

## FROM THE NAIC CONSUMER REPRESENTATIVES

To: Government Relations (EX) Leadership Council

Date: February 24, 2026

### **Re: Priorities for NAIC Comments in Response to the Proposed Notice of Benefits and Payment Parameters Rule for 2027**

On behalf of the undersigned Consumer Representatives to the National Association of Insurance Commissioners (NAIC), we urge the NAIC to submit comments in response to the 2027 Notice of Benefit and Payment Parameters (NBPP) proposed rule, with a focus on states' abilities to ensure consumer affordability and access. Our primary concern is that as consumers continue to feel the strain of rising health care costs, the provisions proposed in the rule will only exacerbate affordability problems. We are also concerned that many of the proposed provisions lack important clarity and detail to fully understand how they will be implemented, how they will impact state regulator oversight, and how the provisions will impact consumers. Please see below for our analysis of provisions that could undermine important consumer protections as well as the state regulatory authority needed to enforce these protections.

#### **Expansion of catastrophic coverage**

The proposed rule would make catastrophic coverage more widely available under the supposition that consumers struggling with premium increases (for example, because the enhanced premium tax credits (PTCs) expired at the end of 2025) might benefit from more choices that trade low premiums for higher deductibles. Proposed changes include: codifying flexibility announced by CMS last year expanding availability of catastrophic plans beyond individuals under 30 years old; allowing carriers to offer a new type of catastrophic plan available for a multi-year term as long as ten years; and increasing the out-of-pocket maximum for catastrophic (and bronze) plans. **The NAIC and states should comment in opposition to these provisions as they are likely to make coverage less affordable for individuals who depend on higher metal level coverage, limit the ways in which regulators can mitigate the impact, and drive up premiums for consumers.**

We are wary of policy changes aimed at expanding the availability of catastrophic plans for several reasons:

- We are concerned that the proposed flexibility for catastrophic and bronze plans to increase their maximum out-of-pocket amounts will harm consumers. Plan designs with high out-of-pocket maximum amounts and high deductibles leave people with complex or chronic conditions, who have higher health care utilization, with very high out-of-pocket costs. This proposal will erode fundamental consumer protections that have limited these plans to a small segment of the population. The

policy solution for premium affordability for unsubsidized consumers should not be to foist more cost sharing onto already struggling consumers.

- Because catastrophic plans have separate risk adjustment than other metal-level plans, making catastrophic plans available to a larger pool of healthier enrollees will increase premiums for consumers who remain in regular metal level plans.
- A ten-year catastrophic plan appears to be a policy solution to a problem that does not exist. Allowing plans to design a product with varying out-of-pocket maximum amounts by year and by disease or condition would allow for discriminatory plan designs. This proposal, coupled with the provision allowing anyone with an affordability hardship to enroll in a catastrophic plan, essentially creates a pathway for a skimpy plan with very little consumer financial protections to siphon off healthy enrollees from other metal levels, exposing consumers whose health needs change over the course of the 10 years to high costs when plans set the out-of-pocket maximum higher in early years than in later years. The rule also asks for comment on whether to expand this multi-year option to other metal levels. We believe there is insufficient information or detail provided to move forward with the proposal at all, let alone expand to all metal levels.
- We have significant concern about the underdevelopment of the proposed multi-year plans. The proposal has been presented without clarity on many aspects of the proposed multi-year plans, including whether the premium per year of the plan would be fixed for the duration of the plan contract, how issuers would calculate the index rate for both multi-year plans and other plans if at least one of its plans is a multi-year plan, whether consumers would be able to switch plans during Open Enrollment or enroll in an existing multi-year plan during a special enrollment period, what happens if a plan is no longer offered or the insurer leaves the marketplace. These are key criteria of coverage that would greatly impact the drawbacks or benefits of these plans.
- As the primary regulators of insurance, states should have the opportunity to comment on these key implementation issues. Given the complexity of the products envisioned, regulators these details will be critical to guide implementation and enforcement of existing consumer protections. However, the paucity of detail in the proposed rule does not offer such an opportunity.

