March 12, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Administrator Oz,

Paragon Health Institute appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule CMS-9883-P, RIN 0938-AV62, titled "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program." Paragon is a nonprofit health policy research institute committed to reforming government programs and restoring Americans' control over their health and health care. We believe empowering consumers, not increasing government control, is the key to lowering costs and improving health outcomes.

The Affordable Care Act (ACA) exchanges are not performing well. Over the past decade, premiums and deductibles have escalated substantially, while many exchange products rely on extremely narrow networks that limit meaningful access.[1] At the same time, federal subsidies have grown dramatically, distorting market incentives and producing widespread improper enrollment. Paragon estimates that approximately 6.4 million exchange enrollees in 2025 were improperly enrolled in fully subsidized coverage,[2] and CMS data show that in 2024, roughly 35 percent of enrollees did not submit a single claim[3] — raising concerns about phantom enrollment[4] and program integrity.[5]

Enrollment growth is no longer a meaningful measure of success. Given the substantial share of improper and phantom enrollees, it has become a sign of failure. Regulators should not fear falling enrollment because such declines largely reflect the removal of improper enrollees, enrollees with other forms of coverage, enrollees unaware of their

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[1] Daniel Cruz and Greg Fann, "It's Not Just the Prices: ACA Plans Have Declined in Quality Over the Past Decade," Paragon Health Institute, September 2024, https://paragoninstitute.org/private-health/its-not-just-the-prices-aca-plans-have-declined-in-quality-over-the-past-decade/.
[2] Brian Blase, Chris Medrano, Niklas Kleinworth, and Jackson Hammond, "The Greater Obamacare Enrollment Fraud: The Fraud Got Much Worse in 2025," Paragon Health Institute, June 2025, https://paragoninstitute.org/private-health/the-greater-obamacare-enrollment-fraud/.
[3] Brian Blase, "Explaining the Rise of Phantom ACA Patients," Paragon Health Institute, August 25, 2025, https://paragoninstitute.org/private-health/explaining-the-rise-of-phantom-aca-patients/.
[4] Niklas Kleinworth, Liam Sigaud, and John R. Graham, "Ghostbusting ACA Fraud: Millions Who Don't Use Their Health Insurance Expose Abuse in the Program," Paragon Health Institute, October 1, 2025, https://paragoninstitute.org/private-health/ghostbusting-aca-fraud-millions-who-dont-use-their-health-insurance-expose-abuse-in-the-program/.
[5] Brian Blase and Jackson Hammond, "Policy Changes Needed to Reduce Massive Improper Affordable Care Act Subsidy Expenditures," Paragon Health Institute, July 2, 2025, https://paragoninstitute.org/private-health/policy-changes-needed-to-reduce-massive-improper-affordable-care-act-subsidy-expenditures/.

coverage, or enrollees who never used their coverage. In fact, by limiting abuse and improving eligibility reviews, the rule *should* reduce improper and phantom enrollment.

Certain ACA design features have driven higher premiums, reduced plan innovation, and increased costs, waste, and fraud. Those features include the medical loss ratio (MLR) rules, expansive essential health benefit (EHB) mandates with no coverage limits, and inflationary subsidy structures. A new approach is needed, grounded in consumer choice, competition, flexibility, plan innovation, and commonsense program integrity. The 2027 Notice of Benefit and Payment Parameters (2027 NBPP) contains many important reforms that move in that direction, including reforms that implement program integrity provisions in the Working Families Tax Cut (WFTC), also known as the One Big Beautiful Bill Act (OBBBA).

1. Maximizing Consumer Choice and Competition

Expansion of Hardship Exemption Eligibility (§ 155.605(d)(1))

CMS proposes to expand and codify eligibility for hardship exemptions so that certain individuals age 30 and older can enroll in catastrophic coverage. As proposed, individuals whose projected household income makes them ineligible for premium tax credits (PTCs) and cost-sharing reductions (CSRs) could qualify for a hardship exemption and be eligible to purchase a catastrophic plan. Most of the beneficiaries of this change will have income above 400 percent of the federal poverty level (FPL), above the eligibility threshold for PTCs, and will not have coverage through an employer-sponsored insurance plan.

We support this policy and urge CMS to finalize this proposal. We also encourage the agency to expand upon this initiative through further rulemaking to expand access to short-term limited-duration insurance (STLDI) plans.

Catastrophic plans offer lower-cost alternatives that would benefit American families. Catastrophic plans operate in a distinct segment of the individual market. People who purchase them do not qualify for PTCs. For unsubsidized consumers — including many middle-income families — catastrophic coverage offers a lower-premium alternative that preserves protection against major medical events. The ACA has largely failed to sustain a competitive, unsubsidized individual market, so expanding catastrophic eligibility is an important, targeted, and common-sense step toward restoring meaningful options for those priced out of traditional exchange products. The reality is that standard ACA exchange coverage is unaffordable for far too many Americans.

Catastrophic plans better reflect the core purpose of insurance — protection against high-cost, unpredictable events — while allowing consumers greater control over routine spending. Combined with expanded health savings account (HSA) eligibility contained in

the WFTC, expanded access to catastrophic plans enables consumers to direct premium savings into tax-advantaged accounts rather than inflated premiums.

CMS sought comment on whether risk-adjustment transfer calculations should be separate for individual catastrophic plans or combined with the entire ACA individual market. *We urge CMS to keep catastrophic plans as a distinct, unsubsidized market segment that has a separate risk-adjustment system*. Subjecting catastrophic plans to the broader ACA risk-adjustment system would transfer funds from unsubsidized enrollees to heavily subsidized pools, raising premiums and undermining the reform's purpose. These consumers should not be required to pay inflated premiums to cross-subsidize heavily subsidized exchange pools.

The Superiority of STLDI Plans

CMS should promulgate separate rulemaking expanding access to STLDI. Such a policy would complement the expanded catastrophic plan offerings. Short-term plans offer lower premiums (likely far lower than catastrophic plan premiums), broader benefit flexibility, and wider provider access than ACA plans. Preserving and expanding STLDI flexibility alongside catastrophic reforms would maximize affordability and consumer choice.

As Paragon research shows, the ACA individual market improved significantly more in states that did not restrict short-term plans after the Trump administration's 2018 rule allowing short-term plans for up to 36 months.[6] Such states had lower premiums, increased insurer participation, and higher enrollment in the ACA market than states that restricted these plans. This empirical analysis shows that many critics' theoretical fears of STLDI remained just that: theoretical. The agency should take this real-world experience into account when promulgating new rulemaking.

In the year before launching Paragon, Brian Blase's family enrolled in a short-term plan because it offered much lower premiums, much broader provider access, and superior plan design flexibility compared to the available ACA exchange options. His family's experience underscores a simple reality: for many families, short-term plans provide better financial protection and access than heavily regulated exchange plans.

The Trump administration's 2018 rule permitting short-term plans for up to 36 months expanded options for people.[7] CMS should work with the Departments of Labor and the Treasury to reinstate the provisions of that rule.

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[6] Brian Blase, "Short-Term Health Plans, Long-Term Benefits: States that Allow Short-Term Coverage Have Stronger Health Insurance Markets," Paragon Health Institute, September 2023, https://paragoninstitute.org/private-health/short-term-health-plans-long-term-benefits/.
[7] Internal Revenue Service, Employee Benefits Security Administration, and Department of Health and Human Services, "Short-Term, Limited-Duration Insurance," 83 Fed. Reg. 38212, August 3, 2018, https://www.federalregister.gov/documents/2018/08/03/2018-16568/short-term-limited-duration-insurance.

Multi-Year Terms for Catastrophic Plans to Improve Health (§§ 156.130(c) and 156.155(a)(6)) and Cost Sharing for Bronze and Catastrophic Plans (§§ 156.136 and 156.155)

CMS proposes to allow issuers to offer catastrophic plans for multiple consecutive years, up to ten years. CMS also proposes to permit multi-year catastrophic plans with terms of at least two years to cover additional preventive services pre-deductible as a form of value-based insurance design.

We support and urge CMS to finalize the proposal to permit long-term catastrophic plans for up to ten years. Allowing longer-term catastrophic plans strengthens continuity incentives and gives consumers lower-cost options by aligning insurance with its intended function. Allowing longer-term catastrophic plans is a meaningful step toward treating health insurance like insurance.

Multi-year contracts improve incentives for both consumers and issuers by reducing churn and encouraging investment in prevention and care management. Longer-term products also reduce the hassle and costs of annual health insurance plan selection. CMS's proposal to allow additional pre-deductible preventive services for multi-year catastrophic plans is a sensible start and should be implemented with maximal flexibility.

CMS should allow premium stability features, reduced cost-sharing, or benefit enhancements that vest with continued enrollment. Multi-year plans could allow deductible carryover or premium stability features — for example, if an enrollee does not meet the deductible in year one, the issuer could offer premium stability or enhanced benefits in subsequent years.

For multi-year plans, CMS should allow dynamic maximum out-of-pocket (MOOP) design. Plans could incorporate higher MOOP exposure in early years paired with reduced exposure, enhanced benefits, or premium stability in subsequent years for continuously enrolled individuals.

These suggestions are both logical outgrowths of the proposed rule because such provisions would make it easier for enrollees to remain enrolled in these plans, thus ensuring greater continuity of coverage. These types of continuity incentives would reduce churn, strengthen insurer investment in long-term health management, and restore product flexibility constrained by statute. Given the rule's other provisions allowing greater flexibility in cost structure (see Cost Sharing for Bronze and Catastrophic Plans §§ 156.136 and 156.155), commenters could reasonably foresee that such provisions could be part of the final rule.

