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March 13, 2026

Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATTN: CMS-9883-P
P.O. Box 8016
Baltimore, MD 21244

Re: Notice of Proposed Rulemaking, “Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program” (Published in Federal Register Volume 91, Number 28, page 6292 on February 11, 2026)

Dear Secretary Kennedy:

The Massachusetts Health Connector (“Health Connector”), a State-based Exchange (“Marketplace” or “SBM”) authorized under the Patient Protection and Affordable Care Act of 2010 (“ACA”), and the Massachusetts Division of Insurance appreciate the opportunity provided by the Department of Health and Human Services (HHS) to comment on the proposed Notice of Benefit and Payment Parameters (NBPP) for 2027.

Founded in 2006 as part of bipartisan state health reform, the Massachusetts Health Connector is the longest-running SBM in the country. The Health Connector is designed to connect Massachusetts residents and small businesses with high quality, affordable health coverage and to promote universal health coverage in the Commonwealth. Today, the Health Connector provides non-group health coverage to over 351,000 individuals and small group coverage to nearly 15,000 small business employees from more than 2,400 small businesses. In parallel, the Division of Insurance monitors health insurers across fully insured markets, working with stakeholders and agencies, to advance our goals of affordability. Our combined

efforts have contributed to the Commonwealth's status as one of the healthiest states in the nation,¹ with a nation-leading health insurance rate of 98 percent,² and average Marketplace premiums that are among the lowest-cost in the country in 2026.³

The Health Connector and the Massachusetts Division of Insurance share CMS's goals of providing quality coverage, minimizing administrative burdens, advancing program integrity, addressing affordability for all Massachusetts residents including the unsubsidized population, preserving state flexibility, and maintaining a stable and robust insurance market. However, several of the strategies CMS proposes would negatively impact these shared goals rather than advance them. We respectfully offer comments on the proposed rule sections that would have the greatest impact on enrollees, SBMs, and the Massachusetts merged commercial individual and small group insurance market.

These comments generally fall into three main categories:

- 1. Supporting State Flexibility to Develop Solutions that Address the Unique Needs of their Residents and Markets:** We share CMS's goal of preserving and enhancing flexibility among SBMs to implement data-driven approaches to meet the unique needs of their local markets and residents. However, some of the proposed changes will eliminate that flexibility which has enabled Massachusetts to achieve historic rates of uninsurance, high value coverage, and stellar program integrity results.
- 2. Impractical Timelines for Implementation, Increasing Risk of Adverse Outcomes:** The provisions detailed in this rule are impractical to implement according to the proposed effective dates, on top of an already full release schedule for our technical and operational systems, particularly given the late arrival of this annual NBPP and extensive implementation activities already underway as a result of the "Working Families and Tax Cut" (WFTC) Act, also referred to as the "One Big Beautiful Bill Act" (OBBBA).
- 3. Harm to the Risk Pool and Increases in Premiums:** The proposed rule will cause harm to the Massachusetts merged market risk pool and result in premium increases for all market segments, including the unsubsidized population.

¹ See <https://wellbeingindex.sharecare.com/interactive-map/?defaultState=MA, State Rankings | 2025 Annual Report | AHR>

² Center for Health Information and Analysis (CHIA) 2025 Massachusetts Health Insurance Survey (MHIS), at <https://www.chiamass.gov/massachusetts-health-insurance-survey>.

³ Kaiser Family Foundation analysis of data from Healthcare.gov, state rate review websites, and state plan finder tools, at <https://www.kff.org/affordable-care-act/state-indicator/marketplace-average-benchmark-premiums/>

Supporting State Flexibility to Develop Solutions that Address the Unique Needs of their Residents and Markets

SBMs must be empowered to implement innovative, data-driven approaches to meet the unique needs of their residents and markets. This flexibility enables long-standing SBMs like the Massachusetts Health Connector to preserve historic achievements in providing affordable commercial market coverage to Massachusetts residents in partnership with the federal government, while ensuring program integrity, high-value plans for all market segments, and market stability. We thank and applaud CMS for recognizing these shared values of State flexibility and innovation in past rule making and in some sections of the proposed 2027 NBPP. States continue to be best suited to understand the unique aspects of their local markets and avoid the unintended consequences of policies that may be a good fit for the FFM given its unique policy and operational context but not necessarily for all SBMs.

Massachusetts does not experience the challenges that CMS describes within the FFM. In fact, the Health Connector's careful, long-standing approach to program integrity has affirmatively prevented those exact challenges from emerging in the first place. If such solutions are universally applied to SBMs in a one-size-fits-all fashion, it would worsen the Health Connector and Division of Insurance's ability to reach the shared goals of providing high-value plans to all, including the unsubsidized population; advancing program integrity; and protecting the stability of our merged market risk pool. We appreciate the instances in which CMS does provide SBMs with flexibility, for example, FTR implementation for 2027; the ability to not use agents, brokers, or web-brokers in the individual market; network adequacy standards; and the ability to set our own Medical Loss Ratio (MLR).

