹

Further, HHS's proposal at 45 C.F.R. § 156.130(c) would permit issuers of multi-year plans to alter cost-sharing limitations across the life of a plan in ways that not only violate statutory cost-sharing requirements in the ACA, but could place enrollees at even greater financial risk than single plan-year catastrophic coverage.²⁰⁰ For example, HHS describes a scenario in which an enrollee suffering from a disease that requires multiple years of treatment, like cancer, could be subjected to higher cost-sharing during earlier years of a multi-year contract in order to "entice" them to remain in the plan during later years when cost-sharing could theoretically be reduced to achieve expected actuarial value, "as long as the average over all plan participants and over years of the annual limitation on cost sharing equals the average" over the length of the contract term of the annual statutory cost sharing limit.

As noted above, the ACA requires catastrophic plans to adhere to annual cost sharing limitations.²⁰¹ HHS does not have the authority to alter these statutory limits. Even if this type of plan design did not conflict with the statute, it raises serious affordability and access concerns for consumers. Most households cannot simply float deductible costs that exceed the already extremely high cost-sharing limits permitted for single-year catastrophic health plans. This can be true during a period of intensive medical treatment that could impact the ability of multiple family members to earn wages due to illness or caregiving obligations. HHS also fails to explain how this front-loaded cost sharing design would effectively drive down overall plan costs, even for enrollees who can absorb higher cost sharing in early contract years and maintain coverage in the same plan long enough to access relatively lower cost sharing in later contract years. Research proves that higher cost sharing reduces access and discourages individuals from using high-value and medically necessary services.²⁰² This research shows that front-loaded cost sharing would simply encourage individuals to go without essential services or to delay care until they can access lower cost-sharing limits in later contract years.²⁰³ Such

¹⁹⁹ *Id.* at 6454.

²⁰⁰ 42 U.S.C. §§ 18022(c)(1)(B) and (e)(B)(1).

²⁰¹ § 18022(e)(B)(1), applying annual cost-sharing limitations at § 18022(c)(B).

²⁰² Emmett B. Keeler, Effects of Cost Sharing on Use of Medical Services and Health, 8 MED. PRAC. MGMT. 317 (1992), <https://www.rand.org/pubs/reprints/RP1114.html>; Rajender Agarwal et al., *High Deductible Health Plans Reduce Health Care Cost and Utilization, Including Use of Needed Preventive Services*, 36 HEALTH AFF. 1762 (2017), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0610>.

²⁰³ Sujha Subramanian, *Impact of Medicaid Copayments on Patients with Cancer*, 49 MED. CARE 842 (2011), https://journals.lww.com/lww-medicalcare/Abstract/2011/09000/Impact_of_Medicaid_Copayments_on_Patients_With.9.aspx; Amitabh Chandra et al., *Patient*

delays often translate into worse health outcomes and higher costs for enrollees, especially for enrollees with higher health risks, like older adults, people with disabilities, and people battling cancer.²⁰⁴ Delays to care will also translate to higher costs for issuers, since delay and deferment in care will ultimately drive up costs across a sicker risk pool.

The Multi-Year Plan Proposal would neither resolve churn nor encourage issuers to offer more robust preventive services. HHS claims that single-year health plans on the individual market promote churn and fail to incentivize issuers to cover preventive services. We agree that a system that financially rewards issuers who delay or deny care does not promote positive health outcomes or protect consumers from financial distress. But HHS fails to explain why a multi-year catastrophic plan operating in essentially the same system would yield better results. HHS compares the different incentives between individual market issuers and large employers, stating that large employers have an incentive to invest in long-term employees through health promotion activities with a goal of reducing costs associated with a sicker work force and promoting overall health.²⁰⁵ However, HHS does not provide evidence to support its statement that benefits provided by large-group employers result in better health outcomes among their employees compared to individual market enrollees. Even if this statement were true, it fails to acknowledge that people in the individual market tend to be much older and significantly sicker than people in the large group market.²⁰⁶

Moreover, large employers have a relationship with their employees that goes beyond simply that between an insurer and a covered enrollee. Employers invest significant resources in their workforce and provide health insurance coverage as a fringe benefit to compete for and retain talent and to gain tax advantages. Similarly, workers have reasons other than retaining a specific health plan to remain employed. Merely extending the potential term of an individual market insurance contract does not convert the relationship between the two parties into that

Cost-Sharing and Hospitalization Offsets in the Elderly, 100 AM. ECON. REV. 193 (2010), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2982192/>.

²⁰⁴ *Id.*

²⁰⁵ 2027 NBPP NPRM at 6371.

²⁰⁶ Cotter, L., et al., Petersen-KFF Health Tracker, *How ACA Marketplace costs compare to employer-sponsored health insurance* (Nov. 2025), <https://www.healthsystemtracker.org/brief/how-aca-marketplace-costs-compare-to-employer-sponsored-health-insurance> (comparing the mean, median, and mode ages in Marketplace coverage [40, 41, and 64] to that of employer-sponsored coverage [33, 34, and 40]; Brett Lissenden and Marc Horvath, RTI International, *The ACA Individual Market Enrollees are Relatively Sick, but also Relatively Cheap, to Insure* (May 28, 2021), <https://www.rti.org/insights/aca-individual-market-enrollees> (finding that ACA individual market enrollees had 20% higher health risk than enrollees in the large employer market, but 27% lower health care costs than enrollees in the large employer market, due to higher cost-sharing and narrower networks in individual market plans).

between an employer and employee or convert individual market coverage into employer-sponsored insurance.

