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Submitted via www.regulations.gov

Secretary Robert F. Kennedy, Jr.
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Administrator Mehmet Oz
Centers for Medicare and Medicaid Services
7500 Security Boulevard
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Re: Comment Regarding "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program" Proposed Rule, Docket No. CMS-9883-P, RIN 0938-AV62, 91 FR 6292 (Feb. 11, 2026)

Dear Secretary Kennedy and Administrator Oz:

Governing for Impact ("GFI") submits this comment on a proposed rule, "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program" ("the Proposed Rule"), issued by the Centers for Medicare and Medicaid Services ("CMS") within the Department of Health and Human Services ("HHS").[1] GFI is a regulatory policy organization dedicated to ensuring that the federal government operates more effectively for everyday working Americans.[2]

The Proposed Rule introduces a host of changes to Marketplace plans, eligibility, and enrollment, including some that, if finalized, would exceed the agencies' regulatory authority under the Affordable Care Act ("ACA") and violate the Administrative Procedure Act's requirements.[3] Because the unusually short comment period does not provide us with adequate time to analyze all of the Proposed Rule's provisions, we focus on its provisions relating to the State-Based Exchange Enhanced Direct Enrollment pathway, the expansion of catastrophic plans and plan design, the failure to file and reconcile amendments, burdensome new income and other verification requirements, and the elimination of the standardized plan designs. Taken together, these proposals undermine the ACA's basic goals by limiting consumer choice, access, and plan affordability. We therefore respectfully request that the agency withdraw these provisions of the Proposed Rule. We

[1] U.S. Dep't Health and Hum. Serv., Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program, 91 Fed. Reg. 6292 (Feb. 11, 2026).
[2] Governing for Impact, https://governingforimpact.org/.
[3] *See generally* 42 U.S.C. §§ 18031, 18052; 5 U.S.C. § 706(2)(A), (C).

also request that the agency disclose any use of artificial intelligence in this rulemaking and extend the comment period to allow adequate time for the public to comment on all of CMS's proposals.

I. The proposed State-Based Exchange Enhanced Direct Enrollment pathway (45 C.F.R. Part 155) is not authorized by the ACA and is arbitrary and capricious.

The Proposed Rule would allow states to implement State-Based Exchange Enhanced Direct Enrollment ("SBE-EDE") as the exclusive pathway through which consumers can apply, receive an eligibility determination, and purchase an individual market qualified health plan ("QHP").[4] Rather than requiring states to establish and maintain a centralized exchange website (like Healthcare.gov) where consumers can compare, select, and enroll in QHPs, as they have been able to do for over a decade, the Proposed Rule would permit states to "rely entirely on web-brokers (a type of non-Exchange entity) for implementing and operating consumer-facing websites that facilitate the eligibility and enrollment process in a State Exchange."[5] That change conflicts with the overall structure and design of the ACA, including many of its specific requirements. And by empowering self-interested parties like web brokers and other private companies, the Proposed Rule would make it more difficult for consumers to enroll in the plans that are appropriate for them while exacerbating the potential for fraud and improper enrollment by agents and brokers.

A. *The SBE-EDE proposal is contrary to the ACA's requirements.*

The ACA requires states to provide a centralized website where consumers can complete the enrollment process, from start to finish. Specifically, Section 1311(b) of the ACA requires states to establish an Exchange that "facilitates the purchase of qualified health plans."[6] That Exchange must "be a governmental agency or nonprofit entity that is established by a State" and "[o]ffer[] … coverage"—i.e., it must "make available qualified health plans to qualified individuals and qualified employers."[7] Section 1311 further requires the HHS Secretary to maintain, and offer to state Exchanges as a template, a website to direct consumers to QHPs, assist them in determining eligibility for plans or financial assistance (whether premium tax credits or cost-sharing reductions), and to present standardized information to aid in comparison of available plans.[8] Taken together, the ACA envisions a "one-stop shop" where consumers could view and compare the full range of plan options, determine eligibility, apply, and enroll in Marketplace plans. The SBE-EDE proposal defies this purpose. Plans have not been meaningfully offered or made available by the Exchange if a consumer is required to visit another website to complete the enrollment process.

This understanding is also consistent with the structure and purpose of the ACA. As a GAO Report published shortly after the enactment of the ACA concluded, Exchanges were meant to "provide a seamless, single point of access for individuals to enroll into private health plans, apply for income-based financial subsidies established under the law, and, as applicable, obtain an eligibility

[4] 91 Fed. Reg. 6300.
[5] 91 Fed. Reg. 6328.
[6] 42 U.S.C. § 18031(b)(1)(A).
[7] 42 U.S.C. § 18031(d).
[8] 42 U.S.C. § 18031(c)(5)(B).

determination for other health coverage programs."[9] To that end, Sections 1103(b)(1) and 1311(d)(4)(E) require Exchanges to provide information about coverage options in a "standardized format," meaning one that does not vary depending on decisions made by private web-brokers.[10] And Section 1401 extends premium tax credits, a core feature of the ACA, to taxpayers "enrolled in through an Exchange established by the State," which presupposes that consumers are enrolled in QHPs through Exchanges themselves.[11]

CMS has also repeatedly affirmed its own understanding that the ACA requires Exchanges to serve as a comprehensive enrollment pathway. As CMS noted in 2021, "[o]ne of the primary advantages of th[e] [Exchange] design is that consumers can access one-stop shopping for all QHPs offered through an Exchange and can access relevant details on such plans in a standardized format."[12] CMS has also explained that allowing states to make EDEs the exclusive providers of eligibility and enrollment functions, would "unnecessarily fractur[e] enrollment processes."[13]

To justify its newfound change in course, CMS now insists that Sections 1311(c)(4) and (d)(4)(C) require only that Exchanges maintain a website where enrollees can obtain comparative information on available QHPs.[14] But CMS's reading would ignore Section 1311(b)(1)(A)'s general mandate that Exchanges facilitate the purchase of plans into the more specific requirement that they maintain a website with comparative information, depriving the latter mandate of meaning. That approach violates the "cardinal principle of statutory construction" that "a statute ought, upon the whole, to be so construed that, if it can be prevented, no clause, sentence, or word shall be superfluous, void, or insignificant."[15] CMS also asserts that requiring states to provide their own "consumer-facing, centralized eligibility and enrollment consumer website…may prohibitively restrict Exchange flexibility and innovation," but CMS's policy views provide no basis for overriding Congress's judgments about how Exchanges should function.[16]

The fact that CMS does not have the authority to allow for SBE-EDEs as proposed is further evidenced by its previous approval of a Section 1332 waiver permitting Georgia to establish a nearly identical pathway only after waiving multiple provisions of Section 1311. Section 1332 allows states

