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

Submitted Electronically

RE: RIN 0938-AV62; CMS-9883-P
Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program

The National Women's Law Center (NWLC) comments to express our strong opposition to the proposed rule "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program" (hereinafter "Proposed Rule"). Since 1972, NWLC has fought for gender justice in the courts, in public policy, and in our society. We have worked to advance the progress of women and their families in core aspects of their lives, including health and reproductive rights, income security, employment, and education, with an emphasis on the needs of people who face multiple and compounding forms of discrimination. Through our work to advance and implement the Affordable Care Act (ACA), we have seen its positive impact on the health and wellbeing of women and LGBTQI+ people, and we firmly believe that robust enforcement of its provisions is needed to continue to improve access to coverage and care.

Rather than enforcing the ACA and furthering its aims as it should to fulfill its mission, the Department of Health and Human Services ("the Department") instead proposes to weaken and destabilize it. If promulgated, the Proposed Rule would create barriers to enrollment, reverse consumer protections, and decrease the quality and affordability of plans. Such policies would upend ACA marketplaces, deprive people of basic protections, lead to higher rates of uninsurance, and inflict far-reaching harms on the individuals and communities the ACA was designed to benefit.

I. Creating Barriers to Enrollment

a. Pre-Enrollment Special Enrollment Period Verification [§ 155.420(g)]

In the 2025 Marketplace Integrity and Affordability rule,[1] the Department required Exchanges on the Federal platform to conduct Special Enrollment Period Verification (SEPV) beyond just the Loss of Minimum Essential Coverage (MEC) Special Enrollment Period (SEP), to a range of SEPs. A second provision required Federal and Federally-Facilitated Exchanges (FFEs) to conduct SEPV for at least 75% of new enrollments. These provisions were set to sunset on December 31, 2026. In August 2025 a federal district court stayed both provisions on the grounds that the Department adopted them based on conclusory, unsupported statements that enrollees were "gaming" SEP coverage to avoid verification.[2]

In the Proposed Rule, the Department asserts that there have been "changes in circumstances and new supporting information" since the April 2025 rule was promulgated that allow them to repropose these same provisions again.[3] But there is no evidence to support this claim. The Department fails to provide a rationale that would distinguish this Proposed Rule from its previous failed attempt. For example, the Department references the passage of what it refers to as the Working Families Tax Cut legislation (H.R. 1), without explaining what part of this statute supports the imposition of pre-enrollment SEP verification.

It also references changes in enrollment after the resumption of SEPV for Loss of MEC, following a pause on this verification due to the COVID-19 pandemic. The Proposed Rule notes that the number of enrollments for this type of SEP dropped significantly as verification was required again, while enrollment under other types of SEPs increased. The Department claims this evidences that "consumers shifted their SEP attestation so as not to have to provide verification of eligibility for the SEP."[4]

In coming to this conclusion, the Department either completely overlooks or purposely ignores the most likely explanation of the drop: eligible consumers experienced barriers to enrollment due to the reimposed verification process. Requiring enrollees to submit documentation to confirm eligibility before coverage takes effect prevents people from

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[1] Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 27,074 (June 25, 2025) (codified at 45 C.F.R. pts. 147, 155, and 156).
[2] *City of Columbus v. Kennedy*, 796 F. Supp. 3d 123, 159-60 (D. Md. 2025).
[3] Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program, 91 Fed. Reg. 6292, 6352 (proposed Feb. 11, 2026) (to be codified at 42 C.F.R. pt. 600 and 45 C.F.R. pts. 153, 155, 156, and 158) (hereinafter "Proposed Rule").
[4] *Id*. at 6353.

enrolling and delays their coverage.[5] This is particularly true for people with low incomes, who are more likely to have inadequate internet access,[6] use a primary language other than English,[7] and face other barriers to submitting documentation.

