



March 13, 2026

Health

**NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE**

**Gotham Center
42-09 28th Street, WS 3-45
Queens, NY 11101-4132**

via electronic submission: www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services

**45 CFR Part 600
45 CFR Parts 153, 154, 155, 156, and 158
CMS-9883-P
RIN 0938-AV62**

**Re: Patient Protection and Affordable Care Act, HHS Notice of
Benefit and Payment Parameters for 2027; and Basic Health
Program**

Dear Administrator Oz:

The New York City Department of Health and Mental Hygiene (Health Department) appreciates the opportunity to provide comments in response to the U.S. Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) proposed Notice of Benefit and Payment Parameters for 2027 (Payment Notice) as published on February 11, 2026. The Health Department is concerned by a number of proposals in the rule that, if implemented, would threaten access to health coverage and services to New Yorkers.

Eligibility Changes for Catastrophic Plans (§ 155.605)

CMS solicits comments on its proposal to codify guidance from last September, which expanded eligibility for catastrophic plans to enrollees age 30 and above. The changes would make individuals ages 30 and over with household incomes below 100% of the federal poverty level (FPL) or above 250% FPL newly eligible for a hardship exemption. The Health Department has serious concerns that this change would contradict the aims of the Affordable Care Act (ACA) and fail to lower health care costs for enrollees, especially given recent policy changes such as H.R. 1 and the expiration of enhanced premium tax credits (ePTCs). We offer the following recommendation:

Recommendation #1: CMS should not implement changes that would expand eligibility for catastrophic plan coverage. The agency should maintain current age-based restrictions on enrollment in catastrophic plans.

Under the ACA, catastrophic coverage is only broadly available to those under age 30, while individuals 30 or older must qualify for an affordability or hardship exemption. Based on these restrictions, catastrophic plans are intended as a last resort for those who cannot afford to pay for metal-tier coverage. High maximum out-of-pocket (MOOP) limits, which currently exist and are only scheduled to increase in 2027, make catastrophic plans an untenable choice for anyone with a serious condition; even young, healthy enrollees run the risk of high out-of-pocket costs and/or severe debt in the case of a medical emergency.

Although the new proposal is intended to promote affordability, a multi-state study from October suggests that switching to catastrophic coverage will not lower insurance premiums for many people. Notably, after the expiration of ePTCs, a 45-year-old enrollee with an income of 250% FPL would pay \$436 less on average per month for the cheapest bronze-tier plan in their county compared to the least expensive catastrophic plan.¹ By county, premiums for catastrophic plans could be slightly cheaper on average (around \$100 monthly) for those with incomes above 400% FPL. However, any premium difference could be offset by substantially higher out-of-pocket costs if an enrollee experiences an emergency or needs ongoing care.

While the population ages 30 and over with incomes under 100% FPL are currently eligible for zero-premium Medicaid coverage in New York, a subset of this group is likely to become uninsured as a result of eligibility changes enacted through H.R. 1. Expanding their eligibility for catastrophic coverage, especially given the proposed increases to MOOP limits, could expose this group to much higher medical costs. The Health Department encourages CMS to explore ways to keep this population covered through Medicaid to prevent any disruptions in care or increased costs.

In addition to changes enacted through H.R. 1 that will restrict Medicaid eligibility, other federal policies may further shift individuals into catastrophic plans, even though, as noted above, such plans are intended to serve as a last resort. For example, the recent expiration of ePTCs has increased the cost of qualified health plans (QHPs) for many New Yorkers. In 2025, the White House Council of Economic Advisors estimated that as a result of increased access to Health Savings Accounts (HSAs) under H.R. 1 and expanded catastrophic plan eligibility, the number of catastrophic plan enrollees nationwide would rise from 54,000 to 3 million.² The New York City (NYC) region's individual marketplace, which had around 2,000 people covered by catastrophic plans in March 2024, could see a proportionally similar surge.³

Finally, the introduction of HSAs for catastrophic and bronze plans under H.R. 1 are unlikely to defray much of pre-deductible expenses for most lower-income households with less income to spare.⁴ A 2025 Government Accountability Office study showed that HSAs were more commonly used by those with higher incomes, as well as people in excellent or very good health.⁵ Among individuals enrolled in high-deductible health plans, 62 percent of those earning at least 1000% FPL were enrolled in HSAs or similar, compared to

¹ Anderson, D. M., Nagy, D., Drake, C. (2025, October 23). Will expanding catastrophic coverage eligibility increase marketplace premium affordability in 2026? *Health Aff Sch.* 3(11):qxaf202. doi: 10.1093/haschl/qxaf202.

