AMERICAN ACADEMY of ACTUARIES

March 13, 2026

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

Re: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027 and Basic Health Program Proposed Rule

To Whom It May Concern:

On behalf of the Individual and Small Group Markets Committee and the Health Solvency and Financial Reporting Committee (Committees) of the American Academy of Actuaries (Academy),[1] we appreciate the opportunity to provide comments regarding the Notice of Benefit and Payment Parameters for 2027; and Basic Health Program (Payment Notice) proposed rule. The Committees appreciate HHS' efforts to improve the implementation of the Affordable Care Act (ACA). The proposed rule includes several provisions that will impact a wide range of plan, broker, and state activities related to 2027 rates. The Committees acknowledge the efforts by HHS to increase choices available to consumers in the individual market, expand the range of plan offerings within the ACA's plan design, and focus on the overall integrity of the single risk pool. Our comments focus on the following:

- **Defrayal of state-mandated benefits:** Implementing changes to the defrayal of state-mandated benefits for the 2027 plan year may not allow states sufficient time to budget for increased costs or to make changes to benefit mandates. This could create solvency risk in 2027, particularly if retroactive defrayal is required.
- **Cost-sharing reduction data reporting:** The proposed approach is consistent with prior Academy analysis of cost-sharing reduction (CSR) loading methodology options.[2] However, the requirement to use the standard methodology to determine amounts actually paid for claims prior to plan year 2027 without any allowance for estimation methods could be difficult for issuers to implement.

[1] The American Academy of Actuaries is a 20,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For 60 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

[2] https://actuary.org/wp-content/uploads/2024/12/Academy_CSR_Load_Letter_09.08.22.pdf

- **Catastrophic plan proposals:** The proposed changes are innovative but may not have much impact on enrollment. Additionally, these proposals, and in particular multi-year catastrophic plans, may be challenging to implement and price.
- **Non-network plans:** Non-network plans are generally incompatible with the actuarial value calculator (AV calculator), as they are generally more consistent with insurer-facing copayments than member copayments or coinsurance.

Overall, many of the proposed policies have potentially broad implications and may pose additional challenges for consumers who are trying to understand new products, regulators who are trying to review rates and forms, providers who are evaluating new contracts, and carriers seeking to finalize plan portfolios and price them appropriately.

Rate filing activities for 2027 are already well underway for many market participants. The delayed publication date for this year's Payment Notice significantly increases the complexity of accurate pricing of new and novel proposals, as key downstream deadlines, including state and federal rate review timelines, are not correspondingly delayed. The uncertainty is further compounded by the significant uncertainty about the actual size and risk composition of 2026 markets. Although many of the provisions have the intention of reducing 2027 premiums, higher levels of uncertainty usually result in higher rates.

We suggest that HHS focus on a more limited set of policies for 2027, delaying the effective date of the proposals with more complex implementation and pricing issues to future years. Doing so would best position consumers, issuers, and regulators for successful implementation without introducing additional uncertainties.

Specifically, we recommend that HHS limit the implementation of new proposals in 2027 to incremental adjustments to risk adjustment, user fees, and the statutory requirements associated with the recently passed budget reconciliation bill.

Additionally, we suggest that the following proposed actions be delayed:

- The defrayal of state-mandated benefits until plan year 2029 or later. This would allow states the time to appropriate funding or make changes to state benefit mandates.
- Proposed CSR reconciliation reporting requirements to use the standard methodology until the 2029 pricing year (which will use plan year 2027 experience), to ensure that systems have time to be tested and can be used at the initial time of claims processing. In the interim, we'd request HHS provide additional guidance on what estimation approaches may be acceptable.
- Actions on non-network plans.
- Proposals related to catastrophic plans, until key details necessary to price these products can be provided and evaluated in their entirety.

The remainder of this letter offers our specific comments on the proposals in the proposed Payment Notice.

Additional Required Benefits (§ 155.170), Provision of EHB (§ 156.115(d)), State Selection of EHB-benchmark Plan (§ 156.111)
HHS proposes to again consider any benefit mandated by a State action after Dec. 31, 2011, excluding benefits for compliance with Federal requirements, as not being an EHB, even if the benefit is part of the state-selected EHB benchmark plan. Under this approach, states could be required to defray the cost of such benefits for QHP enrollees.

