March 13, 2026

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Department of Health and Human Services
Attention: CMS-9883-P
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As organizations dedicated to promoting the health of our nation's children, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program" (proposed rule). We believe that insurance coverage for children must ensure access to timely, affordable, high-quality, and age-appropriate health care that meets their unique developmental needs and enables them to meet their full potential as adults. Access to health care for children and their families is vital to long-term health, well-being, and productivity. While we share CMS's goal of promoting program integrity and efficiency in the Marketplace, we believe the proposed rule must be substantially revised to ensure that children and their families – particularly children with chronic, complex, or serious health conditions – continue to have access to affordable and appropriate care.

We are alarmed that the rate of uninsured children under age 19 increased from 5.4% in 2023 to 6% in 2024, the highest rate since 2014.[1] Nearly 2.6 million children under age 18 were enrolled in Qualified Health Plans (QHPs) in 2025, up from more than 2 million in 2024, making Marketplace coverage an increasingly important component of children's coverage overall. However, numerous provisions in the proposed rule would restrict access to affordable and comprehensive healthcare coverage and risk increasing the number of uninsured children as well as their parents and other family members.

Therefore, we strongly recommend that CMS not finalize a number of provisions in the final rule, including but not limited to:

- The expansion of catastrophic plans and increase in out-of-pocket limits for Bronze and Catastrophic plans.
- The expansion of red tape and paperwork to make it more difficult for eligible people to enroll.
- The proposal to reduce network adequacy standards and oversight and essential community provider (ECP) percent threshold requirements.
- Certification of non-network plans.

We also note that the proposed rule provides for only a 30-day comment period, which does not allow sufficient opportunity to do the review and analyses necessary to determine what will likely be major impacts on coverage, premiums, affordability, and access. Furthermore, the proposed rule omits critical information and provides an inadequate Regulatory Impact Analysis, without which it is not possible to fully analyze the rule and allow for a comprehensive set of comments.

[1] Georgetown University Center for Children and Families analysis of the U.S. Census Bureau American Community Survey (ACS) data. https://ccf.georgetown.edu/2025/09/12/u-s-and-state-by-state-child-health-coverage-trends/

Standards for Establishing a State-Based Marketplace (§§ 155.105 and 155.106)

We oppose the proposal to eliminate the requirement that a state transitioning to a state-based marketplace must first rely on the federal platform for one year. This requirement ensures that states have sufficient time to ensure that all necessary websites, application processes, eligibility and enrollment systems, and assister training are working appropriately and that eligible consumers are able to enroll in Qualified Health Plans (QHPs) and advanced premium tax credits (APTCs) on a timely, accurate basis.

Amending Requirements for State Exchanges to Operate a Centralized Eligibility and Enrollment Platform on the State Exchange's Website (§ 155.205(b))

We oppose the proposal to ignore the statutory requirement that State-based Exchanges (SBEs) operate a consumer-facing centralized eligibility and enrollment platform and instead allow a new "State-Based Exchange-Enhanced Direct Enrollment" option that relies on web brokers. This proposal also directly reverses a policy finalized in the Plan Year (PY) 2025 Payment Notice, which required SBEs to maintain a centralized platform. CMS adopted this policy to strengthen oversight of eligibility determinations and maintain program integrity—goals that remain consistent with CMS' priorities.

We continue to believe that the final determination of eligibility for Marketplace coverage and premium subsidies should remain the responsibility of the SBE. Doing so ensures transparency, accountability and accuracy for families applying for and enrolling in Marketplace plans and subsidies and reduces the risk of fraud. It also ensures that individuals who are determined to be eligible for Medicaid and CHIP will be able to enroll in those programs.

Proposals Related to FFE Standards of Conduct and Mandating a Standard Eligibility Application Review Form and Consumer Consent Form (§ 155.220(j)(2))

We support CMS's proposals at § 155.220(j)(2)(ii) and (iii) to require agents, brokers, and web-brokers (collectively "brokers") to use the HHS-approved and -created consumer consent form[2] to meet the eligibility application review documentation and consent documentation requirements. We agree that requiring this standardized consumer consent form will improve information accuracy, streamline CMS review and removal of noncompliant brokers, and ultimately improve consumer protection.

