



601 Pennsylvania Avenue, NW T 202.778.3200
South Building, Suite 500 F 202.331.7487
Washington, D.C. 20004 ahip.org

March 13, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9911-P
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

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

Dear Administrator Oz:

AHIP appreciates the opportunity to provide comments in response to the Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2027 (“Payment Notice”), published February 11, 2026, in the *Federal Register*. AHIP is the national trade association representing the health insurance industry. AHIP’s members provide health care coverage, services, and solutions to more than 200 million Americans, including millions who enroll in coverage through the individual market through the Health Insurance Marketplaces (Marketplaces).

AHIP and our member health plans are committed to making sure Americans who purchase their own health insurance can access affordable, comprehensive options. We share with HHS goals to reduce costs, enhance program integrity, and encourage innovation. The Marketplace stands as a strong example of a public-private partnership aimed at these goals while improving the experience for consumers. Recently, AHIP and the industry worked with HHS to help stop and prevent unauthorized enrollments and plan switches initiated by agents and brokers, a joint effort crucial in reducing fraud and abuse. We aim for our comments to enhance this partnership and provide useful insights.

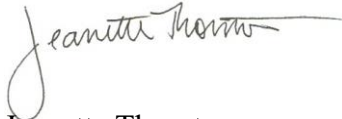
We support proposals to promote flexible, affordable coverage options and stable health insurance marketplaces, while noting that some of the proposed regulations would benefit from additional data and enrollment experience, further detail, input, or phased implementation. The attached detailed comments from AHIP address:

- **Standardized Plans and Non-standardized Plan Limitations:** Marketplace choice and competition thrive when issuers can design and offer innovative plan designs that meet consumer needs. AHIP supports HHS's proposals to eliminate standardized plan requirements and remove the existing numerical limits.
- **Network Adequacy:** AHIP supports network adequacy standards that ensure consumers can get the care they need, with flexibility to account for local dynamics. States are best positioned to evaluate the unique conditions in their markets, and AHIP supports HHS' proposal to allow states to conduct their own network adequacy and ECP reviews.
- **Essential Health Benefits:** AHIP supports proposals that will clarify Essential Health Benefit (EHB) requirements and reduce costs for consumers including requiring a clearer, more robust process for states to defray benefits and prohibiting issuers from including routine non-pediatric dental as an EHB. We recommend HHS work closely with states to consider legislative schedules and delay implementation of defrayal requirements until plan year (PY) 2028.
- **Enhancing Program Integrity:** We support proposals to strengthen program integrity, including permanently rescinding the 150% FPL SEP, reinstating SEP verification, and strengthening oversight of agents and brokers. However, some additional verification proposals should be deferred until HHS can evaluate whether the Working Families Tax Cut (WFTC) pre-enrollment verification requirement and other recently enacted measures are achieving their intended program integrity effects.
- **Non-Network Qualified Health Plans:** HHS should not finalize provisions allowing non-network plans to receive QHP certification. The proposal raises important questions about consumer protection, balance billing, claims processing, adverse selection and compliance with existing ACA requirements. We urge HHS to pursue this through separate notice-and-comment rulemaking.
- **Multi-Year Catastrophic Plans:** Given the expanded hardship exemption has been in effect for only one enrollment period, it is premature for issuers to comment on the proposal, let alone design multi-year products. We recommend HHS wait until plans have at least two full plan years of experience before proceeding, which will afford HHS the opportunity to design a more complete regulatory framework.

We provide detailed comments on these proposals and other provisions of the proposed rule in the attachment. Together, we will continue to work towards our shared goal of quality, affordable health coverage for all Americans.

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Sincerely,

A handwritten signature in cursive script that reads "Jeanette Thornton". The signature is written in black ink and includes a horizontal flourish extending to the right.

Jeanette Thornton
Executive Vice President, Policy and Strategy

AHIP Detailed Comments on 2027 Notice of Benefit and Payment Parameters
Proposed Rule

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

AHIP supports HHS' proposal to remove standardized plan option requirements for Federally-facilitated Exchange (FFE) and State-based Exchange on the Federal Platform (SBE-FP) qualified health plan (QHP) issuers. Standardized plans offer uniform cost-sharing structures, but consumers select plans based on an array of features, including networks, formularies, care management, negotiated rates, value-based design, Health Savings Account (HSA) eligibility, virtual care, and additional benefits like vision or dental coverage. Despite several years of requiring standardized plan offerings, enrollment in these plans remained proportionally low, indicating they did not meet the varied needs of Exchange consumers. Removing the requirement while preserving issuers' ability to voluntarily offer standardized plans strikes the right balance.

Recommendations:

- **Remove standardized plan option requirements.**
- **Preserve the option for QHP issuers to continue offering standardized plan designs.**

II. Non-Standardized Plan Option Limitations (§ 156.202)

AHIP supports discontinuing non-standardized plan option limits and the related exceptions process. This policy has limited consumer choice without any meaningful improvements in plan selection or consumer experience. In our comments on the 2025 Payment Notice, AHIP reported results of a member survey covering approximately 7.5 million lives across 15 issuers participating in the FFE. As a result of the policy that required limiting the number of plan options to four non-standardized plans per product network type for each metal level in a service area, the survey indicated a 24 percent reduction in plan offerings - over 2,500 individual plans impacting more than 900,000 enrollees. Plans that were discontinued tended to be those with broad networks, virtual primary care, and varied cost-sharing or deductible designs. HHS enacted additional non-standardized plan limitations, limiting the number of plan options to two non-standardized plans per product network type for each metal level in a service area, further limiting issuer capacity to offer a broad selection of plan options.

AHIP strongly supports the ability for issuers to design and offer innovative plans that promote value-based insurance designs aligned with consumer needs and preferences. Using a blunt instrument like a numerical limitation hurts competition, disrupts coverage, and inhibits innovation. To complement the removal of plan limits, we encourage HHS to explore ways to optimize consumer tools on Healthcare.gov, such as enhanced filter options, plan feature

comparisons, utilization-based recommendations, and educational prompts to help consumers meaningfully differentiate among options.

In the preamble, HHS concludes that imposing non-standardized plan option limits has not been an effective strategy in counteracting plan proliferation and enhancing consumer experience. Further, any marginal improvements cannot overcome the disadvantages of increased regulatory complexity, market and enrollee disruption, inhibition of issuer innovation in plan design, constrained consumer choice, and plan discontinuations resulting from this policy. AHIP concurs with HHS' rationale and supports this proposal.

