Center on Health Policy at BROOKINGS

March 13, 2026

Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Administrator Oz:

Thank you for the opportunity to comment on the proposed 2027 Notice of Benefit and Payment Parameters issued by the Centers for Medicare and Medicaid Services (CMS).[1] My letter comments on several aspects of the proposed rule. I make three main points:

1. Combining the catastrophic and metal-tier risk pools for risk adjustment purposes, as CMS seeks comment on, would improve the risk adjustment system's ability to meet its goals.

2. CMS proposes to allow insurers to offer bronze plans with out-of-pocket maximums that exceed the statutory limit, with the stated goal of ensuring that it remains feasible to offer a plan with an actuarial value (AV) low enough to qualify for the bronze tier. However, this limit is not currently a barrier to offering bronze plans and it is unlikely to become a barrier for many years unless CMS changes the AV calculator methodology.

   Moreover, the recent upward trend in the AV of a plan that provides no coverage below the required out-of-pocket maximum—which is what CMS expects to threaten the long-term viability of bronze plans—likely at least partly reflects the AV calculator's failure to account for prescription drug rebates. Fixing this issue would likely meaningfully reduce reported AVs and their tendency to rise over time; thus, it would offer CMS an alternative path to achieving its stated goal of ensuring the continued viability of bronze plans.

3. CMS proposes to allow insurers to offer plans without a provider network as long as the insurer can demonstrate that enough providers will accept its schedule of allowed amounts as payment in full. If this access requirement can be effectively enforced, it is doubtful that there is much scope for these plans to offer lower premiums than existing plans, in which case this proposal would likely have little effect on market outcomes. If, on the other hand, this requirement cannot be effectively enforced, as seems quite possible, then these plans likely would offer lower premiums and, in turn, reduce federal spending, but at the cost of meaningfully reducing access to care for enrollees who shift into non-network plans, increasing what enrollees who remain in traditional plans pay for their coverage, and

[1] The views expressed in this letter are my own and do not reflect the views of the Brookings Institution or anyone affiliated with the Brookings Institution other than myself. I thank Richard Frank for helpful comments on a draft of this letter, as well as Chloe Zilkha and Rasa Siniakovas for research and editorial assistance, respectively.

perhaps even threatening the continued viability of some traditional plans. In short, if the access requirements work as intended, then this proposal seems likely to be less impactful than CMS hopes, and if these requirements do not work as intended, then the proposal has potentially significant downsides that the proposed rule fails to grapple with.

The remainder of this letter examines these points in greater detail.

Treatment of catastrophic plans in risk adjustment

CMS currently treats catastrophic and metal-tier plans as separate risk pools for risk adjustment purposes. Concretely, CMS conducts separate transfer calculations for each type of plan and, thus, the risk adjustment system does not aim to offset differences in risk mix between catastrophic and metal-tier plans. In the proposed rule, CMS seeks comment on whether its proposed expansion of catastrophic plan eligibility merits combining these risk pools for risk adjustment purposes.

Such a change would likely improve the risk adjustment system's ability to meet its goals. The goal of risk adjustment is to break (or, at least, weaken) the link between who an insurer enrolls and the claims costs it incurs. By doing so, risk adjustment encourages insurers to set premiums for different plans that reflect differences in plan characteristics rather than differences in the enrolled population. That, in turn, encourages enrollees to select the plans that offer the best balance between the quality of the coverage they offer and the cost at which they can deliver that coverage, rather than gravitating toward plans that happen to attract healthier enrollees.

Segregating catastrophic plans means that risk adjustment fails to offset differences in enrollee characteristics between catastrophic and metal-tier plans. In practice, it is likely that catastrophic plans attract enrollees who have lower costs than those who select metal-tier plans since catastrophic plans require higher cost-sharing than non-bronze metal-tier plans, and healthier enrollees tend to gravitate toward less generous plans.[2] This likely results in higher premiums for metal-tier plans relative to catastrophic plans and, in turn, causes some enrollees who would be more efficiently served by metal-tier plans to select catastrophic plans instead.[3]

This distortion is likely modest in practice, as catastrophic plans attracted only around 69,000 life-years of enrollment in total in 2024.[4] Nevertheless, there is little clear rationale for tolerating it. And while the fact that catastrophic enrollees are ineligible for premium tax credits will likely continue to limit how many people opt for catastrophic plans, CMS' proposals to expand eligibility for catastrophic plans and change the catastrophic benefit design in ways that increase the

[2] See, for example, Victoria R. Marone and Adrienne Sabety, "When Should There Be Vertical Choice in Health Insurance Markets?," *American Economic Review* 112, no. 1 (2022): 304–42, https://doi.org/10.1257/aer.20201073.