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

CMS proposes to allow "non-network" plans to be certified as Qualified Health Plans (QHPs) if they meet specified access and consumer-protection standards. In a non-network model, the plan sets a defined payment amount paid regardless of the choice of provider. Under the proposed rule, CMS would evaluate whether a sufficient range of providers — including essential community providers (ECPs) — accept the plan's benefit amounts as payment in full, without unreasonable delay, such that enrollees can realistically access care.

We support this proposal and commend CMS for providing flexibility for states to allow non-network plans as QHPs, promoting choice and competition in plan design. We urge CMS to adopt rules that are fair to this type of coverage. CMS's proposal that ECPs must accept the plan's benefit amount as payment in full is too strict, would limit the development of these types of plans, and would lead to higher premiums and deductibles. Consistent with the actuarial value (AV) of the ACA benchmark plan, CMS should lower this threshold and require that an ECP accept 70 percent of the price as payment in full.

Non-network plans can strengthen price competition by making prices visible and by encouraging consumers to become more engaged shoppers. When consumers can see what the plan will pay and how provider prices vary, they have incentives to shop. This was confirmed in the RAND Health Insurance Experiment, which found that patients with higher cost-sharing spent as much as 30 percent less on health care without negatively affecting health outcomes.[8] This result shows that consumers with incentives become more discerning about their health care decisions. Providers also would have a direct incentive to compete on price. Some models of non-network plans also incorporate shared savings, rewarding consumers for selecting lower-cost providers.

Consumer-driven competitive pressure is essential for driving efficiency in a health care system otherwise dominated by opaque, third-party pricing. Traditional carrier models have often relied on percentage-of-Medicare pricing and opaque chargemaster discounts while benefiting from substantial federal subsidies. Greater competition from non-network models can discipline pricing and encourage efficiency among all market participants. Allowing non-network plans as QHPs is a pro-consumer, pro-competition reform that recognizes a basic reality of exchange coverage: in many areas, ACA enrollees have few choices and are limited to plans with extremely narrow networks and restricted provider

[8] Michael E. Chernew and Joseph P. Newhouse, "What Does the RAND Health Insurance Experiment Tell Us About the Impact of High-Deductible Health Plans on Health Outcomes?," American Journal of Managed Care, 14(7), 412–414, 2008, https://www.ajmc.com/view/jul08-3414p412-414.

participation. For many families, an ultra-narrow network plan is not meaningful "coverage" if few local providers accept it.[9] Allowing non-network options gives consumers a transparent alternative in a system rife with constrained networks and limited access — especially in markets where exchange network adequacy has become largely theoretical.

Non-network models can also reduce administrative waste, leading to lower premiums. Traditional network contracting, credentialing, directory maintenance, and complex claims adjudication drive high overhead. Non-network designs can simplify payment, reduce billing and collections friction, and generally pay providers more promptly — cutting administrative costs for both payers and providers. Lower overhead can translate into lower premiums and savings for American consumers as well as lower frustration from billing complexities.

Some critics will incorrectly argue that non-network plans are "not real insurance" or that they resemble fixed indemnity coverage. CMS should reject that characterization. A defined payment structure for payments to all providers can be a well-designed component of comprehensive major medical coverage, and CMS should not insist that payment models must copy legacy carrier business models, particularly since those models have led to escalating prices, costs, and frustrations.

Balance billing risk is a legitimate issue to address, but it is manageable with the right design and transparency tools. Scare tactics should not preempt reform. CMS should focus on giving consumers accurate information so that they can shop for themselves, not imposing rigid rules that preclude innovation. Many consumers will prefer a non-network option with lower premiums, even with some balance billing exposure, over a narrow-network ACA plan that purports to be comprehensive but still effectively blocks access to preferred physicians and hospitals.

While we support the general direction on non-network plans, we have concerns that CMS's proposed approach — requiring evidence that a sufficient range of providers accept the benefit amount as payment in full — may stifle innovation. This approach effectively treats non-network plans much more stringently than the law treats ACA plans. *CMS should adopt the most flexible, market-oriented access criteria possible and allow plan designs and consumer tools to evolve. CMS should consider a more flexible standard — consistent with the standard ACA benchmark plan — and evaluate whether the payment amounts cover at least 70 percent of the actual price.* This proposal is a logical outgrowth of the original proposal because it advances the same policy goal: requiring evidence that a sufficient range of providers accept meaningful payment from non-network plans. Comments could have foreseen this 70-percent benchmark because the proposed rule seeks to treat non-network plans as QHPs. Therefore, it is foreseeable that the agency

[9] Daniel Cruz and Greg Fann, "It's Not Just the Prices: ACA Plans Have Declined in Quality Over the Past Decade," Paragon Health Institute, September 2024, https://paragoninstitute.org/private-health/its-not-just-the-prices-aca-plans-have-declined-in-quality-over-the-past-decade/.

would finalize a rule that treats non-network plans similarly to other QHPs by using an alternative method like the 70-percent benchmark.

Non-network plans are compatible with value-based care. These plans can still participate in quality rating frameworks, and plan design can incorporate quality-sensitive incentives (for example, differential cost-sharing or shared savings) that encourage consumers to choose high-value providers.

Paragon employees using Individual Coverage Health Reimbursement Arrangements (ICHRAs) have had trouble accessing providers in states such as Florida due to narrow exchange networks. For many families, a well-designed non-network plan would offer better access than a severely limited network product and at a better price point.

Submission of Rate Filing Justification—Regarding CSRs (§ 154.215(B))

CMS proposes targeted program-integrity guardrails to address excessive CSR loading. Rather than prohibiting silver loading outright, CMS would require issuers that apply CSR loads to demonstrate, through standardized rate review documentation, that the additional premium amounts reflect actual unreimbursed CSR costs. Unreimbursed CSRs are the difference between the AV required by statute for CSR-eligible silver variants and the base silver plan reimbursement that insurers receive absent direct federal CSR payments. Specifically, insurers would need to report the value of CSRs provided, the revenue collected from prior CSR loads, the CSR load factor proposed for the upcoming year, and an actuarial comparison showing that projected CSR-load revenue does not materially exceed expected unreimbursed CSR obligations. The purpose of this proposal is straightforward: CSR adjustments should recover unpaid CSR costs — not inflate benchmark premiums and, by extension, federal subsidies.

We support and urge CMS to finalize these proposals addressing silver and CSR loading. We urge CMS to take additional steps and prohibit silver loading altogether to further reduce distortions and achieve CMS's stated goals. This proposal addresses one of the largest distortions in the ACA's subsidy structure. When CSR costs are embedded into silver premiums, benchmark premiums rise and federal PTC spending increases — contributing to fully subsidized bronze and gold plans, fueling improper and phantom enrollment, and punishing unsubsidized enrollees with much higher silver plan premiums.

CMS is right to focus on excessive CSR loading. CSR loading was permitted as a workaround to allow issuers to recover unreimbursed CSR costs after the Trump administration ceased payments in compliance with a federal court ruling that the ACA lacked a valid congressional appropriation for CSR reimbursements. This practice had begun under the Obama administration. Although legally complex, the practice originated as a response to that funding gap, not as a permanent structural feature of exchange

pricing. CSR loading was not intended to create windfall revenue or to subsidize other pricing objectives through inflated benchmark premiums.

CSR loads should be limited to actual unreimbursed CSR costs and calibrated to experience. When CSR-load revenue materially exceeds CSR obligations, the excess effectively expands federal subsidies and distorts plan competition. CMS's data collection will help identify where assumptions or state-directed loading methods are causing over-collection and subsidy inflation.

Requiring issuers to show their math, using a standardized methodology, is a basic accountability measure. Notably, issuers and regulators were required to perform CSR reconciliation and related calculations in the past, so CMS's proposal would simply restore that approach.

CMS should anticipate and reject the argument that higher silver premiums are justified because the "average actuarial value" of the silver risk pool exceeds 70 percent due to CSR variants. The statutory actuarial value requirement applies to the base silver plan, which remains a 70 percent AV product. CSR variants increase actuarial value for eligible enrollees, but those additional costs represent separate CSR obligations, not a redefinition of the base silver plan's value. Treating the higher average AV of the silver pool as justification for higher base silver premiums effectively allows issuers to recover more than the actual cost of CSR benefits, inflating benchmark premiums and federal subsidies.

Stronger CSR-load guardrails complement other exchange integrity goals. Benchmark inflation and "free plan" dynamics can fuel waste, fraud, and abuse by weakening premium payment signals and reducing consumer engagement. The one-time reporting burden associated with CSR documentation is justified given the magnitude of federal PTC exposure and the documented risk of subsidy inflation.

While CMS proposes guardrails, Paragon urges CMS to consider prohibiting silver loading altogether. Bronze plans, silver plans, and gold plans should reflect AV differences — not subsidy gaming. Silver loading distorts metal-tier pricing, penalizes unsubsidized enrollees, inflates federal subsidy costs, and undermines market transparency. CMS should evaluate eliminating silver loading as part of a broader reform of exchange pricing mechanics.

Ending silver loading would be a logical outgrowth of the proposed rule. In the proposed rule, CMS has requested comment on alternative approaches, giving commenters notice that it may finalize broader reforms. CSR loading has always been a temporary workaround that is inconsistent with the statute's original framework and intent. By identifying silver loading as a driver of benchmark inflation and subsidy distortion and proposing guardrails to limit its impact, CMS placed the continued permissibility of silver loading directly at issue. A prohibition on silver loading would represent a stricter version of the same corrective objective as the proposed rule's reform. Stakeholders were therefore on notice

that CMS might conclude that the only effective way to prevent subsidy distortion is to eliminate silver loading entirely.

