March 13, 2026

Submitted electronically

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2027 [CMS-9883-P]

Dear CMS,

The Council for Affordable Health Coverage (CAHC) and the Health Benefits Institute (HBI) appreciate the opportunity to provide comments on the proposed Notice of Benefit and Payment Parameters (NBPP) for the 2027 plan year.

CAHC (www.cahc.net) is a broad-based alliance with a primary focus: making health care affordable for all Americans. Our members include employers, medical providers, patient groups, agents and brokers, technology companies, and pharmaceutical manufacturers, who collectively cover millions of lives in the private market. We support consumer interests through policies based on free market principles.

The Health Benefits Institute (www.thehealthbenefitsinstitute.org) is a policy organization supported by agents, brokers, insurers, employers, benefit platforms and others seeking to protect the ability of consumers to make their own health care financing choices. We support policies that expand consumer choice and control, promote industry standards, educate consumers on their options, and foster high quality health outcomes through transparency in health care prices, quality, and the financing mechanisms used to pay for care.

Together our organizations support the proposed rule's provisions to:

1. Enhance benefit design innovation by removing standardized plan requirements;
2. Promote no network plans to reduce costs and dramatically expand access to services;
3. Ensure essential health benefits requirements are consistent with the statute and that additional costs are not heaped on consumers; and
4. Expand protections against fraud and bad actors.

The rule will help lower relative costs while providing more options to consumers. We appreciate that CMS has taken steps to ensure that all consumers retain access to plans across every metal tier. However, certain conflicts created by the statute itself remain and cannot be resolved through rulemaking alone. We therefore encourage the Administration and Congress to work together to address these statutory design flaws so that all consumers can benefit from lower-cost plan options.

Payment Parameters and Risk Adjustment Program (45 CFR Part 153; 45 CFR §§153.20, 153.610; 45 CFR §§156.130–156.150; ACA §§1302(c), 1343)

CMS's proposed updates to the annual payment parameters for the 2027 plan year represent a necessary step to maintain the integrity of the individual and small group markets. Because these parameters form the financial foundation of these markets, it is essential that they be updated using current premium and expenditure projections.

The proposed adjustments to the premium adjustment percentage, maximum annual limitation on cost sharing (MOOP), and required contribution percentage appropriately reflect the underlying growth in health care costs and premiums. Updating these parameters ensures that statutory cost-sharing protections established under section 1302(c) of the Affordable Care Act remain aligned with real-world market conditions.

Failing to update these parameters appropriately would distort plan design incentives and create unnecessary market instability. CMS's approach maintains predictability for issuers and consumers alike while preserving the actuarial integrity of Marketplace coverage.

We also strongly support CMS's proposal to maintain the HHS-operated risk adjustment user fee at $0.20 per member per month under 45 CFR §153.610. The risk adjustment program established under ACA section 1343 remains a cornerstone of the individual market. Without an effective risk adjustment framework, issuers would face strong incentives to avoid higher-risk enrollees, which would undermine the stability of the Marketplace.

Maintaining predictable administrative costs for the program supports continued issuer participation and reinforces the long-term sustainability of the risk adjustment system.

Exchange User Fees and Marketplace Financing (45 CFR §156.50)

Maintaining the Federally Facilitated Marketplace (FFE) user fee rate at 2.5 percent and the State-Based Exchange on the Federal Platform (SBE-FP) user fee rate at 2.0 percent provides an appropriate and balanced approach to financing Exchange operations. Because user fees are incorporated directly into Marketplace premiums, they should remain closely aligned with the actual cost of operating the federal Marketplace and its eligibility, enrollment, and consumer assistance infrastructure. Fees that exceed operational costs unnecessarily increase premiums and undermine coverage affordability.

User fees should also remain stable and predictable from year to year. Issuers set premiums and make participation decisions well in advance of the plan year, and significant changes in fee levels introduce unnecessary uncertainty into the rate-setting process. Maintaining consistent fee levels allows issuers to better anticipate administrative costs and incorporate those costs into premiums—supporting more predictable pricing and greater market stability.