We also support making brokers ensure that all marketing-related materials produced on their behalf adhere to new marketing restrictions. This requirement should also apply to materials and information used by lead generators and field marketing organizations on which brokers rely. In addition, CMS should do more to protect consumers from inappropriate broker activity that harm families. For example, there should be an exceptional circumstances special enrollment period (SEP) for consumers found to have been improperly switched to a new plan. Furthermore, consumers should be held harmless for APTCs for a plan where their consent to enroll cannot be documented.

Failure To File and Reconcile (FTR) Policy (§ 155.305)

[2] Available at https://www.cms.gov/marketplace/agents-brokers/files/cms-model-consent-form-marketplace-agents-brokers.pdf

We urge CMS to retain current policy and focus its efforts on consumer education and the streamlining of the APTC reconciliation process to address concerns about improper enrollment. Consumer education and outreach with clearer guidance on tax filing requirements will help prevent unnecessary coverage loss for enrollees and their dependents.

The current two-year threshold was implemented to account for the administrative burden involved in the reconciliation process, delays from the IRS, and the complex nature of failure-to-file-and-reconcile process. Furthermore, the IRS has existing enforcement mechanisms in place for the individuals who fail to file their tax returns, making the additional penalty of immediate APTC loss both duplicative and disproportionately harmful to children of lower-income individuals. The proposed change to permit each Exchange to choose to enforce either the one-year or the two-year FTR rule would only increase confusion and the likelihood of families with children losing coverage due to administrative hurdles rather than intentional non-compliance.

Data Matching Issues (§ 155.320)

We urge CMS to not adopt two proposals that would significantly increase paperwork burdens for eligible families applying for APTCs by creating additional Data Matching Issues (DMIs). CMS offers no evidence in the proposed rule that there is substantial unaddressed improper payments justifying these new DMIs. The proposed rule would generate DMIs when tax data show income below 100% of the Federal Poverty Level (FPL) or when tax data is absent. Requiring additional documentation will deter enrollment among eligible families and their children, especially those with low incomes who experience greater income volatility. This will lead to more uninsured and higher premiums due to erosion of the risk pool.

Premium Payment Threshold (§ 155.400)

We urge CMS to restore the premium payment thresholds included in the PY 2026 Payment Notice that protect enrollees from losing coverage when they miss a premium payment that are currently subject to a one-year moratorium, which the proposed rule would extend. We also encourage CMS to allow other guardrails to take effect, such as consistency in which payment thresholds are offered, and implement new measures, such as requiring insurers to notify enrollees of any outstanding balance before terminating coverage or setting a reasonable cap on fixed-dollar thresholds.

Premium payment thresholds grant insurers crucial flexibility to avoid termination of coverage due to de minimis non-payments, which disproportionately affect enrollees with low-dollar premium obligations. Research has found that families faced with this additional financial burden may delay needed care, which can increase inappropriate utilization of emergency room care and affect a child's long-term health outcomes and future productivity. Notably, the proposed rule does not offer any evidence that premium payment thresholds would contribute to improper enrollment.

Proposal Relating to the 150 Percent FPL Special Enrollment Period Beyond Plan Year 2026 (§ 155.420(d)(16))

We appreciate CMS's concerns about fraudulent activity by brokers that is leading to higher numbers of improper enrollment in this monthly special enrollment period (SEP). Rather than permanently eliminating this coverage pathway, we encourage CMS to establish an oversight policy focused on enrollment practices by brokers with a history of fraudulent activity to address program integrity

concerns. This oversight should be combined with robust outreach and education efforts to eligible consumers to ensure individuals and their dependents who qualify can access and receive coverage.

The monthly SEP for those who are APTC-eligible with a projected household income at or below 150% of the federal poverty level has played a critical role in ensuring that children in those eligible families have continuous access to health coverage. Many low-income families experience fluctuations in income that may not align with the annual open enrollment period and without the low-income SEP, may find themselves without the opportunity to secure affordable health insurance. While H.R. 1 (P.L. 119-21) prohibited APTC for anyone enrolled through any income-based SEP starting with PY 2026, low-income people who are not eligible for an APTC could still benefit from this monthly SEP.

We urge CMS to ensure that families understand any policy changes and their implications on insurance coverage. Maintaining continuous coverage is essential for children's health and overall well-being; gaps in coverage can lead to missed preventative services, interruptions in treatment for chronic conditions, and reliance on more costly emergency care.