[3] Importantly, while the current risk adjustment treatment of catastrophic plans likely reduces the *relative* premiums of catastrophic plans, it does not necessarily reduce their *absolute* premiums because the additional enrollees attracted by the catastrophic plans' lower relative premiums are likely more costly than other catastrophic enrollees. For more discussion of these types of enrollment dynamics, see Michael Geruso et al., "The Two-Margin Problem in Insurance Markets," *The Review of Economics and Statistics* 105, no. 2 (2023): 237–57, https://doi.org/10.1162/rest_a_01070.

[4] This reflects my calculations based on CMS' risk adjustment summary report for 2024.

difference in generosity between catastrophic and metal-tier plans will likely magnify the existing distortion to some degree, strengthening the case for a risk adjustment change.

Out-of-pocket maximums for bronze plans

CMS proposes to permit insurers to offer bronze plans with out-of-pocket maximums that exceed the statutory limit in certain circumstances. While this proposal raises many questions (including about its substantive desirability and statutory basis), I limit my comments to the empirical claim that CMS uses to justify disregarding the statutory limit: namely, that this change is necessary to allow insurers to continue to offer plans with AVs low enough to qualify as bronze plans.

Viability of bronze plans in 2027

Setting aside the statutory limit is clearly unnecessary for 2027. Under the final AV calculator for 2027, a "MOOP-only" plan (i.e., a plan with an out-of-pocket maximum ["MOOP"] equal to the statutory limit that offers no coverage below that level) would have an AV of 57.7%.[5] This AV falls well below the top of the de minimis range for standard bronze plans (62%) and even farther below the top of the de minimis range for expanded bronze plans (65%). Thus, insurers face no barriers to designing and offering bronze plans for the 2027 plan year under CMS' current rules.

Potential future trends in bronze plan viability

CMS suggests that insurers could encounter greater difficulty in the future since the AV of a MOOP-only plan has tended to rise over time. This is certainly possible, but it is far from guaranteed. As CMS notes, the driver of the historical increase in the AV of a MOOP-only plan has been that the per enrollee spending reflected in the continuance tables underlying the AV calculator (which CMS constructs from health insurance claims databases) has grown faster than the maximum out-of-pocket limit (which is updated annually based on estimates of premium growth). Absent a clear understanding of why these two growth rates have differed, something that CMS does not offer in the proposed rule, it is hard to be confident whether this differential will persist and, thus, whether it poses a realistic threat to the viability of bronze plans.

While I examine one factor that may have contributed to the upward trend in AVs in the next subsection, it is worth noting that even if this trend persisted in full, it would be many years before it would become impossible to offer a bronze plan (unless CMS makes changes to the AV calculator that increase reported AVs). For 2014, the reported AV of a MOOP-only plan was 58.0%. If one removes the effect of changes CMS has made to the AV calculator methodology to exclude certain high-spending enrollees, that number would have risen to around 63% in 2027,[6] a rate of increase of only around 0.4 percentage points per year. At that rate of increase, it would take around a decade for the AV of a MOOP-only plan to reach the top of the bronze de minimis range and many years more to reach the top of the expanded bronze de minimis range. It is thus hard to see how this trend could justify a near-term change like the one CMS proposes.

[5] This and all other calculations using the AV calculator employ the bronze continuance tables.

[6] This estimate reflects the 57.7% AV for such a plan from the actual 2027 AV calculator, plus 5.5 percentage points, which is the midpoint of the range that CMS provides in the proposed rule for how excluding high-spending enrollees affects the reported AV of a plan in the bronze tier.