Particularly given that enrollees could still terminate their enrollment in a multi-year plan for any reason, including to select a different plan during annual Open Enrollment or if eligible for a Special Enrollment Period, it is unclear how a multi-year plan truly differs from single plan-year coverage, except providing issuers the flexibility to impose cost sharing in excess of statutory limitation during early contract years. Far from incentivizing issuers to offer richer preventive services benefits, the proposed multi-year catastrophic plans are more likely to place enrollees at greater financial and health risk. Ultimately, this approach to coverage will push enrollees who actually need health care to leave a multi-year catastrophic plan quickly for more affordable coverage, rather than remaining in a plan for the potential that cost sharing will be reduced in some future year.

HHS lacks evidence proving the Multi-Year Plan Proposal would decrease issuers' administrative costs. HHS states that issuers of multi-year catastrophic plans would benefit from reduced administrative costs related to marketing and enrollment but provides no support for this conclusory statement. As noted above, it is unclear whether simply offering the option for a multi-year plan would result in less churn, since enrollees could end the contract at any time. Particularly given the stated uncertainty regarding consumer demand for these products, HHS's assertion that multi-year catastrophic plans would allow issuers to reduce marketing and enrollment costs is unsupported by evidence. Separately, the proposal appears to allow enrollees to remain eligible for catastrophic coverage for up to a ten-year plan term on the basis of the enrollee's eligibility at the start of the contract, although the language in the preamble is unclear.²⁰⁷ While allowing an individual to remain enrolled in the same plan for up to a decade regardless of eligibility may reduce churn, it conflicts with statutory eligibility requirements for catastrophic health plans, which are based on an enrollee's eligibility in each plan year.²⁰⁸ Further, it raises the risk that the enrollee will remain in a plan that does not meet their evolving needs.

Further, the proposal would permit individuals to remain in a plan without re-verifying eligibility, which appears to conflict with the requirement in § 71303 of the One Big, Beautiful Bill Act.²⁰⁹ Given that HHS appears to be considering a future proposal to allow issuers to offer

²⁰⁷ This sentence in the preamble appears to be missing key language: "We propose that an individual who satisfies the requirements for a catastrophic plan at the time of enrollment in the plan under section 1302(e)(2) of the Affordable Care Act at the time of enrollment in the multi-year plan." *Id.* at 6371.

²⁰⁸ 42 U.S.C. § 18022(e)(2)

²⁰⁹ Pub. L. No. 119-21 (2025).

multi-year plans for other metal tiers, we note that the pre-verification requirements in § 71303 present a legal barrier to offering PTC-eligible metal-tier plans for multi-year terms in the future.²¹⁰

The Multi-Year Plan Proposal increases the risk of discrimination against people with disabilities. HHS would allow issuers of multi-year catastrophic plans to impose greater cost sharing on the basis of disease. Specifically, HHS states that an issuer of a multi-year catastrophic plan with a five-year term “could opt to vary the annual limitation on cost sharing in the plan by disease, for example, cancer, if that disease requires treatment that spans multiple years, so long as the average over all plan participants and over years of the annual limitation on cost sharing equals the average over 5 years of the annual limitation on cost sharing as required by statute.” HHS justifies this as a form of VBID, authorized under 42 U.S.C. § 300gg-13(c). But this type of plan design could easily be manipulated to allow issuers to screen out people with disabilities. Charging higher cost sharing for people with conditions that “span... multiple years” is an effective way to discourage people with chronic conditions and disabilities from selecting such a plan at all. Nor does the proposal foreclose the possibility that an issuer could increase cost sharing requirements for a current enrollee who receives a new diagnosis during the term of coverage. Raising cost-sharing on the basis of such health conditions would not only increase financial burden and reduce access to care when that individual needed it most but would also be likely to push the enrollee to seek a different plan at the next enrollment opportunity. HHS’s proposal appears ripe for abuse by issuers of multi-year catastrophic plans who could adjust cost-sharing to discriminate against individuals with disabilities and to encourage their movement to other carriers.

The Multi-Year Plan proposal does not provide sufficient detail to allow public comment on key design features. HHS has simply failed to provide sufficient detail on the Multi-Year Plan proposal to permit the public to submit comments without significant speculation. The gaps in the design of the proposal are numerous and raise fundamental questions about implementation of multi-year plans. For example, the proposal does not address whether issuers and regulators would be expected to develop and approve actuarially sound premium rates up to 10 years in advance or under what circumstances issuers would be permitted to alter cost-sharing, premiums, and other plan design features to keep a product viable and actuarially sound over the entire term of the contract. To the extent issuers can adjust these plan characteristics throughout the life of the contract, the value of a multi-year contract seems entirely weighted to benefit issuers, who HHS would permit to impose cost-sharing limitations that exceed the statutory requirements and discriminate on the basis of disability, chronic

²¹⁰ 2027 NBPP NPRM at 6371.

condition, and/or disease, while harming consumers who could be locked in to plans with unaffordable costs until they become eligible for another enrollment opportunity.

