NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

March 13, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9883–P
P.O. Box 8016
Baltimore, MD 21244–8016

Via Regulations.gov

To Whom It May Concern:

On behalf of the members of the National Association of Insurance Commissioners (NAIC), we submit the following comments as well as the attached actuarial memo in response to the proposed Notice of Benefit and Payment Parameters for 2027 (Notice), as published in the Federal Register on February 11, 2026. NAIC represents the chief insurance regulators in the 50 states, the District of Columbia, and five United States territories.

Summary

While state insurance regulators support a number of the proposed regulatory changes included in the Notice, we highlight our concerns with four areas:

- The Notice's proposals impacting states' defrayal of the cost of benefits in addition to essential health benefits would force states to reevaluate past decisions and potentially bear new, unanticipated costs. We request alterations and clarifications to the proposal in our comments below.
- The proposals affecting catastrophic plans are not sufficiently developed and we urge delay in implementation while questions are answered.
- The proposal to allow non-network plans as qualified health plans could burden consumers' access to providers and complicate state enforcement of access standards. If this proposal is finalized, we strongly recommend maintaining state and marketplace authority to approve non-network plans and additional disclosures to consumers about how to use such plans.
- While we welcome discussion on the underlying methodology supporting medical loss ratio (MLR) requirements, we strongly oppose the idea of HHS imposing a lower MLR requirement on plans in states that have not requested an MLR adjustment.

Timing of Notice and Comment Period

As in some prior years, state regulators wish to express concern about the timing of this proposed Notice and urge the Department of Health and Human Services (HHS) to publish it much earlier in

future years. Planning for plan year 2027 is already under way. The comment period ends with little time before state filing deadlines for 2027. HHS must review the comments and publish the final rules, then states must provide guidance for carriers that reflects the final rules, and carriers must modify and submit filings to comply with the final rule. State insurance regulators as well as state-based marketplaces (SBMs) need more time with the rules in place to prepare for the filing and rate review season. And health insurance carriers need more advance notice of the rules under which they will be operating to fully weigh their options and develop appropriate plans and rates.

In addition, the brief 30-day period allowed for comment on the Notice makes it challenging for state regulators to understand and analyze complex proposals, consult with stakeholders and colleagues in other states, and provide meaningful comments. We encourage the Administration to publish future proposed Notices by the end of November and then provide a longer comment period.

Requirements for State-Based Marketplaces (155.105-155.221), State Exchange Improper Payment Measurement, and Eligibility Verification Processes

State insurance regulators generally support regulatory changes that facilitate adoption of state-based marketplaces (SBMs) and reduce the burden associated with operating them. We support removal of the requirement for an SBM to operate for one year on the federal platform before becoming a full SBM. When an SBM can show its capacity to meet all applicable requirements it should be permitted to begin full operations. We also support removal of the requirement for SBMs to provide supporting documentation since such a requirement is duplicative with the State Exchange Blueprint.

State regulators appreciate the proposed flexibility offered to states by allowing SBMs to rely on enrollment through enhanced direct enrollment entities (EDEs) rather than the SBM's own website. We support maintaining "the flexibility to determine their own business controls" while complying with Federal web-broker and EDE requirements applicable to SBMs. However, we urge HHS to update federal EDE requirements to limit improper enrollment activity. In particular, limiting the use of national producer numbers (NPNs) to agents that are licensed by the state and appointed by the appropriate insurance carrier would help to combat improper enrollments. Broadening the use of EDE without limiting the use of shared NPNs introduces greater risk of improper enrollments.

State regulators recognize the need to measure and analyze improper payments of advance premium tax credits (APTC). The proposed State Exchange Improper Payment Measurement (SEIPM) program would complement existing measures of improper payments through federally-facilitated marketplaces (FFMs). However, SBMs are already subject to extensive reporting and oversight requirements which provide HHS with detailed information on their operations. We urge HHS to eliminate duplicative data collection between SEIPM and existing reporting by SBMs. We are also concerned that implementing SEIPM will introduce significant new administrative burdens for SBMs. We urge HHS to establish a longer transition period to full operation of SEIPM and to tailor the program to reduce the compliance effort by SBMs, providing technical assistance and other support as needed.

