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VIA ELECTRONIC TRANSMISSION

March 13, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

RE: HHS Notice of Benefit and Payment Parameters for 2027 – Proposed Rule

Dear Administrator Oz:

On behalf of CareFirst BlueCross BlueShield (CareFirst), thank you for the opportunity to provide comments on the Proposed Rule: "Patient Protection and Affordable Care Act; Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2027." Throughout our more than 85-year history, we have dedicated our efforts to providing our members with access to affordable, high-quality healthcare where and when they need it.

CareFirst is one of the nation's largest not-for-profit healthcare organizations, serving 3.5 million members. Although the CareFirst service area is Maryland, Washington, DC, and Northern Virginia—which all operate State-based Exchanges—we believe in furthering the goals of the Affordable Care Act (ACA) and have proudly participated in the individual and small group markets since their inception. We strongly support some of the policies in the proposed rule (e.g., state defrayal of mandated benefits and allowing states to establish network adequacy requirements), but believe others would require additional time to implement properly, could negatively impact enrollees, or would have adverse impact on the stability of Exchanges (e.g., cost-sharing load reporting, expansion of catastrophic plans, and certification of non-network plans). We detail our comments and recommendations below.

Cost-Sharing Reduction Load Reporting and Justification

CareFirst recognizes the value of appropriate transparency and actuarial support for cost-sharing reduction (CSR)-related rate adjustments. However, we have concerns with CMS' proposal to require issuers that intend to load rates to account for unpaid CSRs to submit certain information specified in the plan year (PY) 2026 Rate Filing Guidance in the unified rate review template (URRT) and actuarial memoranda for each plan year in which CSRs are not

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funded. As written, the proposal's timing and structure create significant feasibility and cost concerns. If CMS moves forward on this proposal, CareFirst recommends the following:

- Delay implementation and apply the requirements prospectively beginning in a later year to provide sufficient lead time to build and validate related operational functions. CMS proposes retrospective CSR calculations using the standard CSR reconciliation methodology, including claims re-adjudication, while PY 2027 rate filings are already underway. Retrospective reconciliation is operationally different from running dual adjudication during a benefit year and requires handling appeals, retroactive adjustments, and manual corrections. Standing up such a process is not simply a matter of turning on an existing IT system. Additionally, the data generated from dual adjudication may not be credible without intensive, ongoing auditing and monitoring. As such, plans will need additional time and resources to ensure the data can be accurately captured and reported.
- Clarify how CMS will treat issuer reporting when CSR loading approaches are required or strongly encouraged by states, and how federal expectations will be reconciled with state rate review requirements. In states where regulators specify the assumptions and magnitude of the load, issuers have limited discretion and are implementing state policy rather than making independent loading decisions. CMS should clarify how it will evaluate issuer submissions in such instances and avoid conflicting federal and state expectations during rate review.
- Focus the requirements in the actuarial memorandum (including explanation and context) and limit URRT fields to high-level indicators, to reduce the risk that isolated numbers are misinterpreted or treated as comparable across issuers. Placing detailed discussion and explanation in the actuarial memorandum through a narrative format will allow issuers to describe methodology, limitations, audit status, reliance on vendor processes, and state-directed constraints. On the other hand, collection of extensive data in the URRT will not allow for a fair comparison across issuers.

State Defrayal of Mandated Benefits

CareFirst supports the proposal to restore the requirement for states to defray the costs of mandated benefits in excess of essential health benefits (EHBs). Such a policy will bring the regulations back in line with the statutory requirements of the ACA, which allow states to require benefits beyond the EHBs, but explicitly requires states to "defray the cost of any additional benefits." The 2025 Notice of Benefit and Payment Parameters (NBPP) effectively nullified this statutory requirement, leading to unfunded benefit mandates that increase the cost of coverage for consumers, employers, and the federal government and taxpayers through federal advance premium tax credits (APTCs). While we acknowledge the need to provide appropriate, high-quality coverage to our members through EHBs, adding benefits beyond those established by the ACA makes coverage less affordable. Therefore, we urge CMS to finalize the policy to restore enforcement of the statutory requirement for state defrayal of the cost of benefit mandates in excess of EHB.

