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March 13, 2026

Robert F. Kennedy Jr.
Secretary
U.S Department of Health and Human Services
Attention: CMS-9884-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically: www.regulations.gov

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

Dear Secretary Kennedy:

The Healthcare Association of New York State, on behalf of our member nonprofit and public hospitals, nursing homes, home health agencies and other healthcare providers, welcomes the opportunity to comment on the proposed rule focused on marketplace quality and affordability.

HANYS is commited to supporting policies that build affordable, high quality and comprensive health insurance coverage through federal and state marketplaces. While we understand that the stated intent of this proposed rule is to lower healthcare costs, promote competition and stenghten program integrity in the federal and state exchanges, we strongly oppose many of the proposals because they would have significant adverse impacts on both patients and providers.

We also urge HHS to continue its deference to the experience and role of the states, particularly those that have created and run successful state marketplaces, such as New York.

HANYS is deeply concerned that many of the proposals, if finalized, would severely restrict marketplace eligibility, enrollment and healthcare affordability, negatively impacting and reversing improvement in health insurance coverage for the state of New York, and negatively impacting the health of patients, communities and the hospitals and health systems that care for them.

HANYS and our members are committed to ensuring all New Yorkers, regardless of age, race, ethnicity, gender, income level or geographical location, have access to the care they deserve. This includes supporting policies that build affordable, high-quality and comprehensive health insurance coverage through federal and state marketplaces.

HANYS is proud to support our marketplace, the New York State of Health, and its 6.7 million enrollees, of which well over 200,000 are enrolled in qualified health plans. Unfortunately, the expiration of enhanced premium tax credits has created significant financial consequences for those who relied on those subsidies to afford coverage and will cause economic ripple effects in hospitals and health systems across the state.

Additionally, in response to reports of fraudulent activities by certain insurance brokers to enroll low-income people in zero-dollar premium plans without their knowledge, HANYS supported recent CMS and HHS rulemaking and proposals to prevent unauthorized marketplace activity among agents and brokers.

However, reports of unauthorized coverage changes in New York are few, and the NYSOH already has safeguards in place to ensure that agents have consumers' consent prior to making any coverage changes.

HANYS urges HHS to carefully consider how the proposed changes would affect the individuals who rely on the state and federal exchanges for comprehensive and affordable coverage. We are concerned that several of the proposals in the rule would drive up the cost of coverage — contrary to HHS' stated goal of improving affordability.

Centralized eligibility and enfollment infrastructure

HHS proposes removing the requirement that state-based exchanges operate a consumer-facing centralized eligibility and enrollment platform on the SBE's website. Instead, HHS would permit SBEs to exclusively use web-brokers to operate these consumer platforms. However, HHS does not establish any new oversight or safeguards to hold these web-brokers accountable for misconduct or unauthorized enrollments. Futhermore, many web-brokers receive commissions from particular insurers, creating an incentive to bias consumers toward certain products without transparency or regard for the consumer's best interest.

HANYS is concerned that exclusively relying on web-brokers or direct enrollment entities to operate the consumer-facing website would create unnecessary consumer confusion regarding which platform to use when applying for health insurance and may increase consumer susceptibility to inaccurate eligibility determinations, misleading marketing practices or fraudulent actors.

Maintaining an integrated, state-operated eligibility and enrollment system will enable more accurate and real-time eligibility determinations in an ever changing policy environment, allow for seamless transitions between programs and help ensure that consumers are enrolled in the coverage for which they qualify without delay.

Recommendation: HANYS strongly urges HHS to reject this proposed change.

Expansion of catastropic plans

HHS proposes significant changes to increase the availability of catastrophic plans. HHS proposes to allow payers to offer catastrophic plans with terms of up to 10 consecutive years, with no requirement for income eligibility reverification. This proposal contradicts other provisions in this proposed rule that would require eligibility verification.

In addition, HHS proposes to codify and expand on its September 2025 hardship guidance, allowing a hardship exemption for anyone, regardless of age, as long as their household income is below 100% of the federal poverty level or above 250% of FPL.

Catastrophic plans are qualified health plans that only cover preventive services and three primary care visits before an enrollee reaches the plan's annual maximum out-of-pocket limit. While catastrophic plans have lower premiums, they have significantly higher out-of-pocket costs for enrollees and premium tax credits cannot be used toward purchasing this type of coverage. The *Affordable Care Act* designed these types of plans to cover individuals with low expected utilization — catastrophic plans are not designed as long-term coverage solutions.

While New York permits catastrophic plans in certain circumstances, given the lack of comprehensiveness compared to QHPs, the NYSOH routinely encourages individuals to choose more comprehensive coverage.

