FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

March 13, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via regulations.gov

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

Dear Administrator Dr. Oz:

As the longtime national, non-partisan health care consumer advocacy organization, Families USA appreciates the opportunity to comment on the 2027 Notice of Benefit and Payment Parameters (NBPP) proposed rule.

For more than 40 years, Families USA has worked to improve the health and health care of the nation. We are committed to ensuring that consumers have access to high-quality, affordable coverage that protects their health and financial security.

Many of the policies proposed in the 2027 NBPP, individually and taken together, would substantially undermine coverage and the overall individual insurance marketplaces by weakening consumer protections, increasing plan design flexibility without adequate safeguards, and shifting oversight responsibilities away from federal standards. While these proposals are framed as reducing regulatory burden and increasing innovation, several of the changes would likely increase consumer confusion, weaken market transparency, and expose consumers and patients to greater financial risk at a time when our nation's families are begging lawmakers to lower their health care costs, not increase them. If finalized, this proposed rule would systemically destabilize many of the core components of the Affordable Care Act (ACA) marketplace which ensure its success including clear plan comparisons, strong consumer protections, and robust regulatory oversight.

Families USA therefore urges the Centers for Medicare & Medicaid Services (CMS) to reconsider many of the changes proposed in this rule. Specifically, CMS should withdraw or substantially revise several provisions that would undermine access to comprehensive, affordable coverage, and weaken consumer protections in the marketplaces.

Families USA offers comments on the following sections of the proposed rule:

- Discontinuation of Standardized Plan Options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, 156.202, and 156.265(b)(3)(iv)))
- Comment Solicitation on Potential Adjustment to the MLR for a State's Individual Market (Subpart C)
- Submission of Rate Filing Justification (§ 154.215)

- Amending Requirements for State Exchanges to Operate a Centralized Eligibility and Enrollment Infrastructure (§§ 155.205(b) and 155.221(k))
- Proposals Related to Creating Standards of Conduct Related to Marketing (§ 155.220(j)(3))
- Provision of EHB (§ 156.115(d)) and Additional Required Benefits (§ 155.170)
- Network Adequacy Standards and Use of Non-network Plans (§§156.230, 156.235, 155.1050, 156.230, 156.235, and 156.236)
- Proposals and Comment Solicitation Regarding Catastrophic Plans (§§153.320, 155.605, 156.80, 156.130, 156.155, 156.605)
- Data Matching Issues (§§155.320 (c)(3)(iii) and 155.320(c)(5))

Discontinuation of Standardized Plan Options (§§ 155.20, 155.205(b)(1), 155.220(c)(3)(i)(H), 156.201, 156.202, and 156.265(b)(3)(iv)))

CMS proposes to eliminate the requirement that Qualified Health Plan (QHP) issuers in the Federally Facilitated Exchanges (FFE) and State-Based Exchanges on the Federal Platform (SBE-FP) offer standardized plan options beginning in plan year 2027. CMS also proposes to remove limits on the number of non-standardized plans issuers may offer.

Families USA strongly opposes these proposals. Standardized plans are a key consumer protection that improves the ability of individuals and families to compare health coverage options and access needed services at predictable cost-sharing levels.[1]

A central challenge facing consumers in the marketplace is the complexity of plan choice. Marketplace shoppers in many areas face dozens, and in some cases more than one hundred, plan options with varying deductibles, copayments, and coinsurance structures.[2] Research has consistently shown that excessive choice can lead to poorer decision-making, with consumers more likely to select plans that do not meet their health or financial needs. Standardized plans were developed to help address this problem by establishing consistent cost-sharing structures across insurers.[3] By holding deductibles and copayment structures constant, standardized plans allow consumers to compare plans primarily based on premiums and provider networks, factors that allow consumers to more meaningfully evaluate plans.