### **Removal of provider network requirements**

The proposed rule loosens requirements for marketplace plans to contract with a certain number of providers to ensure comprehensive access to enrollees. CMS reasons that some of the requirements are onerous and do not necessarily have discernible access benefits. Provisions include: allowing carriers to offer “non-network” plans; removing time and distance standards for SBM states; allowing FFM states to do their own network adequacy reviews and certification; and scaling back Essential Community Provider (ECP) requirements for FFM states.

Allowing plans flexibility with regard to provider networks also forwards the overarching goal to reduce premiums. **The NAIC and states should comment in opposition to these provisions as they would limit or completely overturn substantial work undertaken by regulators to ensure consumers have access to the providers they need.**

We are concerned about the erosion of these protections for the following reasons:

- Instead of the traditional requirement of plans to have a published network of providers with whom the plan contracts, “non-network” plans agree to pay providers a capped amount (fixed indemnity plans, for example, use this model). Consumers in these plans would need to do a lot of front-end work before they saw a provider to ensure the provider would accept their plan’s payment as payment in full, and – since non-network providers would not be required to accept assignment – would likely be forced to deal with the bureaucracy of both the provider’s billing system and the plan’s claims systems. Even savvy consumers may not be able to prevent a balance bill, especially because they cannot rely on the protections available in network plans. While this Administration has touted consumer transparency provisions, they are simply not yet available nor enforced at a scale that would allow any consumer to navigate this type of policy.<sup>1</sup> “Non-network” plans will also encourage providers to overcharge patients up front and put the onus on the consumer to closely track their cost-sharing and pursue refunds from providers in cases of overpayment, which increases burden and affordability barriers for consumers. Because these non-network plans don’t have traditional provider networks, there won’t be provider lists available in advance, limiting any ability to pick a plan based on the network.
- We are also concerned that CMS has not articulated how certain key consumer protections that limit a consumers’ out-of-pocket spending would apply to non-network plans, such as the requirement to cover preventive services without cost sharing and the limits on maximum out-of-pocket spending. We recommend that the NAIC urge CMS to not finalize the proposed provision at this time, and focus on rulemaking that would better protect consumers in non-network plans prior to any future efforts to certify non-network plans as qualified health plans. Specifically, we recommend CMS work with the Tri-Departments, as appropriate, to issue rulemaking addressing the aforementioned consumer protections issues, as well as additional requirements that would help ensure enrollees are able to navigate these plans, such as the requirements regarding advanced explanation of benefits.
- We are also concerned that CMS’s proposals related to non-network plans assume both CMS and state regulators have access to information about providers’ billed charges to assess issuers’ statements that their reimbursement rates provide access to a sufficient

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<sup>1</sup> Darius Tahir, KFF Health News, Trump Required Hospitals To Post Their Prices for Patients. Mostly It’s the Industry Using the Data, February 7, 2026, <https://kffhealthnews.org/news/article/price-transparency-trump-hospitals-insurers-health-care-costs/>

choice of providers. This information simply is not available. Indeed, we question how issuers would be able to reasonably make such an assertion.

- We are also concerned that multiple proposed provisions in the NBPP could operate together to undermine core protections for marketplace coverage. For example, if a non-network plan design is paired with the flexibilities noted above for catastrophic plans, that product starts to look a lot like a pre-ACA coverage with potential for significant financial exposure if someone actually uses their coverage. While attractive to young, healthy consumers, this type of plan design does work well for people who have higher health care utilization. And contrary to assumptions made by CMS about a monolithic “young and healthy” group of consumers, health status is not static. Individuals could enroll in a 10-year non-network catastrophic plan while healthy and if they are diagnosed with a condition requiring more annual health care utilization, they will be stuck in an unworkable product until the next open enrollment period.
- We are also concerned about proposed changes to several federal protections regarding network adequacy, including removing the requirement for SBM states to implement time and distance standards and allowing FFM states to do their own network adequacy review if they demonstrate to CMS their program is sufficient. We understand that states have an important role to play in network adequacy protections, but without a strong federal floor, we are concerned that consumers may experience access challenges depending on the state.
- Finally, we are concerned that scaling back requirements that marketplace plans contract with at least 35% of available essential community providers (ECPs) within their service areas to 25% within their service areas will harm low-income enrollees. ECP requirements are designed to ensure that plans contract with a sufficient number of providers that provide often specialized focus on low-income and other marginalized communities. While the justification for lowering the threshold of available ECPs that must be included in plan’s provider network is that plans are already meeting the threshold, this is not an affirmative rationale for lowering this requirement and it is dubious to assume if this will hold into the future once the requirement is gone. In addition, with federal budget cuts already putting the financial viability of ECP providers at risk, we are concerned that lowering these thresholds would further jeopardize states’ safety net providers by allowing private issuers to drop them from networks.