HANYS believes that HHS must maintain the current structure and limitation of catastrophic plans. Further eligibility expansion would lead to more underinsured people, which in turn would directly impact New York's hospitals and health systems under our state's Hospital Financial Assistance Law. HFAL requires hospitals to reduce or eliminate cost shares for those with incomes up to 400% FPL and have a medical cost share exceeding 10% of their gross income in the past 12 months (across all providers). In addition, expanded eligibility would negatively impact the risk pool for QHPs, further increasing premiums for those individuals.

Recommendation: HANYS strongly urges HHS to reject this proposed change.

Higher cost-sharing for catastrophic and bronze plans

HHS proposes to increase the annual maximum out-of-pocket costs for both catastrophic and bronze-level plans. Catastrophic plans would rise to $15,400 for an individual and $27,600 for a family, with plans not covering additional benefits beyond the statutory three primary care visits and free preventive care until the enrollee's cost-sharing has reached 130% of their MOOP. Bronze plans would also be allowed to exceed the statutory limit on out-of-pocket costs as long as the insurer offers at least one bronze plan that does not exceed the limit. These proposals reinterpret the ACA requirement that plans meet both actuarial value and MOOP.

Higher cost-sharing increases financial burdens on consumers, decreasing access to healthcare and worsening health outcomes. It also increases hospitals' and health systems' costs due to more uncompensated care. With the additional changes to Medicaid and marketplace eligibility from H.R. 1 and the expiration of advanced premium tax credits, the number of uninsured and underinsured patients at New York hospitals and health systems will continue to grow, along with their uncompensated care.

Recommendation: HANYS strongly urges HHS to reject this proposed change.

Eligibility limitations

HHS proposes aligning its regulations with the changes in H.R. 1 that limit eligibility for premium tax credits. CMS would add a new definition of "eligible noncitizen" that is consistent with the definition of "eligible alien" in H.R.1. In addition, CMS proposes to add "eligible noncitizen" to the Basic Health Program rules.

HANYS acknowledges that these changes are consistent with H.R. 1 and only affect eligibility for federal premium tax credits. While it is our understanding that these changes do not impact eligibility for the BHP or for full pay QHPs offered on the NYSOH, we have concerns over the anticipated cost shift to states that currently operate BHPs.

> Recommendation: **HANYS requests clarification from HHS that this provision does not impact eligibility for the BHP or full-pay QHPs. HANYS urges HHS to continue to allow BHPs to receive federal funding for eligible noncitizen participation.**

Low-income monthly special enrollment period

HHS proposes to end the monthly special enrollment period for those with projected household incomes at or below 150% of the federal poverty level. For a single adult, that's an income of $23,940 for 2026. This provision, originally in the 2025 Marketplace Integrity and Affordability final rule, was only meant to be in effect for 2026, meaning the option would be available in 2027. HHS is now proposing to permanently end this option.

HANYS supported the creation of this special enrollment period when it was originally proposed in 2021. We have consistently advocated for policies that decrease the uninsured population. Offering more opportunities to enroll in coverage, especially for populations that experience high enrollment instability, supports the goal of protecting patients and increasing insurance coverage. This SEP acts as an additional safety net for consumers transitioning from Medicaid or the Children's Health Insurance Program into other coverage and has had a lower-than-anticipated risk of adverse selection.

The NYSOH continuously and consistently ensures the integrity of the SEP application process. CMS has not presented any evidence of fraudulent enrollment in state-based exchanges. HANYS opposes the elimination of this SEP and strongly supports continued state flexibility with respect to all SEPs.

> Recommendation: **HHS should not finalize this proposal.**

Essential health benefits

HHS proposes reversing a policy that allowed plans to include routine non-pediatric dental services as an EHB. Routine adult dental services are a key piece of preventive healthcare. Access to dental care improves health outcomes for costly chronic conditions and reduces risk for adverse birth outcomes; untreated dental disease can contribute to more serious and costly medical conditions over time.

It is important to continue to address longstanding gaps in dental care coverage for adults. Combining this coverage into benchmark plans makes it easier for enrollees to navigate their own coverage and have access to more comprehensive care. Requiring stand-alone dental coverage creates additional barriers, including separate premiums, provider networks and deductibles.

In addition, HHS proposes restoring a prior standard as it relates to EHBs and states defraying the costs of additional mandated benefits in the small group and individual markets. HHS would undo its 2024 rule that required states to defray the costs of new benefit mandates that went beyond the benefits in the state's benchmark plan, but did not require states to absorb the cost of a new mandate if the benefit is already included in the benchmark plan. Under this proposal, any state-required benefit would be considered "in addition to EHB" if it is required by state action after Dec.