Recommendations:

- **Discontinue non-standardized plan option limits and the related exceptions process.**
- **Preserve ability for issuers to choose whether to continue offering chronic and high-cost condition plans originally offered through the exceptions process.**
- **Explore ways to optimize consumer tools on Healthcare.gov.**

III. Proposals Related to Network Adequacy and Essential Community Providers: Deferral of Network Adequacy Reviews to States with an Effective Provider Access Review Program (§§ 156.230 and 155.1050); Essential Community Provider Standards for Network Plans (§ 156.235) and Implementation of the Effective Essential Community Provider Review Program (§ 155.1051)

Network Adequacy

AHIP supports network adequacy requirements that ensure consumer access to high-quality care while remaining flexible enough to account for local conditions — geography, care patterns, provider shortages, and market dynamics. States have long demonstrated specialized experience in designing and assessing standards for their unique markets, and state regulators are best positioned to evaluate whether networks meet the needs of their residents.

In our comments on the 2024 Payment Notice, AHIP included a report from the Wakely Consulting Group reflecting their findings about the impact of Federal network adequacy requirements based on qualitative interviews with AHIP member plans who offer QHPs in the FFE.¹ Member plans shared concerns about the Federal network adequacy standards forcing them adding higher cost, lower quality providers to meet the standards, and causing those plans increased difficulty with provider contracting, particularly in health systems with "all-or-nothing" contracting approaches and increasing provider consolidation. Health plans also identified concerns with higher administrative burden resulting from the requirements, and

¹ Wakely, Network Adequacy Report, 2023. <https://www.ahip.org/resources/network-adequacy-report>

recommended improvements to the review process, many of which were ultimately adopted by HHS.

AHIP appreciates HHS' recognition of the ongoing challenges with Federal network adequacy standards and supports the proposed approach to defer provider access reviews to states where appropriate. We also encourage HHS to continue to recognize the value of virtual care and evaluate how telehealth can be appropriately measured under network adequacy standards.

Regarding appointment wait time standards, significant unresolved challenges remain. Issuers have limited ability to influence appointment availability. Provider response rates are inconsistent, results are difficult to reliably replicate, and secret shopper methodologies produce variable outcomes. We recommend HHS rescind appointment wait time standards.

Recommendations:

- **Defer network adequacy reviews to FFE States that elect to conduct reviews, demonstrate sufficient authority and technical capacity, and satisfy the applicable criteria to be considered to have an Effective Provider Access Review Program.**
- **Remove requirements for State Exchanges and SBE-FPs to establish and impose quantitative time and distance standards that are at least as stringent as standards for QHPs on the FFE.**
- **Rescind appointment wait time standards.**

Essential Community Providers (ECPs)

A robust ECP network ensures access to safety-net providers and treatment facilities. However, challenges like provider shortages and unequal geographic distribution cannot always be addressed within existing ECP requirements. We support HHS' proposal to lower the ECP contracting threshold from 35 percent and remove specific category thresholds for FQHCs and family planning providers.

We also support allowing states to conduct their own ECP certification reviews. However, because ECPs serve safety-net populations whose access should not vary based on geography or state policy choices, we recommend HHS maintain a minimum federal ECP standard even when deferring reviews to states. This ensures a consistent baseline of access to critical providers nationwide.

Recommendations:

- **Finalize the reduced minimum percentage requirements for contracting with ECPs and remove the narrative justification and description requirements.**

- **Allow FFE states to conduct their own ECP certification reviews, provided HHS maintains a minimum federal ECP standard.**

IV. Proposals Related to Essential Health Benefits (EHBs): Additional Required Benefits (§ 155.170); Provision of EHB (§ 156.115(d))

Additional Required Benefits

AHIP supports HHS' proposal to clarify when state-required benefits are considered in addition to EHB and subject to defrayal. The current EHB structure balances comprehensive benefits with affordability and state flexibility within a broad federal standard. Under the ACA, states may mandate additional benefits but must defray the cost. Despite this requirement, many states have enacted new or expanded mandates without appropriately offsetting costs through defrayal, increasing premiums for consumers, employers, the federal government, and taxpayers.

AHIP supports this proposal to increase clarity regarding benefits that may be subject to defrayal. HHS should work closely with states to provide technical assistance and clarify when benefit mandates require defrayal. This includes helping states consistently determine which benefits exceed EHB, establishing processes for defrayal in annual rate submissions, ensuring adequate financial controls, and addressing timing considerations.

With respect to timing considerations, legislative calendars and plan filing timelines present significant challenges to defraying state mandate costs. States frequently pass new mandates that do not allow sufficient time to determine whether the state must defray costs before filing deadlines for the first year the mandate is effective. HHS should work with states to implement a process to determine: (1) whether a mandate is subject to defrayal well in advance of the deadline for impacted plans to be filed with the state and (2) how to resolve disputes over defrayal of benefits in addition to EHB that ensures plans and enrollees are appropriately reimbursed.

HHS should also revisit its 2013 interpretation of state rules related to provider types, cost-sharing, or reimbursement methods to ensure that mandates that limit cost-sharing are appropriately evaluated as subject to EHB defrayal.² Mandates that prohibit cost-sharing for non-preventive services increase overall costs and lead to higher premiums for all enrollees.

Given the timing of this proposal in the rate filing cycle, defrayal is unlikely to take effect for PY 2027. State officials will need additional time and guidance to evaluate mandates, consult with

² <https://www.govinfo.gov/content/pkg/FR-2013-02-25/pdf/2013-04084.pdf>

CMS, and communicate with issuers for rate development. We ask HHS to delay implementation until PY 2028.

Recommendations:

- **Require that any state-required benefits that meet the proposed criteria be considered “in addition to EHB” and subject to defrayal, beginning with PY 2028.**
- **Work closely with states to provide technical assistance and further clarify when benefit mandates require defrayal.**

Provision of EHB

AHIP supports the proposal to prohibit issuers from including routine non-pediatric dental services as an EHB. Dental coverage is widely available through employers and on Exchanges as standalone dental plans (SADPs) and in medical plans with embedded dental coverage. This flexibility allows consumers to select coverage that works best for them.

HHS’ prior policy allowing non-pediatric dental coverage to be adopted as an EHB posed operational and legal concerns, and the implementation of that policy likely lead to increased costs. Adding routine non-pediatric dental as an EHB creates adverse selection risk when patients enroll, seek costly treatments, and drop coverage when work is complete. In addition, the legal rationale originally offered for this policy does not support an expanded interpretation of “typical employer plan” to include any employer benefit, and AHIP supports HHS’ proposal to return to a more limited, and appropriate, definition. AHIP appreciates HHS’ acknowledgement of these concerns and recommends HHS finalizes this proposal.