NAIC shared its concerns with eligibility verification changes with Congress as it considered the verification changes that HHS now seeks comment on before implementing. As we stated then, state insurance regulators agree that only eligible individuals should be allowed to purchase marketplace plans and only those who meet the income, immigration status, residence, and access to coverage

requirements for financial assistance should have their premiums reduced with an APTC. At the same time, all marketplaces must be open to eligible individuals and tax credits must be available in a timely manner for those who qualify. For many consumers, marketplace coverage is their only affordable option for health insurance and unnecessary barriers to coverage will leave them without access to coverage or needed care.

State regulators urge HHS to apply maximum flexibility as the marketplaces implement requirements to verify applicants' eligibility for special enrollment periods and APTC. If applied too broadly, new requirements could prevent many consumers from accessing coverage in a timely manner. The individuals most likely to drop coverage due to the new verification requirements and changes to automatic re-enrollment are younger and healthier people who expect to use their coverage the least. When healthy individuals leave the risk pool, insurance markets are less stable and more costly for those who remain. We believe HHS should carefully weigh the risks to coverage and market stability that added verification requirements are likely to introduce and new rules should not unnecessarily limit state authority to operate SBMs.

We urge HHS to implement new verification requirements for all marketplaces in a way that complies with the law while also preserving efficient access to coverage for eligible individuals. SBMs should retain the authority to set their own verification processes to the greatest extent possible. We note, SBMs have not experienced the same improper activity as the federal marketplace—any new verification rules should take this into account. HHS rules should maintain the ability of marketplaces to automatically re-enroll individuals as frequently as possible. Automatic re-enrollment is widely used and marketplaces already verify eligibility information against trusted data sources as part of automatic re-enrollment.

SBMs will need time to implement any changes to eligibility verification rules. We ask HHS to consider comments and establish new rules quickly. If they are to be in place for plan year 2028, we urge HHS to communicate new verification rules by July 2026.

State-Required Benefits in Addition to Essential Health Benefits (155.170)

State insurance regulators oppose regulatory changes that impose new obligations on states based on decisions states made in the past in reliance on then-existing rules and guidance. We request that any changes to HHS's standards for defraying the cost of mandates in addition to EHB be applied prospectively and only to state benefit mandates adopted in the future. We strongly support maintaining paragraph 155.170(a)(3) that recognizes states as the authority in identifying which benefits are in addition to EHB. We also request that any implementation date for changes to EHB identification and defrayal guidance be delayed until at least 2028. Several states have short or no legislative sessions in 2026, and this would give state legislatures a more meaningful opportunity to consider any changes in benefit mandates and, if necessary, appropriate funds for defrayal.

We understand the proposal to rescind the changes made in the 2025 Notice of Benefit and Payment Parameters that recognized benefits included in a state's EHB-benchmark plan as essential health benefits. The 2025 change remedied a situation in which some benefits were EHB (because of their inclusion in the benchmark plan) but could simultaneously be labelled "in addition to EHB" for defrayal purposes (because they were mandated by state action). We supported the 2025 change and we believe the reasons for making that change remain valid.

At the same time, we recognize the importance of limiting premium growth for unsubsidized consumers and of establishing in regulation a clear set of standards for when defrayal is due. We

understand the proposed Notice would give states that have enacted a benefit mandate after 2011 two choices: either 1) defray the cost of the benefit and render the benefit's EHB status null and void, forfeiting the consumer protections associated with EHB status or 2) avoid defrayal by repealing the benefit mandate.

In addition to requiring defrayal payments a state may not have planned for, option 1 has other effects that impact consumers across markets and may not be desirable for a state. State-required benefits in addition to the EHB under the proposed rule would no longer be subject to protections like the prohibition on discrimination, limitations on cost sharing, and restrictions on annual and lifetime dollar limits for these benefits. The benefits would lose these protections not only in the individual and small group markets, but also when they are included in large group health insurance and self-funded health plans.