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[9] U.S. Gov't Accountability Off., GAO-13-601, Status of CMS Efforts to Establish Federally Facilitated Health Insurance Exchanges 2 (June 2013), https://www.gao.gov/assets/660/655291.pdf.
[10] 42 U.S.C. §§ 18003(b)(1), 18031(d)(4)(E).
[11] 26 U.S.C. § 36B(b)(2)(A). The ACA also refers to plans "offered through" an"Exchange" in numerous other places. *See, e.g.*, 42 U.S.C. §§ 18031(c)(1)(F), 18032(d)(3)(D)(i)(II).
[12] U.S. Dep'. Health and Hum. Serv. and U.S. Dep't. of the Treasury, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022; Updates to State Innovation Waiver (Section 1332 Waiver) Implementing Regulations, 86 Fed. Reg. 6178, 6141 (Jan. 19, 2021).
[13] U.S. Dep't Health and Hum. Serv. and U.S. Dep't. of the Treasury, Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond, 86 Fed. Reg. 53412, 53426 (Sep. 27, 2021). A version of CMS's SBE-EDE proposal was first finalized in January 2021 (though it never went into effect) in its 2022 payment notice. 86 Fed. Reg. 6141. HHS then rolled back that provision later that year finding that establishing a new EDE pathway would detract from other agency priorities and harm consumers by "unnecessarily fractioning enrollment processes[.]" 86 Fed. Reg. 53412, 53426.
[14] 91 Fed. Reg. 6329.
[15] *Duncan v. Walker*, 533 U.S. 167, 174 (2001) (internal quotations omitted).
[16] 91 Fed. Reg. 6328.

to apply to waive certain ACA provisions for state innovation.[17] In its waiver application, Georgia requested a partial waiver of Section 1311 to implement its Georgia Access Model, which would have allowed private web-brokers to deliver the front-end functions of plan shopping and enrollment using the federal EDE certification standards.[18] In CMS's approval of the waiver—which occurred only after multiple public comment periods, negotiations, and several modifications by the state—CMS agreed to waive subsections 1311(b), (c), (d), (e), and (i) of the ACA to the extent that they conflict with the Georgia Access Model.[19] There would have been no need to waive these requirements if they did not otherwise prohibit Georgia's proposed plan.

B. *The SBE-EDE proposal is arbitrary and capricious.*

Even if CMS had authority to allow SBE-EDEs, the proposal does not meet the basic requirements for reasoned decisionmaking under the APA. When an agency "acts inconsistently with an earlier position" or "reverses its former views as to the proper course" on a given issue, it is changing its position.[20] As noted above, CMS has previously interpreted Section 1311 to provide a "one-stop shop" for Exchange plans,[21] and has declined to pursue similar SBE-EDE proposals because they would "unnecessarily fractur[e]" the enrollment process.[22] Now the agency proposes to change course, asserting without evidence that the EDE process can "enhance the consumer enrollment experience" and improve Exchange "flexibility and innovation,"[23] but CMS provides no basis for dismissing its prior concerns about the fractioning of the enrollment process.

Moreover, an agency's decision cannot be based on "internally inconsistent" reasoning.[24] CMS's proposal to empower agents, brokers, and web-brokers through the SBE-EDE format directly contradicts the agency's stated concerns about how those companies have engaged in fraud and abuse—concerns it aims to address elsewhere in the Proposed Rule by regulating them more closely.[25] As CMS itself notes, it has "observed numerous abusive, misleading, and coercive practices that harm consumers both financially and medically, necessitating these proposed amendments."[26]

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[17] 42 U.S.C. § 18052.
[18] Georgia Section 1332 State Innovation Initial Waiver Application 17 (Oct. 9, 2020), available at: https://www.cms.gov/marketplace/states/section-1332-state-innovation-waivers#Section_1332_State_Application_Waiver_Applications1332.
[19] Georgia Approval Letter and STCs PDF page 28 (Nov. 1, 2020), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-/1332-GA-Approval-Letter-STCs.pdf.
[20] *Food & Drug Admin. v. Wages & White Lion Invs., L.L.C.*, 604 U.S. 542, 569-70 (2025) (internal quotations omitted).
[21] 86 Fed. Reg. 6141.
[22] 86 Fed. Reg. 53426.
[23] 91 Fed. Reg. 6328–30.
[24] *ANR Storage Co. v. FERC,* 904 F.3d 1020, 1024 (D.C. Cir. 2018); *Farmers Union Cent. Exch., Inc. v. FERC*, 734 F.2d 1486, 1520 (D.C. Cir. 1984). *See also*, *e.g.*, *Am. Fed'n of Gov't Emps., AFL-CIO v. Fed. Lab. Rels. Auth.*, 25 F.4th 1, 5–6 (D.C. Cir. 2022) ("To start, the policy statement's description of the problem it seeks to solve is inconsistent.").
[25] 91 Fed. Reg. 6294.
[26] *Id.* at 6335, *citing* Gov't Accountability Office, Patient Protection and Affordable Care Act: Preliminary Results from Ongoing Review Suggest Fraud Risks in the Advance Premium Tax Credit Persist, GAO-26-108742, (Dec. 3, 2025), https://www.gao.gov/products/gao-26-108742.

Indeed, abuse and fraud perpetrated by approved EDE platforms is well-documented. For example, in 2024, a class action lawsuit was filed against health insurance web-brokers leveraging data from the EDE platform to run fraudulent ads, replace consumers' healthcare plans with similar or worse plans to generate commissions, and create falsified additional or multiple policies for consumers without their consent, among other tactics.[27] Between January and August 2024, CMS received 183,533 complaints of unauthorized enrollments.[28] CMS suspended 850 brokers for suspicion of fraudulent or abusive behaviors, some of which included web-brokers using the EDE process, but then inexplicably reinstated many of the suspended brokers in 2025.[29]

Instead of limiting the role of EDEs within Exchanges, given documented evidence that they have perpetuated fraud, the agency has counterintuitively decided to build on what it refers to as the "success" of the EDE pathways and expand EDE utilization by State Exchanges. But the agency has no experience with state EDE pathways as proposed. Georgia's 1332 waiver was later suspended in part out of concern that the Georgia Access Model would no longer satisfy statutory requirements under Section 1332. As such, the Georgia Access Model never took effect, meaning CMS has never seen this option in action. The agency's belief that the current EDE processes contribute to fraud and abuse in the Marketplace contradicts the agency's apparent position that states should be allowed to turn Marketplace enrollment over to EDEs entirely. For these reasons, the agency has failed to engage in reasoned decisionmaking.