² Council of Economic Advisors, Executive Office of the President. (2025, September 26). *Expansion of HSA Eligibility Under OBBB Act to Improve Marketplace Coverage, Affordability, and Access*. Retrieved from: <https://www.whitehouse.gov/research/2025/09/expansion-of-hsa-eligibility-under-obbb-act-to-improve-marketplace-coverage-affordability-and-access/>

³ Health Department analysis of insurer-reported data: New York State Department of Financial Services. (30 August, 2024). *2025 Final Exhibits*. Retrieved from: <https://myportal.dfs.ny.gov/web/prior-approval/2025-final-exhibits>

⁴ Park, E. (2006, June 12). *Health Savings Accounts Unlikely To Significantly Reduce Health Care Spending*. Center on Budget and Policy Priorities. Retrieved from: <https://www.cbpp.org/research/health-savings-accounts-unlikely-to-significantly-reduce-health-care-spending>

⁵ United States Government Accountability Office. (2025, November 20). *Health Savings Accounts: Information on Features and Use, and Characteristics of Account Holders*. GAO-25-107480. Retrieved from: <https://www.gao.gov/products/gao-25-107480>

32 percent of those earning up to 274%. Although the HSAs are designed to reduce the financial impacts of out-of-pocket expenses in a catastrophic plan, those who might benefit most are least likely to use them.

For the reasons outlined above, the Health Department strongly discourages the expansion of catastrophic plan eligibility to enrollees ages 30 and over.

Plan Changes to Bronze and Catastrophic Plans (§ 156.136, § 156.155)

CMS proposes that in order to keep up with increasing health care costs and to meet actuarial value (AV) requirements, insurers that offer bronze plans in the individual marketplace should be allowed to exceed the annual limitation on cost sharing by increments of 50 dollars, potentially with no upper bound. The proposal requires these insurers to have at least one bronze plan option that complies with ACA statutory limits. The Payment Notice also states that in order to maintain a “meaningful difference” between bronze and catastrophic plan AVs, insurers should be allowed to offer catastrophic plans that reach as high as 130% of MOOP limits. The Payment Notice states that this change is intended to make catastrophic plans more appealing to consumers.

In addition, CMS proposes to allow catastrophic plans to be designed with up to 10-year limits, with the goal of encouraging “value-based insurance designs.” The Payment Notice also suggests that insurers could vary plan designs in other ways, for instance by applying cost sharing limits on an annual versus term-long basis; or by varying cost sharing limits based on disease type, such as cancer.

The Health Department has concerns that these combined changes would, on top of expanded eligibility for catastrophic plans, expose individuals to even greater cost-sharing burdens and harm overall health care affordability. We offer the following recommendations:

Recommendation #2: CMS should not allow insurers to exceed the ACA maximum out-of-pocket limits for bronze and catastrophic plans. Instead, the agency should continue to follow ACA guidelines.

Allowing bronze-tier and catastrophic plans to have MOOP limits that exceed ACA standards would violate both the spirit and the letter of the ACA. MOOP increases would place unprecedented burdens on families already struggling to afford health care in NYC, especially when combined with other proposed changes in the Payment Notice.

As mentioned above, it is clear from the ACA design that catastrophic plans are not intended to be an appealing consumer option; instead, they stave off the worst health care costs but may still expose enrollees to thousands of dollars of expenses. Even before ePTCs expired, a 2025 KFF survey found that 62% of Marketplace consumers found it somewhat or very difficult to pay for out-of-pocket costs such as deductibles and copays.⁶

The Payment Notice would increase MOOP limits for catastrophic plans to \$15,400 for individuals and \$27,600 for families in 2027 – an untenable amount for many households, including those that would be newly eligible for a hardship exemption.⁷

⁶ Lopes, L., Sparks, G., Mulugeta, M., Valdes, I., Kirzinger A. (2025, December 4). *2025 KFF Marketplace Enrollees Survey*. KFF. Retrieved from: <https://www.kff.org/public-opinion/2025-kff-marketplace-enrollees-survey>

⁷ Keith, K. (2026, February 11). HHS Proposes Sweeping Changes For 2027 Marketplace Plans (Part 1). *Health Affairs Forefront*. DOI: 10.1377/forefront.20260211.352520

Recommendation #3: CMS should not allow insurers greater flexibility in catastrophic plan design, including allowing multiyear contracts, without conducting further research on potential impacts. Instead, the agency should follow precedent for “value-based insurance design,” ensuring future changes actually result in higher-value care.

Other changes to catastrophic plan structures permitted by the Payment Notice, including allowing multiyear contracts, could exacerbate the negative effects on consumers explained above. Given the broad flexibility afforded to insurers under the Payment Notice, it is hard to predict exactly how the proposed changes to catastrophic plan structures might affect health outcomes and costs for consumers. However, the proposal prioritizes cost-effectiveness for insurers rather than safeguarding the health of consumers.

