STATE OF CALIFORNIA OFFICE OF THE ATTORNEY GENERAL ROB BONTA

COMMONWEALTH OF MASSACHUSETTS OFFICE OF THE ATTORNEY GENERAL ANDREA JOY CAMPBELL

STATE OF NEW JERSEY OFFICE OF THE ATTORNEY GENERAL JENNIFER DAVENPORT

March 13, 2026

Via Federal eRulemaking Portal at www.regulations.gov
Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

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

Dear Dr. Oz:

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

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

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 For the reasons discussed below, most of the Proposed Rule's changes should therefore be withdrawn.

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

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

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

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

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

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

[3] *King*, 576 U.S. at 481.

[4] 91 Fed. Reg. at 6,463.

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

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

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

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

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

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

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

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

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

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

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

---

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

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

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

As discussed in this comment letter, *infra* at 9-11 and 20-21, the Department has offered cost estimates in the Proposed Rule that are unclear and do not account for the full current and future impacts on Marketplace enrollment caused by H.R. 1.[9] Of particular concern, the Department's cost estimates appear to rely, at least in part, on data that pre-dates the passage of H.R. 1, and thus does not account for the millions of previously eligible lawfully present noncitizens who have been disenrolled or will disenroll from the Marketplace due to the changes made by H.R. 1.[10] The reliance on pre-H.R. 1 data is improper and renders the Proposed Rule's cost estimates inaccurate.

H.R. 1 has made the risk pool less healthy and more fragile overall. As an initial matter, as H.R. 1's provisions are implemented, Marketplace enrollment is projected to decline in both 2027 and 2028.[11] Yet, the Department implausibly, and without explanation, suggests a slight increase in enrollment between 2026 and 2027, before a decline in 2028. Moreover, because H.R. 1 reduces the number of younger and healthier individuals that would have otherwise enrolled in the Marketplace,[12] as its provisions are implemented, the risk pool will weaken and costs will increase across the board.[13] The Department relied on outdated data and failed to consider that the impacts of its proposal will be greater now, after the enactment of H.R. 1.

---

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

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

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

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

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

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

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

Three provisions of the Proposed Rule concerning income verification, are substantially identical to provisions in last year's Marketplace Integrity Rule[14] that are currently subject to a stay in *City of Columbus v. Kennedy*, where a federal district court held that the plaintiffs are likely to succeed on the merits of their Administrative Procedure Act claims that the provisions are unlawful or arbitrary.[15] These provisions are also the subject of summary judgment motions in the *Columbus* case as well as a similar challenge brought by a coalition of States, *California v. Kennedy*. [16] Notwithstanding these challenges, the Department has re-proposed these provisions but failed to meaningfully address the issues raised in *Columbus* and *California*.

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

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

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

---

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

[15] 796 F. Supp. 3d 123 (D. Md. 2025).

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

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

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

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

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

The burdens, as the Department acknowledges, are weighty. The Department estimates that these two changes will generate an additional 3.3 million DMIs per year: 548,000 in the case of the contradictory-data DMI, and 2.8 million in the case of the missing-data DMI.[20] Missing IRS tax data is frequently not the fault of the enrollee, and the IRS is poised to suffer extreme backlogs heading into the 2026 tax filing season because the federal Administration has slashed the workforce, as a recent report by the U.S. Treasury's Office of the Inspector General warns.[21] The Department never acknowledges this report—or the consequences for enrollees of the extreme backlogs—in the Proposed Rule. Further, analysts believe the risk of coverage loss is far greater than what the Department has suggested: depending on the disenrollment rate, up to 2.3 million enrollees could lose coverage in 2027.[22]

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

---

[19] 91 Fed. Reg. at 6,346.

[20] 91 Fed. Reg. at 6,431.

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

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

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

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

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

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

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

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

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

---

[23] Sherman, *supra* n.13, at 14.

[24] 91 Fed. Reg. at 6,436 & n.112.

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

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

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

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

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

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

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

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

---

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

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

[29] 90 Fed. Reg. at 27,151.

[30] 91 Fed. Reg. at 6,353.

