March 13, 2026

The Honorable Robert F. Kennedy
Secretary
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Submitted electronically via regulations.gov

RE: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program (CMS-9883-P)

Dear Secretary Kennedy,

On behalf of the American Academy of Family Physicians (AAFP), which represents 124,500 family physicians and medical students across the country, we appreciate the opportunity to comment on the proposed rule published in the Federal Register on February 10, 2026, regarding the annual HHS Notice of Benefit and Payment Parameters for 2027, or NBPP, proposed rule. In this rule, CMS proposes various provisions implementing the One Big Beautiful Bill Act (OBBBA), alongside widespread changes to the structure and oversight of the individual and small-group markets, Qualified Health Plan (QHP) certification, network adequacy, catastrophic plans, agent and broker conduct, and State-Based Exchange (SBE) and Federally Facilitated Exchange (FFE) Marketplace operations.

The AAFP has long supported affordable, comprehensive coverage. Family physicians see firsthand how a lack of comprehensive coverage and high out-of-pocket costs adversely impact patients and can cause them to delay necessary care out of fear of being unable to afford it.

The AAFP respectfully urges CMS to implement the following measures to protect patients as the Marketplace continues to evolve:

- Retain federal standardized plan options on the Marketplace and maintain the requirement for issuers to distinguish a "meaningful difference" among all plans offered.
- Withdraw the proposed amendment to §155.170(a)(2) to redefine certain state-mandated benefits codified in state benchmark plans as outside the Essential Health Benefits framework if those mandates were enacted after December 31, 2011, apply to the individual or small-group markets, require specific services or treatments, and are not necessary to meet federal requirements.

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- Reinstate federal time-and-distance network adequacy standards for State Exchanges and State-Based Marketplace-Federal Platforms.
- Maintain the current 35 percent Essential Community Provider contracting threshold or, at minimum, maintain the 35 percent threshold for Federally Qualified Health Centers.
- Require non-network plans to demonstrate functional and quantitative primary care access beyond theoretical sufficiency to secure Qualified Health Plan certification.
- Prohibit issuers from implementing disease-specific variation in maximum-out-of-pocket limits in multi-year catastrophic plan designs.
- Condition approval of multi-year catastrophic plans (≥ 2 years) on adoption of value-based insurance designs for preventive services.

Standardized Plan Options (§155.20, §155.205(b)(1), §155.220(c)(3)(i)(H), §156.201, and §156.265(b)(3)(iv))

CMS is proposing to remove the definition of "standardized option," repeal all federal standardized plan options across metal tiers, eliminate the requirement for issuers to "meaningfully differentiate" between standardized options, repeal the differential display of standardized plan options on *HealthCare.gov a*nd the corresponding display requirements for approved web-broker and QHP issuer enrollment partners, and stop developing, publishing, and maintaining federal standardized plan templates. If finalized, these provisions would take effect on January 1, 2027.

The proposed rule would also lift restrictions on the number of non-standardized plans that insurers can offer in the Marketplace. Under current rules, insurers are limited to two non-standardized plans per product network type, metal level, and inclusion of dental and/or vision coverage. CMS states that these limits have previously "constrained insurers' ability to offer a sufficiently broad range of plans."

AAFP Comments on Standardized Plan Options (§155.20, §155.205(b)(1), §155.220(c)(3)(i)(H), §156.201, and §156.265(b)(3)(iv))

Standardized plan options are uniform plan designs with consistent cost-sharing within a metal level, including fixed copays for primary care, outpatient mental health visits, and generic drugs. By aligning benefit design across issuers, standardized plans simplify comparison, reduce cognitive burden, and help enrollees better understand their coverage. This function is particularly important in the Marketplace, where enrollees are more likely than those with employer coverage, Medicaid, or Medicare to report difficulty comparing provider access across plans.[i] Moreover, excessive plan choice, when combined with subtle

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plan-by-plan differences in cost-sharing, has been shown to degrade coverage decision quality rather than improve it, especially for enrollees with limited health literacy.[ii]

CMS reinstated standardized plan options in Plan Year (PY) 2023 with the explicit requirement for insurers to demonstrate a "meaningful difference" between plans in response to consumer choice overload on *HealthCare.gov*, where enrollees commonly faced more than 100 plan options—a level shown to undermine consumers' ability to effectively compare plans and make informed enrollment decisions.[iii]

The proposal to simultaneously eliminate the meaningful difference requirement while removing limits on the number of non-standardized plan offerings raises serious concerns. Absent meaningful differentiation standards, issuers would be free to introduce numerous plans with minor or opaque variations in cost-sharing, benefit design, or even plan naming, making it exceedingly difficult for consumers to identify coverage that best fits their health and financial needs.

Repealing standardized plan options would also eliminate the only Marketplace-wide requirement that routine, pre-deductible primary care be accessible before the deductible. If finalized, pre-deductible access to primary care would become optional and issuer-specific, and fixed copays for primary care and behavioral health would no longer be guaranteed. The resulting variability would disproportionately affect individuals with chronic conditions, first-time Marketplace enrollees, and consumers who rely on predictable access to routine primary care. And as cost-sharing becomes less predictable, patients defer chronic and discretionary care, medication adherence declines, and care utilization becomes less stable; effects that are particularly pronounced in primary care and behavioral health settings.[iv,v]

Accordingly, the AAFP urges CMS to retain federal standardized plan options as a core Marketplace safeguard and maintain the requirement for issuers to distinguish a "meaningful difference" among all plans offered.

