March 13, 2026

Via electronic submission at http://www.regulations.gov

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: HHS Notice of Benefit and Payment Parameters for 2027 Proposed Rule; 91 Fed. Reg. 6,292 (Feb. 11, 2026)

Dear Dr. Oz:

As the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States, the Federation of American Hospitals (FAH) appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding the above-referenced *HHS Notice of Benefit and Payment Parameters for 2026 Proposed Rule (Proposed Rule).*

FAH appreciates the Administration's continued efforts through the Notice of Benefit and Payment Parameters (NBPP) to increase competition in the individual market, maintain robust plan participation, and keep premiums affordable for consumers. Premium affordability is an essential component of a well-functioning insurance market. However, affordability challenges for patients do not arise solely – and often not primarily – from premiums. For many families, the most significant financial barriers emerge when they attempt to use their insurance. According to a recent KFF poll, about six in ten (61 percent) Marketplace enrollees report having difficulty affording out-of-pocket costs for medical care. Considering that 37 percent of all U.S. adults reported that they would not be able to cover a $400 expense with cash or its equivalent – an amount that represents only a small fraction of the typical deductible in Marketplace plans – many consumers in plans with high deductibles could find themselves scrambling to pay for health care when they need it. As CMS evaluates policies affecting the individual market, it is important to consider how benefit design, cost-sharing structures, and network practices affect whether coverage translates into meaningful access to care.

Over the past decade, deductibles and other forms of cost sharing have increased significantly across private insurance markets. According to the Kaiser Family Foundation's Employer Health Benefits Survey, the average deductible for single coverage increased by more than 50 percent since 2013, and enrollment in high-deductible plans has grown steadily.[1] When deductibles and coinsurance obligations reach several thousand dollars, many patients effectively face the full cost of care until those thresholds are met. Research shows that higher cost sharing reduces utilization of both discretionary and necessary medical services, meaning many families with insurance coverage delay or forgo care because of cost.[2] For these patients, insurance coverage does not necessarily guarantee access to care when it is needed.

Affordability challenges are compounded by network design and provider directory accuracy. Narrow networks are increasingly common in the individual market and can make it difficult for enrollees to identify participating providers with available appointments. At the same time, inaccurate or outdated provider directories can leave patients believing that care is available in network when, in practice, the listed providers are no longer participating. Studies

[1] Kaiser Family Foundation. *2024 Employer Health Benefits Survey*

[2] Zarek Brot-Goldberg et al., What Does a Deductible Do?, 112 Q.J. Econ. 1261 (2017)

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have found that a significant share of providers listed in plan directories are either not accepting new patients or cannot be reached to confirm participation.[3] Further, nearly 15 percent of all claims submitted to private insurers are initially denied, even when the services were preauthorized.[4] More than half of these denials are eventually overturned, but only after multiple rounds of costly appeals,[5] frustrating patients and providers alike because they divert time and resources away from direct patient care. These practices create substantial barriers to accessing covered services and expose patients to unexpected costs.

Finally, ensuring that premium dollars are used primarily to support patient care must remain a central goal of insurance oversight. The individual market's medical loss ratio (MLR) requirements were designed to ensure that most premium revenue – generally 80-85 percent – is spent on medical care and quality improvement activities rather than administrative costs or profits. However, market consolidation and vertical integration have created new ways for insurers to technically comply with MLR standards while shifting premium revenue within affiliated corporate structures. Payments to insurer-owned provider entities, pharmacy benefit managers, or other subsidiaries are counted as medical spending under current rules, even when the funds remain within the same corporate family.[6] Analysts and policymakers have raised concerns that these arrangements can weaken the consumer protections the MLR framework was intended to provide while maintaining high premiums for consumers and creating an uneven competitive landscape for providers.[5]

Taken together, these trends illustrate why addressing challenges in this market requires attention not only to premiums but also to how coverage functions when patients seek care and how premium dollars are ultimately used to support that care. Consumers reasonably expect that the premiums they pay will translate into meaningful access to hospitals, physicians and other needed services. Ensuring that this occurs requires appropriate oversight of plan design, network adequacy and the use of premium revenue. As the Administration has emphasized in other contexts, strengthening transparency and accountability for insurers is essential to ensuring that coverage is designed to serve patients rather than financial engineering within complex corporate structures.

In light of these trends, FAH is concerned that several provisions in the Proposed Rule could unintentionally exacerbate existing affordability challenges for patients by giving insurers greater latitude to increase cost-sharing or design coverage in ways that limit access to care. As a result, some policies may ultimately work at cross-purposes with the Administration's goal of expanding affordable coverage options. For example, a catastrophic or non-network plan that offers benefits for services that cannot be accessed fails to enhance affordability of health care for consumers. Notably, CMS's own analysis projects that the rule could reduce Marketplace enrollment by approximately 1.2 to 2 million individuals while increasing premiums by 2 to 3 percent.[7]

FAH appreciates the opportunity to provide the following comments on several key provisions of the Proposed Rule and offers recommendations intended to strengthen consumer affordability, promote insurer accountability, and ensure that Marketplace coverage translates into meaningful access to care, as further discussed below:

- Ensure that efforts to improve premium affordability do not come at the expense of meaningful coverage or patients' ability to access needed care.
- Maintain strong network adequacy standards, including requirements that plans maintain contracted provider networks and do not allow non-network plans.
- Reconsider proposed expansions of catastrophic plan eligibility, including broadened hardship exemptions, higher maximum out-of-pocket limits, and multi-year catastrophic coverage, which risk increasing patients' exposure to high upfront costs.
- Improve oversight of brokers and agents to ensure compensation structures align with consumer interests and do not incentivize fraudulent or inappropriate Marketplace enrollments.
- Strengthen MLR oversight to ensure that premium dollars are directed toward patient care rather than financial arrangements within vertically integrated insurer structures.