Publication of the 2027 Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage in Guidance (§ 156.130(e))

The ACA established a MOOP limit — the maximum amount an enrollee must pay in deductibles, copayments, and coinsurance in a plan year for covered, in-network EHBs. Once that cap is reached, the plan must cover 100 percent of additional covered in-network costs for the remainder of the year. The MOOP does not apply to out-of-network services and does not mandate a particular deductible structure; insurers retain discretion in how cost-sharing is designed so long as total exposure does not exceed the statutory ceiling.

Over time, as health care prices increase and cost-sharing accumulates more rapidly, the interaction of core ACA rules makes it increasingly difficult — and potentially mathematically infeasible — for insurers to construct bronze plans that simultaneously (1) meet AV requirements, (2) comply with MOOP limits, and (3) maintain affordable premiums.

CMS's proposal to introduce targeted MOOP flexibility — including permitting, in limited cases, bronze plans with higher MOOPs where necessary to achieve required AV — is a pragmatic response to these structural ACA constraints. Allowing MOOP-compliant and MOOP-adjusted bronze plans to coexist in the same service area can preserve plan availability while expanding consumer choice.

CMS's proposal to allow additional flexibility — including potential adjustments to MOOP structures — should be implemented with maximum regulatory latitude. CMS should avoid imposing rigid upper caps beyond statutory limits and instead prioritize transparency and disclosure so consumers understand cost-sharing tradeoffs. Greater MOOP flexibility does not undermine consumer protection. Rather, it corrects distortions created by rigid statutory design, stabilizes the bronze tier, and improves the functioning of the individual market.

Moreover, greater plan availability may also reduce premiums, as issuers offer alternative plan designs that are tailored to each state's market. Some consumers may prefer higher out-of-pocket maximums in exchange for lower premiums.

Publication of the 2027 Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage in Guidance (§ 156.130(e))

CMS proposes to continue the 2025 Marketplace Integrity and Affordability final rule's methodology for calculating the premium adjustment percentage index (PAPI). This

provision was put in place for PY 2026. The PAPI determines inflation updates to parameters including the MOOP limits on cost sharing and the amounts employers must pay for certain plans. The 2025 rule appropriately calculates the PAPI by including both the individual and employer markets in the index, leading to lower taxpayer costs.

We support and urge CMS to finalize this overdue proposal. This continuation of the PAPI methodology would better align with the statute's plain language by including both the individual market and the employer market in the index, while also reducing taxpayer costs. The ACA, in Section 1302(c)(4), requires the HHS Secretary to determine these amounts based on the "average per capita premium for health insurance in the United States." Nothing in that language indicates that the term "average per capita premium" should exclude the individual market. Yet, as a tacit acknowledgement of the ACA's upheaval in the individual market, that's exactly what the Obama administration did. This decision rapidly increased the cost of PTCs. CMS's proposal would ultimately reduce the fiscal burden on current and future taxpayers and reduce deadweight loss.

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

CMS now proposes eliminating the standardized plan requirements beginning in PY 2027. The agency argues that the policy imposed administrative burdens on insurers and contributed to plan churn and market disruption.

We encourage CMS to finalize this common-sense proposal. The standardized plan requirement was an attempt to address structural problems created by the ACA itself. Because the ACA imposes strict coverage mandates and limits insurers' ability to price based on health risk, insurers have strong incentives to design plans that discourage enrollment by high-cost patients. Insurers often do this through narrower provider networks, restrictive formularies, or cost-sharing structures that make certain services less attractive to use.[10]

The standardized plan policy was intended to counteract these incentives by requiring insurers to offer plans with pre-specified cost-sharing structures and broader pre-deductible coverage. In theory, this would reduce "discriminatory benefit design"[11] and make plan comparison easier for consumers.

However, the policy appears to have produced limited benefits while increasing regulatory complexity. The agency is right to end this requirement for three reasons.

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[10] Michael F. Cannon, "Is Obamacare Harming Quality? (Part 1)," Health Affairs, January 4, 2018. https://www.healthaffairs.org/content/forefront/obamacare-harming-quality-part-1.

[11] Department of Health and Human Services and Department of the Treasury, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2024," 88 Fed. Reg. 27208, 27296–97, May 3, 2023, https://www.federalregister.gov/documents/2023/04/27/2023-08368/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2024.

First, requiring insurers to offer standardized plans increased administrative burden and constrained plan design flexibility. Insurers were required to create new plans that matched federal cost-sharing templates while simultaneously reducing other plan offerings to comply with federal limits on non-standardized plans. The policy appears to have contributed to higher rates of plan discontinuation. CMS reports that 35 percent of plan-county combinations were discontinued between 2022 and 2023, significantly higher than the 17 to 22 percent baseline observed in prior years.

Second, the government does not have the ability to determine the features of plans that are optimal given differences in millions of individuals' preferences, risk tolerances, and evaluation of tradeoffs. The standardized plan requirement may have reduced consumer choice by limiting the number of plans available. Undoing this policy could expand consumer choice, helping to reduce premiums.

Third, consumer demand for standardized plans has been relatively limited. CMS reports that 80 percent of exchange enrollees selected non-standardized plans in 2023, and even after regulatory limits reduced non-standardized offerings, 67 percent of enrollees still chose non-standardized plans in 2024 and 2025. Among consumers actively selecting plans, the preference for non-standardized plans was even stronger, reaching 82 percent in PY 2025. These results suggest that consumers value non-standardized plans' flexibility and variety and that standardized plan requirements did little to meaningfully benefit the market in the way their proponents intended.

For these reasons, we urge the agency to finalize this proposal. This proposal to eliminate the standardized plan requirements would reduce regulatory burden, allow greater insurer innovation in plan design, and better reflect consumer preferences in the exchange marketplace.

Non-Standardized Plan Option Limits (§ 156.202)

CMS proposes to eliminate the federal limits on the number of non-standardized QHPs that insurers may offer on federally facilitated exchanges (FFEs) and state-based exchanges on the federal platform (SBE-FPs), effective beginning in PY 2027. Previously, CMS instituted this limit to prevent "plan choice overload."

We urge CMS to finalize this policy as proposed. This repeal of § 156.202 would expand consumer choice. The current policy of limiting issuers to two non-standardized plans per category in 2025 increased administrative burden and regulatory complexity for insurers and for CMS. It also stifled choice. Removing this limit, combined with removing the previous requirement for standardized plans, would help increase choice and competition. We believe the proposal may reduce premiums and restore choice to consumers.

State Selection of EHB-Benchmark Plan for Plan Years Beginning on or After January 1, 2020 (§ 156.111)

CMS proposes to reverse a 2023 Biden-era provision that removed requirements for states to defray the cost of state benefit mandates that occurred after December 31, 2011, if the benefit is currently in the state's benchmark EHB.[12] In simple terms, CMS is proposing that if a state requires insurers to cover benefits beyond the federal EHB package and those mandates were enacted after January 1, 2012, the cost of those benefits would not be counted for purposes of calculating federal premium subsidies.

We support CMS's proposal to more clearly separate post-2011 state benefit mandates from the federal EHB definition. By excluding newly mandated state benefits from the federal benchmark used to calculate PTCs, the rule would reduce the ability of states to inflate benchmark premiums — and therefore federal subsidies — through the addition of new coverage mandates.

This change would be particularly beneficial for unsubsidized enrollees, who bear the full cost of elevated gross premiums in states with expansive benefit requirements and limited plan competition. It would also help curb premium growth in markets where additional mandates compound affordability challenges. We recommend that CMS also defray the cost of any state mandates or policies that increase the cost of ACA exchange plans, including policies that prohibit out-of-pocket expenditures for certain services or mandate longer coverage durations. In essence, any state requirements on health insurance beyond the ACA's federal requirements should not be subsidized by the federal government through higher premium tax credits.

At the same time, the policy closes a loophole that has allowed states to shift EHB benchmarks over time to incorporate new mandates without formally defraying their cost. Under the current framework, a state could enact a mandate tied to an existing benchmark plan, later select a new benchmark plan already subject to that mandate, and effectively carry the benefit forward without triggering defrayal requirements. Removing this workaround restores fiscal discipline and clarifies that states, not federal taxpayers, are responsible for the cost of benefits exceeding the federal standard.

Provision of EHB (§ 156.115(d))

CMS proposes to bar insurers from treating routine adult dental services as an EHB. This would reverse a policy adopted in the Biden-era 2025 NBPP and would better align with the ACA's requirement that EHBs reflect the scope of benefits offered under a typical employer-sponsored plan.

Paragon supports removing adult dental coverage from the ACA's EHB requirement. Mandating adult dental coverage restricts consumer choice by forcing many people to

[12] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2025, proposed rule, 88 Fed. Reg. 82510 (Nov. 24, 2023), https://www.govinfo.gov/content/pkg/FR-2023-11-24/pdf/2023-25576.pdf.

purchase coverage that they may not value, raises premiums, increases market distortions by driving more spending through insurance, and increases federal subsidy costs.

The ACA explicitly lists "pediatric services, including oral and vision care" among the ten EHB categories, strongly suggesting that Congress did not intend adult dental coverage to be included. While the EHB framework establishes a minimum set of benefits, it also requires that the overall scope reflect that of a typical employer plan. Employer survey data consistently show that dental coverage is generally offered separately from traditional medical plans, not embedded within them. Including routine adult dental in EHB, therefore, stretches the standard beyond what the statute contemplates. Returning adult dental to a supplemental product would reduce ACA premiums and improve affordability, particularly for unsubsidized enrollees.