Challenges associated with immediate application of this provision in 2027
There may be difficulties in implementing this provision quickly. It may be challenging and time-consuming for states to investigate which benefits were required to be covered by state action after 2011 and are also included in a state's EHB-benchmark plan for defrayal. They would then need to either begin funding the defrayals or take legislative or executive action to remove the mandates from QHP applicability. Applying these changes to plan year 2027 creates potential solvency risk. If issuers develop premiums assuming the state-mandated benefits would be defrayed, and states are unable to pass legislation to appropriate funding, issuers would be in the position of providing a benefit without receiving premiums to pay for those costs.

In addition, the calculation and logistics of defrayal amounts may be difficult depending on the benefit and service. Coordination between states and issuers may be required to identify the cost of benefits, including identifying relevant codes, utilization, and service costs. There is a risk that the defrayal amount insufficiently incorporates the cost of the benefit or that defrayal payments lag too far behind the service date.

Interaction with the proposed temporary moratorium on changes to state EHB benchmark plans
The revised interpretation on benefits mandated by states after 2011 is coupled with a moratorium on changes to an EHB benchmark plan. EHB plans, in many cases, represent a tradeoff of benefits and benefit levels. The current benchmark plans were selected or maintained, assuming a specific set of applicable regulations. Offering states flexibility to remove state-mandated benefits without being able to address other considerations impinges on a state's decision-making process and reduces the actuarial value of benefits provided, potentially below minimum required generosity levels of the EHB package.

A delay of applicability would be appropriate
Given the potential solvency concerns and the inability of states to modify EHB benchmark plans, HHS could consider delaying any changes in this regard until states can submit updated EHB packages and/or update state budgets to account for the cost of defraying benefits that would shift from being considered part of the EHB to being considered state-mandated benefits in addition to EHB.

Request for clarification
We would request clarification on two issues.

- Is selecting a new EHB benchmark plan considered a state action?
- If a state-required benefit, subject to defrayal under the proposal, is currently embedded in a state's EHB-benchmark plan, would a state's decision to repeal the applicable state

requirement make the benefit an EHB if it otherwise fit into one of the EHB benefit categories?

Routine non-pediatric dental

Regarding the proposal to remove routine non-pediatric dental, we refer to our comments on this proposal in the 2026 Payment Notice.[3] In particular, most employer group health plans include dental coverage, though this coverage is typically a separate policy with distinct features relative to major medical health insurance. We appreciate the 2027 Proposed Payment Notice clarifying that nothing in regulation prohibits a state from including the quantitative value of routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia in its typicality analysis.

Submission of Rate Filing Justification (§ 154.215): Rate Filing Justifications Regarding CSRs

HHS is proposing to formalize data collection elements for CSRs and related premium loads to account for the unavailability of funding for CSRs beginning in October 2017. These changes follow up on a revision to the single risk pool allowable plan-level adjustment for actuarial value and cost sharing finalized by HHS in the 2026 Payment Notice.

Comments on the data collection

In general, we support the collection of data necessary to evaluate compliance with single risk pool standards, which would reasonably include CSR loads and estimated CSR amounts paid by issuers. However, we are concerned that without any allowance for estimation methods, issuers may find it difficult to use the standard methodology for claims incurred prior to plan year 2027.

Considerations for actuaries required to certify rates and sign actuarial memoranda

There are several operational challenges associated with the proposed requirement for issuers to use the standard methodology (i.e. adjudication of claims under both the CSR plan variation and the underlying plan, commonly referred to as double adjudication). While we are not explicitly commenting on the information technology aspects of this proposal, we note that the new requirements explicitly require the use of the standard methodology and include these amounts in the actuarial memorandum, which actuaries are required to certify. Moreover, there is no allowance for estimation methods in the event that IT systems are unable to produce reliable calculations of the amount of CSRs actually provided in 2025. We would request that HHS provide further guidance on alternative methods for determining CSRs provided and/or delay application of the requirement to use the standard methodology until plan year 2027 or plan year 2028. Using plan year 2027 as a trial year to validate new systems would help facilitate a smoother transition to the standard methodology.

Importantly, allowing actuaries flexibility to use actuarial judgment based on the specific facts and circumstances, as well as the actuarial considerations of the specific market and plan portfolio will help avoid these kinds of situations. Even with such flexibility, actuaries are required to certify that rates are neither excessive nor deficient, protecting the integrity of rates in the single risk pool.