One such burden is requiring individuals to submit a termination of coverage letter from their employer. Many employers fail to respond to such requests from former employees in a timely manner or to respond at all. An additional burden is requiring this documentation to be on official letterhead or stationery, with the individual's name and date of coverage loss, and whether the employer stopped or will stop contributing to the individual's cost of coverage.[8] Or a potential enrollee may have to submit multiple sets of documents when one set by itself is insufficient to confirm eligibility. For example, an individual may have to submit two pay stubs from the past one to three months, including one that shows a deduction for health coverage and another which shows the deduction ended in the past sixty days.[9] Obtaining this documentation may be particularly challenging for people who held multiple, short-term, and/or fluctuating jobs over the relevant period. Such applicants may need to overcome logistical barriers to obtaining and reconciling documentation from multiple sources—a significant challenge when those jobs are low-paying or the employment is less formal, which can make it harder to obtain official documentation from their former employer. This is especially true for women and people of color. Women are more likely than men to hold multiple jobs, and Black women have the highest rate.[10] These pre-enrollment verification hurdles leave individuals attempting to secure insurance in a precarious position where they may experience delayed coverage start dates and gaps in insurance.

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[5] Matthew Fiedler, *Trump Administration's Proposed Change to ACA Special Enrollment Periods Could Backfire* (Feb. 17, 2017), https://www.brookings.edu/articles/trump-administrations-proposed-change-to-aca-special-enrollment-periods-could-backfire/.

[6] Kelly Wert, *Every State Identifies Broadband Affordability as Primary Barrier to Closing Digital Divide* (Oct. 4, 2024), https://www.pew.org/en/research-and-analysis/articles/2024/10/04/every-state-identifies-broadband-affordability-as-primary-barrier-to-closing-digital-divide.

[7] Sweta Haldar, *Overview of Health Coverage and Care for Individuals with Limited English Proficiency (LEP)* (Jul. 7, 2023), https://www.kff.org/racial-equity-and-health-policy/overview-of-health-coverage-and-care-for-individuals-with-limited-english-proficiency/.

[8] *See id.*; U.S. Ctrs. for Medicare & Medicaid, *Submit Documents to Confirm Your Loss of Coverage*, https://www.healthcare.gov/help/prove-coverage-loss/ (last visited Mar. 6, 2026).

[9] *See* U.S. Ctrs. for Medicare & Medicaid, *Submit Documents to Confirm Your Loss of Coverage*, https://www.healthcare.gov/help/prove-coverage-loss/ (last visited Mar. 6, 2026).

[10] Bureau Lab. Stats., *Multiple Jobholders by Selected Demographics & Economic Characteristics*, https://www.bls.gov/web/empsit/cpseea39.htm (last visited Mar. 10, 2026).

b. Permanent Elimination of the Low-Income Special Enrollment Period [155.420(d)(16)]

The Proposed Rule would eliminate the monthly SEP for low-income consumers. In order to be eligible for this SEP, a consumer must have a projected income at or below 150% of the Federal Poverty Level (FPL) and be eligible for an advanced premium tax credit (APTC). The Department first eliminated the low-income SEP in its 2025 Marketplace rule. However, that rule included a sunset provision which would have reimplemented the low-income SEP at the beginning of 2027. The Proposed Rule would permanently eliminate the low-income SEP.

Even though H.R. 1 eliminates eligibility for PTCs, there are still other subsidies available, like Cost-Sharing Reductions (CSRs), which lower deductibles, copayments, coinsurance, and out-of-pocket maximums. But without the low-income SEP, those with low incomes will be unable to enroll in a new plan and access subsidies outside of the Open Enrollment Period, facing up to ten months of uninsurance. Limiting enrollment and subsidy opportunities would further exacerbate the barriers to insurance coverage and care that people with low incomes experience, which in turn would worsen the health disparities they face.[11]

c. Elimination of Standardized Plans [§ 156.201]

The Proposed Rule would eliminate the requirement for plans on the FFEs and State-Based Exchanges on the Federal Platform (SBE-FPs) to provide standardized plan options. Starting in 2027, insurers would no longer be required to offer standardized plans. Additionally, these plans would no longer receive differential displays on the Healthcare.gov website. The Department would also eliminate limits on non-standardized plan options.

After years of requiring standardized plans, the Department now claims that these plans are ineffective in enhancing consumer experience, increasing consumer understanding, and simplifying the plan selection process. The data do not support these justifications.

