



March 13, 2026

Dr. Mehmet Oz  
Administrator  
Centers for Medicare & Medicaid Services

**Via Electronic Correspondence**

Re: 2027 Notice of Benefit and Payment Parameters CMS-9883-P

Dear Administrator Oz:

Aimed Alliance is a non-profit health policy organization that seeks to protect and enhance the rights of health care consumers and providers. We appreciate the opportunity to comment on the 2027 Notice of Benefit and Payment Parameters (2027 NBPP) and specifically urge the Centers for Medicare & Medicaid Services (CMS) to:

- I. Improve health care affordability by banning copay accumulators;**
- II. Clarify that all drugs covered in addition to the Benchmark Plan are essential health benefits (EHBs); and**
- III. Prohibit misleading marketing practices by third-party companies.**

**I. Improve consumer health care affordability by banning the use of copay accumulators**

Aimed Alliance is disappointed that the 2027 NBPP does not address the use of copay accumulators. We are particularly concerned, as a 2026 poll by KFF found that one in five adults have skipped filling a prescription drug due to cost.<sup>1</sup> Addressing the use of copay accumulators can directly improve prescription drug affordability and ensure consumers are able to access their necessary medications.

When patients cannot afford their medications, they may rely on financial assistance from pharmaceutical manufacturers and other third parties to meet their health plan's cost-sharing responsibilities and fill their prescriptions. The value of this financial assistance typically counts toward the health plan's deductible or maximum out-of-pocket limit, unless the health plan has implemented a copay accumulator program. Copay accumulator programs exclude the value of financial assistance distributed by third parties from counting toward the health plan's deductible or maximum out-of-pocket limit.

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<sup>1</sup> KFF, *Americans' Challenges with Health Care Costs*, <https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/>.

For many consumers, copay accumulators are not transparently disclosed at open enrollment, resulting in consumers being caught by surprise when they learn their copay assistance no longer counts towards their annual cost-sharing requirements. Moreover, since open enrollment has passed, they have no option but to stick with the accumulator plan for the remainder of the plan year. As a result, consumers are then required to pay more annually out-of-pocket to meet their health care needs while health plans are allowed to collect double – once from the patient and once from the copay assistance fund.<sup>2</sup>

Aimed Alliance appreciates this Administration’s commitment to improving the U.S. health care system and holding stakeholders accountable for lowering prescription drug costs. However, many of the proposals implemented by this Administration, such as the pharmaceutical company agreements to lower prescription drug costs, do not have a direct impact on consumer out-of-pocket costs. In contrast, addressing the use of copay accumulators would have a direct impact on consumers, as counting copay assistance towards their annual out-of-pocket limit will ensure they can meet their cost-sharing requirements sooner with fewer unexpected expenses. Therefore, Aimed Alliance encourages CMS to take regulatory action to ensure that all copays received by or on behalf of a consumer count towards their annual out-of-pocket requirements.

Aimed Alliance also notes that CMS may, but is not required to, engage in rulemaking to ban the use of copay accumulators. In 2023, a District Court ruled that the 2021 NBPP, which permitted the use of copay accumulators, was void for violating notice and comment requirements under the Administrative Procedures Act.<sup>3</sup> As a result, the 2020 NBPP was reinstated as enforceable law. Under the 2020 NBPP, all health plans are required to count copay assistance towards consumers’ annual out-of-pocket costs, unless there is a brand-name medication with a medically appropriate generic alternative available. However, due to a lack of enforcement, this *existing federal regulation* is not being complied with by health plans. Thus, CMS could issue an enforcement notice clarifying its intent to enforce all requirements of the 2020 NBPP without engaging in additional rulemaking. As such, Aimed Alliance urges CMS to pursue all alternatives to banning the use of copay accumulators.

## **II. Clarify all drugs covered in addition to the EHB Benchmark Plan are also EHBs**

Federal law 42 U.S.C. § 156.122 states that a health plan does not cover EHBs unless it covers one drug in each United States Pharmacopeia (USP) Category or the same number of drugs as the state EHB benchmark plan.<sup>4</sup> This requirement was intended to create a floor, not a ceiling, for EHB coverage requirements. Consistent with this intent, CMS clarified in the 2025 NBPP that all drugs covered in addition to the EHB were meant to be treated as EHBs for the

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<sup>2</sup> Aimed Alliance, *Copay Accumulator 101*, <https://aimedalliance.org/copay-accumulator-101/>.

<sup>3</sup> *HIV & Hepatitis Pol’y Inst. v. U.S. Dep’t of Health & Hum. Servs.*, 1:22-cv-02604 (D.D.C. 2023).

<sup>4</sup> 42 U.S.C § 156.122.

purposes of annual out-of-pocket limits and cost-sharing requirements.<sup>5</sup> Likewise, in FAQ 66, the Department of Labor, Department of Health and Human Services, and Treasury Department stated the tri-agencies would engage in rulemaking to clarify this requirement applies to all health plans, including large group and self-insured plans.<sup>6</sup> However, the tri-agencies have not issued this clarification. Aired Alliance urges CMS and the tri-agencies to swiftly publish the promised regulation, as consumers are actively being harmed by non-EHB designations.