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[3] https://actuary.org/wp-content/uploads/2024/12/health-comment-2025-NBPP.pdf

Comment Solicitation on Retaining Separate Risk Adjustment Transfer Calculations for Individual Catastrophic Plans and Individual Non-Catastrophic Plans, Expansion of Hardship Exemption Eligibility (§ 155.605(d)(1)), Multi-Year Terms for Catastrophic Plans to Improve Health (§§ 156.130(c) and 156.155(a)(6)), Permitting Plan-Level Adjustments for Multi-Year Catastrophic Plans (§ 156.80(d)(2)(ii)), Publication of the 2027 Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing (§ 156.130(e)), Cost Sharing for Bronze and Catastrophic Plans (§§ 156.136 and 156.155)

HHS is proposing a wide range of changes to catastrophic and bronze plans that would, if adopted, represent some of the most significant modifications to single risk pool plan designs since the rollout of single risk pool coverage in 2014. The effects of these provisions interact with each other to varying degrees.

Who do these proposals target?

The vast majority of enrollees in the individual market are subsidy eligible, whereas catastrophic plans remain statutorily ineligible for premium tax credits. Most subsidy-eligible individuals receive enough in subsidies that bronze plans are both less expensive and as generous as catastrophic coverage. As a result, the proposed changes are unlikely to have a meaningful impact on most enrollees who currently choose an ACA plan. However, for enrollees who are ineligible for premium subsidies or whose premium subsidies are too small to bridge the gap between catastrophic and bronze coverage, these changes could have a material impact on available plan choices and premium affordability.

How catastrophic plans currently fit into single risk pool pricing

Catastrophic plans occupy a distinct position within the single risk pool. The main reason they can often be priced lower than bronze plans is that eligible individuals generally have lower morbidity risk but do not affect metallic pool risk adjustment. Otherwise, catastrophic plans would likely be payers into the overall risk adjustment pool. Specifically, catastrophic plans are the only coverage level ineligible for subsidies, and they have a unique allowable plan-level adjustment factor designed to reflect the characteristics of the population eligible for catastrophic coverage. Specifically, the adjustment factor accounts for the lower morbidity of catastrophic plan enrollees. Apart from the eligibility restrictions, catastrophic plans are essentially the same as bronze plans, making the adjustment factor the primary reason why catastrophic plans are less expensive. In states with a 3:1 age curve, most of the premium difference is driven by the relative health status of those eligible for catastrophic coverage rather than demographic differences.

Integrating the metallic and catastrophic risk pools in individual and merged market risk adjustment

HHS is requesting feedback on the continuation of the separate risk adjustment treatment of catastrophic plans within the broader individual/merged market single risk pool. The arguments for and against this proposal boil down to two perspectives.

- Perspective 1: If eligibility for catastrophic coverage is expanded so that it resembles the broader single-risk pool, there may no longer be a reason to treat catastrophic plans separately in risk adjustment.

This perspective would lead to the combination of the risk adjustment pools. This would generally be expected to cause premiums for catastrophic plans to increase significantly. There would be offsetting reductions to metallic plan premiums, but these reductions would be much smaller in size due to the relative size of the two risk adjustment pools. In most cases, it is likely to be small enough to be unnoticeable relative to other drivers of premium change.

- Perspective 2: For catastrophic coverage to have value, it must remain as affordable as possible for individuals who lack access to subsidies.

  This perspective would lead to keeping the risk adjustment pools separate. Even with expanded eligibility criteria, separation might still be warranted. Enrollees eligible for CSRs are ineligible for the expanded hardship exemption and the October 2021 risk adjustment report included a discussion on CSR enrollees and showed distinct utilization differences between CSR enrollees and other single risk pool enrollees.

The decision to integrate the two risk pools has significant implications for the other catastrophic and bronze plan proposals in the Payment Notice, as it would fundamentally alter the pricing relationship between catastrophic plans and the rest of the single risk pool. The impacts of either combining or retaining separate risk adjustment pools depend in part on the degree to which catastrophic enrollment increases, the morbidity of enrollees, and whether the increase in enrollment comes from those who are previously uninsured or from enrollees shifting from metallic coverage.

Market stability considerations for the catastrophic risk adjustment pool, assuming separate risk pools

If the current separate risk adjustment pool policy is maintained, expanding hardship exemptions and increasing the maximum out-of-pocket (MOOP)/deductible of catastrophic plans would likely widen the premium gap between catastrophic plans and the rest of the single risk pool. The appeal of catastrophic coverage could increase materially, particularly for healthier, unsubsidized consumers who want insurance but do not find value in current non-catastrophic products. It would also introduce another element of volatility into the market, particularly if issuers offering catastrophic plans are unable to assess the health status of enrollees effectively. To date, catastrophic risk adjustment has shown lower market size-adjusted variability than the rest of the individual market risk adjustment pool, likely attributable to the relative homogeneity of catastrophic enrollment—the product of the limited pool of eligibles and the identical nature of catastrophic plan designs.