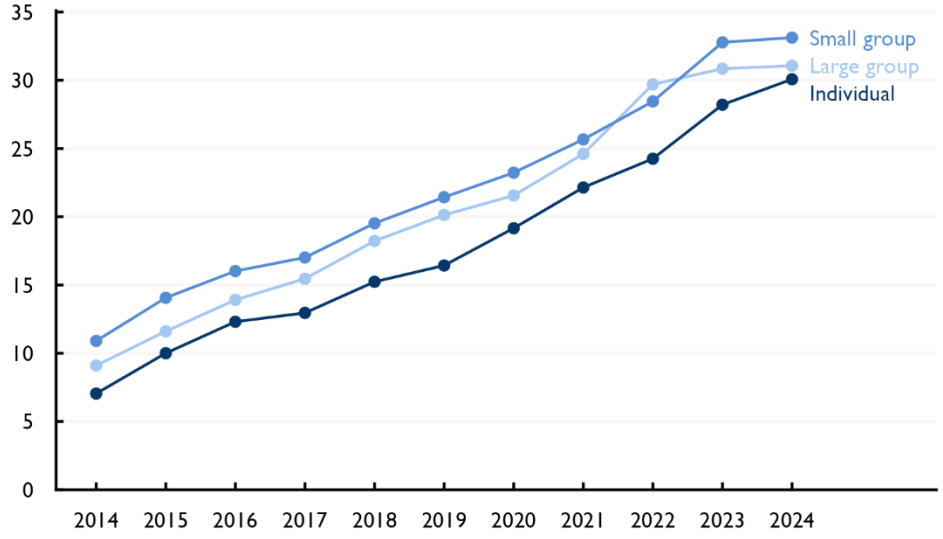
Prescription drug rebates and the AV calculator

In the remainder of this section, I briefly consider one factor that is likely distorting plan AVs and may help explain the upward trend in the AV of a MOOP-only plan: the AV calculator's failure to account for rebates paid by drug manufacturers after the point of sale. The core issue in this regard is that the continuance tables that underlie the AV calculator are based on claims data and, as such, do not reflect manufacturer rebates that are paid after the point of sale. Cost-sharing is based on point-of-sale prices, so this does not distort the AV calculator's estimates of enrollee cost-sharing liabilities. But failing to net out rebates does cause the calculator to overstate the total cost of the care enrollees receive and, correspondingly, to understate the share of total costs that are borne by enrollees. Equivalently, this causes the calculator to *overstate* plan AVs.

This distortion is likely sizeable and growing. Using data from insurers' medical loss ratio (MLR) filings, Figure 1 shows that rebates offset a large and growing fraction of what individual and small group market insurers spend on prescription drugs. While MLR data on drug rebates should be interpreted with some caution because they are not used to calculate an insurer's MLR, the levels and trends shown here are broadly consistent with those found in prior research.[7]

Figure 1. Prescription drug rebates by insurance market

Share of plan prescription drug claims spending (%)



Source: MLR public use files; author's calculations.

[7] Inmaculada Hernandez et al., "Changes in List Prices, Net Prices, and Discounts for Branded Drugs in the US, 2007-2018," *JAMA* 323, no. 9 (2020): 854–62, https://doi.org/10.1001/jama.2020.1012; Elizabeth Plummer et al., "Trends of Prescription Drug Manufacturer Rebates in Commercial Health Insurance Plans, 2015-2019," *JAMA Health Forum* 3, no. 5 (2022): e220888, https://doi.org/10.1001/jamahealthforum.2022.0888; Justine Mallatt et al., "Consumer Out-Of-Pocket Drug Prices Grew Faster Than Prices Faced By Insurers After Accounting For Rebates, 2007–20," *Health Affairs* 43, no. 9 (2024): 1284–89, https://doi.org/10.1377/hlthaff.2023.01344; Andrew W. Mulcahy et al., *Prescription Drug Prices, Rebates, and Insurance Premiums* (2024), https://www.rand.org/pubs/research_reports/RRA1820-3.html; Adam J. Fein, "U.S. Brand-Name Drug Prices Fell in 2025 as the Net Pricing Drug Channel Emerges," *Drug Channels*, January 7, 2026, https://www.drugchannels.net/2026/01/us-brand-name-drug-prices-fell-in-2025.html.