Essential Community Provider Standards for Network Plans (§ 156.235) and Implementation of the Effective Essential Community Provider Review Program (§ 155.1051)

CMS is proposing to restore the ECP participation threshold from 35 percent back to 20 percent, returning to the standard from the first Trump administration before the Biden administration increased it. The change would apply to both the overall ECP requirement and specific categories, including federally qualified health centers and family planning providers. CMS also proposes eliminating the narrative justification requirement during ECP certification reviews, simplifying the compliance process for insurers.

We support this proposal and the return to reduced ECP thresholds. Restoring the ECP threshold from 35 percent back to 20 percent would return to the standard adopted during the first Trump administration and better balance access requirements with market stability. While the ACA requires QHPs to include ECPs that serve low-income and medically underserved populations, increasing the threshold to 35 percent imposes additional contracting pressure on insurers that can ultimately drive up premiums. The earlier reduction to 20 percent was intended to ease administrative burdens and reduce barriers to insurer participation, and there was little evidence of widespread harm to access following that change.

2. Improving and Strengthening Program Integrity

Factors CMS Uses to Determine the Amount of a Civil Money Penalty (CMP) (§ 150.317)

CMS proposes to reaffirm and clarify HHS's authority to impose CMPs and exercise direct enforcement of exchange and QHP requirements when a state fails to substantially enforce applicable standards. Specifically, HHS may step in if a state notifies HHS that it is

not enforcing federal requirements or if HHS independently determines that the state is failing to substantially enforce exchange standards.

This clarification is a necessary and overdue step, and we urge CMS to finalize this proposal. Under the ACA, SBEs bear primary responsibility for enforcing QHP certification and market conduct standards, with HHS serving as a secondary backstop when a state declines to enforce or fails to substantially enforce federal requirements. In practice, inconsistent enforcement roles across exchange models and reliance on subregulatory guidance have created ambiguity about when HHS will intervene—contributing to weak oversight and insufficient consequences that have fueled program integrity concerns across exchanges, particularly involving improper enrollments and intermediary misconduct.

By codifying and reaffirming its authority to impose civil monetary penalties, CMS is reinforcing that compliance failures will have consequences and beginning to restore accountability for issuers and other market participants. It also underscores a simple principle for SBEs: primary enforcement responsibility comes with real obligations, and when states fail to carry them out, federal intervention is warranted. Explicitly empowering HHS to impose CMPs when states fall short reinforces that violations have tangible costs, encourages better state performance, and helps maintain baseline accountability across all exchange types without broadly overriding state roles in routine cases.

Disallow APTC for Individuals Who Are Ineligible for Medicaid Due to Their Immigration Status and Have Income Below 100 Percent of the FPL (§ 155.305(f)(2))

CMS proposes to implement a provision of the WFTC that reverses an ACA provision that allowed certain non-citizens to access subsidies, thereby getting around the Medicaid waiting period, which Congress required in Section 71302 of the WFTC. The proposal would bar APTC eligibility for individuals who both (a) have income below 100 percent of the FPL and (b) are ineligible for Medicaid due to immigration status.

We support this necessary policy and encourage CMS to finalize it. This proposal is necessary to comply with the WFTC. This provision closes the Medicaid-waiting-period loophole that allows lawful permanent residents, parolees, and those granted conditional entry to receive PTCs if their income is below the FPL in non-expansion states or below 138 percent of the FPL in expansion states. Under the previous law, those groups of noncitizens were able to access premium subsidies that are not even available to U.S. citizens in the same income categories. This provision effectively restores the intent of the Medicaid waiting period.

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

During the COVID-19 pandemic, the Biden administration finalized a rule that, starting in 2024, prohibited an exchange from denying APTCs to an individual unless the individual failed to pay back excess subsidies for two consecutive years. This policy incentivized abuse by allowing people who were improperly enrolled in the exchanges to receive an additional year of subsidized coverage, despite being ineligible. Excessive subsidies could have been received because of overestimating or underestimating income.

The proposed rule would require exchanges to deem individuals ineligible for APTCs if they do not repay their excess subsidies from the previous year. While the 2025 Marketplace Affordability and Program Integrity final rule only required this for 2026, this new proposed rule would extend the requirement starting in 2028. In 2027, it would be optional for SBEs. This provision was ultimately stayed by a federal district court.

We support the proposed provisions relating to FTR. CMS should finalize this proposal to protect enrollees from unanticipated tax liabilities and to protect taxpayers from improper subsidy payments. By returning to the policy that ensures individuals who fail to reconcile past APTCs are deemed ineligible the following year, the rule protects enrollees from accumulating unanticipated tax liabilities. These unanticipated liabilities are of much greater concern given the sharp rise in the share of enrollees with coverage automatically renewed from one year to the next. Restoring this policy also would protect taxpayers from bearing the cost of improperly advanced subsidies.

We recommend that CMS also make this change mandatory for SBEs in 2027. A mandatory 1-year FTR policy would still be preferable because it would prevent the loss of a significant amount of federal subsidy payments. Because the proposed rule already identifies the 1-tax-year FTR policy as the preferred policy and contemplates its implementation in PY 2027 on an optional basis, commenters have clear notice that the timing of adoption for that year is under consideration. Requiring SBEs to implement the 1-tax-year FTR policy beginning in PY 2027 would therefore be a logical outgrowth of the proposal because it would only adjust the degree of flexibility afforded to exchanges, not introduce a new regulatory framework. Stakeholders are already invited to comment on the feasibility and implications of 2027 implementation, so a mandatory approach for that year would fall within the scope of issues presented in the proposed rule.

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

Section 71303 of the WFTC requires that exchanges verify eligibility for PTCs before enrollment by requiring individuals to confirm their coverage decisions each year. This section of the 2027 NBPP seeks comment on how to implement this, including operational considerations, compliance timelines, and any potential costs or impacts on enrollment.

We urge CMS to require enrollees to take steps that would indicate they understand the responsibility they are undertaking in signing up for APTCs. This includes a prohibition on simply receiving a pre-filled form that they would only need to sign. Furthermore, consumers should be prohibited from having someone else fill out the form for them, with extremely limited exceptions for exigent circumstances. Consumers should be aware that misestimating their income could result in significant tax liabilities. Too many individuals have been put on the hook for thousands of dollars in tax liabilities due to such misunderstandings.[13]

We urge CMS to require such verification prior to eligibility for all individuals. Pre-enrollment eligibility verification across all exchanges is necessary in light of significant program integrity concerns. While the expiration of the enhanced APTCs for the COVID-19 pandemic reduces the risk of fraud, it still remains high given the widespread availability of fully subsidized bronze and gold plans and incentives for brokers to enroll people in fully subsidized plans.

Income Verification Policy When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii))

CMS proposes to require applicants to provide documentation to the exchanges if they attest to an income above 100 percent of the FPL but available data sources indicate a lower income. Typically, these data sources include Social Security Administration data, IRS data, and Department of Homeland Security (DHS) data. The 2025 Marketplace Integrity and Affordability final rule would have sunset this provision after PY 2026. This provision was stayed by the federal district court. However, the proposed rule would permanently make this important change.

In order to protect the integrity of the exchanges and ensure the law is enforced, we urge CMS to finalize this policy as proposed. While the Obama administration initially interpreted the ACA to provide for a multistep process to verify people's incomes and accurately determine subsidy amounts, the Biden administration undermined the ACA's guardrails by requiring exchanges to accept an individual's self-attested income if they claim that they have an income that is higher than available information indicates. This incentivized rogue brokers and enrollees to claim higher household incomes because those who make less than 100 percent of the FPL are not eligible for any subsidies (since they are eligible for Medicaid), so claiming a higher income generates greater payments from the government.

This proposed rule cites a recent GAO study in which 23 out of 24 fictitious applications were enrolled in coverage with a subsidy that covered the entire premium.[14] The proposed rule also cites how in 2025, CMS cancelled 250,000 unauthorized enrollments and stopped

[13] Gabrielle Kalisz, "Victims of Biden's Enrollment-At-Any-Cost Exchange Strategy," Paragon Health Institute, July 18, 2025, https://paragoninstitute.org/paragon-prognosis/victims-of-bidens-enrollment-at-any-cost-exchange-strategy.
[14] U.S. Government Accountability Office, Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist, GAO-26-108742, December 3, 2025, https://www.gao.gov/products/gao-26-108742.

submitting APTC payments for another 500,000 individuals who had another form of coverage besides ACA coverage.

This provision is also necessary because, even with the expiration of the enhanced APTCs from the pandemic, there are still many fully subsidized plans available, particularly given silver loading. This means that individuals, enrollment intermediaries, and insurers still have incentives to manipulate applicant income in order to secure higher payments through the program. Some media outlets have portrayed the documentation requirement as overly burdensome. However, HHS estimates that it takes individuals only about an hour to complete the documentation process,[15] and enrollees would have 90 days to do so.[16]

Much of Paragon's research supports the case for this policy change. Paragon has done extensive work showing how rogue brokers, agents, and enrollment intermediaries improperly or fraudulently enroll applicants into coverage, with standard empirical estimates of improper enrollment. *While our estimates were criticized, the criticisms rely on incomplete data and misunderstand the methodology used in Paragon's analysis.*[17]

Criticism #1: Other data sources show that fraud in the ACA exchanges is low. Critics who make this claim cite a Treasury Inspector General for Tax Administration (TIGTA) report and CMS analyses to undermine our findings. However, both reports suffer from significant limitations and rely on outdated data. Paragon's analysis corrected for these issues and is more up to date.