We appreciate the clarification that failure by CMS to respond to a state's request for determination of whether new mandates require defrayal by the state does not relieve a state from its defrayal obligation. Additionally, because state legislatures frequently pass new mandates with unworkable effective dates, HHS should work with states to implement a determination process for mandates subject to defrayal well in advance of the deadline for impacted plans to file rates with the state.

Expanding Catastrophic Plans

- CareFirst supports the concept of reduced administrative burden and innovative cost-sharing arrangements that CMS intends by expanding catastrophic plan options; however, multi-year plans pose serious risks for issuers and consumers. Multi-year plan terms create meaningful challenges for issuers in accurately projecting costs and adjusting premiums as healthcare trends, regulations, and market conditions evolve. This is further compounded by consumers' ability to leave these products if their healthcare needs change. This convergence of factors increases the potential for mispricing and financial instability that could jeopardize consumer coverage.
- Multi-year plans would adversely impact enrollees. The proposed rule does not appear to require a multi-year rate guarantee and suggests that plan benefit features, such as deductibles, can be reset annually. CareFirst believes such changes mid-contract would adversely impact enrollees. If allowed, we believe multi-year plans must be required to include strong consumer disclosures to ensure enrollees are fully informed about how mid-term cost, benefit, and provider network changes may affect their coverage, and their rights to terminate coverage. Such transparency and informed decision-making are critical while the market evaluates the viability of multi-year products. Furthermore, CMS should not consider allowing multi-year plans in other metal tier levels until the impacts of multi-year catastrophic plans on consumers and market stability are better understood.
- Multi-year catastrophic plans should be risk adjusted along with other catastrophic plans, with appropriate adjustments to reflect the unique factors of the plans. They should not be in a separate risk adjustment pool.
- Requiring catastrophic plans to have a maximum out of pocket (MOOP) threshold exceeding 100 percent conflicts with statute and the intent behind catastrophic plans. We oppose this proposal. Congress intended for catastrophic plans to be a narrowly available, lower cost product primarily for younger enrollees with minimal impact on the overall risk profile of the individual market. Higher MOOP thresholds and expanded eligibility threaten to turn catastrophic plans into a widely available, low premium option without grounding in statute. As bronze plan actuarial values continue trending towards the lower end of permissible ranges, the differences between bronze and catastrophic plans will narrow and may not meaningfully improve consumer understanding or choice. More importantly, higher cost-sharing thresholds will make catastrophic plans less expensive and likely shift enrollment, particularly among healthier enrollees, from bronze to catastrophic plans. Because catastrophic plans are treated separately for risk adjustment, the average morbidity in the metallic risk pool will increase, driving up benchmark premiums and increasing federal spending on APTCs.

Expanding Hardship Exemption Eligibility

CareFirst does not support codifying and expanding the hardship exemption eligibility to individuals in all states, including Maryland and the District of Columbia, who are ineligible for APTC or CSR due to their income. Issuers in these states, including CareFirst, are close to finalizing 2027 rates and benefits and cannot accurately account for such a significant change in such a short time. Expanding the hardship exemption in these states should be delayed until at least 2028 to allow for development of actuarially sound rates and products that account for anticipated enrollment and shifts in risks associated with expanded eligibility for catastrophic plans.

