March 13, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9884–P
P.O. Box 8016
Baltimore, MD 21244-8016

Subject: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program (RIN 0938-AV62)

Dear Administrator Oz,

Covered California welcomes the opportunity to offer the following comments in response to the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), proposed Notice of Benefit and Payment Parameters for 2027.

Since Covered California launched in 2014, millions of Californians have gained coverage through the Marketplace, helping drive California's uninsured rate to historic lows and demonstrating the enduring strength of the Affordable Care Act (ACA). Today, Covered California connects more than 1.9 million[1] Californians to high-quality, affordable, and comprehensive coverage and administers federal financial assistance to eligible households. Covered California's active purchaser model continues to promote affordability, choice, and market stability by negotiating directly with qualified health plan issuers and holding plans accountable for delivering value to consumers.[2]

Covered California's success in making healthcare a reality for millions of Californians is rooted in state flexibility and our ability to implement innovative strategies tailored to the state's unique needs. By leveraging this flexibility and deep market expertise, we have expanded financial assistance through premium assistance and cost-sharing reduction programs, streamlined enrollment into more generous plans, and established robust fraud prevention and enforcement standards. These efforts have safeguarded consumers, held agents and brokers accountable, and delivered one of the healthiest

[1] Covered California, Press Release, As Enhanced Federal Subsidies Expire, Covered California Ends Open Enrollment With State Subsidies Keeping Renewals Steady — for Now — and New Signups Down (Feb. 26, 2026).
[2] Covered California, Press Release, Covered California Rates and Plans for 2026: Consumer Affordability on the Line With Uncertainty Surrounding Federal Premium Tax Credit Extension (Aug. 14, 2025).

risk mixes in the nation—all while reducing barriers to coverage for those who need it most.

Covered California appreciates that this proposed rule acknowledges the importance of preserving state flexibility in certain areas and that State-based Marketplaces (SBMs) are uniquely equipped to craft policies that address the specific needs of their populations, systems, and market dynamics. However, at the same time, **several provisions in the proposed rule reflect a broader federal shift that diminishes meaningful state discretion.** A central principle of the ACA is allowing states to operate Marketplaces that respond to their own unique circumstances. This proposed rule risks undermining that principle by limiting state authority in critical areas while introducing new flexibilities that could inadvertently harm consumers, affordability, and market stability. These shifts constrain states' ability to structure coverage solutions while opening pathways that may weaken access, quality, and risk pool stability.

Within this broader context, Covered California has utilized this flexibility to strike a critical balance between maintaining program integrity and enhancing consumer access and experience. **We strongly support the goals of program integrity and accurate eligibility determinations and share CMS's commitment to reducing fraud and preventing improper enrollments. However, program integrity measures must be carefully balanced to avoid creating barriers for eligible individuals seeking coverage or retaining it.** Proposals related to data matching issues (DMIs), failure to reconcile, and expanded verification requirements risk increasing administrative burden, coverage churn, and inadvertent terminations for consumers acting in good faith.

California's experience demonstrates that effective safeguards can mitigate fraud while simultaneously reducing consumer burden. For example, Covered California enforces rigorous standards through agent agreements, certification requirements, and a code of conduct, which together ensure strong oversight while facilitating enrollment assistance in a Marketplace where more than half of enrollments are supported by certified agents. We agree that strengthening agent and broker marketing standards is a critical opportunity to enhance program integrity while minimizing burdens on consumers. Covered California supports CMS's efforts to align Federally-Facilitated Marketplace (FFM) requirements with proven best practices, which would bolster consumer protections across all Marketplaces without creating unnecessary barriers for eligible individuals. Unfortunately, other provisions of this proposed rule—particularly those concerning Enhanced Direct Enrollment—move in the opposite direction by decentralizing critical Marketplace functions and weakening oversight, potentially granting unscrupulous brokers greater latitude to engage in fraudulent practices.