The Health Connector engages in robust program integrity activities to prevent improper enrollment and to ensure people meet eligibility requirements for the coverage in which they enroll. Massachusetts does not experience the same program integrity challenges that CMS describes as occurring within the FFM or via agents and brokers. Instead, many of CMS's proposals to address improper enrollments and fraud in the FFM would have the opposite of the intended impact here in Massachusetts. We agree with CMS's assertion that SBMs "do not all face the same problem in regard to unauthorized enrollments." In particular, the Health Connector does not use brokers or web-brokers for individual coverage or allow enhanced direct enrollment websites to enroll residents. We carefully considered and assessed how direct enrollment and enhanced direct enrollment would impact the market and proactively made the decision to not to pursue these options explicitly due to concerns about negative impacts to program integrity and the risk of misuse of taxpayer resources. Massachusetts residents looking to enroll in Health Connector coverage must apply directly through the Health Connector's portal and may access help from certified Assistors and Health Connector call center agents. Assistors and call center agents undergo robust and continuous training to assist individuals and only act with explicit individual consent. To date, out of the more than

1,266,000 people that have enrolled in Health Connector coverage since 2014, the Health Connector has received zero complaints or reports about fraudulent or unauthorized activity by Assistants, or that members were unaware of their coverage and suspected fraudulent enrollment.

We are deeply committed to preserving program integrity to ensure that member data is secure and that health insurance eligibility, including the allocation of premium tax credits and state subsidies, are awarded correctly. In Massachusetts, we offer additional state premium subsidies and cost sharing reductions as a part of our ConnectorCare program. To be eligible for ConnectorCare, one must first be eligible for federal premium tax credits. Thus, we share CMS's goal to safeguard program integrity related to eligibility, and depend upon confidence in the measures in place to ensure that eligibility is conducted accurately so that state dollars are used appropriately and efficiently to support access to affordable coverage to those who are eligible.

Our careful attention to program integrity has resulted in several years of no findings on financial audits, programmatic audits, and compliance reviews conducted by CMS and the IRS. Like other SBMs, the Health Connector regularly undergoes intense and comprehensive reviews, audits, and evaluations by different state and federal agencies and offices. In addition, our robust outreach to members through carefully designed education, notices, and public webinars ensures that members and applicants maximally understand the responsibilities associated with enrolling in Marketplace coverage, including keeping information up to date and reconciling tax credits received as part of their annual tax filing.

Impractical Timelines for Implementation, Increasing Risk of Adverse Outcomes

Many of CMS's proposals include impractical timelines for implementation, threatening program integrity and increasing risks associated with hasty implementation. The Massachusetts Health Connector shares an integrated eligibility system with MassHealth, our state's Medicaid program, which requires detailed and deliberate coordination between both agencies any time a new policy requiring system changes occurs. Any system changes require careful integration approximately a year in advance of planned technical releases. The Health Connector and MassHealth, the state Medicaid agency, are already engaged in significant systems changes as a result of the OBBBA legislation referenced in the proposed rule, with upcoming implementation dates for several provisions across Medicaid and Marketplace changes starting in August 2026, to prepare for Open Enrollment 2027. These changes include community engagement requirements and six-month renewals in Medicaid as well as eligible noncitizen changes that have different effective dates across Medicaid and Marketplaces. Adding modifications to income inconsistencies for 2027, in particular, would be challenging to add to an already full schedule.

The Health Connector takes very seriously applicant and enrollee experience, program integrity, and system accuracy. It generally takes about a year for a high priority item to be carefully planned and implemented into the integrated eligibility system, ensuring proper testing to avoid adverse outcomes. The current technical release schedule is already full as we seek to carefully implement provisions required by law from the OBBBA legislation. These provisions require extensive system changes. Adding new requirements on top of the already full technical release schedule will put the Commonwealth's integrated eligibility system at risk of adverse outcomes.

In addition, the late release of the proposed NBPP this year significantly adds to the operational burden and unworkable timeline of the proposed rule. Typically, the NBPP is issued in the fall and finalized in early spring to give insurers, states, and other stakeholders time to understand, adjust to, and implement the rules for the next year.

The late release of this proposed rule, coupled with eligibility system changes already well into development for Open Enrollment 2027, particularly at a time when Marketplaces (perhaps particularly those with integrated systems they share with Medicaid programs) are already managing extensive system changes in response to OBBBA, makes new implementation activities especially difficult to add to the queue without adding significant risk for adverse outcomes.

Harm to the Risk Pool and Increases in Premiums

Policies impeding and delaying enrollment in the Massachusetts merged market, especially those with the effect of reducing enrollment in the subsidized population, will have a negative impact on market stability, increase premiums for all market segments, including the unsubsidized market and the small group market, and increase federal per-enrollee spending. Since 2007, Massachusetts has maintained a merged market, a unique market structure that combines the individual and small group markets. In 2019, former Governor Baker authorized a Merged Market Advisory Council (MMAC)⁴ to analyze market stability and cost drivers in the merged market for individual and small employer health coverage in Massachusetts. The MMAC's final report provided data-driven insights on the health of the Massachusetts merged market based on independent actuarial analyses.⁵ Notably, one of the key findings of that report is that ConnectorCare, the Health Connector's flagship program in which qualifying low- and moderate-income residents up to 300 percent of the federal poverty level (FPL) can access coverage with state and federal subsidies, contributes positively to the risk pool.⁶

⁴ The Council was comprised of 13 members, chaired by Commissioner of Insurance, and included leaders, experts and stakeholders with experience in and knowledge of the health insurance industry, including carriers, brokers, actuaries, and individual purchaser representatives, as well as persons representing the business community, including representatives of employers and small businesses.

