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March 13, 2026

Secretary Robert F. Kennedy, Jr.
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

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

Dear Secretary Kennedy:

The Colorado Center on Law and Policy (CCLP) is a state-based, anti-poverty organization that advocates for the rights of all Coloradans. Our mission includes improving access to affordable, quality health care for Coloradans and furthering the rights of Coloradans to access public programs for which they are eligible. CCLP appreciates the opportunity to submit comments regarding the proposed rule, entitled *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program* (hereafter referred to as 2027 NBPP.[1] The text of this comment, as well as the text of all references identified in the body or footnotes of this document, should be considered part of the official record and considered prior to finalization of the proposed rule.

The Department of Health and Human Services (HHS) has proposed an expansive set of policies with a shortened comment period and has done so months later than is customary. The voluminousness of the proposed rule, the number of individual policy changes proposed, and the shorter-than-typical comment period are significant barriers to stakeholder engagement. At a minimum, we request that implementation be delayed

[1] U.S. Dep't. Health & Human Srvs., *Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program*, 91 Fed. Reg. 6292 (proposed Feb. 11, 2026), https://www.govinfo.gov/content/pkg/FR-2026-02-11/pdf/2026-02769.pdf (hereinafter "2027 NBPP").

until 2028. The better course would be for HHS to withdraw the rule, to allow time for a more reasoned and appropriately supported set of policies to be proposed.

Policies contained in the proposal are overall untested, unsupported and impossible to evaluate based on information provided. Where slightly more support is offered, it is clear that the rule would impose enormous administrative burdens on states, state exchanges, carriers and people seeking coverage, interfering with efficient administration of the exchange, de-stabilizing insurance markets, removing many thousands from affordable coverage they need to maintain their health, and throwing a bewildering range of changes at people seeking affordable coverage. The amount of change that would be imposed through this rule on states, exchanges and carriers would be disruptive, at best.

In many respects, the rule repeats errors in process that resulted in court action on the 2025 PPACA Marketplace Integrity and Affordability rule. As described below, in the 2027 NBPP, HHS has failed to consider important aspects of the problem, has offered explanations for its proposals that run counter to the evidence or that lack evidence. *City of Columbus v. Kennedy*.[2]

Because time to comment was inadequate, the following comment is necessarily limited. Had adequate time been permitted, there is more we would have liked to share about impacts on Colorado and nationally. As a result, we note our opposition to many other provisions, including those on Pre-Enrollment SEP Verification (§ 155.420(g)) (also barred by the court's stay in *City of Columbus v. Kennedy)* and State Exchange Improper Payment Measurement (SEIPM) (§§ 155.1600-155.1650), but lack capacity and time to outline and document the basis of our opposition.

1. **HHS speculates about the causes and outcomes of the proposed changes and provides minimal support for its reasoning.**

The authors stating they "believe" or "do not believe" in certain principles or theories over 190 times, often linking several unproven theories together to land on a final, speculative conclusion. For many provisions, no facts are offered or there is no explanation offered that logically connects the facts found and the choice made.[3] If there are sources on which the agency relied, they must identify those and allow stakeholders the opportunity to assess and comment on the soundness and applicability of those sources.

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[2] Memorandum Opinion, Aug. 22, 2025, pp. 10-11. Case 1:25-cv-02114-BAH.
[3] See *Motor Vehicle Manufacturers' Association v. State Farm Mutual Automobile Insurance Co.,* 463 U.S.29 at 43 (1983).

- Justifying selective use of EDGE data, HHS says, "we believe this promotes stability" and provides no evidence for that statement.[4]
- Justifying imposing a burden on carriers to report a set of information on past and prospective Cost-Sharing Reductions (CSRs), in the discussion of the impact of silver-loading, HHS says, "While we recognize the additional burden on issuers to provide this information…, we believe collection of this information is an important program integrity measure."[5] No facts are offered for the implication that program integrity for the CSR program is lacking.
- "We believe that in the absence of a centralized consumer facing website for eligibility and enrollment… web-brokers may provide that provide that service in a manner that is similar…" [6] No evidence is provided for web-brokers' ability to do so, and there is no consideration of the influence that different commission levels may have on web-broker behavior.
- Regarding defrayal of state-mandated EHB, HHS includes footnote 85, citing a report of the Government Accountability Office and implying that the report recommended a reversal of the policy on defrayal of state-mandated benefits. That mischaracterizes the report. In fact, it simply recommends a risk assessment to determine "whether additional oversight is needed."[7] HHS goes on to state, with no evidence of the impact on premiums or the impact on unsubsidized enrollees of state failure to defray, "[W]e believe we should not jeopardize the affordability of premiums."[8]
- Regarding the policy on failure to file and reconcile (FTR), and without providing any additional evidence, HHS states "we believe that the 2-tax-year FTR process could incentivize tax filers to not file and reconcile…"[9] Evidence from a prior period where a 1-year FTR process was in place was available but not cited here; it showed that enrollees experienced confusion and that the resulting appeals increased costs.[10]
- Based on a series of statements that lack any supporting evidence, including that standardized plans have not enhanced the consumer experience, have added to issuer burdens, have constrained choice, and that few consumers enroll in them, HHS states "…we believe now is not an appropriate time to once again" require standardized plans.[11]