The Department asserts that even though these plans are highlighted on the Marketplace website, non-standardized plans are more popular. However, this is not demonstrated by the data. There was a 16% decrease in non-standardized plan enrollment from PY 23 to PY 24 alone. In states that have implemented standardized plans over a long period, even larger shares of consumers have opted to switch to such plans. For example, Washington State began offering standardized plans on its state exchange in 2019. By 2023, two-thirds of all enrollees were enrolled in a standardized plan. Washington State's standardized plans have

[11] Daniel M. Finkelstein et al., *Economic Well-Being and Health: The Role of Income Support Programs in Promoting Health & Advancing Health Equity*, 41 HEALTH AFFS. 1700 (Dec. 2022), https://www.healthaffairs.org/doi/epdf/10.1377/hlthaff.2022.00846.

made it easier to compare plans from different carriers and allow consumers to engage in a controlled comparison of benefits and cost-sharing so they can focus on premiums, provider networks, and customer service.

The Department also claims that standardized plans "fail[] to meaningfully reduce decision complexity for consumers."[12] However, it provides no evidence to support this claim. Standardized plans make the often-complex enrollment process easier by simplifying the variation in cost-sharing and allowing people to compare a more targeted range of features, especially benefitting people who face barriers to health literacy or who have complex health needs.[13] These features help consumers navigate their plan options and focus on the considerations most relevant to them.[14]

The selection of "dominated plans" offers an illustration of the impact of the choice overload that standardized plans can help reduce. Dominated plans charge more for equal or less coverage than other available plans. In one study of the health plan choices of nearly 24,000 employees, researchers found that the majority of these employees chose a dominated plan.[15] Importantly, those earning less than $40,000 were substantially more likely to select dominated plans than their higher-compensated colleagues.[16] Standardized plans address this issue by providing transparency and clarity to consumers. By offering the same deductibles, cost-sharing, MOOP and uniform benefits across metal levels,[17] they push health plans to compete on premiums, quality, and provider networks.[18] Variations between plans often cannot be identified without a detailed analysis and may create barriers for people who already have constrained resources for navigating insurance—such as people with limited English proficiency,[19] low incomes, complex health needs, or inadequate internet access.[20]

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[12] Proposed Rule, 91 Fed. Reg. at 6387.
[13] Karen Pollitz et al., *Standardized Plans in the Health Care Marketplace: Changing Requirements* (May 8, 2023), https://www.kff.org/private-insurance/standardized-plans-in-the-health-care-marketplace-changing-requirements.
[14] Rose C. Chu et al., *Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces* 3 (Dec. 28, 2021), Dep't of Health & Hum. Servs., https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf.
[15] Saurabh Bhargava et al., *Choose to Lose: Health Plan Choices from a Menu with Dominated Options*, 132 Q. J. OF ECON. 1319 (2017), https://doi.org/10.1093/qje/qjx011.
[16] *Id*.
[17] *See* Chu et al, *supra* note 16; Pollitz et al., *supra* note 15.
[18] *See* Chu et al., *supra* note 16.
[19] Haldar, *supra* note 7.
[20] *See, e.g.*, Krutika Amin et al., *How Might Internet Connectivity Affect Health Care Access?* (2020), https://www.healthsystemtracker.org/chart-collection/how-might-internet-connectivity-affect-health-care-access.

Importantly, standardized plans have also been shown to limit discriminatory benefit designs, such as the exclusion of specialists in a certain field or the adverse tiering of drugs for targeted conditions—often conditions that disproportionately affect women of color, disabled women, and LGBTQI+ people.[21]

The Proposed Rule reduces consumer clarity and makes health insurance choices more difficult.

II. Reversing Consumer Protections

a. Failure to File and Reconcile [§ 155.305(f)(4)]

In the 2025 Marketplace rule, the Department adopted a policy that would make an enrollee ineligible for Marketplace subsidies if the enrollee failed to file and reconcile (FTR) their past receipt of APTC for a single year. This rule reversed the prior policy where consumers were only ineligible after two consecutive years of FTR, in recognition of the numerous barriers that APTC recipients face to understanding their tax obligations, accurately reconciling their APTC, and receiving clear notification of their FTR status after only a single year. The provision in the 2025 Marketplace rule was set to sunset at the end of PY 2026. The Department now reproposes the one-year FTR policy, making it mandatory for all FFEs starting in PY 2027 and for SBEs starting in PY 2028.