⁵ <https://www.mass.gov/merged-market-advisory-council>

⁶ Note, the 300 percent FPL eligibility for ConnectorCare was at the time of that report. ConnectorCare eligibility in 2026 is up to 400 percent FPL.

The independent actuarial analyses conducted as a part of the above-mentioned report found that the subsidized population in Massachusetts's ConnectorCare program plays a crucial role in stabilizing the Commonwealth's risk pool and in ensuring unsubsidized individuals have the opportunity to participate in a large, stable market with lower premiums than they otherwise would experience. Throughout this comment letter, our agencies detail how certain provisions in the proposed rule would worsen the risk pool by creating barriers to coverage for a large portion of the individual market, disproportionately impacting younger individuals and those who have historically had lower-than-average medical expenses. If lower cost enrollees lose coverage, thereby leaving the risk pool, it will likely increase premiums for *everyone*, including the unsubsidized population and small groups. Additionally, policies that destabilize the market will unnecessarily increase premiums and federal APTC dollars leading to an increase in per-enrollee costs for the federal government. These pressures will erode the Commonwealth's lowest-in-the-nation uninsured rate and raise costs for Massachusetts families and small businesses.

The Health Connector and Massachusetts Division of Insurance respectfully offer the following comments on specific provisions of CMS's proposed rule that would have the most significant impact on members, SBMs, and the state's insurance market.

GUIDANCE ON PRE-ENROLLMENT VERIFICATIONS

The pre-enrollment verification requirement of Section 71303 of the OBBBA will require significant systems and operational changes and will benefit from state flexibility in designing approaches to achieve its aims. The specific implementation requirements for this law remain unknown at this time, resulting in the Health Connector needing to consider a range of possible implementation approaches based on the language in the OBBBA. The new pre-enrollment verification policy touches multiple aspects of the process of applying for and enrolling in Marketplace coverage, will require significant investments of time and money to implement, and could result in considerable member abrasion and delayed and forgone care if not done thoughtfully, which could have broader implication for our health care system and the functioning of the insurance market. The Health Connector is pleased to provide CMS with some of the considerations that have arisen as staff have begun assessing an approach for pre-enrollment verification.

The requirement of pre-enrollment verification will significantly alter the flow of eligibility, shopping, payment, and enrollment functions in Massachusetts and nationwide, resulting in back-end systems changes to long-standing functionality to operationalize the new requirements. These back-end system changes will require additional Marketplace and vendor staff time to develop, review, and modify the updated requirements, to implement code changes and configuration changes, and to review test cases to ensure the system is functioning as intended. This requires many months of lead time, prior to these changes going

live in the system. The Health Connector is already considering the resource needs for this to be implemented by August 1, 2027, but has limited guidance at this time to appropriately scope the release and allocate staffing needs.

To ensure accurate implementation without risks, CMS guidance is needed now. Such guidance should be accompanied by appropriate flexibility for SBMs that promotes program integrity, while recognizing the value in SBM innovation and flexibility to build off decades of robust and secure eligibility and verification processes to ensure effective implementation and limit the risk of errors. We further ask that any comment period on pre-verification enrollment regulations be at least a typical 60-day long comment period and not the minimum 30-day period so that we can provide meaningful feedback and ensure implementation is feasible and accurate. According to Regulations.gov, the federal website facilitating regulatory publication and comment, “in a typical case, an agency will allow 60 days for public comment.”⁷ An agency typically tailors the comment period to reflect the breadth and depth of the substantive issues raised by the proposed rule. The complexities raised by the pre-verification enrollment process, independent of other proposals that might be issued along with it, necessitate a 60-day window to ensure CMS receives the thoughtful responses it aspires to obtain when putting a rule out for comment.

Pre-enrollment verification will add complexity and volume to downstream processes, including noticing and enrollment. The content and timing of member notices will need to be updated to accurately convey to members the new process to enroll in coverage. This will require additional Marketplace staff time to develop the updated content, additional vendor staff time to update the logic and text in the notices to reflect the reordered process, and corresponding testing to ensure the notices are generated as expected. These changes will include updates to notices related to eligibility sent during renewals, eligibility approval notices any time someone reports a change throughout the year, special enrollment period (SEP) verification notices, and data matching inconsistency (DMI) notices and reminders. These will require additional costs and time for notice translation to ensure members can receive these communications in their preferred language.

Delaying enrollment into a QHP with APTC will lead some people to drop out of coverage entirely, increasing premiums, and worsening the risk pool. Keeping as many people as possible covered in Massachusetts is critical to support a strong merged market risk pool and to prevent premium increases for everyone in the market. In Massachusetts, we have observed that people who auto-enroll and auto-renew and people who are in subsidized Health Connector coverage have lower risk scores. This helps to keep our merged market risk pool stable and premiums lower. If these individuals drop out of coverage due to administrative burdens, our risk pool will worsen and premiums will increase.