Market stability considerations for the metallic risk adjustment pool, assuming separate risk pools

Metallic premiums are required to reflect the overall morbidity of the entire individual market, including catastrophic plan enrollment. Growth in catastrophic plan enrollment will tend to put downward pressure on the index rate and on overall metallic premiums. The revenue effects can be quite significant when catastrophic enrollment exceeds 10% of an issuer's business. If a good portion of this growth is taken from current bronze enrollment, the overall actuarial risk of the metallic risk adjustment pool would probably increase. Since bronze plans typically pay into risk

adjustment, exit of those members increases morbidity in the single risk pool overall, resulting in less favorable risk adjustment outcomes than assumed in pricing if issuers fail to correctly estimate the shift. If shifts are large enough, plans could be materially underpriced, adding another source of instability to the market. Concerns regarding underpricing the metal tier plans can result regardless of whether new catastrophic plan enrollment comes from the previously uninsured or from metal tier plans, if new enrollment is material.

Changes to MOOP limits for catastrophic plans

HHS is proposing to increase the catastrophic plan MOOP to 30% higher than the ACA's maximum annual cost-sharing limitation, which would reduce the AV of catastrophic plans and likely also reduce premiums. Creating actuarial value separation would create a more visible distinction in plan design between bronze and catastrophic plans, likely restoring some rate separation between catastrophic plans and bronze plans if catastrophic plans are integrated into the risk adjustment pool for metallic plans. Generally, this proposal would likely result in a modest increase in catastrophic plan enrollment when viewed in isolation. The proposal to allow increased MOOPs for bronze coverage would work at cross purposes, as a higher MOOP bronze plan could be harder for consumers to distinguish in value from a catastrophic plan.

HHS also discussed an option in which catastrophic plan MOOPs could vary between the ACA maximum annual limitation and the proposed catastrophic maximum annual limitation. This would introduce another variable into catastrophic risk adjustment, as the underlying plan designs would no longer be uniform. If catastrophic plans are kept in a separate risk adjustment pool, this option could discourage issuers from offering catastrophic plans, as lower premium levels give issuers less financial capacity to absorb unpredicted movements in risk adjustment.

Notes on the computation of the proposed catastrophic maximum annual limitation on cost sharing

We note that 130% of the 2027 Maximum Annual Limitation on Cost-Sharing of $12,000 would be $15,600, as opposed to the value of $15,400 indicated in the Payment Notice. This appears to be the case even when the 2014 base value of $6,350 is trended to 2027, multiplied by 1.3, and then rounded down to the nearest $50. We request that HHS clarify whether the family limit for catastrophic plans would be twice the individual limit.

The argument for multi-year products and the counterbalancing risk

HHS is proposing to allow multi-year terms for catastrophic plans. Multi-year plans may encourage longer-term, continuous enrollment in the individual market, which may allow issuers to invest in preventive care and other benefits that have longer-term health benefits and promote healthier outcomes. However, as noted below, various aspects of these plans could also result in increased risk to insurers and may drive higher premiums.

Uncertainty regarding which provisions would be fixed over time in multi-year catastrophic plans

HHS notes a number of potential flexibilities but leaves open a consequential set of questions that must be answered before actuaries can assess the risk associated with a multi-year product and how to price it. The questions include, outside of the initial eligibility determination:

- What provisions would be fixed at the time a multi-year contract is effectuated?
- Would premiums be fixed?
- Would rate increases for the whole term be set at the initial filing?
- Would area factors be fixed?
- Would enrollees progress through the age curve each year?
- Would the issuer have to keep any dependents on the contract until the full term expired?
- Would covered benefits be fixed?
- What valuation assumptions would be fixed?

Answering these questions is essential for understanding the costs that need to be estimated, the potential product design risk exposure linked to offering longer-term contracts, and gaining a basic understanding of the underlying actuarial liabilities.

Other key questions that would shape member experience and product pricing
Other questions that need to be addressed include:

- Would issuers be able/required to adjust rates on an annual basis as part of the annual single risk pool premium filing?
- How would coverage apply for newly added dependents during the plan's term?
- How would premiums be handled for consumers who move between rating areas?
- Would the plan-level adjustment for multi-year catastrophic plans have a trend component, like the quarterly trend adjustment in the small group market?
- If the adjustment functions like quarterly trend, when would premium refilings be permitted?
- If premium refilings are permitted, would refilings affect the rates of currently issued products?