In 2025, approximately 90% of those enrolled on Marketplace insurance, nearly 22 million people, received APTCs.[22] A one-year FTR policy would lead to substantial losses of APTC for eligible individuals, causing harms that far outweigh any deterrent value this policy may have. Providing consumers with a single notice that they must reconcile their APTC is often insufficient. Consumers may find notices regarding their tax responsibilities difficult to understand or navigate. Some might not even receive the notice or receive it too late, particularly if they are experiencing housing changes or instability or, in the case of online notices, if they face challenges accessing electronic communications. Even consumers who are aware of their responsibilities might find that unintended errors put them in FTR status.

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[21] Chu, *supra* note 16.

[22] Kaiser Fam. Found., *Estimated Total Premium Tax Credits Received by Marketplace Enrollees* (last accessed Mar. 12, 2026), https://www.kff.org/affordable-care-act/state-indicator/average-monthly-advance-premium-tax-credit-aptchttps://www.kff.org/affordable-care-act/tracking-the-affordable-care-act-provisions-in-the-2025-budget-bill/.

As a result, the one-year FTR policy denies many consumers a meaningful opportunity to identify and correct any potential issues before losing APTC. CMS' own data on APTC terminations following its 2025 Marketplace rule already demonstrates this likely harm: While approximately 235,000 enrollees lost APTC due to their FTR status for PY 2025, that number spiked to approximately 430,000 enrollees for PY 2026, even though PY 2026 removals are still in progress.[23]

b. Premium Payment Threshold [§ 155.400(g)]

Existing regulations allow issuers to implement a threshold where enrollees are considered to have paid the full amount of their premium payment, such that non-payment of de minimis amounts does not lead to termination of enrollment or trigger a grace period. The Department previously recognized that terminating enrollment or triggering a grace period was an overly severe consequence for non-payment of de minimis amounts. Instead, the Department allowed issuers to adopt a gross-percentage or fixed-dollar threshold in addition to the existing net-percentage threshold.

The Department now seeks comments on whether to permanently bar the use of gross-percentage or fixed-dollar thresholds and limit issuers' options to net-percentage threshold only. It states that gross-percentage and fixed-dollar thresholds could lead customers to stay enrolled in a plan without their knowledge. The Department has no evidence to support this speculation, nor the extent of its theorized harms: The previous policy was only implemented between January and March 2025 before the Department reversed it, precluding any data on its impacts over a meaningful amount of time or during an open enrollment period. By contrast, the evidence demonstrating the risks of the proposed policies is clear: It will put more consumers at risk of delinquency or loss of coverage.

Affordability is a major concern for enrollees,[24] particularly for women with low incomes,[25] and enrollees may fail to pay their full premium payments due to financial hardship. Many consumers have a higher payment burden under the net-percentage threshold, so allowing fixed-dollar and gross-premium payment thresholds can decrease the risk of coverage terminations for enrollees struggling to pay their full premium amount. But the Proposed

[23] Press Release, Centers for Medicare and Medicaid, CMS Actions to Protect Consumers and Strengthen Exchange Program Integrity (Jan. 28, 2026), https://www.cms.gov/newsroom/fact-sheets/cms-actions-protect-consumers-strengthen-exchange-program-integrity.
[24] Grace Sparks et al., *Americans' Challenges with Health Care Costs,* Kaiser Fam. Found. (Jan. 29, 2026), https://www.kff.org/healthcosts/issue-brief/americans-challenges-with-health-care-costs.
[25] Usha Ranji et al., *Health Policy Issues in Women's Health* (Oct. 8, 2025), https://www.kff.org/womens-health-policy/health-policy-101-health-policy-issues-in-womens-health.

Rule would renew these harms and lead to loss of coverage even in cases where nonpayment is negligible when measured in fixed dollars or as a gross percentage.

III. Decreasing the Quality and Affordability of Plans

a. Catastrophic Plans

The Department is proposing policies that will steer consumers towards catastrophic plans, even though these plans carry significant risks and leave many underinsured and with unexpected financial liabilities.