Covered California is also deeply concerned that certain provisions within this proposed rule risk undermining the quality, comparability, and financial protections of Marketplace coverage. Proposals to expand catastrophic coverage

through broader hardship exemptions, adjust catastrophic and bronze cost-sharing, permit multi-year catastrophic plans, allow non-network plans, and eliminate standardized plans on the FFM collectively raise the risk of steering consumers toward less protective products that are harder to compare and offer weaker financial safeguards. To address these concerns, Covered California welcomes collaboration with CMS to develop implementation strategies that ensure continuity of coverage, preserve consumer choice architecture, and sustain a balanced health risk mix that protects the integrity of the ACA Marketplaces.

Finally, **we are concerned that several provisions in this proposed rule—particularly when combined with policies implementing H.R. 1 and the Marketplace Integrity and Affordability Rule—further commit to restrictive eligibility requirements that will reduce enrollment and disproportionately impact low-income and immigrant communities.** Narrowing premium tax credit (PTC) eligibility for lawfully present immigrants, tightening income verification standards, and introducing pre-enrollment verification requirements risk creating significant enrollment barriers. These policies move further away from the ACA's core goals of expanding access to affordable, high-quality coverage, promoting equity, and fostering Marketplace stability.

Drawing on our experience and shared commitment to advancing the ACA's goals, we offer the following detailed comments on the specific provisions of the proposed rule to reduce eligibility and enrollment barriers, strengthen consumer protections, coverage quality, and Marketplace stability, and optimize Marketplace operations.

REDUCING ELIGIBILITY AND ENROLLMENT BARRIERS

Income Verification Requirements

Covered California is deeply committed to program integrity and supports CMS's efforts to address fraudulent activity on the FFM. However, **the proposed income verification changes fail to account for the proven systems and safeguards already in place within SBMs like Covered California. By applying a one-size-fits-all approach, CMS risks creating unnecessary burdens for consumers and states while undermining efficient and effective systems tailored to the unique needs of individual Marketplaces.**

Covered California has continually invested in robust fraud prevention systems and takes swift action if improper activity is identified. As a result, we have no indication of widespread fraud or abuse in our Marketplace, nor do we share the vulnerabilities specific to HealthCare.gov outlined in the Government Accountability Office's

preliminary report—findings that solely studied the FFM, not SBMs.[3] This success stems from tailored approaches designed for California's unique market and systems, ensuring the over 14,000 enrollment partners we work with adhere to the highest standards under comprehensive oversight. Covered California's fraud prevention measures[4] effectively ensure program integrity while minimizing barriers for eligible consumers, including:

- Consumers must affirmatively delegate access to enrollment partners before any application changes can be made, preventing unauthorized changes by brokers or agents.
- AI-driven identity verification systems proactively prevent fraud by identifying anomalies in real time and verifying consumer identities through biometric and document validation.
- Duplicate enrollments across programs, including Medi-Cal, are actively monitored and resolved to ensure financial assistance integrity.
- A dedicated fraud team investigates risks, collaborates with external partners, and hosts an annual Fraud Summit to share best practices.

Because California does not experience such widespread fraud, the proposed changes instead would only exacerbate existing challenges for both consumers and Marketplaces. Requiring additional documentation would significantly increase DMIs, delay income determinations, and prolong uncertainty for consumers. This is especially problematic given significant Internal Revenue Service (IRS) backlogs[5] and longstanding data gaps. Income DMIs already take months to resolve, and under the proposed framework, consumers could face prolonged periods of uncertainty and higher premium liability while their cases are pending. Starting in 2028, when Marketplaces would be prohibited from providing advanced premium tax credit (APTC) during the verification period, the consequences would be even more severe. Eligible consumers could face unaffordable premiums and risk losing access to financial assistance altogether if they cannot meet documentation requirements on time.

These changes also impose substantial operational burdens on SBMs, particularly as they are already working to implement broader eligibility and enrollment changes. Accordingly, Covered California urges CMS to provide flexibility for SBMs to tailor income verification policies to their established systems and practices, recognizing that

[3] U.S. Government Accountability Office, Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist, GAO-26-108742 (Dec. 2025).
[4] U.S. Government Accountability Office, Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist, GAO-26-108742 (Dec. 2025).
[5] Diana M. Tengesdal, Deputy Inspector Gen. for Audit, Dep't of the Treasury, *Memorandum for Commissioner of Internal Revenue: The Internal Revenue Service's Readiness for the 2026 Filing Season (Audit No. 2026400002)* (Jan. 26, 2026).