While HHS seeks public comment on a lengthy list of issues related to the implementation of these plans — including how offering such plans would affect an issuer's costs and MLR, how they interact with tax-preferred accounts such as HSAs and ICHRAs, market-wide premium and PTC impacts, and consumer impacts including how such coverage would affect a consumer whose health status changed during the term of a multi-year plan — simply requesting public feedback and data does not provide sufficient evidentiary and logical support to finalize design elements that are entirely lacking in the proposed rule. HHS even admits that there is currently no available evidence on these potential effects and data that could help understand the potential unintended consequences of the proposal.²¹¹ Given that lack of evidence, as well as the clear statutory authority issues and likelihood of negative impacts on consumers and the individual market risk pool, we strongly oppose this proposal.

§ 156.136 – Cost Sharing Requirements, § 156.155(a)(3) – Enrollment in Catastrophic Plans

HHS proposes to allow issuers that offer at least one bronze plan that meets the ACA's actuarial requirements and cost-sharing limits to also offer, in the same geographic area, a bronze plan that exceeds the established maximum out-of-pocket (MOOP) by an amount in increments of \$50.²¹² Similarly, HHS proposes to require catastrophic plans to only begin covering services when a consumer reaches 130% of the MOOP in order to effectuate distinctions between bronze plans and catastrophic plans and make the latter more appealing for healthier individuals.²¹³ HHS justifies these proposals by arguing that several factors (mainly the cost of covering EHBs and the increasing costs associated with enrolled populations) are making it difficult for insurers to comply with statutory actuarial requirements related to cost-sharing and levels of coverage even after taking into account actuarial value calculation adjustments.²¹⁴

While we acknowledge the mathematical difficulties that HHS and insurers face given the increasing costs of health care, we urge HHS to withdraw this proposal. As the agency repeatedly recognizes in the preamble to the Proposed Rule, the proposal would be contrary to the unambiguous terms of the ACA and, therefore, HHS has no authority to finalize it.

²¹¹ 2027 NBPP NPRM at 6455.

²¹² 91 Fed. Reg. 6373–6382.

²¹³ *Id.* at 6382–6383.

²¹⁴ *Id.* at 6374–6386.

The ACA requires all metal-tier plans to subject coverage of all EHBs to cost-sharing limits or MOOP.²¹⁵ This statutory requirement is not waivable. The agency does not have statutory authority to make exceptions or increase the cost-sharing limit in certain situations or for certain plans simply because not following the law would make it more feasible for plans to comply with other parts of the law. While HHS recognizes the statutory obligation throughout the preamble to the proposed rule, the agency nonetheless claims that the proposal is in line with Congressional intent because otherwise it would be essentially impossible to meet other actuarial requirements.²¹⁶ This statutory interpretation is erroneous. We see no need to decipher further congressional intent when the statute unambiguously indicates its intent: to not allow bronze and catastrophic plans from subjecting EHBs to cost-sharing beyond the MOOP. HHS must simply follow the law.

We also question why HHS is proposing to allow certain exceptions to the cost-sharing limits for bronze plans now when, as the agency acknowledges, plans are still able to meet their actuarial requirements despite the mathematical difficulties. As long as that is the case, HHS cannot claim that the different “statutory requirements cannot reasonably be satisfied simultaneously.”²¹⁷ As the Proposed Rule states, HHS could have proposed to allow bronze plans with higher MOOP “only when bronze plans would otherwise be non-viable (that is, impossible to design).”²¹⁸ While even that scenario goes beyond the ACA’s unambiguous directive, it would at least indicate that HHS is only proposing to deviate from the law when it is absolutely necessary in order to comply with other actuarial requirements and harmonize the overall implementation of the law. Instead, HHS carelessly disregards the statutory text in anticipation of a potential future conundrum. Without statutory authority, HHS’s only recourse is to ask Congress to change the law to account for these difficulties.

Likewise, HHS has no authority to deviate from the ACA requirements regarding catastrophic plans. The statute unambiguously establishes that, for a product to be considered a catastrophic plan, the plan must only cover services when the MOOP has been reached.²¹⁹ The

²¹⁵ 42 U.S.C. § 18022(c)(1)(B) (“In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall— (i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and (ii) in the case of other coverage, twice the amount in effect under clause (i). If the amount of any increase under clause (i) is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50).”

²¹⁶ 91 Fed. Reg. 6379.

²¹⁷ *Id.*

²¹⁸ *Id.* at 6381.

²¹⁹ 42 U.S.C. § 18022(e)(1)(B)(i) (“the plan provides – except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual

only exception to this rule, per the ACA, is to permit catastrophic plans to cover preventive services before the MOOP is reached. In fact, prohibiting catastrophic plan coverage before reaching a higher MOOP than contemplated in the law is directly contrary to the obvious and unambiguous intent of the statute to permit coverage after a lower MOOP level. There is no scenario where HHS is allowed or should unilaterally introduce exceptions to the statutory requirement.