Catastrophic plans are designed to deal primarily with major emergencies. These plans offer limited benefits, include substantial cost-sharing obligations, and are not structured to act as a substitute for comprehensive insurance coverage. Catastrophic plans tend to have lower monthly premiums but very high deductibles. For example, in PY 2026, the deductible for catastrophic plans is $10,600 for an individual and $21,200 for a family. These plans typically do not pay for any benefits other than preventive services and limited primary care visits until after the enrollee has reached the plan's deductible. Enrollees may therefore be forced to pay tens of thousands of dollars out of pocket before most benefits are covered. Moreover, consumers cannot apply PTCs toward a catastrophic plan. As a result, catastrophic plans may put enrollees' health and security at significant risk. Some enrollees opt for catastrophic plans based on the mistaken belief that they are lower-premium alternatives equivalent to standard insurance; other enrollees may be aware of their limitations but incur higher health expenses than they initially anticipated. Consequently, many people enrolled in catastrophic plans may find themselves with medical costs they are unable to afford, forcing them to postpone or avoid needed care or to pay out-of-pocket even when doing so results in financial instability.

These risks may be especially significant for enrollees who are more likely to incur high medical costs or experience financial insecurity—including women overall and in particular women of color, women with low incomes, and disabled women.[26] Women utilize health care services more regularly than men, even when pregnancy-related services are excluded.[27] Women also experience certain conditions at higher rates than men, such as chronic pain, multiple sclerosis, depression, and osteoporosis.[28] Disabled people overall (regardless of gender) have higher health care utilization than nondisabled people and are

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[26] Lois K. Lee et al., *Women's Coverage, Utilization, Affordability, and Health After the ACA: A Review of the Literature*, HEALTH AFFS. (Mar. 2020), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01361.
[27] *Id*.
[28] Alison Warren, Krista Garrett & Leigh A. Fame, *Disparities in Women's Health and Clinical Considerations from a Translation Science Perspective: A Narrative Review and Framework for Future Directions*, 21 Women's Health, https://doi.org/10.1177/17455057251399009.

more likely to experience a range of chronic conditions.[29] Black and Indigenous women also experience disproportionately high rates of chronic conditions and negative health outcomes such as morbidity and mortality.[30] For example, Black women have a higher prevalence of conditions like heart disease, stroke, cancer, and diabetes.[31]

Additionally, Black and Indigenous women, disabled women, and women overall have higher medical expenses. For example, women pay 18% more, or about $15 billion more, than men in annual out-of-pocket health care expenses, not including premium costs.[32] Additionally, 46% of men tend to have $1,000 or less in annual claims, as opposed to only 35% of women.[33]

These disparities in medical expenses are compounded by higher rates of poverty and financial insecurity for women: A NWLC analysis of 2024 data found that nearly one in seven (13.7%) women were living in poverty, compared to 11.9% of men.[34] Poverty rates were especially high for Black (21.2%), Latina (21.0%), and Asian (13.3%) women.[35] They were also higher among disabled women (24.3%) and women born outside of the United States (20.7%).[36] Taken together, higher medical costs and poverty rates put these communities at significant risk of incurring health-related expenses that they would be unable to pay without insurance coverage. Enrollment in catastrophic plans that do not cover their needs would therefore be particularly likely to jeopardize their health and financial security. Those who do not forgo needed care may be forced to take on medical debt, which already disproportionately affects women, disabled people, and Black and Latine people[37]; medical debt itself has numerous consequences for people's health, access to care, and financial wellness.[38]

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[29] Sungchul Park et al., *Health Care Utilization Patterns Among Adults With or Without Functional Disabilities*, 8 JAMA NETWORK OPEN e254729 (Apr. 11, 2025), http://doi.org/10.1001/jamanetworkopen.2025.4729.
[30] Nambi Ndugga et al., *Key Data on Health and Health Care by Race and Ethnicity*, Kaiser Family Found. (Dec. 16, 2025), https://www.kff.org/racial-equity-and-health-policy/key-data-on-health-and-health-care-by-race-and-ethnicity.
[31] Juanita J. Chinn et al., *Health Equity Among Black Women in the United States*, 30 J. Women's Health 212 (Feb. 2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC8020496.
[32] Charlotte Edmond, *US Women are Paying Billions More for Healthcare than Men Every Year*, World Econ. F. (Oct. 18, 2023), https://www.weforum.org/stories/2023/10/healthcare-equality-united-states-gender-gap/.
[33] *Id*.
[34] Shengwei Sun, *National Snapshot: Poverty Among Women & Families in 2024* 3 (Nov. 2025), https://nwlc.org/wp-content/uploads/2025/11/National-Snapshot-Poverty-Among-Women-Families-in-2024.pdf.
[35] *Id*.
[36] *Id*. at 4.
[37] Shameek Rakshit et al., *The Burden of Medical Debt in the United States* (Feb. 2024), https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states.
[38] Lunna Lopes et al., *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills* (Jun. 16, 2022), https://www.kff.org/health-costs/kff-health-care-debt-survey.