Recommendation:

- **Finalize the policy to prohibit issuers from including routine non-pediatric dental services as an EHB.**

V. Proposals Related to Catastrophic Plans: Expansion of Hardship Exemption Eligibility (§ 155.605(d)(1)); Permitting Plan-Level Adjustments Multi-Year Catastrophic Plans (§ 156.80(d)(2)(ii)); Multi-Year Terms for Catastrophic Plans to Improve Health (§§ 156.130(c) and 156.155(a)(6))

Catastrophic plans offer a more affordable, limited coverage option for a subset of Marketplace consumers who do not anticipate significant health care costs and are primarily seeking protection against unexpected serious illness or injury. AHIP recognizes their role as part of the coverage continuum.

The expanded, streamlined hardship exemption has been in effect for a single enrollment period, and its scope and impact remain untested. HHS only recently streamlined the hardship exemption process, and the open enrollment period for 2026 coverage ended in January. Catastrophic plan enrollment grew but remains very low relative to metallic plans, and thus far there is much too little data to evaluate consumer behavior, pricing adequacy, or market impact. Before building new multi-year product structures on top of this exemption, issuers need at least two full plan years of all-ages catastrophic enrollment experience to meaningfully assess product design and develop actuarially sound pricing. Proceeding without that data would require issuers to set multi-year rates with insufficient actuarial foundation.

Beyond the data limitations, several fundamental policy questions must be answered before HHS can move forward with multi-year catastrophic plans. Individual market enrollees frequently experience income and life changes that affect their coverage. A significant share of multi-year catastrophic enrollees would likely terminate early for any number of reasons, including: becoming eligible for an enrolling in an employer-sponsored plan, Medicare, Medicaid, or a Basic Health Program plan; developing a high-cost condition and seeking lower cost-sharing; or choosing to go uninsured. Evaluation of this policy requires additional information about:

- how terminations and disenrollments would be treated under multi-year catastrophic plans,
- requirements a multi-year catastrophic contract would need to qualify as a multi-year plan,
- medical cost trends, data assumptions, and actuarial implications for rate determination,
- how issuers would apply monthly cost-sharing and the impact on actuarial value, consumer behavior, and utilization patterns,
- appropriate actuarial methods and accounting standards for rate review processes,
- whether issuers would need to lock in rates and cost-sharing for multiple years,
- how the hardship exemptions will apply for reenrollment purposes, and
- whether enrollees can access plans during special enrollment periods.

The current regulatory framework for the individual market is built around annual cycles for risk pooling, rate setting, QHP certification, and calculations of MLR standards and risk adjustment that are not designed to account for premiums, claims, and risk spread over multiple years. Such dynamics and rules should be detailed in a detailed regulatory proposal. In any scenario, significant consumer education, materials, and notices would be necessary to ensure consumers are aware of the unique structure of multi-year catastrophic plans and other important distinctions from plans available on the Exchange today.

AHIP supports HHS' recognition that value-based insurance design (V-BID) principles can improve catastrophic plan benefit structures. V-BID has a strong evidence base demonstrating

that reducing cost-sharing barriers to high-value services improves outcomes and lowers total costs. But the case for V-BID is not limited to catastrophic plans, and its impact would be far greater if applied across metal levels, where enrollment is concentrated and the effect on utilization, outcomes, and affordability would be most meaningful. We encourage HHS to pursue V-BID flexibility as a broader Marketplace strategy rather than confining it to a new product type with low enrollment outside the single risk pool.

Given the limited enrollment data and unresolved structural questions, we ask HHS to delay finalizing multi-year catastrophic plan provisions. HHS could consider a pilot — for example, two-year plans only — to test the concept before broader implementation.

Recommendations:

- **Delay finalizing multi-year catastrophic plan provisions until at least two full plan years of all-ages catastrophic enrollment data are available and a more detailed regulatory framework can be proposed for comment.**

VI. Part 153 – Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

Data for HHS Risk Adjustment Model Recalibration for the 2027 Benefit Year (§ 153.320)
AHIP supports the proposed approach to use the three most recent consecutive years of enrollee-level EDGE data for recalibration. No anomalies or outliers have been identified that would affect inclusion of these years. HHS should finalize this proposal.

Recommendation:

- **Finalize the recalibration of the 2027 benefit year HHS risk adjustment models with 2021, 2022, and 2023 benefit years' enrollee-level EDGE data.**

Comment Solicitation on Retaining Separate Risk Adjustment Transfer Calculations for Individual Catastrophic Plans and Individual Non-Catastrophic Plans Under the State Payment Transfer Formula

HHS seeks comment on whether it should retain separate risk adjustment transfer calculations under the State payment transfer formula for individual catastrophic plans or whether it should calculate State transfers for these plans together.

There is not sufficient data at this time to evaluate enrollment trends and consumer behavior related to catastrophic plans. The catastrophic proposals under consideration elsewhere in this rule would add further uncertainty. We do not believe changes to the risk adjustment transfer calculations are warranted for PY 2027.

We encourage HHS to closely monitor these trends, particularly movement from Bronze into catastrophic coverage, and to solicit additional stakeholder input to determine whether future action is necessary. HHS should also support the effective use of rate review by state Departments of Insurance (DOIs) to ensure that issuers' rates are actuarially sound and work with the National Association of Insurance Commissioners (NAIC) to identify and communicate state best practices to protect against issuer insolvencies that could impact the risk adjustment program.

Risk Adjustment Data Validation Requirements When HHS Operates Risk Adjustment Data Validation (RADV) (§§ 153.350 and 153.630)

AHIP supports the proposed additional scaling factor to the error estimation methodology, which will more accurately capture the proportion of total risk associated with enrollees with HCCs. HHS should finalize this change.

Recommendation:

- **Finalize the addition of a scaling factor to the HHS-RADV error estimation methodology.**

HHS Risk Adjustment User Fee for the 2027 Benefit Year (§ 153.610(f))

AHIP supports the proposed risk adjustment user fee of \$0.20 PMPM for the 2027 benefit year. The program estimates and proposed fee are comparable to previous years and align with expected enrollment trends and administrative costs.

Recommendation:

- **Finalize as proposed the 2027 risk adjustment user fee of \$0.20 PMPM.**

VII. Part 154 – Health Insurance Issuer Rate Increases: Disclosures and Review Requirements

Submission of Rate Filing Justification (§ 154.215)

HHS proposes to continue to require issuers that make a plan-level adjustment to account for unreimbursed CSRs to submit certain information specified in the PY 2026 Rate Filing Guidance in the unified rate review template (URRT) and actuarial memoranda for each plan year in which CSRs are not federally funded.