Provisions regarding Agents and Brokers' role in State-Based Exchange Operations (§155.205(b), §155.221(k), §155.221(k), §155.220(j), §155.220(j)(2), and §155.220(j)(3))

CMS is proposing changes to how State Exchanges may structure eligibility and enrollment operations by allowing them to rely entirely on private web-brokers for consumer-facing eligibility and enrollment websites through a new "State-Based Exchange-Enhanced Direct Enrollment" (SBE-EDE) model. Accordingly, CMS is also proposing to remove the requirement for State Exchanges to operate their own centralized consumer-facing eligibility and enrollment platforms, provided they retain responsibility for eligibility determinations, enrollment records, Medicaid/CHIP assessments, and compliance with all federal standards.

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If finalized, web-brokers would serve as the exclusive consumer enrollment pathways, while the State Exchange would continue to operate an informational website with comparative plan information and maintain legal oversight, privacy, accessibility, and program integrity controls.

In parallel, CMS also proposes to strengthen oversight of marketing practices for QHPs offered on the Exchanges by imposing more stringent requirements on agents, brokers, and web-brokers that support QHP enrollment through FFEs and State-Based Marketplace-Federal Platforms (SBE-FPs). Specifically, CMS would distinguish conduct related to consumer enrollment from conduct related to consumer marketing; establish new standards of conduct and additional consumer protection requirements for agents, brokers, and web-brokers; and introduce new marketing requirements, including a list of prohibited marketing practices. CMS also proposes to require agents, brokers, and web-brokers to use an HHS-standardized form to satisfy eligibility application review documentation and consumer consent documentation requirements. In addition, CMS would establish standards of conduct governing how agents, brokers, and web-brokers engage in marketing activities related to assisting or facilitating enrollment of qualified individuals, qualified employers, or qualified employees in coverage through FFEs, or assisting with applications for advance premium tax credits or cost-sharing reductions for QHPs sold through FFEs or SBE-FPs.

AAFP Comments on Provisions regarding Agents and Brokers' role in State-Based Exchange Operations (§155.205(b), §155.221(k), §155.221(k), §155.220(j), §155.220(j)(2), and §155.220(j)(3))

The AAFP recognizes CMS's goal of increasing flexibility for SBEs but given limited real-world implementation of SBE-EDE, CMS should proceed cautiously and condition any expansion on clear, enforceable consumer protection and program integrity standards.

Under this proposed model, third-party web-brokers may inadvertently shape consumer inputs, eligibility attestations, and plan selection decisions, while the SBE would retain full legal and fiscal responsibility for eligibility determinations, program integrity, and compliance. This separation of operational control and accountability increases the risk that errors, beneficiary harm, and improper enrollments will occur without a clear enforcement pathway, leaving beneficiaries and states exposed.

This concern is heightened by CMS's recent identification of enrollments facilitated by agents, brokers, and web-brokers as a significant source of improper enrollment activity, which informed the 2025 Marketplace Integrity and Affordability Final Rule. Also, the HHS Office of Inspector General has documented widespread eligibility determination errors linked to weaknesses in verification processes and reliance on applicant-reported information.[vi] In this context, expanding an exclusive third-party enrollment pathway in SBEs

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without platform-level monitoring and audit requirements comparable to federal EDE standards risks recreating known integrity challenges rather than mitigating them.

SBE-EDE exclusivity also raises concerns regarding consumer access. Fragmenting the enrollment "front door" across multiple private platforms may disadvantage individuals with limited access to broadband or low digital literacy and introduce inconsistent framing of income, household composition, and plan options. Urban Institute analyses show that simplified and centralized application processes are associated with materially higher completion and retention rates in income-based public programs, especially among low-income populations.[vii,viii]

Further, CMS suggests that the State-Based Marketplace Annual Reporting Tool (SMART) represents sufficient oversight to manage these risks. However, SMART is a retrospective tool that relies on annual attestations and audits. It does not provide platform-specific performance data, eligibility error metrics, or visibility into third-party enrollment operations. As such, SMART cannot substitute for dedicated guardrails when eligibility and enrollment functions are operationally offloaded outside the Exchange.

Thus, the AAFP recommends that CMS pair the expansion of the SBE-EDE model with strengthened platform-level federal oversight as states gain experience with implementation. In tandem, we urge CMS to finalize the proposed provisions strengthening agent, broker, and web-broker standards of conduct. In our response to the 2026 Notice of Benefit and Payment Parameters, and our recent response to the 2025 Marketplace and Integrity Proposed Rule, we wrote in support of CMS's policy to review and enforce compliance against lead agents for insurance agencies. We continue to support CMS in its continued efforts to protect enrollees from agents and brokers who fail to comply with regulations designed to safeguard consumers. Coverage decisions must prioritize the best interests of consumers. However, commissions earned by agents and brokers create conflicts of interest. Whenever financial incentives have the potential to influence coverage decisions, CMS must rigorously enforce regulations to prevent misconduct and protect consumers.

Provision on "Additional" Essential Health Benefits (§155.170)

CMS proposes to redefine certain state-mandated benefits as outside the Essential Health Benefits (EHB) framework if those mandates were enacted after December 31, 2011, apply to the individual or small-group markets, require specific services or treatments, and are not necessary to meet federal requirements. Under this approach, these benefits would be treated as "in addition to EHB" even if they are currently included in a state's EHB benchmark plan, with states required to defray their cost beginning in plan year 2027.

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The cost of such benefits would also not count towards the premium for purposes of the premium tax credit (PTC) calculation. Notably, benefits classified as outside EHB would no longer be subject to core consumer protections, including nondiscrimination requirements, cost-sharing limits, and prohibitions on annual or lifetime dollar caps. If finalized, states can avoid a defrayal obligation by repealing the mandated benefit, or by exempting Marketplace plans from the coverage requirement.