Certification of Non-Network Plans as QHPs

CareFirst does not support the proposal to certify non-network plans as QHPs. While we believe appropriate regulatory flexibility to offer innovative plan designs can increase consumer choice

and improve affordability, the proposed rule does not provide enough details on how these plans would be regulated and comply with foundational elements of QHPs, including MOOP limits, actuarial value, mental health parity, surprise billing protections, transparency in coverage, continuity of care, and others. If CMS were to move forward with its proposal, clearer regulatory guidance is needed to guarantee that these products remain sustainable, do not result in consumer or provider dissatisfaction, and avoid disrupting the individual market risk pool. More importantly, for Exchanges to remain stable, competitive insurance marketplaces, HHS must maintain a level playing field where all issuers and plans must comply with the same standards. Our specific concerns and recommendations include:

- Non-network plans must be subject to the same statutory requirements as existing QHPs. CMS should explicitly clarify this requirement, including how any requirements that appear to presuppose a provider network apply in the case of non-network products. All consumer protections available in-network for a network-based QHP must be extended to consumers in non-network plans, including protections related to MOOP. For example, while out-of-pocket costs may vary depending on which provider a consumer sees, the statutory MOOP must define overall financial exposure for the year.
- Regulations must clearly distinguish non-network QHPs from excepted benefit products such as hospital or fixed indemnity insurance. Non-network plan rules must not inadvertently allow unscrupulous actors to offer supplemental products with inadequate benefits on the Exchanges that mislead consumers and undermine the integrity of the non-network QHP concept.
- States must have the authority to determine whether to permit non-network plans to be offered and certified as QHPs in their markets. State regulators have direct knowledge of local market conditions, provider supply, and consumer protection frameworks that are unique to each state. A non-network plan may be inappropriate or harmful to consumers in a market with limited provider supply, high consolidation, or weaker state consumer protection infrastructure. Preserving state authority to make this determination ensures that non-network QHPs are introduced with local conditions in mind, rather than imposed uniformly on markets with little regard for those unique factors.
- CMS should establish clear, specific, and verifiable standards for demonstrating provider access sufficiency for non-network plans. These standards should define the methods and data issuers must use to demonstrate adequate access, as well as the benchmarks CMS will use to evaluate issuer submissions. We believe issuers should be required to demonstrate adequate access through contracts or other binding participation agreements with providers who agree to accept the issuer's allowed amount as payment in full and not to balance bill consumers. Using an agreement-based approach provides both administrative efficiency and stronger consumer protections to ensure access to an appropriate set of providers.
- Issuers must provide comprehensive pre-enrollment disclosures to consumers about how their non-network plans differ from network-based QHPs. We believe issuers must state in plain language how benefit amounts are determined, what percentage of local provider charges they represent, and what out-of-pocket costs or balance billing enrollees may face. Without robust pre-enrollment disclosures, consumers may select non-network plans without understanding the financial risks they are assuming, particularly for high-cost or non-shoppable services. Most notably, enrollees should be fully aware of potential balance billing when a provider's charges exceed the plan's benefit amount.
- Require Exchanges to clearly indicate non-network plans on shopping and enrollment portals. Given the significant differences between non-network and network-based QHPs, Exchanges should clearly identify non-network plans on the Exchange portal using a special symbol, icon, or differentiated text. A clear indicator will ensure consumers can easily distinguish non-network plans from traditional QHPs when considering plan options.

- Establish robust cost-sharing requirements. Because a non-network plan does not have a distinction between in-network and out-of-network cost-sharing, this ambiguity could expose consumers to uncapped financial liability. CMS should establish a clear rule that all cost-sharing, regardless of provider used, counts toward the MOOP, effectively making all providers "in-network" for non-network plans. Additionally, because many high-cost services are not shoppable, including emergency care, inpatient hospitalizations, complex episodes such as cancer treatment, and services in specialties or geographic areas with limited provider supply, CMS should establish clear and enforceable standards on how network access will be assessed and cost-sharing should be applied in these circumstances. This includes clear guidance on how non-network plans will guarantee balance billing protections for emergency services and facility-based providers who are not employed by the facility. Finally, CMS must clarify how non-network plans are expected to structure their benefit amounts or coverage rules to ensure that enrollees can access all required preventive services without incurring any out-of-pocket costs. Without additional guidance, a plan could be in violation of the no cost-sharing requirement if a provider's charges for a covered preventive service exceed the plan's benefit amount.
- Require non-network plans to demonstrate compliance with metal level actuarial value (AV) requirements using the existing AV calculator. Failing to do so would create an unlevel playing field with network-based QHPs and expose consumers to plans that appear affordable but provide inadequate coverage. If modifications to the AV calculator are deemed necessary to account for differences with non-network plans, those changes should be subject to public notice and comment before being used for certification purposes.
- Provide guidance on interaction with other regulatory requirements. CMS should provide guidance on whether and how non-network plans can satisfy other regulatory requirements imposed on QHPs, including:
    - Ensuring consumer protections under the No Surprises Act;
    - Complying with transparency in coverage requirements in a manner that is functionally equivalent to the obligations applicable to network-based QHPs;
    - Meeting requirements of the Mental Health Parity and Addiction Equity Act, including how quantitative treatment limitations (QTLs) and non-quantitative treatment limitations (NQTLs) will be assessed in a non-network context; and
    - Satisfying continuity of care requirements for individuals undergoing treatment for a serious and complex condition, a terminal illness, or scheduled surgery when a provider leaves a plan's network.