AHIP understands HHS' interest in additional information about unfunded cost-sharing reductions and how states handle CSR loading scenarios. Our comments provide recommendations on ways to provide additional transparency into CSR amount and CSR load data, while addressing operational, timing, and data challenges.

Timing for CSR reporting is challenging. For plan year 2027, any new requirements included in the final Payment Notice would most likely be finalized after filing deadlines in many states. Because of this late timeline, we ask that at a minimum, HHS delay this reporting requirement until PY 2028 rate filings and allow issuers to provide reasonable estimates of actual CSR amounts for PY 2025.

In future years, retrospective CSR reporting will remain challenging. Operational burden related to claims appeals, retroactive adjustments, and manual claims processes are difficult to reconcile and calculate. We request that HHS establish a safe harbor for good faith efforts to calculate actual CSR amounts to account for these challenges.

Issuers must comply with state laws and regulations governing CSR loads applied during rate development, which often mandate or strongly encourage specific CSR loading methodologies. In particular, states with robust rate review procedures require that HHS acknowledge both state authority and issuer adherence to these standards when evaluating “excessiveness.” This approach helps prevent potential conflicts between state and federal oversight within the rate review process.

Any CSR information required should be limited to actuarial memoranda and not included in the URRT. Allowing more flexibility in explaining the relationship between CSR amounts and how they are used to set loads will provide more meaningful information to HHS, such as methodology limitations, audit status, vendor processes, and state-directed constraints. This approach would also avoid public access to confidential and proprietary rate setting information and prevent misinterpretation or inappropriate comparison across issuers or jurisdictions.

Recommendations:

- **Delay CSR reporting requirements until PY 2028 rate filings; allow reasonable estimates for PY 2025.**
- **Establish a safe harbor for good-faith CSR calculations.**
- **Recognize state authority over CSR loading requirements.**
- **Limit CSR information to actuarial memoranda; exclude from the URRT.**

VII. Part 155 – Exchange Establishment Standards and Other Related Standards

Approval of a State Exchange (§ 155.105 and 155.106)

We urge HHS to maintain the one-year transition period for states seeking to operate a State Exchange. This transition period is a critical safeguard ensuring states are operationally prepared

to assume eligibility and enrollment responsibilities before fully transitioning from the federal platform.

The phased approach allows issuers to work with states to address data feed inconsistencies, enrollment file alignment, carrier agreement modifications, filing and certification changes, and consumer communication gaps. The recent Georgia Access transition illustrates this directly: the one-year transition was essential to operational success, and even with that transition year, operational issues still arose.

Eliminating the transition period would compress implementation timelines and impose substantial burden on issuers, who rely on this period to update systems, test data interfaces, modify business rules, and ensure compliance with new state-specific requirements. This creates heightened risk of enrollment errors, eligibility determination failures, delayed APTC determinations, and consumer confusion.

We also recommend HHS retain the requirement that states provide documentation demonstrating progress toward meeting State Exchange Blueprint requirements. Issuers making multi-year systems investments rely on this transparency for planning certainty and market stability.

Recommendations:

- **Maintain the one-year transition period for states seeking to operate a State Exchange to ensure operational readiness, minimize system and enrollment errors, and protect consumers from coverage disruptions.**
- **Retain documentation requirements demonstrating progress toward State Exchange Blueprint milestones.**

Amending Requirements for State Exchanges to Operate a Centralized Eligibility and Enrollment Infrastructure (§§ 155.205(b) and 155.221(k))

AHIP supports state flexibility to address the needs of their residents and unique market dynamics. Many states have implemented State Exchanges to ensure meaningful consumer education and outreach, enrollment support, and robust program integrity measures. AHIP has also long supported Enhanced Direct Enrollment (EDE) as a tool to streamline application, enrollment, and post-enrollment activities for both issuers and consumers.

At the same time, we are concerned that allowing State Exchanges to rely on a decentralized enrollment framework that lacks a clear and consistent one-stop shopping experience could risk eroding consumer trust, misleading consumers, and undermining Exchange integrity, particularly if non-ACA-compliant products are introduced on platforms that consumers perceive as official

Exchange pathways. Should HHS finalize this provision, clear and enforceable consumer protection guardrails will be needed to ensure State Exchanges continue to meet the core transparency and consumer protection goals of the ACA.

We strongly urge HHS to consider the importance of consumer protections, as well as impacts on market fairness and affordability, operational readiness, and access for consumers.

Consumer Protection. Third-party web-brokers operating the primary enrollment platform for a State Exchange raise concerns about preferential display and consumer confusion. Web-brokers market and sell multiple types of health coverage, including non-ACA-compliant products. Existing web-broker standards were developed to supplement a centralized Exchange website and may not be sufficient when web-brokers are the primary platform. Without strong guardrails, consumers could be presented with QHPs alongside non-compliant products in ways that blur important distinctions. HHS should prohibit SBE-EDE platforms from including non-ACA-compliant products on primary enrollment platforms and from offering issuers preferential display in exchange for payment. Any plan sorting or display practices should be transparent, disclosed, and subject to oversight. HHS should also assess whether the burden of switching between platforms (including re-entering information, repeating identity proofing, re-submitting consent) increases the likelihood a consumer feels locked in to the first web-broker they encounter, limiting overall choice.

Market Fairness and Affordability. Unlike State Exchanges, which fund operations through user fees, EDE vendors often charge issuers to participate. In markets with limited platform competition, issuers may have little choice but to pay those charges, increasing costs and premiums. HHS should prohibit SBE-EDE platforms from charging issuers to participate, while preserving states' ability to assess user fees for eligibility determinations, operations, and consumer outreach.

Operational Readiness. Prior to launch, SBE-EDEs should validate the accuracy of State Exchange renewal BAR file data, confirm Medicaid/CHIP Periodic Data Matching capability, and meet standardized operational readiness benchmarks. HHS should require standardized Operational Readiness Review templates, limit additional state-specific reporting, require CMS-certified technical frameworks for enrollment transactions, and ensure SBE-EDEs meet the same enrollment verification, security, and reporting requirements as Federal and State Exchanges. Implementation should be delayed until current EDE platforms have adopted any required fraud prevention measures.

Centralized Consumer Assistance. SBE-EDEs should operate a centralized consumer assistance center. CMS should explicitly define responsibility for APTC questions, eligibility

disputes, enrollment corrections, and broker termination requests to prevent inappropriate shifting of core Exchange servicing obligations onto issuers.

