



March 13, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9883-P
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Administrator Oz:

For the past 55 years, the National Association of Community Health Centers (NACHC) has been the leading national, nonpartisan organization dedicated to supporting Community Health Centers (CHCs), also known as Federally Qualified Health Centers, as the Employer, Provider, and Partner of choice in all communities. Collectively, CHCs are the largest primary care network in the nation, serving as the medical home for 52 million patients,¹ and employing 326,000 dedicated staff.

For 60 years, CHCs have provided high-quality, affordable, comprehensive care – including primary, preventive, dental, behavioral health, pharmacy, vision, and other essential health services at over 17,000 locations across rural and nonrural communities. This includes 1 in 3 rural residents and 1 in 2 in poverty. As our nation’s largest primary care system, there is strong evidence, including from the Congressional Budget Office, that our work saves lives and also saves Medicaid and Medicare billions annually by reducing costly emergency, inpatient, and specialty care.² Research shows that every dollar invested in primary care yields a 13-to-1 return in overall health system savings.³

CHCs serve a critical role in the success of Marketplaces in every state. They serve as the medical home for millions of Americans eligible for reduced-cost coverage through Federal and State marketplaces. Twenty-one percent of CHC patients have private insurance⁴ and often are eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost-sharing reductions. Additionally, CHCs are a vital source of outreach and enrollment (O&E) assistance nationally. With support from the Health Resources and Services Administration (HRSA) and, often, from CMS programs, CHCs helped over 5 million individuals seeking coverage in 2024.⁵ This assistance includes helping individuals enroll in Medicaid, CHIP, Medicare, or the

¹ Weitzman, 2025.

² Volerman A, Carlson B, Wan W, Murugesan M, Asfour N, Bolton J, Chin MH, Sripipatana A, Nocon RS. Utilization, quality, and spending for pediatric Medicaid enrollees with primary care in health centers vs non-health centers. *BMC Pediatr.* 2024 Feb 8;24(1):100. doi: 10.1186/s12887-024-04547-y. PMID: 38331758; PMCID: PMC10851548.
<https://pubmed.ncbi.nlm.nih.gov/38331758/>

³ <https://www.oregon.gov/oha/HPA/dsi-pcpc/ Documents/PCPCH-Program-Implementation-Report-Final-Sept-2016.pdf>

⁴ 2024 UDS HRSA Health Center Program Data

⁵ <https://data.hrsa.gov/topics/healthcenters/uds/overview/national/table?tableName=ODE&year=2024>

Marketplace; assisting with re-enrollments, renewals, or redeterminations; and helping them understand and utilize their newly acquired insurance.

The proposed rule emphasizes potential benefits for healthier individuals seeking lower-cost coverage options. However, CHCs consistently report that patients with chronic and complex health conditions are the most likely to experience harm when policies increase cost-sharing, reduce network participation, or create new barriers to enrollment and retention. These concerns arise at a time when states and safety-net providers are already facing significant financial pressure from implementing H.R. 1, which is expected to strain provider capacity and increase the number of uninsured and underinsured patients relying on CHCs for care.⁶ Additionally, several provisions in the proposed rule would increase administration and operational burdens for O&E staff, which CHCs have consistently reported can result in delays in coverage, increased coverage turnover, and greater operational burden for providers assisting patients with marketplace enrollment.⁷ We urge CMS to strongly consider the negative impact these proposals will have on CHCs and their patients and to reconsider implementing these changes.

NACHC welcomes the opportunity to comment on the 2027 Notice of Benefit and Payment Parameters. Our comments are broken into four sections:

I. Essential Community Providers and Network Adequacy Protections

NACHC appreciates the Administration's continued focus on oversight of Marketplace plan compliance. CHCs are the largest single source of primary care in medically underserved communities and serve as critical access points for low-income and rural patients nationwide. CHCs serve more than 52 million patients, the majority of whom live at or below 200 percent of the Federal Poverty Level (FPL).⁸ **Robust Essential Community Provider (ECP) and network adequacy standards are essential to ensuring that coverage expansion translates into meaningful access to care.** While we recognize CMS's goal of improving transparency and reducing duplicative oversight, NACHC has concerns that several of the proposed changes would weaken protections ensuring that Marketplace enrollees can access CHCs and other trusted community providers.

Effective ECP Review Program Requirements for Non-Network Plans and Implementation of an Effective ECP Review Program (§ 155.1051 and § 156.235)

NACHC strongly opposes the proposal to reduce the minimum percentage of ECPs that issuers must contract within each plan's service area from 35 percent to 20 percent, including the separate threshold applicable to CHCs. As CMS is aware, the increase to 35 percent for plan year 2026 has only recently been enacted.⁹ It is premature to reverse course before CMS, states, and stakeholders have had the opportunity to assess the impact of the higher threshold on access, plan participation, and enrollee outcomes. Reducing the threshold to 20 percent would substantially weaken requirements for Qualified Health Plans (QHPs) to contract with CHCs that serve predominantly low-income and medically underserved individuals. Section 1311 of the

⁶ [https://shvs.org/wp-content/uploads/2026/02/Proposed-Marketplace-and-Insurance-Changes-in-the-2027-Notice-of-Benefit-Payment-Parameters -Implications-for-States_2.13.26.pdf](https://shvs.org/wp-content/uploads/2026/02/Proposed-Marketplace-and-Insurance-Changes-in-the-2027-Notice-of-Benefit-Payment-Parameters-Implications-for-States_2.13.26.pdf)

⁷ Ibid.