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[3] Haeder, Weimer, Mukamel. "Secret Shoppers Find Access to Providers and Network Accuracy Problems in Health Insurance Marketplace Plans." Health Affairs.
[4] https://premierinc.com/newsroom/blog/trend-alert-private-payers-retain-profits-by-refusing-or-delaying-legitimate-medical-claims
[5] Ibid.
[6] January Angeles & Michael Bailit, *How Insurers That Own Providers Can Game the Medical Loss Ratio Rules*, Health Affairs Forefront (Sept. 2025)
[7] 91 Fed. Reg. 6,463 (Feb 11, 2026).

Network Adequacy

Exchange Network Adequacy Standards (III.D.18)

FAH urges delaying the introduction of many of the proposed changes to network adequacy standards, particularly when a broad expansion of new benefit offerings such as non-network and catastrophic plans are being proposed. As consumers in the Marketplaces are challenged by the affordability of new and higher out-of-pocket costs and premiums, they will want assurance that the benefits, coverage and services they purchase are meaningful and can be accessed. Narrow networks and inaccurate provider directories already create challenges for patients seeking in-network care. Empirical studies of Marketplace plans have found significant inaccuracies in provider directories, including listings for physicians who were unreachable or not accepting the listed coverage.[8] The U.S. Government Accountability Office has also noted that regulators rely heavily on provider directories to evaluate network adequacy and that oversight of those directories varies across jurisdictions.[9]

At the very least, network adequacy standards should not be reshuffled at the same time a host of new coverage alternatives are being introduced to consumers. A recent study by the Kaiser Family Foundation suggests that current tools and enforcement are inadequate for consumers to evaluate and compare Exchange plan networks, whether applied at the state or federal level.[10] Without clear and enforceable network adequacy standards, consumers risk purchasing coverage that appears affordable but fails to provide meaningful access to needed care.

Proposal to Remove Time and Distance and Wait Time Standards for Evaluating Network Adequacy

Proposals that would allow State Exchanges and State-based Marketplaces-Federal Platform (SBE-FPs) to remove time and distance standards and appointment wait time standards for purposes of evaluating network adequacy could significantly weaken consumers' confidence in their access to the providers, services and coverage for which they enroll. These standards are long-standing measures used in Medicare Advantage and Medicaid programs to evaluate network adequacy. **Applying the same minimum standards of timely access to Exchange enrollees provides the assurance and consistency that Exchange (or Marketplace) enrollees need to evaluate new plans with increasingly complex benefit designs and cost-sharing structures.**

Proposal to Remove Requirement for State Network Adequacy Reviews Before Certification

CMS proposes eliminating the requirement that State Exchanges and SBE-FPs conduct quantitative network adequacy reviews to evaluate Qualified Health Plans' (QHPs') compliance with network adequacy standards **before certification**. With a potential flood of new products and plans being offered with a wide array of benefits and out-of-pocket costs, consumers will want some assurance that their physician or local community hospital will be accessible when they need it. A flexible standard that is potentially permitted after QHP certification would give little solace to patients if a state regulator begins its inquiry as to network adequacy after the plan has been certified and while the patient seeks services. A retrospective review of network adequacy provides little relief after the patient has purchased coverage and then cannot access covered services from a listed network provider or from a non-network plan provider.

Thus, FAH urges CMS to maintain network adequacy review prior to certification, especially if the proposed rule results in a broader range of plan designs and coverage options in the Marketplace.

Network Adequacy and Post-Acute Providers

Network adequacy standards for post-acute providers such as Inpatient Rehabilitation Facilities (IRFs) and Long-term Care Hospitals (LTCH's) are also critical for patients with marketplace coverage. These facilities frequently serve as medically appropriate settings for a patient that can be safely discharged from a hospital when discharge to home is not medically indicated. Too often, patients with brain injuries, spinal cord injuries, stroke victims, and others with complex, but common conditions do not receive the intensive care they need to live independently and return to work because health plans do not contract adequately for these services. **FAH urges consideration of these facilities for**

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[8] Haeder, Weimer & Mukamel, *Health Affairs* (2016)

[9] GAO-23-105642 (2022)

[10] *How Narrow or Broad Are ACA Marketplace Physician Networks*, Kaiser Family Foundation Report, August 26, 2024. "Other than a limited pilot operating in two states (Tennessee and Texas), the only tool available for HealthCare.gov consumers to evaluate a plans network is to search for individual providers, one by one, in directories, which may not always be up to date."

inclusion in network adequacy standards for an approved "Effective Provider Access Review Program" to encourage appropriate levels of care for beneficiaries after hospitalization.