AAFP Comments on "Additional" Essential Health Benefits (§155.170)

In the proposed rule, CMS cites section 1311 of the ACA as justification for this provision, but the statute establishes a clear and sequential framework that this proposed provision disrupts. Section 1302 of the ACA assigns the Secretary authority to define EHB based on the ten statutory categories and the scope of benefits offered under a typical employer plan, and not on the timing of State enactment. Section 1311(d)(3)(B) of the Affordable Care Act (ACA) authorizes defrayal only for benefits that are truly additional to EHB and does not authorize CMS to redefine EHB through a timing-based reclassification. **Thus, CMS lacks the statutory authority to finalize the proposed amendment to §155.170(a)(2) to treat State-required benefits as "in addition to EHB", regardless of their inclusion in a CMS-approved State EHB-benchmark plan.**

Congressional intent reinforces this conclusion. Congress delegated to the Secretary the responsibility to define EHB through a stable, employer-based framework designed to promote uniformity, predictability, and nondiscrimination, while preserving State flexibility through benchmark selection. Reclassifying benchmark-included benefits as non-EHB solely based on when a State enacted a mandate, risks undermining the benchmark framework Congress authorized CMS to implement.

As CMS acknowledges in the proposed rule, current regulation under 45 C.F.R. §155.170(a)(2) provides that a benefit covered in a State's EHB-benchmark plan is considered an EHB, and only post-2011 State mandates that are not included in the benchmark are treated as "in addition to EHB." Further, 45 C.F.R. §155.170(a)(3) states that the "State will identify which State-required benefits are in addition to the EHB." CMS also publicly describes EHB as being defined through state-specific EHB-benchmark plans, and CMS has approved multiple state benchmark updates pursuant to that framework.[ix]

States that have updated their EHB benchmark plans since 2011 have done so through CMS-approved processes to refine coverage within existing EHB categories and close documented access gaps. For example, in 2022, CMS approved benchmark updates in Oregon, Michigan, New Mexico and Illinois to provide opioid use disorder treatment, which falls under the EHB category of mental health and substance use disorder. Likewise, as of

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2022, CMS approved benchmark updates in numerous states including Oregon, North Dakota, and Washington to provide diabetes and weight-loss management services for obesity.[x,xi] **These approvals reflect a longstanding CMS practice allowing states to modernize EHB coverage to address emerging clinical standards and population health needs.** CMS's proposal would unsettle this reliance by allowing service-specific benefits embedded in approved benchmarks to be reclassified as outside the EHB framework, notwithstanding prior federal approval.

CMS's reliance on a temporal reclassification rule is also unnecessary. The agency has long demonstrated its ability to draw principled, content-based boundaries around EHB through the benchmark framework itself. For example, long-term custodial nursing home care is routinely excluded from state EHB-benchmark plans based on its substantive divergence from typical employer coverage. This illustrates that CMS can and does adjudicate EHB scope based on benefit content, rather than basing approval on an arbitrary state enactment date.

Further, this proposal is inconsistent with CMS's own innovation and delivery-system priorities. Initiatives such as AHEAD and ELEVATE emphasize primary care investment, early intervention, and integrated behavioral health as essential to improving outcomes and reducing avoidable downstream utilization. Removing EHB protections from services that strengthen primary care undermines these CMMI models by discouraging use of the very services essential to their success.

Additionally, the proposed expansion of state defrayal obligations is not feasible for states to implement as proposed, given the scale of the financial exposure and the administrative infrastructure required. Under 45 C.F.R. §155.170, defrayal is not a one-time payment but an ongoing obligation that requires states to identify each benefit deemed "in addition to EHB," and requires issuers to submit benefit-specific cost reports, review and reconcile those reports, administer payments to issuers or enrollees, and maintain audit and dispute-resolution processes on a recurring basis. For example, in 2014, Utah enacted legislation requiring coverage of Applied Behavioral Analysis therapy for children with autism spectrum disorder as a benefit "in addition to EHB." To implement that mandate, the Utah Insurance Department determined that the resulting state defrayal cost would average approximately $1.9 million per year between FY 2020 and FY 2022.[xii] That figure reflects the recurring regulatory and fiscal impact associated with defrayal for a single service. Thus, expanding defrayal obligations to encompass post-2011 state-mandated EHBs, particularly where those benefits have long been embedded in CMS-approved benchmark plans, would substantially increase the number of benefits subject to defrayal and the magnitude of state fiscal liability, while requiring states to significantly expand financial and reporting systems that many lack the resources to maintain. Administratively, state implementation of this proposed provision would require revised systems for issuer reporting, cost reconciliation,

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dispute resolution, and payment administration, along with continuous oversight as benefit utilization and plan offerings change year to year. Taken together, these financial, operational, and administrative demands create a level of uncertainty and complexity that many states will struggle to implement and sustain, particularly without advance determinations that would allow states and issuers to price, design, and administer coverage with confidence.

Although this provision may reduce federal advance premium tax credit spending in the near term, reclassifying services already embedded in state EHB benchmarks as "in addition to EHB" will shift long-term costs to the point of care and across federally administered programs. When states cannot sustain ongoing defrayal obligations, they predictably narrow benefits or freeze coverage standards, weakening access to clinically valuable outpatient care and pushing utilization toward higher-cost emergency and inpatient settings. This effect will be most acute for EHB services addressing behavioral health, substance use, and chronic disease care where reduced outpatient access reliably translates into crisis-driven care. Reclassification also removes core EHB protections from these services, including prohibitions on annual and lifetime dollar limits, limits on cost sharing, and nondiscrimination requirements. The resulting increase in underinsurance and uncompensated care will flow into federally financed safety-net spending and downstream utilization.