31, 2011; is specific to required care, treatment or services; and is not mandated for compliance with federal requirements.

These two proposals undermine states' ability to strengthen the health and well-being of their residents and forces states to spend substantial resources to amend state laws, incur significant operational costs or otherwise face large penalties for failure to comply.

> Recommendation: HANYS requests that CMS preserve a state's flexiblity to include routine non-pediatric dental services as an EHB. We strongly urge HHS not to finalize these two proposals.

Non-network plan certification

HHS proposes allowing non-network plans to receive QHP certification. Non-network plans do not rely on a contracted set of providers; instead, these plans set specific benefit amounts based on an established methodology such as a percentage of a publicly available benchmark, a reference-based pricing structure or another reimbursement standard (Medicare). As part of the proposal, payers would need to demonstrate that a sufficient range of providers would accept the plan's benefit amount as payment in full.

Allowing exchanges to certify non-network plans would lead to insufficient, untimely and unreliable access to providers, compared to network plans. We have concerns about how a state is supposed to monitor these types of plans and ensure that a considerable number of providers accept the benefit amount as payment in full. While HANYS appreciates that HHS is not requiring SBEs to permit non-network plans, we fundamentally oppose the idea of allowing QHPs to offer non-network plans.

> Recommendation: HANYS requests that HHS not finalize this proposal.

Failure to file and reconcile

HHS proposes to reinstate a policy deeming an individual ineligible for future premium tax credits if they fail to file their federal income tax and reconcile premium tax credits for one year. However, this time, the proposal would only apply to federal-facilitated exchanges. CMS would allow SBEs to select either the re-proposed one-year policy or continue the current two-year policy until plan year 2028, at which point all exchanges would have to follow the one-year policy.

HANYS supported the prior change to two consecutive tax years as it offered a method for both ensuring that consumers are correctly filing and recording APTCs for tax purposes and maintaining affordable coverage for the greatest number of people. The punitive result of denying APTCs to consumers who fail to file and reconcile on their taxes is detrimental to the goal of ensuring healthcare coverage.

HHS offers no specific data to support its assertion that "a large number of people with FTR status are ineligible for APTC and that pausing removal of APTC due to an FTR status allows ineligible enrollees to accumulate tax liabilities." Furthermore, HHS is ignoring a federal court decisions that found no statutory basis to condition APTC eligibility on reconciling tax information.

> Recommendation: HANYS urges HHS not to finalize this proposal.

Income verification for income less than 100% FPL

HHS proposes requiring all enrollees who attest to a projected household income between 100% and 400% of the FPL but whose income verification results in a household income below 100% FPL to answer additional verification questions and provide supporting documentation. This policy is intended to ensure only eligible individuals above 100% FPL receive premium tax credits.

As HANYS noted in our repsonse to the 2025 Marketplace Integrity and Affordability rule, nothing has changed since the 2021 decision by the U.S. District Court for the District of Maryland vacating previous attempts to implement this policy. The court found that the provision effectively eliminated coverage for low-income consumers without any evidence that it would prevent fraud or abuse. Once again, HHS proposals would make it more difficult for individuals who need health insurance to access coverage. New York has strong processes in place to ensure the accuracy and integrity of eligibility determinations. This proposal would result in a significant unfunded cost for the NYSOH.

Furthermore, following finalization of the 2025 rule, the U.S. District Court for the District of Maryland stayed this provision, finding that HHS acted arbitrarily by instituting additional verification requirements without sufficient data justifying the need to do so.

> Recommendation: **HANYS urges HHS not to finalize this proposal.**

These proposals should be rejected

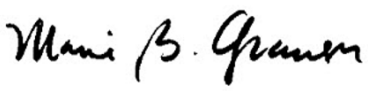
If finalized as is, many of the proposals would significantly restrict marketplace eligibility, enrollment and affordability. HHS proposes measures that would increase premiums, reduce access to healthcare and increase the administrative burden of applying for and verifying enrollment. All would discourage enrollment and decrease the number of people eligible for coverage.

Given the late timeline for this year's proposed rule, HANYS is concerned that a final rule will not be published before the premium rate filings and plan certification for plan year 2027 are underway.

> Recommendation: **We ask HHS to not finalize the proposals we have highlighted above.**
>
> **Alternatively, given the significant effects the proposed rules would have on state health insurance markets, HANYS respectfully requests a delay in implementation for any proposals with an effective date for 2027. This includes a phase-in approach for any finalized changes beginning no sooner than 2028.**

If you have questions, please contact Victoria Aufiero, vice president, insurance, managed care and behavioral health, at 518.431.7889 or vaufiero@hanys.org.

Sincerely,



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