Deferral of Network Adequacy Reviews to States with an Effective Provider Access Review Program (III.E.10)

CMS proposes to defer reviews of network adequacy to FFE-States that elect to conduct the reviews and satisfy criteria to be considered to have an Effective Provider Access Review Program. **FAH has concerns that providing such broad discretion to states to develop their own network adequacy standards could lead to standards that are not specifically defined or transparent to consumers and could result in wide variation from state to state, making it more difficult to compare whether the standards applied are truly effective at measuring network adequacy.**

CMS also proposes to grant states exceptions to the established criteria for an Effective Provider Access Review Program if it would be "in the interests of the qualified individuals in the State." An exceptions process that gives states even more flexibility under a broadly defined "interests of the qualified individuals" would invite exceptions that could swallow the rule. **FAH suggests eliminating the exceptions or at least providing more specific criteria as to what may constitute "the interest of qualified individuals in the State."** Such criteria could impose guardrails to ensure that a state has the resources and capacity to conduct adequate network adequacy reviews and maintain appropriate consumer access to providers.

ECP Standards and Reviews by States with an Effective ECP Review Program (Section III.D19/E11)

CMS proposes to reduce the Essential Community Provider (ECP) threshold from 35 percent to 20 percent for purposes of the percentage of available ECPs in each plan's service area. CMS further proposes to allow FFE states to conduct their own ECP certification review if the state elects to do so and satisfies criteria established by CMS for an Effective ECP Review Program. **FAH recommends that CMS maintain the 35 percent threshold and delay deferring oversight of the ECP Standards to FFE States at least until the impact of a broad array of new products can be evaluated for purposes of their impact on the participation of ECPs in a network.**

Regarding the proposal of a 20 percent ECP threshold, the statute requires establishment of criteria for certification of QHPs that "ensure a sufficient choice of providers" and specific inclusion within QHP networks of "those essential community providers, where available, that serve predominantly low-income, medically underserved individuals."[11] ECP participation is critical in networks for these patients but is likely to diminish by reducing the ECP threshold from 35 to 20 percent, particularly with the continued use of a case-by-case exception process when this threshold is not met by QHPs.

We also are concerned about delegating ECP standard enforcement to states because is not clear that states have the resources and ability to conduct ECP reviews and likely will develop inconsistent standards across states, creating a patchwork of varying criteria. It is also unclear how FFE states, when conducting reviews of non-network plans, would apply a standard to ensure appropriate ECP access.

QHP Certification of Non-Network Plans (Part III.E.12)

FAH urges CMS to preserve network adequacy review as an element of the QHP certification process and not to allow certification of QHPs that lack contracted provider networks. An indemnity plan that offers benefits for services that cannot be accessed fails to enhance affordability of health care for Americans seeking coverage in the Marketplace. Even if a non-network plan has low premiums, it may not provide meaningful access at the point an enrollee actually requires care. Indeed, non-network plans threaten to provide illusory benefits if few providers furnish services at the stated benefit amount, or if that changes due to fluctuations in market conditions over time. In these circumstances, enrollees will face significant out-of-pocket spending obligations, and may face difficult decisions if their cost-sharing obligation for needed health care services vastly exceeds the typical amount an American with health coverage expects to pay as a copayment or as coinsurance.

FAH also respectfully requests that CMS clarify that non-network plans must comply with applicable law. In particular, non-network plans are subject to those provisions of the No Surprises Act that require coverage of emergency services (including post-stabilization services) and limit the cost-sharing the plan may impose. Reference-based pricing and similar strategies employed by non-network plans cannot be applied to emergency services (including

[11]ACA Section 1311(c)(1)(B)-(C), 42 U.S.C. Section 18031(c)(1)(B)-(C)

post-stabilization services), which must be paid by plans at the "out-of-network rate" pursuant to section 2799A-1(a)(1)(C)(iv)(II) of the Public Health Services Act. Moreover, as part of the oversight for non-network plans, we recommend monitoring the impact on the independent dispute resolution (IDR) process or state mechanisms if non-network plans fail to provide an appropriate benefit amount for emergency and post-stabilization services. An increase in reliance on the IDR process would impose significant administrative burdens on providers and federal agencies alike, while also signaling potential deficiencies in plan payment practices that should be addressed through stronger upfront oversight and enforcement.

While we appreciate the attention CMS has given to states' ability to enforce the "payment in full" requirement when conducting their own network adequacy reviews, in the absence of enforceable contracts, there is no guarantee that the benefit amount will ensure meaningful access to care via non-network plans throughout a plan year. Proposed 45 C.F.R. section 155.1050(d)(3) would require a state conducting its own review to "ensure" that a non-network QHP issuer "provides access to a sufficient choice of providers that accept the non-network plan's benefit amount as payment in full, including ECPs and providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible without unreasonable delay." Indeed, the Proposed Rule contains no specific requirements to ensure that a state conducting its own review of network adequacy and adherence to the ECP standard can monitor compliance to the "payment in full" requirement.