Multi-year plans also create a range of actuarial/valuation considerations:

- How would multi-year plans be treated in risk adjustment and RADV, particularly if annual rate adjustments are not permitted?
- How would multi-year plans be treated in MLR calculations?
- How would multi-year plans be treated under state 1332 waiver programs?
- What kinds of novel financial reporting issues would multi-year plans raise under GAAP and statutory accounting?
- What discount rates would be appropriate for any longer-term valuation of benefits?
- When insurance product designs and rating limitations result in a disconnect between the premiums collected and benefits received over the contract term, the product typically has a cash value. Would any cash value accumulate if a similar situation arises for multi-year catastrophic plans?
- What modifications to regulatory capital requirements would be warranted for multi-year plans to reflect the increased risk they pose to issuers?
- What additional rate review requirements would be required for multi-year catastrophic plans, particularly if contract terms are largely fixed at pricing?

We would be happy to provide subsequent comments that provide information on the impacts of alternative approaches.

The MOOP flexibilities are creative, but raise several questions

For catastrophic plans with multi-year terms, HHS proposes that plans could elect to have annual limits that could also be applied as monthly limits over the life of the plan. This unique design option could be significantly favorable to consumers in lowering MOOP for specific services within a month. However, a range of challenges exist:

- Operational/implementation issues: Plans currently operate on an annual deductible/ MOOP accumulation footing, where exact timing of a claim within a year is less impactful. As long as the plan processes claims in a predictable order (i.e. the order approved and paid), the consumer will receive essentially the same cost-sharing. But claims can take six months or more to be paid. That is typically, at most, one extra plan year, but potentially six or more monthly MOOP cycles, which could lead to consumer confusion and additional administrative complexity.
- New consumer utilization behavior patterns (e.g., stacking services within a month to take advantage of the lower MOOP limits): Such behaviors could arise, particularly if multiple, higher cost elective services are in play. This could lead to material increases in actuarial value which, if unpriced for, could create significant solvency challenges
- Pricing complexity: Current actuarial continuance tables are designed for annual products and do not take into account how consumer behavior might change under a monthly benefit.

HHS proposed a number of other options of varying complexity

Some of the proposals, like a constant MOOP through the entire term, are easier to envision, although claims trend becomes an extremely critical pricing component, particularly if premium rate refilings are limited. Others, such as different MOOPs for different medical conditions, appear to have significant operational and ethical challenges that render them entirely impractical. The risk of adverse selection alone could mean that the plan must be priced as if it has the condition-specific MOOP and not the targeted average. We appreciate HHS' search for innovative options for consumers. However, the challenges detailed above may be insurmountable.

Extending multi-year plan flexibilities to other metal tiers

HHS also requested comments on extending multi-year flexibilities to metallic coverage, as well as to catastrophic coverage. In addition to the issues raised above, applying a multi-year process across plans of different generosity introduces an opportunity for additional levels of adverse selection, particularly if rate guarantees are in place that prevent multi-year coverage at higher benefit levels from keeping pace with prevailing trends. Consumers are relatively insulated from higher-than-expected rate increases, as they can shop for a new plan if trends are lower than expected under a rate guarantee, while higher-than-expected trends will result in greater persistency and additional risk exposure for the issuer offering such coverage. Unlike catastrophic coverage, which requires a significant member commitment for non-preventive services before plan responsibility begins in earnest, other metal tiers typically have lower deductibles and out-of-pocket maximums which leave the issuer with significantly greater

exposure. This consideration is likely to limit issuer willingness to engage on multiple-year metallic products unless sufficient rating protections are available to ensure that they can adjust rates as necessary to keep pace with medical inflation.

A cautionary note regarding guaranteed issue, voluntary multi-year term health products
Previous attempts at guaranteed issue, voluntary health products with multi-year terms, such as long-term care insurance, have not always worked as originally expected. The annual open enrollment period for ACA coverage can mitigate some of the worst outcomes but cannot entirely insulate issuers whose prices cannot keep pace with member expenditures.

The number of open questions is cause for additional caution
Delaying finalization of these proposals pending further investigation and stakeholder engagement may be appropriate. At a minimum, it seems appropriate to us that multi-year terms receive a slower phase in, perhaps 2- or 3-year terms initially, with a gradual scale out to longer terms as regulators and issuers identify and address the potential issues of this policy.