⁷ <https://www.regulations.gov/learn>

Analyses of total medical expenses of more than two million member months of 2024 claims data suggest that individuals who auto-renewed for Health Connector coverage and never subsequently shopped were lower cost than those who shopped for coverage during Open Enrollment 2025. In addition, the state's Merged Market Advisory Council (MMAC) found that enrollees in ConnectorCare, the state's flagship program that combines state and federal subsidies for people under 300 percent FPL, had the lowest proportion of members with claims over \$5,000.⁸ Additionally, the risk scores for non-ConnectorCare individual market members were over 30 percent higher than the risk scores for ConnectorCare members.

Given CMS's request for input on the "required timelines to comply with the law" and the clear complexity and cost of implementing this provision, we strongly recommend that CMS consider strategies for phased implementation of the pre-enrollment verification policy to enable Marketplaces sufficient time to implement these complex changes. We appreciate that CMS plans to issue regulations, guidance, technical assistance, and educational materials in the future to facilitate implementation of these provisions. However, we need that guidance now. Given the level of disruption associated with these changes, the complexity of processes that will result, and the lack of timely guidance, CMS should provide states with broad flexibility in designing and implementing these changes, including considering phased implementation and delayed enforcement.

CMS should identify and prioritize policies that enable consumers to easily access and maintain the coverage that they are eligible for. Such strategies should reduce the burden on consumers and streamline the application process to improve accurate program determinations, reduce the amount of time it takes to enroll in coverage, and eliminate unnecessary costs to individuals and the system. To reduce unnecessary delays in coverage effectuations, CMS should support state flexibility and encourage innovations in the approach to reliable verifications, particularly strategies that support positive outcomes among applicants and enrollees such as promoting continuous coverage. CMS should advocate for more data sources to be included in the federal data services hub to promote greater program integrity and enable more applicants and members to have their applications for coverage verified electronically by reliable data sources. We also recommend that CMS develop guidance that ensures members do not experience a reset of deductibles and maximum out of pockets if they enroll in a qualified health plan without subsidies for a short period of time and then later enroll in a plan with subsidies based on these new rules.

INCOME VERIFICATION RULES

The Health Connector opposes CMS's proposal to eliminate Marketplaces' acceptance of income attestation when the IRS cannot verify household income because this is an issue

⁸ Note, ConnectorCare is up to 400 percent FPL in 2026.

with IRS data. Individuals and families should not have to face extra administrative burdens because of issues with the IRS's data (§155.320(c)(5)). Individuals and families should not have to experience burdensome, unnecessary, and costly consequences to correct for IRS data challenges. The Health Connector experienced a 40 percent reduction in income inconsistencies after implementing changes to consider income verified in the event of a non-income response from the IRS, indicating that the IRS fails to return income data in a large number of cases, even when a return has been filed by the applicant/enrollee. CMS's proposal to reverse the ability to accept attestation of income when no IRS data is available would result in significantly more individuals receiving unnecessary requests to prove their income, significantly increasing administrative burdens for applicants and members, and leading to coverage erosion. Such coverage erosion would adversely impact the merged market risk pool and increase premiums for all in the market, as adult applicants under age 45 are slightly more likely to receive a non-income response from the IRS, at 41.5 percent compared to 38.5 percent of applicants over 45.

Recent federal reports emphasize the lack of adequate staffing at the IRS, impacting the ability of the agency to process tax returns in a timely way, which could in turn lead to lack of data received from the IRS as part of Marketplace eligibility processes. A January 26, 2026, memo from the Deputy Inspector General to the Commissioner of Internal Revenue echoed the deep concerns that the Taxpayer Advocate Service's 2025 Annual Report raised about the IRS's readiness for the 2026 Filing Season, taxpayer services, and tax processing.^{9,10} In 2025, the IRS saw a workforce reduction of 27 percent which spanned across all IRS functions. Significant staffing shortages and backlogs are expected to further worsen IRS data issues. The Health Connector often receives a response from the federal data services hub indicating that no tax return information was available to verify an applicant's attested income and has found that the receipt of a null income response from the IRS is not correlated with a particular income group or with a particular tax status. It is unclear why the IRS is unable to provide return information for these cases, but we do not support making it more difficult for individuals to obtain health insurance coverage as a result.

Maintaining continuous coverage is critical to a healthy risk pool. The Health Connector saw a significant decrease of about 33 percent in unnecessary subsidy loss due to unverified income during Open Enrollment 2025 as a direct result of accepting an individual's attestation of income when no income data was received from the IRS. Enabling eligible individuals to maintain their same level of coverage from one year to the next makes it more likely that people stay enrolled and supports a balanced, strong, and stable risk pool.