To enable better oversight and inform future policy in this area, if CMS finalizes the proposal to allow certification of non-network plans as QHPs, we encourage CMS to require these issuers to report on key metrics that would reflect whether the "payment in full" standard is being satisfied on an ongoing basis, including (i) the frequency with which enrollees face out-of-pocket costs for covered services because geographically-accessible providers do not accept the benefit amount as "payment in full" for covered services, (ii) related details regarding services and associated payment amounts, as well as (iii) the frequency with which the QHP issuer's payment amounts are challenged by providers using the IDR process established under the No Surprises Act. Plans also should be required to meet transparency requirements and clearly identify on an enrollee's patient benefit card that the plan is a non-network plan. Finally, we urge CMS to revisit the question of whether these plan types are even consistent with statute, which contemplates provider networks that satisfy specific standards, including with respect to ECPs.

Expanded Access to Catastrophic Plans

FAH is committed to the goal of expanding access to affordable health care for hardworking Americans. Although catastrophic plans typically have lower premiums than metal-tier plans, the cost-sharing obligations associated with catastrophic plans are significant, which may place care out of financial reach for many enrollees. As reflected in the name, catastrophic plans are meant to provide coverage in the most extreme circumstances when the cost of care would exceed the annual out-of-pocket limit, but they do not enable meaningful access to more typical or routine care due to their unaffordable cost-sharing obligations. Although catastrophic plans were included in the law for a small segment of population who might otherwise opt out of coverage altogether, their availability was never intended to encourage a broader segment of the population to select these plans, incur unaffordable cost-sharing obligations, and burden the health care delivery system with resulting bad debt and uncompensated care costs. **We are concerned that several proposals related to catastrophic plans in the Proposed Rule would indeed encourage more widespread enrollment in catastrophic plans. At a time when Americans are concerned about health care affordability, we encourage CMS to promote metal level plans that provide meaningful coverage, not catastrophic coverage.**

FAH opposes the proposed expansions of catastrophic plan eligibility through broadened hardship exemptions, higher maximum out-of-pocket (MOOP) limits that exceed statutory limits and serve as a core consumer protection, and multi-year catastrophic coverage.

Hardship Exemptions to Expand Eligibility for Catastrophic Plans (Part III.D.17)

We urge CMS not to codify its guidance expanding catastrophic coverage eligibility by allowing a hardship exemption to include individuals over the age of 30 who are ineligible for Advanced Payments of the Premium Tax Credit (APTC) or Cost-Sharing Reductions (CSRs) due to projected household income. **Instead, we encourage CMS to maintain the standards for a hardship exemption that are currently in place.** Catastrophic plans are not designed to facilitate access to care on a day-to-day basis, and such a broad expansion of access to catastrophic plans would disrupt the careful balance that Congress established when it specified that eligibility for catastrophic plans would be limited to those under the age of 30 or those who have a certification in effect regarding their lack of affordable coverage or experiencing a hardship. This also could encourage healthier individuals to choose a catastrophic plan,

further skewing the risk pool while increasing premiums and exacerbating the unaffordability of meaningful comprehensive coverage for millions.

Multiyear Catastrophic Plans (Part III.E.6)

FAH has strong concerns about the potential impacts of allowing QHP issuers to offer multiyear catastrophic plans, including the potential effects of such a policy change on affordability of coverage, market stability and the possibility of gaming by QHP issuers. FAH urges CMS not to finalize this proposal at this time, as it lacks sufficient specificity and was issued with an abbreviated public comment period that does not allow stakeholders adequate time to conduct a thorough analysis and provide meaningful feedback.

We urge CMS' consideration of several critical dynamics, affecting the affordability of, and access to, health insurance coverage related to this proposal.[12] First, the notion of multiyear plans runs counter to the actuarial principles that underlie the statutory framework and operation of the Exchanges, and we are concerned about the destabilizing effect on the risk pool, particularly if individuals disenroll before the end of the contract. These could be particularly compounded by premium spikes if issuers are permitted to vary from the premiums disclosed during the initial enrollment. More broadly, any mid-term changes in premiums, benefits, and networks would constitute issuer gaming that denies consumers their chosen coverage.

Second, the Public Health Service Act contemplates annual plan terms for individual market insurance (in the same way that prevailing commercial coverage options are typically offered on an annual basis with renewal options). In fact, CMS only cites to section 2713(c) of the Public Health Service Act, which addresses guidelines for value-based insurance designs in the context of preventive coverage. Section 2713(c)'s guidelines authority, however, does not provide any authority to waive the provisions of section 2713 or other applicable laws. Similarly, FAH questions whether multiyear plan designs that vary by disease can satisfy the statutory prohibition against discriminatory plan design, which prohibits defining essential health benefits in a manner that discriminates against individuals based on age, disability, or expected length of life, as set forth in section 1302(b)(4)(B).