Recommendations:

- **Prohibit SBE-EDE platforms from charging issuers to participate, from offering preferential display for payment, and from including non-ACA-compliant products on primary enrollment platforms.**
- **Require SBE-EDE platforms to meet standardized operational readiness expectations, CMS-certified technical frameworks, and the same verification and security standards that apply to Federal and State Exchanges.**
- **Require SBE-EDEs to operate centralized consumer assistance and clearly assign responsibility for core Exchange functions.**
- **If finalized, delay implementation until EDE programs have adopted necessary fraud prevention measures.**
- **Remove and prevent barriers in account management so consumers can easily shop across web-brokers and enrollment pathways.**

Ability of States to Permit Agents and Brokers and Web-Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (§ 155.220(j))

AHIP supports proposals to strengthen oversight of agents, brokers, and web-brokers. Agents and brokers play an important role in helping consumers navigate Marketplace options, but a small number of bad actors have exploited gaps in oversight to enroll consumers without their knowledge or consent. Strong, uniform standards of conduct are essential.

Proposals Related to FFE Standards of Conduct and Mandating a Standard Eligibility Application Review Form and Consumer Consent Form (§ 155.220(j)(2))

We support the proposal to require agents, brokers, and web-brokers to use a standardized consent form and obtain consumer consent confirmation through specified action. A standardized consent process will provide additional clarity around current compliance measures and ensure stakeholders are held to a fair, universal standard of conduct.

As enrollment fraud becomes more sophisticated, HHS should also strengthen mechanisms to address emerging risks driven by artificial intelligence (AI). Issuers have reported fraudulent voice calls during CMS three-way call processes and forged or manipulated digital signatures. We recommend Exchanges conduct targeted manual reviews and invest in system enhancements capable of detecting AI-enabled fraudulent patterns.

We encourage HHS to consider additional consumer protections, such as phone verification, two-factor or multi-device authentication, or other measures to verify and protect consumer information and consent. Notably, the specific measure(s) that would be appropriate may vary across different consumer categories and should be tailored to address the risk of unauthorized activity without imposing unnecessary burdens on legitimate consumers; further, HHS should account for evolving technology and measures.

Recommendations:

- **Finalize the requirement for standardized consumer consent and eligibility application review forms, with confirmation through specified consumer action, as proposed.**
- **Update and enhance oversight mechanisms to address AI-enabled fraudulent behavior, including fraudulent voice calls and manipulated digital signatures.**
- **Consider additional safeguards, such as two-factor or multi-device authentication, to verify and protect consumer information and consent.**

Proposals Related to Creating Standards of Conduct Related to Marketing (§ 155.220(j)(3))
AHIP supports HHS' proposal to increase enforcement and transparency of agent, broker, and web-broker marketing practices. Misleading advertisements have been a significant driver of unauthorized enrollments, often enticing consumers to provide personal information through promises of gift cards or financial incentives for health care, groceries, gas, or other expenses. In many cases, consumers may be unaware that clicking on such offers could authorize changes to their Marketplace application or coverage. Enhanced marketing standards and enforcement are critical tools for protecting consumers from deceptive practices and preventing unauthorized enrollment.

We also encourage HHS to disallow compensation for agents, brokers, and web-brokers who engage in misleading marketing. Specifically, if an agent, broker, or web-broker engages in misleading marketing for 30 days, issuers should be allowed to claw back compensation from such individuals for the period in which they engaged in prohibited marketing activity. Removing compensation is a key means of deterring fraud and will further issuer and agency efforts to deter bad actors.

Recommendation:

- **Finalize standardized consumer consent and eligibility review forms as proposed.**
- **Update oversight mechanisms to address AI-enabled fraud, including fraudulent voice calls and manipulated digital signatures.**
- **Consider two-factor or multi-device authentication for consumer verification.**
- **Finalize the proposal to strengthen marketing practice enforcement.**

Failure To File and Reconcile (FTR) Policy (§ 155.305)

AHIP supports aligning Exchange regulation with the WFTC legislation by requiring a one-year FTR process by PY 2028. A shorter FTR window reduces improper enrollments, limits inappropriate APTC payments, and helps consumers avoid unexpected tax liabilities.

We are still concerned about operational issues, ranging from timely data to Internal Revenue Service (IRS) capacity. For a one-year FTR policy to work well, the IRS must be able to check tax filing and reconciliation accurately and share that information quickly with Exchanges. Ongoing staff shortages or delays at the IRS could make it harder to determine eligibility and disrupt coverage for people who should qualify. To reduce these risks, HHS should make sure the IRS has enough resources to support the updated standard, including fast data exchanges and clear communication with affected taxpayers. Strong coordination between HHS and the IRS will be crucial to ensure the one-year FTR policy improves program integrity without causing unnecessary enrollment problems or confusion for consumers.

Recommendations:

- **Require a one-year FTR process by Plan Year 2028.**
- **Coordinate with the IRS to ensure adequate staffing, timely eligibility checks, effective data sharing with Exchanges, and clear notification to impacted taxpayers.**

Comment Solicitation on Eligibility Verification Provisions of the WFTC Legislation, Section 71303

We appreciate the opportunity to provide feedback on a critical implementation task ahead, related to section 71303 of the WFTC, which requires Exchanges to verify household income and eligibility information prior to enrollment beginning with open enrollment for PY 2028. Given the longstanding use of automatic re-enrollment in the Marketplace and other insurance markets, this requirement represents a significant change for consumers. Policies and procedures should ensure that no one loses coverage because of missed actions or deadlines. Effective implementation will require close collaboration among Exchanges, issuers, agents and brokers, EDE vendors, and other stakeholders to modify enrollment and eligibility procedures, assess operational readiness, and protect consumers during the transition.

AHIP recommends that HHS convene a working group with issuers and other relevant stakeholders to design and implement the revised re-enrollment process. AHIP has a successful track record of working closely with the Department to implement core Marketplace enrollment processes, including automatic re-enrollment, enhanced direct enrollment, and Medicaid unwinding, and we stand ready to work together to implement these changes under the WFTC. Specifically, we recommend HHS work with issuers on consumer-facing timing and process

changes to eligibility verification and reenrollment as well as the impacts to Batch Auto Re-enrollment (BAR), consumer notices, and plan selection. Ongoing and proactive communication will be critical to facilitate a smooth transition, minimize consumer confusion that could lead to coverage gaps, and fulfill statutory obligations while maintaining stability and continuous coverage within the Marketplaces.

The statute requires applicants and enrollees to annually affirm verified income and eligibility information prior to plan selection, and requires Exchanges to use trusted data sources to re-verify consumer information to minimize paperwork. We strongly recommend Exchanges pre-populate applications with data obtained from trusted sources wherever possible. Pre-population would reduce consumer burden, improve data accuracy, and minimize inadvertent errors — such as typographical mistakes or incorrect data entry — that trigger unnecessary data matching issues (DMIs) and force consumers into burdensome resolution processes. For consumers whose information is verified electronically, Exchanges should allow “one-click” verification, preserving the statutory requirement for active consumer verification while significantly simplifying the process.

