March 13, 2026

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

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

Dear Secretary Kennedy:

Thank you for the opportunity to submit comments on the Notice of Benefit and Payment Parameters (NBPP) for 2027 Proposed Rule, issued by the Department of Health and Human Services (herein "Department" or "HHS").

The undersigned organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country, including individuals who rely on the patient protections provided under the Affordable Care Act (ACA). Our organizations have a unique perspective on what patients need to prevent disease, cure illness and manage chronic health conditions. Our breadth enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion.

In March of 2017, our organizations came together to form the Partnership to Protect Coverage. Together, we agreed upon three overarching principles[1] to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefit (EHB) package.

The Department's proposals would, if finalized, substantially undermine each of these principles. The 2027 NBPP would create new coverage products with sky-high deductibles in excess of legal limits, which, according to the Department, consumers could be "locked into" for multiple years. It would authorize insurers to sell products where all doctors are out-of-network and consumers would be expected to bargain with providers for all services and prescriptions, or else face near-total exposure to a surprise medical bill. The Department would allow states to offload all marketplace enrollment responsibilities to private companies – even though these companies have been the source of consumer confusion and, in some cases, outright fraud. And it would try again to erect burdensome administrative barriers for consumers seeking to enroll in marketplace coverage — barriers that a federal court just last fall set aside.

Many of the ideas offered in the NBPP are lacking in supporting detail and analysis. If finalized, these underdeveloped proposals will create confusion and uncertainty in insurance markets already navigating significant shifts in federal policy. The Department's own best estimate is that the rule would cut marketplace enrollment by up to 2 million people while also raising premiums.[2] These effects will hit the same people already facing massive cost increases due to the expiration of the enhanced marketplace premium tax credits. Simply put, the proposals would make coverage more complicated and less affordable.

We provide additional comments and recommendations regarding specific provisions of the rulemaking below.

Catastrophic Plans

Catastrophic plans provide the skimpiest coverage available in the marketplaces. In 2026, they carry a deductible of $10,600 for an individual ($21,200 for a family) and, with the exception of three primary care visits and specified preventive services, cover no services until the enrollee meets this deductible. These plans provide basic financial protection against catastrophic costs. They offer little value to consumers with anticipated care needs, even less to the patients we represent who would have to bear the full cost of treatment for serious, often chronic medical conditions up to that high deductible.

[1] https://www.protectcoverage.org/ppc-consensus-healthcare-reform-principles

[2] We address more fully the Department's assertions regarding the premium impact of its proposals, below.

The value of these plans is limited by statutory design, and the ACA narrowly circumscribes who is eligible to enroll in them. Under the law, catastrophic plan eligibility is restricted to people under age 30 and those who are, for specific reasons defined in statute, exempt from having to pay the ACA's (now defunct) individual mandate penalty. The relevant scenario is this: if an individual "suffered a hardship with respect to the capability to obtain [metal tier marketplace] coverage," they would be excused from paying the tax penalty and could enroll, as a last resort, in a catastrophic plan.

The Department offers a cluster of proposals to transform catastrophic plans in ways neither intended nor authorized by federal law. These proposals would launch a new, multi-year coverage product that would feature a $31,200 deductible or higher, as the Department suggests insurers could impose a much higher deductible if the deductible averages to $31,200 over the life of the product. The Department would offer consumers the opportunity to be locked into such a plan for multiple years, perhaps as many as ten. And it introduces new risks: private actors eager to exploit this novel and poorly defined regulatory option could end up destabilizing the market, and harming all consumers, including those who avoided these products entirely.

Catastrophic Plans: Expansion of Hardship Exemption (§ 155.605(d)(1))

As observed above, eligibility for catastrophic plans is restricted by statute, in a manner that reinforces other elements of the ACA framework and that is consistent with the law's purpose. These limited plans, which cannot be paid for with premium tax credits, were not intended to be available broadly to marketplace consumers. Rather, they were designed as a "better than nothing" option for young and healthy people and individuals with extenuating circumstances (who "suffered a hardship") such that imposing a tax penalty on them would be unfair.

As it stands in 2026, there is no federal tax penalty for anyone. The original rationale for making available a hardship exemption no longer exists. There is no practical reason to obtain a hardship exemption, other than to enable the purchase of an unsubsidized catastrophic plan to which Congress has otherwise restricted access.

The Department proposes to disregard this framework and codify a "broad nationwide hardship exemption" for all people who are ineligible for premium tax credits or cost-sharing reductions due to their income. We note that many of the individuals now ineligible for premium tax credits are in that position because Congress and the Administration did not maintain enhancements to the premium tax credits.

Department regulations currently interpret the hardship exemption to apply to individuals 1) who experienced circumstances, such as a natural or human-made disaster, that caused the individual to have a significant unexpected increase in essential expenses; 2) for whom the expense of purchasing marketplace coverage would have caused them to experience serious deprivation of food, shelter, clothing, or other necessities; or 3) who experienced other circumstances that "prevented" them from obtaining coverage. Whatever flexibility may exist under the ACA to expand eligibility for a hardship exemption and catastrophic coverage beyond these traditional bases, the Department has clearly exceeded it in this proposal. The proposed rule casts so broadly as to include individuals (from 250%-400% FPL) who remain eligible for premium tax credits. These consumers can continue to use financial assistance to purchase more robust metal tier coverage. Indeed, analysis suggests they can enroll in this

more protective marketplace coverage while spending less on premiums than they would for a catastrophic plan.[3]

We urge that the Department to tailor its exemption to low-income individuals ineligible for premium tax credits.

Catastrophic Plans: Multi-Year Plans (§§ 156.130(c) and 156.155(a)(6))

The Department's planned expansion of eligibility for catastrophic plans is paired with proposals that would create a new catastrophic insurance product that individuals could enroll in for up to 10 years at a time. Health coverage with a policy term of more than one year does not exist in the individual market, nor anywhere else as we understand it. (Certainly, the proposal identifies no precedent for its this approach.)[4] Numerous ACA provisions are premised on plans having an annual term. Catastrophic plans, specifically, are defined through criteria they must satisfy in the given "plan year." These plans are, for example, subject to the "annual" limitation on cost-sharing that is in effect "for the plan year" — a requirement that makes sense, given that this annual limitation is required by statute to be recalculated on an annual basis. HHS attempts to resolve the mismatch by ignoring the word "annual": the proposal would allow insurers to sell plans that exceed the annual statutory cap, so long as their cost-sharing limits average to the statutory threshold over the duration of the plan.