Some states also have concerns with option 2. While a repealed mandate may, for the time being, remain an EHB, states lack clarity on how long this will be the case. HHS has paused review of state requests to update EHBs under existing rules. And state regulators are aware that HHS plans to update its EHB rule. Since EHBs and the process for selecting them may be subject to change under a new rule, any formerly-mandated benefits could cease to be EHB in the future, depending on yet-unknown rules.

States have valued their role in the EHB selection process since the original EHB rule in 2014. State policymakers have carefully considered new mandates since the passage of the Affordable Care Act, taking into account the requirement for defrayal and the regulations and guidance HHS has released to interpret it, including the 2025 NBPP. States have enacted mandates to respond to recognized needs in their states and have defrayed their cost when appropriate. This proposed change would expand the set of benefits that could trigger defrayal. While, under the proposal, new defrayal would only be required for benefits delivered in plan year 2027 and after, the obligation to defray would be triggered by decisions states made in the past, under previous regulatory regimes.

We also request that HHS revise the proposal to recognize that its previous rulemaking in the 2025 NBPP has influenced state decisions. Instead of only looking back to the 2011 deadline established in the original EHB rule, HHS should also set a future date beyond which inclusion in the EHB benchmark plan no longer eliminates the need for defrayal. Such a date should be after 2027 or after states have an opportunity to select an EHB benchmark under a new EHB rule, whichever is later. Under this approach, benefits mandated by state action before 2012 would not require defrayal. Consistent with the 2025 NBPP, benefits mandated by state action from 2012-2027 would not require defrayal if included in a state's EHB benchmark plan. State actions to mandate benefits that take place after 2027 (or after a new EHB rule's selection process) would trigger defrayal when the four elements outlined in the proposed 2027 Notice are satisfied. This approach would avoid changing the rules after states have already acted and provide clear notice of the choices confronting states when they consider new mandates.

Further, a final rule must clarify the application of the elements that require defrayal and the effects of changes in state mandates. HHS should explicitly clarify that state selection of an EHB benchmark plan does not constitute "state action" to mandate benefits. And the Department should make it clear that a state's EHBs remain in full effect under the new rule should a state repeal a benefit mandate that has already been made part of its EHB.

Marketing Practices (155.220)

State regulators support the proposed strengthening of marketing standards applicable to agents, brokers, and web-brokers. The proposal would explicitly ban misleading conduct and provide examples of prohibited conduct, including cash offers, false promises of zero-premium plans, the use of false celebrity endorsements, and other improper conduct we have observed in state markets. We strongly support the proposal to make agents, brokers, and web-brokers responsible for marketing content "created, written, released, or otherwise produced" by them or on their behalf. These provisions would provide more clear authority for both federal and state regulators to investigate and take action against improper marketers.

We urge HHS to take further steps to combat improper marketing by establishing a federal prohibition on sharing national producer numbers (NPNs). NPNs are unique identifiers assigned to individuals and business entities. Improper sharing of NPNs has contributed to harmful unauthorized plan transfers. A number of states have acted to limit the practice and it would be helpful for federal officials to take similar action.

State regulators also work to combat improper marketing activity using their own authorities. They can be more effective when they can leverage information from federal investigations and enforcement activity. We request HHS to continue to improve information sharing by providing timely and complete reports of its enforcement actions against any state-licensed entities. We seek detailed information including evidence, contact information for all parties, and other records held by federal agencies. We welcome continued conversation on how we can craft information sharing agreements that facilitate timely exchange of all case files.

Provider Access Review (155.1050 and 156.230)

State insurance regulators appreciate the proposed opportunity for states to demonstrate that they have Effective Provider Access and Essential Community Provider (ECP) Review Programs and take on greater responsibilities for provider access review. States can be better positioned than federal officials to evaluate provider availability and some states have invested in their capacity to examine provider access in recent years.