  Before non-network plans are allowed to enter the individual market, CMS should ensure such protections apply to non-network plan enrollees in a functionally equivalent manner as network-based QHPs.
- Evaluate potential modifications to the HHS risk adjustment model to account for the implications of non-network plans before permitting them to enter the individual market. Like other lower-premium products, non-network plans are likely to attract a disproportionately healthy population, which could have significant implications for the stability of the market. To avoid adverse selection dynamics, the risk adjustment model must be capable of appropriately capturing and redistributing risk associated with non-network plan enrollment. These dynamics should be addressed before non-network plans are available to consumers.
- Require non-network plans maintain and publish a list of providers with current charges. In a non-network plan, a list of providers whose current charges fall within or below the plan's benefit amount will be necessary for enrollees to make informed decisions about where to get care while avoiding unexpected out-of-pocket costs. CMS should require non-network plans to maintain a resource functionally equivalent to a provider directory that must be updated monthly and verified at least every 90 days.

Exchange Network Adequacy Standards

CareFirst supports the proposal to remove the requirement that state exchanges establish and impose quantitative time and distance network adequacy standards that are at least as stringent as standards for QHPs participating in the Federally-Facilitated Exchange. We believe all QHPs must be able to provide consumers with access to the care they need, and state exchanges are in the best position to determine the adequacy of a QHP's network in a manner that recognizes the nuances of their local markets. Providing states the flexibility to establish standards on a variety of factors, including time, distance, appointment wait times, provider-to-enrollee ratios, and topographical considerations, ensures that the standards make sense for that state.

State Exchange Improper Payment Measurement

CareFirst supports efforts to enhance program integrity, including cracking down on improper payment of APTCs; however, we strongly recommend any enforcement action not be extended to issuers in the state exchange. Oversight and corrective action related to improper APTC payments are most appropriately managed between CMS and state exchanges, because these entities are directly responsible for administering APTC eligibility determinations and payment processes. Issuers do not have authority over the underlying eligibility systems or payment controls and cannot remediate payment issues. Enforcement action against issuers would be unfair, impose unnecessary administrative burden, and ultimately affect consumers who rely on stable coverage.

State-Based Exchange Enhanced Direct Enrollment

CareFirst recommends CMS not finalize the State-Based Exchange Enhanced Direct Enrollment (SBE-EDE) option until the federal Marketplace's own EDE platform has robust program integrity controls in place and can demonstrate its effectiveness in preventing or significantly reducing fraudulent and unauthorized enrollments. While we conceptually support web-based enrollment platforms, including through direct enrollment application programming interfaces to improve consumer access, CMS should continue developing and enhancing such technology to ensure secure and efficient operations before rolling out more broadly to states.

We appreciate CMS' consideration of our comments and its commitment to ensuring Americans have access to affordable and comprehensive health insurance benefits. We would be happy to discuss any issues at your convenience.

Sincerely,



David Schwartz