The legal and operational challenges of making the Department's multi-year plan concept work are evident in the many questions the proposal leaves unanswered. How would these new plans "interact[]" with the ACA's statutory consumer protections? How would they interact with federal tax policy; would these plans create conflicts with those federal laws? How would multi-year plans be treated for purposes of Medical Loss Ratio (MLR) requirements? How should risk adjustment work; what data should the Department use? What coverage terms will an insurer be allowed to change over the life of the policy, and at what intervals? Here, it seems at least some changes to cost-sharing parameters are on the table, but we are not told more.

These are not minor implementation details. They are foundational policy questions whose answers will determine how multi-year plans are priced and regulated. The Department is creating a situation where there will be a new coverage product with which no one has any experience and for which insurers may be afforded extraordinary latitude to fill in the blanks, creating the potential for abuse and instability.

The Department tells insurers they should market a multi-year product with a deductible above the statutory limit in the early years and more consumer-favorable limits in the later years, to "entice" consumers to remain enrolled for the duration of the plan. Yet insurers could offer this enticement and then terminate the plan mid-term, after benefiting from the low-exposure years but before the enrollee reaches the more consumer-friendly later years Insurers could cause significant harm to enrollees and the broader market by discontinuing these plans mid-term, even once.

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[3] [3] David M Anderson, et al., Will expanding catastrophic coverage eligibility increase marketplace premium affordability in 2026?, Health Affairs Scholar, Volume 3, Issue 11. November 2025. https://doi.org/10.1093/haschl/qxaf202

[4] While we understand that employers or plan sponsors may sometimes enter into multiyear purchasing contracts with insurers or administrators, these arrangements are fundamentally different than one in which the actual coverage instrument is locked for years at a time.

The proposed rule lacks clarity and consistency regarding an enrollee's option for switching coverage under a multi-year plan. While HHS clarifies, in one part of the preamble, that it is not proposing to revoke statutory guaranteed availability and renewability rights, it elsewhere observes that its multi-year product may "reduc[e] consumer flexibility to switch plans in response to changing health needs or life circumstances" and says it is uncertain how consumers will respond when they are "locked into" a multi-year catastrophic plan and then get sick.

In fact, this is one element of the proposal that is certain: a consumer who develops cancer, is diagnosed with multiple sclerosis, or experiences a serious mental health crisis while enrolled in a catastrophic plan will face enormous out-of-pocket costs with no meaningful pre-deductible coverage beyond three primary care visits and preventive services. A consumer "locked into" that plan for years is a consumer locked into inadequate coverage during the period they need care the most.

We strongly oppose any policy that would lock consumers into a multi-year plan, or that would penalize enrollees who would choose a different plan during open enrollment or a special enrollment period for which they are otherwise eligible. Health needs change. Financial circumstances change. A consumer who enrolls in a 10-year catastrophic plan at age 35 may, by age 40, have developed a condition that makes catastrophic coverage wholly inadequate, or may have experienced a change in income that makes them eligible for subsidized metal tier coverage. A consumer may become eligible for employer-sponsored coverage or may need to relocate — scenarios the Department itself identifies. Policies that create barriers to exiting multi-year plans will trap consumers in coverage that no longer serves them, and the Department should not pursue them.

Bronze Plans: Disregard of Statutory Limitation on Consumer Cost-Sharing (§ 156.136)

The Department proposes to disregard the statutory limitation on annual consumer cost-sharing so that insurers can sell bronze plans that expose consumers to spending in excess of the statutory cap. We oppose the proposal.

By the Department's own admission, the proposal to allow insurers to sell bronze plans that exceed the annual limit on cost-sharing violates the law. The Department suggests its approach is nonetheless permissible because it is as limited as possible in order to still implement the statutory requirements as Congress intended.

But this is clearly not the case. Compliance is very much possible today (and in 2027). Indeed, the Department proposes that insurers must offer a legally compliant bronze plan if they want the opportunity to sell plans that are noncompliant.

There is an insufficient basis for the Department to preemptively excuse insurers from their statutory obligations and we urge that this proposal not be finalized.

Catastrophic Plans: Disregard of Statutory Limitation on Consumer Cost-Sharing (§ 156.155)

The discussion above also applies to the Department's proposal to require catastrophic plans to use a cost-sharing limit and deductible that exceeds the statutory limit – that is equal to 130 percent of that limit, $31,200 for family coverage in 2027. And there are additional reasons why this proposal is unlawful and should not be finalized.

As the Department acknowledges, catastrophic plans do not have prescribed actuarial value (AV) requirements. The tension between statutory provisions that, it argues, justify disregarding the annual limit on cost-sharing for bronze plans simply does not exist for catastrophic plans. Still, HHS asserts that catastrophic plans may be unappealing to consumers, when compared to bronze plans, unless there is a "clear difference" between the two. When there is a clear difference between them, says the Department, healthier consumers will generally choose catastrophic plans instead of bronze plans, as Congress "plainly" intended for them to do. But, the Department worries, such differences may become obscured if catastrophic plans must continue to adhere to the statutory cost-sharing limit.

There is no statutory requirement for there to be a "clear difference" between the pricing of catastrophic and bronze plans. Congress did not design catastrophic plans to sit on the AV continuum and compete for enrollees among the general population of marketplace consumers. As observed above, what Congress intended was to offer a carefully circumscribed subset of consumers a last-ditch option for ACA-compliant coverage outside the metal tiers. That is why catastrophic plans are not subject to AV rules; why they can't be used with premium tax credits; and why eligibility is limited by the statute to young adults and people exempt from the individual mandate's tax penalty. These are the clear differences that set these plans apart. There is no need to increase the cost-sharing limit and deductible for catastrophic plans at such an affordable level for consumers.

Non-Network Plans (§§ 155.1050, 155.1051, 156.230, 156.235, 156.236, 156.275, and 156.810)

The Department proposes to rescind regulations prohibiting health plans that do not use a provider network ("non-network plans") from being sold through the marketplaces. The proposal would allow the sale of non-network plans beginning as early as next year and establish new standards and review processes for the purpose of determining whether such products satisfy statutory provisions requiring them to ensure enrollees have access to a sufficient choice of providers.

Our patients, and consumers broadly, face real and persistent challenges obtaining timely access to care and budgeting and paying for its costs. These challenges are often made worse when forced to navigate restrictive provider networks and inaccurate provider directories.