Finally, while CMS highlights the goal of affordability with this proposal, we urge CMS to consider whether a multiyear plan serves that goal. In particular, varying MOOP limits year-to-year may create the possibility that enrollees will face extremely high – perhaps unaffordable – out-of-pocket spending in certain years, directly undermining the goal of affordability. A QHP issuer is unlikely to design a multiyear plan that would provide a patient with a financial advantage if that individual disenrolls *early*; rather, an individual is likely to "unlock" the benefits of a multiyear plan (such as *lower* cost-sharing for the year) if that individual remains enrolled through the end of the contract. This suggests that enrollees who are unable or do not, for any reason, remain enrolled throughout the duration of a multiyear plan's contract would not benefit from the value of the full range of consumer protections, and would likely be financially penalized by their early disenrollment. Because the statute affords individuals flexibility in enrollment choices year over year, a plan's imposition of such a penalty seems inappropriate and fundamentally inconsistent with the statute, which specifically establishes the MOOP limit as an *annual* limit on cost-sharing.

Cost-Sharing for Catastrophic Plans & Bronze Plans (Part III.E.7)

FAH urges CMS to maintain the critical, statutory consumer protections established under the ACA, including maintaining and enforcing the MOOP limits pursuant to section 1302(c) and declining to finalize proposed sections 156.136 and 156.155, which would allow certain bronze and catastrophic plans to subject enrollees to financially crippling cost-sharing burdens in excess of $12,000 (self-only) or $24,000 (family). Although we share CMS' general support for innovation in plan design, this cannot come at the expense of adequate coverage and extraordinarily burdensome cost-sharing obligations, nor can it justify a violation of statutory requirements. **We thus urge CMS to abandon its proposal to allow issuers of catastrophic and bronze plans to exceed the statutory MOOP limits and thereby protect enrollees from excessive and debilitating cost-sharing obligations.**

The MOOP limit operates to ensure enrollees do not face such disproportionate out-of-pocket spending obligations that their coverage is not meaningful (except in extraordinary circumstances). Without an appropriate MOOP, issuers may impose so much cost-sharing that patients cannot afford health care even when they have health insurance.

[12] FAH appreciates CMS' request for comment on a proposal relating to satisfaction of the requirements for a catastrophic plan at the time of the enrollment in the multi-year plan (91 Fed. Reg. at 6,371 ("We propose that an individual who satisfies the requirements for a catastrophic plan at the time of enrollment . . . in the multi-year plan. We seek comments on this proposal and how it would interact with other laws."), but unfortunately, it appears that the substance of the proposal was omitted from the Proposed Rule, so FAH is unable to evaluate the proposal and provide comment.

Whether enrollees leave their health care bills unpaid because their deductible, copayments or coinsurance amounts are simply too high, or they make the impossible decision to forego care, the root cause in either case is the same: coverage is insufficient. We disagree that increasing the MOOP serves the primary policy goal of increasing affordability, because even if enrollees are offered lower premiums and/or greater pre-deductible coverage as a result of this policy change, they are still not protected from high out-of-pocket costs as intended by the statutorily mandated MOOP. Coverage that leaves enrollees responsible for more than the statutory MOOP—$12,000 (self-only) or $24,000 (family) in possible out-of-pocket responsibility in 2027—leaves enrollees with financial burdens that Congress acted decisively to remove and that threaten to negate the value of private coverage. These excessive and unaffordable cost sharing obligations also would inappropriately burden the health care delivery system with bad debt and uncompensated care costs despite Congress's express establishment of a statutory MOOP that limits the financial risks of providing care to enrollees. **We thus urge CMS to exhaust alternative policy tools (discussed below) as appropriate and continue to require adherence to the statute's MOOP limits.**

CMS' proposal to allow catastrophic and bronze plans to impose cost-sharing burdens on members in excess of the statutorily mandated MOOP amount is based on the assertion that these plans have had less and less flexibility to innovate with respect to cost-sharing because of the constraints created by the MOOP. But this is not so. In fact, based on Marketplace public use files, the difference between the average deductibles of bronze plans and the MOOP in recent years has well surpassed the difference from the early years of the Marketplace. In the first year of the Marketplaces, bronze plans had an average deductible of $5,113, which was $1,237 less than the MOOP. In contrast, the average bronze deductible is $3,124 less than the MOOP for 2026, and there has been no long term trend of the deductible approaching the MOOP.[13] Notably, since the 2017 market stabilization amendments to 45 C.F.R. section 156.140(c), permitting bronze plans to qualify with an actuarial value (AV) up to 65 percent if a major service beyond preventive services is covered before the deductible, the average bronze plan deductible has fallen between $1,348 (2018) and $3,124 (2026) below the MOOP for each year, indicating that issuer's flexibility to reduce deductibles for bronze plan offerings as compared to the MOOP is similar or more favorable than what it was in 2014. To the extent that AV requirements and the MOOP limit bronze plans' flexibility with respect to cost-sharing design, these limitations are established by statute and cannot give way to policy preferences with respect to plan flexibility. Moreover, this data confirms that there is room for bronze plans to navigate AV requirements and the MOOP with deductible adjustments or otherwise, such that CMS is not yet presented with a situation "where two statutory requirements cannot reasonably be satisfied simultaneously," 91 Fed. Reg. at 6,379, and must continue to apply the statutory MOOP limits to catastrophic and bronze plans.