Bronze Plan Cost-Sharing Parameters
HHS proposes allowing insurers to offer bronze plans with cost-sharing levels that exceed traditional ACA limits, provided the issuer also offers at least one standard bronze plan that meets both actuarial value and MOOP requirements. As framed, the proposal creates the possibility of an arbitrarily high MOOP.

As a practical matter, truncation of values in the 2027 AV calculator means that changes to the MOOP no longer affect AV once a certain level is reached. Clearly a plan with an $84,000 MOOP offers much more protection than a plan with a $2,000,000 MOOP, even if relatively few people would reach that threshold. In essence, arbitrarily high MOOPs take away any practical functionality of the ACA's maximum annual limitation on cost-sharing. This illustrates the importance of highlighting to consumers not just a plan's premium, but also its cost-sharing features.

Another consequence of an arbitrarily high MOOP would be the potential interaction from the high-cost risk pool (HCRP). Under current plan designs, there is no plausible way for plan-paid claims to reach $1,000,000 before the member reaches their MOOP, yet this could always be the case under some potential plan designs. In this case, how would the MOOP and the HCRP interact? Along the same lines, these plans will grow increasingly different from the bronze plans used to develop risk adjustment coefficients. Would risk adjustment appropriately adjust the risk of these plans? Lastly, we note that the AV calculator is not a pricing tool. Regulator-approved actuarial value and cost-sharing factors suggest that the current de minimis ranges allow for significantly wider pricing actuarial values. To the extent that arbitrarily high MOOPs allow plans to have pricing AVs that vary even further from the nominal metal tier AVs, less expensive extra-lean bronze plans could be inexpensive enough to pull some CSR members out of silver and into a plan with even less catastrophic cost protection than current bronze plans, with a cost sharing level they almost certainly could not afford.

These issues are most apparent when plans stray further away from traditional ACA plan designs. These effects could be mitigated to some degree by appropriate guardrails. Such guardrails could

take the form of a "minimum necessary" standard, where the MOOP can only be adjusted as much as necessary to bring the plan into the bronze de minimis range. Or create a requirement that the plan be a modification of a design that would still fall into a bronze or potentially expanded bronze de minimis range with the ACA maximum annual limitation as the MOOP. This would give additional plan design space for issuers, a distinct difference for consumers to identify, and ensure that the plan design is essentially bronze in nature.

QHP Certification of Non-Network Plans (§§ 155.1050, etc.): Proposed Alternative Regulatory Standard for Non-network Plans (§ 156.236)

HHS proposes to again allow non-network plans to be sold as qualified health plans. There are numerous practical uncertainties from an actuarial perspective.

How will the actuarial value of non-network plans be determined? Since non-network plans establish a set payment rate for a given service, the structure of the AV calculator may not appropriately capture the value of benefits for the standard population underlying the calculator without significant modification. For example, a plan with 50% coinsurance will cover 50% of whatever allowed amount is in the AV calculator. A plan with a $50 copay will cover all but $50 of the allowed amount in the AV calculator. But the AV calculator cannot handle a plan that pays only $50 towards a service. It is unclear how much of such a plan design would fit into the AV calculator, nor how a rate reviewer would be able to validate that a non-network plan's calculated AV was consistent with the utilization of the AV calculator's standard population.

Non-network plans can create compliance challenges around the ACA's consumer protections. Non-network plans have less direct accountability to providers to ensure that rates remain sufficient in the provider's view. Any contractual agreement with sufficient providers to accept the plan's predetermined fee would create a network product and obviate the need for special treatment. States would need to ensure that appropriate monitoring and enforcement mechanisms are in place to ensure that consumers retain access to an actual out-of-pocket maximum.

We recognize that HHS and the Department of Labor have provided some guidance on this in the context of employer-sponsored coverage in prior years, and that the standards suggested in the payment notice largely mirror those requirements. In employer-sponsored coverage, the employer can act as an advocate for the member and has a fiduciary obligation to the employee. This dynamic does not exist in the individual market, so greater consumer protections may be appropriate.