The proposed rule would compound these challenges. The Department proposes to allow products where all health care providers are out-of-network and provider directories, by definition, cannot be relied upon. The non-network plans it would authorize are premised on the unrealistic expectation that consumers, regardless of their circumstances or health needs, will negotiate the price of all of their care in advance of receiving it. People who do not or cannot manage to do this will be nearly completely exposed to additional medical bills ("balance" or "surprise" bills) of the kind that Congress intended to do away with in recently enacted legislation. The Department's proposed oversight standards are inadequate and unworkable. The Department's justification for reversing its judgment that non-network plans has clear deficiencies and lack key details. These proposals should not move forward.

Non-Network Plans: Consumer Price Negotiations

The Department's case for non-network plans rests on the premise that consumers will "shop" for their care — all of their care.

The Department would require non-network plans to publicize the amounts it will pay for each covered benefit. Armed with this information, HHS anticipates enrollees will be able to compare prices among

providers and negotiate payment amounts directly. The Department acknowledges that these plans — which are entirely absent from the individual and small group markets and, tellingly, exist as non-comprehensive excepted benefits in the large group market — "may not be immediately intuitive" and could create "different pricing dynamics" for consumers. Nevertheless, it is confident that if consumers behave more proactively, they can get the best value for medically necessary services.

This vision is fundamentally at odds with how health care is actually delivered and consumed, particularly for the populations our organizations represent.

Patients managing cancer, autoimmune diseases, bleeding disorders, organ transplants, or other serious conditions require care from specialized providers. They often may have limited choice of doctors and facilities, particularly in rural or medically underserved areas, and little to zero practical leverage to bargain over the costs of treating complex or rare conditions or emergent needs. Expecting a patient about to begin chemotherapy to negotiate the price of each infusion, each lab test, and each imaging study (or even, for that matter, some bundled price for certain of these services) is not reasonable. Expecting a parent of a child with a rare disease to comparison-shop among the handful of specialists in the country who treat the condition is not reasonable. These patients need their plan to work, not a "reference price" they must then attempt to convince a provider to accept.

While non-network plans offered as excepted benefits are not obligated to pay for prescription drugs, these plans would be; prescription drugs are an EHB. Yet it is not clear how this would work. Does the Department expect enrollees to negotiate the prices of their prescriptions with pharmacies prior to each refill? Or does it assume that the plans' payment amounts will always be sufficient to ensure patients can continue to access the medications they need, whether generic or of the range of specialty medications on which our patients rely?

The Department acknowledges that non-network plans "can have a particular impact on low-income, medically underserved populations who may face disproportionate challenges in paying for large out-of-pocket costs." This is true. And indeed, marketplace consumers in particular are disproportionately lower-income individuals for whom unexpected medical bills can be financially devastating. These consumers are the least likely to have the time, resources, health literacy, and bargaining power to negotiate effectively with providers.

Non-Network Plans: Exposure to Surprise Medical Bills

The defining feature of a non-network plan is that no provider has a contractual obligation to accept the plan's benefit amount as payment in full. Unlike a network plan, where in-network providers are bound to accept negotiated rates and are prohibited from balance billing enrollees for covered services, a non-network plan simply sets a benefit amount and shifts the negotiation and cost exposure to the enrollee. The Department sometimes shies from this distinction, referring to the non-network plan's "de facto" network. But as the Department elsewhere acknowledges, "there is no guarantee that the plan's benefit amounts are actually sufficient to cover the provider's full charges, and there is no requirement imposed by the non-network plan on providers to accept the plan's benefit amount as payment in full."

Nearly every service, provider encounter, and claim under a non-network plan carries the risk that the patient will receive an additional surprise (or balance) bill from the provider.[5] The enrollee's exposure is not limited to a discrete set of out-of-network scenarios, as in a network plan; it is the baseline condition of the coverage. In effect, every provider is out-of-network, because no provider has agreed to the plan's terms.

Congress recognized the serious harms caused by surprise medical bills and passed a law to prevent them. The No Surprises Act (NSA), which our coalition strongly supported, protects consumers from unexpected costs when they receive care from out-of-network providers in certain settings. It's the Department's job to implement and enforce the NSA and we deeply appreciate its work to do so. We are, in turn, deeply disappointed that it now proposes to execute an end run around these protections by sanctioning a product for which exposure to surprise bills is inherent.

The proposal expresses confidence that empowered consumers will be able to negotiate for all of their care and instructs the plans to come up with a strategy for telling the public about "potential balance billing scenarios." But information about the risk of balance billing is not a substitute for protection against it. The fact is, for enrollees in a non-network plan, nearly every single interaction with a provider is a potential balance billing scenario. Given the increased risk of surprise or balance billing, we urge HHS not to finalize this proposal.

Non-Network Plans: Inadequate and Unworkable Oversight Standards

The Department proposes new standards for non-network plans to demonstrate that they provide access to a sufficient choice of providers, including essential community providers (ECPs). On paper, these standards are inadequate to the task; in practice, they are unworkable and likely to be rendered effectively meaningless.

The Department's first standard requires the non-network plan to assess the percentage of available providers in its service area that accept the plan's benefit amount as payment in full. The Department will consider this standard to be met if the non-network plan attests that it has done the work.[6]

It is telling that the core regulatory requirement for non-network plans is, in effect, that they attest to having a de facto network. (Or a quote-in-quote "network," as the Department says.[7]) But there really is a difference between a network and a "network." Because no provider is under contract to accept the non-network plan's benefit amount, the "assessed percentage" is, at best, a point-in-time estimate that is out-of-date and, by definition, unreliable, the moment the communication between the non-network plan and each provider ends. A provider who indicates they would accept the plan's benefit amount as payment in full today is under no obligation whatsoever to do so tomorrow. Indeed, one member of a

[5] While non-network plans expose enrollees to balance billing in nearly every circumstance, we interpret the No Surprises Act to prohibit balance billing for emergencies services even in the case of a non-network plan. Unfortunately, the proposal is silent on this issue.

[6] Non-networks plans will demonstrate compliance by answering "Yes" or "No" on form that asks whether they meet each requirement. The Department estimates it will take plans between 30 seconds and a minute to answer each question.

[7] According to the Department: a "non-network plan's 'network' consists of the providers in the appliable area that would accept the plan's benefit amount as payment in full."

provider's staff might tell a plan it will accept the benefit amount as payment in full, *at the exact same time* another staff member charges an enrollee a higher price.

The Department acknowledges that providers "may choose to change their charges for their services based on any multitude of factors, including changes in their operating expenses, changes in medical advancement, competitive pressure, or for no particular reason at all. And, they may choose to change this amount at any time."