To the extent that any conflict were to exist between AV requirements and the MOOP, FAH disagrees that the statute's MOOP limits should give way to its provisions governing AV levels, and that compromising the MOOP best serves Congress's intent. Although we disagree that the two statutory directives cannot be followed, and note that Congress itself must resolve any tension here instead of CMS, we urge that the "general consumer protection ceiling" created by the statute's MOOP provision is specific, absolute, and not disposable. Congress established the MOOP as a definitive backstop on enrollee cost-sharing, adopted a statutory formula for the MOOP under section 1302(c)(1), and provided no discretion for deviating from the MOOP. In contrast, the AV requirements in section 1302(d) expressly confer some regulatory discretion, requiring the Secretary to develop guidelines to provide for a *de minimis* variation in the actuarial valuations." Thus, to the extent that any conflict exists or emerges between the AV requirements and the MOOP, if Congress fails to act to resolve the issue, only the AV requirement could give way through CMS' authority to permit de minimis variation from the target AV values under section 1302(d)(3).

More specifically, to the extent that current AV limits create issues, FAH urges CMS to extend bronze de minimis variability further above the statutory target of 60 percent (i.e., up to 65 percent) and to limit downside variability (i.e., limiting downside de minimis variability such that the AV of silver plans falls between 70 and 72 percent) to promote distinctions between metal tiers. Beyond CMS' de minimus variation authority for the AV, Congress has also provided other levers that could address any concerns. For example, CMS might consider further refinements to the premium adjustment percentage index (PAPI) methodology or further changes to the outlier trim on enrollee spending that is reflected in the AV calculator's standard population. In short, Congress has afforded CMS particular flexibilities with respect to implementation of QHP requirements, while establishing an express and definite MOOP limit. We disagree that "no administrable alternatives exist" to allow adherence to the various standards to the extent that they might be seen as incompatible.

[13] https://www.kff.org/affordable-care-act/deductibles-in-aca-marketplace-plans/.

Furthermore, with respect to catastrophic health plans, the Proposed Rule does not identify any conflict between the MOOP requirement and any other statutory requirement that could justify deviating from the MOOP for these plans. Catastrophic plans are not subject to any requirement to provide coverage within *de minimis* ranges of specific AVs or to provide coverage that is meaningfully different from bronze plans. In other words, there is no need to allow for catastrophic plans with cost-sharing in excess of the MOOP based on AV requirements. Even if the actuarial pressures described in the preamble operate to drive up the AV of catastrophic plans, that does not create tension with any statutory requirement or justify any deviation from the statutory MOOP.

If CMS adopts the proposal to allow plans at the bronze and/or catastrophic level to exceed the statutory MOOP limits, we urge CMS to require the display of clear language disclosing if a specific plan has a MOOP limit that exceeds statutory limits and exceeds the limits applicable to other bronze or catastrophic plans that do not display the same disclosure. This disclosure should be in plain language that helps the reader appreciate that they cannot compare this plan on an apples-to-apples basis to plans at the same level whose cost-sharing *does* fall below the MOOP. The disclosure should make clear to consumers that they may ultimately spend *more* when enrolled in this plan, even if its premiums are lower than other plans offered at the same level. Finally, we urge CMS to limit this policy to the individual market and not expand it to the small group market.

Medical Loss Ratio (III.F.1)

CMS solicits comment on the impact of the Federal MLR standard on individual market stability and whether the agency should use its authority under section 2718(b)(1)(A)(ii) of the PHS Act and §158.301 to adjust the MLR standard in a State to promote individual market stability. Comments are also solicited on whether and how to amend regulations allowing States to request an adjustment to the MLR standard in their individual market to reduce burden and encourage States to request adjustments, such as permitting adjustments to the MLR standard for up to 5 years instead of 3 years as is currently allowed, reducing information requirements to support requests for an adjustment to the MLR standard, the criteria used for assessing a request for such an adjustment, and the amount of adjustment that could be made to the MLR standard.

Ensuring that premium dollars are used primarily to support patient care must remain a central goal of insurance oversight. The individual market's MLR requirements were designed to ensure that most premium revenue – generally at least 80 percent – is spent on medical care and quality improvement activities rather than administrative costs or profits. Since their implementation more than a decade ago, these standards have functioned as a core accountability mechanism for how insurers use premium dollars.

Since the rule took effect, insurers have returned nearly $12 billion to consumers in rebates when they failed to meet the statutory minimum spending thresholds.[14] These rebates reflect the accountability function that Congress intended: ensuring that when premium revenue exceeds what insurers spend on medical care, those funds are returned to consumers rather than retained by plans. In practice, MLR and rate review function as complementary safeguards: rate review evaluates whether premiums are justified prospectively, while MLR ensures that premium dollars are ultimately spent on patient care retrospectively.[15] Lowering the MLR standard would weaken this retrospective accountability and is unlikely to improve affordability for consumers.