For these reasons, the AAFP strongly recommends CMS withdraw this provision and preserve the integrity of state EHB benchmarks as a stable statutory foundation that supports accessible primary care, early intervention, and the success of CMS's broader innovation and care-delivery reforms.

Provision on Non-Pediatric Dental Services as EHB (§156.115(d))

In this rule, CMS also proposes to prohibit issuers from including routine, non-pediatric dental services as an EHB.

AAFP Comments on Non-Pediatric Dental Services as EHB (§156.115(d))

As the AAFP has previously stated in response to the 2025 Payment Notice, we continue to encourage CMS to enable issuers to include routine non-pediatric dental services as an EHB. The AAFP actively encourages collaboration between family physicians and dental health practitioners to provide comprehensive oral health care at all stages of life. Compromised oral health is associated with cardiovascular disease, endocarditis, diabetes, premature birth, low-birth weight, pneumonia, and malnutrition. Patients routinely raise concerns about oral health and frustration with inadequate coverage during primary care visits, making our

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members acutely aware of the impact limited dental coverage has on patients. As noted by CMS in the 2025 Payment Notice, "it is up to each State to consider the potential costs and network burden and determine whether to add routine non-pediatric dental services as an EHB." **Accordingly, the AAFP urges CMS to rescind this provision so that states may retain this discretion and issuers may include non-pediatric dental services as an EHB where permitted under state benchmark plans.**

Provisions regarding Noncitizens (§155.20, §155.305(f)(1), §155.320(c)(3), and §155.305(f)(2))

CMS proposes to require Exchanges to verify "eligible alien" status to limit PTC eligibility, consistent with the OBBBA. CMS also proposes to update Basic Health Program (BHP) regulations to define "eligible noncitizen" and to specify that, beginning January 1, 2027, an individual must be a citizen or eligible noncitizen to be included in the calculation of federal BHP payments to states operating a BHP.

CMS also proposes to deny advance premium tax credit (APTC) eligibility to lawfully present immigrants who are not "eligible aliens" and whose household income is below 100 percent of the federal poverty level (FPL). States would no longer receive federal BHP payments attributable to individuals in this population who are enrolled in a BHP as of January 1, 2026.

In addition, CMS proposes to remove the special enrollment period (SEP) for individuals with household income below 100 percent of the FPL who did not enroll in coverage while awaiting verification of citizenship or immigration status.

AAFP Comments on Provisions regarding Noncitizens (§155.20, §155.305(f)(1), §155.320(c)(3), and §155.305(f)(2))

We recognize CMS's obligation to align Marketplace and BHP eligibility policies with the requirements enacted under the OBBBA. However, the cumulative effect of the proposed changes raises serious concerns about coverage loss for vulnerable populations and the stability of the Marketplace.

Prior to this proposed rulemaking, the Congressional Budget Office estimated that the OBBBA's restrictions on eligibility for federally funded health coverage for lawfully present immigrants would result in approximately 1.3–1.4 million individuals losing access to subsidized coverage nationwide, with many becoming uninsured rather than transitioning to alternative coverage options.[xiii] These effects are compounded by this proposed rule, which would deny APTC eligibility to lawfully present immigrants who are not deemed "eligible aliens," eliminate associated BHP payments, and remove the special enrollment period for individuals awaiting verification. Together, these changes significantly increase the risk of

coverage loss during transitions and verification delays, particularly for populations that face administrative and documentation barriers outside their control.

Beyond the direct coverage effects, these changes have system-level implications for the Marketplace. Lawfully present immigrant enrollees tend to be younger and healthier than the overall Marketplace population, with lower risk scores and lower average health care utilization.[xiv] As a result, restricting subsidies for lawfully present immigrants is likely to disproportionately reduce enrollment among a lower-cost population, worsening risk pool composition and increasing premiums for remaining enrollees. When combined with the projected loss of coverage for millions of individuals, these effects create a meaningful risk of Marketplace destabilization as eligibility pathways narrow and administrative friction increases.

The AAFP believes that all people should have access to essential health care services, regardless of their immigration status. Accordingly, we oppose this provision and urge CMS to implement these OBBBA-mandated policies with clear guidance, adequate transition periods, and operational safeguards to prevent unintended coverage disruptions. CMS should also require standardized notice and timeline protections, including clear notices and response windows, before terminating financial assistance or excluding individuals from BHP payment calculations, particularly given that this proposed rule simultaneously tightens eligibility standards while eliminating the SEP. **At minimum, we encourage CMS to maintain a scoped SEP for individuals who can demonstrate that their enrollment was delayed due to pending HHS verification**.

Provisions regarding Marketplace Eligibility and Enrollment (§155.305, §155.320(c)(3)(iii), §155.320(c)(5), §155.400, §155.420(d)(16), and §155.420(g))

CMS proposes a collection of provisions on eligibility and enrollment, in alignment with OBBBA and the 2025 Marketplace Integrity Final Rule. Many of these provisions were originally slated to sunset at the end of 2026 per the Marketplace Integrity Rule or delayed in implementation due to the stay granted in *City of Columbus et al. v. Kennedy et al*. CMS now proposes to remove this sunset date and cement the following provisions beyond 2027:

- Require exchanges to implement a one-year APTC failure-to-reconcile (FTR) process by PY 2028, giving Exchanges the option to continue the current two-year process for PY 2027.
- Require income verification when an applicant's attested projected household income is at or above 100 percent of the FPL, but federal data sources indicate the consumer's household income is below 100 percent of the FPL.