CMS also fails to address prior concerns raised by commenters—both on Georgia's waiver and in prior rulemaking—about an EDE Exchange option. For instance, CMS ignores that an "overwhelming majority of commenters" opposed a prior rule to allow for expanded EDE options because direct enrollment entities have potential conflicts of interest that could lead these entities to steer consumers to products that offer a higher commission, even if a different product is more appropriate for their needs.[30] Despite receiving significant prior comments, CMS makes no mention of how the new proposal would address this fundamental concern or other concerns previously raised by commenters.

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[27] Compl., *Turner et al. v. Enhance Health, LLC et al.*, Case No. 24-cv-60591 (S.D. Fla. filed Apr. 12, 2022), available at: https://litigationtracker.law.georgetown.edu/wp-content/uploads/2024/04/Conswallo_2024.04.12_COMPLAINT.pdf. The case has since been dismissed. *Turner et al. v. Enhance Health, LLC et al.*, Case No. 24-cv-60591 (S.D. Fla. filed May 30, 2025) (order on stipulation of dismissal), https://litigationtracker.law.georgetown.edu/wp-content/uploads/2024/04/Turner-et-al_2025.05.30_ORDER-ON-STIP-OF-DISMISSAL-OF-DEFS-TRUECOVERAGE-LLC-SPERIDIAN-TECHNOLOGIES-LLC-BENEFITALIGN-LLC-GIRISH-PANICKER-AND-MATTHEW-GOLDFUSS.pdf.

[28] Kaye Pestina *et al.*, Fraud in Marketplace Enrollment and Eligibility: Five Things to Know, Kaiser Fam. Found. (June 30, 2025), https://www.kff.org/patient-consumer-protections/fraud-in-marketplace-enrollment-and-eligibility-five-things-to-know/ (citing CMS Newsroom, CMS Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity (Oct. 17, 2024), https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity); Amy Lotven, Regulator Presses CCIIO on Broker Reinstatements, Inside Health Policy (April 14, 2025), https://insidehealthpolicy.com/daily-news/regulator-presses-cciio-broker-reinstatements#:~:text=CMS%20has%20reinstated%20agents%20and,least%20one%20state%20regulator%20who.

[29] *Id.*

[30] 86 Fed. Reg. 6147.

In addition, CMS offers no projections or estimates regarding the impact of the SBE-EDE proposal. CMS makes no attempt to estimate the burden that this proposal would place on consumers in states that take up the SBE-EDE option, such as the time it would take for consumers to navigate a new process and enroll or re-enroll through a new platform. CMS also does not estimate how such changes might affect enrollment levels and thus premiums, noting only that the proposal "may have varied impacts" and that a higher number of enrollment websites "might impact consumers and consumer behavior." In fact, the agency offers no data on the current use of EDE, even though the agency did so in prior rulemaking, and this data is available to CMS.[31]

Without these types of projections or current data, commenters are unable to fully assess and comment on CMS's claims that EDE pathways are a suitable replacement for HealthCare.gov or a centralized SBE, which are trusted sources of coverage for millions of Americans. If CMS wishes to proceed with this proposal—which would dramatically reshape enrollment in any state that takes up this option—it should first share such estimates and provide a new opportunity to comment.

II. The proposed changes to catastrophic plan eligibility, plan duration, and maximum-out-of-pocket costs (45 C.F.R. Part 155) are not authorized by the ACA and are arbitrary and capricious.

The Proposed Rule would significantly expand the availability of high-deductible, low-coverage catastrophic plans. First, the Proposed Rule would revise §155.605 to expand hardship exception eligibility to enroll in catastrophic plans, allowing individuals who are ineligible for advance payments of the premium tax credit ("APTC") or cost sharing reductions ("CSR") due to projected household income below 100 percent or above 250 percent of the federal poverty line ("FPL") to qualify.[32] It would also modify the requirements for catastrophic plans in §156.155 to allow enrollment for up to 10 consecutive years, among other changes to plan design and cost-sharing requirements.[33] Lastly, the Proposed Rule would amend §156.155 to allow catastrophic plans to offer plans with up to 130% of the annual limitation on cost-sharing set by Section 1302(c)(1) of the ACA.[34] Each of these proposals is unlawful and, taken together, arbitrary and capricious.

A. *CMS's proposal to expand the hardship exception is not authorized by the ACA.*

The Proposed Rule would essentially codify CMS's 2025 guidance allowing any individual ineligible for APTC or CSR due to projected household income (those that are either below the 100 percent or above the 250 percent FPL) to purchase a catastrophic plan.[35] CMS argues that this change would "improve access to affordable coverage…as [the agency] believe[s] there are a substantial number of consumers for whom purchasing a QHP relative to a catastrophic plan could cause a financial

[31] *Id.* at 6142.
[32] 91 Fed. Reg. 6301.
[33] *Id.* at 6302.
[34] *Id.* at 6482.
[35] 91 Fed. Reg. 6353, citing CMS, Guidance on Hardship Exemptions for Individuals Ineligible for Advance Payment of the Premium Tax Credit or Cost-sharing Reductions Due to Income, and Streamlining Exemption Pathways to Coverage (Sept. 4, 2025), https://www.cms.gov/files/document/guidance-hardsthe ishiip-exemptions.pdf.

hardship."[36] However, this proposal has no direct link to the affordability of QHP coverage—for example, an individual with 400% FPL who could afford a QHP would still be able to qualify for a catastrophic plan under this provision—and is therefore contrary to the ACA and CMS's own rationale.

The expansion of catastrophic eligibility is neither authorized by the statute nor supported by past agency practice. Aside from consumers who are under the age of 30, Section 1302(e) expressly limits catastrophic coverage to consumers who have no access to affordable coverage or are facing a hardship in affording coverage.[37] And under Section 1501, the hardship exemption applies to individuals who "have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan."[38] In structuring access to catastrophic plans, Congress was aware that some younger consumers and those who were unable to enroll in a Marketplace plan because of a hardship or affordability challenge may want access to Marketplace coverage even without premium tax credits. In response, Congress created a narrow and specific exemption to apply to only individuals under 30 or those who obtained an exemption from the ACA's individual mandate penalty.

CMS now proposes to rewrite these statutory eligibility criteria by functionally eliminating the age restriction and allowing individuals at a wide range of incomes to enroll in catastrophic plans. Had Congress wanted to allow this eligibility without regard to age or based on specific income levels, it would have done so clearly when it wrote the ACA. Congress also could have made these changes in subsequent legislative amendments with respect to catastrophic plans, including changes made over the past year, but it did not do so. Specifically, in July 2025, Congress made catastrophic plans eligible to be paired with health savings accounts but did not amend the statutory eligibility criteria.[39] And, in December 2025, Congress considered, but failed to advance, legislation that would have done what CMS now proposes to do by codifying and expanding upon CMS's fall guidance.[40] As such, Section 1302(e) remains as it was when Congress enacted the ACA, and CMS is not free to rewrite these eligibility criteria.

