



Tribal Technical Advisory Group



To the Centers for Medicare & Medicaid Services

c/o National Indian Health Board | 50 F Street NW | Washington, DC 20001 | (202) 507-4070 | (202) 507-4071 fax

March 10, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted via regulations.gov

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

Administrator Oz,

On behalf of the CMS Tribal Technical Advisory Group (TTAG), I write to respond to the Centers for Medicare and Medicaid Services (CMS) proposed rule, "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2027; and Basic Health Program" (CMS-9883-P) (Proposed Rule). This Proposed Rule is an important step towards updating the Affordable Care Act implementation for the 2027 benefit year. However, we hope CMS considers these comments and recommendations regarding how the Proposed Rule will affect AI/AN enrollment, affordability, and the sustainability of I/T/U program revenue within the Tribal health system.

Requested Guidance for Tribal SEP Distinction

We urge HHS to clearly restate and reaffirm that Tribal SEPs are not subject to broader SEP verification requirements. Tribal Special Enrollment Periods (SEPs) allow AI/AN consumers to enroll or change plans once per month without needing another qualifying life event. In response to SEP provisions in the Proposed Rule, the Tribal SEPs must remain distinct from other SEP verification requirements. State-Based Exchanges and Federally Facilitated Marketplace (SBE/FFM) should not conflate Tribal SEP rules with general SEP verification processes, as this could create barriers for AI/AN enrollees, including excessive documentation requirements, administrative delays, or enrollment barriers. This SEP goes into effect for the 2028 plan year, and SBE/FFM must implement it by August 2027 for open enrollment. Clear federal guidance in advance of the deadline will ensure timely barrier-free enrollment for Tribal consumers.

Market Affordability, CSR Loading, and Tribal Co-Financing Risk

The TTAG urges CMS to delay its plan to require issuers of qualified health plans (QHPs) that make a plan-level adjustment to account for unreimbursed cost-sharing

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reductions (CSRs) to submit certain information specified in the Plan Year 2026 Rate Filing Guidance in their unified rate review template and actuarial memoranda for each unfunded plan year. While we understand the intent behind the proposed provision, the high degree of uncertainty regarding its impact on enrollees' out-of-pocket costs, in combination with marketplace uncertainty following the expiration of enhanced premium tax credits (EPTCs), warrants a delay before implementation. In particular, the TTAG cannot support a policy that risks further increasing healthcare costs for AI/AN enrollees.

Issuers of QHPs are required to provide CSRs to eligible low- and moderate-income silver-level plan enrollees (enrollees with income between 100% and 250% of the federal poverty level) as well as eligible AI/AN enrollees at any metal level. Following the discontinuation of federal CSR reimbursement payments in 2017, issuers incorporated those CSR costs into silver plan premiums sold on the Federally Facilitated Marketplace/State-Based Exchange (FFM/SBE), referred to as "CSR loading". The incorporated costs increased benchmark premiums and advanced premium tax credits (APTCs), as tied to the second-lowest-cost silver plan.

Stability in silver-tier pricing is particularly important in rural and limited issuer markets, including many areas serving Tribal Nations. IHS, Tribal, and urban Indian organizations (I/T/U) providers depend on third-party revenue to ensure access to and maintain vital services. A key source of third-party revenue comes from AI/ANs enrolled in Affordable Care Act marketplace insurance plans. Tribes often support enrollment in marketplace coverage through Tribally Sponsored Insurance plans (TSIPs), which rely on predictable APTC valuation to maintain affordability and ensure their access to care. The plans function as Tribal premium sponsorship arrangements, often covering remaining premium costs not fully offset by tax credits. In effect, Tribal Nations operate as co-financers for coverage.