This harm becomes apparent when health plans classify certain prescription drugs as non-EHBs, even when those drugs are otherwise covered. When a consumer's prescription drug is deemed a non-EHB, they are denied their right to appeal an adverse benefit decision and are often required to work with third-party companies to access their medication.<sup>7</sup>

First, when a health plan designates certain *covered* prescription drugs as non-EHBs, consumers are often unaware of this designation until they attempt to fill the prescription. At this point, consumers are told their prescription drug is a covered non-EHB, that this is a non-appealable decision, and they must work with the third-party company to access their prescription drugs. Denying consumers the ability to appeal the non-EHB designation is a violation of federal law. Specifically, under 42 U.S.C. § 156.122(c), “[a] health plan providing essential health benefits must have the following processes in place that allow an enrollee, the enrollee’s designee, or the enrollee’s prescribing physician (or other prescriber, as appropriate) to request and gain access to clinically appropriate drugs not otherwise covered by the health plan (a request for exception). In the event that an exception request is granted, the plan must treat the excepted drug(s) as an essential health benefit, including by counting any cost-sharing towards the plan’s annual limitation on cost-sharing . . .” As such, denying consumers their right to appeal and have their prescription drugs deemed medically necessary, and thereby an EHB, is inconsistent with federal law and harms consumers’ rights under the Patient Protection and Affordable Care Act (ACA).

Second, once a consumer receives the notification that their drug is a covered non-EHB, they are often directed to work with a third-party company to access their medications. These third-party companies can be aggressive and require consumers to sign a power of attorney, and provide inaccurate information to patient assistance programs so the consumer appears uninsured or underinsured for program eligibility purposes. While these programs may not appear harmful to consumers, one study has found that being required to work with third-party programs can

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<sup>5</sup> *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*, 89 Fed. Reg. 26,218 (Apr. 15, 2024), <https://www.federalregister.gov/documents/2024/04/15/2024-07274/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2025>.

<sup>6</sup> Employee Benefits Security Administration, *FAQ about Affordable Care Act Implementation Part 66*, <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-66>.

<sup>7</sup> Aired Alliance, *Alternative Funding Programs*, <https://airedalliance.org/alternative-funding-programs/>.

delay access to care by nearly 70 days.<sup>8</sup> Delays in accessing the appropriate treatment can result in disease regression, progression, and in some cases, irreparable harm.

Therefore, to protect consumers and ensure they are able to access their rights under federal law, Aimed Alliance urges CMS to clarify that all health plans are required to consider all covered prescription drugs in addition to the benchmark plan, as EHBs.

### **III. Prohibit misleading marketing practices by third-party companies**

Aimed Alliance applauds CMS's decision to address misleading marketing practices by agents, brokers, and web brokers. Misleading practices result in consumers paying for coverage that does not provide the benefits they need and may result in consumers foregoing opportunities to purchase more comprehensive coverage through state or federal health care exchanges during open enrollment. Aimed Alliance urges CMS to work with the tri-agencies to expand this requirement to large group and self-insured plans, and third-party companies that pitch their services to employers. Greater transparency can ensure employers fully understand the implications of proposed third-party initiatives, and consumers are aware of changes to their health plan benefits before open enrollment ends.

In addition, Aimed Alliance appreciates the challenge of tracing liability between web brokers, agents, and brokers, and urges CMS to adopt a nuanced approach that ensures the originator of the misleading advertisement is held accountable. For example, in the 2024 Nondiscrimination in Health Programs and Activities proposed rule,<sup>9</sup> HHS clarified that if a third-party administrator (TPA) was responsible for developing a discriminatory plan design, it could be liable for such discrimination. Prior to this clarification, TPAs could allege they couldn't be held liable for plan discrimination as they were just executing the plan's terms. However, the 2024 clarification reaffirmed that if the TPA convinced the plan to adopt the discriminatory benefit design, it was also liable under federal law. Here, CMS could impose similar liability requirements and clarify that if any party proposed the misleading advertisement, it would be accordingly liable. This would ensure that no party could use the other as a liability scapegoat.

### **IV. Conclusion**

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<sup>8</sup> [William B. Wong, et al., \*A descriptive survey of patient experiences and access to specialty medicines with alternative funding programs\*, 30 JOURNAL OF MANAGED CARE & SPECIALTY PHARMACY \(Oct. 29, 2024\), <https://www.jmcp.org/doi/full/10.18553/jmcp.2024.30.11.1308>.](https://www.jmcp.org/doi/full/10.18553/jmcp.2024.30.11.1308)

<sup>9</sup> *Nondiscrimination in Health Programs and Activities*, 89 Fed. Reg. 37,522 (May 6, 2024), <https://www.federalregister.gov/documents/2024/05/06/2024-08711/nondiscrimination-in-health-programs-and-activities>.

In conclusion, we thank you for your time and consideration of this comment. If you have any questions, please contact us at [policy@aimedalliance.org](mailto:policy@aimedalliance.org).

Sincerely,

Ashira Vantrees  
Director of Legal Strategy & Advocacy