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[4] 2027 NBPP, p. 239
[5] 2027 NBPP, p. 328
[6] 2027 NBPP, p. 346
[7] *https://files.gao.gov/reports/GAO-25-107220/index.html*
[8] 2027 NBPP, p. 375
[9] 2027 NBPP, p. 476
[10] 88 Fed. Reg. 25740, 25814-18 (Apr. 27, 2023).
[11] 2027 NBPP, p. 1597

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2. The rule omits or minimizes consideration about how the proposed policies will affect enrollment and retention rates, despite broader enrollment being a primary goal of the PPACA.

Increasing access to affordable coverage is a primary goal of the PPACA.[12] The 2027 NBPP disregards that goal in the rule, failing to propose any policy that would tend to or aims to increase coverage rates or prevent decreases in coverage. HHS also omits discussion of that primary goal when describing policies that evidence shows will tend to depress enrollment. Nowhere in the rule do the words "increase," "support," or "maximize" appear paired with the words "coverage" or "enrollment." Clearly HHS has again "entirely failed to consider an important aspect of the problem," as stated by the court in *City of Columbus v. Kennedy*.[13]

Proposed policies that add verification requirements will result in loss of coverage, due to the administrative burden involved in developing and sending notices on the part of an exchange, and the administrative burden involved in understanding, documenting, and mailing or submitting relevant paperwork. Evidence shows that simplifying processes and reducing burdens tends to increase enrollment,[14] while adding to burdens decreases it.[15] Whether verification requirements result in the loss of coverage or the loss of advance premium tax credits (APTC), the outcome will be that fewer people have health coverage.[16]

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[12] I42 U.S. §§18091(2)(C) and (I). *National Federation of Independent Business v. Sibelius*, 567 U.S. 519 (2012); see also *About the Affordable Care Act*. U.S. Department of Human Services. Retrieved Mar. 9, 2026https://www.hhs.gov/healthcare/about-the-aca/index.html

[13] *City of Columbus v. Kennedy*, Memorandum Opinion, Aug. 22, 2025, pp. 10-11. Case 1:25-cv-02114-BAH.

[14] Keith Marzilli Ericson, et al. Reducing Administrative Barriers Increases Take-Up Coverage: Evidence from a Field Experiment. THE REVIEW OF ECONOMICS AND STATISTICS, (March 5, 2025). https://direct.mit.edu/rest/article-abstract/doi/10.1162/rest_a_01573/128264/Reducing-Administrative-Barriers-Increases-Take-Up?redirectedFrom=fulltext

[15] Yue Li, Manasi Deschpande, Who is Screened Out? Application Costs and Targeting of Disability Programs. ECONOMICS FACULTY SCHOLARSHIP (Nov. 2019). https://scholarsarchive.library.albany.edu/cgi/viewcontent.cgi?article=1000&context=economics_fac_scholar; Paola Cantarelli, Reducing administrative burdens to increase the uptake of public services: the case of vaccination intentions. PUBLIC MANAGEMENT REVIEW (2024). https://www.tandfonline.com/doi/full/10.1080/14719037.2024.2345203

[16] A case in point is the impact of loss of e-PTC for households with over 400 FPL. Notwithstanding that this higher-income population may be less price sensitive than those with less income, analysts predict coverage losses between 3.8M and 4.8M in 2026. June 2024 letter, CBO Director Phillip Swagel to House Republican leaders, https://www.cbo.gov/system/files/2024-06/60437-Arrington-Smith-Letter.pdf; September 2025 Urban Institute letter. https://www.urban.org/sites/default/files/2025-09/9.24_Changes%20in%20Health%20Care%20Spending%20and%20Uncompensated%20Care%20under%20Enhanced%20Tax%20Credit%20Expiration%20for%20Marketplace%20Coverage.pdf