In an effort to address challenges, the Department proposes that non-network plans to have a "strategy for conducting continuous outreach" to providers. Plans must simply attest that they have a strategy. It is unclear what would constitute adequate outreach, how frequently it must occur, what documentation the plan must maintain, or how regulators would evaluate the effectiveness of these efforts: none of these issues is addressed. This lack of detail puts the patients we represent at serious risk.

Non-Network Plans: Legal Deficiencies and Unanswered Questions

In the 2024 NBPP, the Department concluded, after extensive discussion, that non-network plans cannot receive marketplace certification because they are inherently unable to comply with section 1311(c)(1)(C) of the ACA (which requires, as a condition of certification, that a plan "include [specified essential community providers] within health insurance plan networks"). The Department provided lengthy analysis even though, as it noted, the conclusion that plans must include ECPs within network in order to be certified was a "straightforward" reading of the statute.

Although this provision remains in statute and its meaning continues to be straightforward, the Department now embraces a different interpretation. The Department now says that section 1311(c)(1)(C) offers "broad flexibility governing the status of a contractual relationship between a plan and provider" and, asserts that non-network plans can be certified without any discussion explaining this significant shift.

The proposal is deficient in its treatment of other applicable federal provisions that are defined in terms of in-network benefits. For example, the ACA's limitation on annual cost-sharing applies to spending on EHB provided in-network. It does not cap consumer costs for, among things, balance billing. As proposed in the context of a non-network plan, what costs count towards the cap, what costs do not and how would the cap be administered? Further questions arise: a plan's AV is calculated based on in-network claims and utilization; how would AV be calculated, how would AV requirements apply, to a plan where all enrollee spending is out-of-network? All of these questions have significant implications for the patients we represent and must be answered before this proposal can move forward.

Non-Network Plans: Market Risks

By shifting responsibility for provider negotiation and contracting to consumers, non-network plans are likely to offer a lower — perhaps significantly lower — premium than their competitors that use a network. This is likely to have several detrimental effects for consumers who rely on the marketplaces.

First, it is likely to reduce the buying power of marketplace consumers, making it harder for people who want to enroll in a plan with a network to afford it. Because they can undercut their network-based competitors, non-network plans are likely to become the benchmark silver plan in the rating areas where they are sold. This means consumers' premium tax credits will be lower than they would be in the

absence of these plans. A consumer may have no interest whatsoever in this new product the Department is proposing, but they will still feel its impact in the form of a higher premium.

Second, these plans are likely to create risk selection issues that, together with the pricing advantage non-network plans benefit from, may destabilize markets. The Department notes non-network plans "may typically attract healthier enrollees who are generally more willing and able to engage" in price negotiations with providers. By contrast, consumers who are relatively less healthy will be less "willing and able" to bargain for their care and will remain, if they can afford it, in a network plan.

We are concerned that these plans could introduce significant uncertainty in the markets they enter, at a time when participating insurers are already dealing with substantial policy changes that will affect pricing and participation decisions. For all of the reasons described above, we strongly urge the Department not to finalize its non-network plan proposals.

Network Adequacy Standards and Review Processes (§§ 156.230 and 155.1050)

Federal law contains protections designed to ensure that all marketplace enrollees have timely, meaningful access to the care and services they need, as well as accurate information sufficient to enable them to understand plans' networks and identify the plans and providers most likely to meet their needs. These protections apply to all marketplace plans and safeguard all consumers, no matter the state in which they live.

In recent years, the Department established quantitative measures of network adequacy and regulatory processes to review insurer compliance that have served as a federal baseline for marketplace coverage. Health plans sold through the federal marketplace have been subject to this federal minimum. State-based marketplaces (SBMs), meanwhile, have been required to implement a network oversight regime that is "at least as stringent as" the federal approach.

The use of a federal regulatory floor is not unique to network adequacy. It's how most ACA consumer protections have been implemented and allows states flexibility to regulate in ways that meet or exceed the baseline federal safeguard. Our organizations strongly supported the adoption of this approach.

The Department proposes to erode these minimum standards. It would remove the requirement that SBMs regulate network adequacy at least as stringently as the federal approach, and would create a new process through which states on the FFM could opt out of the federal network adequacy framework. We oppose these proposals.

Marketplace network adequacy is a federal obligation, and a marketplace consumer's ability to access an adequate network of providers should not depend on where they live. We continue to believe that having a robust federal regulatory floor in this area strikes the best balance wherein states have flexibility to regulate while enrollees remain protected by baseline federal standards.

Network Adequacy: Effective Provider Access Review Program

Although our organizations urge the Department not to finalize its network adequacy proposals, we offer three suggestions we think are important to help the proposed effective provider access review program operate as intended.

The proposed review program includes various criteria that states seeking to apply their own network standards and oversight processes must satisfy. If the Department does move forward with such a review program, we urge, first, that it follow through with its asserted commitment to the program as proposed. The program should include, at minimum, the six criteria proposed to be codified at §155.1050(d)(4); none should be removed. HHS says it intends to "thoroughly investigate" states' processes to determine whether they satisfy the proposed criteria and offers to work in partnership with states, and offer extensive resources to them, so they may further develop and enhance their network adequacy review capabilities. We thank the Department for these statements and we believe it is strongly in the interest of consumers for the Department to follow through with them.

Second, we ask the Department to modify its first criterion to require states to establish provider access standards that are consistent with those set forth in §156.230(a)(1)(ii), (iii), *and (a)(2)*. We understand that the Department does not believe it necessary for all states to implement the same specific criteria for assessing network adequacy. The Department identifies situations where, for example, the federally specified time/distance standards have posed challenges for states. Given these concerns, we believe states could be relieved of the requirement to use the specific standards set forth in federal guidance, giving them significantly greater flexibility and room to innovate than they now enjoy, while ensuring they enforce the same kinds of standards. In particular, we believe consumers are better served when plans are required to demonstrate compliance with quantitative measures of network adequacy, including time/distance and appointment wait time standards. Under our proposed modification, states would be free to depart from the federally specified metrics and construct quantitative standards appropriate for their circumstances. Their obligation, consistent with §156.230(a)(2), would be to ensure plans demonstrate compliance with time/distance and wait time standards that they, the states themselves, establish.