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- Remove self-attestation of income as an acceptable source of income verification if IRS data is unavailable and require Exchanges to apply a 90-day inconsistency period when attested household income cannot be verified.
- Permanently discontinue issuer options for fixed-dollar and gross percentage-based premium payment thresholds.
- Expand pre-enrollment verification for all types of Special Enrollment Periods (SEPs) and require pre-enrollment verification for at least 75 percent new SEP enrollments, only in FFE states.
- Eliminate monthly SEPs for individuals with household incomes at or below 150 percent of the FPL, which currently allows eligible low-income consumers to enroll in Marketplace plans at any time throughout the year.

AAFP Comments on Provisions regarding Marketplace Eligibility and Enrollment (§155.305, §155.320(c)(3)(iii), §155.320(c)(5), §155.400, §155.420(d)(16), and §155.420(g))

These proposed provisions represent a systemic shift toward front-end eligibility enforcement that will disproportionately burden low-income, rural, and underserved populations. If finalized, **policies such as the Accelerated 1-year FTR, expanded income verification, and broad SEP verification, all substantially increase the likelihood that eligible consumers lose or fail to obtain coverage due to procedural barriers rather than lack of eligibility.** As we stated in our response to the 2025 Marketplace Integrity proposed rule, stricter verification and reconciliation requirements pose significant risks for individuals with income volatility, limited financial or health literacy, language barriers, and constrained access to documentation or enrollment assistance. These challenges are particularly acute in rural and underserved communities, where consumers often rely on episodic employment, informal income, or seasonal work and face limited access to broadband internet to repeatedly attest eligibility. Coverage disruptions for these populations predictably lead to higher uninsured rates, delayed care, increased reliance on emergency services, and worsening health outcomes, with downstream costs borne by providers, states, and the broader health system.

The expansion of SEP verification requirements, particularly when paired with the permanent elimination of the 150 percent FPL monthly SEP, is especially concerning. Monthly SEPs for individuals at or below 150 percent of the FPL have been critical for low-income individuals experiencing frequent changes in employment, household composition, or income. These consumers are also the most likely to miss an increasingly compressed Open Enrollment Period. In rural areas, where documentation delays and limited enrollment support are common, verification-based denials can result in prolonged gaps in coverage and increased strain on rural hospitals and clinics already operating on thin margins.

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Thus, we recommend CMS:

- **Focus verification efforts on high-risk categories** identified by CMS's own data as more prone to enrollment discrepancies, conserving federal and state resources while minimizing unnecessary barriers for eligible consumers.
- **Provide provisional coverage or clear interim pathways for consumers whose eligibility is under review,** ensuring continuity of care while verification is pending and reducing avoidable coverage gaps.
- **Strengthen insurer accountability**, including enhanced oversight of issuer marketing practices, enrollment transactions, subsidy reconciliation processes, and consumer outreach. Insurers possess the data, scale, and operational capacity to detect and prevent improper enrollments and should bear greater responsibility for doing so.
- **Pair verification efforts with consumer assistance**, including plain-language notices, multilingual outreach, and clear pathways for consumers with limited broadband or enrollment assistance.
- **Exempt income verifications that are triggered by data mismatches** that commonly reflect data lags, seasonal earnings, or informal work, as opposed to ineligibility, especially prevalent in rural economies.

Provisions regarding Network Adequacy and Provider Access Standards (§155.1050, §155.1051, §155.1050, and §156.230)

a. Federal network adequacy standards

CMS proposes a series of interrelated changes to federal network adequacy and Essential Community Provider (ECP) oversight. The proposed rule would remove federal time-and-distance network adequacy standards for State Exchanges and SBE-FPs, allowing states to define their own network adequacy standards. In lieu of federal network adequacy standards, CMS proposes to establish an Effective Provider Access Review Program (EPARP) under §155.1050(d), allowing FFE states that demonstrate sufficient legal authority and technical capacity to assume responsibility for provider access reviews. If an FFE state does not have the authority or capacity to maintain an EPARP, then CMS would continue to conduct network adequacy reviews for that state.

b. Essential Community Provider (ECP) standards

Further, the proposed rule would reduce the minimum ECP contracting threshold from 35 percent to 20 percent, including lowering the separate minimum requirements for Federally Qualified Health Centers (FQHCs) and family planning providers to 20 percent. CMS is also proposing to remove requirements that insurers who do not meet the threshold provide justification for, and documentation of, their efforts to contract with ECPs in their service areas.

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In parallel, CMS proposes to allow qualifying FFE states to conduct their own ECP certification reviews for QHPs (both network and non-network plans) under a new "Effective ECP Review Program" if qualifying states:

- Demonstrate legal authority and methodology to conduct these reviews.
- Ensure network plans maintain a "sufficient number" and geographic distribution of ECPs for low-income enrollees and individuals in Health Professional Shortage Areas.
- Ensure non-network plans maintain "reasonable and timely access" to ECPs that accept the plan's payment as payment in full.

CMS also notes that the agency would continue to collect ECP data from issuers even in States with approved State review programs and provide standardized data back to States.

c. Non-network QHP certification

As mentioned above, CMS also proposes to allow non-network plans to qualify for QHP certification by demonstrating "sufficient" access to ECPs willing to accept the plan's payment amount as payment in full. Under this framework, the plan would be required to show that providers within its service area are willing to accept the plan's payment terms, rather than balance bill enrollees.

Specifically, CMS proposes that non-network plans could satisfy network adequacy requirements by demonstrating that a sufficient number of providers, including ECPs and behavioral health providers, accept the plan's payment amount as payment in full. To support this determination, non-network plans would be required to report:

- The percentage of available providers in the service area that accept the plan's payment as payment in full.
- Whether at least 20 percent of available ECPs accept the plan's payment as payment in full.
- Whether the plan offers payment-in-full arrangements with at least one ECP in each of the eight ECP categories, per county, within the plan's service area.

