March 13, 2026

Dr. Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
Department of Health & Human Services

Peter Nelson
Deputy Administrator & Director, Center for Consumer Information & Insurance Oversight
Department of Health & Human Services

Attention: CMS-9883-P, P.O. Box 8016, Baltimore, MD 21244-8016.

Submitted via regulations.gov.

RE: "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program"

Dear Administrator Oz and Director Nelson,

United States of Care (USofCare) submits comments to express deep concerns with a number of the policies included in the proposed rule by the Centers for Medicare & Medicaid Services (CMS) entitled "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program;" and urges CMS not to finalize them.

USofCare is a nonpartisan, nonprofit organization working to ensure everyone has access to quality, affordable health care regardless of health status, social need, or income. We drive change at the state and federal level in partnership with everyday people, business leaders, health care innovators, fellow advocates, and policymakers. Together, we advocate for new solutions to tackle our shared health care challenges — solutions that people tell us will bring them peace of mind and make a positive impact on their lives. We uplift the voices of people whose perspectives and experiences with the health care system shape our advocacy. Through our work in the states, we are able to identify unique perspectives from people on the ground to amplify on both the state and federal levels.

Cost is *the* driving concern people across demographic, geographic, and ideological spectrums have about health care – and this is irrespective of their coverage type or status. Through USofCare's extensive work listening to people about the health care system and their experiences with it, cost is consistently the first – and most prominent – issue people raise. It is not solely about their inability to pay, but also the anxiety and the worry they won't be able to afford the care they or a family member need in the future. For people, affordability impacts every facet of their experience – it's the through-line of every single entry point into the health care system and impacts every decision they make. Cost also impacts people's decisions not to seek care.

Affordability is a shared goal of policymakers across the political spectrum. Advocacy organizations share the same goal, channeling consumer interests in achieving and maintaining optimal health. USofCare's research reflects that in order to be healthy, people need access to affordable coverage. We, therefore, evaluate the policies included in the proposed 2027 NBPP through the lens of the significant health care affordability challenges that people are currently

facing as they have been communicated directly to us, as well as our extensive experience developing and advocating for affordability policies at the state level. It is through this lens that we submit this letter, focusing our comments on:

I. **Changes to Catastrophic and Bronze Plans**
II. **Policy Changes Related to Essential Health Benefits**
III. **Proposals that Limit Consumers' Access to Care**
IV. **Proposals that Make Enrolling in Coverage More Challenging or Burdensome**

To that end, USofCare responds below, weaving in our listening research as compelling insights to further underscore the need for reconsideration of these proposals.

I. Changes to Catastrophic and Bronze Plans

Changes to Cost-Sharing for Catastrophic and Bronze Plans

USofCare opposes proposed policy changes that will (1) increase out-of-pocket costs for consumers, and (2) introduce confusion for consumers at the point of enrollment, likely putting them at risk of increased OOP cost exposure.

It is important to note that there isn't one specific out-of-pocket cost that is clearly the most troublesome for consumers. When we asked people with private insurance to identify the top 1 or 2 most challenging costs for them to bear personally, they identified deductibles, hospital costs, premiums, and prescription drugs (in that order), followed by a slight drop-off for unexpected medical bills and copays. There isn't one major out-of-pocket cost that's especially prominent. In one survey, over 40% of respondents told us they believe insurance premiums, deductibles, copay, prescription drug prices, and surprise medical bills are "big issues."

> *"We do have Blue Cross Blue Shield with a $40 primary care copay, so I can go to the doctor. But I waited a long time to have knee surgery — too long — because I didn't want to pay $8,500 out of pocket. And in the end, that's exactly what I had to pay."*
>
> *~ Black Woman, North Carolina*

While catastrophic plans can sometimes have lower premiums than bronze plans on the Marketplace, they often have higher deductibles, which will only increase if CMS finalizes the higher maximum out-of-pocket (MOOP) limit of $15,600 for an individual and $31,200 for a family. As noted above, people already find it challenging to afford their deductibles – so even with the potential of premium savings by enrolling in a catastrophic plan, the proposed changes will not make seeking care more affordable for people.

Additionally, CMS proposes to allow insurers that offer at least one bronze plan that complies with the Affordable Care Act's (ACA) actuarial and cost-sharing requirements related to the MOOP limit to also offer a bronze plan that exceeds the MOOP limit in certain circumstances. These plans would be offered alongside each other on the Marketplaces, which will likely create confusion for consumers and will expose them to extremely high out-of-pocket costs and limit their ability to receive or seek the care they need to keep themselves healthy if they are unable to afford it. Through our listening research, we consistently hear from people that cost drives their

decisions not to seek medical treatment – which, in one survey, 41% of people under the age of 30 told us they'd done in the last year.

Additional Changes to Catastrophic Plans

USofCare opposes policies aimed at accelerating enrollment in catastrophic plans, which will exacerbate the affordability crisis for enrollees, strain peoples' access to care, and destabilize the risk pool in "metal level" Marketplace plans.