In a federal policy context, including previous initiatives in Medicare, value-based insurance design has involved reducing cost-sharing for patients with certain health conditions in order to encourage high-value care.⁸ Allowing consumers to enroll in long-term catastrophic plans with higher MOOP limits would likely lead to reduced utilization of all but the most basic care, since only preventive care and three primary visits are covered free of charge. For people with serious health conditions such as cancer, this could have disastrous impacts on both physical and financial health.

For the reasons outlined above, CMS should not implement its proposed design changes to catastrophic plan coverage.

Additional Required Benefits (§ 155.170)

CMS proposes to redefine certain state-required benefits as “in addition to EHB [Essential Health Benefits]” such that benefits meeting exclusion criteria are no longer considered EHBs, regardless of inclusion in a state’s approved EHB-benchmark plan. Under this proposal, states would be responsible for defraying costs for additional required benefits that fall outside CMS’ proposed definition for inclusion unless a state repeals the mandated benefit or exempts coverage requirements for qualified health plan issuers. The Health Department has serious concerns that allowing the federal government to decide which state benefits are outside the scope of EHBs would undermine Congressional intent to ensure broad discretion to states in deciding which benefits should be included as EHBs under the ACA. Furthermore, the Health Department is concerned that this proposal would undercut access to services that states deem essential by increasing cost burden amid other federal funding cuts. Given these concerns, we make the following recommendation:

Recommendation #4: CMS should not modify the definition of state-required benefits to exclude certain services from EHB cost-sharing calculations. CMS should consider all state-required benefits listed in a state’s approved EHB-benchmark plan to be EHBs.

Under the ACA, the ten EHBs are defined in broad terms, intentionally leaving room for states to interpret and implement these benefits in ways they determine are most beneficial for their unique populations. Each EHB represents a broad category of care, under which a number of specific benefits might fall. By statutory design, these benefits often look different from state to state. In fact, CMS’ own regulations aim to ensure that EHBs are comprehensive and flexible for each state by defining the specifics of EHBs based on state-specific benchmark plans. In CMS’ 2025 payment rule, the agency clarified that any state-required benefits

⁸ Doshi, R., Fendrick, A. M. (2025, February 11). The End Of The MA Value-Based Insurance Design Model: What Next? *Health Affairs Forefront*. DOI: 10.1377/forefront.20250207.262401; Yeung, K. (2019, July). Value-Based Insurance Design: Current Evidence and Future Directions. *J Manag Care Spec Pharm*. 25(7):738-741. doi: 10.18553/jmcp.2019.25.7.738.

included in a state’s approved EHB-benchmark plan are to be considered EHBs for purposes of calculating federal subsidies and waiving state cost defrayal obligations.⁹ These cost protections appropriately incentivize states to adapt coverage requirements to meet evolving public health needs. For example, six states added mandated benefits to their benchmark plans between 2020 and 2024 for medications that treat opioid use disorder and/or reverse overdose in response to the nationwide opioid epidemic.¹⁰

In a reversal of such policies, the proposed rule aims to limit which benefits are counted as EHBs by excluding benefits that (1) were mandated by the state after December 31, 2011; (2) apply to small-group and/or individual insurance markets; (3) are specific to required care, treatment, or services; and (4) were not implemented as part of federal compliance. These conjunctive exclusion criteria would also extend to benefits approved in a state’s EHB-benchmark plan.

CMS’ proposal would limit the scope of services subject to federal cost-sharing calculations and ACA guardrails. State-required benefits that meet exclusion criteria would no longer be counted towards premium estimates for purposes of advanced premium tax credit (APTC) calculations, which would increase a state’s cost responsibilities and potentially deter states from adding new or maintaining existing benefit mandates. If states chose to keep non-EHB benefits in their benchmark plans, such services would no longer be subject to ACA protections, including non-discrimination requirements, annual cost-sharing limits, and restrictions on annual or lifetime dollar limits. This result contradicts CMS’ own stated aim in the 2025 payment rule of “promot[ing] consumer protections”.¹¹

The Health Department opposes these efforts by CMS to expand control over state EHB-benchmark plans, as such broad-reaching policies do not adequately account for states’ unique population needs. We urge CMS to omit this provision from the final rule.

Exchange Network Adequacy Standards (§ 155.1050, § 156.235, § 155.1051)

CMS seeks comment on several provisions that would loosen network adequacy standards for qualified health plans, including a proposal that would eliminate uniform network adequacy requirements across state-based exchanges (SBEs) and the federally facilitated exchange (FFE). Under this provision, SBEs and SBEs that use the federal platform (SBE-FP) would no longer need to meet minimum time and distance standards imposed by the FFE, nor conduct a formal quantitative network adequacy review to assess compliance with such standards.