While tied to the mathematical difficulties with the actuarial calculation HHS uses to justify the proposed cost-sharing changes for bronze plans, HHS also justifies the proposed changes to the MOOP limits for catastrophic plan coverage by arguing that, increasingly, consumers are selecting bronze plans over catastrophic plans. We disagree with HHS's assessment that such a result contradicts Congress's intent. The ACA's Marketplace reforms sought, primarily, to ensure that individuals who were previously unable to participate would now be able to join the market. The market is stronger when more people, including young and healthy individuals, select metal-tier plans rather than catastrophic plans.²²⁰ Therefore, while catastrophic plans are important for specific situations, lower enrollment levels do not justify ignoring the plan language of the statute.

§ 156.202 – Non-Standardized Plan Option Limits

We oppose HHS's proposal to discontinue non-standardized plan option limits and exceptions. Choice overload and the complexity of comparing plans in the ACA marketplace has been a challenge for many consumers. A 2023 Kaiser Family Foundation Study found that at least 35% of marketplace enrollees cited difficulties in choosing a plan; 41% percent of enrollees found it difficult to compare doctors, hospitals, and health care providers across plans; 31% had difficulty in comparing copays and premiums; and 25% reported challenges in comparing premiums.²²¹ Evidence has shown that choice overload can lead to poor outcomes for enrollees. A recent RAND Corporation study shows that when consumers are given too many plan choices, there is greater potential to make poor enrollment decisions. Multiple factors result in less-than-optimal plan choice, including but not limited to the challenge of processing complex health plan information, inadequate decision support tools, and low health literacy

has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713)").

²²⁰ See, e.g., Am. Acad. of Actuaries, *Step Towards a More Sustainable Individual Health Insurance Market* (2017), <https://actuary.org/steps-toward-a-more-sustainable-individual-health-insurance-market/>.

²²¹ Kaye Pestaina et al., Kaiser Family Found., *Signing Up for Marketplace Coverage Remains a Challenge for Many Consumers* (Oct. 30, 2023), <https://www.kff.org/affordable-care-act/signing-up-for-marketplace-coverage-remains-a-challenge-for-many-consumers/>.

and numeracy.²²² Consumers may incorrectly calculate costs, or focus on premiums without even considering total out-of-pocket costs. When there are too many options, consumers may also be susceptible to how choices are presented on the website. For example, someone might select a plan merely because it is presented first on the website. Of most concern, consumers may experience decision fatigue and not enroll in health insurance at all.

HHS also claims that part of the rationale for discontinuing non-standardized plan option limits and exceptions, is that these policies are “an ineffective strategy in counteracting plan proliferation.”²²³ To bolster this argument, HHS cites plan data from plan years 2023, 2024, and 2025. Doing so ignores the fact that the strictest plan limitations on non-standardized plans were only introduced in plan year 2025. One year is simply not enough time to measure the impact of this policy.

In addition to limiting plan selection, the evidence shows that outreach efforts help optimize plan selection and help consumers avoid choice errors. A Covered California analysis found that nearly 20,000 Covered California consumers selected more expensive gold and platinum plans in 2019 despite being eligible for a less expensive enhanced silver plan with richer benefits.²²⁴ Covered California sent additional emails and letters to these consumers describing the financial savings if they switched to the silver product, and as a result, roughly 20% of these individuals switched to a silver plan with a lower premium and cost-sharing savings.²²⁵ This analysis clarifies that consumers make suboptimal plan selections simply because of the sheer number of plans to choose from, and the complexity of information on Marketplace platforms. HHS should require Marketplaces to implement a multi-pronged approach to helping consumers navigate the platforms to make sound plan selections. Further, if HHS truly wants to improve consumer experience in navigating and selecting the best health plan, they should restore Federal Navigator funding to its previous levels.²²⁶ Federal Navigators are unbiased representatives trained to help consumers search for an optimal plan to meet their individual needs.

²²² Erin Audrey Taylor et al., *Consumer Decisionmaking in the Health Care Marketplace*, RAND Corp. (2016), https://www.rand.org/pubs/research_reports/RR1567.html.

²²³ 91 Fed. Reg. at 6391.

²²⁴ Andrew Feher & Isaac Menashe, *Using Email and Letters To Reduce Choice Errors Among ACA Marketplace Enrollees*, Health Affs. 812, 814 (May 2021), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.02099>.

²²⁵ *Id.* at 815.

²²⁶ Dept. of Health & Human Servs., *CMS Announcement on Federal Navigator Program Funding* (Feb. 14, 2025), <https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding> (noting that funding for Federal Navigators was cut by 90%).

§ 156.235 – Essential Community Providers

HHS proposes, beginning in plan year 2027, to lower the Essential Community Provider (ECP) participation standard from 35% to 20% for both medical QHP and SADP issuers. HHS also proposes to reduce the separate minimum thresholds for Federally Qualified Health Centers (FQHCs) and Family Planning Providers that qualify as ECPs from 35% to 20%. We strongly oppose reducing these minimum percentage requirements. The current threshold or a higher percentage is appropriate to help ensure that QHP enrollees have access to these providers.