Prior to CMS guidance issued in September 2025, eligibility for catastrophic plans was limited to people under the age of 30 for whom the lowest cost bronze plan exceeded a certain percentage of their income and qualified for a "hardship exemption." CMS proposes to expand eligibility for catastrophic plans by broadening the hardship exemption to allow individuals over the age of 30 to enroll in these plans based solely on the basis of their income.

The original intent of these plans was to provide a limited number of individuals with protection from catastrophic health care costs and help them meet the ACA's individual coverage mandate in the event that Marketplace "metal level" (bronze, silver, gold, and platinum) plans were unaffordable. USofCare is concerned that these proposed policy changes aimed at expanding eligibility for and increasing enrollment in catastrophic plans will do little to help address people's health care affordability challenges – and will likely exacerbate them. Individuals who newly enroll in catastrophic plans will now face high-out-of-pocket costs; and individuals in "metal level" Marketplace plans could see their premiums increase as a result of a degraded risk pool, which can result from healthier consumers migrating from these plans to catastrophic plans, leaving the risk pools in metal-level plans less healthy overall.

We are also concerned about CMS's proposal to allow automatic re-enrollment in catastrophic plans across multiple years, particularly when CMS is implementing a policy to end automatic re-enrollment in higher-quality Marketplace plans. In addition to the issues raised above, multi-year catastrophic plans puts consumers at risk of facing significant out-of-pocket costs that they will be unable to afford. This is especially concerning given that the proposed rule raises the possibility of consumers being "locked into multi-year catastrophic plans."

II. Policy Changes Related to Essential Health Benefits

Essential Health Benefit (EHB) Defrayal Changes

USofCare urges CMS to reconsider proposed changes that would reverse the current EHB defrayal policy. Preserving access and availability to critical benefits for people seeking to maintain health and wellness is critical in ensuring people stay healthy and access the care they need.

USofCare has long recognized the unique role states play in proposing and enacting creative and innovative policies to address many of our nation's most pressing health care challenges. Since its founding, USofCare has provided technical support to states and supported state-level policymakers and advocates in advancing durable policy change that often acts as a template for the federal government to implement.

Based on our expertise in supporting states, USofCare opposes CMS's proposed changes to defrayal requirements for states when they require coverage of additional benefits in their essential health benefits (EHB)-benchmark plan. The current defrayal policy has allowed states to expand access to critical benefits, such as substance use disorder and mental health treatment, fertility treatment, and others, without fear of incurring additional costs through defrayal. States made these changes to their benchmark plans on the basis of CMS policy on defrayal clearly stated in an October 2018 CMS FAQ, and, in a number of cases, with direct approval from CMS. For example, in 2020, CMS approved changes to EHB benchmark plans for Michigan, New Mexico, and Oregon to improve access to services for people with opioid use disorder.

By ensuring these additional benefits are considered EHBs, these additional benefits are also subject to EHB non-discrimination rules and consumer protections like restrictions on annual or lifetime dollar limits, further benefiting the people who have come to depend on these services.

CMS's proposed policy may result in states incurring unexpected costs, particularly given the proposed 2027 implementation date, which likely does not allow enough time for many state legislatures to revisit previously enacted benefit mandates. It may also result in states rolling back these important benefit expansions, which will negatively impact people getting the tools they need to improve their health.

Adult Dental as an Essential Health Benefit

USofCare opposes CMS proposed policy to roll back states' ability to add adult dental benefits as EHBs.

While the ACA included pediatric dental benefits as one of the ten EHBs, federal regulations outlining the benchmarking process began allowing states to include adult dental benefits as EHBs in 2025. We know that the health of someone's teeth impacts the health of their entire body. The prior restriction on the inclusion of these benefits exacerbated more limited access to dental care and insurance coverage more generally. Despite the gains that have been made over recent years in increasing the traditional medical insured rate, dental coverage has lagged behind, with one in four Americans lacking dental coverage. USofCare supported the inclusion of adult dental benefits as EHBs when CMS finalized this policy for 2025.

> *"Why is it that you have major medical insurance, but dental and vision isn't covered? Because somehow you don't need teeth?" ~White man, New York*

CMS's proposal to reimpose the EHB restriction on adult dental benefits ends an important path states currently have to add adult dental care into their EHB benchmark plans, which could make needed improvements in the availability of adult dental coverage and improve access to these critical services. USofCare urges CMS not to finalize this proposed policy.

III. Proposals that Limit Consumers' Access to Care

"...I tried to find a very specific doctor. It's really hard to find someone who meets your criteria and is in your insurance network. And on top of that, you never really know if they'll be the doctor you expect. It's just a lot, especially since there aren't that many options depending on where you live."