#### **Removal of required standardized plan options for FFM and FFM-FP states**

The proposed rule rolls back the requirement that states using healthcare.gov offer a set of standardized plans and removes the limitation on the number of non-standardized plan options an insurer can offer. **The NAIC and states should comment in opposition to this proposal as it will limit states’ ability to aid consumers in differentiating between plans and ultimately purchasing one that meets their needs.**

We are concerned about this proposal for the following reasons:

- Standardized plans make plan selection easier for beneficiaries and provide upfront certainty and limits to patient cost-sharing for various services making the use of insurance more affordable. Removing them will make plan selection more difficult and subject beneficiaries to higher costs, depending on their health needs.
- We are concerned that because [healthcare.gov](https://www.healthcare.gov) will no longer differentially display standardized plan options, FFM states won't actually have a meaningful choice to continue requiring issuers to offer these plans. Without the differential display option, it will be very difficult for consumers to discern which plans are standardized and which are not. Combined with the proposed removal of the limitation on non-standard plan options, consumers may again be faced with an array of confusing choices and struggle to pick the plan that will be best for their needs, and FFM states will be hamstrung in preventing this. It is also highly likely removing limits on non-standardized plans will lead to "silver-spamming" by carriers to attempt to monopolize the first page of plan options displayed to consumers in FFM states, potentially distorting the market or creating significant swings in carrier market share and risk year to year. This would significantly increase workload for state regulators who would be faced with many more plans to review and approve, with questionable benefit to consumers or the market.
- Research and consumer testing studies have consistently found that too many plan choices can impede the ability to make the best plan choice.<sup>2</sup> Analyses have also found that standardized plans can help reduce discriminatory plan designs (e.g., by making it more difficult in plans to engage in "adverse tiering" where all or most drugs used to treat a particular condition are placed on the highest cost-sharing tier.<sup>3</sup> Coupled with meaningful difference standards (which CMS could opt to reinstate here), reducing plan numerosity could not only help consumers, but could also reduce regulator burden.

## Changes to Essential Health Benefits (EHB)

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<sup>2</sup> Quincy L. What's Behind the Door: Consumers' Difficulties Selecting Health Plans. Consumers Union. Jan. 2012. [https://advocacy.consumerreports.org/wpcontent/uploads/2013/03/Consumer\\_Difficulties\\_Selecting\\_Health\\_Plans\\_Jan2012.pdf](https://advocacy.consumerreports.org/wpcontent/uploads/2013/03/Consumer_Difficulties_Selecting_Health_Plans_Jan2012.pdf).

<sup>3</sup> HHS, ASPE, Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces, December 2021, <https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf>; Jacobs D.B. and Sommers B.D. Using drugs to discriminate--adverse selection in the insurance marketplace. N Engl J Med, vol 372, no. 5 (Jan. 2015): 399-402. <https://www.nejm.org/doi/10.1056/NEJMp1411376>.