In addition, current federal guidance related to the No Surprises Act asserts that non-network plans do not have any in-network facilities. Consequently, consumers are never protected from providers they may be unable to select, even if they do their due diligence and find a facility within their plan's fee budget and if a provider with whom they consult is within their plan's fee budget. The practical inability of most consumers to pre-emptively determine that any ancillary providers (such as assistant surgeons, anesthesiologists, and radiologists) are in-network was one of the key drivers behind the No Surprises Act. HHS should consider carefully if this same treatment would be appropriate for a qualified health plan or if an alternate standard, such as requiring the plan to treat any facility on the list of facilities that accept its rate as in-network for purposes of these consumer protections.

Finally, a non-network plan, by definition, has no contracts with providers and no ability to require reporting of diagnoses with claims for submission with risk adjustment or obtaining charts in RADV. This may result in significant risk adjustment payables, and potentially very large RADV transfer payment adjustments that would occur well after the plan year. If these are beyond the financial capacity of a non-network plan, then other plans in the market would be unable to collect risk adjustment amounts owed. It would be inappropriate to exempt non-network plans from risk adjustment or RADV, as doing so gives a clear incentive to engage in health status rating and avoid individuals with greater health care needs.

Non-network plans can be an effective option for consumers and would help the consumer engage in active decision-making when choosing where to receive care. However, regulators should take care when evaluating an issuer's rate filing and whether the plan will offer comprehensive coverage that provides the core protections all health plans in the single risk pool must provide, that non-network plans have sufficient monitoring to ensure that those protections are maintained through the year, and that non-network plans have sufficient resources and financial capacity to participate effectively in risk adjustment.

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

HHS is seeking feedback on how to integrate eligibility verification processes required by recent Working Families Tax Credit (WFTC) legislation. Most state-based exchanges have already completed budgeting and resource allocation for plan year 2027 and are in the process of allocating budget and technical resources for plan year 2028. We would request that HHS provide guidance well in advance of next year's Payment Notice timing, allowing states sufficient time to implement any new requirements while avoiding any enrollment shocks and resulting deterioration of the risk pool.

Part 158—Issuer Use of Premium Revenue: Comment Solicitation on Potential Adjustment to the MLR for a State's Individual Market

HHS is requesting comments on whether it should be allowed to set state-specific adjustments to individual market minimum medical loss ratio (MLR) requirements. There are two prevailing points of view in the discussion of MLR and individual market products.

- Viewpoint 1: MLR ensures that administrative costs are limited as a percentage of premium. Under this viewpoint, MLR provides a cap on administrative costs that don't contribute directly to care or pay for taxes and fees owed. This encourages issuers to be efficient and to focus on managing care consistent with their filed premium rates. In this sense, MLR puts downward pressure on rates If claims don't change at the same rates as administrative costs, then administrative costs must be managed and, on average, premiums will only grow as fast as paid claims

- Viewpoint 2: MLR causes inflated health cost growth because the only way to increase profit is to increase claims. Under this viewpoint, MLR represents a solved-to factor, if administrative costs are capped at 20% of premiums (or more pertinently, 25% of claims), the only way to increase the funds available to pay

> administrative costs (which include profit), is to increase claims and premium. This can lead to inflated premiums and/or inefficient care management as an issuer tries to increase the margin.

MLR works best when costs are relatively predictable. In times of risk pool volatility, when average claims projections are less certain, underpricing carries greater risk but MLR presents a limit on the financial benefits of overpricing. This is one of the reasons that MLR averages costs over three years. However, this hasn't always been sufficient to bring stability to MLR filings. It has been a moderating influence since MLR's establishment.

One area where MLR can present a practical hurdle is for lower-cost products, such as dental and other voluntary products. In many cases, the lower cost of these benefits doesn't result in a commensurate drop in administrative costs, resulting in higher loss ratios. In theory, this could present problems for low-cost issuers in the individual market. To the extent that a state operates in a low-cost environment where the MLR requirement can be shown to present a barrier to lower premiums for comprehensive coverage, allowing for reduced MLR requirements at a state level may be appropriate. However, the cost of coverage and the value provided to consumers should be monitored to ensure that a higher MLR requirement doesn't lead to excessive premiums relative to the value provided to consumers.

Finally, claims trend has exceeded administrative cost trend in the years since MLR requirements were finalized. In theory, this should make the 80% and 85% MLR thresholds easier to meet. This could create opportunities for states to exercise their authority to impose higher MLR standards via regulation. We also note that 42 USC 300gg–18(b)(1)(A)(ii) does give HHS the authority to modify the 80% statutory minimum MLR in states where the 80% MLR requirement may destabilize the individual market.