Third, the Department seeks comment on what level of transparency is necessary and appropriate for the review program. Information provided in connection with this program, and the Department's decisions, are likely to have a significant impact on consumers' ability to access care in a manner consistent with federal law and are of public interest. We urge that the default approach be full public disclosure of 1) all information submitted by the state to demonstrate it satisfies the criteria for having an effective provider access review program; 2) the Department's written determination pursuant to proposed §155.1050(d)(7); 3) any decision to evaluate whether a state's circumstances have changed such that it has begun to or has ceased to satisfy the criteria for having an effective provider access review program; and 4) any determinations, and their factual bases, made as a result of such evaluations.

Essential Community Providers: Effective ECP Review Program (§ 155.1051)

The ACA requires marketplace plans to include within their networks ECPs that serve predominately low-income, medically underserved individuals. While the Department currently reviews prospective marketplace plans for compliance with ECP standards, it proposes to allow states on the FFM to conduct their own ECP certification reviews if they satisfy proposed criteria intended to demonstrate their authority and capacity to do so. We ask the Department to refrain from finalizing this proposal until it can obtain more information regarding state approaches to ECP regulation.

In the proposal, the Department offers the view that it "should continue to primarily conduct ECP certification reviews as the default approach." It observes, first, that "centralized Federal ECP certification reviews are continuously valuable to perform complex analyses that aim to protect [the]

more vulnerable populations [served by ECPs] and decrease potential disparities in access across States." The Department recognizes that ECPs predominately serve individuals who are relatively sicker and less equipped to face high out-of-pocket costs, and the services ECPs provide are often more highly specialized, with greater levels of acuity and expense. Against this backdrop, federal experience and resources are critical to ensuring compliance with the statute.

Second, the Department acknowledges that it has only a limited understanding of state ECP rules and capacity to regulate. It says that "less is known" about whether states maintain standalone ECP requirements, that "it is unknown" how many states could develop and maintain a qualified ECP list, and that state tools and methodologies for assessing ECP data are similarly unclear. The Department is aware, it says, that some states have "limited resources and bandwidth to conduct ECP certification reviews, which are highly complex and data intensive."

Given both what is unknown at this time (state authority and capacity) and what is known (that ECP review is critically important and challenging to execute), we urge the Department to continue to collect the information it lacks and, based on that information, revisit its proposal for an Effective ECP Review Program in subsequent rulemaking if warranted. With a clearer picture of where states stand, the Department will be equipped to establish approval criteria that safeguard low-income, medically underserved individuals' access to these essential providers.

State-Based Marketplaces: Enhanced Direct Enrollment Option (§ 155.221)

We strongly oppose the proposal to eliminate the requirement for SBMs to maintain a centralized, consumer-facing eligibility and enrollment website and to allow marketplace enrollment to occur exclusively through private entities.

Enhanced direct enrollment (EDE) is already an option for all marketplaces. Indeed, it's ubiquitous, and millions of people use it to sign up for coverage. At the same time, millions of other people decide differently, and choose to enroll through a trusted, government-run marketplace website. What the Department proposes to do is take away the option of a state-run enrollment site and require purchases through private sellers.

A core goal of the ACA marketplaces was to reduce the burden of enrolling in a health plan by giving consumers a one-stop shop for coverage: a single place to view their coverage options, the tools to understand and compare them, the opportunity to apply for federal financial assistance to help pay for such coverage, and finally, the ability to enroll. An ACA marketplace that does not actually allow consumers to enroll in the marketplace is one at odds with section 1311 of the statute.[8]

The Department's proposal appears to rely on the assumption that it will promote "flexibility and innovation." However, it does not explain how permitting a marketplace to fully delegate enrollment onto private entities that it is free to contract with today is innovative, or how such change would advance the interest of the consumers the marketplace is designed to serve.

[8] The Department attempts to read statutory provisions that plainly contemplate a government-run enrollment portal in a manner it suggests does not technically require one. But "[a] fair reading of legislation demands a fair understanding of the legislative plan." *King* v. *Burwell*, 576 U.S. 473, 498 (2015). Section 1311(d)(2)(A) requires marketplaces to "make available" marketplace plans to eligible individuals by enabling them to enroll in such coverage in the marketplace itself.

The FFM currently relies heavily on EDE. States that want to rely heavily on it can do so. There have been substantial developments in how plans are marketed and sold, both via government-run sites and EDE, over the years, with no indication that the mere existence of the government portals is inhibiting these changes. Indeed, evidence suggests that "innovation" among some private sellers is what poses the biggest risk to consumers and to program integrity. As the Department knows — as it details elsewhere in this proposed rule — misconduct by bad actor agents and brokers has caused significant harm to consumers, and the dangers of misleading marketing, confusion, and improper steering remain.

We urge the Department not to finalize this proposal and to retain the requirement that SBMs operate a centralized, consumer-facing eligibility and enrollment website.

Eliminating Standardized Plans and Non-Standardized Plan Limits (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, 156.265(b)(3)(iv), and 156.202)

The Department proposes to eliminate the requirement that insurers in FFM and SBM-FPs offer standardized plan options, remove the differential display of these plans, and repeal the limit on the number of non-standardized plan options insurers may offer. Our organizations oppose these proposals and urge that they not be finalized.

Standardized plan options serve important functions for consumers with serious, acute, and chronic conditions. By establishing uniform cost-sharing, including pre-deductible coverage of primary care, specialist visits, mental health and substance use services, and some prescription drugs, they reduce barriers to essential care. Flat copayments rather than coinsurance for key services enhance cost predictability and reduce unexpected financial harm. These features are particularly valuable for the patients our organizations represent. Standardized plans also enable meaningful comparison across insurers on premiums, networks, formularies, and quality—attributes that matter most but are hardest to evaluate when cost-sharing structures vary widely across plan options.

The Department's primary rationale for discontinuing standardized plan requirements is that it believes the policy led to an increase in the total number of plan offerings. It's true that plan offerings increased from 2022 (before standard plans returned) to 2023 (the first year of the policy); as the Department recognizes, its complementary rule limiting non-standardized plans was not in effect in 2023. A weak version of that limit became effective in 2024, and a somewhat stronger version kicked in in 2025, such that by 2025, plan offerings were lower, albeit marginally, compared to the baseline. This data shows that a non-standardized limit is an important component of addressing choice overload and a more robust limit would have a greater impact. However, the Department appears not to have even considered strengthening the limit on non-standardized plans as an alternative regulatory approach to address the problem it identifies.

The Department has other complementary tools it could use to support effective choice architecture. For it is not solely the total number of plan offerings that matters, but also how those options are presented. The Department has numerous tools at its disposal related to plan display that could facilitate consumer understanding and decision-making. We urge HHS to explore and utilize these tools that already exist.