Including adequate levels of ECPs – including FQHCs and Family Planning Providers – in QHP networks is essential to improving health outcomes and advancing health equity.²²⁷ ECPs serve predominantly low-income and medically underserved populations. ECPs function as a lifeline for patients who would otherwise struggle to access or afford care. Lowering the thresholds from 35% to 20% would narrow provider networks and significantly impede access to essential services, particularly for women of childbearing age; Latinos and members of other historically marginalized communities; young people; LGBTQIA+ individuals; people with disabilities; and individuals living in rural communities.

QHPs serve large numbers of women of childbearing age, making it critically important that networks include sufficient family planning providers and other ECPs equipped to meet their reproductive and preventive health needs.²²⁸ Access to quality family planning services is associated with improved maternal and infant health outcomes by enabling individuals to plan, delay, and space pregnancies.²²⁹ Access to family planning providers has become increasingly difficult due to the defunding of clinics, stagnant Title X funding, low reimbursement rates, and

²²⁷ Cristina Jade Peña et. al., KFF, *Federal and State Standards for “Essential Community Providers” Under the ACA and Implications for Women’s Health* (2015), <https://www.kff.org/womens-health-policy/federal-and-state-standards-for-essential-community-providers-under-the-aca-and-implications-for-womens-health/>.

²²⁸ Jennifer J. Frost et. al., Guttmacher Inst., *Publicly Supported Family Planning Services in the United States: Likely Need, Availability and Use, 2020*, <https://www.guttmacher.org/report/publicly-supported-FP-services-US-2020>.

²²⁹ See Laurel W. Rice et al., *Universal Access to Contraception: Women, Families, and Communities Benefit*, 222 Am. J. Obstet. Gynecol. 2 (2020), <https://www.sciencedirect.com/science/article/abs/pii/S0002937819311214>; Megan L. Kavanaugh & Ragnar M. Anderson, Guttmacher Inst., *Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers* (2013), https://www.guttmacher.org/sites/default/files/report_pdf/health-benefits.pdf; Office of Disease Prevention and Health Promotion, *Healthy People 2020, Family Planning*, <https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/family-planning> (highlighting some of the negative health outcomes associated with unintended pregnancy).

other attacks on sexual and reproductive health care.²³⁰ Reducing the minimum participation thresholds for Family Planning Providers that qualify as ECPs from 35% to 20% would further limit QHP enrollees' ability to access timely and adequate family planning services.

Ensuring meaningful access to these providers is particularly urgent given the nation's maternal mortality crisis, which disproportionately affects Black and other historically marginalized communities.²³¹ Black women experience higher rates of preterm birth and are more likely to have chronic conditions such as anemia, heart disease, diabetes, and hypertension that increase the risk of severe maternal morbidity and poor birth outcomes if left unmanaged prior to pregnancy.²³² Additionally, they face a higher risk of developing life-threatening heart failure during the late stages of pregnancy and postpartum.²³³ Robust ECP participation standards help ensure access to preventive care and chronic disease management services that are critical to addressing these disparities.

ECPs – including Community Health Centers, Ryan White providers, and STD clinics – also deliver essential preventive and treatment services. Early detection and treatment of sexually transmitted infections can prevent chronic pelvic pain, infertility, miscarriage, neonatal complications, increased HIV risk, cancer, neurological consequences, and death.²³⁴ Early HIV diagnosis is key to successful treatment outcomes.²³⁵ Likewise, routine screenings for breast and cervical cancer improves survival by facilitating early detection and timely care.²³⁶ Weakening ECP participation standards would jeopardize access to these life-saving services.

²³⁰ Céline Gounder, KFF Health News, *The Quiet Collapse of America's Reproductive Health Safety Net* (Oct. 2025), <https://kffhealthnews.org/news/article/title-x-family-planning-hhs-opa-trump-cuts-reproductive-health-maine/>.

²³¹ The United States has the highest maternal mortality rates among well-resourced nations with Black women experiencing significantly higher rates than other demographics. Latoya Hill *et al.*, KFF, *Racial Disparities in Maternal and Infant Health: Current Status and Key Issues* (Dec. 2025), <https://www.kff.org/racial-equity-and-health-policy/racial-disparities-in-maternal-and-infant-health-current-status-and-key-issues/#:~:text=Pregnancy%2Drelated%20mortality%20rates%20among,14.9%20per%20100%2C000>.

²³² Jasmine D. Johnson *et al.*, *Racial Disparities in Prematurity Persist Among Women of High Socioeconomic Status*, *Am. J. Obstet. Gynecol.*, (Aug. 2020), <https://pmc.ncbi.nlm.nih.gov/articles/PMC7654959/>.

²³³ Black women are also more likely to be diagnosed later and less likely to recover. Olga Corazón Irizarry *et al.*, *Comparison of Clinical Characteristics and Outcomes of Peripartum Cardiomyopathy Between African American and non-African American Women*, *JAMA Cardiol.* 2:1256–1260 (2017), <https://pubmed.ncbi.nlm.nih.gov/29049825/>.