We recommend HHS maintain existing verification processes. Current processes work, and the WFTC's requirement that consumers verify any inconsistency before receiving tax credits directly addresses the problem of improper enrollments. Adding new documentation requirements on top of this — such as requiring proof of the lack of employer-sponsored coverage when no employer data system exists — would contradict the statute's emphasis on electronic data sources and layer additional system complexity onto what is already a massive implementation lift. Exchanges, stakeholders, and vendors cannot simultaneously build a new pre-enrollment verification system, redesign re-enrollment workflows, and develop separate consumer and agent/broker pathways without overwhelming capacity, increasing costs, and destabilizing trusted enrollment processes. HHS should evaluate the impact of pre-enrollment verification in reducing improper enrollments before imposing additional verification requirements.

The WFTC requires Exchanges to establish a pre-enrollment verification process no later than August 1 for the upcoming plan year but does not prescribe a window during which consumers must complete verification. We recommend consumers be permitted to update and confirm their eligibility information at any time. Many Marketplace participants rely on automatic re-enrollment and do not actively return to the Exchange during Open Enrollment — requiring them to do so during the summer, when many families are traveling and planning for the school year, represents a significant behavioral shift. A narrow verification window would increase the likelihood of missed deadlines, create confusion, and lead to unnecessary coverage losses.

The statute requires active verification by new and returning subsidized enrollees but does not address automatic re-enrollment. We recommend HHS preserve automatic re-enrollment for consumers who complete pre-enrollment verification and do not actively select a new plan. Millions of consumers depend on automatic re-enrollment for continuous coverage, as they do in employer-sponsored plans. Eliminating it would disrupt coverage continuity and create unnecessary confusion — particularly for unsubsidized enrollees, for whom the statute makes no changes to existing enrollment requirements.

HHS should identify and clearly communicate which trusted data sources Exchanges may use for pre-enrollment verification. Exchanges will need adequate lead time to contract with and integrate vendors where relationships do not already exist. CMS should also consider expanding access to trusted electronic data sources to meet increased verification demand. Ongoing IRS staffing shortages risk creating processing delays that undermine verification timelines and cause unnecessary consumer disruption. Where CMS is simultaneously building verification infrastructure for other programs — such as Medicaid community engagement compliance — there may be opportunities to leverage that technology across programs.

Timely data exchange will be critical for effective implementation. Verified eligibility data must flow seamlessly among trusted data sources, Exchanges, issuers, and enrollment platforms so that stakeholders can act on it. HHS should address how verified data will be incorporated into consumer-facing notices — including the Marketplace Open Enrollment Notice (MOEN) — to reflect updated financial assistance and eligibility status. Consumer notices should also clearly explain the consequences of not completing verification (e.g., no renewal, renewal without a tax credit, or renewal into a different plan) and provide instructions for confirming status. To align issuer notices with verification timelines, we recommend HHS allow issuers flexibility to use generalized language in renewal notices, such as “if you did not verify your eligibility, your coverage or financial assistance may change.”

This new verification requirement represents a major departure from current enrollment practices, particularly for consumers accustomed to automatic re-enrollment. HHS should establish a coordinated consumer education campaign to ensure enrollees understand what is required, when action is needed, and how to maintain coverage.

Recommendations:

- **Convene a working group with Exchanges, issuers, agents and brokers, and other stakeholders.**
- **Require pre-population from trusted data sources and allow one-click verification.**
- **Allow consumers to update and verify eligibility information at any time.**
- **Preserve automatic re-enrollment.**

- **Maintain existing verification processes to promote operational stability.**
- **Clarify trusted data sources, expand access, and ensure timely data exchange.**
- **Implement robust consumer outreach and education.**

Income Verification and Attestation Provisions (§§ 155.320(c)(3)(iii) and 155.320(c)(5))

HHS proposes two related verification changes: requiring additional income verification when data sources indicate income below 100% FPL, and removing the requirement to accept attestations of household income when tax data is unavailable. We address these together because they raise similar concerns and have overlapping operational impacts.

We recommend HHS delay both proposals until it can evaluate whether recently adopted program integrity measures — WFTC pre-enrollment verification, the one-year FTR requirement, SEPV reinstatement, and strengthened agent and broker oversight — are sufficient to address improper enrollments and APTC payments. Layering additional verification before assessing the effectiveness of existing measures creates unnecessary burden for enrollees and operational complexity for Exchanges.

If finalized, AHIP recommends that HHS:

- **Make both policies optional for State Exchanges.** State Exchanges have not experienced the same rates of improper enrollment as the federal platform. Mandating these provisions would require them to build new APTC calculation logic, create verification systems, and modify timelines — complex, resource-intensive changes that are unnecessary where the underlying problem does not exist.
- **Adopt exceptions for unavailable tax data.** Tax data may be unavailable through no fault of the applicant — for example, if the applicant was not required to file a return, IRS privacy rules preclude data sharing due to changes in family composition, or an enrollee could not verify eligibility during enrollment but would have qualified based on reported income and tax return data. These situations warrant exceptions.

Recommendations:

- **Delay implementation of this proposal until HHS evaluates the effectiveness of other eligibility and income verification policies, including the WFTC pre-enrollment verification requirement.**
- **If finalized, make both policies optional for State Exchanges.**
- **Adopt exceptions for situations where tax data is unavailable through no fault of the applicant.**

Comment Solicitation on Premium Payment Threshold (§ 155.400)

Issuers should be permitted to adopt percentage-based and/or fixed-dollar premium payment thresholds to protect consumers from unnecessary coverage terminations due to financial hardship or inadvertent payment shortfalls — particularly as consumers face rising premiums following the expiration of enhanced premium tax credits. These thresholds should apply only to payments made after coverage is effectuated, preserving the binder payment requirement so that enrollees must take affirmative action to initiate coverage. Issuers need flexibility to design threshold policies that respond to their enrollees' needs and local market dynamics.

Recommendations:

- **Allow issuers to adopt percentage-based and/or fixed-dollar premium payment thresholds in PY 2027 and beyond.**
- **Continue to require binder payments to effectuate coverage prior to application of any threshold policy.**

Extend the Removal of the 150 Percent FPL SEP Beyond Plan Year 2026 (§ 155.420(d)(16))

AHIP supports permanently rescinding the 150% FPL SEP consistent with the WFTC legislation. This expansive SEP created a targeted opportunity for unscrupulous agents, brokers, and lead generation companies to exploit unsuspecting consumers. Issuers worked closely with HHS to coordinate enforcement and help consumers reinstate their original coverage. Permanent removal will ensure these protections extend beyond PY 2026.