SBMs are best equipped to maintain program integrity without creating barriers for eligible consumers.

If CMS applies these requirements to all Marketplaces, Covered California strongly recommends delaying implementation to minimize further disruption. The current timeline is operationally unfeasible due to system limitations, competing federal and state requirements, and the volume of changes already underway.

Restricting PTC Eligibility to Limited Immigrant Groups

Covered California recognizes that the proposed changes to PTC eligibility for certain lawfully present immigrant groups are driven by recent statutory amendments and that CMS cannot, through this rulemaking, alter those underlying legal requirements. Within those constraints, however, CMS retains important discretion in how it interprets, sequences, and operationalizes these provisions, especially through engaging and communicating with impacted consumers. **Covered California therefore strongly urges CMS to fully evaluate the far-reaching consequences of these statutory changes and minimize the impact on vulnerable communities as much as possible.** These changes, if not carefully implemented, will have significant negative impacts on enrollment, access to care, and the financial stability of affected populations.

In California alone, an estimated 123,000 lawfully present Covered California enrollees are projected to lose access to APTC and cost-sharing reductions by 2027 as a result of statutory changes affecting eligibility for financial assistance. These individuals—who include those with asylum or pending asylum status, work or student visas, refugees, and survivors of trafficking, domestic violence, and other serious crimes—are lawfully present in the United States and rely on Marketplace coverage to access necessary healthcare services. While the underlying statute may require changes to their eligibility status, CMS's implementation choices will materially affect the extent of coverage loss, the timing and magnitude of disruptions, and the availability of mitigations.

Pre-Enrollment Verification

We appreciate the opportunity to provide feedback on how CMS should implement this proposal, as the policy has the potential to cause significant harm to consumers and Marketplaces. These impacts could be mitigated with a flexible approach that prioritizes consumer needs and minimizes administrative burdens. Given the importance of this policy, we respectfully request a minimum 60-day public comment period for any subsequent proposed verification regulations.

Specifically, the requirement introduces new hurdles for consumers to retain coverage, and when combined with income verification provisions, could exacerbate denials of APTC for millions of eligible individuals awaiting paperwork processing. A study in the

American Economic Review[6] found that adding even one extra administrative step reduces enrollment by 33 percent, disproportionately affecting healthy, younger, and low-income individuals. This adverse selection would destabilize the risk pool and raise premiums for unsubsidized enrollees.

Given the low incidence of fraud in SBMs, Covered California strongly supports the statutory provision allowing consumers to affirm electronically verified data for eligibility determinations. Current Marketplace processes have proven effective in simplifying enrollment and keeping eligible individuals covered. CMS should preserve these successful approaches and avoid replacing them with more cumbersome and disruptive processes. Further, CMS should recognize that SBMs have different systems and operational approaches for many core areas of eligibility and enrollment from the FFM. Regulations should allow for state flexibility and avoid unnecessarily rigid requirements that are designed around FFM operations without a full understanding of variation across SBMs.

Additionally, this proposal places a significant burden on Marketplaces, requiring costly and complex implementation. Covered California urges CMS to issue pre-enrollment verification regulations or guidance no later than July 2026 to ensure SBMs have sufficient time to design, build, test, and implement the required changes. Even with this timeline, implementation would remain highly challenging. CMS estimates that implementing new verification requirements would cost Marketplaces approximately $198 million annually, diverting resources from other critical priorities, including broader eligibility changes under H.R. 1.

For states like California, which operate integrated eligibility systems coordinating Marketplace coverage and Medicaid, the difficulties are even greater. SBMs are already navigating packed implementation schedules, including major changes related to Medicaid work requirements and eligibility rules for noncitizens in both Medicaid and the Marketplaces. These efforts demand more than technical adjustments—they require new policies, procedures, and solutions, while simultaneously unwinding longstanding operational processes that have successfully supported enrollment and eligibility determinations for years.

If CMS proceeds with changes in this area, it must establish a timeline that allows SBMs to implement updates thoughtfully and effectively, without compromising the consumer experience or operational soundness.