²³⁴ Jeffrey S. Crowley *et al.*, *Sexually Transmitted Infections: Adopting a Sexual Health Paradigm*, Nat'l Academies of Sciences, Engineering, and Medicine (2021) <https://pubmed.ncbi.nlm.nih.gov/34432397/>.

²³⁵ Margaret T. May, *Better to Know: The Importance of Early HIV Diagnosis*, 2 *The Lancet Public Health* e6 (2017), [https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667\(16\)30038-X/fulltext](https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(16)30038-X/fulltext).

²³⁶ American Cancer Society Recommendations for the Early Detection of Breast Cancer,

ECPs are trusted providers within many marginalized communities. These populations frequently encounter discrimination, bias, and culturally incongruent care in other health settings. Robust participation standards are necessary to guarantee that QHP networks meaningfully include the providers these communities rely upon. Reducing the thresholds risks destabilizing safety-net providers, including Family Planning Providers, and diminishing access to critical services in historically underserved areas. Illustrating the importance of these providers, two-thirds of Federally Qualified Health Center patients come from historically marginalized communities, including nearly 40% who are Latino.²³⁷

HHS seeks comment on whether the proposed 20% threshold would maintain access to ECPs for enrollees in rural areas and reduce barriers to issuer participation in rural areas. We believe the proposal would diminish rural residents' access to ECPs. Rural residents already face reduced access to care and poorer health outcomes compared to urban and suburban populations.²³⁸ These disparities have been exacerbated by rural hospital closures and the loss of obstetric services.²³⁹

In regions such as Appalachia, life expectancy lags significantly behind the national average, and residents experience elevated rates of disability, diabetes, preterm birth, low birthweight, maternal diabetes, maternal hypertension, and maternal mortality.²⁴⁰ At the same time, these

<https://www.cancer.org/cancer/types/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html>; American Cancer Society Guidelines for the Prevention and Early Detection of Cervical Cancer, <https://www.cancer.org/cancer/types/cervical-cancer/detection-diagnosis-staging/cervical-cancer-screening-guidelines.html>.

²³⁷ Eun Kyung, et al. (July 1, 2023). "[Spatial availability of federally qualified health centers and disparities in health services utilization in medically underserved areas](#)". *Social Science & Medicine*. **328** 116009. doi:10.1016/j.socscimed.2023.116009. ISSN 0277-9536. PMID 37301106

²³⁸ CDC, About Rural Health (2024), <https://www.cdc.gov/rural-health/php/about/index.html#:~:text=People%20who%20live%20in%20rural,exposure%20to%20specific%20environmental%20hazards>.

²³⁹ During the past two decades, rural counties experienced persistent losses of hospital-based obstetric services, with losses disproportionately affecting the most remote, rural areas of the United States. Katy Backes Kozhimannil *et al.*, Health Affairs, Obstetric Care Access Declined In Rural And Urban Hospitals Across US States, 2010–22 (July 2025), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2024.01552>. See also Christine Durrance *et al.*, *The Effect of Rural Hospital Closures on Maternal and Infant Health*, Health Serv Res. (April 2024), <https://pmc.ncbi.nlm.nih.gov/articles/PMC10915477/>; Paula Chatterjee, *Causes & Consequences of Rural Hospital Closures*, 17 J Hosp Med. 938-939 (Nov. 2022), <https://pmc.ncbi.nlm.nih.gov/articles/PMC9633454/>.

²⁴⁰ David L Driscoll *et al.*, *Assessing and Addressing the Determinants of Appalachian Population Health: A Scoping Review*, 5 J Appalch Health 85-102 (Dec 2023), <https://pmc.ncbi.nlm.nih.gov/articles/PMC11110904/>; Gopal K. Singh *et al.*, 36 Health Affairs 1423-32 (Aug. 2017) *Widening Disparities In Infant Mortality And Life Expectancy Between Appalachia And The Rest Of The United States, 1990–2013*.

communities face persistent provider shortages.²⁴¹ Lowering ECP thresholds would further narrow already limited rural networks. Rural communities need more ECP participation not less.

HHS suggests that lowering the thresholds would reduce administrative burden for QHP issuers, particularly in rural states, which have fewer ECPs. However, Section 1311(c)(1)(C) of the Affordable Care Act requires that a QHP's network include ECPs, *where available*.²⁴²

Additionally, issuers are required to contract with a percentage of available ECPs in a service area, not a fixed number. Moreover the regulatory history demonstrates that issuers are capable of meeting the current standards.

HHS suggests that reducing the overall threshold, FQHC threshold, and Family Planning Provider threshold requirements from 35% to 20% would provide additional flexibility for QHP issuers to build provider networks and minimize disruptions for issuers in adjusting to meet the threshold requirements. However, from 2015 through 2017, issuers were required to contract with at least 30% of available ECPs. That threshold was reduced to 20% beginning in 2018 and then raised to 35% beginning in PY 2023. At the time, many stakeholders including providers, provider associations, and consumer advocacy groups supported raising the threshold from 20% to 35% to strengthen access to care.²⁴³ The Final NBPP Rule for PY 2024 further strengthened standards by adding separate 35% thresholds for FQHCs and Family Planning Providers.