We recognize that adopting rigorous standards for qualifying as an Effective Provider Access Review Program helps HHS fulfill its own responsibility under the ACA to assure plans offer sufficient access to providers. Given these rigorous standards, states will benefit from technical assistance and shared data from HHS related to provider access. We support the proposal for HHS to continue to collect provider access data from issuers serving all FFE states and to share it with state regulators. We emphasize that all FFE states would benefit from access to this data, whether the state has an Effective Provider Access Review Program, is working to develop one, or continues to rely on HHS for provider access review.

We support the Notice's proposed increases in flexibility for SBMs in their network adequacy or provider access reviews.

Catastrophic Plans (156.155, et al)

State regulators urge further consideration and consultation with stakeholders before HHS finalizes its proposed changes with regard to catastrophic plans. We believe the proposed changes raise many questions that are not answered in the Notice and will require additional analysis and further

refinement. These reforms should not be implemented until all questions have been resolved. With 2027 filing deadlines quickly approaching there simply is not enough time for market participants and regulators to adequately address all the unknowns for this cycle.

Additionally, the lack of effectuated enrollment data makes it impossible for states using FFMs to understand the current state of their markets and the full effect of the 2025 federal changes. When combined with the short comment period for the Notice, state regulators have not had adequate opportunity to provide meaningful comments on the impact of any provision that alters the availability of catastrophic plans

The proposal would expand access to catastrophic plans, introduce multi-year plans, and increase maximum allowable out-of-pocket amounts for catastrophic plans. HHS seeks comment on whether it should maintain separate risk adjustment procedures for catastrophic plans and metal level plans. State regulators emphasize that changes to the accessibility of catastrophic plans may affect the risk pool and cost of metal level plans even if catastrophic risk adjustment remains separate. If catastrophic plans gain more enrollment due to all of the proposed changes, that enrollment is likely to be healthier as a group. Metal level plans could then see increased premiums due to a less healthy enrollment group. Because APTCs are calculated based on the cost of the "benchmark" silver plan, these premium hikes will trigger an increase in federal subsidies. Consequently, while the proposal aims to offer lower-cost options to some, it would create an upward pressure on federal spending to offset the rising costs for the majority of enrollees. Combining risk adjustment procedures could even out overall risk among catastrophic and metal level plans, eroding the premium advantage catastrophic plans have demonstrated in past years.

Please see the attached memo on Key Actuarial Issues for more comments on these proposals.

Cost Sharing for Bronze and Catastrophic Plans

State regulators believe the introduction of variable out-of-pocket (OOP) limits could create confusion for regulators and insurance companies. Should variable limits be allowed, we request the nominal OOP limit be qualified as only applying to Platinum, Gold, Silver, and at least one Bronze.

We strongly support limiting the expanded Bronze OOP to ensure distinction from the proposed OOP on Catastrophic plans. For example, a 58% Bronze plan could be devised with the same or higher OOP limit than what is proposed for the 55% Catastrophic plan. From testing of the actuarial value calculator, there is no constraint on how high a bronze OOP max can be set; it is easy to design plans with a $2 million OOP max that fit within the bronze range. If the bronze OOP limit is to be expanded, it is essential that a cap be placed on it. However, there is concern with exceeding the statutory OOP limit to begin with. The increase from $10,600 to $12,000 is already significant to consumers, and our data shows that the sickest 5% of bronze members are reaching their OOP maximum.

Standardized Plan Options and Non-Standardized Plan Option Limits (156.201-202)

State insurance regulators support a flexible approach to standardized plan options that allows for variation based on market conditions in each state. The number of plan choices is more of a concern in some services areas and less in others. We support the removal of strict limits on the number of non-standardized plan options as well as the continued authority of SBMs to require standardized options.