⁸ Weitzman, 2025; 024 UDS Data, HRSA.

⁹ CY26 NBPP Final Rule.

Affordable Care Act (ACA) provides that QHPs “shall ... include within health insurance plan networks those essential community providers, where available, that serve predominantly low-income, medically underserved individuals.”¹⁰ This language reflects Congress’s clear intent that issuers engage in good-faith contracting with ECPs located in their service areas. Reducing the participation standard, particularly when paired with the proposed removal of the narrative justification requirement, would diminish transparency and erode accountability mechanisms that help ensure compliance with this obligation.

NACHC is also concerned that allowing Federally Facilitated Exchange (FFE) states to conduct their own provider access and ECP certification reviews would result in inconsistent oversight and application of standards across states. Variability in how states interpret or operationalize “effective” review programs, particularly in the absence of a clear federal floor, risks inconsistent application and enforcement of ECP standards. NACHC has consistently supported strong federal oversight of ECP participation standards to ensure that families have adequate access to affordable, quality care delivered within their own communities.¹¹ Congress designed the ECP provision to guarantee that consumers purchasing coverage through the Marketplace have access to trusted providers, including CHCs.¹² **We urge CMS to establish clear, uniform criteria and publicly available benchmarks that states must satisfy to qualify as having an effective ECP Review Program.** Without safeguards, there is a risk that ECP contracting requirements will be interpreted or enforced less rigorously, potentially limiting CHCs’ inclusion in QHP networks.

The financial and operational implications for CHCs are significant and directly affect patient access to care. CHCs contract with marketplace plans to expand access to affordable, accessible primary care services in their communities. If CHCs become out of network due to contractual changes with marketplace plans, this will cause financial harm by increasing their uncompensated care costs or by losing patients with established relationships due to changes in coverage. Reducing the number of in-network providers has been shown to lower plan costs but also to limit enrollee choice, increase waiting times, and complicate continuity of care for individuals who must switch plans to stay with their provider of choice. Additionally, enrollees who receive care from out-of-network providers frequently face coverage denials or substantially higher out-of-pocket costs, undermining the financial protection that coverage is intended to provide.¹³ These findings underscore that the size and composition of provider networks directly affect both access to care and the degree of financial security afforded to enrollees. CHCs report that reducing the ECP contracting threshold would increase the risk that issuers would contract with fewer CHCs. They have raised concerns that this change could lead to narrower Marketplace networks and a greater likelihood of CHC exclusion, disrupting established care relationships and increasing out-of-network costs for patients with limited access to health care. Such disruptions to established patient-provider relationships undermine continuity of care and may further limit access in rural and medically underserved communities where CHCs are often the primary source of care.

¹⁰ 42 U.S.C. § 18031(c)(1)(C).

¹¹ [NACHC CY2024 NBPP Comment Letter](#)

¹² 42 U.S.C. § 18031(c)(1)(C).

¹³ <https://www.kff.org/private-insurance/how-narrow-or-broad-are-aca-marketplace-physician-networks/#:~:text=Reducing%20the%20number%20of%20providers,care%20for%20those%20switching%20plans>

NACHC recommends that CMS maintain the 35 percent ECP threshold for at least three full plan years before considering any revisions, and that CMS additionally publish data evaluating plan compliance and enrollee access during that period. Maintaining the current threshold would allow CMS to evaluate policy impacts using complete and reliable evidence, reduce the risk of unintended access disruptions, and strengthen the administrative record supporting any future modifications while preserving stable access to community-based care.

QHP Certification of Non-Network Plans (§§ 155.1050, 156.230, 156.235, 156.236, 156.275, and 156.810)

NACHC is concerned that CMS’s proposal to allow non-network plans to qualify for Qualified Health Plan (QHP) certification based primarily on providers’ willingness to access a plan’s payment amount as payment in full could weaken network adequacy protections and create uncertainty for CHC patients. Quantitative network adequacy standards help ensure that Marketplace plans maintain a meaningful provider infrastructure before enrollment begins. Without these safeguards, plans with limited or nonexistent networks may be certified even when clinicians are not accepting new patients or when access to primary and behavioral health services is limited. For patients served by CHCs, who often face language barriers, health literacy challenges, or chronic health conditions, the expectation that individuals will negotiate payment arrangements directly with providers is unrealistic and shifts the administrative and financial burden onto patients. NACHC urges CMS to maintain robust, quantitative access standards for QHP certification and to ensure that non-network plans demonstrate clear, enforceable measures of access to CHCs and other ECPs before they are approved to participate in the Marketplace.