⁹ The Internal Revenue Service's Readiness for the 2026 Filing Season (Audit No.: 2026400002), at <https://www.tigta.gov/sites/default/files/reports/2026-01/2026400002-Readiness-Memo.pdf>

¹⁰ Taxpayer Advocate Service 2025 Annual Report to Congress, at <https://www.irs.gov/newsroom/national-taxpayer-advocate-delivers-annual-report-to-congress-finds-taxpayer-service-was-strong-in-2025-but-foresees-challenges-for-taxpayers-who-encounter-problems-in-2026>

The Health Connector opposes CMS's proposal to verify income when data sources indicate household income is less than 100 percent FPL because this policy would not help the Health Connector advance program integrity and would only create unnecessary and costly operational and administrative burdens (§ 155.320(c)(3)(iii)). CMS presents data within the proposed rule to support this proposal by highlighting FFM program integrity gaps related to unauthorized broker enrollments. In Massachusetts, where unauthorized broker enrollments literally do not exist due to our proactive decision to never allow them in the first place due to our concerns about the risks of misuse of taxpayer resources, this policy only serves to penalize low-income individuals with unpredictable incomes. Further, Massachusetts has an integrated Marketplace-Medicaid eligibility system, which more accurately helps residents qualify for the correct coverage. This means that individuals who apply for coverage will be considered eligible for Medicaid or eligible for Marketplace coverage with APTC simultaneously, depending on their income. Longstanding rules suggest that if an individual attests to an income that is higher than what the federal data services hub tells us, we should believe the attestation and adjust their eligibility accordingly so as to not provide more APTC than they are eligible for. This is often the case when someone secures a new job that may have changed their income relative to the previous year's tax return. It is irrational and inconsistent to apply this rule to applicants who report income above 100 percent FPL and have an electronic data source similarly report income above 100 percent, but a completely different rule to those who attest to income above 100 percent FPL but have an electronic data source report income below 100 percent FPL.

This proposed rule would turn this longstanding rule on its head. In a Medicaid-expansion state like Massachusetts, a person who attested to income above 100 percent FPL but received an electronic data report of income below 100 percent FPL would newly be issued a DMI. If that person takes no action to respond to the DMI, their eligibility would be redetermined based on the data provided by the hub, which would then provide them with Medicaid eligibility. It is unclear if this is the intended outcome of the proposed rule. Regardless, this inconsistent application of rules based on an applicant's income is unnecessary and does not solve any program integrity concerns for the Marketplace or Medicaid. Program integrity should be considered more holistically, as this does not make programmatic sense from a Medicaid perspective. **To resolve this inconsistency, this rule should not apply in Medicaid expansion states.**

In addition, it bears repeating that Massachusetts does not have and has never had agents, brokers, and web-brokers enrolling people in individual Marketplace coverage because we did not believe they would be able to uphold our high standards of program integrity, and we therefore do not experience the same issues that the FFM experiences related to these entities. As a result, applying this one-size-fits-all proposal to SBMs like Massachusetts—a Medicaid expansion state with an integrated eligibility system and without agents, brokers, or web-brokers involved in the Marketplace—would only create costly and unnecessary

administrative and operational burdens without any added benefit. We respectfully disagree with CMS' statement that long-term program integrity savings would outweigh the operational costs to Marketplaces and CMS provides no evidence to demonstrate that there are any such program integrity issues to solve for SBMs. For example, HHS states that nearly 80 percent of income data matching issues were generated for households who worked with an agent, broker, or web-broker. Massachusetts does not have any such agents involved in our SBM. Additionally, the new data CMS offers to support this proposal and highlight what they refer to as "obvious risk" is solely focused on unauthorized FFM enrollments and CMS does not specify whether these unauthorized enrollments on the FFM were linked to income verifications or to individuals whose income is below 100 percent FPL.¹¹

The Health Connector appreciates the flexibility to apply the two-year FTR policy for plan year 2027 because Massachusetts does not have the same issues with agent, broker, and web-broker improper enrollments that CMS describes the FFM having and is concerned about the impact of IRS data challenges (§155.305(f)(4)). CMS argues that one of the reasons to deny APTCs after one year instead of two is because agents, brokers, and web-brokers are improperly enrolling people in coverage with APTC without their knowledge. The Health Connector does not permit and has never permitted the use of agents, brokers, web-brokers, or private external entities, such as direct-enrollment entities, to enroll individuals and families in the individual market. Instead, the Health Connector relies on a network of qualified Assistants who receive robust training, especially around reconciliation rules. In addition, challenges with timely and reliable data from the IRS, as detailed by the Inspector General, may inadvertently lead to denial of APTC to individuals who have submitted taxes and reconciled, but the IRS has not processed them due to delays.¹² We thank CMS for proposing to give SBMs the flexibility to adopt the one-year or two-year policy for the 2027 plan year. Having a longer timeframe to implement system changes that significantly impact applicants and members in Massachusetts is greatly appreciated.

PLAN DESIGN, BENEFITS, AND REQUIREMENTS

The Health Connector has extensive experience in managing our insurance market successfully and responsibly in partnership with the Massachusetts Division of Insurance. Massachusetts is well positioned to continue to monitor cost-sharing reduction (CSR) loading in the absence of federal appropriation of CSRs. Additional federal reporting will increase costs and administrative burdens, potentially increasing premiums, without creating any clear value for Massachusetts (§ 154.215). As has long been recognized by CMS and other federal partners, states are and continue to be best suited to understand the unique aspects of their

¹¹ CMS Actions to Protect Consumers and Strengthen Exchange Program Integrity at, <https://www.cms.gov/newsroom/fact-sheets/cms-actions-protect-consumers-strengthen-exchange-program-integrity>