In areas where the number of plan options is high, we support the application of a flexible meaningful difference standard. Under a flexible standard, state and federal regulators would collaborate to determine whether the number of plans submitted for certification is in the best interest of consumers. When regulators determine the number is unreasonably high, the flexible standard would require plans to be meaningfully different in cost-sharing levels, network type, or other relevant factors.

QHP Certification of Non-Network Plans (156.236)

State insurance regulators caution that the Notice's proposal to allow non-network plans to be certified as qualified health plans may challenge consumers' access to care, require significant additional disclosures before enrollment, and complicate state enforcement of provider access. If this proposal is finalized, we strongly support state and marketplace authority to determine whether non-network plans may be offered.

The proposal would create standards aimed at ensuring that non-network providers offer a benefit that a sufficient number of providers would accept as payment in full. However, state regulators are concerned that the real-world application of this benefit design will leave consumers without adequate access and/or increase consumer burden in identifying affordable providers. The preamble notes that, under this plan design, consumers would have the opportunity to negotiate on prices with providers. State regulators believe this is not a practical approach for most consumers and removes important protections. Consumers frequently lack information about what services they need before they see a provider and often do not have ready access to comparative prices for use in negotiations.

Ensuring ongoing access to a sufficient set of providers would also be a challenge, whether state or federal officials perform provider access reviews. As stated in the preamble, whether a provider will accept a certain amount as payment in full is "a moving target," subject to change by the provider at any time, for any reason. State regulators are concerned the proposal does not provide effective mechanisms for monitoring consumers' experiences with finding and using providers and the ultimate cost to the consumer.

If non-network plans are certified as QHPs, state regulators recommend that marketplaces be required to provide extensive information to potential enrollees about what to expect in using the plan. Potential enrollees should receive advice on how they are expected to interact with providers as well as access to a provider directory that lists the providers the plan has determined will accept the plan's benefits as payment in full and for which services.

Comments on Medical Loss Ratio

State insurance regulators appreciate HHS' interest in reforms to the ACA's medical loss ratio (MLR) requirements. We welcome discussion on the MLR's underlying methodology and whether it could be improved to meet the goals of ensuring that consumers and employers get value from their premium dollars. Nonetheless, we strongly oppose the idea of HHS imposing a lower MLR requirement on plans in states that have not requested an MLR adjustment. As contemplated in the ACA, states should retain the prerogative to explore MLR flexibility in collaboration with HHS, rather than HHS forcing MLR changes on states.

A broad lowering of MLRs could increase premiums and weaken consumer value protections in markets with limited competition. A lower minimum MLR could become a new pricing target rather than a mechanism to produce consumer savings.

State regulators recognize that the current approach to MLR may cause unintended consequences contrary to the statutory goals of the requirement. Issuers may meet the MLR requirement not by reducing administrative costs or profits, but instead by increasing provider payments or other claim costs or quality improvement payments. Sometimes these payments go to providers within the same vertically integrated ownership group as the issuer, subverting the purpose of MLR requirements.

We welcome collaboration with HHS on ways to improve the underlying MLR methodology to prevent "gaming" and unintended consequences but oppose any HHS action to force states to adopt lower MLRs. The attached memo on Key Actuarial Issues provides further comments on this topic.

Thank you for your consideration of our comments in this letter and in the memo below. We look forward to continued collaboration between state and federal regulators to improve health insurance markets and better serve consumers.

Sincerely,

Scott White
NAIC President
Commissioner
Virginia Bureau of Insurance

Elizabeth Kelleher Dwyer
NAIC President-Elect
Director
Rhode Island Department of Business Regulation

Jon Pike
NAIC Vice President
Commissioner
Utah Insurance Department

Michael Wise
NAIC Secretary-Treasurer
Director
South Carolina Department of Insurance

Risk Adjustment Individual Market Risk Pools

We believe the individual catastrophic and non-catastrophic pools should be maintained separately unless combining calculations would improve market stability without material cross-subsidies or transfer volatility.