Using methods detailed in the appendix to this letter, I use MLR and other data to estimate that the AV calculator's failure to account for rebates likely inflated the reported AV of a MOOP-only plan by 2.5 percentage points in 2024. In light of the upward trend in rebate percentages depicted in the figure, this distortion is likely growing over time. In particular, this distortion will likely be larger in 2027 than it was in 2024, and it would likely have been mostly absent as of 2014.

This has two key implications. First, trends in rebates can account for a substantial fraction of the underlying upward trend in the reported AVs of MOOP-only plans in recent years; importantly, while a rising rebate share does cause the distortion in reported AVs to grow over time, it likely does *not* affect trends in the maximum out-of-pocket limit since, as noted above, this limit is indexed to premiums, and premiums are likely to reflect net, rather than gross, claims spending. Second, CMS' concerns about the viability of bronze plans would be substantially ameliorated if it revised the AV calculator to more appropriately account for prescription drug rebates.

Implications of permitting non-network plans

CMS proposes to begin allowing insurers to offer plans that lack a provider network and instead specify a fixed schedule of payment rates for health care services, apparently in hopes of bringing lower-premium options into the market. Under the proposal, insurers would be required to "ensure access to a range of providers that accept the non-network plan's benefit amount as payment in full" instead of complying with network adequacy requirements. The effects of this proposal would likely hinge on whether these access requirements can be effectively enforced.

Effects with effective enforcement

If they can be effectively enforced (and crafted to ensure a level of access equivalent to existing plans), it is doubtful that non-network plans could offer meaningfully lower premiums. Importantly, non-network plans do not offer insurers useful new strategies for disciplining prices. Even under current rules, an insurer could publish a schedule of allowed amounts, permit any willing provider to sign a contract at those amounts, and base out-of-network payments on those amounts. A non-network plan presents providers and enrollees with exactly the same options and incentives except that it removes the option for providers to sign a network agreement and obtain the potentially improved access to the plan's enrollees that in-network status entails; if anything, this difference is likely to make it harder for the plan to induce providers to accept a given set of rates and thus necessitate higher, not lower prices. And if access to providers is comparable, enrollees would likely also use similar amounts of care as they do under existing plans.

Non-network plans would avoid administrative costs associated with contract negotiations. However, they would need to implement new processes to verify that their payment rates were accepted by enough providers. Claims processing might also become more cumbersome since providers and insurers would no longer have a venue in which to agree on claims submission protocols. Thus, it is unclear whether administrative costs would even fall on net. In any case, it is

doubtful that any administrative savings would allow large premium reductions, as insurer administrative spending of all kinds averages only around 10% of claims spending.[8]

Effects without effective enforcement

In practice, it seems likely that CMS would have trouble enforcing the access requirements it envisions. Unlike with network plans, it may not always be obvious whether enough providers are willing to accept the plan's rates. If this is the case, non-network plans likely would offer lower premiums, mainly by paying lower prices for care and making accessing care harder.

This outcome likely would reduce federal tax credit costs by reducing the benchmark premiums those credits are based on. But those savings would come at a cost. Enrollees who shifted into non-network plans would experience worse access to care but would generally not pay less since these plans' lower gross premiums would be offset by smaller tax credits. At the same time, enrollees who remained in traditional plans would pay more, for two reasons. First, as noted above, tax credits would shrink. Second, because non-network plans would offer more limited access to providers, they would likely differentially siphon off healthier enrollees, raising the gross premiums of traditional plans, perhaps substantially.[9] In certain cases, these selection dynamics could even threaten the continued viability of some types of traditional plans. Regardless, it is likely that the migration of enrollees out of traditional plans would be inefficiently large since some enrollees would opt for non-network plans to gain the benefits of pooling with lower-risk enrollees rather than because non-network plans offered a better price-quality tradeoff.

In short, if CMS' proposed access requirements work as intended, then this proposal seems likely to be less impactful than CMS hopes. If, on the other hand, these requirements do not work as intended, then the proposal has potentially significant downsides that the proposed rule fails to grapple with. In either case, the proposal seems unlikely to function as CMS expects.

Thank you for the opportunity to comment on this proposed rule. I hope that this information is helpful to you. If I can provide any additional information, I would be happy to do so.