Enrollment assisters and navigators consistently report that standardized plans significantly simplify plan comparisons and reduce confusion during the enrollment process.[4] Marketplace enrollment data from 2025 indicates that more than 8 million consumers have selected these standardized plan options.[5] Even consumers who ultimately enroll in non-standardized plans benefit from the availability of standardized plans because they provide a clear benchmark against which other plan designs can be compared.[6]

Standardized plans also improve access to care by requiring certain commonly used services—including primary care visits, specialist visits, mental health services, urgent care visits, and generic prescription drugs—to be covered with fixed copayments before the deductible.[7] This plan and cost sharing structure is critical given that it is well established that high deductibles discourage patients from seeking necessary care, including critical preventive health and chronic disease management services.[8] By reducing upfront cost barriers for routine services, standardized plans help ensure that consumers and patients can access care earlier, which can reduce downstream health costs.[9]

In its proposed rulemaking, CMS justifies its proposal to eliminate standardized plans on the basis that they may contribute to excessive numbers of plan offerings in the marketplaces.[10] However, if that is the concern, CMS should instead withdraw its concurrent proposal to eliminate limits on non-standardized plan offerings, which would likely increase, not reduce, the number of plans available to consumers.[11] We agree with the academic research that shows limiting the number of plan choices can improve consumer decision-making, but we also emphasize that standardized plans provide help for consumers in making sense of a multiplicity of plans. As such, we strongly oppose CMS's proposal and its justification that focus on only eliminating the more comprehensive benefits promised through standardized plans while simultaneously allowing non-standardized plans to proliferate and create more complexity for consumers.

Eliminating standardized plans would only serve to increase consumer confusion, reduce transparency in plan comparisons, and weaken access to affordable routine care for our nation's families. As a result, **Families USA strongly opposes CMS's proposal to eliminate standardized plans and recommends that CMS maintain the requirement that issuers offer standardized plan options, and that CMS retain limits on non-standardized plans to preserve meaningful consumer choice and protect access to care.**

Comment Solicitation on Potential Adjustment to the MLR for a State's Individual Market (45 Part 158 Subpart C)

CMS requests comments on whether the federal Medical Loss Ratio (MLR) standard should be adjusted for individual markets in particular states and whether such adjustments should be allowed for longer periods of time.

Under Section 2718 of the Public Health Service Act, health insurers in the individual market must spend at least 80 percent of premium revenue on clinical services and activities that improve health care quality. If insurers fail to meet this threshold, they must provide commensurate rebates to consumers. The MLR standard plays a critical role in protecting consumers from excessive and inflated premiums and ensuring that premium dollars are used primarily for medical care rather than administrative expenses or profits.[12] **Families USA strongly opposes any reduction in the federal MLR standard for the individual market.** Lowering the MLR threshold would allow insurers to retain a greater share of premium revenue for administrative costs and profits, reducing the value consumers receive from their coverage.[13]

CMS accurately acknowledges in its proposed rule that no states have recently requested adjustments to the individual market MLR standard as a mechanism to stabilize their markets.[14] This fact counters CMS's suggestion that the existing standard has posed a barrier to the stability of the individual market. Moreover, allowing lower MLR standards would only serve to weaken incentives for insurers to control administrative costs and would undermine consumer confidence in marketplace coverage. If states were permitted to lower the MLR threshold, consumers could pay higher premiums without receiving additional medical benefits, exposing them to higher cost care with less access to needed services.[15]

CMS also seeks comment on whether catastrophic plans, and specifically its new proposal under §§ 156.130(c) and 156.155(a)(6) of this rule for multi-year catastrophic plans, should be subject to different MLR requirements (see our detailed comments on these sections of the rule below). **Families USA strongly opposes any policy that would allow catastrophic plans to operate under lower MLR standards—especially since catastrophic plans already expose enrollees to very high deductibles and**

cost-sharing requirements. Further exposing consumers to any increased costs would only deepen their financial insecurity at a time when consumers and patients need greater protections from rising health care costs.[16] Allowing insurers to spend an even smaller share of premiums on medical care would further weaken the value of these plans and expose consumers to greater financial risk.[17] **We strongly recommend that CMS maintain the existing 80 percent MLR standard and not allow lower MLR thresholds for catastrophic or other marketplace plans.**

Submission of Rate Filing Justification (§ 154.215)

CMS proposes to collect additional information regarding how issuers calculate the "CSR load factor" used to account for the costs of unreimbursed cost-sharing reductions.

While Families USA supports efforts to improve transparency in rate filings and to ensure that pricing methodologies are actuarially justified, we urge CMS to ensure that any new requirements remain consistent with the ACA's statutory requirement for insurers to treat all enrollees in the individual market as part of a single risk pool.