¹² The Internal Revenue Service's Readiness for the 2026 Filing Season (Audit No.: 2026400002), at <https://www.tigta.gov/sites/default/files/reports/2026-01/2026400002-Readiness-Memo.pdf>

local markets and to oversee them. In 2017, Massachusetts and other states began “silver loading” to make up the difference in unpaid CSR with increased APTC. Massachusetts has a robust Effective Rate Review Program and has responsibly and successfully overseen how insurers make up for unpaid federal CSRs. CMS states that this new reporting requirement would cost \$1.14 million per insurer in the first year in addition to annual costs of more than \$574,000 per insurer per year. Additionally, CMS states that it will cost the federal government more than \$2.4 million per year to review and evaluate the CSR-related information submitted by insurers. The Commonwealth has already proven that it is best suited to handle how insurers manage the CSR load and information; adding these costly and burdensome requirements on issuers and the federal government is unnecessary. Increased costs and burden for insurers could further increase premiums for all market segments at a time when people are already struggling to afford coverage due to recent federal policy changes. We recommend that CMS allow states and their Divisions of Insurance to continue to monitor their market’s CSR loading since they are best positioned to do this work. As the longest-running SBM in the country, Massachusetts’s unique policy context only amplifies the need for tailored, data-driven approaches to ensure shared goals and positive outcomes are achieved.

The Health Connector recommends that CMS not finalize their proposal to require states to defray state-mandated benefits included in the state’s EHB-benchmark plan for 2027 because it would be challenging for states to implement on such a short time frame and would erode important protections for consumers (§ 155.170). Considering the late release of the proposed 2027 NBPP, implementing this change for 2027 would create too many administrative and budgetary challenges on top of the many other changes already required. States just recently changed this policy at CMS’s direction under the 2025 NBPP—reverting back to the policy before the final 2025 NBPP will create significant waste and inefficiencies without a clear benefit to consumers or the market. In addition, this proposed policy would increase costs for consumers by treating more benefits as non-EHB. ACA consumer protections such as the ban on dollar limits and cap on annual out-of-pocket costs would no longer apply to benefits considered non-EHB, exposing individuals and families to higher premiums and out-of-pocket costs, on average. CMS acknowledges that states looking to reassess their current mandated benefits may need additional time, given legislative calendars, and we agree that additional time is needed for states to respond, should CMS finalize this reversal of its current policy.

The Health Connector urges CMS not to finalize proposals to allow Bronze plans with out-of-pocket maximums in excess of the annual limit or to require that Catastrophic plans offer no benefits until an amount equal to 130 percent of the out-of-pocket limit has been incurred. Allowing and/or requiring these plans to exceed the annual limit would cause financial harm to individuals and families (§§ 156.136 and 156.155). Out-of-pocket limits exist under the ACA to protect members from significant financial hardship when they need to access care.

While Bronze and Catastrophic plans expose individuals to extremely high out-of-pocket costs, allowing plans to exceed the annual limit would only exacerbate affordability challenges even further. Continuing to erode affordability will lead to increased medical debt and forgone care. According to the Health Connector’s 2025 Member Experience Survey, 15 percent of members in Bronze or Catastrophic plans reported problems paying or were unable to pay medical bills in the last 6 months, and 34 percent of members in Bronze or Catastrophic plans reported delaying or forgoing health care due to cost in the past 6 months. Feedback from members suggests that the prevalence of Bronze plans closer to the high end of the allowable actuarial value range is not because plans are “mathematically impossible” to create at lower actuarial values, but because consumers do not find those plans valuable. Catastrophic plans are even less popular in Massachusetts, with only 0.19% of the Health Connector’s more than 351,000 individual market enrollees choosing a catastrophic plan.¹³

While we recognize the challenges that the federal actuarial value calculator (FAVC) calculator creates in designing Bronze plans, we do not think that allowing plans to exceed the out-of-pocket limits is the answer. The text of Section 1302 of the ACA prescribes clear and specific limits on out-of-pocket limits and the proposed change to Bronze plans disregards those unqualified limits. Instead of focusing on increasing the out-of-pocket limits, CMS could explore other policy opportunities to address challenges with the FAVC or health care affordability more broadly. We welcome CMS’ partnership in addressing the growing challenge of designing affordable, quality plans under the FAVC requirements and would support CMS convening stakeholders to discuss the growing challenge of designing ACA-compliant tier plans that feature reasonable cost-sharing levels.

The Health Connector and Division of Insurance have concerns about CMS’s proposal to allow multi-year catastrophic plan contracts for up to ten years and generally advises CMS against focusing on increasing enrollment in Catastrophic plans as a response to the affordability challenges individuals and families face (§ 156.80(d)(2)(ii)). Multi-year plans may create issuer solvency issues and destabilize insurance markets. Such plans create uncertainty in whether set rates are sufficient to pay for the enrolled population long-term. As we all experienced with the Covid-19 pandemic, certain unforeseen circumstances may negatively impact a population’s health and worsen their risk profile unexpectedly. The risk of unforeseen circumstances, whether a major public health event or unexpected individual health development, is exacerbated by a longer-term contract. While the population enrolling in catastrophic plans is “supposed to be” a healthier, lower risk group, when rates are set for multiple years, this assumption may not hold over time. No one plans to develop a chronic condition, have a life-altering physical accident, receive a cancer diagnosis, or have a family member develop a substance use disorder. In general, we recommend that CMS not rely on

¹³ Massachusetts Health Connector. (2026). February 2026 Health Connector Enrollment Report. Available at <https://www.mahealthconnector.org/about/data-and-reporting/health-connector-monthly-enrollment-dashboard>

enrollment in catastrophic coverage or multi-year contracts to address the significant affordability challenges Americans face today.