Sincerely,

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[8] Matthew Fiedler, *Capping Prices or Creating a Public Option: How Would They Change What We Pay for Health Care?* (Brookings Institution, 2020), https://www.brookings.edu/research/capping-prices-or-creating-a-public-option-how-would-they-change-what-we-pay-for-health-care/.

[9] See, for example, Geruso et al., "The Two-Margin Problem in Insurance Markets"; Mark Shepard, "Hospital Network Competition and Adverse Selection: Evidence from the Massachusetts Health Insurance Exchange," *American Economic Review* 112, no. 2 (2022): 578–615, https://doi.org/10.1257/aer.20201453.

Methodological Appendix

This appendix describes how I estimate how much the AV calculator's failure to account for the rebates paid by prescription drug manufacturers distorted reported plan AVs in 2024. To that end, I let G denote gross allowed spending under a plan, R denote the rebates received by that plan, and C denote enrollee cost-sharing. A plan's "true" AV, AV_t, is defined to be

$$AV_t = \frac{G - R - C}{G - R} = 1 - \frac{C}{G - R}.$$

Consistent with the discussion in the main text, the AV calculator computes the correct amount of cost-sharing for a given plan design but overstates the total cost of an enrollee's care because it fails to net out rebates. Formally, it delivers a "reported" AV, AV_r, given by

$$AV_r = \frac{G - C}{G} = 1 - \frac{C}{G}.$$

Combining these two definitions, we thus find that the distortion $AV_r - AV_t$ can be written as

$$AV_r - AV_t = (1 - AV_r)\left(\frac{G}{G - R} - 1\right). \quad (1)$$

Equation (1) shows that estimating the distortion for a plan with a known AV_r only requires an estimate of the gross-to-net spending ratio $G\ /\ [G - R]$. In what follows, I use a market-wide aggregate version of this ratio, with the caveat that this ratio could, in principle, vary across different types of plans to some degree. Formally, for a variable X, I let $\bar{X}_m$ denote sum of the amounts X for each insurer across all insurers in market $m \in \{I, SG\}$, where I denotes individual and SG denotes small group. I then define $\bar{X} = \bar{X}_I + \bar{X}_{SG}$ and use the aggregate ratio $\bar{G}\ /\ [\bar{G} - \bar{R}]$.

I rely principally on data from 2024 MLR filings to estimate $\bar{G}$ and $\bar{R}$. The aggregate rebate amount $\bar{R}$ can be calculated directly by aggregating the corresponding amounts on MLR filings (part 1, line 2.3). Estimating $\bar{G}$ is more difficult because MLR filings report plan claims liability rather than the total allowed costs. To get around this issue, I note that $\bar{G}_m$ can be written as

$$\bar{G}_m = \frac{[\bar{G}_m - \bar{C}_m - \bar{R}_m] + \bar{R}_m}{[\bar{G}_m - \bar{C}_m]/\bar{G}_m}. \quad (2)$$

The two amounts in the numerator of equation (2) can be obtained from MLR filings: the rebate amounts $\bar{R}_m$ as described above; and the net plan liability amounts $\bar{G}_m - \bar{C}_m - \bar{R}_m$ by aggregating amounts on MLR filings (part 1, line 2.1). The denominator is an average reported actuarial value for market m. For the individual market, I estimate this using the 2024 Open Enrollment Public Use Files, which break down enrollment by income and metal level; I assign enrollees in non-silver plans the base actuarial value of their metal level, while I assign silver enrollees the appropriate actuarial value corresponding to their income level, and I then compute an enrollment-

weighted average of 78.4%.[10] For the small group market, I compute an enrollment-weighted average AV of 77.2% using the 2024 risk adjustment summary report for that year.[11]

Combining these AVs with the amounts from the MLR data generates a final ratio $\bar{G}/[\bar{G} - \bar{R}] = 1.063$. Because the 2024 AV calculator reports that the AV of a MOOP-only plan was 60.2% in that year, equation (1) then implies that the overall distortion is 2.5 percentage points.

[10] This approach omits the relatively small number of enrollees in off-Marketplace plans.

[11] This approach is not feasible for the individual market because the actuarial value reported in risk adjustment data does not account for the existence of cost-sharing reductions.