Special Enrollment Period Verification (§ 155.420(g))

We understand CMS's intention of ensuring the integrity of the Marketplace but are concerned that permanently extending onerous pre-enrollment verification for a broad array of SEPs would create unnecessary barriers to coverage for eligible families and their children to enroll in QHPs. Rather than implementing broad pre-enrollment verification for SEPs, CMS should focus program integrity efforts on the monitoring and oversight of enrollment through brokers and agents flagged for fraud and other high-risk program integrity categories.

As CMS acknowledges, a pre-enrollment verification process would likely discourage some consumers from enrolling. Requiring pre-enrollment verification for SEPs could also result in unintentional delays that interrupt access to necessary care for families that are eligible. SEPs are essential for ensuring that individuals and their dependents who experience qualifying life events can maintain continuous access to health care coverage. Children, particularly those with chronic conditions or ongoing health needs, depend on consistent access to health care and delays in enrollment can lead to disruptions in their treatment and care continuity that can result in poorer health outcomes.

Amending Exchange Network Adequacy Standards and Deferral of Network Adequacy Reviews to States with an Effective Provider Access Review Program (§§ 156.230 and 155.1050)

We urge CMS to retain the current network adequacy standard policy. An active federal role in the review and oversight of provider networks is critical to helping ensure that families are not faced with exorbitant out-of-pocket expenses because they must seek out-of-network care for their child. The absence of a federal minimum set of standards for provider networks will lead to a patchwork of state standards and processes and will impede children's access to timely needed pediatric specialty care.

A child's access to an appropriately trained pediatric provider should not be a function of whether their state has a federally-facilitated or state-based Exchange. A strong framework of standards and review of plans' provider networks is absolutely critical to ensuring that children have access to the providers they need, particularly pediatric specialists. The trend toward more limited (and inadequate) networks leaves families with exorbitant out-of-pocket expenses when they must seek out-of-network care for their child

because there is not an appropriate in-network provider. Without a minimum framework of standards, this inconsistency in provider network adequacy among states and plans will continue.

Expansion of Catastrophic Plans and Multi-Year Terms (§§ 156.130(c), 156.155(a)(6) and 155.605(d)(1))

We have significant concerns about the proposal to expand eligibility for catastrophic plans in all states. CMS is limited in its authority to define hardship exemptions, and the proposal appears to exceed this authority. In addition, the likely impact on consumers will be an overall increase in enrollment in plans with unaffordable deductibles -- $30,800 for a family -- thereby preventing families from accessing needed care.

While these plans cover preventative services and up to three primary care visits—often with cost-sharing— most other services, including specialty services, diagnostic testing, mental health services, and more, require families to pay the full cost of this care before their deductible is met. Families and children often need such services and would incur high costs to ensure proper access. Fortunately, most children are relatively healthy and do not have catastrophic health care needs. However, they do need coverage for common illnesses. As a result, families enrolled in catastrophic plans may face substantial upfront costs when seeking care for their children, particularly those with chronic or complex conditions who rely on specialty care and ongoing monitoring. Moreover, other consumers will face higher premiums in non-catastrophic plans due to adverse selection as healthy people enroll in catastrophic plans.

We also urge CMS to rescind the proposal to permit insurers to offer multi-year catastrophic health plans for periods of up to 10 years. Multi-year catastrophic plans are not just contrary to law but also would expose families and their children to a grave risk of harm. CMS proposes allowing multi-year catastrophic plans to apply the annual limitation on cost-sharing over the entire contract term, meaning that such plans may not have to pay any claims for years. CMS also suggests an issuer could discontinue a catastrophic plan product early and never pay any claims. As a result, the expansion of these plans will increase the likelihood that families are enrolled in coverage that does not adequately meet their children's health care needs. At the same time, CMS implies that consumers may be locked into multi-year catastrophic plans by insurers limiting their ability to transition to more comprehensive coverage as the needs of their family change.

Cost Sharing for Bronze and Catastrophic Plans (§§ 156.136 and 156.155)

Additionally, we urge CMS to rescind the proposal to ignore statutory requirements and allow bronze plans to significantly exceed current maximum out-of-pocket (OOP) limits and to increase maximum OOP requirements for catastrophic plans (to 130% of the maximum out-of-pocket limit). Higher cost sharing can create significant barriers to care for children and families. While these plans may have lower premiums, families may face substantial upfront costs for many services. For children with complex or chronic conditions, these costs can accumulate quickly and may discourage families from seeking care. We encourage CMS to carefully consider the impact of these proposals on children and families and maintain policies that ensure Marketplace coverage options provide meaningful access to pediatric care without imposing excessive OOP costs.