Data confirms issuers' capacity to comply. For PY 2021, 80% of medical FFE issuers apparently satisfied a 35% threshold.²⁴⁴ In 2017, only 6% of issuers failed to meet the 30% threshold and were required to submit a narrative justification.²⁴⁵ As explained in the current proposed rule, based on an analysis of PY 2025 FFE plan data only a small additional number of issuers would newly satisfy the reduced thresholds.

This data demonstrate that most issuers have not struggled to meet the current ECP standards and likely have the capacity to maintain broader networks. Maintaining the current 35%

²⁴¹ Kaitlyn Palmer *et al.* *Unique Health Care Delivery Considerations in Rural America*, Int J MS Care (Feb. 2025), <https://pubmed.ncbi.nlm.nih.gov/40045977/>.

²⁴² Patient Protection and Affordable Care Act § 1311(c)(1)(C), Pub. L. No. 111-148, 124 Stat. 119 (2010).

²⁴³ 87 Fed. Reg. 27208 (2022), *Notice of Benefit and Payment Parameters for 2023 Final Rule*, <https://www.federalregister.gov/d/2022-09438/p-1623>.

²⁴⁴ *Id.*

²⁴⁵ 82 Fed. Reg. 10980 (2017), *Market Stabilization Proposed Rule 2017* <https://www.federalregister.gov/documents/2017/02/17/2017-03027/patient-protection-and-affordable-care-act-market-stabilization>.

threshold would not impose new or unprecedented obligations, as issuers have complied with this requirement since PY 2023.

HHS proposes to revise §§ 156.235(a)(3) and (b)(3) to eliminate the requirement that issuers provide a narrative justification when they do not meet the ECP participation standard, describing how their network ensures an adequate level of service for low-income enrollees and how the plan's provider network will be strengthened toward satisfaction of the ECP standard prior to the start of the benefit year. Instead, issuers would only need to report the status of contract offers to qualified ECPs available in the plan's service area as part of its QHP application. We oppose this proposal.

This provision has the potential to become the exception that swallows the rule. Without meaningful enforcement of ECP participation standards, individuals who depend on ECPs will have diminished access to the care they need. Given the importance of including ECPs in QHP networks, HHS should not provide issuers with leeway to avoid meeting ECP standards.

Given the central role ECPs play in advancing health equity and ensuring access to care, HHS should preserve and strengthen existing participation requirements rather than weaken them.

§ 156.236 Provider access and essential community providers standards for non-network plans.

This unjustified policy reversal would allow issuers to administer so-called non-network plans as qualified health plans. The proposed guardrails are insufficient to prevent widespread confusion and virtually ensure a major spike in rates of medical debt if non-network plans are allowed to proliferate.

The proposed defined-benefit plan structure is a recipe for medical debt disaster. The administration justifies its proposal to allow non-network plans based on two assumptions that these plans will lower health care costs: (1) empowering enrollees to utilize price transparency information to shop for lower prices and negotiate directly with providers, thus fostering increased competition, and (2) eliminating substantial administrative overhead associated with traditional network management, potentially resulting in lower premiums.²⁴⁶

²⁴⁶ CMS, *Fact Sheet: HHS Notice of Benefit and Payment Parameters for 2027 Proposed Rule* (Feb. 9, 2026), <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-payment-parameters-2027-proposed-rule>.

The first assumption glosses over the realities of how and when people access health care services and ignores the complexities and ongoing lack of transparency of health care costs. Despite some recent regulation changes affecting hospitals and ambulatory surgical centers, efforts to improve transparency in health care pricing remain in their infancy. Health care is not a grocery store. Different prices are commonly negotiated with different payers, so even if hospitals report their actual standard charges, those may show up to a consumer as a range of rates.²⁴⁷ Other types of providers may not be subject to even these rudimentary transparency requirements. Recent reports provide ample details on the multiple, on-going challenges of achieving effective price transparency in health care.²⁴⁸ The fact is consumers still have extremely limited capacity to find out ahead of time what a given health service might cost, or how different potential charges might adhere to a given procedure.

Even if health care consumers were able to quickly and reliably price out services needed during a health care episode, the reality is that people who need health care often do not have the luxury of comparing or negotiating prices across a range of providers. For example, an individual experiencing chest pains and shortness of breath will call an ambulance and go to the nearest hospital without first checking the cost of the ambulance or emergency room visit. Under a non-network plan, this individual would be liable for any charges above what the plan's benefit amount might be. Subsequent charges in a single episode could pile debt on debt. An older adult with shingles may be in too much pain to haggle over how much a provider charges for an exam and recommended course of treatment

While it is true that other health care services, like a knee surgery, may not be so time dependent and could allow for cross-provider price comparisons, the individual has extremely limited power to negotiate prices with providers. One of the main sources of leverage that payers have in negotiating health care provider prices is the number of potential patients they bring to the table. No individual has that kind of leverage. They will instead be largely at the mercy of providers who are under no contractual obligation to accept the benefit offered by the non-network plan as full payment. Even if the provider first attests that they would accept the payment, there is little to hold them accountable to stick to their promise. The end result under this policy is that consumers lose. Contractual obligations govern more than just price,

²⁴⁷ See, CMS, *Fact Sheet: CY 2026 OPPS and Ambulatory Surgical Center Final Rule - Hospital Price Transparency Policy Changes* (Nov. 21, 2025), <https://www.cms.gov/newsroom/fact-sheets/cy-2026-opps-ambulatory-surgical-center-final-rule-hospital-price-transparency-policy-changes> (requiring hospitals and ambulatory surgical centers to disclose real median prices along with the 10th and 90th percentile charges, for common services).