Stable and transparent user fee policy also supports state flexibility in Exchange administration. States considering whether to transition from the federal platform to a State-Based Exchange under 45 CFR §155.105 must evaluate the costs of operating their own Marketplace

infrastructure. Predictable federal platform fees allow states to make these decisions using clear and reliable cost comparisons.

Clarification of Essential Health Benefits Treatment for Adult Dental and Vision Services (45 CFR §§156.110, 156.115; ACA §1302)

CMS's proposal to clarify that routine adult dental and vision services are not required components of the Essential Health Benefits (EHB) package for Qualified Health Plans and may not be added to the EHB benchmark by states appropriately reinforces the statutory limits established under the Affordable Care Act. Maintaining clear boundaries around the EHB framework is essential to ensuring that the federally defined benefit package remains consistent, states do not drive up costs for all consumers by requiring purchase of additional benefits, and that federal subsidies are not expanded beyond their intended scope through state benchmark changes.

Routine adult dental and vision benefits have long been provided through stand-alone coverage in both the individual and employer markets. These specialized plans are designed specifically to address dental and vision needs and typically offer broader preventive services, specialized provider networks, and benefit structures tailored to these services.

Preserving the availability of stand-alone dental and vision plans ensures that consumers continue to have access to coverage specifically designed for these services. In many cases, these plans offer more comprehensive and specialized benefits than would likely be available if routine dental and vision services were incorporated into comprehensive medical coverage through the EHB framework.

Agent and Broker Marketing Standards (45 CFR §§155.220, 155.260, 156.1230)

CMS's efforts to strengthen marketing standards governing agents, brokers, and web-brokers participating in the Marketplace represent an important step toward addressing deceptive marketing practices and protecting consumers during enrollment.

Most licensed agents operate ethically and provide valuable assistance to consumers navigating complex coverage options. However, a small number of bad actors have caused disproportionate harm to consumers and to the integrity of the Marketplace.

Unauthorized agent-of-record changes and plan switching have become a significant concern. Regulators and issuers have documented cases in which consumers were moved into different plans without their knowledge or consent—often into zero-premium plans that generated commissions for the enrolling agent while disrupting existing provider relationships and ongoing care. These practices undermine consumer trust and impose unnecessary administrative costs on issuers, Exchanges, and regulators.

Many of the practices CMS seeks to address—misleading marketing, unauthorized enrollments, and improper inducements—are already prohibited under state insurance laws and agent licensing standards. State insurance departments have been on the front lines investigating

these issues and have reported increasing consumer complaints involving unauthorized broker assignments and deceptive marketing.

Clarifying federal marketing standards under 45 CFR §155.220 is therefore necessary. The proposed rule strengthens prohibitions on misleading marketing, restricts improper inducements, and requires documentation for agent-of-record changes to ensure consumers are enrolled only with their authorization. The rule also improves CMS oversight by requiring agents, brokers, and web-brokers to maintain records of consumer consent and provide marketing materials upon request.

Federal oversight should complement—not replace—the important role state regulators play in licensing and disciplining agents. Greater coordination between CMS and state insurance departments would further strengthen oversight and help ensure that agents who violate professional standards are held accountable.

Eligibility Verification and Program Integrity (45 CFR §§155.302, 155.315, 155.320; ACA §1411)

CMS's proposals to strengthen eligibility verification requirements for advance premium tax credits (APTC) and cost-sharing reductions represent an important step to combat fraud and reduce improper enrollments in the Marketplace.

The Marketplace now represents one of the largest federal subsidy programs supporting private health insurance coverage. Ensuring that subsidies are provided only to individuals who meet statutory eligibility requirements is essential to maintaining the credibility and fiscal integrity of the program.

Recent experience has demonstrated that weak verification standards create opportunities for fraud and abuse. Limited documentation requirements have allowed improper enrollments and subsidy payments, including cases where individuals were enrolled without sufficient verification of income, immigration status, or other eligibility criteria. The availability of zero-premium plans combined with weak verification requirements also created incentives for unethical enrollment practices, including unauthorized plan switching by agents seeking commissions.

