The Commonwealth Fund

Affordable, quality health care. For everyone.

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Submitted via https://www.regulations.gov/

The Honorable Robert F. Kennedy, Jr.
Secretary
Department of Health and Human Services

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services

Attention: CMS-9883-P, Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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 Mr. Kennedy and Dr. Oz:

Thank you for the opportunity to comment on the Notice of Benefit and Payment Parameters for 2027. The Commonwealth Fund is a nonprofit, nonpartisan foundation dedicated to affordable, quality health care for everyone. We support independent research on health care issues and make grants to promote better access, improved quality, and greater efficiency in health care, particularly for society's most vulnerable — including people of color, people with low income, and those who are uninsured.

Since 2003, the Commonwealth Fund has used our nationally representative Biennial Health Insurance Survey to measure the share of U.S. working age adults who have health insurance all year but are *underinsured*. People who are insured all year are considered to be underinsured if their coverage doesn't enable affordable access to health care. That means at least one of the following statements applies:

- Out-of-pocket costs over the prior 12 months, excluding premiums, were equal to 10 percent or more of household income.
- Out-of-pocket costs over the prior 12 months, excluding premiums, were equal to 5 percent or more of household income for individuals living under 200 percent of the federal poverty level.
- The individual or family deductible constituted 5 percent or more of household income.

Because out-of-pocket costs occur only if a person uses their insurance to obtain health care, we also consider the deductible when determining whether someone is underinsured. The deductible is an indicator of the financial protection that a health plan offers as well as the risk of incurring costs before a person gets health care. We do not, however, consider the risk of incurring high costs owing to an

insurance plan's other design features, such as out-of-pocket maximums, copayments, or uncovered services, since we do not ask about these features in the survey. Because of this, our estimate is a conservative measure of people's ability to affordably access the health care system.

In our most recent survey in 2024, nearly a quarter (23%) of the U.S. working age population had insurance coverage all year but had such high out-of-pocket costs and deductibles relative to their income that they were effectively underinsured. Because average deductibles are quite high in many marketplaces for people who are not eligible for the largest cost sharing reductions (those with incomes of 200% of poverty or more), 50 percent of those who were insured all year with marketplace plans were underinsured. Deductibles are on average lower in employer plans, which is why a smaller share of people with employer plans are underinsured (29%).

In the survey, being underinsured had significant consequences for people's ability to afford needed health care, their financial security, and their overall health. Nearly 6 of 10 (57%) underinsured adults reported that they did not get needed health care because of the cost including not going to the doctor when they were sick, not filling a prescription, skipping a recommended test, treatment or follow up visit, or not getting needed specialist care. More than two of five (43%) underinsured adults who reported not getting needed care due to costs said that a health problem worsened because of it.

Underinsured adults reported the highest rates of medical debt. More than two of five (44%) underinsured adults said that they were paying off medical debt over time.

Several proposed changes in the Notice of Benefit and Payment Parameters for 2027 could increase the number of underinsured people in the marketplaces. This could result in higher rates of cost-related delays in getting needed health care, worsening of health problems, higher rates of medical debt, and more uncompensated health care for providers. We offer comments on these proposed changes:

- Cost-Sharing for Bronze and Catastrophic Plans (Sections 156.136 and 156.155)
- Expanding Eligibility for Catastrophic Plans (Section 155.605(d)(1))

Cost-Sharing for Bronze and Catastrophic Plans (Sections 156.136 and 156.155)

For bronze plans, CMS proposes to allow an insurer to offer bronze plans that fail to comply with the Affordable Care Act's (ACA) current maximum annual limitation on cost sharing (MOOP), if the insurer offers a bronze plan that complies. In addition, CMS fails to specify an upper bound for a non-compliant bronze plan's annual limit on cost-sharing. This means that CMS is not simply changing the upper limit of the MOOP, but effectively voiding the requirement.

CMS's justification for their proposal is the rates of change of the three components of the actuarial value (AV) calculation (the standard population, the maximum annual limitation on cost sharing (MOOP), and essential health benefits (EHB) costs) have limited insurers' flexibility in designing plans that conform to the de minimis range for bronze plans, and made it harder for insurers to differentiate bronze and silver plans to make the choice meaningful for consumers. CMS points out that "eventually the maximum annual limitation on cost sharing will be too low to allow for an AV calculation for the most basic bronze plan design." But under the statute, a repair that addresses this issue would require Congressional action.

Lifting the maximum out-of-pocket limit for bronze plans would leave marketplace enrollees facing even higher out-of-pocket costs before their coverage kicked in. As noted above, we estimate that half of people insured all year with marketplace plans were underinsured in 2024. This proposed change could increase the number of underinsured enrollees in the marketplaces rather than alleviate cost pressures for beneficiaries. Our evidence shows that this could in turn increase the share of people who avoid needed care because of cost, increase medical debt loads among marketplace enrollees, and leave hospitals and other providers uncompensated for care that people can't afford to pay for.