[6] Mark Shepard & Myles Wagner, *Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment*, 115 Am. Econ. Rev. 772, 822 (2025).

STRENGTHENING CONSUMER PROTECTIONS, COVERAGE QUALITY, AND MARKETPLACE STABILITY

Expanded Eligibility for Catastrophic Plans

Covered California urges CMS to preserve state flexibility regarding expanded eligibility for catastrophic plans. A one-size-fits-all approach is not appropriate for states like California, which independently process hardship exemptions and have developed systems and standards tailored to their unique markets.

California's Legislature deliberately reinforced this approach when it enacted the Minimum Essential Coverage Individual Mandate and directed Covered California to establish a state-administered hardship exemption process tailored to California's individual market. In doing so, the Legislature made a careful, evidence-based judgment about how best to stabilize our market in the wake of the repeal of the federal mandate penalty, including allowing targeted access to catastrophic coverage where it would promote continuous coverage and affordability. Overly prescriptive federal catastrophic eligibility rules would undermine this state-specific statutory framework and limit California's ability to use the very tools the Legislature provided to protect consumers and keep our market stable. These measures were designed to stabilize the individual market, lower premiums, and increase coverage following the repeal of the ACA's mandate penalty, ensuring affordability and stability in California's individual market.

Against this backdrop, expanding access to catastrophic coverage raises significant concerns around market stability. In California, the premium differential between catastrophic and bronze plans varies widely across issuers and regions, with some differences being substantial. Broadening eligibility would likely lead to a meaningful migration of younger, healthier enrollees from bronze plans to catastrophic plans, disrupting Marketplace risk pools and introducing considerable uncertainty into rate-setting. As issuers adjust to new enrollment patterns, these shifts could strain plan financials and result in more conservative pricing, ultimately increasing premiums across all metal tiers. Furthermore, increased enrollment in catastrophic plans could adversely impact morbidity patterns within the remaining metal tiers. As healthier enrollees migrate out of bronze and silver plans, premiums for those tiers would likely rise, reducing the cross-subsidization that currently stabilizes the Marketplace.

Covered California is also concerned that encouraging migration to leaner benefit designs may undermine the ACA's goal of improving population health. Catastrophic plans offer limited coverage for non-preventive services, which may lead some consumers to delay or forgo necessary care due to higher cost exposure. While plan liability may be lower for catastrophic plans compared to bronze plans due to higher cost-sharing, the financial burden on consumers would increase. Many Marketplace enrollees already struggle to meet deductibles and out-of-pocket maximums under

bronze plans; catastrophic plans could exacerbate financial hardship and increase medical debt.

Additionally, the affordability advantage of catastrophic plans may erode over time. As enrollment patterns shift and premiums adjust to reflect evolving risk pools, catastrophic premiums may gradually approach current bronze plan pricing, diminishing affordability benefits while leaving consumers with less comprehensive coverage.

Finally, these dynamics raise important questions regarding how catastrophic plans should be integrated into the risk adjustment framework. Covered California urges CMS to carefully evaluate these potential consequences and maintain flexibility for states to address the needs of their unique markets.

Risk Adjustment Transfer Methodology for Catastrophic Plans

In response to CMS's request for comment on the treatment of catastrophic plans within the risk adjustment framework, **Covered California emphasizes the importance of ensuring that the methodology appropriately addresses the selection dynamics associated with these products, particularly as policies to expand access to catastrophic coverage are considered.**

Catastrophic plans tend to attract a distinct enrollment population, skewing younger and healthier compared to other metal tiers. Expanding eligibility for these plans could amplify these selection effects, as a larger share of lower-risk enrollees may migrate into catastrophic coverage. Under these circumstances, maintaining separate risk adjustment pools for catastrophic and non-catastrophic plans could meaningfully exacerbate adverse selection pressures across the individual market.

Significant enrollment shifts into catastrophic plans could weaken the current risk adjustment program's ability to balance risk effectively across plans. Specifically, segregating catastrophic plans from the broader metal tier pool may diminish the program's capacity to offset morbidity differences, as healthier enrollees increasingly select catastrophic coverage while higher-risk enrollees remain in other tiers.