Network Adequacy Standards and Reviews (§ 156.230)

NACHC urges CMS to retain the minimum quantitative time and distance standards as a federal floor used in State-based Exchanges (SBEs) and State-based Exchanges on the Federal platform (SBE-FPs), even where states conduct their own reviews. These quantitative standards establish objective, measurable criteria that promote consistent oversight and accountability across Exchanges and help ensure that coverage translates into meaningful access to care. Eliminating a clear federal floor risks creating variability in oversight across states and may weaken enforceable benchmarks that ensure Marketplace enrollees have geographically reasonable access to providers. These standards are designed to ensure that providers are geographically accessible and that enrollees are not required to travel unreasonable distances for care.

NACHC has previously supported requiring State Exchanges and SBE-FPs to conduct quantitative network adequacy reviews consistent with FFE standards.¹⁴ However, enforcement of network adequacy requirements has historically been inconsistent. A 2022 GAO report found that 243 out of 375 plan issuers on the Federal Exchanges were not complying with network adequacy standards for the 2023 plan year, with time and distance deficiencies among the most common issues.¹⁵ Given this documented history of noncompliance, removing the requirement for the time and distance standard would likely exacerbate variability between states and further diminish oversight. Removing the requirement for quantitative time and distance standards risks further variability across states and may disproportionately affect rural communities, where CHCs often

¹⁴ [NACHC CY25 NBPP Comment Letter](#)

¹⁵ <https://www.gao.gov/products/gao-23-105642>

serve as the only accessible primary care provider. Without clear, measurable benchmarks, states may rely heavily on issuer attestations, limiting transparency and accountability. For CHC patients, particularly in rural areas, these changes could result in narrower networks and increased travel burdens, thereby undermining timely and affordable access to care. **We also encourage the agency to require public reporting of network adequacy findings, including where network deficiencies persist.** Strong network adequacy standards are essential to ensuring that insurance coverage translates into actual access to care. For CHCs serving rural and medically underserved populations, these protections are foundational safeguards that support continuity of care, financial stability, and patient health outcomes. **NACHC urges CMS to reconsider its proposals that would diminish the uniformity and enforceability of network adequacy standards.** Robust federal oversight and clear benchmarks are essential to ensuring that coverage offered through the Marketplace translates into meaningful, timely access to comprehensive, community-based care.

II. Eligibility Verification and Income Determinations

Failure to File and Reconcile (§ 155.305)

NACHC requests CMS reconsider amending § 155.305(f)(4) to deny APTCs to tax filers who have failed to file and reconcile their APTCs for a single year. While we appreciate CMS’s decision to permit State-Based Exchanges (SBEs) to adopt the policy beginning in PY 2028, we remain concerned that implementation on the federal platform in PY 2027, along with optional earlier adoption by SBEs, would negatively impact enrollees, including CHC patients, who face more non-clinical factors of health. In 2025, one in four Americans waited until the last minute to file their taxes, with 21% of respondents stating they do not feel prepared and feel the tax filing process is too complicated and stressful.¹⁶ Additionally, a 2024 survey of over 2,000 people aged 18 or older found that more than half lacked basic tax knowledge, with only 2% possessing “proficient” tax knowledge.¹⁷ With the median household income reported at \$83,730 in 2024, access to APTCs can be crucial for affording comprehensive coverage.¹⁸ CHCs serve some of the most financially vulnerable patients, with nearly 90% of our patients at or below 200% FPL, and this provision would negatively impact their ability to afford Marketplace insurance, if eligible.

We also know that failing to file APTCs properly is not always the consumer’s fault. This proposed rule and the 2025 Marketplace Final Rule¹⁹ acknowledge that delays and errors in the Internal Revenue Service (IRS) processing of tax returns, as well as issues with sharing tax return information with the Exchanges, can cause the IRS to incorrectly note an enrollee with a Failure to File and Reconcile (FTR) status. We understand and appreciate the Administration’s intention to maintain program integrity, but we ask that CMS leverage Marketplace communications to help prevent enrollees from losing financial assistance due to misunderstandings or miscommunications. **We also urge CMS to continue the current policy of denying APTC only after a tax filer fails to file and reconcile their APTC for two consecutive years.** If the Administration does finalize the change, we urge them to sunset the policy after one year, as

¹⁶ <https://www.cnbc.com/2026/01/26/why-you-should-file-tax-return-early.html>

¹⁷ [US Tax Literacy Poll: Taxpayer Knowledge & Perceptions](#)

¹⁸ [Income in the United States: 2024](#)

¹⁹ <https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability>

originally finalized in the 2025 Marketplace Final Rule.²⁰ This will help balance competing concerns and better understand the potential impacts of the new policy on improper APTC payments in Exchanges.