Any disruption to silver pricing dynamics, issuer participation, or subsidy valuation has immediate affordability implications for AI/AN enrollers and direct fiscal implications for Tribal Nations in rural rating areas with limited competition. Even modest increases or issuer withdrawal can affect affordability and Tribal sponsorship responsibilities. Administrative cost pass-throughs from new federal requirements, and other premium increases caused by this proposal, will effectively shift costs downstream to AI/AN enrollees and Tribal Nations. Enrollees are already facing significant uncertainty about their out-of-pocket costs due to the expiration of Enhanced Premium Tax Credits (EPTCs). There is a significant likelihood that many are facing increased premiums. Although a complete analysis of the impact of the recent expiration is still underway, the Congressional Budget Office (CBO) estimated that benchmark premiums would increase because of the expiration by 4.3% in 2026 and 7.7% in 2027, with an average overall increase of 7.9% between 2026 and 2034.¹

¹ Bernadette Fernandez, *Enhanced Premium Tax Credit and 2026 Exchange Premiums: Frequently Asked Questions* 5 (Dec. 10, 2025), available at <https://www.congress.gov/crs-product/R48290>.

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Furthermore, we note the risk that these reporting requirements will lead to additional premium changes beyond those identified in the Proposed Rule, driven by follow-on marketplace impacts. For example, the CBO concluded that marketplace premiums would rise due to the expiration of EPTCs in part because less generous subsidies would lead to the departure of healthier enrollees.² This same rationale applies to this Proposed Rule. If the reporting requirements outlined in the Proposed Rule cause premiums to rise, that may further drive healthier enrollees from the exchange, leading to even higher premiums. CMS itself states that "there might also be distributional enrollment shifts among enrollers across metal levels on-Exchange and in silver plans offered off-Exchange."³

We urge HHS to delay implementation of these reporting requirements until it can carefully assess whether the new reporting requirements justify the risk of premium changes in markets heavily relied upon by AI/ANs and Tribal Nations. Due to the high degree of uncertainty regarding this proposal's impact on out-of-pocket costs and marketplace uncertainty following the EPTCs, TTAG cannot support a policy that risks further increasing healthcare costs for AI/AN enrollees.

We request that CMS release the information it collected under its PY 2026 Filing Guidance and subsequent Frequently Asked Questions guidance, as well as the analysis it conducted of this data, so that the TTAG and other interested parties can more fully evaluate the current proposal and its impact on AI/AN enrollees.

High-Cost Sharing Parameters for Bronze Plans

The TTAG encourages HHS to evaluate the downstream effects on subsidy adequacy and on the stability of the Indian health system revenue before finalizing this policy. The Proposed Rule would allow higher cost-sharing for certain bronze plans, including higher out-of-pocket maximums that exceed statutory limits. Adjustments to bronze plan design may alter metal-tier pricing dynamics and affect the silver benchmark used to calculate APTCs. If these changes result in a depreciation of APTCs, AI/AN enrollers and Tribal sponsors may experience higher net premium liability. Loss of APTC eligibility would make marketplace coverage unaffordable for low-income individuals. Similarly, APTC reductions can create affordability gaps.

Marketplace coverage does not operate in a vacuum within the Tribal health systems. I/T/Us use third-party collections from individuals covered by Marketplace plans to recruit, hire, and maintain badly needed health care providers. I/T/Us must also use these to meet health quality and accreditation requirements. Marketplace structural adjustments that affect subsidies and the affordability of care directly impact AI/AN enrollees. They may affect overall provider recruitment, the services offered, and accreditation compliance in I/T/U facilities.

² Bernadette Fernandez, *Enhanced Premium Tax Credit and 2026 Exchange Premiums: Frequently Asked Questions* 5 (Dec. 10, 2025), available at <https://www.congress.gov/crs-product/R48290>.

³ 91 Fed. Reg. at 6445

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APTC Eligibility Impacts

TTAG urges that HHS adopt targeted exemptions and safeguards for AI/AN enrollees to prevent disproportionate coverage losses in Tribal communities. While integrity objectives are important, suspending subsidy eligibility for the coverage year would have disproportionate effects on Tribal communities. In rural Tribal communities, geographic isolation and limited access to tax preparation services and support may increase the risk of filing delays, potentially resulting in disproportionate disruption to coverage.