The hardship exception is limited to particular circumstances, like if an individual would face "deprivation of food, shelter, clothing or other necessities" if they purchased a QHP, or if the individual has experienced an unexpected event creating an increase in essential expenses preventing them from purchasing a QHP.[41] In contrast, the Proposed Rule would add an exemption without

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[36] 91 Fed. Reg. 6354.
[37] 42 U.S.C. § 18022(e)(2), referencing 26 U.S.C. § 5000A(e)(1) (affordable coverage) and § 5000A(e)(5) (hardship).
[38] 26 U.S.C. § 5000A(e)(5).
[39] H.R.1 - 119th Congress (2025-2026): An act to provide for reconciliation pursuant to title II of H. Con. Res. 14, H.R.1, 119th Cong. (2025), Sec. 71307, https://www.congress.gov/bill/119th-congress/house-bill/1/text.
[40] S.3386 - 119th Congress (2025-2026): Health Care Freedom for Patients Act of 2025, S.3386, 119th Cong. (2025), Sec. 104, https://www.congress.gov/bill/119th-congress/senate-bill/3386.
[41] 45 C.F.R. § 155.605(d)(1). Subsequent guidance provided other circumstances where marketplaces could provide a hardship exemption, if they prevented an individual from obtaining coverage under a QHP. CMS, Guidance on Hardship Exemption Criteria and Special Enrollment Periods (June 26, 2013), available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/exemptions-guidance-6-26-2013.pdf.

any reference to an individual's particular inability to afford a QHP.[42] By automatically allowing hardship exemptions for all consumers who are either below the 100 percent or above the 250 percent FPL and therefore ineligible for APTC or CSRs, CMS would impermissibly bypass the ACA's requirement that hardship be determined by a consumer's specific inability to afford a QHP.

B. *The Proposed Rule's 10-year plan term violates the ACA's limits on catastrophic plan duration and eligibility.*

CMS asserts it has authority under Section 2713(c) of the Public Health Service Act to allow value-based insurance designs, including the novel idea of allowing catastrophic plans to offer multi-year plans up to 10 consecutive years based on an initial eligibility determination.[43] But Section 2713(c) of the PHAS—which governs the coverage of preventive services under the ACA—does not grant CMS broad authority to change the statutory definition of catastrophic plans. And Section 1302(e) of the ACA repeatedly references single plan years and mandates annual eligibility determinations.[44] Indeed, Section 1302(e) of the ACA provides that catastrophic plans must provide "no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect…for *the plan year*."[45] The ACA therefore does not permit catastrophic plans with terms longer than one year.

Moreover, by allowing plans to extend long after an individual has actually qualified for a hardship exemption, CMS is, in effect, impermissibly waiving the eligibility requirements for any plan year in which an individual does not meet the eligibility requirements. For example, the individual mandate penalty exemptions in the Internal Revenue Code—which allow eligible consumers to enroll in catastrophic plans without incurring a penalty—are determined on a monthly or yearly basis.[46] Section 1302(e) defines individuals who are eligible for catastrophic plan coverage as those who qualify for the same IRC exemptions.[47] Congress made specific eligibility determination periods attach to both the individual mandate and catastrophic plan eligibility, further highlighting their intent to only allow individuals to enroll in substandard plans when they are actually facing difficulty affording better coverage.

[42] *Compare* 91 Fed. Reg. 6476 *with* 45 C.F.R. § 155.605(d)(1) (limiting each hardship exemption to those that directly affect an individual's ability to obtain coverage under a QHP).
[43] 91 Fed. Reg. at 6370–72.
[44] *See* 42 U.S.C. § 18022(e) (defining catastrophic health plans as meeting coverage requirements if they meet certain requirements "with respect to any plan year[;]" requiring catastrophic plans to provide essential health benefits unless an individual has met the cost-sharing limits for the plan year; and determining eligibility based on being younger than 30 years old or obtaining an exemption during a specific plan year.)..
[45] *Id.* § 18022(e)(1)(B)(i) (emphasis added).
[46] 26 U.S.C. § 5000A(e)(1) (determining eligibility due to unaffordability on an annual basis); *id.* at (e)(5) (determining hardship eligibility on a monthly basis).
[47] 42 U.S.C. § 18022(e) (individuals are eligible for enrollment if they "[have] a certification in effect for any plan year under this title that the individual is exempt from the requirement under [26 U.S.C. § 5000A(e)(1) or § 5000A(e)(5)]").

C. *The proposed maximum out-of-pocket limits also violate the ACA.*

Section 1302(e) of the ACA also requires catastrophic plans to limit cost-sharing to the annual limitation set for QHPs.[48] Nevertheless, CMS proposes to increase the cost-sharing maximum to up to 130% of the QHP limit, beginning in PY 2027.[49] The agency argues that this would incentivize enrollment because issuers would offer plans at lower premiums, and the additional 30% would offset issuer costs.[50] But nowhere in the statute does Congress give CMS the authority to raise the out-of-pocket maximums for catastrophic plans, the agency's policy views notwithstanding.[51]

The agency claims it must raise the out-of-pocket maximum for catastrophic plans to "address an irreconcilable conflict between section 1302(c) through (e) of the [ACA]" which supposedly makes it impossible for bronze plans and catastrophic plans to meet their actuarial value ("AV") requirements under the statute.[52] But CMS's description of the relevant ACA provisions is wrong. Catastrophic plans do not have a statutorily-mandated AV floor, and are defined by the fact that their AV is lower than the mandated 60% AV of bronze plans.[53] Even if there was an apparent inconsistency with the required AV and maximum out-of-pocket costs, the statute requires all health plans to abide by a maximum cost-sharing requirement, set annually by HHS using the statute's formula.[54] Were it actually impossible to offer plans that meet these standards (which CMS affirms it is not), catastrophic or bronze plans simply would not be offered through the Marketplace. In order for catastrophic plans to require 30% more than the maximum cost-sharing requirement for all other health plans, Congress, not CMS, would need to amend the ACA. CMS cannot rewrite the statute or pick and choose which consumer protections should, or should not, apply to Marketplace coverage.

CMS also ignores the express requirement in Section 1302(e)(1)(B), which requires catastrophic plans to provide no benefits "until the individual has incurred cost-sharing expenses *in an amount equal to* the annual limitation in effect under subsection (c)(1) for the plan year."[55] Congress made clear that catastrophic plans must comply with the annual maximum cost-sharing limit, not a multiple of this amount as the agency has proposed.