Policy proposals that, based on evidence, will increase administrative burden on exchanges, states, and/or enrollees, but where disenrollment impacts are discounted or not mentioned at all, include but are not limited to the following:

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

Based on the holding in *City of Columbus v. Kennedy,* HHS lacks authority to require any failure to reconcile (FTR) process until the 2028 plan year.[17]

The proposed rule would allow SBEs the option of using a 1- or 2-year FTR policy in 2027 and requires the 1-year policy as of plan year 2028. This provision would require additional paperwork for exchanges and enrollees both when enrollees had failed to file and reconcile, and when IRS processing delays resulted in inaccurate information on enrollee tax filing status. Loss of PTC and potentially loss of coverage will result when enrollees cannot navigate those paperwork challenges.

Processing of tax returns, if delayed, will affect access to coverage even when enrollees are current with tax filing obligations. As acknowledged in footnote 105, IRS processing delays during the COVID-19 pandemic led to a backlog in processing that would have affected FTR processes. However, HHS fails to acknowledge that delays are likely to occur going forward due to extensive changes in tax law and a 27 percent reduction in agency staff by the Trump Administration.[18]

HHS demonstrates far more concern about unauthorized enrollments – for which it provides no evidence in the 2027 NBPP – than it does about maintaining enrollment in subsidized plans. "While we acknowledge concerns about [negative impacts on low-income consumers and the negative impact on the risk pool], the overriding policy need for the Federal Exchange is to be able to remove unauthorized enrollments from the Marketplace."[19]

Verification Process Related to Eligibility for Insurance Affordability Programs. §155.320 (c)(3)(ix).

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[17] *City of Columbus v. Kennedy,* 796 F. Supp. 3d 123, 160-63 (D. Md. 2025), *appeal pending* (4th Cir. 2025) (No. 25-2012). The court found that "[t]he statute does not contemplate that the existence of a prior tax debt affects an applicant's eligibility for APTCs in any way"; that Congress knew how to condition issuance of coverage on payment of premiums, but did not do so; and that HHS general rule making authority did not allow it to re-write the statutory formula for APTCs. *Id.* at 162-63.

[18] National Taxpayer Advocate delivers Annual Report to Congress; finds taxpayer service strong in 2025 but foresees challenges for taxpayers who encounter problems in 2026. IR-2026-15, Jan. 28, 2026. https://www.irs.gov/newsroom/national-taxpayer-advocate-delivers-annual-report-to-congress-finds-taxpayer-service-was-strong-in-2025-but-foresees-challenges-for-taxpayers-who-encounter-problems-in-2026

[19] 2027 NBPP, p. 483

New verification processes related to immigration status will result in inaccuracies, will add significant burdens for exchanges and enrollees, and will result in improper coverage loss. Colorado's exchange currently must submit information to HHS, which is responsible for taking necessary steps to verify status with the Department of Homeland Security (DHS).[20] HHS provides no basis for requiring exchanges to take their own duplicative steps to submit information directly to DHS, as current rules already align with requirements in OBBBA. Doing so will be wasteful of exchange dollars, requiring additional time and training and new programming, to establish this new data connection. Because HHS also provides no route to resolving discrepancies between the results obtained by exchanges and HHS, eligible applicants will be improperly denied affordable coverage.

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

Again, in the name of "improved payment integrity measures" and without disregard to the impact of burdensome administrative requirements on enrollment, HHS would require extra documentation if data sources suggested income might be below 100 percent of the FPL. This is not the first attempt at doing so through rule, though both attempts have been stayed by federal courts.[21] Here as well, the claims of a "massive volume" of improper enrollments is unsupported by any evidence. Instead, HHS offers only a study with 20 fictitious applicants and extrapolates from there.[22]

The Paragon Institute report[23] cited in the 2025 proposed rule for the data on alleged fraud used questionable methodology[24] and failed to account for flaws in the data, as follows:

- The US Census Bureau identifies a likely undercount for the South region, and when looking at a state level, undercounts for Arkansas, Florida, Mississippi, Tennessee, and Texas.[25] All but Arkansas are states that the