²⁴⁸ Gary Claxton et al., Peterson-KFF, *Challenges with Effective Price Transparency Analyses* (Feb. 25, 2025), <https://www.healthsystemtracker.org/brief/challenges-with-effective-price-transparency-analyses/>.

they also incorporate elements of care quality, coordination across providers, and other consumer protections that would be lost under this proposed non-network structure.

The second assertion HHS makes is that non-network plans may save on the administrative cost of managing and maintaining a provider network, which could lead to lower premiums. This is a largely meaningless assumption, however, when considering the full cost of health care. These plans will no doubt be designed to look inexpensive with low front-end premiums, because they have no apparent obligation to cover the full cost of services should those costs exceed the defined benefit amount. These plans do not appear to be subject to rules about out-of-pocket maximums and it is unclear how ACA consumer protections like no-cost sharing preventive care would extend to these proposed non-network plans.²⁴⁹

In short, most of the cost risks in proposed non-network plans appear to accrue to individual enrollee who purchases the plan, and the proposed rule includes little analysis on how key consumer protections would be maintained.

In addition, HHS's proposal to ensure that non-network plans provide adequate access to care is insufficient. HHS previously expressed "doubt that a plan without a network can comply with the statutory requirement at section 1311(c)(1)(C) of the ACA."²⁵⁰ We are not aware of any regulatory standards that evaluate whether a non-network plan offers a sufficient selection of providers without excessive burden on its members.²⁵¹ It is not at all clear how HHS's proposal to ensure that non-network plans provide adequate access to care would be implemented, or what recourse non-network plan members would have if they are unable to access necessary care. We agree with HHS's previous conclusion that this type of plan is not consistent with the ACA's statutory mandate and should not be permitted.

We oppose the reintroduction of the option to certify non-network plans as QHPs. The proposed "assurances" in this NPRM simply do too little to allow individuals to reasonably evaluate the true risks and costs associated with this plan structure.

²⁴⁹ 45 CFR 147.130(a). The current federal regulation requires network plans to cover preventive services provided by in-network providers without cost sharing, but it does not contemplate how a non-network plan, which has no in-network providers would prevent balance billing for these services.

²⁵⁰ Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024, 87 Fed. Reg. 78206, 78286 (2022).

²⁵¹ We note that California's Department of Insurance has issued adequacy and access standards that apply across licensed health care products, including both network plans (such as PPOs) and traditional indemnity plans. See Cal. Dep't Ins., Provider Network Adequacy, <http://www.insurance.ca.gov/01-consumers/110-health/10-basics/pna.cfm> (last visited Mar. 3, 2026). While these standards account for the selection of providers, they do not measure the burden on members, and thus we cannot recommend them.

§ 156.1130 – Quality Standards: Quality Improvement Strategy

While there is no actual regulatory text, HHS seeks comment on proposed changes to the Quality Improvement Strategy (QIS). We oppose HHS's proposal to eliminate a guideline that QHP issuers address health and health care disparities as a specific topic area within their QIS. As recognized in the 2023 Payment Notice, addressing persistent inequities in health care outcomes is critically important.

HHS rationalizes this proposal saying it would allow QHP issuers to select the two topic areas most relevant to their population and operational context. However, all QHPs should be enrolling diverse populations and identify and address existing inequities focusing their efforts on recognizing and eradicating them. Instead, the proposed change would allow QHPs, and HHS itself, to ignore health care disparities and the interventions that could address them.

Overt discrimination remains prevalent, but does not explain the full range of health disparities. Implicit bias — unconscious attitudes or stereotypes that affect our actions and decisions — and structural racism and discrimination reproduce disparate outcomes. Structural discrimination refers to the systems, public policies, institutional practices, cultural representations, and other norms that generate and reinforce inequities among specific groups, such as racial and ethnic groups.

We recognize, as HHS noted in the preamble, that improving health care quality and outcomes for all is important. Yet, ample evidence documents health care inequities. Ignoring the evidence and eliminating a focus on health and health care inequities will only serve to whitewash QIS and allow these inequities to continue unabated. Further, interventions to address the inequities often improve health care quality for everyone. We strongly oppose the elimination of the existing guideline that QHP issuers address health and health care disparities in their QIS.

Conclusion

We have included numerous citations to supporting research, including direct links to the research. We direct HHS to each item we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If HHS is not planning to consider these materials part of the

record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies and articles into the record.

Thank you for your attention to our comments.