D. *Even if CMS had the statutory authority to expand the use of catastrophic plans, its policy decision violates the APA's reasoned-decisionmaking requirement.*

Agency action is arbitrary and capricious if the agency "entirely failed to consider an important aspect of the problem, [or] offered an explanation for its decision that runs counter to the evidence before the agency."[56] The agency argues that increased access to catastrophic plans would result in

[48] *Id.* § 18022(e)(1)(B).
[49] 91 Fed. Reg. 6456.
[50] *Id.*
[51] CMS proposes a similar change for bronze plans without any upper limit on the out-of-pocket maximum; we oppose this change because the agency similarly lacks the authority to violate the ACA's out-of-pocket requirements as it relates to bronze plans. 91 Fed. Reg. 6380.
[52] *Id.* at 6456.
[53] 42 U.S.C. § 18022(d)(1)(A).
[54] *Id.* § 18022(c)(4).
[55] 42 U.S.C. § 18022(e)(1)(B). (emphasis added).
[56] *Motor Vehicle Manufacturers Ass'n of the United States, Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

more people enrolling in what CMS views as affordable coverage. However, the ACA does not charge CMS with ensuring that catastrophic plans have high enrollment levels. To the contrary, Congress set narrow eligibility restrictions to limit, not promote, enrollment in catastrophic plans. CMS is responsible for implementing and enforcing the law consistent with statutory requirements. It cannot abandon that responsibility to pursue its own goals of attempting to create a parallel catastrophic plan market that competes with metal-level Marketplace plans.

Further, catastrophic plans may offer lower premiums, but they also carry significantly higher levels of cost-sharing and provide poor coverage levels.[57] Some price-sensitive consumers may sign up for catastrophic plans because of low premiums, but will have a difficult time covering out-of-pocket costs when they actually need to use their insurance. A recent poll shows that about 6 in 10 Marketplace enrollees report having difficulty affording out-of-pocket costs for medical care, and about 37% of all U.S. adults reported that they would not be able to cover a $400 expense.[58] A $400 expense would equal about 4% of the current catastrophic individual deductible, which will undoubtedly increase if the Proposed Rule also increases the out-of-pocket maximums.[59] If healthy consumers (who would be most attracted to catastrophic plans) pull out of metal-level plans, that could also increase premiums for metal-level plans, since they would have a sicker risk pool.[60] Furthermore, research—which was available during the time CMS contemplated the Proposed Rule but which the Proposed Rule does not address—has shown that, for at least individuals between 250% and 400% FPL, expanding catastrophic eligibility will not improve premium affordability.[61]

Pushing consumers to lower-quality plans, while at the same time allowing catastrophic plans to increase out-of-pocket limits, contradicts the statute's mandate—and CMS's purported rationale—of lowering barriers to affordable healthcare. CMS has therefore failed to provide a "satisfactory explanation" for its decision.

III. The proposed failure to file and reconcile requirements (45 C.F.R. § 155.305(f)(4)) are contrary to law.

The Proposed Rule would require Federally-facilitated Exchanges ("FFEs") to adopt the 1-year failure to file and reconcile ("FTR") policy, and would make it optional for State-based Exchanges, during PY 2027.[62] Under this policy, Exchanges would be required to "determine a tax filer ineligible for APTC if: (1) HHS notifies the Exchange that the tax filer (or their spouse if the tax filer is a married couple) received APTC for a prior year for which tax data will be utilized for verification of

[57] Michelle Long, *et al.*, Policy Changes Bring Renewed Focus on High-Deductabile Health Plans, KFF (Jan. 5, 2026), https://www.kff.org/patient-consumer-protections/policy-changes-bring-renewed-focus-on-high-deductible-health-plans/ (*hereinafter* "KFF 2026 Report").
[58] Lunna Lopes, et al., 2025 KFF Marketplace Enrollees Survey, KFF (Dec. 4, 2025), https://www.kff.org/public-opinion/2025-kff-marketplace-enrollees-survey/#:~:text=and%20housing%20costs.-,Figure%204,-Many%20Marketplace%20Enrollees; KFF 2026 Report.
[59] KFF 2026 Report.
[60] *Id.*
[61] David M. Anderson *et al.*, Will expanding catastrophic coverage eligibility increase marketplace premium affordability in 2026? Health Aff Sch. 2025 Oct 23;3(11), doi: 10.1093/haschl/qxaf202.
[62] 91 Fed. Reg. 6301.

income, and (2) the tax filer or tax filer's spouse did not comply with the requirement to file a Federal income tax return and reconcile APTC for that year."[63]
CMS's prior attempt to establish this policy was stayed by the court in *City of Columbus v. Kennedy* on the grounds that the agency has no authority under the ACA to condition APTC eligibility on reconciling tax information.[64] That remains true. While the One Big Beautiful Bill Act ("OBBBA") establishes such a policy for all exchanges beginning in PY 2028,[65] it did not alter or amend the agency's authority to do so under the ACA for PY 2027. In the Proposed Rule, CMS recognizes that the provision does not apply until PY 2028, but believes that "it is important to begin implementing this policy in PY 2027 to protect people from accumulating tax liabilities."[66] Whether or not CMS believes that doing so is sound policy, CMS continues to lack the authority to impose the policy before PY 2027, and so the proposal is unlawful.

IV. The proposed SEP verification requirements for FFEs (45 C.F.R. § 155.420(g)) are arbitrary and capricious.

The Proposed Rule would require Exchanges using the Federal Platform to verify at least 75 percent of new SEP enrollments, including the loss of Minimum Essential Coverage ("MEC") SEP.[67] CMS finalized this same policy (with a sunset provision) in the 2025 Marketplace Integrity Rule, which was subsequently stayed in *City of Columbus v. Kennedy* on the grounds that the agency did not provide sufficient evidence that program integrity concerns existed or that the policy would ameliorate these concerns.[68]

The agency argues that it is reproposing the SEP verification policy ("SEPV") due to "the passage of the [OBBBA] legislation and additional insights from the resumption of SEPV for [MEC] that occurred on May 16, 2025."[69] However, the agency generally does not offer any additional evidence that it had not already considered during the 2025 Marketplace Integrity Rulemaking—evendence that the *Kennedy* court found lacking.[70] Its most recent analysis of the data mirrors its analysis of the same data found to be insufficient in the 2025 Marketplace Integrity Rule, and so is insufficient for the same reasons. For example, in both the 2025 Marketplace Integrity Rule and the current Proposed Rule, the agency relies on data from PY 2019 to conclude that the majority of consumers were able to submit documents to resolve SEP verification issues.[71]