The Department argues that standardized plan requirements constrain issuer innovation. To support this claim, it identifies a few plan types that it asserts that insurers are constrained in offering. But it

presents no evidence that insurers cannot use these designs as their non-standard offerings; they just can't offer them in unlimited fashion.[9] It also provides no basis to conclude that there is unmet consumer demand for these designs, no reason to think that these plans are even desirable.

In the 2019 NBPP, the Department eliminated the first iteration of standardized plans on the grounds that they hampered innovation. That decision was challenged in federal court and ultimately vacated as arbitrary and capricious. The current proposal is no better substantiated. Our organizations urge the Department to retain the standardized plan option requirements and non-standardized plan option limits, and to strengthen the framework for supporting informed consumer choice.

Essential Health Benefits

The Essential Health Benefits (EHB) benchmark is a core protection for patients, including those with chronic, acute or high-cost conditions, and a key component of our organizations' guiding principles. It anchors other key protections, including the annual limit on out-of-pocket costs and the measure of a plan's generosity.

Since 2020, at least 11 states and the District of Columbia[10] have updated their benchmark plans to address gaps in covered benefits. Five additional states have already undertaken the work and cost of preparing updates for the 2027 plan year. We believe more states should consider doing the same to keep their benchmark plans current with medical advances and sufficiently robust to meet the needs of consumers, as the statute intended.

With this proposed rule, the Department announces that it has paused review of the benchmark update applications of the five states seeking improvements for 2027 and indicates it plans to conduct a "comprehensive review" of Section 1302. This review has significant ramifications not just for states but ultimately for the patients our organizations represent. We ask the Department not to consider changes to the benchmark selection rules that would undermine states' existing EHB packages or otherwise reduce their ability to update their benchmarks to address gaps in access or changes in medical evidence or scientific advancement.

Beyond this, the Department proposes changes to the treatment of state-mandated benefits and would rescind the state option to require coverage of adult dental care, both of which would constrain states' ability to set benefits standards that work best for their states. We oppose those proposals.

Essential Health Benefits: State Mandated Benefits (§155.170)

Under a provision enacted in the 2025 Payment Notice, a benefit already covered in a state's EHB benchmark plan is treated as EHB, and therefore not subject to state defrayal. Our organizations supported this approach, which makes it easier for everyone to understand what benefits constitute EHB, helps state regulators ensure that patients and consumers receive the protections that attach to benefits designated as EHB, and facilitates decision-making by state policymakers seeking to ensure a robust benefit package for marketplace consumers.

[9] We note that insurers should be in the clear for at least one of these "constrained" plan types. A provision of the One Big Beautiful Bill Act requires all bronze tier plans to be considered HSA-eligible by default, so insurers will not be limited in their ability to offer these designs.

[10] Enhancing Essential Health Benefits States Update Benchmark Plans | Commonwealth Fund

The Department has proposed changing this approach, though the preamble is at times unclear and raises several questions. We are commenting on what we understand to be the proposed change – to rescind the 2025 provision – and its effects. To the extent the Department contemplates changes that will have a broader reach, we ask that you provide additional information and clarification so that we may fully evaluate such a proposed change.

We concurred with the arguments the Department made in putting forth and finalizing the 2025 update to the EHB benchmark rules and the treatment of state mandated benefits. That rule made states' options clearer and easier to navigate and reduced burdens on states seeking to undertake an EHB-benchmark plan selection. It helped to clarify state policy options and made the benchmark selection process more accessible, which we believe can help promote greater public engagement.

In support of the proposal to rescind the 2025 rule, the Department offers a misleading argument, saying, "over time, the accumulation of new State-required benefits that are EHB could substantially increase Federal [advanced premium tax credit] (APTC) costs." In fact, states' ability to add covered benefits to their benchmark plan is bounded by the requirement that it be equal in scope to the "typical" employer plan and no more generous than the most generous plan among a set of comparison plans. Within those boundaries, though, states have significant authority to tailor their benefit standards to reflect state priorities. The Department's proposal will no doubt stifle state action and limit their options. We oppose this proposed change. At a minimum, if finalized as proposed, it should take effect no sooner than 2028.

For the states that have updated their benchmark plans under the regulations in effect at the time of their undertaking, this proposed rule pulls the rug out from under them, potentially imposing substantial consequences for a decision already made and implemented. A delay in the effective date is needed to allow states time to consider any needed changes. The proposed rule even recognizes that additional time may be necessary for states to react to this change and we encourage HHS to provide that time.

Essential Health Benefits: Adult Dental Services (§156.155(d)):

The Department proposes to reinstate the prohibition on states requiring coverage of adult dental services, which we supported removing in the 2025 rule. Our organizations believed the restriction was not well-supported by the statute and, as a policy matter, did not well serve patients and consumers. The prohibition helped perpetuate a false distinction between oral health and the health of the rest of the person and between the oral health of children and adults, which can lead adult patients to forgo needed services and potentially experience worse health outcomes.

Furthermore, in removing the prohibition, the Department offered a clear rationale and helpfully noted considerations for states seeking to update their benchmark plans to require this coverage, including the need to establish adequate networks for the newly covered services. Though no state moved forward with an update that would add adult dental services, some had considered it, designing the benefits and estimating the cost We urge the Department not to finalize this proposal. [11]

[11] State Flexibility To Add Adult Dental Care to Essential Health Benefits: An Update on State Action | Center on Health Insurance Reforms

Premium payment thresholds (§155.400)

In the past, the Department gave issuers flexibility to effectuate a consumer's coverage, or allow an enrollee to remain in coverage, if their premium payment met or exceeded an insurer-determined threshold (among threshold types stipulated in regulation). We supported that consumer-friendly policy, which promotes continuity of comprehensive coverage. In a reversal last year, HHS limited insurer discretion to determine the threshold from August 2025 through 2026, with a return to granting insurers greater flexibility in 2027.

Now, the Department seeks comments on whether to extend the one-year ban on insurers' ability to set a more consumer-friendly threshold, and whether to impose that ban on all marketplaces. We strongly oppose the more restrictive policy. Consumers who intend to obtain and maintain health insurance may, due to other financial pressures or simple error, fall behind on owed premium by a de minimis amount. Issuers should not be required to deny or terminate coverage in these cases.