States have adopted a range of approaches to incorporate the cost of unreimbursed cost-sharing reductions into premiums including "silver loading" which concentrates CSR costs in silver-tier plans while allowing premium tax credits to increase accordingly.[18] This approach has helped many consumers obtain lower premiums in bronze and gold plans and has improved affordability for millions of marketplace enrollees.[19]

As CMS notes, some issuers have priced silver level on-exchange plans based on the utilization they anticipate among silver plan enrollees alone, while others have priced the increased utilization across all metal levels in the individual market (a "single risk pool"). We anticipate that state loading policies may change further as consumers make different enrollment choices. We urge CMS to continue to allow states to consider the claims experience of all enrollees in all health plans and at all metal levels to be members of a single risk pool in setting metal-level plan rates, as this approach is consistent with the law and is advantageous for many states' marketplace populations.

The Affordable Care Act at Section 1312(c) and Regulation § 156.80(a) explicitly states that an issuer must consider the claims experience of all enrollees in all health plans to be members of a single risk pool. It further states in § 156.80(d) that issuers may vary premium rates only by five listed factors, which do not include actual plan-level experience. Calibrating the CSR load factor on the actual claims experience of those enrolled in silver plans (the only plans eligible for CSRs) would create a separate risk pool. In practice, this approach results in mispriced silver plans relative to bronze and gold plans and can cause 97% of marketplace consumers to spend more for coverage.[20] **As a result, Families USA recommends that CMS allow states to continue using approaches that treat all individual market enrollees as part of a single risk pool and that support stable and affordable marketplace premiums.**

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

CMS proposes to remove the requirement that all State Exchanges operate a centralized, consumer-facing eligibility and enrollment platform. Under the proposal, states could instead rely entirely on privately operated web-broker platforms using an Enhanced Direct Enrollment (EDE) model. **Families**

USA strongly opposes this proposal to allow state marketplaces to rely entirely on private web brokers' platforms.

Maintenance of a state-run platform creates legitimacy, supports better oversight, and builds consumer trust. Allowing private companies to operate their own enrollment and eligibility platforms, with no option for consumers in the state to instead use a government-run platform, may cause confusion for prospective enrollees, lead to significant marketplace attrition and invite new opportunities for bad actors to engage in fraud and deceptive practices.

Such web brokers are unlikely to serve all the functions of a public platform. Unlike a state-operated platform, EDE platforms have no obligation or financial incentive to help direct prospective consumers who are eligible for other types of coverage to those programs.[21] For example, when Georgia proposed to move to an EDE platform in 2022, researchers estimated losses of 4.4 to 8.3% in individual market enrollment in 2023, and continued enrollment losses of 8.4% annually from 2024 to 2027.[22] Coverage losses in Medicaid could be particularly acute as web-brokers do little to support Medicaid enrollment since they are not compensated for directing Medicaid-eligible enrollees into Medicaid coverage.[23] Instead, some brokers might even direct Medicaid-eligible populations into non-marketplace coverage they offer.[24] Importantly, CMS's proposal does not address how states might mitigate coverage losses during a future transition away from operating a centralized, consumer-facing enrollment platform suggesting that coverage losses may in fact be the goal.

Of further concern, many operators of Direct Enrollment (DE) and EDE platforms have deeply problematic track records of anti-consumer behavior, with many engaging in deceptive if not illegal marketing practices that put consumers at risk.[25] Some DE platforms have used screening tools to direct consumers away from marketplace options or collect personal and health information to sell non-marketplace plans to consumers later.[26] Notably, web-brokers using DE and EDE platforms have been associated with significant marketplace fraud, including some of the more than 90,000 instances of unauthorized plan switches and more than 180,000 instances of unauthorized enrollment between January and August 2024.[27] This widespread fraud led to the suspension of 850 agents and brokers and two EDE enrollment websites by CMS in 2024,[28] though under the Trump administration, all 850 of these agents and brokers were reinstated.[29]

Families USA has significant concerns that some agents and brokers using EDE platforms will continue to commit enrollment fraud or other types of deceptive marketing and enrollment practices, given the minimal punishment they have thus far faced amidst hundreds of thousands of cases of fraud and evidence of other practices harmful to consumers. **As a result, Families USA strongly opposes this proposal and recommends that CMS rescind this proposed change in order to protect consumers from falling prey to fraudulent actors.**

<u>Proposals Related to Creating Standards of Conduct Related to Marketing (§ 155.220(j)(3))</u>

CMS proposes to align the definition of "sex" with Executive Order 14168[30] by removing language from § 155.220(j)(2)(i) that defines the term "sex" to include sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes. CMS further states that they "do not believe this change would result in or facilitate any discrimination against consumers."