NACHC understands the conforming change to notice requirements at § 155.305(f)(4)(i) and the removal of notice requirements at § 155.305(f)(4)(ii) and urges the Administration to leverage data from CHCs when sending direct notices about FTR status. We are concerned that our transient, less technologically literate patients are not receiving these notices about their FTR status. Based on CHCs' established and trusted relationships with the hardest-to-reach patients, NACHC recommends that CMS encourage health plans to partner with CHCs to ensure patients have up-to-date and timely information about their FTR status. We want to ensure these direct notices, sent via the U.S. Postal Service (USPS) to the address of record for tax filers, reach the CHC patient, especially if they do not realize their FTR status after receiving an indirect notice. We also recommend that States partner with homeless services providers, including the assigned health care providers, to help ensure addresses are up to date.

Income Verification When Data Indicates Income <100% FPL (§ 155.320(c)(3)(iii))

NACHC recommends CMS reconsider the proposal at § 155.320(c)(3)(iii) to require all Exchanges to generate annual household income inconsistencies in certain circumstances when applicants report a household income that is *greater than the income amount represented by income data from trusted sources.* We anticipate that this proposal will impact Exchange operations and ultimately have negative ramifications for the lowest-income enrollees, many of whom are served by CHCs. The provision directs the use of both the applicant's projected income for the coming year and recent IRS tax return data to determine whether the applicant qualifies for APTCs. If projected income is inconsistent with the tax data, the Exchange generates a "data matching issue" (DMI). The consumer must then provide additional information to substantiate their projection; if they do not, APTC eligibility is determined based on tax data.

This proposal will impact very low-income consumers; over 45% of CHC patients are 100% below the FPL – meaning they make a little over \$15,000 per year as a single person.²¹ It will create a substantial administrative burden on these enrollees, who would be required to respond to the DMIs by submitting pay stubs or additional information, which could be difficult to gather to support their income projections, or risk losing tax credits. The proposed rule estimates that 81,000 people annually would be denied tax credits, reducing APTC payments by \$213 million, and would create nearly 550,000 DMIs a year. NACHC is also concerned that this provision will divert valuable time and money at the Exchanges away from other pertinent enrollment and eligibility issues. The proposed rule states that the increased DMIs will cost over \$32 million per year to both Federal and State-Based Exchanges. Additionally, these Exchanges will incur one-time costs to perform technical updates to eligibility systems, amounting to almost \$776,000 for FFE and more than \$16.3 million for SBEs in 2026.

²⁰ <https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability>

²¹ 2024 UDS HRSA Data

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

NACHC recommends that CMS continue accepting enrollee self-attestation of income rather than modify § 155.320(c)(5), given the anticipated negative impact a change could have on CHC patients. We understand the Administration’s desire to maintain program integrity within the Exchanges. This proposal appears to treat Exchanges with incomplete information as a DMI, placing the onus on enrollees to help alleviate the burden. This proposal also does not account for why a person’s tax data is unavailable, beyond DMI. For instance, low-income taxpayers do not have to file a tax return or pay taxes if their income falls below the standard deduction amount for their filing status. For tax year 2026, for a single tax filer, it is \$16,100, and for a married couple, \$32,200,²² which includes many enrollees served by CHCs.

We appreciated the clarification in the 2025 Marketplace Final Rule that people who have legitimate reasons for not having tax data available, like marriage, the birth of a child, name changes, and other demographic updates, would have the opportunity to be verified through other trusted data sources, which was not included in this proposed rule.²³ However, we believe this verification through other trusted data sources should apply to all enrollees, not just those with cases that fall under the reasons above. Additionally, we believe the Administration underestimates that enrollees may need only one hour to submit documentation for this income verification requirement. In instances where the enrollee is experiencing homelessness or falls below the income threshold, gathering adequate documentation showcasing their situation would be difficult. They may need to work with case workers, their healthcare team, and others to gather sufficient evidence to demonstrate their potential income. This reality faced by enrollees, including those served by CHCs, makes self-attestation of income so crucial to prevent undue denial of affordable health insurance.

Pre-Enrollment SEP Verification (§ 155.420(g))

NACHC echoes our concerns with the proposal at § 155.420(g) to include pre-enrollment verification of eligibility for applicants in all categories of individual market SEPs. We are concerned about the amendment requiring all Federal Exchanges to conduct pre-enrollment eligibility verification for at least 75% of new SEP enrollments. NACHC is concerned about the administrative burden placed on SBEs to perform pre-enrollment verifications and the delay in insurance coverage for enrollees. Applicants must submit additional documentation to verify the SEP. While they can select a plan before submitting proof, their enrollment is “pending” until verification is complete. Although SBEs may request the use of alternative SEP verification methods, doing so may impose substantial implementation costs. The estimates in the 2025 Marketplace Final Rule indicate that most SBEs would incur approximately \$12 million in one-time costs to implement alternative verification approaches, while five SBEs are estimated to incur about \$60 million in one-time costs.²⁴ This is in addition to ongoing annual costs to implement and operationalize SEP verification requirements. NACHC is also concerned that the implementation timeline and cost for this proposal could delay approvals and the start of enrollee coverage. Our members have reported that these changes would increase administrative workload for CHC enrollment assistance programs, noting that additional documentation and processing