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[63] *Id.*
[64] 796 F. Supp. 3d 123, 163 (D. Md. 2025) (appeal filed).
[65] H.R.1, 119th Cong. (2025), Sec. 71303.
[66] 91 Fed. Reg. 6344.
[67] 91 Fed. Reg. 6352.
[68] 796 F. Supp. 3d at 160 (explaining that "CMS offered no good reason to impose this burden on enrollees")(internal quotation omitted).
[69] 91 Fed. Reg. 6352.
[70] *Id.* For example, the agency relies on a 2016 GAO report which was used to support the 2017 Marketplace Stabilization rule and its own research of plan years between 2017 and 2021. *Id.*
[71] *Compare* 91 Fed. Reg. 6325 ("We conducted additional research for the following plan years through 2021. Based on data from PY 2019, the last year prior to the COVID19 PHE, which greatly impacted SEPV processing, the majority of consumers (73 percent) were able to submit documents within 14 days of their SEP verification issue (SVI) being generated. Also, we found that the majority of consumers (63 percent) were able to fully resolve their SVI within 14 days of it being generated. That resolution percentage increased to 86 percent by 30 days. We also found that for PY 2019,

The one piece of additional evidence that CMS does provide is data about SEPV trends observed after resuming the loss of MEC verification in 2025.[72] During this time, the agency notes a shift in consumer SEP selection, finding a decrease in loss of MEC SEPs and an increase in other SEPs.[73] The agency also notes that when SEPV was first implemented from 2017 to 2018, the loss of MEC SEP also decreased, though at a lower rate than in 2025.[74] The agency argues that these enrollment shifts suggest a "high likelihood action is being taken to intentionally avoid SEP verification."[75] But the Proposed Rule itself acknowledges some of these shifts naturally occur due to best SEP logic—consumers are encouraged to apply for the best SEP in their situation as they may qualify for several SEPs at the same time.[76] Thus, the agency has not provided sufficient evidence, other than a conclusory statement, to support its assumption that the shifts between verified and non-verified SEPs are due to intentional manipulation of non-verified SEP applications. Relying on that sort of "unwarranted assumption" is similarly not indicative of reasoned decisionmaking.[77]

Further, the agency's rationale does not address the *Kennedy* court's other issues with the agency's rationale in the 2025 Marketplace Integrity rule. For example, the court noted that the agency had failed "to address the very real concern raised by numerous commenters that the Rule change will improperly hinder the enrollment of eligible individuals."[78] The same is true for the 75% audit requirement in the Proposed Rule.[79] The additional SEP eligibility requirements would hinder enrollment because it would generate verification issues, producing administrative burdens that make consumers less likely to enroll—particularly younger and healthier people, thereby worsening the risk pool.[80] Because the agency has, once again, "entirely failed to consider an important aspect of the problem," the additional SEP verification requirements, if finalized, would likely be found to be arbitrary and capricious by a reviewing court.[81]

V. The proposed income verification requirements (45 C.F.R. § 155.320(c)(3)) are arbitrary and capricious.

In the Proposed Rule, CMS—for a third time—attempts to resuscitate an income verification policy for enrollees reporting less than 100% FPL. The Proposed Rule would amend §155.320(c)(3) to

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only approximately 14 percent or 75,500 individuals were unable to resolve their SVI out of the total population of SEP consumers who received an SVI.") *with* 90 Fed. Reg.FR 27149 ("We conducted additional research for the following plan years through 2021. Based on data from PY 2019, the last year prior to the PHE which greatly impacted SEPV processing, the majority of consumers (73 percent) were able to submit documents within 14 days of their SEP verification issue (SVI) being generated. Also, we found that the majority of consumers (63 percent) were able to fully resolve their SVI within 14 days of it being generated. That resolution percentage increases to 86 percent by 30 days. We also found that for PY 2019, only approximately 14 percent or 75,500 individuals were unable to resolve their SVI out of the total population of SEP consumers who received an SVI.").

[72] 91 Fed. Reg. 6353.

[73] *Id.*

[74] *Id.*

[75] *Id.*

[76] *Id.*

[77] *Friends of Back Bay v. U.S. Army Corps of Eng'rs*, 681 F.3d 581, 588 (4th Cir. 2012).

[78] *City of Columbus*, 796 F. Supp. 3d at 160.

[79] *Id.*

[80] *Id.* at 158-59.

[81] *State Farm*, 463 U.S. at 43.

require the submission of documents to verify income when an applicant's attested income is at or above 100 percent of the FPL, but trusted data sources instead indicate that the consumer's household income is below 100 percent of the FPL.[82] First finalized in the 2019 Notice of Benefit and Payment Parameters ("NBPP"), the policy was vacated by *City of Columbus v. Cochran*, which found that "HHS's decision to prioritize a hypothetical risk of fraud over the substantial risk that its decision [will] result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic."[83]

Later, following CMS's purported discovery of "a massive volume of improper enrollments in 2023 and 2024," the agency reproposed the income verification policy in its 2025 Marketplace Integrity Rule.[84] The policy was stayed by the court in *City of Columbus v. Kennedy*, echoing the court in *Cochran* and holding that plaintiffs were likely to show that CMS acted arbitrarily in finalizing the added verification requirements "without sufficient data justifying the need to do so."[85] The court in *Kennedy* was particularly concerned with the agency's reliance on faulty data and refusal to engage with comments critiquing the conclusions CMS made using available data.[86] In one particularly egregious example, CMS failed to address a comment by one of the authors of a study the agency relied on to justify its policy, who noted the study did not support the agency's conclusions.[87]

CMS has once again failed to satisfy its burden to justify its policy. The only additional rationale the agency provides is yet another set of hypotheticals. For example, the agency states that since the stay of the 2025 Marketplace rule, "the use of inflated incomes *could* have resulted in consumers being improperly enrolled."[88] It also notes, without providing any supporting data, that the federal Exchange has received "reports that agents, brokers, and web-brokers *may* be using artificial intelligence to impersonate consumers and falsely attest to household income that *could potentially* qualify the consumers for decreased APTC and CSR benefits now that the enhanced subsidies have expired."[89] Without any data or context, it is impossible to estimate the frequency of such reports, nor does CMS offer any insight into the veracity of such reports. This is exactly the type of unsupported hypothetical rationale that courts have rejected as arbitrary and capricious.[90]

VI. The elimination of standardized plans for FFEs and State-based Exchanges on the Federal platform (42 C.F.R. Parts 155 and 156) is arbitrary and capricious.

The proposed rule would remove regulations requiring issuers to offer standardized plan options and provide differential display for those options on the federal Exchange platform.[91] Standardized options were first introduced in the 2017 and 2018 NBPPs, and then discontinued in the 2019

[82] 91 Fed. Reg. 6346.
[83] 523 F. Supp. 3d 731, 762 (D. Md. 2021).
[84] 91 Fed. Reg. 6346.
[85] 796 F. Supp. 3d at 168.
[86] *Id.*
[87] *Id.*
[88] 91 Fed. Reg. 6346 (emphasis added).
[89] *Id.* (emphasis added).
[90] *See, e.g.*, *City of Columbus v. Cochran*, 523 F. Supp. 3d. at 762.
[91] 91 Fed. Reg. at 6383.