Families USA opposes this change. The removal of language related to sex characteristics, sexual orientation and gender identity from the definition of "sex" dehumanizes transgender, nonbinary, and intersex people and defies medical and scientific consensus on the understanding of sex and gender.[31]

Families USA strongly recommend CMS rescind this proposed change.

Proposals Related to Provision of EHB (§ 156.115) and Additional Required Benefits (§ 155.170)

CMS proposes to restrict pathways for states to update Essential Health Benefit (EHB) benchmark plans without being required to defray the costs. and to prohibit states from including routine adult dental services as EHB. **Families USA strongly opposes these proposals to limit the ability of states to update and improve essential benefits.**

The ACA established Essential Health Benefits to ensure that health insurance plans provide comprehensive coverage across ten core benefit categories. The EHB framework also allows states to update their benchmark plans to reflect evolving medical standards and changing health needs.[32] In recent years, several states have used this flexibility to improve coverage for important services, including hearing aids, prosthetic devices, and treatment for substance use disorders.[33] As medical knowledge advances, patients, especially those with chronic conditions like diabetes, will need benefits to be revised and updated. These updates reflect advancements in clinical care and respond to longstanding gaps in coverage that can affect health outcomes.[34] If finalized, this proposal would prevent states from improving EHBs to be on par with other states or meet current clinical guidelines for services that are shown to improve health outcomes and reduce costs for patients—services like routine adult dental coverage.[35] Importantly, poor oral health is associated with a range of serious medical conditions, including cardiovascular disease, diabetes complications, and adverse pregnancy outcomes.[36] Expanding access to dental care is one of the best interventions states and policymakers have to improve population health while reducing long-term health care costs.[37]

Further, the proposed changes would create confusion and uncertainty among states regarding how to clarify or improve EHBs to be equal in scope to benefits provided under employer-based plans and as to what requires defrayal of costs by the state. The lack of clarity around these issues will stifle action by states to improve EHBs. **As a result, Families USA strongly opposes this proposal and recommends that CMS preserve states' flexibility to update EHB benchmark plans, and to specifically preserve coverage of routine adult dental services.**

Proposals Regarding Network Adequacy Standards (156.230, 156.235, 155.1050, 156.230, 156.235, and 156.236)

Scaling Back Federal Review and Deference to States for Network Adequacy

CMS proposes to defer network adequacy reviews to states and reduce federal requirements for quantitative network adequacy standards. **Families USA strongly opposes these proposals to scale back review requirements for network adequacy, a fundamental patient protection to ensure access to care.**

Network adequacy standards are critical to ensuring that insurance coverage translates into meaningful access to care. Without sufficient provider networks, enrollees may face long wait times, excessive travel distances, or an inability to obtain appointments with needed specialists.[38]

Federal quantitative standards such as time and distance requirements and appointment wait time standards provide an objective framework for evaluating network adequacy. Eliminating these standards could result in inconsistent oversight across states and reduce accountability for plans that fail to maintain adequate networks.[39]

Importantly, secret shopper surveys have proven to be an effective tool for verifying whether providers listed in plan directories are actually accepting new patients and participating in plan networks. These surveys have found significant inaccuracies in provider directories, particularly for mental health services.[40] For example, in a 2018 survey, about half of privately insured English-speaking people in health plans with provider networks reported inaccuracies in insurers' mental health provider directories; though they were unlikely to file grievances, those experiencing inaccuracies were four times as likely as other patients to receive surprise bills.[41] More recently, the New York State Attorney General used a secret shopper survey to monitor ghost networks in 2023, and found that among 13 health plans surveyed, the number of mental health providers who accepted new patients ranged from 0 to 35 percent. As a result, the New York Office of the Attorney General recommended several changes to better support network adequacy including regular audits of provider networks including secret shopper surveys, robust appointment time wait standards, regular analysis of network adequacy indicators, vigorous enforcement, and a centralized provider directory among plans.[42]

In fact, secret shopper surveys have been so effective they became a federal standard for Qualified Health Plan (QHP) certification in 2025.[43] Furthermore, secret shopper surveys are an important tool in ensuring compliance with the No Surprises Act, which requires that plans and providers regularly update information about providers that participate in a given plan. As a result, maintaining strong oversight tools such as secret shopper surveys is essential to ensuring that provider networks function as advertised. All Americans should have these basic patient protections to safeguard access to care, and to ensure that federal laws are followed, even if they live in states that don't have the capacity or commitment to do such reviews at the state level.