The Department is now proposing several policies that attempt to direct consumers into catastrophic plans, mislead them into thinking that these plans offer a cheaper alternative to standard insurance coverage, and allow issuers of these plans to impose even higher financial liability on enrollees. As a result, individuals may end up enrolling in these plans expecting basic coverage and not realizing the major risks to which these plans expose them. These policies would particularly harm those with higher medical expenditures and reduced ability to pay out of pocket—including women, women of color, and disabled women. Promotion of these minimal coverage plans is a move in the wrong direction; it will only increase the number of underinsured people, leading to more instances of consumers going without needed care because of their plan's inadequate coverage.

i. Expanded Eligibility for Catastrophic Plans [§ 155.605(d)(1)]

Previously, catastrophic plans have been available only to those under the age of thirty or those eligible due to a type of hardship such as experiencing homelessness, domestic violence, or a natural disaster. The Department proposes to expand hardship eligibility to all individuals – regardless of age or specific barriers to care – who are ineligible for APTC or CSR due to a projected household income below 100% or above 250% of the federal poverty level. Enrollees with lower incomes are already less likely to be able to afford large or unexpected medical costs and more likely to have preexisting medical debt: For example, one study found that 57% of people with household incomes below $40,000 currently had medical debt and 26% believed they would never be able to pay it off.[39] By targeting its promotion of catastrophic plans to people below or just above the poverty line, the proposed rule threatens to exacerbate these disparities even further.

The Department also proposes to offer these catastrophic plans as multi-year plans under which enrollees would not need to confirm their eligibility on an annual basis. This is likely to mislead consumers to believe they are enrolling in standard, comprehensive insurance coverage rather than filler plans designed to deal with emergency situations. In addition to broadly expanding eligibility and general access to catastrophic plans, the Department is actively steering individuals to these plans by streamlining the application process and automatically displaying these plans for eligible enrollees.

With the expiration of enhanced premium tax credits at the end of 2025, millions of people had their monthly premiums increase by double or more, and lost access to enhanced subsidies.[40] As a result, more consumers may consider catastrophic plans as a lower-

[39] *Id*.

[40] Justin Lo et al., *Mapping the Uneven Burden of Rising ACA Marketplace Premium Payments Due to Enhanced Tax Credit Expiration* (Nov. 24, 2025), https://www.kff.org/affordable-care-act/mapping-the-uneven-burden-of-rising-aca-marketplace-premium-payments-due-to-enhanced-tax-credit-expiration.

premium alternative, especially if they are unaware of the limitations of these plans. But instead of ensuring that people have the information they need to navigate their options and make an informed decision, the Department is seeking to push more consumers towards substandard plans that would likely leave them without the coverage they need.

ii. Higher Cost-Sharing for Catastrophic Plans [§ 156.155(a)(3)]

The Department also proposes to allow insurers to offer bronze and catastrophic plans with MOOPs that exceed statutory limits. The Department proposes to raise catastrophic MOOPs to an estimated $15,600 for an individual and $27,600 for a family.[41] Additionally, these plans would provide no benefits until 130% of the MOOP is reached. Further, insurers that offer at least one bronze plan that satisfies statutory cost-sharing requirements could also offer a bronze plan that exceeds the MOOP.