[20] 42 CFR 155.315(c)(2)
[21] *City of Columbus* v. *Cochran,* 523 F. Supp. 3d 731 (D. Md. 2021). *City of Columbus* v. *Kennedy*, 796 F. Supp. 3d 123 at 168. This stay remains in effect at the time of submission.
[22] 2027 NBPP, p. 511
[23] Brian Blase, Drew Gonshorowski. "The Great Obamacare Enrollment Fraud," Paragon Health Institute, June 2024. https://paragoninstitute.org/wp-content/uploads/2024/06/The-Great-Obamacare-Enrollment-Fraud_FOR_RELEASE_V2.pdf
[24] KAC Response to Paragon Paper: Full Report. Feb. 27, 2025. https://americanscovered.org/wp-content/uploads/2025/02/Paragon-Response-Report-FINAL.pdf
[25] Census Bureau Today Releases 2020 Census Undercount, Overcount Rates by State. Census.gov. May 19, 2022. https://www.census.gov/library/stories/2022/05/2020-census-undercount-overcount-rates-by-

Paragon report identifies as having over-enrollment in subsidized ACA plans.

- The populations most likely to seek subsidized coverage, i.e. lower-income residents, are also most likely to be in undercounted. The American Community Survey reports that in 2010 and 2020, Black, Hispanic persons, and renters were undercounted, while white people, adults over 50 and homeowners were overcounted.[26] The majority of the U.S. Black population lives in the South, where the authors found the greatest discrepancies between eligible and enrolled populations.[27] Each of these undercounted groups is statistically more likely to have lower-than-median income, while those who are overcounted are more likely to have higher incomes.[28] Conclusions made by the Paragon report authors, and by the authors of the proposed rule, about the number of individuals eligible for subsidies versus those who enrolled would need to account for those factors.

While HHS may have authority to verify income under these circumstances, in devising methods to assess income, HHS must also consider the chief aim of the PPACA, namely maintaining coverage for eligible enrollees. It has failed to do so.

§155.320(c)(5) Income Verification When Tax Data is Unavailable

Currently, exchanges accept self-attestation when tax data is unavailable. The rule proposes to require additional documentation when information from a prior tax filing is not available. The policy will harm vulnerable populations: seniors, low-income residents,[29] and people with low literacy who have trouble navigating tax policies and forms. There was hope that filing rates might have improved with Direct File, which was

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state.html

[26] Census Bureau Releases Estimates of Undercount and Overcount in the 2020 Census. Census. Gov, March 10, 2022. https://www.census.gov/newsroom/press-releases/2022/2020-census-estimates-of-undercount-and-overcount.html

[27] Gracie Martinez and Jeffrey S. Passel. Facts About the U.S. Black Population. Pew Research Center, Jan. 23, 2025. https://www.pewresearch.org/race-and-ethnicity/fact-sheet/facts-about-the-us-black-population/

[28] Lisa Neidert, Reynolds Farley, Jeffrey Morenoff. How Census Undercount Became a Civil Rights Issue and Why It Is Increasingly Important. THE RUSSELL SAGE FOUNDATION JOURNAL OF THE SOCIAL SCIENCES. January 2025. https://www.rsfjournal.org/content/11/1/26

[29] James Cilke, Joint Committee on Taxation, U.S. Congress. https://ntanet.org/wp-content/uploads/proceedings/2014/029-cilke-case-missing-strangers-know-don.pdf

found to make filing easier and faster and improve users' trust in government.[30] The Trump Administration, however, chose to eliminate that program.[31]

According to data, seniors are significantly less likely to file and most non-filers have very low incomes.[32] Some of those very-low-income applicants are likely to have been enrolled in Medicaid and have not historically met filing thresholds; when higher income allows enrollment in the exchange, this policy will be an obstacle as they transition to greater self-sufficiency. In addition, non-filing rates can be expected to increase because of fear, not only for workers without documentation,[33] but also in mixed-status families, that is stoked by unprecedented new policies that allow data sharing between the IRS and the Department of Homeland Security. Last, delays in processing by the IRS can also result in someone appearing to be a non-filer.

Again, HHS expresses a primary goal of deterring improper enrollment, ignoring the vulnerabilities of populations most affected, and failing to give weight to the collateral consequence of deterring appropriate enrollment. Although they say the policy aims to prevent people from being responsible for large repayments related to ineligibility for PTC, there are other, less harmful steps the IRS or HHS could take within their rulemaking authority to mitigate the potential tax impacts for enrollees.