²² [IRS releases tax inflation adjustments for tax year 2026, including amendments from the One, Big, Beautiful Bill | Internal Revenue Service](#)

²³ <https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability>

²⁴ [Federal Register: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability](#)

requirements could delay coverage effectuation and increase the risk of coverage gaps for patients with unstable income, limited documentation, or housing instability. One CHC in Indiana estimates that each patient will require more time and effort from all their Navigators to confirm the accuracy of their enrollment documentation, requiring multiple visits. They raised concerns about patients needing transportation assistance for these meetings, adding additional burden to the enrollment process and reducing access to care.

As we have highlighted throughout our response, this could lead to decreased patient access and increased costs for CHCs and states. We strongly urge consideration of streamlined implementation approaches to minimize delays for populations with limited access to health care. **At a minimum, we urge CMS to include a sunset clause similar to the finalized 2025 Marketplace Final Rule.**²⁵ However, if this is finalized as proposed, we recommend that CMS mandate retroactive coverage for enrollees upon verification of enrollment, to ensure any medical needs sought during the pending period are covered and to prevent a financial burden on enrollees.

Changes to Catastrophic Plans (§ 156.155)

NACHC opposes the proposed expansion of catastrophic plans. We believe this change would shift many low- and moderate-income individuals into coverage with extremely high cost-sharing and limited benefits, potentially destabilizing patient enrollment patterns for CHCs. By broadening eligibility for these plans and increasing the maximum out-of-pocket limits to unprecedented levels, CMS risks encouraging enrollment in multi-year plans that lock CHC patients into high-deductible coverage that does not meet their evolving health care needs. A Midwestern Primary Care Association (PCA) noted that expanding non-network plans and multi-year catastrophic plans could increase complexity for patients navigating Marketplace coverage, and additional plan variability may make it more difficult for patients to identify plans that include their CHC providers and support continuity of care. Additionally, because APTCs cannot be applied to catastrophic plans, patients who would otherwise qualify for subsidized bronze or silver coverage may instead enroll in lower-premium catastrophic plans, undermining continuity of care and resulting in forgone or delayed treatment.²⁶

Another CHC in Indiana raised concerns that their patients would not fully understand the limitations of catastrophic plans, nor would they be properly educated about the details of these plans. Patients might initially be attracted to the option because of its low premium, but they would face high out-of-pocket costs due to the extremely high deductibles. Additionally, patients on these plans may not be able to afford their copays. Knowing that each time they visit their CHC, a copay will be charged could deter them from getting the care they need. Over time, this shift could reduce consistent Marketplace enrollment among CHC patients and increase uncompensated care costs and financial burdens for CHCs and other safety net providers.

Expansion of Hardship Exemption Eligibility (§ 155.605(d)(1))

NACHC acknowledges CMS's intent to provide relief to individuals with projected household incomes that do not qualify them for APTCs or cost-sharing reductions (CSRs) by expanding hardship exemption eligibility at § 155.605(d)(1). **However, NACHC has serious concerns about**

²⁵ <https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability>

²⁶ <https://www.healthaffairs.org/content/forefront/hhs-proposes-sweeping-changes-2027-marketplace-plans-part-1>

this proposal and how it interacts with broader Marketplace changes, particularly those expanding catastrophic coverage. While this expansion aims to give certain individuals access to more affordable options, the policy may produce unintended consequences for enrollees, CHCs, and Marketplace stability. Under the proposal, individuals otherwise ineligible for APTCs or CSRs would qualify for a hardship exemption and thus be eligible for catastrophic plans—coverage with low premiums and high deductibles designed to protect against major medical costs, limited to a minimum of three primary care visits before the deductible. Although this may reduce premium costs on the front end, catastrophic plans expose consumers to far greater out-of-pocket expenses for most services, which can deter patients from receiving the care they need, including patients managing chronic disease or multiple comorbidities, a population CHCs serve in large numbers.

NACHC is further concerned that this hardship exemption could interact with other proposed changes that expand access to catastrophic coverage and make such plans more attractive relative to comprehensive Marketplace plans. CMS proposes to broaden access to catastrophic plans and even allow multi-year catastrophic plan terms at § 156.155, intended to increase consumer choice and affordability.²⁷ However, analysis of the proposed changes suggests that increasing reliance on high-deductible catastrophic coverage could cause healthier individuals to abandon more comprehensive coverage, raising premiums across the remaining risk pool and reducing affordability for enrollees who need robust benefits.²⁸ For CHC patients, these dynamics risk creating dual harms: patients enrolled in catastrophic plans may delay or avoid needed care because of high-deductible barriers, which undermines continuity of care and worsens health outcomes. Additionally, CHCs may experience revenue loss as a larger proportion of their patient population has less comprehensive coverage with significant cost-sharing obligations. Revenue volatility and an increased uncompensated care burden would strain CHC capacity, just as affordability challenges elsewhere in the Marketplace may increase overall uninsurance rates.²⁹