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

We urge CMS to retain the current standardized plan policies, in place since PY 2023, as we disagree with CMS's proposal to eliminate the full suite of standardized plan option policies in PY 2027. The current standardized plan policies make it easier for families to truly compare plan offerings and choose a health insurance plan that fits their needs. Eliminating the requirement that insurers offer standardized plans and differentially display standardized plans on *HealthCare.gov*, will confuse families that are trying to find the right plan for their children's needs.

It is crucial for families to be able to see differences in provider networks, formularies, etc. between plan options when selecting coverage that meets the unique needs of their children. In order to prevent any gaps in care and maintain their child's medical home and, a family will want to make sure the plan's provider network includes their child's primary care provider and has a full range of pediatric specialty providers, such as an in-network children's hospital and pediatric mental health providers. Being able to compare differences in pediatric coverage will ensure children can access the care they need, when they need it and help ensure continuity of care in the event they are moving between plans during open enrollment periods.

Non-Standardized Plan Option Limits (§ 156.202)

We urge CMS to rescind the proposal to discontinue non-standardized plan option limits. Currently, insurers are limited to two non-standardized plans per product network type, metal level, inclusion of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage, in any service area. We supported CMS clarifying insurers' flexibility to vary the inclusion of adult dental, pediatric dental, and adult vision benefits under the non-standardized plan option limits in the PY 2025 and PY 2026 Payment Notices, and we were pleased to see CMS's recognition of the distinction between pediatric and adult dental benefits. We continue to assert that, by limiting the number of non-standardized plan options that issuers can provide on Exchanges, plan choice overload and confusion can be avoided.

Essential Community Provider Standards for Network Plans (§ 156.235)

We thank CMS for continuing to recognize the importance of essential community providers (ECPs), including children's hospitals, in meeting the needs of underserved communities throughout the country, but strongly disagree with CMS's proposal to reduce the minimum percentage requirement from 35 to 20%. A lower minimum percentage standard does not guarantee that QHPs will contract with a representative mix of ECPs, nor does it ensure an adequate quantity of ECPs in the networks. Regardless of the established minimum, most plans will achieve that standard and go no further without, necessarily, addressing ongoing gaps in networks. Networks without a sufficient number and scope of ECP types, including children's hospitals, could lead to gaps in care for children, resulting not only in poor health outcomes, but additional costs to the health care system and long-term costs to the nation's economy.

ECPs, including children's hospitals, play a particularly critical role in the care of low-income children and children with serious, complex, or chronic conditions or special health care needs. These children rely upon a comprehensive and diverse range of medical and ancillary services to meet their unique developmental and growth needs, which ECPs are designed to provide. Pediatricians, family practice

physicians, and adult community hospitals refer their patients to ECP children's hospitals for treatment of everything from complicated fractures to complex congenital heart conditions, because of the expertise of the specialists working in the hospital.

QHP Certification of Non-Network Plans (§§ 155.1050, 155.1051, 156.230, 156.235, 156.236, 156.275, and 156.810)

We generally disagree with the proposed option to allow plans that do not use a network (non-network plans) to receive QHP certification by demonstrating that they ensure a sufficient choice of providers that would accept the plan's benefit amount as payment in full. While CMS cites the administration's price transparency initiatives and focus on individual consumers' ability to shop for a lower price, this proposal does not accurately convey the increased burden on the consumer to identify providers, negotiate the price of their care, and process the payment for a service. These administrative burdens will fall on the family, leading to added stress when already navigating a complex system. Additionally, if the non-network plan's benefit amount does not cover the full cost of care, children and families could face potentially higher out-of-pocket costs. This eventual financial uncertainty would do nothing to alleviate families' financial strains.

Non-ACA-compliant plans can have serious negative implications for children's health and health care. They can result in exposure to higher costs due to coverage limits or benefit denials and limit access to appropriate pediatric providers. Family confusion about the difference between network and non-network plans may lead to the purchase of a plan that does not cover necessary pediatric services, including vision and dental, habilitation or mental health services as well as long term gaps in coverage.

In conclusion, the undersigned organizations appreciate this opportunity to share our views regarding the proposed rule. We look forward to working with you to ensure that the unique health care needs of children and families are met in the individual and larger group markets.

Sincerely,

American Academy of Pediatrics
Children's Defense Fund
Children's Hospital Association
Family Voices
First Focus on Children
Georgetown Center for Children and Families
March of Dimes
National Association of Pediatric Nurse Practitioners