The stay in *City of Columbus v. Kennedy* related to this provision remains in effect, and this provision should accordingly be withdrawn.[34]

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

In Colorado, which as a State-Based Marketplace (SBM) state is not affected by the proposed changes for 2027, data is overwhelmingly favorable in support of the benefits to consumers of standardized plans. Colorado's standardized plan, the Colorado Option, was the choice of 47 percent of enrollees in 2025 and 50 percent in 2026, both because plan design made it easier to access outpatient benefits and the ease of shopping for a

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[30] Jory Heckman, IRS Direct File sees higher scores among users, despite a push to shutter it. FEDERAL NEWS NETWORK (May 30, 2025). https://federalnewsnetwork.com/it-modernization/2025/05/irs-direct-file-sees-higher-scores-among-users-despite-a-push-to-shutter-it/

[31] Trump White House Officially Ends Direct File Program. Americans for Tax Fairness, (July 31, 2025). https://americansfortaxfairness.org/trump-white-house-officially-ends-direct-file-program/

[32] James Cilke, The Case of the Missing Strangers: What we Know and Don't Know about Non-Filers. (2014). https://ntanet.org/wp-content/uploads/proceedings/2014/029-cilke-case-missing-strangers-know-don.pdf

[33] The Potential impact of IRS-ICE Data Sharing on Tax Compliance. The Budget Lab, Apr. 8, 2025. https://budgetlab.yale.edu/research/potential-impact-irs-ice-data-sharing-tax-compliance

[34] *City of Columbus v. Kennedy*, Memorandum Opinion, Aug. 22, 2025, pp. 10-11. Case 1:25-cv-02114-BAH.

plan.[35] Plans on the market with FFE and SBE-FP enrollment were nearly as popular, with uptake of 33 percent in 2025.[36] Researchers reported that based on the Colorado experience, informational barriers for customers, i.e. understanding plan provisions, were fewer with the standardized plans and allowed more thoughtful comparison among plans, and helping satisfy a core function of an exchange.[37] Contrary to the evidence from Colorado, and without providing any evidence on the experience for the federal exchange, HHS makes the conclusory statement that standardized plan options are "ineffective" in enhancing the consumer experience or improving consumer understanding.

Rather than endorsing steps that could assist consumers in making optimal choices that reduce cost and improve access to quality care, HHS proposes changes that would stymie successful plan selection. Better solutions would be to limit plan selection, impose plan limits, expand the use of copays (rather than allowing the uncertainty that comes with coinsurance), and improve online tools that can assist with sorting plans for the factors that matter most to consumers,

There is also no justification offered for the conclusory statement that the stability of the federal exchange requires that they remove these popular choices from the exchange. In fact, discontinuing these plans will leave millions of Americans forced to drop a product they prefer and to shop for a new plan. That process itself can be onerous and time-consuming, can create confusion when enrollees being using a plan with new and different rules, and may also result in a new plan that excludes a trusted provider or a needed prescription drug.

§156.202 Discontinuation of Non-Standardized Plan Option Limits and Exceptions.

Having to sort through unlimited plan options is a considerable burden for consumers, who tend to make lower-quality decisions when presented with many choices.[38] Evidence shows that a choice of 30 or more plans actually decreased enrollment[39] as presumably overwhelmed customers abandoned the process. HHS states, citing no

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[35] R. Vincent Pohl et al., Analysis of the Colorado Option, pursuant to § 10-16-1310, C.R.S. Mathematica. Jan. 16, 2026. https://doi.colorado.gov/sites/doi/files/documents/CO-Option-10-16-1304-Report.pdf
[36] Katie Keith et al., HHS Proposes Sweeping Changes For 2027 Marketplace Plans (Part 2), HEALTH AFF. (Feb. 13, 2026), https://www.healthaffairs.org/content/forefront/hhs-proposes-sweeping-changes-2027-marketplace-plans-part-2
[37] *King v. Burwell*, 576 U.S. 473, 479 (2015)
[38] S.S. Iyengar and M.R. Lepper, When Choice Is Demotivating: Can One Desire Too Much of a Good Thing? JOURNAL OF PERSONALITY AND SOCIAL PSYCHOLOGY (Dec. 2000). https://faculty.washington.edu/jdb/345/345%20Articles/Iyengar%20%26%20Lepper%20(2000).pdf
[39] Williams M.J., Afendulis C.C., McGuire T.G., and Landon B.E. Complex Medicare Advantage Choices may Overwhelm Seniors—Especially Those with Impaired Decision Making. HEALTH AFFAIRS, (Sept. 2011): 1786-1794.https://pubmed.ncbi.nlm.nih.gov/21852301

evidence and contradicting sources cited here, that "offering standardized plan option and imposing non-standardized plan option limits…[imposes] additional burden and [constrains]…consumer choice."[40]