Barring coverage of benefits until 130% of the MOOP is reached would make care inaccessible, particularly given that the Proposed Rule seeks to drive the already-high MOOP of catastrophic plans even higher. These upfront costs would discourage individuals from seeking routine services. These cost-based delays can turn a preventable and treatable condition into a much more severe one. Moreover, one emergency could cost thousands of dollars, and enrollees may still not have met their MOOP to have additional benefits covered. For example, an enrollee may receive treatment for a broken leg which can cost over $7,500 and still need to pay thousands more to access their plan's coverage.[42]

The Trump administration touts that all catastrophic plans are now eligible for a Health Savings Account (HSA), but this will not mollify the financial catastrophes that will result from these plans. It is higher-income individuals, who typically have the disposable income to contribute to these accounts, who will benefit, not lower-income individuals. While those with low incomes may be drawn to these plans due to lower premiums, for many, the result will be either no care or tens of thousands of dollars of medical debt.

b. Defrayal of State-Required Benefits [§155.170]

Plans in the individual and small-group markets must cover an Essential Health Benefits (EHBs) package that includes at least 10 categories of care and is equal in scope to the benefits provided under a typical employer plan. These categories include preventive and

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[41] Katie Keith, *HHS Proposes Sweeping Changes For 2027 Marketplace Plans (Part 1)*, HEALTH AFFAIRS (Feb. 11, 2026), https://www.healthaffairs.org/content/forefront/hhs-proposes-sweeping-changes-2027-marketplace-plans-part-1.

[42] *See* U.S. Ctrs. for Medicare & Medicaid Servs., *Why Health Insurance is Important*, https://www.healthcare.gov/why-coverage-is-important/protection-from-high-medical-costs/ (last visited Mar. 7, 2026).

wellness services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, and mental health services, among others.

Under existing policy, state coverage mandates adopted through the EHB benchmark process are considered EHBs. This means that the state is not required to defray the costs of covering services established through such mandates, and those benefits are subject to cost-sharing protections, including annual or lifetime out-of-pocket caps. Meanwhile, the cost of covering benefits considered to be included "in addition to" the EHBs must be defrayed.

In 2020, the Department expanded the flexibility states have to add benefits without being subject to the defrayal requirement. These added flexibilities have encouraged states to expand their benefits, with at least eleven states and Washington, D.C. updating their benchmark plans.[43] These updates include changes that respond to the opioid epidemic and cover services related to fertility treatments and joint disorders.[44] Many states have used benchmark plan modifications to reduce health disparities, such as by expanding coverage for conditions disproportionately experienced by medically underserved communities.

The Department now proposes to upend this system and require states to defray a much broader range of added EHBs, including retroactively defraying previously added EHBs. In order to avoid defrayal, states would need to reverse course and remove state-mandated benefits from benchmark plans. However, even if states chose to keep their updated benchmark plans in place, those state-mandated EHBs would still lose consumer protections, like the cost-sharing limits, annual dollar restrictions, and non-discrimination protections.[45] Additionally, issuers would be required to exclude the costs of these state-mandated benefits from their premium tax calculations, resulting in lower PTC amounts for enrollees.[46]

The defrayal of state-mandated benefits is critical for the continued care of enrollees and should remain in place.

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[43] Stacey Pogue et al., *Enhancing Essential Health Benefits: How States are Updating Benchmark plans to Improve Coverage*, The Commonwealth Fund (Nov. 14, 2024), https://www.commonwealthfund.org/publications/issue-briefs/2024/nov/enhancing-essential-health-benefits-states-updating-benchmark-plans.

[44] *See, e.g.*, *id*.

[45] Christina Cousart, *What State Leaders Should Know About CMS' New Annual Proposed Health Insurance Rule*, Nat'l Acad. for State Health Pol'y (Mar. 3, 2026), https://nashp.org/what-state-leaders-should-know-about-cms-new-annual-proposed-health-insurance-rule.

[46] *Id*.

IV. The Proposed Rule Will Reduce Access to Affordable, Comprehensive Insurance.

Taken together, the proposed provisions would jeopardize access to affordable and comprehensive care—a harm that the Department cannot and does not reconcile with the intent of the ACA. The Proposed Rule would increase barriers to enrollment, undo critical consumer protections, and reduce the quality and affordability of care. As a result, many individuals who would have previously benefited from the ACA's protections will be left without adequate, comprehensive insurance—or without any insurance at all. By the Department's own estimates, 2 million people are likely to lose access to care in 2027 alone if this Proposed Rule is finalized.[47]