Prior CMS program integrity rules have begun addressing these issues by strengthening oversight of agent conduct and limiting unauthorized agent-of-record changes. However, stronger eligibility verification requirements remain necessary to address the underlying vulnerabilities that enabled these abuses.

Enhanced verification of income, immigration status, and other eligibility factors will help deter improper enrollments and ensure federal subsidy dollars are distributed in accordance with section 1411 of the Affordable Care Act.

CMS's proposal to implement the State Exchange Improper Payment Measurement (SEIPM) program will further strengthen oversight by establishing a consistent framework for identifying and measuring improper payments across state-based Exchanges.

Taken together, these proposals will help protect consumers, strengthen program integrity, and ensure that Marketplace subsidies are administered responsibly.

Special Enrollment Period Verification (45 CFR §155.420)

We support CMS's proposal to expand verification requirements for Special Enrollment Periods (SEPs).

SEPs play an important role by allowing consumers to obtain coverage following legitimate qualifying life events. However, insufficient verification requirements have allowed these enrollment pathways to be misused in ways that introduce significant adverse selection into the Marketplace risk pool and undermine market stability.

When individuals are able to enroll through SEPs without experiencing a qualifying event, coverage is often obtained only after medical needs arise. This type of opportunistic enrollment concentrates higher-cost individuals in the risk pool while discouraging continuous enrollment by healthier consumers. Over time, this dynamic drives higher claims costs and ultimately increases premiums for all Marketplace enrollees.

Strengthening documentation requirements and reinstating more robust verification standards will help ensure that SEPs operate as intended and are reserved for individuals who legitimately qualify. These safeguards are critical to limiting adverse selection, maintaining balanced risk pools, and protecting Marketplace affordability for consumers and issuers alike.

Exchange Operational Flexibility and State Marketplace Authority (45 CFR §§155.105, 155.106, 155.120, 155.221)

States have demonstrated significant innovation in developing Marketplace enrollment systems, consumer assistance programs, and outreach strategies. Providing states with greater flexibility in Exchange operations appropriately recognizes their role as the primary regulators of health insurance markets and allows them to design enrollment systems that reflect local market conditions and consumer needs.

In particular, expanding the role of enhanced direct enrollment (EDE) entities under 45 CFR §155.221 is an important step toward improving Marketplace accessibility and consumer engagement. EDE platforms leverage private-sector technology and distribution channels to offer consumers streamlined eligibility determinations, intuitive plan comparison tools, and personalized enrollment assistance.

Enhanced direct enrollment also expands the reach of the Marketplace by allowing consumers to enroll through trusted brokers, agents, and private enrollment platforms rather than relying solely on government-operated systems. This model can improve the enrollment experience, increase consumer awareness of coverage options, and help ensure individuals receive informed guidance when selecting plans that best meet their needs.

Standardized Plan Requirements (45 CFR §156.201)

The federal requirement that issuers offer standardized plan options in the Federally Facilitated Marketplace has unnecessarily constrained plan design and limited issuers' ability to respond to

consumer preferences. We support CMS's proposal to eliminate this requirement because it appropriately restores flexibility and promotes competition.

While standardized plans were intended to simplify consumer comparisons, in practice they imposed rigid templates that restricted innovation and limited insurers' ability to tailor products to evolving consumer needs. Health insurance markets function best when issuers can design coverage options that reflect different preferences regarding premiums, cost sharing, and provider access.

Removing the standardized plan requirement will allow issuers to develop plan designs that better align with consumer demand. Greater flexibility in benefit structures, cost-sharing arrangements, and provider networks will promote innovation and provide consumers with a broader range of meaningful coverage options.

Non-Network Qualified Health Plan (QHP) Option (45 CFR §§156.230, 156.235, 156.300)

Allowing Qualified Health Plans (QHPs) to be offered without a traditional provider network represents an important step toward expanding consumer choice and reducing unnecessary regulatory constraints on plan design while maintaining appropriate consumer protections.

Non-network QHPs provide an additional coverage option for consumers who value flexibility in choosing providers rather than relying on a defined network. This option may be particularly valuable for individuals who receive care from multiple providers, travel frequently, or live in areas where network construction is challenging due to provider shortages or highly concentrated hospital systems.