Covered California recommends that CMS carefully evaluate whether the current risk adjustment structure for catastrophic plans remains appropriate if eligibility is expanded. Integrating catastrophic plans into the broader individual market risk pool could be a potential solution to mitigate selection pressures. However, implementing such structural changes would require thorough analysis and sufficient time for issuers and Marketplaces to adjust their rate-setting processes. As CMS considers these policy options, it is essential to ensure that the risk adjustment framework continues to promote balanced enrollment across coverage levels and supports stable premiums in the individual market.

Bronze and Catastrophic Plan Cost-Sharing

Covered California strongly urges CMS to withdraw its proposal to increase cost-sharing for bronze and catastrophic plans beyond the ACA's established maximum annual limitation on cost-sharing. First and foremost, the proposal is clearly contrary to the statutory requirements of section 1302(c) of the ACA. CMS has previously acknowledged that bronze plan designs can comply with actuarial value (AV) requirements and out-of-pocket maximum limits, leaving no legal or practical justification for adopting these changes.

In addition to legal concerns, the proposed policy undermines one of the ACA's core principles: providing meaningful financial protection for consumers. Increasing the maximum out-of-pocket limit in catastrophic plans to 130 percent of the ACA cap, while failing to set an upper limit for bronze plans, would significantly increase medical debt and weaken consumer protections. This could result in some enrollees paying nearly half of their annual income for non-preventive care before coverage becomes effective—a consequence fundamentally at odds with the promise of catastrophic coverage as a financial safeguard.

These changes would further erode the already limited protections of lean plan designs, exposing enrollees to substantial financial harm. Covered California urges CMS to reconsider this proposal and prioritize policies that enhance—not diminish—consumer protection.

Multi-Year Catastrophic Plans

Covered California strongly urges CMS to withdraw its proposal to allow issuers of catastrophic plans to enroll individuals for multiple terms lasting up to ten years. The proposal lacks sufficient clarity to enable meaningful feedback and raises significant unanswered questions regarding plan design, pricing, and integration into existing risk adjustment and rating structures. For instance, it is unclear whether CMS intends to apply a single plan-level catastrophic adjustment regardless of the term purchased or to vary adjustments based on the duration of coverage. Additionally, the proposal does not address how risk adjustment's zero-sum framework would account for differences between single-year and multi-year catastrophic products.

Operationally, implementing multi-year plan terms would require extensive and costly changes to claims adjudication systems, accumulators, enrollment operations, consumer notices, and other infrastructure, all of which are currently designed around annual benefit years. The administrative burden would be substantial and difficult to justify.

Furthermore, Covered California sees little consumer value in this proposal. Longer-term catastrophic plans are likely to have higher costs over time as the frequency of claims increase, thereby reducing affordability benefits. Additionally, market churn—typically driven by changes in Medicaid or employer-sponsored insurance eligibility—is unrelated to the annual terms of Marketplace plans. Multi-year catastrophic plans would therefore introduce unnecessary complexity and confusion without addressing the root causes of consumer churn.

Benefit Cost Defrayal

We urge CMS to reconsider its proposal on state benefit requirements and defrayal. Since 2018, CMS policy has provided states with flexibility to revise and update their essential health benefit (EHB) benchmark plans without triggering new defrayal obligations for benefits incorporated through the update process. This was reaffirmed in the 2025 Payment Notice, which explicitly finalized that benefits covered under a state's EHB benchmark plan are considered EHB and exempt from defrayal. These policies have offered essential clarity to states in determining which benefits qualify as federal EHB and are exempt from defrayal obligations.

Reversing this policy would expose states to new financial liabilities after they relied on CMS's prior guidance to make changes to their benchmark plans. Abrupt policy shifts risk undermining states' efforts, destabilizing markets, and reducing access to care for consumers. If states are required to repeal existing benefit mandates enacted in good faith reliance on CMS rules, consumers could face additional out-of-pocket costs and barriers to care.