Without robust evidence of the interaction between the expanded hardship exemptions and changes to catastrophic plans, NACHC urges CMS to gather additional data and stakeholder feedback before finalizing these significant changes. NACHC recommends that CMS conduct and publish an actuarial analysis quantifying the projected impact of this hardship exemption on Marketplace risk pools, premiums, and federal subsidy costs before implementation. We also encourage the agency to ensure robust consumer education and disclosures that explain the trade-offs between catastrophic coverage and comprehensive Marketplace plans so that individuals can make informed decisions about coverage. Additionally, NACHC urges CMS to incorporate detailed information regarding these Marketplace policy changes into Navigator and O&E staff training curricula to ensure that assisters are equipped to provide clear, accurate, and timely information to consumers. Without targeted training and updated educational materials, consumers, including patients served by CHCs, may lack the objective guidance needed to evaluate the comparative costs, coverage limitations, and financial risks of catastrophic plans. These measures would help mitigate unintended consequences and ensure that expanded hardship eligibility enhances access without undermining the affordability, comprehensiveness, and financial viability of coverage options for CHC patient populations.

²⁷ <https://www.federalregister.gov/documents/2026/02/11/2026-02769/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2027-and>

²⁸ <https://www.healthaffairs.org/content/forefront/hhs-proposes-sweeping-changes-2027-marketplace-plans-part-1>

²⁹ <https://kffhealthnews.org/news/article/aca-trump-proposal-catastrophic-coverage-premiums-care-networks/?utm>

III. Plan Design and Standardization Requirements

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

NACHC is concerned about CMS’s proposal to discontinue the requirement that issuers in FFEs and SBEs offer standardized plan options in the individual market. Although CMS would continue to allow SBEs to require standardized plans and differential pricing, eliminating the federal requirement risks reversing progress toward improving transparency and simplifying consumer choice in the Marketplace. NACHC appreciates CMS maintaining the option for SBE to still require standardized plans and differential display. We are, however, concerned about the potential impact on FFE and SBEs that opt in. In 2024, NACHC supported the original change that required issuers offering multiple standardized plan options within the same product network type, metal level, and service area to meaningfully differentiate plans.³⁰ When seeking health insurance coverage, it can be confusing and overwhelming for individuals to understand and ultimately choose from all the different plan options presented on the Exchange. For instance, in 2019, the number of plans shown to the average marketplace consumer had grown from 25.9 to 113.6 in 2023.³¹ Some studies have shown that too many plan choices—such as over 30—can lead to poor enrollment decisions because they confuse and overwhelm the enrollee.³²

NACHC urges CMS to retain a federal requirement for standardized plan options in FFEs and SBEs. At a minimum, CMS should conduct and publish an evaluation of how standardized plans have affected consumer comprehension, enrollment stability, and plan switching behavior before removing this policy framework. Standardized plans provide a clear baseline for comparison, particularly regarding deductibles, cost-sharing, and covered benefits. For patients served by CHCs, many of whom have limited technological literacy, limited English proficiency, and/or complex health needs, standardized plan designs make it easier to identify affordable coverage that includes their CHC and essential prescription drugs. Removing standardized plan requirements could lead to greater variation in cost-sharing structures and benefit designs, making it more difficult for patients and enrollment assisters to distinguish meaningful differences across plans. In addition, standardized plan requirements promote risk pool stability by reducing opportunities for issuers to segment markets through subtle benefit design differences that disproportionately attract healthier enrollees. Eliminating these guardrails could increase product segmentation and contribute to premium volatility over time.

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

NACHC is similarly concerned with CMS’s proposal at §156.202 to eliminate limits on the number of non-standardized plan options that issuers may offer in FFEs and SBEs, as well as the related exceptions process. While CMS states that this change would reduce regulatory burden and enhance issuer flexibility, removing plan limits risks reintroducing excessive plan proliferation, undermining informed consumer decision-making. Prior limits on non-standardized plan offerings appear to have modestly reduced the overall number of plans presented to

³⁰ [NACHC CY26 NBPP Comment Letter](#)

³¹ <https://shvs.org/the-proposed-2024-notice-of-benefit-payment-parameters-implications-for-states/>

³² <https://www.healthaffairs.org/content/forefront/hhs-proposes-sweeping-changes-2027-marketplace-plans-part-2>

consumers.³³ Although the Marketplace continues to offer a high volume of plans, maintaining reasonable limits helps prevent issuers from introducing numerous minimally differentiated products that vary only slightly in cost-sharing, formularies, or provider networks.³⁴ Without such limits, consumers may again face an unmanageable array of options, increasing the likelihood of enrollment errors or selection of plans that do not meet their medical or financial needs. Excessive plan variation can also obscure whether a plan includes a local CHC in-network, whether prescription drugs are covered at affordable tiers, or whether specialty referrals are subject to high cost-sharing. Navigators and enrollment assisters working within CHCs rely on streamlined plan offerings to neutrally guide patients efficiently through coverage selection. An expansion of non-standardized plans would increase administrative complexity and could lead to greater patient confusion and unintended gaps in access.