Importantly, non-network QHPs remain comprehensive major medical coverage subject to all Affordable Care Act requirements governing QHP certification, consumer protections, and transparency standards.

These plans should not be confused with excepted benefit products, such as fixed indemnity coverage. Non-network QHPs provide comprehensive medical coverage, while fixed indemnity plans are excepted benefits designed to offer limited, supplemental financial protection. Both products serve distinct and important roles in the broader health insurance market.

As CMS expands flexibility within the QHP framework, it is important that these changes not be interpreted as limiting or discouraging the availability of excepted benefit coverage. Consumers benefit when both comprehensive major medical coverage and supplemental excepted benefit options remain available. Preserving access to both types of coverage ensures that individuals can select coverage arrangements that best meet their health care and financial needs.

For these reasons, CMS's proposal to permit non-network QHP options is an important step toward empowering consumers while maintaining access to both comprehensive coverage and excepted benefit supplemental products.

Essential Health Benefits and State Mandate Defrayal (45 CFR §155.170; ACA §1311(d)(3)(B))

Allowing state-mandated benefits that exceed the federal Essential Health Benefits (EHB) benchmark to be incorporated into Exchange coverage without appropriate defrayal undermines the framework established by Congress. CMS's proposal to clarify the application of the defrayal requirement is therefore an important step to protect federal taxpayers and preserve the integrity of the EHB structure.

The Affordable Care Act permits states to adopt additional benefit mandates but requires states to bear the cost of those mandates for Exchange coverage. Enforcing this requirement ensures that federal premium tax credits support the core EHB package rather than subsidizing state policy decisions.

Clarifying the defrayal framework will reduce regulatory ambiguity, promote transparency, and ensure that states remain financially responsible for mandates that exceed the federal EHB benchmark.

Catastrophic Plan Flexibility (45 CFR §156.155; ACA §1302(e))

CMS's proposal to provide greater flexibility in the design of catastrophic plans is an important step toward preserving this coverage option in the individual market. Catastrophic plans serve an important role for younger consumers and individuals seeking protection against high-cost medical events while maintaining lower monthly premiums.

Greater flexibility in plan design will allow issuers to develop catastrophic coverage that better reflects consumer demand and evolving market conditions. This flexibility can encourage innovation in benefit structures and cost-sharing approaches while maintaining the core purpose of catastrophic coverage—providing financial protection against significant medical expenses.

Expanding flexibility may also help attract additional participation in the individual market by offering coverage options that appeal to consumers who might otherwise remain uninsured due to premium costs. Maintaining viable catastrophic coverage options therefore supports broader Marketplace participation while preserving meaningful protection against major health care expenses.

Medical Loss Ratio Framework and State Flexibility (45 CFR Part 158; PHSA §2718)

Strengthening state authority to determine appropriate Medical Loss Ratio (MLR) standards appropriately recognizes that states are best positioned to evaluate local insurance market conditions and maintain stable, competitive markets.

States serve as the primary regulators of health insurance markets and have the expertise, market data, and regulatory authority needed to assess local risk pools, competitive dynamics, and consumer needs. Because market conditions vary widely across states, a rigid one-size-fits-all federal MLR requirement may not always reflect local realities.

Providing states greater flexibility to adjust MLR standards where appropriate can help ensure continued issuer participation, particularly in markets with smaller risk pools, higher volatility, or

limited competition. Preserving this flexibility is consistent with the longstanding state-based framework of insurance regulation and will help ensure that MLR requirements remain responsive to local market conditions while maintaining the core consumer protections established under section 2718 of the Public Health Service Act.

Conclusion

We appreciate CMS's efforts to strengthen program integrity, enhance flexibility for states and issuers, and ensure that Marketplace programs continue to operate effectively.

We believe many of the proposals included in the 2027 NBPP represent constructive improvements that will help maintain the long-term sustainability of the individual and small group markets.

Thank you again for the opportunity to comment on the proposed rule.

Sincerely,

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