Section 2718(b)(1)(A)(ii) of the Public Health Service Act and 45 C.F.R. §158.301 provide the Secretary with authority to adjust the MLR standard applicable to the individual and small group markets in a State if the Secretary determines that application of the statutory 80 percent standard would destabilize the market in that State. FAH recognizes that this authority may be necessary in limited circumstances. However, adjustments to the MLR standard should be used sparingly and only where there is clear and compelling evidence that other policy options have been exhausted and that the adjustment is necessary to prevent genuine market destabilization. In the absence of such evidence, maintaining strong MLR standards and improving transparency around how premium dollars are spent will better protect consumers while preserving a stable and competitive individual market.

If enhanced oversight, stronger enforcement, and greater transparency around how insurers allocate premium revenue are effectively established and applied, then in rare cases with clear evidence that application of the 80 percent standard would otherwise destabilize the individual market in a particular State, FAH believes it would be reasonable to allow a State to apply an approved adjustment for up to five years instead of the currently permitted three years. Any such

[14] https://www.kff.org/private-insurance/medical-loss-ratio-rebates/#:~:text=Estimated%20total%20rebates%20across%20all,84%25
[15] https://www.cms.gov/marketplace/health-plans-issuers/insurance-market-reforms

period should be limited to the minimum duration necessary to prevent the identified destabilization, and throughout that period, insurers must remain fully accountable for how premium dollars are spent.

Importantly, there is little evidence that MLR requirements have discouraged insurer participation or contributed to instability in the individual market. Marketplace enrollment has grown steadily, reaching 23 million individuals in 2026.[16] At the same time, insurers in the individual market have consistently reported average MLRs above the statutory minimum, averaging approximately 84-88 percent since 2021, indicating that plans are generally able to comply with the standard without difficulty.[17]

At the same time, changes in the structure of the insurance market warrant renewed attention to how MLR standards are implemented. Consolidation and vertical integration have created new ways for insurers to technically comply with MLR requirements while shifting premium revenue within affiliated corporate structures. Payments to insurer-owned provider entities, pharmacy benefit managers, or other subsidiaries may be counted as medical spending under current rules even when those funds remain within the same corporate family.

These internal transactions can make it more difficult for regulators and consumers to determine whether reported medical spending reflects genuine investment in patient care. The Medicare Payment Advisory Commission has observed that traditional measures of health plan financial performance may not fully capture insurer profitability when plans are part of larger integrated organizations that include providers and other health care businesses.[18] In such environments, financial gains may appear elsewhere in the corporate structure rather than within the plan itself, making it more difficult to assess whether premium dollars are being used to support care delivery or administrative activities.

Further, insurers increasingly rely on affiliated service organizations to conduct programs that combine quality improvement activities with utilization management functions. For example, some insurer subsidiaries administer "continuous quality improvement and utilization management programs" within the same organizational structure, illustrating how activities that may qualify as quality improvement under MLR rules are also designed to influence service use and control spending.

Without greater transparency into these arrangements, the MLR framework risks measuring financial transfers within corporate structures rather than the extent to which premium dollars are actually supporting care for patients. To improve transparency and reinforce the accountability objectives of the MLR framework, CMS should consider several targeted policy improvements:

- **Require issuers to separately report payments counted as medical spending that are made to affiliated entities**, including provider organizations, pharmacy benefit managers, utilization management vendors and other subsidiaries.
- **Require issuers to disclose corporate relationships** between the insurer and entities receiving payments reported as medical claims so that regulators can evaluate the extent of vertically integrated spending.
- **Strengthen reporting requirements for quality improvement activities** to ensure that administrative functions performed by affiliated entities are not recharacterized as medical spending.
- **Expand public reporting of MLR data** to distinguish direct medical claims payments from other forms of reported medical spending, including quality improvement activities and payments to affiliated entities.
- **Incorporate review of vertically integrated payment arrangements into MLR audits and program integrity activities** to ensure that reported medical spending reflects genuine patient care rather than internal financial transfers.

Elimination of Standardized Plans Options (Part III.E.8-9)

FAH encourages CMS to preserve the current requirements for all Federally-facilitated Exchange (FFE) and SBE-FP QHP issuers in the individual markets to offer standardized plan options. Standardized plan options provide a useful touchstone for consumers facing a wide array of options. This is valuable even if consumers select and enroll in other plans, or if there are a large number of plans on display for comparison. Indeed, a number of policy proposals contained in the Proposed Rule are expressly intended to give QHP issuers greater flexibility in configuring

[16] https://www.cms.gov/newsroom/fact-sheets/marketplace-2026-open-enrollment-period-report-national-snapshot-2#:~:text=The%20Centers%20for%20Medicare%20&%20Medicaid%20Services,signed%20up%20for%202026%20individual%20market%20health
[17] https://www.kff.org/medicare/health-insurer-financial-performance/?utm_source=chatgpt.com#5de82c82-3058-4319-9c42-d4652784cac7.
[18] https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_SEC.pdf.

plan benefit designs. If the proposed elimination is finalized, consumers are likely to face an even wider variety of QHP options, and would benefit even more from the reference point created by the standardized plan options. An evolving Marketplace can be overwhelming, and the presentation of standardized plan options will facilitate a better plan selection process for consumers, who may, for example, compare different issuers' standardized plan options to identify the extent to which factors beyond the plan design (*e.g.*, provider networks) impact premiums.