While CMS notes that non-network plans would remain subject to EHB requirements, the proposal does not provide additional operational detail regarding how those requirements would be assessed in the absence of a contracted provider network.

AAFP Comments on Provisions regarding Network Adequacy and Provider Access Standards (§155.1050, §155.1051, §155.1050, and §156.230)

The AAFP appreciates CMS's stated goal of increasing flexibility for State Exchanges and issuers. However, the proposed changes to network adequacy standards and ECP requirements, taken together, represent a significant shift away from measurable,

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enforceable access protections at a time when Marketplace enrollment is growing, plan designs are becoming more complex, and high-cost-sharing plans may play a larger role in coverage, particularly in rural and under-resourced areas.

Primary care shortages are already severe, particularly in rural areas, with an estimated 42.6 million rural residents living in primary care Health Professional Shortage Areas in 2023.[xv] And these shortages are exacerbated by narrow Marketplace networks. Analyses of QHP networks have found that 21 percent of plans included fewer than 25 percent of available physicians, and 21 percent of QHPs included fewer than one-third of available hospitals.[xvi] Thus, narrow networks heighten the risk that primary care is effectively inaccessible even when nominally "covered."

a. Federal network adequacy standards

We strongly oppose eliminating the proposed provision to remove federal time-and-distance network adequacy standards for State Exchanges and SBE-FPs. The AAFP previously supported CMS's decision in the 2025 Payment Notice to establish these very important network adequacy standards, which CMS justified as necessary to ensure reasonable and timely access nationally and to reduce consumer confusion across markets. This core logic remains unchanged in 2027. Removing the federal time-and-distance standards harms patients because it replaces meaningful, real-world access with paper compliance, masking whether enrollees can actually obtain care when they need it.

When time-and-distance standards are weakened, plans can contract with fewer physicians or concentrate them geographically. Networks can appear adequate based on raw provider counts while patients still face long travel distances, closed panels, ghost networks, and delays that disrupt continuity of care—particularly for, behavioral health, post-acute care, and services in rural area. The predictable consequences are longer travel times, fewer in-network options, delayed care, and increased out-of-network requests. These access failures do not disappear, but rather surface downstream in primary care offices as higher-acuity presentations, more fragmented care, increased prior authorization and appeals, and greater administrative burden as practices attempt to reroute patients or document network inadequacy.

These access risks are not theoretical. In 2022, the Government Accountability Office concluded that provider network oversight varies substantially across states and federal agencies and that inadequate networks can impede timely access and push patients out of network.[xvii] Removing federal quantitative standards would further increase variability and reduce transparency precisely when stronger oversight is needed. Further, without enforceable time-and-distance standards, plans retain flexibility to narrow networks through pricing negotiations or mid-year contract changes, while the burden falls on patients who

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selected coverage based on provider access and have limited ability to respond without financial and emotional harm.

Thus, we recommend CMS retain federal time-and-distance network adequacy standards for State Exchanges and SBE-FPs. Time-and-distance standards are one of the few safeguards that translate "in-network" into actual, usable access, rather than access that exists only on paper. Further, we encourage CMS to require State Exchanges and SBE-FPs with CMS-approved EPARP to report plan-level access metrics relevant to primary care, including time-and-distance compliance, appointment wait times, secret-shopper results, and provider directory accuracy error rates.

b. Essential Community Provider (ECP) standards

The AAFP urges CMS to maintain the current 35 percent ECP contracting threshold or, at minimum, maintain the 35 percent threshold for FQHCs. FQHCs represent core primary care capacity in underserved markets and should not be treated interchangeably with other ECP categories. Community health centers are foundational to primary care delivery in underserved communities. In 2024, community health centers served 32.4 million patients and provided 139 million visits, including substantial primary care and behavioral health services. HRSA reports that in 2024, health centers helped 3.6 million patients achieve controlled hypertension and 2.2 million achieve diabetes control; outcomes that depend on consistent access and stable referral relationships.[xviii] **Lowering the ECP contracting minimum from 35 percent to 20 percent, particularly for FQHCs, weakens the safety-net access floor where it matters most.** CMS notes that average ECP contracting rates are currently high among issuers, but minimum standards are designed to constrain outlier plans and thin-network strategies, not to reflect average performance. In low-competition or geographically constrained markets, a weaker floor risks normalizing inadequate safety-net participation.

CMS itself acknowledges in the proposed rule that lower ECP minimums can lead to increased travel time, longer wait times, and reduced care continuity. That is precisely the mechanism by which family physicians experience downstream strain: delayed first-contact care translates into higher acuity, more visits per episode, and more complex chronic disease management. Uneven ECP enforcement destabilizes referral relationships, disrupts care coordination, and shifts additional workload onto primary care practices, while simultaneously worsening performance on quality and continuity measures for which physicians are held accountable. These risks are intensified by CMS's proposal to reduce issuer justification and documentation requirements for ECP contracting.

If CMS proceeds with delegating ECP review authority to states, that delegation must be accompanied by clear minimum contracting criteria and adequate CMS oversight.

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Specifically, we encourage CMS to require states conducting ECP reviews to publicly report data on ECP participation stratified by provider type, appointment availability and wait times at ECP sites, and identification of "ghost networks."

c. Non-network QHP certification

The AAFP reiterates its strong support for CMS's position stated in the 2025 Payment Notice that quantitative network adequacy reviews should occur before QHP certification. Quantitative reviews are relatively straightforward, and plans that fail initial review can be evaluated through a justification process. Certifying plans with narrow or nonexistent networks, particularly when clinicians may not be accepting new patients, predictably results in care delays and higher out-of-pocket costs.