- Independent analysis supports the conclusion that improper enrollment in the exchanges is substantial. The Congressional Budget Office estimated that 2.3 million people were improperly enrolled in exchange coverage in just the ten non-Medicaid expansion states due solely to individuals overstating their income to qualify for subsidies.[18]

- Critics point to a 2023 TIGTA report examining 2021 tax returns, which found that 8.5 percent of PTCs were improperly distributed, with 32.3 percent of recipients receiving excess advance payments. However, this understates the current problem because the TIGTA analysis excluded more than 30 million late-processed tax returns and was based on data from before enrollment surged dramatically (from 12 million in 2021 to 24 million in 2025) following expanded subsidies. The report also did not break down improper payments by income group, despite the strongest fraud incentives occurring among individuals reporting income between 100 and 150 percent of the FPL, a key focus of Paragon's findings. Furthermore, the TIGTA report

[15] Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 27123 (June 25, 2025), https://www.govinfo.gov/content/pkg/FR-2025-06-25/html/2025-11606.htm.
[16] 45 C.F.R. §155.315(f)(2)(ii).
[17] Liam Sigaud and Niklas Kleinworth, "Answering the Critics: How Paragon Discovered Enrollment Fraud in the ACA Exchanges," Paragon Health Institute, August 11, 2025, https://paragoninstitute.org/paragon-prognosis/answering-the-critics-how-paragon-discovered-enrollment-fraud-in-the-aca-exchanges/.
[18] Congressional Budget Office, "Clarifications of Marketplace Coverage and Eligibility Under Public Law 119-21 (H.R. 1) and the 2025 Marketplace Integrity and Affordability Rule," August 25, 2025, https://www.cbo.gov/system/files/2025-08/61506-marketplace.pdf.

missed a significant category of improper enrollees: individuals who did not file tax returns at all, including those allegedly enrolled fraudulently by brokers without their knowledge. Because TIGTA relied on filed tax returns to measure overpayments, these cases would not have been captured.

- Critics also cite a 2024 CMS report based on a small sample of 2022 applications that found a 1.01 percent improper payment rate. However, this analysis likely measured only paperwork processing accuracy rather than true eligibility or subsidy accuracy, used older data, and lacked sufficient income-group breakdowns to detect concentrated fraud in lower-income categories. Overall, Paragon maintains that prior reports dramatically underestimate the scale of improper enrollment and subsidy overpayments.

- Federal enforcement actions further underscore the scale of the problem. In 2025, the Department of Justice announced multiple[19] settlements[20] involving South Florida enrollment schemes in which brokers fraudulently enrolled individuals in ACA exchange coverage without their knowledge or by manipulating reported income in order to qualify for fully subsidized plans.

- Investigative reporting has documented similar patterns. A Bloomberg investigation[21] "Chasing Big Money With the Health-Care Hustlers of South Florida," described networks of brokers who enrolled individuals into subsidized ACA coverage without their consent or with falsified income information in order to collect commissions. Brokers were able to earn commissions of up to $6,000 per day from an assembly-line-like process of improper enrollments. Automatic re-enrollment perpetuated these determinations year after year.

Criticism #2: Combining data from different years invalidates Paragon's analysis. This critique misunderstands standard statistical practice. The organization that made this critique has done this too. Due to data limitations or lags between data collection and publication, researchers are often compelled to use datasets from different sources and years. This is standard practice in empirical analyses. Ironically, one organization that criticized our data practices did precisely the same thing in a recent paper, combining Census Bureau data from 2023 with CMS data from 2025.

- Our research design relies entirely on publicly available federal data. To estimate the numbers of ineligible enrollees, we compared information released by CMS on the number of ACA exchange sign-ups who claim income between 100 and 150

[19] "President of Insurance Brokerage Firm and CEO of Marketing Company Charged in $161M Affordable Care Act Enrollment Fraud Scheme," Department of Justice, February 19, 2025, https://www.justice.gov/opa/pr/president-insurance-brokerage-firm-and-ceo-marketing-company-charged-161m-affordable-care.
[20] "Executive Vice President of Insurance Brokerage Pleads Guilty in $133M Affordable Care Act Fraud Scheme," Department of Justice, April 18, 2025, https://www.justice.gov/opa/pr/executive-vice-president-insurance-brokerage-pleads-guilty-133m-affordable-care-act-fraud.
[21] Zeke Faux, Zachary R. Mider, "How AI Celebrity Deepfakes Fueled a Florida Healthcare Hustle," Bloomberg, June 5, 2025, https://www.bloomberg.com/features/2025-deepfake-ads-fueled-florida-health-insurance-scheme/.

percent of the FPL to the estimated number of people with actual income in this range who would be eligible for such coverage.

To determine the size of the population eligible for coverage, we relied on the American Community Survey (ACS), the largest annual survey of the population carried out by the Census Bureau. The ACS surveys about 3.5 million households and produces highly reliable state-level estimates widely used in health policy research. Households surveyed by the ACS are asked a wide range of questions about their social, demographic, and economic circumstances. The ACS then collects detailed information about respondents' ages, sources of health insurance coverage, and income levels. We focus on non-elderly adults in households with income between 100 and 150 percent of the FPL. These individuals are generally eligible for zero-dollar premium plans on the ACA exchanges under the enhanced Biden COVID credits. We exclude children because, in this income range, they are eligible for Medicaid or CHIP coverage in every state and therefore do not qualify for exchange subsidies. We exclude seniors (age 65 and older) because they qualify for Medicare and therefore do not qualify for exchange subsidies.

- As of mid-2025, the most recent available year of ACS data was 2023. So, we incorporated a small adjustment to account for population growth from 2023 to 2025. This helped ensure comparability with 2025 data on open enrollment sign-ups who claimed income between 100 and 150 percent of the FPL. Our approach is standard for empirical analyses that, due to the lack of data availability, must combine data from different years. In reality, the number of people within income categories changes slowly over time. In most states, our adjustment altered the estimated number of eligible enrollees in 2025 by about 1 percent or less.

Criticism #3: Excess exchange enrollment in the 100 to 150 percent of the FPL income group reflects simple mistakes, not fraudulent behavior. This criticism ignores that the disparities are too massive to be simple mistakes. Though some instances of misreported income are undoubtedly due to good-faith mistakes, there are two reasons to believe that the discrepancies we document predominantly reflect widespread fraud.

- First, if the scale was primarily due to mistakes, one would expect good-faith mistakes to occur in both directions (i.e., some income misrepresentations would lead ineligible people to improperly obtain coverage, while other income misrepresentations would lead eligible people to be improperly excluded from coverage). The net effect on enrollment would be approximately zero. Yet the data indicate that the former "mistake" occurred millions of times more frequently than the latter.

- Second, enrollment in the 100 to 150 percent of the FPL group surged due to the availability of zero-premium plans for this population. If enrollment was driven by good-faith mistakes in income reporting, one would expect to see the same kind of variation in enrollment before fully subsidized plans were available. But the timing

of the variation indicates that fully subsidized plans were indeed a powerful incentive for individuals and rogue brokers to fraudulently enroll people. As we discuss in detail in our papers, many instances of misreported income come not from individual enrollees but from brokers and insurance agents, sometimes acting without the enrollee's authorization or knowledge. Brokers earn commissions for each enrollment and know that many individuals will only enroll if the coverage appears "free." Insurers also benefit from higher enrollment and increased federal subsidy flows. So, every key actor — enrollee, broker, and insurer — has a positive incentive for income manipulation and fraud.

Removal of the Requirement to Accept Attestations of Household Income When Tax Data is Unavailable (§ 155.320(c)(5))

CMS proposes to permanently require applicants to submit documentation verifying household income when the IRS returns no tax return data in response to an income verification request. Previously, exchanges were required to accept an applicant's income attestation in these situations. This provision was included in the 2025 Marketplace Affordability and Program Integrity final rule. It was stayed by a federal district court.

Under this provision, beginning in 2027, exchanges would instead apply the standard verification process, which may require documentation and could lead to loss of APTC eligibility if income cannot be verified within the 90-day inconsistency period. The policy is also justified by the removal of repayment caps on excess APTC beginning in 2026, which increases the risk that consumers could face large tax liabilities if their actual income differs from their estimated income. This differs from the previous provision that applies when data sources indicate income below 100 percent of the FPL but the applicant attests to income above that level. By contrast, this provision applies when the IRS provides no income data at all, meaning verification must occur even in the absence of tax records.

We urge CMS to finalize this policy as proposed.

Comment Solicitation on Premium Payment Threshold (§ 155.400)

CMS requests comment regarding minimum premium payment thresholds for effectuating coverage. This refers to the reversal of a policy under which CMS, during the Obama and Biden administrations, made it easier for insurers to keep individuals enrolled even when they didn't pay the full premium amount they owed. In 2025, CMS implemented a policy that required people to pay 95 percent of their net premium for the insurer to keep their coverage. However, the rule gave insurance companies two additional options on top of that 95 percent requirement: they could still count an enrollee as having paid their premium if (1) the individual owed less than the fixed dollar premium threshold of $10 or (2) the individual had paid 98 percent of the gross premium after the subsidy. These payment options made it easier for people to stay enrolled in coverage for months before the insurer is required to end their enrollment.

The 2025 Marketplace Integrity and Affordability final rule rescinded the latter two options for PY 2026. CMS is now soliciting comments on whether to permanently rescind those options starting in PY 2027.