It is difficult to sort through the tangle of arguments "based on [HHS's] 4 plan years of experience" or to understand their discounting of a study on "Simple Choice" plans that found a related reduction in gross premiums, or to countenance their suggestion that market instability during the same time period could have been the cause of the lower premiums.[41] As is well-established, market instability raises premiums, because fewer people enroll and those who do tend to have greater healthcare needs.[42]

§156.130(c) and 156.155(a)(6) Catastrophic Plan 10-Year Terms.

The proposal to have catastrophic plans that have up to 10-year-terms, with the option of designing plans for particular conditions and with variability in annual out-of-pocket costs, is too vague to thoroughly evaluate. However, there are obvious hazards in a proposal that might lock enrollees into an arrangement that does not accommodate life changes. One threshold issue is the informational barrier this would pose for enrollees, who would be encountering a new, complex, untested product. Accurately forecasting the impact of changes in income, age, health status, residence, household size, and other factors would be nearly impossible. Although the rule indicates that enrollees could leave the plan without penalty, it does not say that the choice to leave would create a Special Enrollment Period, without which the enrollee might become uninsured.

The proposal also proposes allowing variability in cost-sharing limits for multi-year plans, potentially with higher out-of-pocket costs in the initial years. If an enrollee decided they needed a different type of plan, relocated outside the service area, or died, it is unclear how or whether they would be reimbursed for costs beyond the standard annual maximum OOP. The risks to enrollees are enormous.

Catastrophic plans do not promote adoption of healthy habits. Rather, evidence shows that as out-of-pocket costs increase, treatment adherence declines and health outcomes worsen for the poorest and sickest participants.[43] If HHS's goal is to encourage enrollees to adopt healthy habits, we instead recommend wider use of standardized plans like the

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[40] 2027 NBPP, p. 882.
[41] 2027 NBPP, p. 886.
[42] Preethi Rao, Federico Girosi, Christine Eibner. Assessing the Impact of Individual Market Reforms in Minnesota. RAND, Jan. 24, 2024. https://www.rand.org/pubs/research_reports/RRA3074-1.html
[43] Nicole Fusco, et. al. Cost-sharing and adherence, clinical outcomes, health care utilization, and costs: A systematic literature review. Journal of Managed Care and Specialty Pharmacy, (January 2023). https://pmc.ncbi.nlm.nih.gov/articles/PMC10394195/

Colorado Option, where pre-deductible, low cost access to outpatient services encourages people to address problems before a chronic or acute illness develops.

§156.230 Provider access standards for network plans. The 2027 NBPP proposes to weaken the requirements for states to assess network adequacy prior to certification of a QHP. HHS would also shift the responsibility for assessing network adequacy to State Exchanges and SBE-FPs, whether or not they felt they had capacity, and to FFE states if they so elected, and would allow certification of non-network plans. In *City of Columbus v. Cochran*, the court found that the provision in the 2019 payment rule that would have allowed HHS to shift network adequacy assessments to FFE states was arbitrary and capricious.[44] As HHS states, the court "raised concerns about comments stating that State review procedures are often not adequate [and] have no quantitative standards for network adequacy in place."

Here, HHS proposes to *remove* existing quantitative standards, i.e. time and distance standards, and to again shift assessments to FFE states, again leaving consumers with inadequate assurance that they have a way to access plan benefits. The rationale provided by HHS, that states that carriers have identified challenges in contracting with enough providers in different specialties, is not supported by any documentation, making it impossible to know whether the information is anecdotal or more robust. If that information were verified, there would also need to be consideration of alternative methods to address provider shortages or provider reluctance to contract. Again, HHS seems to be operating on belief rather than evidence: "[W]e believe that States are often best positioned to evaluate local provider networks and market conditions . . ."[45]

3. The rule imposes unfunded mandates on states, state exchanges and carriers in violation of the Unfunded Mandates Reform Act (UMRA).