Quality Standards: Quality Improvement Strategy (§ 156.1130)

The draft guidance removes the mandate that issuers cover certain topics in their quality improvement strategy (QIS). Under the draft guidance, issuers can select any two of the five topics from 1311(g)(1), including: improve the health outcomes of plan enrollees, prevent hospital readmissions, enhance patient safety and reduce medical errors, promote wellness and health, and reduce health and health care disparities among enrollees. The update does not prohibit issuers from including QISs related to health and health care disparities, nor does it prevent issuers from selecting the topics they find relevant. We recommend that HHS reconsider this change and retain the mandate that issuers address health and health care disparities as specific topic area within their QIS. Health and health care disparities continue to persist, leading to inefficient use of health care dollars and suboptimal health outcomes for QHP enrollees.

Failure to File and Reconcile (FTR) Policy (§ 155.305), Income Verification Policy When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii)), Removal of the Requirement to Accept Attestations of Household Income When Tax Data is Unavailable (§ 155.320(c)(5)), Comment Solicitation on Premium Payment Threshold (§ 155.400), Extend the Removal of the 150 Percent FPL SEP Beyond Plan Year 2026 (§ 155.420(d)(16)), Special Enrollment Period Verification (§ 155.420(g))

HHS is re-proposing a number of policies originally included in the 2025 Marketplace Integrity and Affordable Rule which were subsequently stayed by judicial action. We would reiterate the comments we offered on those provisions in our 2025 Marketplace Integrity and Affordability Rule[4] comment letter, which remain unchanged. While not included in the 2027 Payment Notice language, we would ask that HHS clarify any intentions related to the expanded de minimis ranges, which were also impacted by the judicial action. This is particularly important, given the proposed changes to bronze cost sharing considered elsewhere in the current proposed rule.

Risk Adjustment Data Validation Requirements When HHS Operates Risk Adjustment (HHS-RADV) (§§ 153.350 and 153.630): HHS-RADV Error Estimation Modification to Incorporate IVA Sampling Changes

HHS is proposing an adjustment to the RADV error rate estimation process to account for the exclusion of members with zero HCCs from sampling. As we noted in our comments on the exclusion in the 2026 Payment Notice,[5] this change does not meaningfully address our concerns with the ACA implementation of RADV.[6] However, this change would better align the error rate calculation used with the basis of that calculation in relation to an insurer's enrolled population and represents a reasonable way to address one of many flaws in the current process.

HHS Risk Adjustment User Fee for the 2027 Benefit Year (§ 153.610(f)), FFE and SBE-FP User Fee Rates for the 2027 Benefit Year (§ 156.50)

HHS is proposing to keep risk adjustment user fees at $0.20 per billable member per month, FFE user fees at 2.5% of premium, and SBE-FP user fees at 2.0% of premium, while maintaining the parameters of the high-cost risk pool at 60% of costs in excess of $1 million. These are the same levels as in plan year 2026. We appreciate the consistency of rate assumptions given the timing of this rule.

HHS Risk Adjustment (§ 153.320): Data for HHS Risk Adjustment Model Recalibration for the 2027 Benefit Year, Proposed List of Factors to Be Employed in the HHS Risk Adjustment Models (§ 153.320), Model Performance Statistics

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[4] https://actuary.org/wp-content/uploads/2025/05/health-comment-Proposed-Market-Integrity-2025-Proposed-Rule.pdf

[5] https://actuary.org/wp-content/uploads/2024/12/health-comment-2026-NBPP.pdf

[6] Proposed Notice of Benefit and Payment Parameters for 2025; American Academy of Actuaries; 2024, January 8. December 2019 HHS-RADV White Paper; American Academy of Actuaries; 2020, January 2. Amendments to the HHS-Operated Risk Adjustment Data Validation Under the Patient Protection and Affordable Care Act's HHS-Operated Risk Adjustment Program; American Academy of Actuaries; 2020, July 2.

Regular updates to the risk model are essential to the long-term stability of the single risk pool, and we appreciate HHS's efforts in this update. We continue to urge HHS to provide transfer payment simulation results for the new model to help issuers evaluate the effects of the model update.

The Committees appreciate the opportunity to provide comments on the 2027 Payment Notice. Many of the challenges and current unknowns associated with multi-year plans are actuarial in nature and, as the national association for the actuarial profession, we are happy to share our expertise. We welcome the opportunity to speak with you to provide more detail and answer any questions you might have regarding these comments. Should you have any questions, please contact Michelle Anaba, the Academy's health policy project manager (anaba@actuary.org).

Sincerely,

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