Recommendation:

- **Finalize the proposal to permanently rescind the 150 percent FPL SEP.**

Special Enrollment Period Verification (§ 155.420(g))

AHIP supports HHS' proposal to reinstate SEPV for Exchanges on the federal platform. SEPV is an effective tool to reduce improper enrollments while supporting a stable and sustainable risk pool.

Successful implementation depends on efficient, automated verification processes. Consumers experience confusion and gaps in care when SEP enrollments are pended for extended periods, and issuers receive related complaints. Fully operational automated verification should be a prerequisite.

We also recommend HHS pair SEP verification codes with more granular codes to identify vulnerable SEPs requiring stronger verification. Some State Exchanges already transmit specific reason codes that help issuers coordinate care, identify enrollment patterns, and strengthen oversight. This information also helps issuers identify false residency schemes, in which Medicaid enrollees are improperly enrolled in Marketplace coverage in states where they do not

reside, notably in schemes often associated with body-broker activity promising access to substance use disorder treatment.

Recommendations:

- **Finalize the proposal to reinstate SEPV for Exchanges on the federal platform.**
- **Prioritize reliable automated verification processes prior to implementation.**
- **Pair SEP verification codes with more granular codes to identify high-risk SEPs.**

General Program Integrity and Oversight Requirements (§ 155.1200); State Exchange Improper Payment Measurement (SEIPM) (§§ 155.1600 Through 155.1650)

We urge HHS to clarify that enforcement actions under this provision will not extend to issuers. Oversight and corrective action related to improper APTC payments are most appropriately managed between CMS and State Exchanges, which are directly responsible for administering eligibility determinations and payment processes. Issuer enforcement is addressed in other provisions; extending it here would be duplicative and burdensome.

Recommendation:

- **Clarify that enforcement actions under this provision will not extend to issuers.**

VIII. Part 156 – Health Insurance Issuer Standards under the Affordable Care Act Including Standards Related to Exchanges

Cost Sharing for Bronze and Catastrophic Plans (§§ 156.136 and 156.155)

AHIP agrees with HHS that flexibility in bronze plan cost-sharing parameters is necessary to preserve premiums and ensure enrollees continue to have access to affordable coverage. While HHS acknowledges this is a temporary solution, we support the approach and look forward to continued dialogue on core issues of actuarial value (AV) calculation and cost-sharing interactions that will ultimately affect additional metallic levels.

An increasing share of utilization by the highest-cost enrollees requires structural policy solutions, and we look forward to discussing these proposals with HHS in greater detail. HHS should consider prohibiting drug coupons, which drive artificial cost inflation and cost-shifting: even when maximum out-of-pocket costs increase, coupon value and drug prices can increase in tandem, creating an inflationary cycle. HHS could also address the impact of third-party payments, high-cost treatments, and body-broker schemes as part of this effort. Regarding catastrophic plan cost-sharing as described earlier in our comments on Section V, there is not yet

sufficient data to evaluate the market impact. We recommend deferring implementation until additional enrollment data and a more complete regulatory framework is proposed for comment.

Recommendations:

- **Finalize as proposed the option to allow issuers that offer a bronze plan in the individual market that complies with the cost-sharing and levels of coverage requirements to also offer bronze plans in the same service area with cost-sharing designs that exceed the maximum annual limitation on cost-sharing by amounts in increments of \$50 in order to achieve an AV within the standard bronze de minimis variation.**
- **Delay catastrophic plan cost-sharing variation provisions until additional enrollment data and regulatory framework are available.**

QHP Certification of Non-Network Plans (§§ 155.1050, 155.1051, 156.230, 156.235, 156.236, 156.275, and 156.810)

AHIP supports efforts to encourage competition, lower costs, and promote innovative plan designs. However, allowing non-network plans to receive QHP certification raises fundamental concerns about consumer protection, market stability, and compliance with the ACA's statutory framework that cannot be adequately resolved within this rulemaking. We urge HHS not to finalize these provisions and instead pursue this policy through separate notice-and-comment rulemaking.

Consumer burden and financial risk. Non-network plans would shift core responsibilities from issuers and providers to consumers. A consumer who uses the plan's tool to find a provider accepting the benefit amount for an office visit could discover during that visit that the provider ordered lab work processed by a facility that does *not* accept the plan's benefit amount — leaving the consumer with an unexpected bill and no network protections or dispute resolution pathway. Under non-network plans today, enrollees must collect and submit documentation with ICD-10 and procedure codes after receiving a service; if documentation is incomplete or does not meet medical coverage guidelines, the issuer can claw back reimbursement from the enrollee. This model assumes a level of medical and insurance literacy that would be exceptionally challenging for Marketplace consumers and represents a fundamentally different experience from the one Exchange enrollees navigate today.

Compliance with existing requirements. Providers without plan contracts are not obligated to honor posted rates and can change prices at any time, exposing consumers to balance bills. It is unclear how non-network plans would comply with requirements governing network adequacy, annual and lifetime limits, maximum out-of-pocket and deductible limits, coverage of emergency services, the mental health parity requirements, Transparency in Coverage requirements, and the

No Surprises Act. More detail is needed on how non-network plans would mathematically demonstrate network adequacy, provide credible provider reference price data, establish formularies, maintain claims review and appeals processes, appropriately apply cost-sharing to out-of-pocket limits, and calculate AV using in-network benefits. HHS should clearly affirm that all consumer protections applying to networked QHPs apply equally to non-network QHPs.

Market stability. Creating a bifurcated regulatory environment where requirements are interpreted differently for non-network plans would strain market stability. Such environments increase the likelihood of gaming and underpricing, and when combined with consumer misunderstanding, may result in financial challenges for new market entrants and heightened risk of uncompensated care for providers. HHS should work with states and the NAIC to ensure new entrants are sufficiently capitalized, understand the financial commitments of QHP participation (including potential risk adjustment payments), and that states retain full approval authority over plans in their markets. Reliance on non-network plan attestations alone is not a measurable enforcement approach.