The proposed rule cites the requirement from UMRA to assess anticipated costs and benefits before issuing a rule. In UMRA, federal intergovernmental mandates were defined as any provision in legislation, statute, or regulation that "would impose an enforceable duty upon State, local, or tribal governments" or "reduce or eliminate the amount" of federal funding authorized to cover the costs of an existing mandate." 2 U.S.C. §658(5)(A). Authors acknowledge that they "have not been able to quantify all costs," and opine that costs would not exceed the allowable threshold.[46] While such a claim might be plausible in some scenarios, it lacks credibility simply on the basis that states that have expanded Essential Health Benefits (EHB) would be newly responsible for defraying the cumulative cost of benefits added in the last 15 years.

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[44] *City of Columbus v. Cochran,* 523 F.Supp.3d 731 (D. Md. 2021). https://affordablecareactlitigation.com/wp-content/uploads/2021/03/order-3-4-21.pdf.
[45] 2027 NBPP, 98
[46] 2027 NBPP, p. 886.

On top of the cost to states related to EHB, there are many additional administrative costs imposed on states, state-based exchanges and carriers related to revising state rules, reprogramming systems, providing additional noticing, processing additional documentation, utilizing new interfaces, and reporting on cost-sharing reductions, not to mention disallowing labor- and cost-saving efficiencies like auto-re-enrollment. In fact, new recordkeeping and reporting requirements would cost more than $1.34 billion yearly to implement.[47]

Consistent with one of the statutory purposes of UMRA, withdrawal of the rule would allow HHS to comply with its obligation to give states opportunity to provide input and to fully assess the budgetary impact of this proposal.

4. The rule further damages the safety net and will increase medical debt for consumers.

Many parts of the rule compound negative impacts imposed by the One Big Beautiful Bill Act (OBBBA), also called HR1, on community clinics, rural hospitals, and other safety net providers, including 20 percent less revenue for federally qualified health centers and rural providers who are already financially strained. [48] Cuts in Medicaid enrollment that result from exclusions for legally present immigrants and from work requirements will leave those providers with increasing amounts of uncompensated care. The 2027 NBPP's provisions that add to administrative burden, as discussed above, will increase the number of patients without coverage and overall reduce solvency for the health care system that all Coloradans rely on.

§§ 155.1051 and 156.235 Essential community provider standards for network plans: Reductions to Essential Community Provider (ECP) minimum requirements will allow carriers to contract with fewer of these safety net providers. There is no evidence provided in support of HHS's statement that reducing the ECP percentage will reduce carrier burden, since contracting with an ECP is not demonstrably different than contracting with a different provider. Nor does HHS balance the supposed benefit to carriers against the harm to the low-income and medically underserved patients who are likely to rely on ECP providers.[49] While seeing more uninsured patients, those providers will also be likely to get reimbursement at commercial rates less frequently. At the same

[47] HHS Proposes Sweeping Changes For 2027 Marketplace Plans (Part 1), HEALTH AFFAIRS (Feb. 11, 2026). DOI: 10.1377/forefront.20260211.352520
[48] Michael Wang, Paula Chatterjee. Medicaid Financing and the Health Care Safety Net. Penn Leonard Davis Institute of Health Economics. (January 15, 2026). https://ldi.upenn.edu/our-work/research-updates/medicaid-financing-and-the-health-care-safety-net/
[49] 2027 NBPP, p. 1011

time, lower-income households that are transitioning from Medicaid will have fewer opportunities to remain connected to a trusted provider. Although we appreciate that SBEs may impose different standards, we remain opposed to these provisions.

§156.236 Provider access and essential community providers standards for non-network plans. Allowing non-network plans will also be damaging to safety net providers, but even more so to enrollees. Safety net providers, by definition, are required to accept all patients regardless of ability to pay and will have no choice but to accept the amount proposed by a carrier, whether or not sufficient to cover costs. While QHP issuers may be happy to dispense with the need to secure and negotiate networks, any savings will accrue to insurers rather than to enrollees – who themselves will have to take on the burden of identifying providers and negotiating with them, despite having no bargaining power.[50] As the American Hospital Association stated in 2023, "Hospitals and health systems' experience . . . is that patients with these plans often are either unaware of this obligation to shop for services or are unable to find a provider that will accept their coverage."[51]

It is ludicrous to posit, as HHS does, that enrollees could save money through negotiation,[52] and enrollees will have no assurances about the quality of providers, undermining the PPACA goal of improving quality in healthcare. Although HHS states they have "an effective administrable approach," they provide no evidence to support that claim.