Justifying this provision in the proposed rule, CMS suggests that non-network plans allow enrollees to lower costs through individualized price negotiations. However, individualized negotiation is not an accessible option for many patients, particularly those who are acutely ill, face language or health-literacy barriers, or lack the time and leverage to engage in one-off pricing discussions with physicians. In practice, this approach shifts financial and administrative burden onto patients and amplifies payment uncertainty for providers operating in high-volume outpatient settings. Further, this expectation sits in tension with the consumer-protection framework established by the No Surprises Act, which reflects congressional recognition that patients are poorly positioned to negotiate prices and should not bear responsibility for resolving payment disputes.

Thus, the AAFP recommends that CMS require non-network plans to maintain robust consumer protections and demonstrate functional and quantitative measures of primary care access to secure QHP certification. At minimum, CMS should require non-network plans to:

- Ensure standardized patient cost disclosures to protect patients' negotiating position.
- Uphold the No Surprises Act by maintaining robust balance-billing protections for patients and administrative simplicity for providers.
- Re-establish quantitative access metrics, such as wait times and time-and-distance standards, as conditions of non-network QHP approval.

Absent enforceable, quantitative metrics, network adequacy becomes harder to enforce before consumers enroll, and "adequacy" risks being reduced to paper compliance rather than real-world access.

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Provisions regarding Catastrophic coverage (§155.605(d)(1), §156.80(d)(2)(ii), §156.130(c) and §156.155(a)(6))

Under current regulations, Marketplace exchanges are permitted to grant hardship exemptions when circumstances, including unaffordability due to ineligibility for APTC or CSRs, prevent enrollment in a QHP. In this proposed rule, CMS aims to codify and expand this hardship exemption so that individuals with projected household income below 100 percent FPL or above 250 percent FPL who are ineligible for APTC or CSRs may qualify and enroll in catastrophic coverage, including individuals above the age of 30.

The proposed rule also includes several provisions affecting catastrophic plan design and pricing. Catastrophic plans are ACA-compliant QHPs whose benefit package includes EHBs. In these plans, aside from preventive services and at least three primary care visits, enrollees pay the full cost of covered services until a cost-sharing threshold is reached, set to $12,000 for the individual limit. For PY 2027, the individual maximum out-of-pocket (MOOP) limit is $12,000, as established in HHS's annual Premium Adjustment Percentage guidance and applicable across individual and employer-sponsored coverage.

In this proposed rule, CMS seeks to set the catastrophic plan cost-sharing threshold at 130 percent of the applicable MOOP. If finalized, this would require catastrophic plan enrollees to incur up to $15,600 in cost sharing, in addition to monthly premiums, before coverage meaningfully begins.

CMS further proposes to permit issuers to:

- Offer catastrophic plans for one year or multiple consecutive years (not to exceed 10).
- Adjust index-rate pricing to reflect the full contract term in multi-year plan designs.
- Exempt multi-year catastrophic enrollees from annual eligibility reverification.
- Allow plans with terms of at least two years to use value-based insurance design. (VBID) to cover additional, pre-deductible, preventive services.

CMS is also seeking comments on whether maximum out-of-pocket (MOOP) limits and deductible amounts should be set annually or calculated as an average over the full duration of a multi-year contract. Additionally, CMS seeks input on whether insurance issuers should be allowed to modify plan terms during a multi-year period. CMS also clarifies that enrollees will retain the right to terminate multi-year catastrophic coverage at any time without penalty.

AAFP Comments on Provisions on Catastrophic Coverage (§155.605(d)(1), §156.80(d)(2)(ii), §156.130(c) and §156.155(a)(6))

a. Expanded enrollment in Catastrophic Coverage

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Individuals who enroll in catastrophic plans, particularly through the hardship exemption, are oftentimes doing so under financial stress and time pressure – not as a preferred coverage choice. And ASPE analysis shows that individuals experiencing affordability-driven coverage disruptions are more likely to live in rural areas, have lower incomes, and rely on the individual market during periods of employment instability.[xix] At the same time, these populations are more likely to have limited health insurance literacy, reduced access to enrollment assistance, and face challenges navigating digital-first enrollment systems. As a result, many may not fully understand how catastrophic plan deductibles, cost sharing, and pre-deductible limits operate in practice, which increases the likelihood that they will delay or forgo care and encounter access barriers only *after* a health need arises. Accordingly, the AAFP has a strong interest in ensuring that any expansion of catastrophic coverage supports access to longitudinal primary care.

We recognize that CMS is acting in a materially changed affordability environment following the expiration of enhanced premium tax credits at the end of 2025, which increased net premium exposure for many Marketplace enrollees and contributed to widespread enrollment disruptions. Recent analysis of insurer rate filings across all 50 states showed that Marketplace issuers requested a median premium increase of approximately 18 percent for plan year 2026. This figure is more than double the median request in plan year 2025 and marks the largest midpoint increase in recent years. Notably, insurers specifically attributed these premium hikes in part to policy-driven changes in the enrollment mix.[xx] Consistent with these pressures, early state Marketplace indicators following subsidy expiration reflect the growing affordability concerns among consumers. For example, the Washington Health Benefit Exchange reported that during the 2026 open enrollment period, more than 61,000 enrollees changed plans in response to higher premiums following the expiration of enhanced federal premium tax credits. The Exchange further reported more cancellations than any year prior and anticipated additional disenrollment due to affordability pressures.[xxi]

Against this backdrop, the **AAFP appreciates CMS exploring available regulatory levers to preserve lower-premium coverage options for individuals who may otherwise become uninsured. However, we are concerned that this proposed provision may function as a premium-focused solution that risks increasing underinsurance by shifting costs to the point of care.** The minimum statutory requirements in catastrophic plans provide important baseline protections, but access to essential health benefits and three pre-deductible primary care visits does not substitute for longitudinal primary care and chronic disease management, particularly for adults over age 30.