In addition, individuals who enroll in multi-year catastrophic coverage would not need to reassess or reverify their eligibility on an annual basis which conflicts with the arguments CMS makes about the importance of people re-verifying eligibility in other coverage. We strongly recommend that CMS not allow insurers to vary the maximum out-of-pocket limits by disease and ensure that ACA market reforms, including guaranteed issue and age rating, are fully preserved in any affordability policy options CMS considers.

The Health Connector and Division of Insurance support flexibility for states and SBMs to make important choices for their own markets, including whether to certify non-network plans, align with federal network adequacy standards, and to choose their own Medical Loss Ratios (MLR) (§ 156.236, 155.1050). States and SBMs are best positioned to make these decisions for their own markets, and we appreciate the ability to continue to make thoughtful choices for Massachusetts residents informed by our data and unique experience. Through a non-network plan, individuals and families may be responsible for paying a provider the full cost of a benefit or services or a much higher portion compared to a plan with a network, either leaving them with extremely high medical bills or rendering their coverage useless and causing people to forgo care. We are thankful for the option to not certify or sell these plans because these plans put individuals at greater risk of not fully understanding the financial and administrative burden associated with non-network plans and erode the robust standards offered by QHPs that offer them more predictable, robust coverage. The Health Connector also appreciates the ability to continue with our current approach to use the federal network adequacy standards, which required significant time and resources to implement. Moreover, we appreciate the opportunity to modify this approach if needed so we can continue to respond to the unique local needs of our market. Finally, we urge CMS to continue to allow states to choose their own Medical Loss Ratios (MLR) that works best for their own markets. Massachusetts has maintained a higher MLR than what is required under the ACA and continues to be among the states with the most affordable premiums along with a robust and competitive individual market.¹⁴ The Commonwealth's higher MLR works for our unique market, carriers, and consumers.

ELIGIBILITY FOR APTCs

We appreciate the guidance on required attestations for “eligible noncitizens” but is concerned about the short timeframe for implementation, and respectfully requests that CMS delay enforcement of the attestation requirement at (§§ 155.20, 155.305(f)(1), and

¹⁴ KFF. (2026) Average Monthly Marketplace Premiums by Tier. Available at <https://www.kff.org/affordable-care-act/state-indicator/average-marketplace-premiums-by-metal-tier>

155.320). At this point, the restriction of APTC eligibility for a subset of lawfully present non-citizens required by the One Big Beautiful Bill Act would likely result in about 30,000 currently enrolled individuals losing eligibility for APTC. We also expect that this eligibility change is going to worsen the risk pool among those who qualify for APTC, and due to the lack of affordability of coverage without APTC, we expect many of these individuals will drop out of Marketplace coverage all together.

We appreciate that CMS has provided updated guidance to require the option for individuals to attest to their status as an “eligible noncitizen” to be able to align that input with the updated guidance from the Verify Lawful Presence (VLP) service. We believe this is a valuable requirement for members so they can provide the Health Connector with accurate information about their immigration status. The Health Connector has already been engaged in several months of systems design conversations with our eligibility system vendor and our state Medicaid agency and is now having to completely rebuild the systems approach to incorporate these functional requirements. While the Connector is aiming for a timely implementation of both the attestation requirement and the use of updated VLP data, we respectfully request ongoing dialogue with CMS about the good-faith efforts states are making based on existing guidance to be ready for eligibility determinations for the 2027 plan year, which begin for the Health Connector in August 2026. This is another example of the importance of timely guidance from CMS. The Health Connector is essentially having to build these system changes twice due to the lack of timely guidance. This is a costly approach to systems design, leading to unnecessary staff time and increasing the likelihood of systems errors upon final execution.

While we strongly support the attestation approach detailed in the proposed rule and seek to implement it in time for plan year 2027, the timing of the guidance is problematic. We respectfully request that CMS delay enforcement of this provision, recognizing we are doing our due diligence to comply with the statute and implement systems changes as quickly as possible, while reducing the risk of errors or other adverse outcomes.

AGENTS, BROKERS, WEB-BROKERS, AND SBM-ENHANCED DIRECT ENROLLMENT

The Health Connector and Division of Insurance support any efforts to tighten standards for agents, brokers, and web-brokers in the Marketplaces that rely on them to ensure everyone can access high quality and accurate help, though the Health Connector does not have agents, brokers, or web-brokers associated with individual market applications due to program integrity concerns, instead relying on highly trained and qualified Assisters (§155.220(g)(2)). The Health Connector appreciates the ability to not allow agents, brokers, and web-brokers to assist individuals and families with applying for and enrolling in coverage and instead rely on qualified Assisters, such as Navigators and Certified Application Counselors (CACs). The Health Connector proactively chose not to allow these entities for the same program integrity concerns that CMS now identifies and highlights using FFM data. The extensive training

provided to the Health Connector's Assistants has greatly contributed to the strength of our program integrity. State flexibility to establish qualifications for trained assistants and our careful decision to not permit agents, brokers, web-brokers, or direct-enrollment entities to assist individuals with applying, shopping for, and enrolling in health insurance has resulted in robust consumer protection for Health Connector members. The Health Connector supports CMS's proposal to strengthen HHS' ability to hold agents, brokers, and web-brokers accountable. This change would improve transparency in the process for holding these entities accountable for compliance with applicable law, regulatory requirements, and their Marketplace Agreements and protect consumers from the impacts of potential noncompliance, including improper enrollments.