Because catastrophic and non-catastrophic plans differ in eligibility, benefit design, and enrollee behavior, combining calculations could shift transfers from reflecting relative morbidity toward reflecting structural plan differences unless supported by credible data and appropriate guardrails, including the potential impact on catastrophic enrollment and risk profile. Actuarial considerations for any change include comparability of plan liability, risk pool composition and selection dynamics, and interactions for states with merged markets.

Because the specific policy objective(s) were not identified, we recommend CMS provide a description of such objectives in order to properly evaluate the proposal.

Cost Sharing Reduction (CSR) Load in URRT

While we support greater transparency and CSR load reporting, we are concerned the proposal goes beyond standardized reporting and may establish a single acceptable CSR loading methodology, potentially preempting State-directed, actuarially-justified approaches permitted under State law. While we agree that plan-level adjustments to account for unreimbursed CSR amounts are permissible only if actuarially justified under 45 CFR § 156.80(d)(2)(i), in states with Effective Rate Review Programs, the State retains primary responsibility to review the actuarial justifications under 45 CFR § 156.80(d). Any changes to the Unified Rate Review instructions should not inadvertently preempt the State's responsibility.

We suggest CMS not provide a description of what constitutes "actuarially justified" or "actuarially sound." In actuarial practice, those phrases are commonly understood as actuarial opinions rendered by qualified actuaries under professional standards and supported by defined scope, relevant data, explicit assumptions/methods, and disclosures of limitations. The proposal's nationwide assertion of what is "actuarially justified" risks implying an actuarial certification that could be read as overriding state-specific actuarial determinations.

We further recommend that the new CSR-loading data elements be stored in a new URRT worksheet, allowing existing tabs to remain unchanged to minimize disruption and rework for states and issuers.

Plan-Level Adjustments for Multi-Year Catastrophic Plans

While states generally support flexibility in plan design, we encourage any approved term-length adjustment under 45 CFR § 156.80(d)(2)(ii) to consider single risk pool requirements, including interaction with pooling and uniformity concepts across an issuer's catastrophic plans. Additionally, it should be made clear how any such plan-level index rate adjustments differ from plan adjustments to AV and Cost Sharing Design of Plan factors for multi-year terms.

We understand the intent of the term-length factor in § 156.80(d)(2)(ii) is to adjust for multi-year contract and benefit characteristics. However, section III.E.2 mentions "risk profile" which may suggest morbidity/selection-based plan-level adjustments would be allowed. If CMS intends "risk profile" to support any morbidity/selection-based plan-level adjustment, we request clarification on how CMS would align (and, if needed, reassess) catastrophic risk adjustment so morbidity is not addressed twice. This is a key consideration of whether catastrophic transfers should remain calculated separately from non-catastrophic plans. Plan design expected cost differences (attributable to contract term and cost-sharing structure), including utilization differences associated with plan generosity, are distinct from morbidity/health-status differences driven by enrollee selection. Plan-level adjustments can be compatible within a single risk pool when they are limited to these plan design/contract features and applied consistently; adjustments that reflect morbidity/selection risk can function as indirect health-status rating and can overlap with (or counteract) the intended role of catastrophic risk adjustment.

Finally, we encourage adding a brief clarification describing the types of documentation that would generally support a term-length adjustment (for example, key assumptions, rationale, and how the adjustment avoids double counting and is applied consistently within a single risk pool), without prescribing a specific actuarial method.

Multi-Year Terms for Catastrophic Plans to Improve Health

Given the administrative barriers, potential solvency risks, and the complexity of pricing multi-year risk, states request multi-year terms for catastrophic plans remain strictly optional for states and issuers. And given the breadth of impacts and the clarifications and complexities involved, if the proposal is finalized without the optionality for states and issuers, we recommend delaying the implementation of multi-year terms for catastrophic plans.