We urge CMS to finalize this policy. The previous approach of increasing insurer flexibility is inappropriate because of the large amount of improper and phantom enrollment, as CMS acknowledges. Because insurers still receive subsidy payments even when an individual is improperly enrolled or is a phantom enrollee, they have a perverse financial incentive to tolerate improper enrollment. When enrollees owe no premium, insurers still profit from the subsidies even if the enrollees do not need or want the coverage or are unaware of their enrollment. The Biden administration made it easier for insurers to turn a blind eye and let such individuals remain enrolled.

Removing this flexibility would reduce insurers' ability to benefit from retaining non-paying enrollees on coverage, thereby reducing the incentive to keep them enrolled. This new approach would also protect those who have been fraudulently enrolled by reducing the likelihood that they remain enrolled and accumulate tax liabilities. *We urge CMS to finalize this proposal to promote program integrity and accountability.*

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

CMS proposes extending the removal of the 100 to 150 percent FPL special enrollment period (SEP) beyond PY 2026, to comply with the provisions in the WFTC. Originally, SEPs were meant to act as exceptions to the normal open enrollment period (OEP) for individuals who face extraordinary life events, such as job loss or starting a family. The Biden administration created a special SEP for individuals whose income fell between 100 and 150 percent of the FPL.

In the 2025 Marketplace Integrity and Affordability final rule, the Trump administration paused the 100 to 150 percent FPL SEP for PY 2026. By extending the removal beyond PY 2026, CMS is implementing Section 71304 of the WFTC, which disallows SEPs based on income.

We urge CMS to finalize this policy and eliminate this income-based SEP. This SEP raised premiums because, by making it too easy to enroll, it incentivized people to wait until they were sick before they signed up for insurance, thereby defeating the entire point of enrollment periods. It also incentivized improper and phantom enrollment by making it easier for rogue brokers to sign people up for coverage at any time. Overall, having an income of a certain level does not count as an extraordinary life event (like losing a job or starting a family) that would warrant an exception to the normal enrollment period restrictions, and thus removal of this SEP is warranted.

Special Enrollment Period Verification (§ 155.420(g))

CMS proposes to make permanent the 2025 Marketplace Integrity and Affordability final rule's provision that expands pre-enrollment verification for SEPs. CMS had sunset this provision before it was stayed by the federal court. FFEs would have to verify at least 75 percent of new SEP enrollments. FFEs would also be allowed to verify additional SEP types, not just those in the Loss of Minimum Essential Coverage (MEC) SEP. SBEs, however, would not be required to do pre-enrollment verification and would retain discretion.

We support and urge CMS to finalize the SEP verification proposals and encourage CMS to require SBE compliance, rather than offering flexibility. This proposal addresses a significant gap in verification, program integrity, and oversight of unauthorized enrollments. We commend CMS for implementing the WFTC's requirement on a strong foundation by subjecting such SEPs to strong verification requirements. Additionally, we praise CMS's decision to give SBEs greater flexibility to require pre-enrollment verification beyond the MEC SEP. However, we encourage CMS to similarly require, not just allow, SBEs to also conduct pre-enrollment verification. Our research has extensively shown how SEPs combined with zero-dollar premiums are exploiting some of the most vulnerable communities in the country.[22] As more consumers transition into bronze plans, as seen during the 2026 OEP, the vulnerabilities of SEPs and widespread zero-dollar plans persist, further underscoring the need for CMS to finalize SEP verification proposals, extend the requirement to SBEs, and limit exemptions.

Proposals Related to FFE Standards of Conduct and Mandating a Standard Eligibility Application Review Form and Consumer Consent Form (§ 155.220(j)(2) and Proposals Related to Creating Standards of Conduct Related to Marketing (§ 155.220(j)(3))

CMS proposes two significant policies related to consent verification and marketing standards. CMS proposes requiring agents, brokers, and web-brokers to use an HHS-approved standard form to satisfy eligibility application review and consumer consent documentation requirements. Given widespread improper and phantom enrollment, the agency also seeks to clarify what constitutes a consumer "taking an action" to affirmatively review and confirm the accuracy of their application information and consent materials. Additionally, CMS proposes strengthening marketing regulations for QHPs offered through the exchanges, as well as for agents, brokers, and web-brokers operating in the FFEs and SBE-FPs. The proposal outlines specific prohibited practices, including offering cash or cash equivalents to induce enrollment, falsely suggesting eligibility for zero-dollar premiums, and misrepresenting enrollment timelines or deadlines. CMS also seeks to

[22] Brian Blase, "Testimony of Brian Blase before the House Committee on the Judiciary — 'Fighting Obamacare Subsidy Fraud: Is the Administrative Procedure Act Working as Intended?,'" Paragon Health Institute, December 10, 2025, https://paragoninstitute.org/private-health/testimony-of-brian-blase-before-the-house-committee-on-the-judiciary-fighting-obamacare-subsidy-fraud-is-the-administrative-procedure-act-working-as-intended/.

require the timely production of marketing materials for monitoring, audit, and enforcement purposes. Overall, CMS proposes marketing requirements and oversight that better align regulations across federal insurance programs such as Medicare Advantage.

We support the proposed provisions to address misleading marketing tactics that have contributed to improper and phantom enrollments and consumer confusion.[23] By clarifying prohibited conduct and enhancing oversight of marketing activities, CMS aims to improve the accuracy of information provided to consumers, reinforce program integrity, and restore trust between enrollees and enrollment intermediaries. CMS's proposals to mandate a standardized HHS-approved eligibility application review and consumer consent form, coupled with strengthened marketing conduct standards, represent meaningful steps toward restoring integrity in broker-driven enrollment pathways.

Requiring agents and brokers to obtain affirmative consumer consent to enroll in a given plan — beyond a pre-filled signature or passive checkbox — would address a core vulnerability that has led to widespread improper enrollment and has been perpetuated by automatic re-enrollment. The clarification that valid consent must involve a handwritten or electronic signature, recorded verbal confirmation, or a comparable "affirmative step" is particularly important. Such standardized consent should demonstrate that the individual understands they are enrolling in coverage that may involve financial obligations, including potential tax liabilities if their income differs from the income used to determine subsidy eligibility.

CMS should finalize its proposal to prohibit misleading, coercive, or materially inaccurate marketing practices. CMS should ban cash and other inducements, as well as zero-premium guarantees, from all marketing materials and efforts. Moreover, CMS should penalize the misuse of government logos, misrepresentation of enrollment deadlines, and fabricated legislative claims. Requiring the timely production of marketing materials for CMS review and audit purposes further strengthens enforcement capacity. Together, these reforms appropriately shift the focus toward providing complete and accurate information, reinforcing consumer trust, and enhancing the integrity of exchanges.

3. Marketplace Innovation

General Program Integrity and Oversight Requirements (§ 155.1200)

This provision establishes a SEIPM program to measure improper APTC and CSR payments in SBEs. SBEs would have the option to either complete the program or face audits. It outlines sampling procedures and standards for HHS to calculate improper payment rates. It also provides a pathway for SBEs to challenge HHS findings. If they have a significant error rate, states would have to submit a corrective action plan. If states persistently fail to comply, they may lose their authority to operate as a SBE. (See proposed § 155.1650(e)).

[23] Gabrielle Kalisz and Brian Blase, "Unpacking The Great Obamacare Enrollment Fraud: How the Exchanges Became the Wild West," Paragon Health Institute, August 7, 2024, https://paragoninstitute.org/private-health/unpacking-the-great-obamacare-enrollment-fraud/.

We support the administration's efforts to improve improper payment measurement by extending oversight to SBEs and urge CMS to finalize this proposal with caveats. However, currently, the SEIPM seems to mirror the existing FEIPM methodology, which suffers from insufficient sample sizes and imprecise margins of error.[24] As a result, the current FEIPM error rate is laughably low, with the most recent estimate at 0.89 percent.[25] Given GAO findings[26] and our own research into widespread fraud,[27] such an estimate shows that the current FEIPM program is seriously deficient. We are thus concerned that the SEIPM program would similarly fail to provide a useful measure of improper payments.

We recommend that CMS require explicit statistical standards, similar to what GAO[28] has used historically, for both national and State-level improper payment estimates. This method would strengthen the credibility and transparency of the measurement program.This is appropriate because the SEIPM would be optional for states. We also recommend that CMS make public improper payment rates by income group.

We also recommend that CMS similarly bolster the FEIPM program for federal exchanges. This change is a logical outgrowth of the proposed rule. The Payment Integrity Information Act (PIIA) requires agencies to measure and report improper payments in programs susceptible to significant improper payments. CMS states that SEIPM is necessary to close a "critical gap" in oversight. CMS emphasizes parity between FFE and state exchanges. CMS emphasizes accurate estimation, statistically valid sampling, and consistent methodology. If CMS extends improper payment measurement to state exchanges to ensure parity and accuracy, it is logical and necessary to ensure that the underlying measurement methodology itself fully captures substantive eligibility errors for both state exchanges and the FFE.

Approval of a State Exchange (§ 155.105)

CMS proposes to remove the Biden administration's 2023 requirement that a state operate as an SBE-FP for one year before transitioning to a fully operational SBE.[29] Under the proposal, states that are operationally prepared may transition directly from the FFE to a full SBE.

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[24] Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program, 91 Fed. Reg. 6467 (proposed Feb. 11, 2026), https://www.govinfo.gov/content/pkg/FR-2026-02-11/pdf/2026-02769.pdf.

[25] U.S. Department of Health and Human Services, *FY 2025 Agency Financial Report*, January 2026, https://www.hhs.gov/sites/default/files/fy-2025-hhs-agency-financial-report.pdf.