[31] *Id.*

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

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

A. Provisions Relating to Catastrophic Plans and Bronze Plans

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

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

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

---

[32] 91 Fed. Reg. at 6,352.
[33] *See* 91 Fed. Reg. at 6,432.
[34] 91 Fed. Reg. at 6,452.
[35] *See* 91 Fed. Reg. at 6,382. As discussed later on in the comment letter, the proposed rule would also raise the maximum out of pocket for catastrophic plans to $15,600 individual / $31,200 family. *See id.*

The Proposed Rule would permit bronze plans to offer cost-sharing that exceeds the statutory annual maximum out-of-pocket limit established by the ACA and would further require catastrophic plans to impose out-of-pocket costs of 130% of that limit before covering any care other than preventive services and three primary care visits.[36] For plan year 2027, the latter requirement translates to a MOOP of $15,600 for an individual and $31,200 for a family, well over the statutory limits of $12,000 / $24,000 for plan year 2027.[37] These proposals conflict with the plain text of the ACA, expose consumers to financial harm that the statute was designed to prevent, increase the risk of States having to bear the cost of uncompensated care, and rest on an inadequate evidentiary basis. These proposals should thus be withdrawn.

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

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

[36] 91 Fed. Reg. at 6,380, 6,382.

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

[38] 42 U.S.C. § 18022(c), (e)(1)(B).

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

[40] 91 Fed. Reg. at 6,373–74.

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

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

The consequences of these proposals will fall hardest on the consumers least able to absorb catastrophic medical bills. The statutory MOOP for plan year 2027 is $24,000 per family—a figure that is already inflated due to the methodological changes adopted by the Department in the Marketplace Integrity rule and already represents a significant financial burden for most households, which have a median balance of liquid cash of just $8,000, according to 2022 Federal Reserve data.[44] The Department asserts that healthier consumers will be "more motivated to select a catastrophic plan in lieu of a bronze plan" in exchange for lower premiums, and asserts without evidence that this "is plainly what Congress intended."[45] But abundant evidence shows the exact opposite: the purpose of the ACA is to "increase the number of Americans covered by health insurance and decrease the cost of health care."[46] Healthier enrollees dropping metal-tier coverage in favor of catastrophic plan coverage harms the risk pool[47] and is the *opposite* of Congress's intent. And consumers who enroll in a catastrophic plan and then face a severe medical crisis might forego needed care until they can switch back into a more-generous plan, harming their health and potentially increasing the cost of care needed later. The extensive literature on cost-sharing and healthcare utilization confirms that even modest increases in out-of-pocket costs lead to reductions in the use of necessary medical services—and the increases contemplated here are substantial.

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

---

[41] 91 Fed. Reg. at 6,777–79

[42] 91 Fed. Reg. at 6,779.

[43] *See* 91 Fed. Reg. at 6,777–79.

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

[45] 91 Fed. Reg. at 6,382.

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

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

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

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

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

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

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

---

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

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

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

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

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

[53] H.R. 1, § 71307, https://tinyurl.com/3u5va6af.

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

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

The expansion of catastrophic plan eligibility will only benefit healthier and higher-income individuals, who can afford large upfront medical bills and are able to set aside money in tax-advantaged health savings accounts (HSA). This proposal will shift additional risk onto consumers and increase the likelihood that medical costs will bankrupt lower-income individuals and families. Of significance, 24% of American households have no emergency savings, and the median amount of liquid cash available in checking and savings accounts is $8,000.[57] Expanding eligibility for catastrophic plans will expose lower-income consumers to steep medical bills and increased medical debt, and it will burden providers with higher uncompensated care costs. Patients will forgo care due to the high out-of-pocket maximums, which, as even the Proposed Rule acknowledges, will result in even higher overall premiums.[58]

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

[54] Health Care Freedom for Patients Act, §104, https://tinyurl.com/2jbh69a3.
[55] 91 Fed. Reg. at 6,301, 6,353-54.
[56] 91 Fed. Reg. at 6,353-54.
[57] *See Changes in U.S. Family Finances from 2019 to 2022*, *supra* n. 44 at 16.
[58] See 91 Fed. Reg. at 6,371 ("[W]hen individuals receive preventive services and effective disease management, those interventions can help reduce costs in the long run, which in turn may ease pressure on premiums."); *see also* 89 Fed. Reg. at 39,396 (noting that lack of coverage "can have downstream impacts that further disrupt individuals' health and financial stability, and therefore their ability to work or study," and that "[d]elays in care can lead to negative health outcomes …whereas being unable to pay medical bill puts individuals at higher risk of food and housing insecurity").

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

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

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

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

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

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

[59] 91 Fed. Reg. at 6,353-54.
[60] 91 Fed. Reg. at 6,322.
[61] 91 Fed. Reg. at 6,293.
[62] 91 Fed. Reg. at 6,368–71.
[63] 91 Fed. Reg. at 6,370–73.
[64] 91 Fed. Reg. at 6,371–72.
[65] 42 U.S.C. § 399gg-13(c).
[66] 42 U.S.C. § 18022.