Moreover, removing non-standardized plan limits may allow issuers to pursue benefit design strategies that attract lower-risk enrollees, thereby increasing adverse selection pressures in more comprehensive plans. Over time, such dynamics could contribute to premium increases and reduced affordability for individuals with greater health care needs. **Therefore, NACHC urges CMS to maintain reasonable limits on the number of non-standardized plan options offered within a metal level and service area.** If CMS proceeds with this proposal, the agency should at least establish alternative guardrails, such as strengthened meaningful differentiation standards and enhanced display tools that clearly highlight network inclusion and cost-sharing differences. Preserving structured plan offerings remains essential to protecting consumers, supporting informed enrollment decisions, and ensuring stable access to CHCs and other community-based providers.

IV. Marketplace Integrity and Oversight

Prohibition on Including Routine Adult Dental Services as an Essential Health Benefit (§ 156.202(b) and (d))

NACHC strongly urges CMS to reconsider its proposal to prohibit issuers from including routine non-pediatric adult dental services as an Essential Health Benefit (EHB) at § 156.202(b) and (d). Although CMS states that this reversal would better align with section 1302(b)(2)(A) of the ACA, eliminating states' ability to include adult dental services as an EHB would represent a significant step backward in ensuring access to comprehensive, preventive care. CMS's justification for reinstating this prohibition relies in part on an interpretation of the ACA's legislative intent and the structure of typical employer-sponsored coverage. However, this interpretation does not fully reflect how EHBs have been implemented in practice or the statutory authority granted to the Secretary of HHS to periodically review and update EHB standards to reflect evolving medical evidence, market practices, and consumer needs under sections 1302(b)(4)(G) and 1302(b)(4)(H) of the ACA.

Oral health is closely linked to chronic disease management, maternal health, and overall well-being.³⁵ With 82% offering dental services and serving over 6.9 million patients annually, CHCs

³³ CMS Marketplace Public Use Files, Plan Year 2024–2025. <https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files>

³⁴ https://advocacy.consumerreports.org/wp-content/uploads/2012/11/Too_Much_Choice_Nov_2012.pdf

³⁵ https://www.cdc.gov/pcd/issues/2021/21_0060.htm

are a cornerstone of dental care delivery for underserved communities. In 2024, CHCs provided almost 16 million in-person dental visits, demonstrating significant contributions to oral health care.³⁶ These services represent a critical component of the nation’s oral health safety net and illustrate the scale of care that CHCs deliver to individuals who might otherwise lack access to routine dental services. One CHC in Indiana reports that it would face additional cost pressures from reduced adult dental coverage, which would negatively affect both patient outcomes and organizational stability, as 65% of its dental patients are 18+ years old. Additionally, a Midwestern PCA reported that separating adult dental from comprehensive coverage would increase unmet dental needs and place additional financial and operational pressure on their CHCs’ dental programs.

Excluding adult dental services from the EHB framework would likely discourage plan inclusion of these benefits and increase cost-sharing burdens, further limiting access for adults who already face financial and geographic barriers to care. Moreover, concerns outlined in the proposed rule regarding potential market volatility or lack of plan infrastructure are not consistent with current insurance market practices. Since the implementation of the ACA, health insurance markets have matured substantially, and plan sponsors have demonstrated the ability to administer adult dental benefits through both embedded coverage and coordinated offerings. In fact, many QHPs currently include both pediatric and adult dental benefits, and major national carriers participating in Marketplace coverage routinely administer dental benefits across product lines. Removing state flexibility risks widening gaps in access, particularly in rural and medically underserved communities where CHCs are often the primary source of both medical and dental care. **NACHC encourages CMS to maintain the current policy and preserve state authority to include adult dental services as part of a comprehensive EHB package.**

“Additional” Essential Health Benefits (§ 155.170)

NACHC is concerned that CMS’s proposal to reclassify certain state-mandated benefits as “in addition to Essential Health Benefits (EHBs)” would weaken coverage protections that are critical for patients served by CHCs. Under the proposal, benefits currently included in CMS-approved state EHB benchmark plans could be treated as outside the EHB frameworks based solely on when the state enacted the mandate. This change would remove key consumer protections from those services, including limits on cost sharing, nondiscrimination protections, and prohibitions on annual or lifetime dollar limits. Many of the affected benefits support chronic disease management, behavioral health treatment, and other outpatient services relied upon by CHC patients. If states are required to defray these costs beginning in plan year 2027, some may scale back or repeal coverage requirements to avoid ongoing fiscal obligations. As a result, patients may face reduced access to essential services and greater underinsurance. In turn, CHCs would be required to bear a greater financial burden for uncompensated care costs. **NACHC urges CMS to withdraw this proposal and preserve the stability of state EHB benchmark plans that support patients’ access to comprehensive coverage.**