People who lose coverage often have lengthy gaps in insurance, or in some cases simply remain uninsured.[48] This Proposed Rule is therefore likely to worsen uninsurance rates. And because of the Proposed Rule's disproportionate impacts on people who already face barriers to enrollment, it would widen existing demographic gaps in coverage, including gaps affecting women and girls of color. NWLC found substantial racial and ethnic disparities among the 12.2 million women and girls who were uninsured in 2024: Latinas were over three times more likely than white, non-Hispanic women and girls to be uninsured, with Black women and girls also facing higher rates of uninsurance.[49] Similarly, an analysis of the nonelderly population in 2024 found that while 6.5% of white individuals were uninsured, the rate was substantially higher among those who were Indigenous (19%), Latine (18%), Native Hawaiian or Pacific Islander (13%), or Black (10%).[50]

The consequences of losing insurance are multifold. Numerous studies have demonstrated that uninsured individuals are less likely to receive preventive care or to access services for major health conditions and chronic diseases.[51] Uninsured women—disproportionately Black, Latina, and Indigenous women—are less likely to have a regular doctor and to receive services like mammograms, Pap tests, and blood pressure checks.[52] They also get less

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[47] Claire Heyison, *CMS Proposed Rule Would Reduce ACA Marketplace Enrollment by 2 Million People*, Ctr. on Budget & Pol'y Priorities (Feb. 9, 2026), https://www.cbpp.org/research/federal-budget/executive-action-watch?item=30493.

[48] Liran Einav & Amy Finklestein, *The Risk of Losing Health Insurance in the United States Is Large, and Remained So After the Affordable Care Act*, 120 ECONOMIC SCIENCES e2222100120 (Apr. 24, 2023), https://doi.org/10.1073/pnas.2222100120.

[49] Nat'l Women's L. Ctr., *NWLC Resources on Poverty, Income, and Health Insurance in 2024* (Sep. 16, 2025), https://nwlc.org/resource/nwlc-resources-on-poverty-income-and-health-insurance.

[50] Jennifer Tolbert et al., *The Uninsured Population and Health Coverage* (Oct. 8, 2025), https://www.kff.org/uninsured/health-policy-101-the-uninsured-population-and-health-coverage.

[51] *Id.*

[52] Kaiser Family Foundation, *Women's Health Insurance Coverage* (Dec. 12, 2024), https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage.

adequate and lower quality care.[53] As a result, uninsured women are more likely to have unmet medical needs and worse health outcomes, from higher rates of maternal mortality, especially among Black women,[54] to later-stage cancer diagnoses.[55]

Uninsured adults broadly are more likely to forgo needed care than those who are insured: In 2023, nearly half (47%) of uninsured people aged 18 to 64 reported that they had not seen a health care professional in the previous year, approximately three times the rate among insured people.[56] Uninsured people are consequently more likely to be hospitalized for avoidable health problems.[57] And when they are hospitalized, they receive fewer medical tests and services and suffer from higher mortality rates than those with insurance.[58] The health impacts are further compounded by financial ones: 62% of uninsured adults report health care debt,[59] which itself leads to wide-ranging impacts on health and wellbeing.[60]

Throughout the Proposed Rule, the Department fails to adequately consider, and in some cases entirely disregards, these numerous harms. Even when it does acknowledge these harms, it vastly underestimates the burdens its proposed changes would impose on applicants and enrollees, the risk of loss of coverage for eligible individuals, and the downstream effects of uninsurance and underinsurance.

V. Conclusion

NWLC opposes the proposed changes and urges the Department to withdraw the provisions of the rule described above. We request that the supporting documentation that we have made available through direct links in our citations be considered part of the formal administration record for purposes of the Administrative Procedure Act. For further information, please contact Monae White, Ann Kolker Fellow for Health Equity and Justice at the National Women's Law Center, at mwhite@nwlc.org.

[53] *Id*.
[54] Judith Solomon, *Closing the Coverage Gap Would Improve Black Maternal Health* (Jul. 26, 2021), https://www.cbpp.org/research/health/closing-the-coverage-gap-would-improve-black-maternal-health.
[55] Gerard A. Silvestri et al., *Cancer Outcomes Among Medicare Beneficiaries and Their Younger Uninsured Counterparts*, HEALTH AFFAIRS (May 2021), https://doi.org/10.1377/hlthaff.2020.01839.
[56] Tolbert et al., *supra* note 52.
[57] *Id*.
[58] *Id*.
[59] *Id*.
[60] Lopes et al., *supra* note 40.