CMPs As An Enforcement Tool (Part III.E.14)

FAH calls for robust enforcement of program integrity rules and recognizes that civil monetary penalties (CMPs) are a key tool in CMS' arsenal for holding QHP issuers accountable for program violations. It has been FAH's experience that CMS has largely deferred to state oversight and enforcement activities and has not broadly undertaken to impose CMPs directly, even if audit findings reveal non-compliance with QHP certification standards. We support active enforcement with an eye to safeguarding individual and government spending (in the form of consumer premiums and federal premium tax credits) against misappropriation by non-compliant QHP issuers. These efforts are equally valuable in states that have notified CMS they do not have the authority to enforce or are not otherwise enforcing the Marketplace reform provisions, as well as in states that have failed to substantially enforce any individual requirement.

Standards of Conduct/Consumer Protection (III.D.6)

CMS proposes new standards of conduct and additional consumer protection standards related to agents, brokers, and web-brokers who assist consumers with enrollments through FFE's and SBE-FPs. These proposals primarily focus on requirements related to consumer consent documentation (Section 155.220(j)(2) and marketing activities in a newly designated Section155.220(j)(3). **FAH continues to support the adoption of program integrity measures focused on agents, brokers and web-brokers as the most effective way to address improper enrollments without the need for Exchange-wide verification requirements and their attendant administrative costs, access barriers, and adverse risk pool impacts.** FAH continues to encourage implementation of these measures before determining whether additional Exchange-wide verification measures are necessary or appropriate.

Comment Solicitation on Eligibility Verification Provisions on the WFTC Legislation, Section 71,303 (III.D.11)

CMS seeks comment on considerations for future policy development and implementation of a process to seek pre-enrollment verification that permits any applicant to verify their household income and eligibility for enrolment for the upcoming plan year, pursuant to Section 71,303 of the Working Families Tax Cut law. **FAH urges CMS to ensure these provisions are implemented with clear guidance, education, and communication for consumers along with technical support to minimize implementation burden.** This will ensure that individuals who are eligible for coverage are not unnecessarily burdened and opt out of coverage as a result.

Removal of the Requirement to Accept Attestations of Household Income When Tax Data is Unavailable Exchange Applicant Attestations (III.D.13)

CMS proposes to permanently remove the requirement for all Exchanges to accept an applicant's annual household income attestation when the IRS is successfully contacted but returns no tax data. **FAH urges reconsideration of this strict interpretation of the flexibility for enrollee attestations when no tax data is available.** The statute provides many avenues for the resolution of income when there is no tax return information as well as the flexibility for HHS to accommodate other information sources, including attestations of enrollees, when addressing the verification process.

FAH believes the robust set of proposals regarding program integrity standards for brokers in 42 C.F.R. Section 155.220(j)(2) and consumer consents in 42 C.F.R. Section 155.220(j)(3) will address the root cause of improper enrollments without the need to eliminate the ability of otherwise qualified enrollees to obtain coverage. Thus, FAH urges CMS to extend its discretion and allow attestations pending ongoing implementation of broker standards and enrollee consent improvements.

Premium Payment Threshold (III.D.14)

Under current regulations (45 C.F.R. 155.400), an issuer can consider an individual's premium fully paid and not subject to termination under three alternative payment scenarios:

1) Net Percentage: if 95 percent or more of the premium (after accounting for APTCs) is paid;
2) Gross Percentage: if 98 percent or more of the gross premium (including APTCs) is paid; or,
3) Fixed Dollar: if $10 or less of the premium payment is owed.

In the 2025 Marketplace Integrity and Affordability rule, CMS finalized a policy for plan year 2026 that allowed only the Net Percentage threshold to be considered. In this Proposed Rule, CMS has requested comment on whether the options under 42 C.F.R. Section 155.400 should be continued after plan year 2026.

FAH supports extending continued flexibility to issuers as to the measurement of de minimis underpayments. In the Proposed Rule, HHS notes a substantial decrease in unauthorized enrollment complaints comparing January 2025 to January 2026 and predicts complaints are likely to continue to decline now that enhanced APTC's have expired as of January 1. With a continued decline in unauthorized enrollments, the compliance risk from small premium underpayments is reduced.

By applying flexibility, CMS also reduces administrative cost and burden from issuers having to terminate enrollees over small payment errors. For example, under the long-standing Net Percentage threshold of 95 percent, if an enrollee owed a premium of $1.10 but only paid $1, (or 91 percent Net Percentage less than the 95 percent threshold) the payment would trigger a grace period and a potential termination of coverage over a 10 cent underpayment. If, however, an alternative fixed dollar threshold of $10 was allowed, the result would be to continue coverage without any additional costs of notification over a ten-cent underpayment.

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FAH appreciates the opportunity to address these critical issues, and looks forward to collaborating with the Administration and CMS to ensure a robust market for affordable, high-quality private insurance coverage through the Marketplace. If you have any questions or would like to discuss further, please do not hesitate to contact Katie Tenoever, SVP, General Counsel at ktenoever@fah.org.

Sincerely,
/s/
Charlene MacDonald
President and CEO