§156.155. HHS would require much higher maximum OOP limits in catastrophic plans of $15,600 for an individual and $31,200 for a family, putting households at great risk of medical debt and providers at risk of non-reimbursement. People with less health literacy and lower incomes would be at particular risk. At the same time, HHS proposes making more people eligible for catastrophic coverage.

More than 1 million Coloradans have medical debt, and research organization KFF found that nationally, 41% of adults in the U.S. carry medical debt, many of whom are insured.[53] Plans with high deductibles and higher maximum OOP limits leave enrollees

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[50] Bargaining power for carriers is directly related to carrier size, with promises of greater volume balancing lower reimbursement. An individual has no leverage in price negotiations. Jee-Hun Choi. *Insurer Size and Negotiated Hospital Prices: Insights from the Affordable Care Act in Arkansas*. HEALTH ECON (Aug. 1, 2025). https://pmc.ncbi.nlm.nih.gov/articles/PMC12496023/

[51] Ashley Thompson, AHA Comments on the CMS' Proposed Notice of Benefit and Payment Parameters for 2024. American Hospital Association. (Jan. 30, 2023). https://www.aha.org/lettercomment/2023-01-30-aha-comments-cms-proposed-notice-benefit-and-payment-parameters-2024

[52] 2027 NBPP, p. 1083.

[53] John Ingold. My family's $2,000 popsicle and why health care costs so much in Colorado. COLORADO SUN (Jan. 19, 2024). https://coloradosun.com/2024/01/19/medical-health-care-costs-colorado/

with thousands to cover and harm the financial health of households and the providers who serve them, with rural hospitals particularly at risk.[54]

Multiple provisions. Medical debt also correlates closely with being uninsured, even for periods of less than a year.[55] Most of the provisions in the proposed rule that directly affect consumer enrollment processes require that they provide additional documentation or take additional administrative steps. Those requirements will result in loss of coverage if the applicant or enrollee is unable to understand what is required, is unable to navigate online portals or has limited internet access, or if the carrier or exchange is backlogged or makes an error.[56] To impose those burdens and force consumers to risk loss of coverage – despite the lack of justification – contraverts the goals of the PPACA.

Conclusion

CCLP is concerned about the impact of proposed policies in the 2027 NBPP on access to coverage and care for Coloradans and other Americans. The PPACA continues to be good law, despite numerous constitutional challenges.[57] Entangling consumers and exchanges in costly and time-consuming administrative tasks is an inappropriate and potentially illegal way of derailing the law, and threatens to prevent it from achieving its stated aims of improving access to affordable coverage and quality care.

We have included numerous citations and request that the full text of each of the studies and articles be considered part of the record. If HHS is not willing or able to comply with that request, please notify me and provide me with the opportunity to submit copies into the record.

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[54] Markian Hawryluk, High-deductible plans jeopardize the financial health of patients and rural hospitals in Colorado and beyond. KFF HEALTH NEWS (Jan. 11, 2020). https://coloradosun.com/2020/01/11/high-deductible-health-insurance-colorado/

[55] Shameek Rakshit et al. The burden of medical debt in the United States. Peterson-KFF Health System Tracker (Feb. 12, 2024). https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/#Share%20of%20adults%20who%20have%20medical%20debt,%20by%20demographics,%202021

[56] Donald Moynihan, Pamela Herd, Hope Harvey. Administrative Burden: Learning, Psychological and Compliance Costs in Citizen-State Interactions. JOURNAL OF PUBLIC ADMINISTRATION RESEARCH AND THEORY (2014). https://inequality.hks.harvard.edu/publications/administrative-burden-learning-psychological-and-compliance-costs-citizen

[57] Abbe R. Gluck, et al., The Affordable Care Act's Litigation Decade. THE GEORGETOWN LAW JOURNAL (June 2020). https://www.law.georgetown.edu/georgetown-law-journal/wp-content/uploads/sites/26/2020/06/Gluck-Reagan-Turret_The-Affordable-Care-Act%E2%80%99s-Litigation-Decade.pdf

Thank you for your attention. If you have questions or need additional information, please contact Bethany Pray, Chief Legal and Policy Officer, at bpray@copolicy.org.