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 Srvs., *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,

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[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 Rue 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.

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[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/cciio/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]

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[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 Dakota 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-

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[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.

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[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. <u>The SBE-EDE Option is contrary to law</u>

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]

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[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/cciio/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/cciio/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-

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

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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

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[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, 20220), 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

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[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., at 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.

[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/do/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 Srvs., *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.

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[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

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[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 Srvs., 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 Srvs., 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 Srvs., 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

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[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.
[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

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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

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[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]

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[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 sub-set 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

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[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

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[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 OBBB 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

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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

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[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

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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.,* Shawnna 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

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[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.

[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/cciio/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. <u>The ten categories of EHB are only a minimum and HHS can include other benefits as EHBs</u>

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

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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); U.S. Dept. of Health and Human Srvs., *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 Srvs., *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 Srvs., *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

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[154] U.S. Dept. of Health and Human Srvs. *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 Srvs., 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.

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[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 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.
[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

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[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. <u>The multi-year plan proposal is contrary to statute</u>

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. <u>The multi-year plan proposal would harm consumers</u>

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

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[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/cciio/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

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[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

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[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 time[191]. 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. <u>The multi-year plan proposal increases the risk of discrimination against people with disabilities</u>

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

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[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*"

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[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.

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[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

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[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/do/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

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[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 Center*s (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.

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health-current-status-and-key-issues/#:~:text=Pregnancy%2Drelated%20mortality%20rates%20among,14.9%20per%20100%2C000.

[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.

[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

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[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.

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[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

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[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

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[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