Should these features be implemented, we request clarification on how guaranteed renewability and product discontinuation/ market exit rules are intended to apply to multi-year contracts and the associated consumer protections expected in that circumstance. Multi-year designs can create consumer expectations that value will accrue over time (for example, if cost sharing is structured to be less burdensome later in the term). If a product can be discontinued mid-term without an explicit run-off approach, enrollees may not be able to realize the benefit trajectory that was offered at enrollment. This risk is structural and is not fully addressed through general disclosures. This concern

is amplified if premiums are structured to effectively average premiums across the contract term (for example, level premiums) while meaningful cost-sharing value is backloaded to later years.

We further request specific guardrails and minimum disclosures that are clear, administrable, and reviewable by State regulators for "average-over-term" cost-sharing designs, specifically:

- Define the permitted unit of application (for example, whether "monthly" application is permitted and how it interacts with annual cost-sharing accounting and accumulation).
- Specify whether the MOOP and/or deductible may vary by contract year and, if so, define minimum boundaries that prevent extreme front-loading of cost-sharing exposure. Clarify whether the MOOP and deductible averaging approach must be the same or if the approaches can be chosen separately.
- Confirm nondiscrimination constraints that apply to any time-varying cost-sharing design and clarify whether designs that vary by disease/condition would be permissible in practice.
- Require standardized disclosure at enrollment of the full MOOP/deductible (and any other material cost-sharing features), including clear statements of what can change mid-term and under what conditions.

We also request clarification of what premium adjustment structures are intended to be permissible during a multi-year catastrophic contract term and what issuers should file (at a high level) so State rate reviewers can evaluate the product using existing rating/single risk pool frameworks.

Multi-year contracts can create incentives to front-load premiums or to adjust them later in ways that induce lapses before later-year value accrues. In addition, if a multi-year plan uses a premium structure that effectively averages premiums over the contract term (for example, a pre-specified level premium schedule), consumers may implicitly pre-fund later-year value, which heightens the importance of clear run-off/transition protections and transparent premium change rules. Even when individual-level health status rating is prohibited, product-level premium patterns can still undermine consumer expectations and market stability.

Multi-year plans also introduce complexities regarding risk adjustment and MLR reporting/rebates. We encourage specification of the operational approach for how multi-year catastrophic plan enrollment and claims will be treated under these programs. If these cannot be specified for PY2027 implementation, states would encourage delaying multi-year catastrophic plans until these program interactions are addressed. Without explicit program treatment, issuers and regulators could face avoidable uncertainty, and the policy could create unintended incentives that destabilize the catastrophic segment. For example, if a plan is designed with a higher MOOP in early years (lower claims) and a lower MOOP in later years (higher claims), an annual MLR calculation might trigger rebates in the early years, even though the issuer expects higher losses later. A multi-year aggregation method for MLR reporting for these specific blocks could be more appropriate.

Finally, we encourage resolution of other multi-year term plans concerning catastrophic plans, such as those related to issuer discontinuation, risk adjustment, proposed plan-level index rate

adjustments, multi-year cost shares, multi-year premium adjustments, rate review documentation, and MLR treatment prior to extending standards to metal level plans.

Cost Sharing for Bronze and Catastrophic Plans

States believe the introduction of variable out-of-pocket (OOP) limits could create confusion for regulators and companies. Should variable limits be allowed, we request the nominal OOP limit be qualified as only applying to Platinum, Gold, Silver, and at least one Bronze.

We agree limiting the expanded Bronze OOP would be appropriate to ensure distinction from the proposed OOP on Catastrophic plans. For example, a 58% Bronze plan could be devised with the same or higher OOP limit than what is proposed for the 55% Catastrophic plan.

The proposed flexibility for bronze and catastrophic plans, including multi-year catastrophic plan options and cost-sharing adjustments, may support enrollment stability and plan continuity. At the same time, the interaction with affordability standards and consumer cost exposure should be reviewed carefully to avoid unintended consequences. These considerations may be particularly relevant for smaller or geographically isolated markets where issuer participation is limited. CMS should consider revising the AV Calculator to use a single baseline continuance table with explicit, metal-level induced demand adjustments. This directly relates to CMS's cited drivers for the proposed bronze/catastrophic cost-sharing (MOOP-related) changes (year-over-year AV drift, AV Calculator constraints that force benefit redesigns, and reduced metal-tier comparability) by separating the common risk-pool cost distribution from tier-specific utilization effects. This approach could also improve transparency, stability, and alignment between AV certification and standard single-risk-pool pricing mechanics.