As such, **Families USA urges CMS to maintain quantitative measures, including the availability of in-network appointments as measured by secret shopper surveys, as a requirement for both federal and state exchanges' oversight of QHPs.**

- **Furthermore, criteria for an "effective provider access review program" under §155.1050 should include oversight of provider availability throughout the plan year.**
- **Rather than eliminating network adequacy requirements, we urge CMS to make plan network adequacy measures more transparent**. For example, since 2019, marketplaces have displayed some plan quality information to shoppers through a star rating system.[44] The quality rating system that CMS currently uses displays an overall rating of member satisfaction with "ease of getting appointments and services" that is based only on a telephone survey of enrollees.[45]
- **Finally, we recommend that CMS incorporate the results of secret shopper surveys into public plan ratings as they are a much more thorough measure of appointment availability and network adequacy.**

Diminution of Essential Community Provider Standards (156.235)

CMS proposes to reduce the minimum percentage of Essential Community Providers (ECPs) with which plans must contract from 35 percent to 20 percent (including 20 percent of family planning providers, 20 percent of Federally Qualified Health Centers, and 20 percent of other available essential community

providers). **Families USA strongly opposes this change as it would threaten stability of key community providers and jeopardize patient access to care.**

Essential Community Providers including community health centers, family planning providers, rural clinics, and safety-net hospitals serve millions of low-income and medically underserved patients. They offer important services including hemophilia treatment, mental health and substance use disorder treatment, rural emergency care, family planning, and other care that is in short supply and/or that serves low-income enrollees.[46] Reducing contracts of essential community providers would further threaten access to care for underserved populations, harming health and driving health care costs in the long-term as patients without affordable access to timely treatment delay needed care until they are much sicker and forced to seek care in an emergency setting.[47] For example, Federal Qualified Health Centers (FQHCs) provide comprehensive primary care as well as ongoing medical, dental, and behavioral care to about 32 million patients. About 22% of Health Center patients have private insurance, including through the marketplaces.[48] If this rule is implemented, it would further diminish essential community providers' contracts and revenues, likely forcing some FQHCs to cut hours, eliminate services, or go out of business altogether.[49]

Allowing Non-Network Plans in the Marketplace

Families USA strongly opposes CMS's proposal to allow plans without traditional provider networks to participate in the marketplaces.

Traditional insurance networks provide consumers with clear information about which providers participate in their plans and protect consumers from unexpected costs by establishing negotiated payment rates. Allowing non-network plans to participate in the marketplace would undermine these protections and expose consumers to unpredictable and unnecessary medical bills and financial risk.

Although the proposal attempts to establish guardrails requiring plans to demonstrate that some providers would accept the plan's payment rates, these safeguards do not guarantee that consumers will be able to access providers without additional charges throughout the plan year. Additionally, the interaction between non-network plans and existing consumer protections such as the No Surprises Act is unclear at best. Because many surprise billing protections rely on the distinction between participating and non-participating providers, introducing non-network plans could create gaps in consumer protections.[50,51]

Unless and until comprehensive safeguards are established, CMS should not permit non-network plans to participate in the ACA marketplaces.

<u>Proposals and Comment Solicitation Regarding Catastrophic Plans (153.320, 155.605, 156.80, 156.130, 156.155, 156.605)</u>

CMS proposes to expand eligibility for catastrophic plans, increase allowable cost-sharing, and allow catastrophic plans to be sold with multi-year terms of up to ten years. **Families USA strongly opposes these proposals to allow for even more ultra-high deductible and skimpier catastrophic plans.**

Catastrophic plans are designed to provide limited coverage for very high-cost events and currently have extremely high deductibles. Because these plans provide little coverage for routine services, they offer

limited financial protection for most households. These health plans should be available in very limited circumstances given their high cost and lack of comprehensive coverage.