The resulting coverage loss would extend beyond individual market participation. This massive revenue loss could lead to reduced service offerings at I/T/U facilities across Indian Country. Tribal sponsorship programs would face either sharply increased premium obligations or reduced enrollment capacity. These programs have greatly expanded access to healthcare for Tribal citizens, increased resources available to the Tribal health program, and reduced expenditures for services authorized through Purchased and Referred Care.

Implementation of an Effective Essential Community Provider Review Program

The TTAG urges CMS to require states with Federally Facilitated Exchanges (FFE states) to incorporate the relevant IHCP requirements at 45 CFR § 156.235(a)(2)(ii)(A) into the state's essential community provider (ECP) standards if they elect to conduct their own ECP certification reviews of QHP issuers' plans. CMS must set baseline standards and exercise oversight over the ECP review process consistent with existing standards that minimize barriers to care access across FFE states and ensure all FFE enrollees "have a minimum standard for consumer protections on reasonable access to providers."⁴

However, we are concerned that CMS may permit states the authority to develop alternative ECP requirements that do not require QHPs to offer contracts to all Indian Health Care Providers (IHCPs) in a service area. The IHCP requirement ensures that AI/AN enrollees can access care at I/T/U facilities and receive cost-sharing benefits they may be entitled to, depending on their income level. If states are permitted to develop alternative ECP requirements that do not require QHPs to offer contracts to all IHCPs within the service areas, a consistent minimum consumer protection standard will no longer protect AI/AN enrollees, and disparities in access will develop across states. Accordingly, we recommend that CMS utilize the following language at proposed § 155.1051(d):

FFE States with an Effective ECP Review Program that have alternative ECP requirements compared to those described under paragraph (c)(1) and (3) of this section must demonstrate how their requirements would continue to promote a sufficient number and geographic distribution of ECPs to ensure reasonable and timely access to ECPs, and an adequate level of service for low-income enrollees or individuals residing in Health Professional Shortage Areas. FFE States with an Effective ECP Review Program cannot propose alternatives to the Indian health care

⁴ 91 Fed. Reg. at 6403 – 6404

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provider requirement under § 156.235(a)(2)(ii)(A) for network plans and under § 156.236(b)(3) for non-network plans.

Proposed Alternative Regulatory Standard for Non-Network Plans

The TTAG thanks the CMS for its consideration of how to best ensure access to IHCPs for AI/AN enrollees in non-network plans seeking certification as QHPs. We support CMS' proposal to require plans to demonstrate to the FFE that they offer the benefit amount as payment in full to all available IHCPs within a plan's service area.⁵

Conclusion

In conclusion, we respectfully urge CMS to evaluate the impacts of this Proposed Rule carefully and to account for how silver-tier pricing instability and disruptions to APTC eligibility would undermine both access to care for AI/AN enrollees and the already structurally underfunded Indian health system. We urge that CMS delay implementation of the proposed CSR reporting requirements until the agency presents more information regarding their impact on enrollee costs. TTAG supports CMS' efforts to ensure AI/AN enrollers have access to IHCPs in newly proposed review processes for state-level ECP certification reviews and non-network QHP applications. Finally, TTAG urges CMS to make minor revisions to these newly proposed regulations to close potential loopholes that may result in a loss of IHCP access.

Sincerely,



W. Ron Allen, TTAG Chair
Chairman, Jamestown S'Klallam Tribe

Cc: Mark Cruz, Senior Advisor to the Secretary
Rachel Ryan Pedersen, Acting Director, CMS, DTA
Dr. Susan Karol, MD, Chief Medical Officer, CMS DTA

⁵ 91 Fed. Reg. at 6410 – 6413, 6484