Adjustments to Minimum Medical Loss Ratios (MLR)

We believe states should initiate minimum MLR adjustments when the state determines it necessary to promote market stability. We do not support CMS initiating changes to minimum MLR standards without state involvement. States are most familiar with their markets and best suited to evaluate changes to minimum MLRs on issuer participation, competition, and solvency.

We note that broad lowering of the Federal individual market MLR standard, without guardrails, could create a material risk of higher premiums and weaker value protections, particularly in markets with:

- constrained issuer negotiating power due to provider consolidation or shortages,
- declining or volatile individual market enrollment,
- limited issuer competition, and/or
- rising medical prices (especially provider prices) that far outweigh what insurers could save by making small cuts to administrative expenses.

In such conditions, lowering the threshold can be priced into premiums: it increases the share of premium that can be retained for non-claims costs, and in markets with limited competitive pressure that allowance can become a new pricing target. This can raise premiums for the same underlying claims costs and weaken the MLR's role as a consumer value backstop.

Additionally, increasing the Federal individual market MLR standard above 80% could produce short-term premium pressure and/or higher rebates in some markets, but it also reduces the room for administrative costs and margin and may increase issuer exit risk, especially for smaller issuers or fragile/rural markets. If exit occurs, reduced plan availability and competition can offset any near-term gains and contribute to higher premiums over time.

Definition of "market stability"

We recommend CMS redefine "stability" for Subpart C to include one or more of the following:

- Premium stability and affordability, including gross premium growth (before subsidies) and net premium burden (after subsidies)),
- Prioritized access to and use of high-value care (including whether enrollees can get timely, in-network primary care, preventive services, and other evidence-based services expected to improve affordability and reduce morbidity over time), and
- Plan availability and competition (issuer participation, county-level plan availability/plan count, recognizing rural or geographically challenging counties often have fewer options, and market competition).

CMS should then calibrate evidentiary requirements based on which stability dimensions the State is addressing, rather than relying on a single narrow framework.

Streamlining the Waiver and Renewal Process

We support the change allowing States to request waivers for up to 5 instead of 3 MLR reporting years. We also recommend CMS add a streamlined renewal provision: if the State demonstrates meaningful progress on the metrics used to justify the adjustment (and no material consumer harm), renewal should be available for an additional 5 years with minimal disruption and without restarting the process from scratch.

We also support reducing the information required regarding the State's individual market and revising the criteria used to evaluate requests, such as:

- permitting States to cite existing rate review documentation, issuer MLR filings, and Exchange market data as primary evidence,
- allowing a standardized "core packet" with optional modules depending on the type of proposal, and

- establishing a CMS technical assistance process (pre-submission consultation) to reduce rework and uncertainty.

Regarding modifying the criteria in § 158.330, we recommend revising criteria so that States may support pilot proposals through:

- actuarially sound theory and prospective analysis,
- reasoned expert evaluation,
- identification of market failures and incentive misalignment, and
- a clear monitoring and fail-safe framework, even when historical data cannot fully demonstrate the outcome before the fact (which is often the case for innovation pilots).

Sequestration and Risk Adjustment Fee

Under Part 153, continuation of sequestration and the 5.7 percent rate applied to FY 2026 resources will continue to affect transfer amounts. For smaller or limited markets, this may have a more noticeable effect on issuer margins. Ongoing monitoring of solvency and market participation is advisable. The proposed risk adjustment user fee of $0.20 PMPM for the 2027 benefit year appears aligned with administrative cost recovery. However, when viewed alongside other federal adjustments, cumulative impacts on premiums should be considered.