Most households do not have sufficient savings to pay the maximum out of pocket limit in private health plans – which is also the deductible that people must meet before a catastrophic plan pays for anything except preventive care.[52] Further, even now, a significant number of insured adults go without needed care: 25% of insured adults say they delay or forgo some health or dental care due to cost and 10% of insured adults report difficulty paying medical bills.[53] Catastrophic plans by definition leave people more exposed to such cost barriers. Wisely, few people enroll – they prefer bronze plans that cover more care at a similar premium.[54] Expanding eligibility for catastrophic plans to people with incomes below poverty or above 250% of poverty will expose more people to unaffordable costs of care. Increasing the deductibles and out-of-pocket limits beyond what is currently allowed by regulations and statute will cause them further harm.

Allowing multi-year catastrophic plans would create new challenges for consumers whose health needs change over time. For example, individuals may wish to switch plans during open enrollment if they develop chronic conditions or require more comprehensive coverage. However, multi-year plan structures would create financial incentives that discourage consumers from switching plans even when their health needs change and would lock consumers into high-cost health plans that don't serve their health needs over many years. For example, consider a person who was believed to be in good health, until they suffered a stroke. As of 2024, the cost of an initial hospital stay for a stroke among people with spasticity was $62,875 per patient; and beyond the hospital stay, these patients incurred about $12,630 of care costs.[55] Such costs might be incurred over several policy years, depending on when the stroke occurred. Moreover, even if that person had to stop working as a result of their stroke, they would not be eligible for Social Security Disability until five months after the onset of their disability and then would need to wait another 24 months for Medicare.[56] If such a person was locked into a multi-year catastrophic plan or was enticed into such a plan due to its multi-year pricing structure, the proposed cost-sharing charges that average more than $15,000 per plan year could be insurmountable.

CMS specifically seeks comments on whether multi-year catastrophic plans should receive additional adjustments in risk pools. **We strongly urge CMS against making such a change to encourage multi-year plans, especially if they lock consumers into certain prices and benefits even if their needs and the market change.** Also, expanding catastrophic plans, lengthening their terms of coverage, and giving them preferential treatment in risk pooling would likely weaken existing marketplace risk pools by drawing healthier people out of the single risk pool in violation of the statute.[57] This shift would increase premium costs for those that remain in more comprehensive coverage.[58] As a result, **we oppose establishing multiyear catastrophic plans and urge CMS to reject this proposal.**

Data Matching Issues (Section 155.320 (c)(3)(iii) and 155.320(c)(5))

CMS proposes to continue requiring states to generate data matching inconsistencies when consumers attest to incomes above the federal poverty level, but external data sources suggest lower incomes or tax data is unavailable - a change first proposed in the 2026 marketplace integrity rule. **Families USA commented on and opposed this issue in 2025[59] and reiterates our opposition here**.

CMS's policy will deny many enrollees access to subsidized coverage, afford little flexibility for consumers while imposing significant administrative burdens on federal and state-based exchanges, and disproportionately harm lower-income enrollees who experience high income volatility.[60] For these

individuals, income documentation may require collecting dozens of individual paystubs to substantiate their income projection. For these reasons, **Families USA continues to have serious concerns about this policy that would deny access to subsidized coverage for eligible Americans due to data matching inconsistencies, and we urge CMS to drop this proposal.**

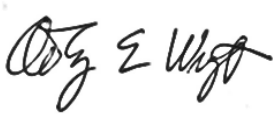
Conclusion

The Affordable Care Act marketplaces have achieved historic coverage gains over the past decade, bringing our nation's uninsured rate to record low levels. These gains have been driven by strong consumer protections, clear plan comparisons, and effective federal and state oversight that builds clarity and trust for many consumers. Many of the policies proposed in the 2027 NBPP would weaken these foundations. Eliminating standardized plans, reducing network adequacy standards, weakening oversight of enrollment platforms, and expanding high-deductible catastrophic plans would increase consumer confusion, reduce access to care, and expose families to greater financial risk.

Families USA urges CMS to withdraw or substantially revise these proposals and to continue strengthening the existing consumer protections that have helped make the ACA marketplaces a reliable source of affordable coverage for millions of Americans.

We appreciate the opportunity to submit these comments and look forward to continued engagement with CMS on policies that strengthen health coverage and improve health outcomes for all.

Sincerely,



Anthony Wright

Executive Director

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