

March 13, 2026

Robert F Kennedy  
Secretary  
Department of Health and Human Services

Mehmet Oz, MD  
Administrator  
Centers for Medicare & Medicaid Services

Peter Nelson  
Deputy Administrator and Director  
Center for Consumer Information and Insurance Oversight  
Centers for Medicare & Medicaid Services

Submitted electronically via: [www.regulations.gov](http://www.regulations.gov)

Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

**Re: Comment on HHS Notice of Benefit and Payment Parameters for 2027, Regarding Non-Network Qualified Health Plans**

Dear Secretary Oz, Administrator Oz, and Deputy Administrator and Director Nelson,

On behalf of the Association for Community Affiliated Plans, Alliance of Community Health Plans, America's Essential Hospitals, AHIP, and the Federation of American Hospitals — organizations dedicated to ensuring access to affordable, high-quality health coverage and care and promoting a stable and competitive health care system — we wish to share our concerns with the Center for Medicare and Medicaid Services' (CMS) proposal to allow non-network plans to receive qualified health plan (QHP) certification. Collectively, our organizations represent health plans and hospitals serving tens of millions of consumers across communities nationwide. While our respective organizations represent opposite sides of the payor-provider continuum, we agree that, by definition, non-network plans cannot offer the comprehensive coverage that would be required for certification as a QHP. We urge CMS not to finalize this provision.

Our foremost concern is ensuring consumers have access to coverage with adequate financial and consumer protections. Individuals shopping for coverage are unlikely to fully appreciate the substantive differences between a non-network plan and a plan with a provider network, creating significant potential for consumer confusion. Without robust, plain-language disclosures — and even with them — many consumers risk enrolling in plans that expose them to significantly higher out-of-pocket costs than they anticipate. Because non-network plans do not contract with providers, consumers would be vulnerable to balance billing, which could trigger the No Surprises Act and exacerbate its Independent Dispute Resolution (IDR) process.

All QHP plans offered through the Marketplaces should be held to the same regulatory standards to ensure consumers can access care. We are further concerned about the feasibility of CMS's proposed provider access standards and exceptions process. Because non-network plans do not contract with providers, neither CMS nor states will be able to verify whether adequate access exists until a plan is in operation and consumers are already enrolled. Even then it is unclear how CMS would track or enforce adequate access. The proposed rule states that a sufficient number of essential community providers must accept a non-network plan's benefit amounts as payment in full, but it is not clear how this requirement would be measured and enforced. Before any finalization, CMS must clarify: (1) what constitutes adequate access and how that meets network adequacy requirements, including for essential community providers; (2) how CMS will enforce adequate access on an ongoing basis; and (3) how consumers will be protected from balance billing.

Our organizations are committed to promoting affordable, competitive Exchange coverage. Permitting non-network plans to compete alongside network-based QHPs would bifurcate the individual market in ways that threaten its long-term stability. Non-network plans attract healthier enrollees with lower premiums — in part by avoiding contracts with high-cost specialty providers — while leaving sicker individuals concentrated in more expensive, network-based plans. This dynamic would distort risk pools, suppress the statewide average premiums used in risk adjustment calculations, and disadvantage plans serving higher-risk enrollees, allowing non-network plans to engage in the very risk segmentation that QHP rules are designed to prevent. The downstream consequences would include a rise in uncompensated care, as hospitals absorb costs from patients who believed they were adequately covered but were not.

Given the significant unanswered questions regarding market impact, provider access, and consumer protection, we urge CMS not to finalize this proposal. At a minimum, we recommend CMS delay finalization and issue a Request for Information to gather meaningful stakeholder input before proceeding with future rulemaking.

Respectfully submitted,

Association for Community Affiliated Plans  
Alliance of Community Health Plans  
America's Essential Hospitals  
AHIP  
Federation of American Hospitals