In establishing the temporary ban, HHS pointed to concern about fraud by bad-actor agents and brokers. There is no evidence that agent and broker fraud had anything to do with premium payment thresholds, and by the Department's own admission in this proposed rule, it lacks data from issuers on whether they have implemented a premium payment threshold policy let alone what threshold type they may have applied. The Department should allow the return to the premium payment threshold flexibilities previously in effect, monitor for abuse, and modify the policy if supported by evidence.

Implementing the Provisions of Public Law 119-21

We strongly opposed enactment of Public Law 119-21 for the many harms it will impose on individuals who rely on the marketplace or Medicaid to obtain affordable, comprehensive coverage. In addition to the estimated coverage losses from that law, the expiration of the enhanced premium tax credits means people who cannot afford to go without coverage, including the patients we represent, will find they can only afford a basic marketplace plan that comes with higher premiums and much higher cost-sharing. Thanks to these two policy developments, those seeking coverage will have to pay more to get less.

The Department has proposed rules to implement two particularly harmful provisions of Public Law 119-21 – stricter limits on APTC eligibility based on immigration status and the elimination of the low-income SEP. Beyond that, HHS seeks comment on how to effectively roll out communications and the necessary timelines to establish a pre-enrollment verification process by August 1, 2027, without offering any indication of what the Department may propose in these areas. We are very much interested in the opportunity to comment on specific proposals well in advance of their effective dates. We also urge the Department to conduct consumer testing on how best to communicate the many upcoming changes to eligibility and enrollment requirements, particularly given the drastic consequences of failure to fully and timely comply, including loss of coverage and APTCs. Our organizations further hope and expect HHS will make every effort to mitigate the coverage losses associated with Public Law 119-21 as you develop specific implementation proposals.

Income Verification Policy to Determine Eligibility for APTCs (§155.320)

In rulemaking last year, the Department finalized a policy to deny APTCs to certain low-income consumers whose projection of annual household income cannot be immediately verified with old tax return data. This latter policy would apply to (1) people who, according to old tax data, had income

below the poverty line, but who project that they will earn more than that amount in the coming year; and (2) people for whom Internal Revenue Services (IRS) systems cannot find a tax return match. As we noted in our comments on that proposed rule, this happens for a host of reasons, including changes in family size or filing status, name changes, or other mismatches in demographic information. The Department pursued that policy even though it acknowledged that making it harder for people to enroll in coverage may deter some people from enrolling. Its own research shows the burdens are likely to deter young and healthy people (but not individuals with immediate coverage and care needs), thereby leading to a sicker and more expensive insurance market.

In this proposed rule, HHS would continue this harmful policy, noting continued concern about fraud and improper enrollment. We continue to strongly oppose this policy. The Department is taking steps in this proposed rule to target the source of improper enrollments by imposing stricter standards for agents, brokers, and web-brokers (and we applaud those efforts). As the Department notes, 80 percent of income data-matching issues were generated by households who worked with an agent, broker, or web-broker to enroll.

In this proposed rule, the Department continues to base its improper enrollment argument on the assumption that low-income individuals below the poverty line who expect to earn more next year are program integrity risks. Furthermore, HHS claimed last year that the availability of $0 premium plans made possible by the enhanced PTCs was driving fraud. Now, acknowledging the expiration of that enhanced assistance, the Department claims its concerns remain, along with concerns about the greater financial exposure for consumers no longer protected by a cap on repayment of excess PTCs (a change in law supported by the administration). This contradicts extensive research regarding the impact of administrative burden and application complexities, which demonstrate both that the Department's approach will reduce enrollment and (by discouraging healthy people from signing up) weaken the risk pool.[12]

Failure to Reconcile (§155.305)

Marketplace enrollees who receive APTCs must file a federal income tax return to reconcile the APTC they received with the premium tax credit they are entitled to based on their actual annual income. Previously, individuals who have failed to reconcile (FTR) their APTCs for two years may be denied APTCs until they comply with the obligation to reconcile their past-year APTCs. Last year, HHS finalized a rule change that would deny APTCs based on an individual's failure to reconcile their APTCs for a single year. However, this rule was struck down by a federal court that concluded it was contrary to law.

Now, the Department proposes to reimpose the 1-year FTR policy for 2027, with the option for SBMs to implement either a one-year or two-year FTR policy for plan year 2027. Public Law 119-21 requires a 1-year FTR policy beginning in 2028, even in SBMs.

We oppose the Department's proposal. This policy runs contrary to the court ruling that HHS does not have the authority to limit APTC eligibility based on a prior tax debt. Individuals who fail to reconcile their APTC remain subject to the Internal Revenue Service's normal enforcement measures. We oppose HHS adding an additional financial penalty not based in statute that hinders access to affordable

[12]American Academy of Actuaries, Response to Senate Budget Reconciliation of H.R.1, One Big Beautiful Bill Act. June 3, 2025. https://actuary.org/wp-content/uploads/2025/06/Academy-Senate-Budget-Reconciliation-Comments.pdf

coverage. At a minimum, notices sent to taxpayers who have failed to reconcile their APTCs should have clear, actionable information, so taxpayers can easily understand the risk of losing their APTC eligibility and the steps they must take to rectify that. In addition, we are concerned that even with clear information, serious understaffing[13] at the IRS will mean taxpayers will be unable to timely resolve their past FTR and will be locked out of affordable coverage without an APTC.

Approval of a State Marketplace (§§155.105 and 155.106)

We oppose the Department's proposals to lower standards for states transitioning to an SBM. Operating for at least one year as an SBM on the federal platform provides states time for careful planning before assuming full responsibility for their marketplace.

We also oppose the proposal to eliminate the requirement that transitioning states provide documentation demonstrating progress toward meeting or implementing state Marketplace Blueprint requirements and rely on states providing that information only upon request. Although the Department claims states generally make this information available when needed, requiring this information to be made available in all cases should be a baseline obligation of states seeking to operate their own marketplace.

Furthermore, as states move from the federal Marketplace to a state-based Marketplace, we urge HHS to extend minimum federal standards to all marketplaces and incorporate additional standards that consumers are not made worse off than they would have been if the state continued to use the federally facilitated Marketplace.

Quality Standards: Quality Improvement Strategy (§156.1130)

An insurer that participates in an ACA marketplace for two or more consecutive years must implement and report on a quality improvement strategy (QIS) that provides increased reimbursement or other incentives for activities designed to improve health care for enrollees. The insurer must implement 1) a strategy for improving performance in at least one of four key categories: health outcomes, hospital readmissions, patient safety and medical errors, and the promotion of wellness and health; and 2) a strategy dedicated to reducing disparities among people of color, LGBTQ+ people, people with disabilities, people who live in rural areas, or people otherwise adversely affected by poverty and inequality in health and health care.