~ Latina Woman, Maryland

Standards on Essential Community Providers (ECP)

USofCare opposes reducing ECP participation in FFM plans as it could decrease peoples' access to care and ability to achieve optimal health.

Primary care is essential to improving prevention and achieving better health outcomes. Consistent access to primary care leads to better overall care, more coordination among health services, improved outcomes, and lower costs. However, our listening research has found that the way people experience primary care varies and there are persistent barriers to access care, especially for underserved populations. In particular, we know that people living in rural areas often face persistent and unique challenges accessing primary care.

In light of these findings, USofCare opposes CMS's proposal to decrease the required participation of ECPs in plans offered through the Federally-facilitated Marketplace (FFM) from 35% to 20%. In 2023, USofCare submitted comments that actively supported the increase in ECPs under FFM plans for plan year 2024. Decreasing the number of available ECPs in plan networks will decrease access to care for many people who need it. The availability of ECPs, such as federally qualified health centers and rural health centers, in plan networks is a critical step in providing and sustaining access to care for people who have been underserved by the health care system.

States have recognized the value that increased availability of ECPs can have on access to needed care. For example, Montana which required marketplace plans to "strive to include" up to 80% ECPs in plan networks before returning to the federal standard in 2024. Additionally, Maryland increased its network standards for ECPs to improve the availability of mental health and substance use disorder treatment for residents.

Deferring to States on Network Adequacy and "Non-Network" Plans

USofCare opposes CMS's proposals to eliminate uniform federal network adequacy standards and allowing "non-network" plans to be certified as qualified health plans.

Access to an adequate number of health care providers across a range of specialties is an important priority for people and better health. For example, in one listening project in rural South Carolina, the people engaged cited an increase in the amount and quality of specialists and health care professionals as a critical need for their communities. Network adequacy is an important factor in determining whether people can access the care they need in a timely manner. Given this, USofCare opposes CMS's proposals to eliminate uniform federal network adequacy standards and revert to state review of network adequacy, as well as the proposal to allow "non-network" plans to be certified as qualified health plans.

Federal network adequacy standards provide consistency for consumers across states and establish an important "floor" to help ensure that consumers have access to a range of health care providers necessary to access the care they need. In fact, the preamble of the proposed rule acknowledges a risk of "potential decreased access to care" if state network adequacy standards and review processes are less protective than the existing federal framework. Additionally, in the absence of a federal standard there is wide variability in state laws and process for determining network adequacy.

With respect to the proposal to allow "non-network" plans, CMS has historically not allowed these types of plans because the agency did not have an effective way to ensure that these plans comply with existing statutory network requirements. CMS is now proposing to allow them on the basis that states will ensure compliance. While the proposed rule states that non-network plans must demonstrate "sufficient access to a range of providers" that accept the plan's benefit amount as payment in full, it is unclear how this access would be measured or how states would ensure compliance with network requirements. Additionally, these plans have the potential to leave consumers facing higher out-of-pocket costs and unexpected medical bills.

IV. Proposals that Make Enrolling in Coverage More Challenging or Burdensome

New Special Enrollment Period (SEP) Verification Requirements

USofCare strongly opposes proposed policy that requires pre-enrollment verification for SEP eligibility within the FFM and across state-based marketplaces (SBMs).

In addition to wanting care that they can afford and understand, we know that people strongly desire the security and freedom that dependable health coverage provides through life's changes. Given this, USofCare urges CMS not to finalize its proposal to require pre-enrollment verification for SEP eligibility for the federal Marketplace and its requirement on SBMs to verify eligibility for at least 75% of new enrollments through SEPs.

This policy adds unnecessary complexity and administrative burden that erects barriers to insurance for consumers, making their insurance less dependable. This proposed policy undermines the risk pool, too, as studies show that healthier individuals are less likely to follow through with completing eligibility check processes – which, in turn, can increase market instability and premiums for consumers.

Direct Enrollment Option

USofCare opposes the establishment of a State-Based Exchange Enhanced Direct Enrollment option, granting third-party access and responsibility for exchange enrollment functions.

USofCare is concerned about CMS's proposal to allow states to establish a new State-Based Exchange known as a new enhanced direct enrollment option (SBE-EDE) to outsource the

exchange enrollment functions to private sector entities, including web-brokers. We are particularly concerned about this proposal, coupled with the proposal to remove the requirement that new state-based marketplaces operate as a state-based marketplace-federal platform for one year with enhanced oversight. As you are aware, EDE continues to raise concerns about privacy and security of consumer information, the potential for fraud, and the possibility that EDE could lead to consumers receiving inaccurate or misleading information that might affect eligibility determinations and consumer choice.

Conclusion

Thank you for the opportunity to respond to the proposed rule. Please reach out to Alyssa Penna, Director of Federal Policy, at apenna@usofcare.org with any questions.

Sincerely,

Lisa Hunter
Senior Director for Federal Policy & Advocacy
United States of Care