NBPP.[92] The discontinuance of the standardized plan options policy was vacated by the *Cochran* court on the grounds that the decision was arbitrary and capricious.[93] Specifically, the court held that the agency "fail[ed] to articulate a rational basis…for why it suddenly, and in contradiction to its previous position, believes standardized options hamper innovation."[94] Additionally, the court found that HHS's decision "disregard[ed] the factual finding underlying its prior policy," which supported the use of standardized options, by failing to explain how and if the agency's previous findings about standardized plans' improvement to consumer choice were incorrect or outdated.[95]

While the Proposed Rule offers some new evidence, its rationale still fails to meet the APA's reasoned-decisionmaking requirement. When changing policy positions, the agency need not "refute the factual underpinnings of its prior policy with new factual data," but it must still "provide a reasoned explanation for discounting the importance of the facts it had previously relied upon."[96] The 2017 NBPP proposed rule noted that "many consumers, particularly those with a high number of health plan options, find the large variety of cost-sharing structures available on the Exchanges difficult to navigate."[97] And in its 2017 NBPP final rule, CMS explained that "standardized options can simplify the consumer shopping experience," without "hamper[ing] innovation or limit[ing] choice."[98] CMS's 2018 NBPP echoed the same findings.[99] CMS's 2023 NBPP resumed standardized plan options because it found that these options "could play a constructive role in enhancing the consumer experience, increasing consumer understanding, [and] simplifying the plan selection process," among other benefits.[100] In its 2024 NBPP, CMS found that "standardized plan options continue to play a meaningful role in [the] simplification [of the plan selection process] by reducing the number of variables that consumers must consider when selecting a plan option, making it easier for consumers to compare available plan options."[101] The agency's 2025 NBPP again echoed the same findings.[102]

Now, CMS argues that, based on its experience with offering standardized plan options, the agency does not believe that the "marginal net reductions in the weighted average number of total plans available per enrollee and the weighted average number of total plans offered per issuer achieved by [the standardized plan policy] … warrant imposing additional burden on issuers or impeding issuer innovation in plan design choice—especially given that these marginal net reductions have likely been largely indiscernible to consumers during the plan selection process."[103]

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[92] *Id.*
[93] 523 F. Supp. 3d at 754.
[94] *Id.* (citing CMS's previous position that standardized options hampered innovation or limited choice); *see also* 81 Fed. Reg. 12292.
[95] 523 F. Supp. 3d at 754.
[96] *U.S. Sugar Corp. v. EPA*, 830 F. 3d 579, 626 (D.C. Cir. 2016).
[97] 80 Fed. Reg. at 75542.
[98] 81 Fed. Reg. at 12292.
[99] 81 Fed. Reg. at 94108.
[100] 87 Fed. Reg. at 27311.
[101] 88 Fed. Reg. at 25849
[102] 89 Fed. Reg. at 26357.
[103] 91 Fed. Reg. 6386.

But the Proposed Rule does not satisfactorily explain why CMS believes the standardized plan policy "is an ineffective strategy in enhancing the consumer experience, increasing consumer understanding, and simplifying the plan selection process,"[104] given the agency's prior conclusions. Research continues to show plan selection simplification improves consumer welfare and discourages enrollment in plans that have unexpected coverage gaps or high cost-sharing obligations.[105] Even modest improvements in plan selection could improve consumer choice.[106] And, if the agency believes these changes have only produced "marginal" improvements, it is likely that more stringent regulation around standardized plan options, not less, would improve consumer choice. In fact, as CMS previously noted, "an excessive number of health plan options makes consumers less likely to make any plan selection, more likely to make a selection that does not match their health needs, and more likely to make a selection that leaves them less satisfied."[107] Because the agency has not adequately explained its basis for rejecting the potential benefits of standardized options to consumers, it cannot claim to have reasonably compared those benefits to the purported harms to plan innovation. Without considering both the "advantages *and* the disadvantages" of its policy decision, the agency has not engaged in reasoned decisionmaking.[108]

CMS's lack of reasoned decisionmaking is underscored by the fact that the agency proposes to eliminate limits on non-standardized plan options,[109] a change that could cause the number of plan options to increase rather than decrease. As such, the agency's proposed "solution" to choice overload, which is to both eliminate standard options and uncap the number of non-standard options, does nothing to prevent the same or more plans from being certified for PY 2027. This presents a fundamental mismatch with the problem that the agency says it is trying to address.

VII. CMS has not provided adequate time to comment on the Proposed Rule.

Allowing only 30 days from *Federal Register* publication for comment is insufficient to allow the public an opportunity to substantively respond to the agency's proposals. This is especially troubling since the Proposed Rule affects nearly every aspect of Marketplace plan enrollment and eligibility, and the version of the rule posted for public inspection consisted of almost 600 pages of complex analysis.[110]

The APA requires agencies to give "interested persons an opportunity to participate in the rule making."[111] Congress designed the APA's notice-and-comment procedures "to reintroduce public

[104] 91 Fed. Reg. 6385.
[105] *See*, *e.g.*, Jeanne M. Lambrew & Christen Linke Young, Lessons from the ACA: Simplifying Choices to Optimize Health Coverage, Commonwealth Fund (Dec. 2, 2025),https://www.commonwealthfund.org/publications/issue-briefs/2025/dec/lessons-aca-simplifying-choices-optimize-health-coverage.
[106] *See, e.g.*, Jason Abaluck & Jonathan Gruber, When Less is More: Improving Choices in Health Insurance Markets, Rev. of Econ. Studies 90(3), 1011-1040 (May 2023), https://doi.org/10.1093/restud/rdac050.
[107] 80 Fed. Reg. 75542.
[108] *Michigan v. EPA*, 576 U.S. 743, 753 (2015) (emphasis in original).
[109] 91 Fed. Reg. 6390.
[110] *See generally*, U.S. Dep't Health and Hum. Serv., RIN 0938-AV62 Public Inspection notice, https://public-inspection.federalregister.gov/2026-02769.pdf?1770671709 (Feb. 9, 2026).
[111] 5 U.S.C. § 553(c).

participation and fairness to affected parties after governmental authority has been delegated to unrepresentative agencies, and to assure that the agency will have before it the facts and information relevant to a particular administrative problem, as well as suggestions for alternative solutions."[112]