Recommendations:

- **Do not finalize non-network QHP provisions. Pursue this policy through separate notice-and-comment rulemaking that provides a detailed regulatory framework and allows stakeholders adequate time for meaningful feedback.**
- **Address applicability of existing regulatory requirements that apply to all marketplace plans.**

Strengthening HHS' Oversight of the Administration of Advanced Payments of the Premium Tax Credit, Cost-Sharing Reductions, and User Fee Programs and Clarify HHS' Compliance Review Authority (§ 156.480)

AHIP supports strengthening program integrity oversight. To balance accountability and administrative burden, we recommend HHS establish a predictable, risk-based audit cadence of every three years while retaining authority for ad hoc reviews in response to specific triggers such as credible complaints, data anomalies, or identified compliance risks. HHS should also allow issuers to consolidate multiple audits into a single audit when conducting the same review across multiple HIOS IDs with common control under a single holding company system.

Recommendations:

- **Establish a predictable, risk-based audit cadence every three years while preserving targeted review authority.**
- **Allow audit consolidation across HIOS IDs under common holding company control.**

Factors Considered in Determining the Amount of CMPs and HHS' Authority to Impose CMPs Against Issuers in State Exchanges and SBE-FPs (§ 156.805)

HHS proposes to subject issuers to federal civil money penalties for compliance with state requirements if HHS later determines those requirements conflict with its interpretation of federal law. That outcome - penalizing issuers for following the rules their state regulators set - is both unfair and legally problematic.

First, we are particularly concerned about the potential of CMPs being imposed upon QHP issuers complying with state requirements if HHS later determines those requirements conflict with its interpretation of federal requirements. We also believe it would be contrary to the statute to penalize issuers for State Exchange failures or for compliance with state guidance.³

Second, we believe HHS' existing authority to enforce the requirements in subpart E of part 156 or in § 156.50 against issuers participating in State Exchanges and SBE-FPs rests on questionable statutory authority.⁴ Absent clear statutory authorization, it is impermissible for the Secretary to interpret the statute in a way that “significantly alter[s] the balance between federal and state power” in an area of traditional state regulation, *i.e.*, health insurance.⁵ At minimum, the Secretary must clearly articulate parameters around its authority when otherwise seeking to supplant enforcement roles so that regulated entities provided requisite fair notice of their obligations.⁶ First, the Secretary should specify circumstances in which it would be appropriate to determine that a State is not “substantially” enforcing federal exchange requirements, given that minor variances in enforcement are insufficient to satisfy the statute (if it provides for any federal enforcement at all).⁷ Second, the Secretary should provide clear notice to regulated parties when enforcement shifts from a state to a federal responsibility, and vice versa, so that issuers are not arbitrarily subject to conflicting regulatory directives.

³ See *id.* § 300gg-22(b)(2)(C)(iii)(I) (precluding penalty when issuer did not know and could not reasonably have known that a “failure existed”); *United States v. Pennsylvania Industrial Chemical Corp.*, 411 U.S. 655, 675 (1973) (regulated entity entitled to raise defense that it was “affirmatively misled into believing that the [acts] in question were not a violation of the statute”).

⁴ HHS has rested this authority on § 1321(c)(2) of the Affordable Care Act. But that statute incorporates the PHS Act federal enforcement scheme, 42 U.S.C. § 300gg-22(b), only for “the enforcement under paragraph (1) of requirements of subsection (a)(1).” *Id.* § 18041(c)(2). The referenced “paragraph (1)” applies only in circumstances in which HHS both “shall ... establish and operate such Exchange within the State *and* ... shall take such actions as are necessary to implement such other requirements.” *Id.* § 18041(c)(1) (emphasis added). In other words, this enforcement authority applies only when a State has declined or failed to operate an Exchange and HHS is operating the Exchange.

⁵ See *Sackett v. EPA*, 598 U.S. 651, 679 (2023).

⁶ See *SNR Wireless Licenseco, LLC v. FCC*, 868 F.3d 1021, 1043 (D.C. Cir. 2017) (“It is a basic principle of administrative law that an agency cannot sanction an individual for violating the agency's rules unless the individual had ‘fair notice’ of those rules.”).

⁷ See 42 U.S.C. § 300gg-22(a)(2).

If HHS finalizes this proposal, we recommend a one-year safe harbor non-enforcement period so that states and regulated entities have adequate time to address any changes in regulatory scope and compliance obligations.

Recommendations:

- **Retain State Exchange authority to review and enforce Exchange operations.**
- **Refrain from expanding HHS CMP authority in ways that undermine state oversight or expose issuers to penalties for good faith compliance with state requirements.**
- **If finalized, allow a safe harbor non-enforcement period of one year so that states and regulated entities have adequate time to address any changes in regulatory scope and compliance obligations.**

Administrative Review of QHP Issuer Sanctions (§§ 156.903 and 156.935)

This provision would significantly restrict issuers' discovery rights in CMP proceedings by requiring issuers to build their entire defense from the audit record alone, precluding their ability to compel HHS to produce internal communications, reasoning regarding enforcement, and other key information.

Discovery is essential to assessing the reasonableness of a civil penalty. The statute premises judicial review of an administrative decision that was made on a full record under 5 U.S.C. § 554. *See* 42 U.S.C. § 300gg-22(b)(2)(D)(i). Without discovery, there is no mechanism for ensuring a full record was appropriately developed, and proceedings would not comply with the statute.

Recommendation:

- **Retain the discovery process for administrative appeals of proposed CMPs.**

Netting and Establishment of Debt Regulations to Include CMPs (§ 156.1215)

This provision would allow CMPs to be immediately collected, offset, or withheld from key issuer revenue streams. Some issuers may not have sufficient revenue to offset potential CMP penalties, creating risk of insolvency. To preserve Marketplace stability and continuity of coverage, HHS should allow exceptions to netting CMPs in exceptional circumstances.

Recommendation:

- **If finalized, allow exceptions to netting CMPs where there is risk of issuer insolvency.**

IX. Part 158 – Issuer Use of Premium Revenue: Reporting and Rebate Requirements

Comment Solicitation on Potential Adjustment to the MLR for a State’s Individual Market (Subpart C)

Medical Loss Ratio (MLR) reporting and rebate requirements ensure premium dollars are spent on medical care and quality improvement. The 80 percent individual market standard is appropriate in many states, but market conditions vary, as competition, enrollment trends, new entrants, and overall stability may make a lower adjustment beneficial in certain markets.

States are best positioned to determine whether MLR adjustments are necessary. The existing adjustment process is accessible, and any adjustments should be made in agreement between the state and federal government and apply equally to all issuers in the market.

Further study would help identify circumstances where a lower MLR increases affordability, competition, or stability. An analytical framework should consider whether “stabilization” should be defined narrowly (preventing systemic risk, insolvencies, or bare counties) and whether extending the measurement timeframe to five years reduces year-to-year volatility. Raising the threshold could have the opposite effect, discouraging market entry and destabilizing the markets HHS is trying to strengthen.