We are particularly concerned that this proposed expansion of catastrophic eligibility will create a risk of underinsurance among newly eligible older adults. These individuals may select catastrophic coverage as a low-premium, short-term bridge prior to Medicare

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eligibility, but will be exposed to prolonged periods of full-cost liability for most services. Older adults are more likely to have chronic disease and behavioral health needs that require comprehensive care extending well beyond three primary care visits per year. The proposed multi-year catastrophic framework materially compounds this risk: allowing contract terms of up to 10 years, waiving annual eligibility reverification, and potentially averaging MOOP or deductible amounts across a multi-year period could functionally lock older, economically vulnerable adults into a coverage structure that delays meaningful access to care precisely as their health needs intensify.

These individual-level access risks also have broader market-level implications. **If multi-year catastrophic plans disproportionately attract healthier, price-sensitive enrollees, risk segmentation may worsen in remaining pools.** A 2025 study of 343,137 adults with chronic illnesses found that enrollment in high-deductible plans was associated with significantly lower receipt of guideline-concordant care across multiple domains, including clinic visits, laboratory testing, and prescription drug care (e.g. reduced likelihood of recommended clinic visits, prescriptions, and labs, with an overall reduction in recommended care versus non-HDHP coverage).[xxii] While catastrophic plans and employer-sponsored high-deductible health plans are distinct plans, they share the same mechanism: high front-end cost sharing that places most non-preventive services behind a substantial deductible.

Thus, the AAFP appreciates CMS's effort to modernize catastrophic coverage, but we urge CMS to ensure that any expanded eligibility to catastrophic plans is paired with concrete consumer protections to preserve access to longitudinal primary care.

Specifically, we recommend that CMS:

- **Require issuers to provide robust, plain-language consumer disclosures** that accurately describe how catastrophic coverage functions in practice, including covered benefits, deductibles, cost-sharing, and pre-deductible services.
- **Require issuers to provide clear and accessible pathways and decision-support tools for consumers to transition from catastrophic coverage to comprehensive plans** when income, health status, or household circumstances change, so catastrophic enrollment does not become an unintended long-term default.
- **Prohibit insurers from averaging MOOP and deductible amounts across multi-year catastrophic plans**, as it would extend the period before meaningful coverage begins for the very enrollees most likely to defer care.
- **Prohibit insurers from making mid-term changes to provider networks or covered benefits,** which risks disrupting established care relationships, with potentially lasting clinical consequences—particularly for patients managing chronic conditions.

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b. Access to Preventive and Primary Care in Catastrophic Coverage

We greatly appreciate CMS's proposal to allow multi-year (≥ 2 year) catastrophic plans to use value-based insurance design, or VBID, to cover additional preventive services without enrollees first satisfying the deductible. This proposal largely aligns with longstanding AAFP policy, and reflects an important recognition that benefit design can mitigate gaps in access set forth by high deductibles. However, optional coverage of baseline preventive services alone will not ensure effective, longitudinal primary care or chronic disease management.

Thus, we recommend CMS to finalize this provision and further strengthen it by:

- **Conditioning approval of multi-year catastrophic plans (≥ 2 years) on adoption of VBID for preventive services.**
- **Requiring insurers to develop VBID programs with meaningful input from physicians who deliver and coordinate preventive care,** thus ensuring benefit designs reflect real-world clinical practice and patient needs.
- **Requiring insurers to apply transparent, evidence-based criteria in selecting preventive services for VBID programs.**
- **Requiring insurers to include high-value primary care services in VBID designs,** such as diabetes management, blood pressure monitoring and medication management, smoking cessation interventions, and structured chronic disease management.

Additionally, the AAFP strongly urges CMS to prohibit issuers from implementing disease-specific variation in MOOP limits. Although CMS presents this variation as an alternative to VBID for multi-year catastrophic plans, even raising the possibility of disease-based MOOP variation risks encouraging benefit designs that shift higher costs onto patients who require care most frequently. In practice, this approach could invite issuers to segment enrollees by health condition and tailor cost-sharing to influence enrollment and retention. This is precisely the dynamic the Affordable Care Act sought to eliminate by prohibiting discriminatory benefit structures based on medical dependency or health condition. Moreover, disease-specific MOOP variation would also create significant confusion for both physicians and patients, particularly for individuals with multiple chronic conditions whose care cannot be cleanly attributed to a single diagnosis. This complexity would make it difficult for physicians to advise their patients on expected costs, and for patients to anticipate their financial obligations.

Rather, we encourage CMS to build on this momentum by strengthening access to longitudinal primary care through potential alignment opportunities between multi-year VBID design and the Health Savings Account (HSA)–Direct Primary Care (DPC) framework clarified in the OBBBA. The OBBBA's recognition of permissible arrangements between HSAs

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and DPC reflects congressional recognition that high-deductible plans require complementary mechanisms to ensure meaningful access to primary care. As bronze and catastrophic plans are now HSA-eligible, CMS has a timely opportunity to examine how these frameworks can be leveraged to support pre-deductible primary care access—particularly for enrollees facing substantial front-end cost sharing.

Thank you for the opportunity to provide comments on this important matter. For additional questions, please contact Sahana Chakravartti, Regulatory Specialist, at schakravartti@aafp.org.

Sincerely,

Jen Brull, MD, FAAFP
American Academy of Family Physicians, Board Chair

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