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

This proposal is also harmful to consumers. While the Department's proposal is unclear and inconsistent in explaining how the multi-year option would operate, averaging the MOOP across ten years means that an enrollee who experiences a serious injury or illness in the beginning of the multi-year contract could face out-of-pocket costs that are significantly higher than under a standard annual catastrophic term. Not only will this increase medical debt and bankruptcy, but it will also result in those who fall ill earlier being strongly incentivized to exit the multi-year plan, leaving only heathier enrollees enrolled for the end of the contract. This is counterproductive to the stated goal of these proposed multi-year plans: promoting continuity of care and stopping the churn of individuals cycling out of particular individual market plans.[67] The Department also suggests, without explanation, that consumers could be "locked into" multi-year catastrophic plans[68], which would also be inconsistent with the ACA's overall structure and consumers' ability to, for instance, switch plans during the annual open enrollment period.

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

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

[67] 91 Fed. Reg. at 6,371–72.
[68] 91 Fed. Reg. at 6,455.
[69] *Id.*
[70] 42 U.S.C. §§ 18116, 18022(b)(4).
[71] 42 U.S.C. §§ 399gg-4.
[72] 91 Fed. Reg. at 6,372.
[73] 91 Fed. Reg. at 6,373.

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

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

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

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

B. Essential Health Benefits

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

---

[74] 91 Fed. Reg. at 6,322.

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

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

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

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

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

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

---

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

[78] Center on Budget and Policy Priorities, *Essential Health Benefits Under Threat*, https://tinyurl.com/4cyyrn92 (last visited March 12, 2026).

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

[80] 42 U.S. Code § 18031(d)(3)(B)(i).

[81] 42 U.S. Code § 18031(d)(3)(B)(ii).

[82] 89 Fed. Reg. at 26,225.

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

[84] 89 Fed. Reg. at 26225; *see also* 45 C.F.R. §§ 147.126; 156.130; 156.125.

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

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

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

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

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

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

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

[88] 89 Fed. Reg. at 26,265.

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

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

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

---

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

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

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

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

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

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

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

[96] 91 Fed. Reg. at 6334.

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

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

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

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

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

---

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

[98] 89 Fed. Reg. at 26265.

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

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

[101] 91 Fed. Reg. at 6334.

[102] 91 Fed. Reg. at 6334.

[103] 89 Fed. Reg. at 26397.

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

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

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

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

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

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

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

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

---

[105] 89 Fed. Reg. at 26,268.
[106] 89 Fed. Reg. at 26,265
[107] 91 Fed. Reg. at 6,334.
[108] 91 Fed. Reg. at 6,333.
[109] 91 Fed. Reg. at 6,333-34
[110] 91 Fed. Reg. at 6,369.
[111] 42 U.S.C. § 18022(b)(2)(A).
[112] *Id.*
[113] *Essential Health Benefits Bulletin*, CMS: Center for Consumer Information and Insurance Oversight (Dec. 16, 2011), https://tinyurl.com/6bs6eaxc.
[114] 42 U.S.C. § 18022(b)(2)(A)-(B).

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

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

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

C. Other Provisions

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

[115] 89 Fed. Reg. at 26,342.
[116] *Id.*
[117] *Id.*
[118] 89 Fed. Reg. at 26,342–44.
[119] 91 Fed. Reg. at 6,293.
[120] 91 Fed. Reg. at 6,369.
[121] *Id.*
[122] *Id.*
[123] *Id.*
[124] 91 Fed. Reg. at 6,369–70.

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

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

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

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

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

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

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

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

[127] 91 Fed. Reg. at 6,422.

[128] 91 Fed. Reg. at 6,433.

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

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

2. Basic Health Program Modifications (§ 600.5)

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

First, the Department claims that 1.6% of BHP enrollees would be affected by the change required by Section 71301 of H.R. 1.[129] It further claims this is an annual figure, yielding "about 2,000 individuals" affected by the Proposed Rule.[130] Table 24 provides baseline enrollment of 155,000 for 2027.[131] Multiplying that figure by 1.6%, as the Department's analysis seems to imply was done, yields 2,480 individuals, not 2,000, meaning the Department has underestimated the affected population by roughly 20%. The difference between 2,000 and 2,480 is not trivial, because the Department uses the artificially lower figure to calculate the anticipated decreases in federal funding that will flow to lawfully present noncitizen communities. Additionally, the Department fails to explain why the number of affected individuals is the same across each year from 2026-2030, even though Table 24 clearly shows total enrollment fluctuating between 144,000 and 155,000 for each of those years.[132] Notably, 1.6% of 144,000 is different from 1.6% of 155,000, and neither number is 2,000.