State Exchange Enhanced Direct Enrollment (SBE-EDE) Option (§ 155.221)

NACHC recognizes CMS’s goal of providing SBEs with greater operational flexibility. However, given the limited real-world experience with the proposed SBE-EDE model, we urge CMS to proceed with caution and ensure that any expansion includes strong consumer

³⁶ 2024 UDS Data, HRSA.

protection and program integrity safeguards. CHCs serve more than 52 million patients, many of whom have incomes below 200% of the FPL and depend on clear, reliable pathways to enroll in affordable, comprehensive coverage. Under the proposed changes, third-party brokers and web brokers could influence consumer inputs, eligibility attestations, and plan selection decisions, while the SBE would remain legally responsible for eligibility determinations and program compliance. This separation between operational control and accountability increases the risk of eligibility errors, improper enrollments, and consumer confusion. These risks are particularly concerning for CHC patients who face barriers related to digital literacy, language access, or reliable broadband. Analysis of public program enrollment systems shows that centralized, simplified application processes improve completion and retention rates for low-income populations.³⁷ Fragmenting the enrollment entry point across multiple private platforms will undoubtedly make it harder for CHC patients to complete applications and maintain coverage.

Recent findings also reinforce the need for caution. CMS has identified enrollment activity facilitated by agents, brokers, and web brokers as a significant source of improper enrollment, which informed the 2025 Marketplace Final Rule.³⁸ The HHS Office of Inspector General has also documented widespread eligibility determination errors linked to weaknesses in verification processes and reliance on applicant-reported information.³⁹ Expanding an exclusive third-party enrollment pathway in SBEs without platform-level monitoring and auditing requirements comparable to federal EDE standards risks repeating these integrity challenges. **For this reason, NACHC recommends CMS delay implementation of the SBE-EDE until additional data is available from early state implementations, including Georgia’s broker-facilitated marketplace platform.**⁴⁰ It will take time and resources for states to assess enrollment accuracy, consumer experience, and oversight capacity as this model scales. Allowing an evaluation period will help ensure that appropriate guardrails are in place before broader adoption. **At a minimum, CMS should require stronger platform-level reporting and enforce existing standards of conduct for agents, brokers, and web brokers to ensure that enrollment practices protect vulnerable patients served by CHCs.**

Misleading Marketing Practices (§ 155.220)

NACHC supports CMS’s efforts to prohibit clearly deceptive marketing practices, including cash inducements and misrepresentations about premium costs or enrollment deadlines. NACHC has previously raised concerns about misleading marketing tactics used by certain agents, brokers, and web brokers to induce Marketplace enrollment.⁴¹ CHCs and PCAs have reported instances in which consumers were targeted through social media advertisements suggesting eligibility for “zero-dollar” plans or cash incentives, only to later discover inaccurate information regarding premiums, provider networks, or coverage start dates. These practices create confusion, disrupt continuity of care, and may result in patients being enrolled in plans that do not include their CHC, thereby undermining access to trusted providers. **NACHC encourages CMS to pair**

³⁷ https://www.urban.org/sites/default/files/2025-08/Landscape_Analysis_of_Public_Benefit_Enrollment_Approaches_in_the_US.pdf

³⁸ <https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability>

³⁹ <https://oig.hhs.gov/reports/all/2020/the-federal-marketplace-properly-determined-individuals-eligibility-for-enrollment-in-qualified-health-plans-but-improperly-determined-that-an-estimated-3-percent-of-individuals-were-eligible-for-insurance-affordability-programs/>

⁴⁰ <https://oci.georgia.gov/press-releases/2024-08-14/georgia-access-launch-state-based-exchange-november>

⁴¹ [NACHC Marketplace Integrity and Affordability Comment Letter](#)

these regulatory changes with clear accountability mechanisms, meaningful penalties for noncompliance, and consideration of standardized training requirements for agents and brokers similar to those required of Navigators. Ensuring that marketing and enrollment assistance activities are accurate and consumer-focused is essential to protecting CHC patients from improper enrollments and maintaining trust in the Marketplace.

Thank you for the opportunity to comment on these proposals. NACHC appreciates CMS's continued efforts to strengthen the Marketplace and promote program integrity. We urge CMS to carefully consider the cumulative impact of the proposed changes and to retain strong, enforceable standards that protect patient access, promote stability, and ensure Marketplace coverage translates into meaningful access to care. If you have any questions about our comments, please contact Elizabeth Linderbaum, Director of Regulatory Affairs, at elinderbaum@nachc.org.

Sincerely,

A handwritten signature in cursive script that reads "Joe Dunn". The signature is written in black ink and is centered on the page.

Joe Dunn
Chief Policy Officer