As the longest-running State-Based Marketplace in the country, the Health Connector has extensive experience in successfully operating an SBM with robust program integrity standards. The Health Connector has significant concerns related to expanding SBM-Enhanced Direct Enrollment (SBM-EDE) options due to the many risks such decentralized options pose to program integrity, consumer protection, value, and competition (§ 155.221(k)). The Health Connector supports CMS's goals of providing flexibility to States to respond to the unique local needs of markets and residents. However, the Health Connector also appreciates that such flexibility needs evidence-based guardrails to preserve program integrity. Thus, the Health Connector does not support the expanded use of direct enrollment entities because doing so would undermine the purchasing power and trusted brand of Marketplaces nationwide. CMS's direct enrollment proposals run counter to the intent and purpose of the ACA by reducing program integrity, consumer protections, interfering with transparency and competition, and providing no clear value over existing Marketplace pathways.

- **The SBM-EDE option worsens program integrity by relying exclusively on web-brokers to operate the consumer-facing websites that facilitate the applicant eligibility and enrollment process.** Expanded reliance on web-brokers will threaten our shared program integrity goals for all Marketplaces. In the proposed 2027 NBPP, CMS notes that they have observed agents, brokers, and web-brokers enrolling consumers with inaccurate information to conceal unauthorized enrollments and detailed these entities' potential for harming consumers. The extensive list of program integrity issues web-brokers present, as highlighted by CMS, cannot be fully rectified by new standards and requirements CMS proposes.
- **Decentralizing Marketplace enrollment functions erodes consumer protections.** Without a clear, consistent, and trustworthy pathway to enrollment, consumers are likely to struggle in finding the health coverage benefits they need and to which they are entitled. One common source of fraud that the Health Connector and Division of Insurance encounter across the insurance market is by residents who come across another entity falsely

claiming to provide Marketplace enrollment functions and instead end up enrolling in a product that is not certified by the Marketplace. Encouraging multiple entities to provide a pathway to Marketplace coverage will further confuse individuals, and make it even more difficult for an individual to tell the difference between a legitimate enrollment entity and a fraudulent actor. Consumers interacting with a direct enrollment entity may not be made aware of eligibility for certain programs and instead be directed to options that are less affordable and less generous than what they would have been determined eligible for through a centralized and streamlined application. Consumers left unaware of their eligibility may choose to forgo coverage altogether. Consumers are already confused by the actions of private companies with misleading and deceptive marketing practices. The expansion of direct enrollment entities exacerbates this problem and creates additional challenges for consumers trying to find their way to legitimate, comprehensive coverage.

- **Marketplaces encourage competition, allowing consumers to make “apples-to-apples” comparisons of available Qualified Health Plans by displaying all options available along with important comparative information such as premiums, cost-sharing information, and provider directories.** This impartial and complete display of certified plans promotes competition and informs consumers that all coverage options through a Marketplace are comprehensive and trustworthy. Direct enrollment entities complicate the shopping process for consumers and risk decreasing competition due to the differences in plan and information display requirements.
- **There is no clear or convincing evidence that SBM-EDE pathways provide more value than ACA exchanges.** A push towards a decentralized SBM-EDE when SBMs have a proven track record of success appears unsupported by evidence. Massachusetts’s 2006 landmark health care reform law demonstrated the value and effectiveness of establishing a centralized health insurance exchange. In the first two years of the Health Connector’s existence, nearly 440,000 Massachusetts residents became newly insured, half of which were enrolled in unsubsidized private plans.¹⁵ Establishing a centralized health insurance exchange helped to propel the Commonwealth from seventh place in the percentage of insured residents to first place, a ranking Massachusetts has maintained over time.¹⁶

Thank you for your careful consideration of our evidence-based perspectives, which are informed by nineteen years of serving as the Massachusetts health insurance marketplace, with the nation’s lowest rate of uninsured, the country’s healthiest population, and among the lowest Marketplace premiums in the nation.

¹⁵ Report to the Massachusetts Legislature Implementation of the Health Care Reform Law, Chapter 58 2006-2008

¹⁶ KFF, at <https://www.kff.org/wp-content/uploads/2013/01/8311.pdf>

The Health Connector and Division of Insurance are committed to protecting and advancing program integrity, addressing affordability for all Massachusetts residents, including the unsubsidized population, and maintaining a stable, robust merged market. Thank you for consideration of these comments in pursuit of the shared goal of a high-functioning Marketplace. Massachusetts has demonstrated the power of state-driven health policy with the Commonwealth's near universal health coverage rate and looks forward to building on its success in partnership with CMS.

Sincerely,



Audrey Morse Gasteier
Executive Director



Michael T. Caljouw
Commissioner of Insurance