[26] U.S. Government Accountability Office, "Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist," GAO-26-108742, December 3, 2025, https://www.gao.gov/products/gao-26-108742

[27] Brian Blase, Chris Medrano, Niklas Kleinworth, and Jackson Hammond, "The Greater Obamacare Enrollment Fraud: The Fraud Got Much Worse in 2025," Paragon Health Institute, June 2025, https://paragoninstitute.org/private-health/the-greater-obamacare-enrollment-fraud/.

[28] U.S. Government Accountability Office, "Using Statistical Sampling," GAO PEMD-10.1.6. May 1, 1992, https://www.gao.gov/products/pemd-10.1.6.

[29] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2025, proposed rule, 88 Fed. Reg. 82510 (Nov. 24, 2023), https://www.govinfo.gov/content/pkg/FR-2023-11-24/pdf/2023-25576.pdf.

We support and urge CMS to finalize this provision. The Biden administration's requirement that states operate as an SBE-FP for a year before transitioning to a full SBE was an unnecessary procedural barrier untethered from clear statutory authority or demonstrated need. The ACA created the SBE-FP as an option for states that did not wish to assume full exchange responsibility, not as a federally imposed waiting period for states prepared to do so. Imposing an additional year in the federal exchange delays state-led reforms, injects avoidable political and logistical risk into the process, and may deter states from pursuing greater control through SBE adoption altogether. This concern is heightened by well-documented program integrity failures in the federal exchange (FFE) and HealthCare.gov, including widespread improper enrollment and weak eligibility verification, as detailed in *The Greater Obamacare Enrollment Fraud*[30] and *Unpacking The Great Obamacare Enrollment Fraud.*[31] Forcing capable states to remain in a system struggling with oversight challenges does not advance accountability. States that have completed the necessary operational work should be allowed to transition directly to an SBE without unnecessary federal delay. The Biden-era requirement is unnecessarily burdensome and can undermine state efforts to establish an SBE. Eliminating the mandatory SBE-FP year removes an arbitrary federal obstacle while preserving appropriate guardrails. Properly implemented, the policy empowers prepared states to move forward without delay while protecting taxpayers and eligible enrollees from the costly consequences of weak oversight.

Deferral of Network Adequacy Reviews to States with an Effective Provider Access Review Program (§§ 156.230 and 155.1050)

CMS is proposing to return oversight of network adequacy to states, as was done in the first Trump administration. CMS proposes to allow states that use the FFE to conduct their own provider access and ECP certification reviews for QHPs, instead of relying solely on CMS.

CMS also proposes restoring greater network adequacy authority to SBEs and SBE-FPs by removing the requirement that they adopt the same federal quantitative time-and-distance standards used in the FFEs. Instead, states would be required to ensure that QHPs offer sufficient provider choice consistent with existing regulatory standards, but would have more flexibility in how those standards are applied.

We support and urge CMS to finalize this proposal. Restoring network-adequacy oversight to states is a sensible course correction. States are better positioned to assess local provider supply, geographic constraints, and market dynamics than federal regulators applying uniform time, distance, and appointment wait-time standards. The 2015 to 2017 federal time-and-distance reviews illustrate the limitations of that approach: they imposed

[30] Brian Blase, Chris Medrano, Niklas Kleinworth, and Jackson Hammond, "The Greater Obamacare Enrollment Fraud: The Fraud Got Much Worse in 2025," Paragon Health Institute, June 2025, https://paragoninstitute.org/private-health/the-greater-obamacare-enrollment-fraud/.
[31] Gabrielle Kalisz and Brian Blase, "Unpacking The Great Obamacare Enrollment Fraud: How the Exchanges Became the Wild West," Paragon Health Institute, August 7, 2024, https://paragoninstitute.org/private-health/unpacking-the-great-obamacare-enrollment-fraud/.

significant administrative burden, required extensive insurer documentation to explain provider gaps, and did not materially expand network breadth; narrow networks persisted, and HHS frequently deferred to state judgments in practice. Reinstating rigid federal standards would likely increase compliance costs that ultimately translate into higher premiums, without clear evidence of improved access. Consistent with the ACA, CMS should maintain backstop authority, but states should conduct primary network-adequacy reviews to avoid duplicative oversight, tailor standards to local conditions, and use CMS-collected data for monitoring and technical assistance.

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

CMS proposes to create a new optional exchange model, the state-based exchange enhanced direct enrollment (SBE-EDE) option, under which an SBE could rely exclusively on private-sector web brokers and direct enrollment entities to operate the consumer-facing platforms that facilitate applicant eligibility and the enrollment process. To provide this pathway, CMS proposes to eliminate the requirement that SBEs maintain a centralized and exclusive, consumer-facing eligibility and enrollment platform. Additionally, CMS is proposing to reduce federal paperwork and progress reporting for SBEs, including certain exchange Blueprint documentation and milestone updates.

Paragon supports CMS's proposal to streamline documentation requirements for SBE exchange Blueprint submissions, which are required for CMS review in facilitating a transfer from the FFE. The current Blueprint process already establishes how a state will meet approval standards and demonstrate operational readiness; duplicative documentation primarily burdens state exchange administrators without improving oversight. So long as CMS retains sufficient oversight to ensure readiness and compliance, this streamlining is warranted.

We strongly oppose CMS's proposal to allow an SBE-EDE option. EDE platforms currently operate only in states that use the federal platform, HealthCare.gov, including FFEs and SBE-FPs. EDE integration has already exposed significant, recurring program-integrity vulnerabilities. CMS therefore should not expand EDE authority or treat EDE-only enrollment as an acceptable substitute for a centralized, exchange-operated pathway — whether on the federal platform or in fully state-run SBEs.

EDEs serve as the consumer-facing interface for exchange applications — handling plan comparisons, application intake, and enrollment submission — while the federal exchange performs the actual eligibility determination. Under the proposal, CMS would extend this framework to SBEs. Consumers would apply and enroll exclusively through approved private EDE entities, which would serve as the sole front-end pathway. The SBE would retain back-end authority: processing eligibility determinations for APTC and CSRs, conducting income and immigration verifications, making Medicaid and CHIP referrals, transmitting enrollment data to CMS and the IRS, and overseeing program integrity. In

practice, this distinction is largely illusory: eligibility determinations are only as reliable as the application data submitted through the front-end intake process.

In theory, EDEs could increase enrollment efficiency.[32] In practice, EDEs have enabled large numbers of improper and phantom enrollees. Agents and brokers operating through EDE platforms earn per-enrollee carrier commissions with large bonuses tied to enrollment numbers — typically $15–30 per enrollee per month, recurring for the life of the policy — plus enrollment volume bonuses. (HealthSherpa pays agents up to $150 per qualifying enrollment during Open Enrollment).[33] In a heavily subsidized market in which many enrollees have fully-subsidized plans and application manipulation is necessary for enrollment, the incentives favor maximizing volume over accuracy.[34]

The fraud record confirms it: documented improper and fraudulent enrollment is overwhelmingly clustered in states that rely on HealthCare.gov (FFEs and SBE-FPs), where EDE and web-broker enrollment dominate the consumer pathway.[35] A Paragon analysis found that HealthCare.gov states reported 8.7 million sign-ups with incomes between 100 and 150 percent of the FPL versus only 5.1 million people likely eligible (170.1 percent, or 1.7 sign-ups per eligible person). By contrast, fully state-run SBEs reported 701,126 sign-ups versus 1,928,208 potential enrollees (36.4 percent). Even holding Medicaid expansion status constant, HealthCare.gov expansion states showed more than double the sign-ups-to-eligible rate compared to expansion states with fully state-run SBEs.[36] This divergence strongly suggests that HealthCare.gov's reliance on EDE enrollment has significantly contributed to large-scale improper enrollment.

Fraudulent enrollment in EDE environments occurs at the intake layer: through manipulated data submissions, submitting applications without consumer knowledge or consent, switching enrollees between plans without authorization, and generating phantom enrollments.[37] These abuses occurred upstream of eligibility determination. The exchange's back-end authority did not prevent them because fraud entered the system before the exchange saw it. Expanding the SBE-EDE model without substantially

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[32] Centers for Medicare & Medicaid Services, "Enhanced Direct Enrollment," January 15, 2026, https://www.cms.gov/marketplace-private-insurance/agents-brokers/direct-enrollment-partners.

[33] HealthSherpa Help Center, "Enrollee Assistance Program," https://faq.healthsherpa.com/en/articles/4586303-enrollee-assistance-program; Agility Insurance Services, "2025 ACA Carrier Commission Schedules," accessed March 9, 2026, https://www.enrollinsurance.com/2025-aca-commissions.

[34] Brian Blase, "Explaining the Rise of Phantom ACA Patients," Paragon Health Institute, August 25, 2025, https://paragoninstitute.org/private-health/explaining-the-rise-of-phantom-aca-patients/.

[35] Brian Blase, "Testimony of Brian Blase before the House Committee on the Judiciary — 'Fighting Obamacare Subsidy Fraud: Is the Administrative Procedure Act Working as Intended?,'" Paragon Health Institute, December 10, 2025, https://paragoninstitute.org/private-health/testimony-of-brian-blase-before-the-house-committee-on-the-judiciary-fighting-obamacare-subsidy-fraud-is-the-administrative-procedure-act-working-as-intended/.

[36] Brian Blase and Drew Gonshorowski, "Fraudulent Exchange Enrollment Much More Severe in Non-Medicaid Expansion States and States Using HealthCare.gov," Paragon Health Institute, July 3, 2024, https://paragoninstitute.org/paragon-pic/fraudulent-exchange-enrollment-much-more-severe-in-non-medicaid-expansion-states-and-states-using-healthcare-gov/.