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

[129] 91 Fed. Reg. at 6,448.
[130] 91 Fed. Reg. at 6,449.
[131] *Id.*
[132] *Id.*
[133] *Id.*

member-per-year data.[134] Perhaps the Department meant that the figures in Table *24*, not 25, served as the inputs—but that does not solve the problem. Substituting the per-member-per-month (PMPM) estimates provided in Table 24, the States are still unable to verify the Department's calculation. For instance: Table 24 indicates that the 2027 average PMPM expenditure is $670.[135] Multiplying that figure by the estimated static 2,000 loss of members discussed above, the result is $670 x 2,000 members x 12 months = $16,080,000, yet Table 23 says that the estimated loss for 2027 is $17 million. Perhaps the Department used the corrected figure of 2,480 rather than 2,000? Not so. That calculation yields $670 x 2,480 x 12 months = $19,939,200, or nearly $20 million, not $17 million.

The remaining numbers in Table 23 fare no better. The Department estimates in Table 23 that there will be a loss in federal funding of $17 million in 2027 that then falls to $16 million in 2028 and stays constant for the remaining years.[136] This is impossible if using the numbers in Table 24 because PMPM costs rise every year after 2027.[137] Nor does the Department ever explain whether this loss in federal funding presents losses relative to a pre-H.R. 1 counterfactual baseline or year-over-year changes, further making these estimated impacts unclear and unverifiable. The rule never discloses the underlying per-member cost figures that are actually used to produce Table 23 and 25, making these spending estimates unverifiable.

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

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

In 2023, the Department required all Marketplace plans to use a network of providers in order to assure "that all plans certified as QHPs offer sufficient choice of providers in compliance with a consistent set of criteria for easier comparison across all QHPs and better ensure substantive consumer protections afforded by the ACA without undue barriers to access those protections."[138] This was a wise decision, as non-network plans, rather than maintaining "a network of contracted providers who agree to accept the plan's payment for services … in full," instead allow for balance billing: "if a provider wishes to be paid more than" what the plan determines it will pay, "the plan enrollee is financially responsible for paying that balance."[139] This poses a significant risk of saddling enrollees with large surprise medical bills and undermines the aims of federal[140] and State

[134] 91 Fed. Reg. at 6,450.
[135] 91 Fed. Reg. at 6,449.
[136] *Id.*
[137] *Id.*
[138] 88 Fed. Reg. at 25,873.
[139] Sabrina Corlette & Tara Straw, *Proposed Marketplace and Insurance Changes in the 2027 Notice of Benefit & Payment Parameters: Implications for States*, Princeton University: State Health & Value Strategies (Feb. 2026), https://tinyurl.com/e7hyjmbj.
[140] *See* 26 U.S.C. § 9816; 42 U.S.C. § 300gg-111 et seq.

laws[141] that restrict or prohibit surprise billing. Critics of such plans have expressed concerns that enrollees would not "actually have access to medical care under plans without an established network," and that non-network plans are "'not going to work as insurance as most people understand it.'" [142] Even the Department acknowledges that non-network health plans are quite rare and concedes that "the plan design may not be immediately intuitive to enrollees."[143]

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

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

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

---

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

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

[143] 91 Fed. Reg. at 6,411.

[144] 91 Fed. Reg. at 6,407.

[145] 91 Fed. Reg. at 4,409.

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

[147] 91 Fed. Reg. at 6,414-15.

[148] Keith & Fiedler, *supra* n. 146.

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

Non-network plans would exacerbate a problem that already makes healthcare less transparent and less affordable. Balance billing and surprise bills are already present even in network plans, due to the prevalence of out-of-network charges: a 2020 study found that "[f]or people in large employer plans, 18% of all emergency visits and 16% of in-network hospital stays had at least one out-of-network charge associated with the care,"[150] with one third of respondents between the ages of 18-64 from another study that year reporting an unexpected medical bill.[151] These unexpected costs are often substantial: the Department's own 2022 reporting shows average costs between $750 to $2,600 for emergency room visits, elective surgeries, and giving birth in a hospital.[152] Non-network plans allow for and encourage such surprise costs: by the Department's own acknowledgment, it is a feature that is baked into their premise, as they offer "no guarantee" against balance billing and surprise costs.[153] As such, by expanding access to such plans, the Proposed Rule runs contrary to the intent of federal and State laws protecting against surprise bills[154] and undermines the ACA's goal of "decreas[ing] the cost of health care."[155]

4. <u>The Department's proposed implementation of the State Exchange Improper Payment Measurement is Needlessly Rushed and Unduly Burdens States.</u>