Providing a mere 30 days to comment on the lengthy and complex Proposed Rule violates these requirements. "[W]hen substantial rule changes are proposed"—as here—"a 30-day comment period is generally the *shortest* time period sufficient for interested persons to meaningfully review a proposed rule and provide informed comment."[113] Courts have found that, in some circumstances, "periods around 30 days—and even, on occasion, longer than 30 days"—are "insufficient."[114] For example, one district court held that 30 days was likely inadequate for comment on a "multi-faceted" proposed rule that implemented "extensive changes … to long-established policy and practice," including some that required analysis of complex litigation, much like the Proposed Rule.[115] Similarly, the Executive Branch's own longstanding standard recognizes that "each agency should afford the public a meaningful opportunity to comment on any proposed regulation, which in most cases should include a comment period of not less than 60 days."[116] And even where CMS has deviated from that standard in the past in proposing rules of analogous complexity and scope, it has still provided substantially more time than the 30 days that CMS has provided here. For example, the proposed NBPP for 2025 and 2024 provided for comment periods of 46 days and 41 days, respectively.[117]

Given the number, complexity, and scope of CMS's proposals, "interested persons," including GFI, need more than 30 days to consider the proposals, the rationales behind them, and the consequences they would have if finalized. With additional time, commenters like GFI and others could potentially submit more detailed and comprehensive "data, views, or arguments" for CMS's consideration to improve its rulemaking.[118] CMS should therefore extend the comment period for the Proposed Rule before finalizing it.

VIII. Any use of artificial intelligence in this rulemaking must be disclosed.

Finally, CMS must disclose information related to any use of artificial intelligence as part of this rulemaking and, to the extent such use is significant, provide an additional opportunity for public comment.[119] Under the APA's reasoned-decisionmaking requirement, "[w]hen an agency uses a

[112] *Am. Hosp. Ass'n v. Bowen*, 834 F.2d 1037, 1044 (D.C. Cir. 1987) (internal quotation omitted).
[113] *Nat'l Lifeline Ass'n v. FCC*, 921 F.3d 1102, 1117 (D.C. Cir. 2019) (emphasis added).
[114] *Chamber of Com. of United States v. SEC*, 670 F. Supp. 3d 537, 552 (M.D. Tenn. 2023) (collecting cases), *aff'd*, 115 F.4th 740 (6th Cir. 2024).
[115] *Centro Legal de la Raza v. Exec. Off. for Immigr. Rev.*, 524 F. Supp. 3d 919, 955 (N.D. Cal. 2021).
[116] Executive Order 12866 § 6(a) (Sept. 30, 1993).
[117] U.S. Dep't Health and Hum. Serv., Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program, 88 Fed. Reg. 82510 (Nov. 24, 2023) (requiring comments to be submitted by Jan. 8, 2024); U.S. Dep't Health and Hum. Serv., Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024, 87 Fed. Reg. 78206 (Dec. 21, 2022) (requiring comments to be submitted by Jan. 30, 2023).
[118] 5 U.S.C. § 553(c).
[119] We adopt the definition of artificial intelligence at Pub. L. 115-232 § 238(g), 132 Stat. 1697–98.

computer model, it must explain the assumptions and methodology used in preparing the model."[120] Moreover, the public must have notice of, and an opportunity to comment on, agencies' uses of models and data, AI-enhanced and otherwise, to regulate.[121] Such disclosures are "[t]he safety valves in the use of…sophisticated methodology."[122]

Beyond being legally required, disclosure of AI usage is prudent policy. Administrative agencies should uphold the values of transparency and public participation.[123] In particular, the Administrative Conference of the United States has recognized that "[a]gencies' efforts to ensure transparency in connection with their AI systems can serve many valuable goals," and it therefore recommends that "agencies might prioritize transparency in the service of legitimizing its AI systems, facilitating internal or external review of its AI-based decision making, or coordinating its AI-based activities."[124] Among other things, disclosure of AI usage allows the public to confirm that agencies are adhering to relevant laws, apply technical expertise to improve agencies' use of technology, assess the risk that federal policies might be influenced by biased or otherwise faulty methods or products, and learn about an emerging and important field of technology. Indeed, the Office of Management and Budget has recognized that the government, in using AI, must "provide improved services to the public, while maintaining strong safeguards for civil rights, civil liberties, and privacy."[125]

Consistent with these requirements and principles, CMS must disclose, first, whether it has used or plans to use AI as part of this rulemaking, including to develop substantive policy, produce supporting analysis, or respond to public comments. If so, CMS must disclose the particular AI product it has used and why it was selected, how that product was procured, whether the product was fine-tuned, what prompts or inputs the agency used to elicit responses from the product, and the responses the product produced. CMS must also disclose how agency staff used AI-produced information, including any quality control, peer review, or other validation performed. And CMS must disclose what measures it took to ensure that its use of AI complied with applicable data security and privacy requirements. To that end, it must disclose whether and to what extent any persons and entities not employed by the agency developed, modified, provided access to, or used AI in the course of the agency's decisionmaking process. To the extent the disclosed use of AI is significant, CMS must provide an additional opportunity for public comment.

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[120] *Owner-Operator Ind. Drivers Ass'n, Inc. v. Fed. Motor Carrier Safety Admin.*, 494 F.3d 188, 204 (D.C. Cir. 2007) (quotation omitted).
[121] *See Am. Radio Relay League v. FCC*, 524 F.3d 227, 236 (D.C. Cir. 2008); *Air Transp. Ass'n v. FAA*, 169 F.3d 1, 7 (D.C. Cir. 1999).
[122] *Sierra Club v. Costle*, 657 F.2d 298, 334 (D.C. Cir. 1981).
[123] *See* Attorney General's Manual on the Administrative Procedure Act 9 (1947) (describing the APA's purposes to include "requir[ing] agencies to keep the public currently informed of their organization, procedures, and rules" and "provid[ing] for public participation in the rule making process").
[124] Admin. Conf. of the U.S., Statement #20, Agency Use of Artificial Intelligence, 86 FR 6612, 6616 (Jan. 22, 2021).
[125] Memorandum for the Heads of Executive Departments and Agencies from Russell T. Vought, Director, Office of Management & Budget 1, M-25-21 (Apr. 3, 2025), *available at* https://www.whitehouse.gov/wp-content/uploads/2025/02/M-25-21-Accelerating-Federal-Use-of-AI-through-Innovation-Governance-and-Public-Trust.pdf.

IX. Conclusion

The proposals addressed above would, if adopted, violate the Affordable Care Act's requirements, the Administrative Procedure Act's reasoned-decisionmaking requirement, or both. Taken together, they threaten to undermine the goals and structure of the ACA, including its fundamental purpose of increasing access to affordable healthcare coverage. We therefore request that CMS withdraw these provisions of the Proposed Rule and provide additional time for comment on the Proposed Rule as a whole.

Sincerely,

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