We oppose CMS's proposal to remove the requirement that insurers address "activities to reduce health and health care disparities" as one of the two required QIS. Requiring insurers to submit QIS for reducing health disparities is a step toward ensuring that health insurance coverage works equitably for all enrollees, including those who have historically experienced systemic barriers to care.

Pre-Enrollment SEP Verification (§155.420(g))

We strongly oppose the Department's proposals to once again add administrative barriers for individuals attempting to enroll in health insurance coverage through a special enrollment period (SEP). The Department proposes to require applicants to submit additional paperwork before they can enroll through five different SEPs (marriage, adoption, moving to a new coverage area, loss of minimum

[13] https://www.tigta.gov/sites/default/files/reports/2025-10/FY%202026%20MMC%20(Final).pdf

essential coverage, and Medicaid/CHIP denial) and for at least 75 percent of new SEP enrollments. The Department proposed these same restrictions last year but claimed they would be temporary and no longer necessary in 2027. Now, the Department says differently, and would impose the restrictions in 2027 and beyond.

Administrative hurdles tied to enrolling in public programs can significantly reduce participation among people who are otherwise eligible.[14] The Department recognizes that requiring additional paperwork makes enrollment more difficult, particularly for younger and healthier adults. The departure of healthy enrollees from the risk pool is, in turn, likely to raise premiums for consumers. We strongly oppose the proposal to reinstate and make permanent these burdensome and harmful requirements.

Marketing Rules for Agents, Brokers and Web-Brokers (§155.220)

Drawing on findings from the Department's oversight of agents, brokers, and web-brokers, the proposal observes that technical assistance and enforcement of current rules are not sufficient to prevent these actors from fraudulently enrolling consumers into marketplace coverage. Accordingly, the Department proposes new limitations on the marketing practices of these entities. Furthermore, the Department proposes to require agents, brokers and web-brokers to use an HHS-created consumer consent form to obtain consumer consent and to clarify what types of consumer actions are adequate to demonstrate that they have, in fact, consented.

We strongly support these actions and believe greater clarification of prohibited marketing practices, use of a standardized consumer consent form, and continued oversight of agents, brokers and web-brokers will help protect consumers from the harms associated with being enrolled in coverage without their knowledge or consent. We believe the Department should also take steps to promote greater awareness of the consumer complaint line that has informed some of the Department's oversight and enforcement actions.

Beyond these common-sense changes to standards for agents, brokers and web-brokers, the Department has included a proposal to eliminate "gender identity" from prohibited discrimination based on sex in regulation governing the activities of state-licensed agents, brokers and web-brokers. The Department offers no justification for this proposal, nor any explanation of how it has any relationship with any of the reasons that motivate the many proposals in this rule, including addressing fraud and higher premiums. We strongly oppose this proposal.

Medical Loss Ratio

The Department seeks comment on multiple questions regarding the definition and application of the ACA's medical loss ratio (MLR) requirements, including its impact on market stability; the potential to adjust the MLR to lower premiums or to reduce incentives for consolidation; whether the Department should adjust the standard; whether it should adjust the process for states to request an adjustment; and how to resolve potential disagreements between the Department and states on whether an adjustment would help stabilize the market.

[14]Jalisa Clark, Justin Giovannelli, and Christine H. Monahan, "Congress and the Administration Are Using Paperwork to Discourage Enrollment in Marketplace Insurance," *To the Point* (blog), Commonwealth Fund, Sept. 4, 2025. (collecting literature). https://doi.org/10.26099/773n-d085

The MLR is an essential protection that ensures consumers get some minimum level of benefit from their insurance in return for the premiums they pay. It is unclear what motivates the interest in potential changes in the name of market stability. If no state has asked to adjust the MLR as a necessary measure to stabilize their market, it would seem there's not a problem here to solve. We do not see any reasonable basis for the Department to assert the authority to override a state and impose a lower MLR, where a state has determined it is not needed or appropriate.

Exchange User Fee

The Department proposes to maintain the current user fee for the FFM as well as SBMs. We have long supported that fees be sufficient to support robust consumer outreach and education, including a strong network of Navigator programs. This will be particularly important given drastically reduced funding for these functions and the many changes underway that will affect eligibility for coverage, available plan options, and restrictive enrollment requirements. These policy changes will require the user fee to adjust to maintain sufficient funding. We therefore strongly urge the Department to raise the user fee to keep pace with declining enrollment and the increased burdens on consumers seeking to enroll in marketplace coverage.

Impact of Proposed Rule on Premiums

In its regulatory impact analysis, the Department concludes that its proposals will increase premiums by about 2 percent. However, it claims that its housekeeping regulation formally removing regulatory text related to the special enrollment period for people with incomes below 150 percent of the federal poverty level (the low-income SEP) is an offset, reducing premiums by 3 to 4 percent. This (3-4 percent reduction) is the same premium effect the Department anticipated when it proposed to end the low-income SEP last year; after reincorporating the same estimate this year, the Department concludes that its rule, as a whole, will reduce premiums.

This estimate is the product of deeply flawed analysis and is contrary to evidence submitted to the Department in connection with the 2025 rulemaking. Furthermore, whatever the effect of ending the low-income SEP – the SEP has already been eliminated. Section 71304 of Public Law 119-21 bars consumers from receiving premium tax credits for any enrollment through an income-based SEP as of January 1, 2026. Whatever the effect of ending the low-income SEP, it is attributable to the statute. The Department's proposals will raise consumer premiums. It should not obscure that point by invoking a statutory policy that is already in effect, and that will remain in effect with or without this rulemaking.

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Thank you for the opportunity to provide these comments. If you have any questions, please contact Theresa Alban at the Cystic Fibrosis Foundation (talban@cff.org).

Sincerely,

AiArthritis
ALS Association
American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund

American Lung Association
Arthritis Foundation
Autoimmune Association
Blood Cancer United (formerly The Leukemia & Lymphoma Society)
Cancer Nation
CancerCare
Coalition for Hemophilia B
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Diabetes Patient Advocacy Coalition
Epilepsy Foundation of America
EveryLife Foundation for Rare Diseases
Family Voices National
Foundation for Sarcoidosis Research
Hemophilia Federation of America
Immune Deficiency Foundation
Legal Action Center
Lupus Foundation of America
Lutheran Services in America
Muscular Dystrophy Association
National Alliance on Mental Illness
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