Similarly, CMS proposes to require catastrophic plans to provide no benefits for any plan year (with limited exceptions) until a plan enrollee spends an amount equal to 130 percent of the maximum out of pocket limit. However, Section 1302(c)(1) of the ACA requires plans to comply with the annual limit on cost sharing. This requirement applies explicitly to catastrophic plans under section 1302(e)(1)(B), which requires catastrophic plans to provide no benefits "until the individual has incurred cost-sharing expenses *in an amount equal to* the annual limitation in effect under subsection (c)(1) for the plan year" (emphasis added). These requirements make clear that catastrophic plans must comply with the annual MOOP–not a multiple of the annual MOOP as CMS has proposed.

Like lifting the MOOP in bronze plans, raising the maximum out-of-pocket limit in catastrophic plans beyond that allowed for under the statute leaves those who might purchase a plan exposed to very high out-of-pocket costs before their coverage kicks in. For catastrophic plans, CMS is suggesting an out-of-pocket maximum equivalent to $15,600 for an individual and $31,200 for a family plan. This means that someone who paid the premium for a catastrophic plan would be on the hook for $15,600 - $31,200 before their insurance plan began to pay for their costs. We know that most moderate and low-income Americans do not have extra savings to pay for such costs, not to mention even substantially lower costs. For example, in the Commonwealth Fund's 2022 Biennial Health Insurance Survey we asked people if they had to pay $1,000 for an unexpected medical bill such as an ER visit, whether they would be able to pay for it within thirty days. Nearly half said no, with that share rising to more than two-thirds (68%) among adults with incomes under 200 percent of poverty. The consequences are more consumers in debt and higher health care provider uncompensated care burdens.

Expanding Eligibility for Catastrophic Plans (Section 155.605(d)(1))

CMS is not only suggesting making catastrophic plans far less cost-protective than required under the ACA, but also expanding eligibility for the plans beyond what the ACA specified. Specifically, the rule would expand eligibility to everyone with income under 100 percent of poverty or over 250 percent of poverty. CMS argues that this change will improve access to affordable coverage based on a belief that there are a substantial number of consumers for whom purchasing a bronze, silver or gold plan relative to a catastrophic plan could cause a financial hardship.

Since Congress failed to extend the enhanced premium tax credits in 2025, annual premiums for marketplace plans have jumped by $750 to $4,035 depending on income. In addition, because of this dramatic decrease in affordability, along with other policy changes in HR.1, which was passed in 2026, and the 2026 Notice of Benefit and Payment Parameters, millions of people are expected to leave the marketplaces for other coverage or no coverage this year. Marketplace premiums overall spiked by more than 20 percent for the 2026 plan year, with the bulk of the increase attributable to these policy changes: insurers were anticipating that healthier people would leave the marketplaces this year leaving a sicker, and thus more costly, group of enrollees. CMS is proposing making catastrophic plans more

widely available, on the assumption the premiums will be much lower than other plans, thus giving people an affordable option. Indeed, the evidence shows that the primary criteria that determines whether someone enrolls in a marketplace plan or not is the premium.

The most straightforward approach to ensuring affordability for marketplace enrollees would have been the extension of the enhanced premium tax credits by Congress. In addition, people with incomes under 100 percent of poverty are eligible for Medicaid under the ACA, except in the 10 states that have so far not expanded their Medicaid programs. Congress could allow people who fall into the so-called coverage gap in these states to enroll in marketplace plans and be eligible for the premium tax credits and cost-sharing subsidies. Making catastrophic health plans with maximum out-of-pocket limits of $15,600 available to people whose annual incomes are roughly equivalent to, or less than, the out-of-pocket limit may not achieve the policy goal. Such a plan, if ever used for a catastrophic health event by someone with income at or below poverty, would wipe out their entire annual income and then some. Even someone with income at 250 percent of poverty, or $39,125 for an individual, would be liable for costs roughly equal to 40 percent of their income before their coverage kicked in.

We hope that CMS will consider these factors when finalizing proposed changes to the maximum out-of-pocket limits for bronze and catastrophic plans and the expanded eligibility for catastrophic plans. The nation is facing an affordability crisis in health insurance and health care, particularly among low- and moderate-income families. Extending the enhanced premium tax credits, extending cost-sharing reduction subsidies beyond 250 percent of poverty, and changing the benchmark plan from silver to gold, are straightforward proposals that could go a long way to making marketplace premiums affordable and health care accessible. By contrast, dramatically increasing what people must pay before their coverage kicks in will increase the number of people who are underinsured and lead to delays in needed care and even greater accumulation of medical debt.

To achieve a productive workforce and a high-performing health care system, it is incumbent upon policy makers to ease coverage enrollment barriers and seek to improve the affordability and cost-protection of health plans across the commercial insurance markets that now cover more than 190 million people. A strong workforce depends on working people and their families having affordable access to health care.

We appreciate CMS's efforts to gain and respond to stakeholder input for this proposed rule. We encourage CMS to continue to seek input from a broad set of stakeholders, including state-based marketplaces, insurers, and researchers.

Please contact Sara R. Collins (src@cmwf.org) with any questions regarding our comments on the Notice of Benefit and Payment Parameters for 2027. For general questions about this response or inquiries for the Commonwealth Fund, please contact Rachel Nuzum (rn@cmwf.org).

Sincerely,

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