Timing is also a critical concern. CMS proposes implementing this defrayal requirement in plan year 2027. However, the timing of this proposed rule, combined with the majority of state legislative calendars, makes it exceedingly difficult—if not impossible—for states to repeal or amend benefit mandates, or alternatively, to appropriate funds to satisfy new defrayal obligations. This proposal would place states in an untenable position, creating unnecessary financial and operational challenges.

If CMS moves forward with changes to defrayal requirements, those changes must be implemented with adequate notice and flexibility to allow states to fully assess the implications, coordinate with regulators and issuers, and avoid disrupting markets. Predictability is essential for states to maintain stable and effective benefit designs that serve consumers and preserve access to care.

Quality Improvement Strategy Standards

Covered California strongly urges CMS to preserve the health disparities reduction component from Quality Improvement Strategy requirements to ensure

issuers remain accountable for improving care for vulnerable and underserved populations. Equity is a cornerstone of meaningful quality improvement and is central to the ACA's commitment to expanding access and improving care for all populations.

Quality improvement efforts that fail to address disparities cannot fully achieve better access, affordability, or outcomes for those who face the greatest barriers to care. Eliminating this component would represent a step backward in federal policy, especially at a time when sustained focus on reducing disparities is critical to advancing equity and improving health outcomes nationwide.

Medical Loss Ratio (MLR)

Covered California recommends that CMS preserve independent state authority over adjustments to MLR requirements by ensuring coordination and collaboration with states, rather than granting CMS unilateral authority. In California, robust state oversight, including solvency regulation and Covered California's active purchaser model, has been instrumental in promoting market stability, ensuring issuer accountability, and maximizing consumer value, all without the need for unilateral federal intervention.

If CMS considers changes to MLR rules, such efforts should focus on targeted improvements that enhance issuer accountability and affordability for consumers. Specifically, CMS should review and refine the definitions of quality improvement activities and administrative expenses to ensure consistent treatment of activities that directly improve health outcomes and consumer value. Additionally, CMS should explore establishing clearer limits on administrative expenses to ensure premium dollars are closely aligned with care delivery and affordability, particularly in the individual market.

OPTIMIZING MARKETPLACE OVERSIGHT

State Exchange Improper Payment Measurement Program (SEIPM)

Covered California supports efforts to ensure the accuracy of APTC determinations and appreciates the collaborative work CMS has undertaken with SBMs through pilot programs and related testing. Covered California previously participated in CMS improper payment measurement efforts and values this ongoing partnership. However, Covered California has concerns about the proposed annual cadence for SEIPM reviews. Conducting reviews every year would place undue operational strain on SBMs and fail to allow adequate time for implementing remediation measures before subsequent reviews. Covered California recommends adopting a three-year review cycle for SEIPM, similar to the IRS's triennial safeguard review of Marketplace compliance with federal tax return information protections. The IRS's model provides

thorough evaluations of systems, platforms, applications, and sample case files, yielding actionable results that Marketplaces can address before the next review. A similar cadence for SEIPM would ensure an efficient and effective oversight process for both CMS and SBMs. Between review cycles, CMS could leverage existing audit and reporting frameworks to support continuous program improvement without duplicating oversight efforts.

Finally, Covered California urges CMS to continue working closely with SBMs to ensure any future measurement framework is appropriately calibrated, operationally feasible, and respectful of state systems and state-held data.

Civil Monetary Penalties Against Issuers

Covered California recommends that CMS collaborate closely with state regulators and SBMs in developing and implementing a civil monetary penalty framework for issuers. Effective oversight depends on coordination and partnership, rather than unilateral federal action that risks duplicating or conflicting with existing state authority and enforcement structures.

State regulators and SBMs bring extensive experience and expertise in issuer oversight, enabling them to assess market dynamics, operational challenges, and the most appropriate corrective actions. CMS should prioritize aligning any federal penalty framework with state oversight efforts to ensure it complements, rather than disrupts, the effective regulation of Marketplaces.

Thank you for the opportunity to provide feedback on this proposed rule. Covered California values CMS's continued partnership and its recognition of the essential role SBMs play in advancing the ACA's mission. We look forward to ongoing collaboration to ensure the ACA continues to evolve, strengthen its foundation, and expand access to high-quality, affordable healthcare for all Americans.

Sincerely,

Jessica Altman
Executive Director