[37] Brian Blase, "Testimony of Brian Blase before the House Committee on the Judiciary — 'Fighting Obamacare Subsidy Fraud: Is the Administrative Procedure Act Working as Intended?,'" Paragon Health Institute, December 10, 2025, https://paragoninstitute.org/private-health/testimony-of-brian-blase-before-the-house-committee-on-the-judiciary-fighting-obamacare-subsidy-fraud-is-the-administrative-procedure-act-working-as-intended/.

strengthening front-end intake controls does not solve this problem — it extends the vulnerable architecture to a new class of states. A recent GAO investigation, cited by CMS in this rule, confirms that the exchanges are highly vulnerable to fraud, finding that the federal exchange approved subsidized health insurance coverage for 23 of 24 fictitious applications submitted.[38]

The Speridian Health case illustrates both the magnitude of risk and the limitations of CMS's supervisory framework. In September 2024, CMS suspended Speridian, an EDE entity that had processed more than one million exchange applications. CMS cited credible evidence that Speridian altered applications, enrolled individuals without consent, and routed substantial enrollment traffic through overseas IP addresses in Hong Kong, India, Japan, Pakistan, Ireland, and Sweden.[39] Notably, Speridian had already faced federal enforcement actions in 2018 and 2022, yet CMS reinstated the entity each time before issuing a final bar in January 2026. Allowing a repeat offender to operate at scale illustrates both the magnitude of risk and the limitations of CMS's supervisory framework.

HealthSherpa — the largest EDE entity and the platform Georgia initially proposed to use in its Access Model — designed its "Resume Link" functionality to streamline enrollment by bypassing the standard three-way Marketplace verification call. Unscrupulous actors exploited the tool to submit unauthorized enrollments and plan switches, prompting the company to pause the functionality. HealthSherpa has reported processing more than 90 percent of all EDE applications submitted to HealthCare.gov in recent years.

Enhance Health in Florida provides a further example of how EDE environments enabled large-scale improper enrollment. Enhance Health, a Florida-based brokerage operating through EDE, ran aggressive and misleading enrollment campaigns targeting low-income individuals — enrolling consumers without meaningful consent and accounting for over $233 million in fraudulent subsidies.[40][41] Each episode exploited the same structural gap: CMS lacks the real-time auditing capacity to detect manipulation at the intake layer before it flows into eligibility determinations. The supervisory gap widens as EDE entities grow more vertically integrated, controlling marketing, call centers, and application submission simultaneously.

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[38] Brian Blase, "GAO Probe Finds ACA at High Risk for Fraud: 96% of Fake Applications Approved," Paragon Health Institute, December 3, 2025, https://paragoninstitute.org/paragon-prognosis/gao-probe-finds-aca-at-high-risk-for-fraud/.
[39] Centers for Medicare & Medicaid Services, "CMS Actions to Protect Consumers and Strengthen Exchange Program Integrity," January 28, 2026, https://www.cms.gov/newsroom/fact-sheets/cms-actions-protect-consumers-strengthen-exchange-program-integrity.
[40] Gabrielle Kalisz, "DOJ Confirms Florida's Rampant Exchange Fraud," Paragon Health Institute, March 10, 2025, https://paragoninstitute.org/paragon-prognosis/doj-confirms-floridas-rampant-exchange-fraud/.
[41] U.S. Department of Justice, "President of Insurance Brokerage Firm and CEO of Marketing Company Sentenced in $233M Affordable Care Act Enrollment Fraud Scheme that Preyed on Vulnerable Consumers," February 18, 2026, https://www.justice.gov/opa/pr/president-insurance-brokerage-firm-and-ceo-marketing-company-sentenced-233m-affordable-care.

Proponents argue that removing the dominant public-sector platform would strengthen private-market participation and reduce state infrastructure costs. Those benefits are not guaranteed and do not automatically outweigh the risks. Market stability depends not only on enrollment volume but also on eligibility accuracy, subsidy integrity, and consumer trust. Expanding EDE dominance without materially strengthening front-end intake controls would replicate — and likely amplify — the vulnerabilities that have already produced widespread improper enrollment and costly subsidy abuse.

We strongly oppose and caution against any expansion of EDEs for these reasons. CMS must address its own oversight deficiencies by establishing mandatory real-time auditing authority over EDE application submission activity; enhanced data transparency and reporting requirements for EDE entities; materially strengthened enforcement mechanisms with meaningful consequences for repeat violations; multi-factor authentication (MFA) or two-factor authentication (2FA) for applications and robust HHS-standardized consent verification that cannot be bypassed or abbreviated.

MLR—Request for Information

The 2027 NBPP does not propose a regulatory change to the MLR standard. Instead, CMS solicits comment on two questions: first, whether HHS should use its existing authority to adjust the MLR standard in a state to promote individual market stability, and second, whether and how to amend the regulations governing the state request process to reduce burden and encourage more states to seek adjustments.

We support CMS revisiting the MLR standard. The 80 percent MLR floor was set without adequate consideration of how it would interact with the ACA's subsidy structure, market concentration dynamics, or the administrative complexity facing smaller issuers. The MLR construct likely increases health care spending, premiums, and prices — giving insurers incentives to avoid rebates and increase spending to increase profits.

The 80 percent floor does not appropriately account for differences across state markets. A smaller issuer operating in a rural or low-population state faces structurally higher administrative costs per member than a large national carrier. States with highly concentrated hospital and insurer markets face conditions in which the MLR floor's perverse incentive effects are most pronounced. CMS is right to examine potential state-level adjustments and should streamline the petition process to make relief accessible to states that can demonstrate market instability or premium inflation attributable to the current standard.

An insurer that spends 80 cents of every dollar on claims but generates those claims through inflated provider contracts and cost-insensitive utilization is not serving consumers well, regardless of its technical MLR compliance. Genuine consumer protection requires

competitive markets and price transparency — not percentage-of-premium accounting rules that can be satisfied through cost escalation as readily as through genuine efficiency.

Massive Benefits of the Proposed Rule: Reducing Improper Enrollment, Premiums, and Deficits

CMS estimates that the proposed rule will modestly reduce exchange enrollment while lowering premiums and generating substantial federal savings through program-integrity reforms. Given the large numbers of improper and phantom enrollees, lower enrollment, lower premiums, and substantial federal savings are desirable outcomes. Paragon supports CMS's premium impact estimates and agrees that expanding plan design flexibility and limiting benchmark inflation are likely to reduce upward pressure on premiums.

CMS projects that 2027 exchange enrollment will decline by roughly 1.2 to 2.0 million enrollees relative to baseline projections because of the policies in the proposed rule. Much of the projected decline reflects the removal of improper or inactive enrollment. CMS data show that roughly 35 percent of exchange enrollees had zero claims in 2024, with 40 percent of enrollees with fully subsidized plans having no claims. As a result, the projected enrollment reduction largely reflects improved program integrity rather than reduced access to coverage for eligible individuals who would actually use that coverage.

The White House Council of Economic Advisers has estimated that expanded catastrophic eligibility could increase enrollment in catastrophic plans from roughly 54,000 individuals to approximately 3 million.[42] This projection underscores the scale of unmet demand among unsubsidized consumers.

CMS projects that the rule will reduce premiums by roughly 2 percent relative to baseline projections. Several provisions contribute to this result. Program-integrity reforms will improve the composition of the risk pool by limiting opportunities for gaming and adverse selection. In particular, eliminating the SEP for individuals with incomes between 100 and 150 percent of the FPL reduces incentives for individuals to delay enrollment until they expect to use medical services. Strengthened verification requirements similarly discourage improper enrollment and stabilize the risk pool.

The rule also contains structural reforms that expand competition and consumer choice. Allowing non-network plans as QHPs would enable insurers to compete using alternative payment models that reduce administrative costs and allow consumers broader provider access. At the same time, expanding eligibility for catastrophic plans will allow more consumers to purchase lower-premium coverage that focuses on protection against high-cost medical events. Reducing regulatory barriers and expanding these lower-premium options increases competition and puts downward pressure on premiums throughout the market.

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[42] White House Council of Economic Advisers, "Expansion of HSA Eligibility Under OBBB Act to Improve Marketplace Coverage, Affordability, and Access," September 2025, https://www.whitehouse.gov/wp-content/uploads/2025/03/Expansion-of-HSA-Eligibility-Under-OBBA.pdf.

The proposed rule also produces substantial federal deficit reduction, primarily by reducing improper PTC payments. Many of these policies are CMS regulations implementing important reforms in the WFTC. Limiting PTC eligibility to individuals who meet statutory immigration requirements is estimated to reduce federal spending by nearly $10 billion per year beginning in 2027. Additional policies — including eliminating the 100-to-150-percent-of-the-FPL SEP, strengthening income verification, restoring failure-to-reconcile requirements, and expanding pre-enrollment verification — generate billions of dollars in additional savings.

Importantly, these estimates are single-year savings, not ten-year totals. When aggregated across the major provisions and projected over the standard budget window, the rule (including key policies implementing last year's reconciliation bill) will likely produce at least $150 billion in deficit reduction over the next decade. Lower federal deficits yield broader economic benefits. Reduced borrowing decreases upward pressure on interest rates and inflation, lowers the likelihood of future tax increases, and reduces the deadweight loss associated with taxation, which occurs when taxes discourage work, investment, and other productive economic activity. By reducing improper spending while improving the functioning of the exchange market, the proposed rule strengthens both fiscal sustainability and economic efficiency. The positive macroeconomic effects provide strong support for the overall direction taken in this rule.

Thank you for considering our views on these reforms.

Sincerely,

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