The proposed rule removes state flexibilities with respect to EHB, including allowing states to add adult dental care to EHB, as well as allowing states to avoid defrayal for any benefits that have been approved by CMS as part of the state's EHB-benchmark plan even if those benefits were part of a state mandate. Changing EHB rules at this stage essentially pulls the rug out from under the states that invested in the process to update EHB benchmark plans, including engaging consumers and commissioning complex actuarial analyses. Moreover, changes to the additional required benefits regulation are so vague and broadly worded that it is not immediately clear which benchmark updates approved by CMS over the past decade will trigger defrayal. **The NAIC and states should oppose these proposals as they take away flexibility for states to enhance their EHB packages in line with state-specific needs, and for many states would increase the cost of defraying benefits at a time when state budgets are especially tight due to other federal actions.**

We are concerned about this proposal for the following reasons:

- Removing the ability of states to add adult dental benefits to EHB will mean dental benefits will continue to only be available as separate plans from major medical health insurance policies, creating logistical and affordability barriers to access.
- Removing the ability of states to enhance their EHB packages takes away an important state tool to ensure benefits are in line with the needs of consumers in their states and limits their flexibility to align EHBs with developments in health care and emerging clinical evidence.

The proposed rule also requests comment on whether the defrayal provisions should go into effect in 2027 or in 2028. While we think that CMS should leave the current policy in place, a longer timeline for implementation is necessary for both states and consumers.

### **Changes to rules on agents, brokers, and web-brokers**

The proposed rule allows SBMs to decentralize and privatize their enrollment operations and also places greater restrictions on misleading or fraudulent marketing by agents and brokers. **The NAIC and states should support additional guardrails to prohibit agent, broker, and web-broker fraud and urge CMS not to illegally strip non-discrimination protections based on gender identity from the regulation.**

- We support the proposed restrictions on misleading or fraudulent marketing by agents and brokers, including the codification of specific examples of deceptive marketing. However, we believe the proposal to eliminate discrimination on the basis of gender identity from prohibited discrimination based on sex is both illegal under current court interpretations of sex discrimination and at odds with the goal of addressing discrimination.

- We are concerned about allowing SBMs to contract their entire enrollment platform to a web broker. Web-brokers have been at the center of a number of high-volume fraud investigations and litigation<sup>4</sup>, and opening up the ability of SBM states to contract exclusively with a web-broker may require additional guardrails to protect consumers. It seems counterintuitive to announce a number of provisions in this proposed rule as well as last year’s Marketplace Integrity Rule to prevent consumer fraud, while at the same opening up a major pathway that high-volume fraud has occurred in the past. If this provision is finalized, we believe there should be appropriate data security standards for this option, including a stronger plan to prevent the fraud perpetrated by web brokers over the past several years. We believe that CMS should wait until it is confident that all web broker problems have been resolved before allowing this proposal to move forward.

### Copay accumulator enforcement

The proposed rule continues to avoid addressing the 2023 federal court decision prohibiting copay accumulator programs. We continue to believe that the lack of enforcement or clarity from federal regulators on the definition of cost-sharing harms consumers. **The NAIC and states should comment asking (again) for CMS to clarify this issue.**

### Implementation of the Reconciliation Law (HR1) and the 2025 Marketplace Integrity Rule

The proposed rule codifies many provisions that were passed into law as part of the sweeping reconciliation law passed by Congress last July. It also extends provisions that were included in the Marketplace Integrity Rule last year to the 2027 plan year. We appreciated NAIC’s comments in response to the Market Integrity Rule last year. **NAIC and states should continue to push back on proposals that take away SBM ability to design systems that best protect consumers, such as through more generous SEP provisions and more flexible approaches to “failure to reconcile” policies.**

Thank you for NAIC’s engagement on the NBPP. If we can be of assistance, please reach out to Amy Killelea, [ae35@georgetown.edu](mailto:ae35@georgetown.edu) or Lucy Culp, [lucy.culp@lls.org](mailto:lucy.culp@lls.org).

Sincerely,

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<sup>4</sup> See, e.g., Complaint filed in Conswallo Turner, et al. v. Enhance Health, LLC, et al., <https://kffhealthnews.org/wp-content/uploads/sites/2/2024/04/2024-04-12-Complaint.pdf>

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