The Proposed Rule implements the State Exchange Improper Payment Measurement (SEIPM), an initiative through which the Department would collect data from State Exchanges to measure improper payments of APTC, with an applicability date of January 1, 2027. This would mean that State Exchanges "would be subject to improper payment measurement under the SEIPM beginning in 2027 for PY 2026."[156] Especially given the delayed issuance of the Proposed Rule,[157] this applicability date does not allow States sufficient times to prepare for SEIPM. The Department has previously proposed and subsequently declined to adopt SEIPM reporting requirements.[158] The 2023 Payment Notice, published in January 2022, proposed SEIPM but would not have required reporting by States until 2025.[159] In contrast, the Proposed Rule would give States less than a year to interpret the Proposed Rule and any final rule, prepare the extensive data required by SEIPM, and send that data to the Department.

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

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

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

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

[153] *See* 91 Fed. Reg. at 6,408-09.

[154] *See supra* n. 140-141.

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

[156] 91 Fed. Reg. at 6,358.

[157] *See supra* at 3–4.

[158] 91 Fed. Reg. at 6,356.

[159] 87 Fed. Reg. at 654–55.

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

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

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

---

[160] 91 Fed. Reg. at 6,356.
[161] 91 Fed. Reg. at 6,357.
[162] *Id.*
[163] 91 Fed. Reg. at 6,357, 6,466.
[164] Katie Keith & Matthew Fiedler, *HHS Proposes Sweeping Changes For 2027 Marketplace Plans (Part 3)*, Health Affairs (Feb. 17, 2026), https://tinyurl.com/3v2eabwn.
[165] 91 Fed. Reg. at 6,366.

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

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

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

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

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

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

---

[166] 91 Fed. Reg. at 6,335.

[167] *Id.*

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

[169] 91 Fed. Reg. at 6,335.

[170] 91 Fed. Reg. at 6,339.

[171] *Id.*

[172] *Id.*

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

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

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

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

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

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

Respectfully submitted,

ROB BONTA
CALIFORNIA ATTORNEY GENERAL

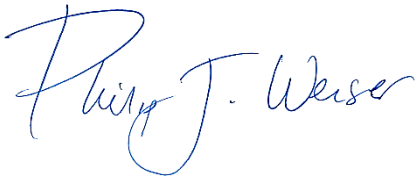
ANDREA JOY CAMPBELL
MASSACHUSETTS ATTORNEY GENERAL

https://tinyurl.com/uarm3x5n.

[175] 91 Fed. Reg. at 6,352.

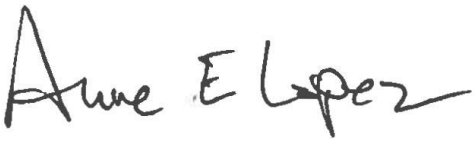
JENNIFER DAVENPORT
NEW JERSEY ATTORNEY GENERAL

KRISTIN MAYES
ARIZONA ATTORNEY GENERAL



PHILIP J. WEISER
COLORADO ATTORNEY GENERAL

KATHLEEN JENNINGS
DELAWARE ATTORNEY GENERAL



ANNE E. LOPEZ
HAWAI'I ATTORNEY GENERAL

KWAME RAOUL
ILLINOIS ATTORNEY GENERAL

AARON M. FREY
MAINE ATTORNEY GENERAL

ANTHONY G. BROWN
MARYLAND ATTORNEY GENERAL

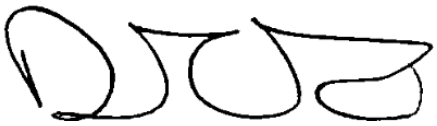
DANA NESSEL
MICHIGAN ATTORNEY GENERAL

KEITH ELLISON
MINNESOTA ATTORNEY GENERAL

AARON D. FORD
NEVADA ATTORNEY GENERAL

RAÚL TORREZ
NEW MEXICO ATTORNEY GENERAL

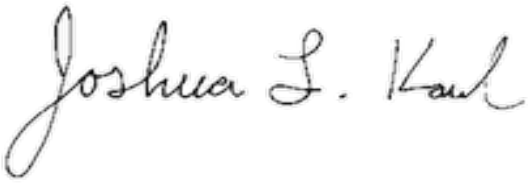
LETITIA JAMES
NEW YORK ATTORNEY GENERAL



DAN RAYFIELD
OREGON ATTORNEY GENERAL

PETER NERONHA
RHODE ISLAND ATTORNEY GENERAL

NICK BROWN
WASHINGTON ATTORNEY GENERAL



JOSHUA L. KAUL
WISCONSIN ATTORNEY GENERAL