In a separate proposal, CMS seeks to scale back a requirement that QHPs contract with at least 35% of essential community providers (ECP), at least 35% of federally qualified health centers (FQHC), and at least 35% of family planning (i.e., Title X) providers in a plan’s service area. Under the proposed rule, this minimum requirement would be reduced to 20% for the total ECP threshold as well as for the FQHC and family planning earmarks.

⁹ U.S. Department of Health and Human Services. (2025, June 25). *Patient Protection and Affordable Care Act; Marketplace integrity and affordability*. (90 Fed. Reg. 27074). Retrieved from: <https://www.federalregister.gov/d/2025-11606>

¹⁰ Pogue, S., Raimugia, S. Giovannelli, J., et al. (2024, November 14). *Enhancing Essential Health Benefits: How States Are Updating Benchmark Plans to Improve Coverage*. The Commonwealth Fund. Retrieved from: <https://www.commonwealthfund.org/publications/issue-briefs/2024/nov/enhancing-essential-health-benefits-states-updating-benchmark-plans>

¹¹ U.S. Department of Health and Human Services. (2025, June 25). *Patient Protection and Affordable Care Act; Marketplace integrity and affordability*. (90 Fed. Reg. 27074). Retrieved from: <https://www.federalregister.gov/d/2025-11606>

The Health Department is concerned that these proposals will weaken protections for consumers to access timely, culturally competent care. For these reasons, we recommend the following:

Recommendation #5: CMS should maintain its current requirement that SBEs and SBE-FPs establish and enforce quantitative time and distance requirements that are at least as strong as FFE standards. CMS should not scale back QHPs' minimum contracting requirements with ECPs, FQHCs, and family planning providers.

From 2015 to 2017, HHS unilaterally set and enforced minimum time and distance standards for plan networks. In 2017, the first Trump Administration rolled back federal oversight and began relying on states to conduct their own assessments. This approach was extended in a 2019 Payment Rule, but was ultimately vacated after a federal judge found that the Administration failed to meaningfully address public comments expressing concern about the adequacy of state standards and review processes.¹² In 2023, HHS resumed direct oversight of network adequacy standards and compliance for states using the FFE. In 2025, the Administration imposed these same minimum standards on SBEs and SBE-FPs.

While the Health Department strongly supports state flexibility in the design of insurance programs, we also recognize that minimum network adequacy standards are necessary to ensure baseline access to primary and specialty care providers. Indeed, inadequate provider networks have been linked to unmet health care needs and delayed care.¹³

CMS justifies eliminating minimum federal oversight by asserting that states have demonstrated standards and reviews that “met or exceeded the requirements finalized in the 2025 Payment Notice.”¹⁴ However, the assertion is based in part on an analysis of the effect of the 2025 policy that is now being reconsidered, and there is no exploration of what states are likely to do in the absence of federal standards and oversight. Further, per CMS’ own admission, there are frequent discrepancies between QHP-reported provider directory data and secret shopper reviews.¹⁵ In removing additional measures of accountability embedded in current federal policy, plan issuers may be less incentivized to align standards and reviews with the FFE baseline, leading to discrepancies in care networks that will invariably impact vulnerable communities. As such, we recommend that CMS omit this provision from the final rule.

CMS’ proposal to scale back plan obligations to ensure sufficient access to ECPs, including FQHCs and family planning providers, also undermines the Administration’s purported goal of improving the health of U.S. residents. According to the Health Resources and Services Administration: “health center [FQHC] patients have better outcomes at lower cost.” This is true even when accounting for disproportionate

¹² City of Columbus v. Cochran, 523 F.Supp.3d 731 (D. Md. 2021)

¹³ Hughes, P. M., Wu, B. S., Annis, I. E., Brunelli, C., Kurth, N. K., Hall, J. P., & Thomas, K. C. (2022). Association of Inadequate Provider Networks with Unmet Need for Health Services and Self-Employment among People with Disabilities. *Journal of health care for the poor and underserved*, 33(2), 984–997. <https://doi.org/10.1353/hpu.2022.0076>

¹⁴ U.S. Department of Health and Human Services. (2026, February 11). *Patient Protection and Affordable Care Act, HHS notice of benefit and payment parameters for 2027; and Basic Health Program* (91 Fed. Reg. 6292) (proposed rule). Retrieved from: <https://www.federalregister.gov/d/2026-02769>

¹⁵ United States Government Accountability Office. (2022, December). *Private Health Insurance: State and Federal Oversight of Provider Networks Varies*. (Report to Congressional Committees). Retrieved from: <https://www.gao.gov/assets/gao-23-105642.pdf>

morbidity rates among patients who use FQHCs versus other health care settings.^{16,17} Additionally, other ECPs like Title X clinics and Ryan White providers are considered trusted sources of care for sensitive health conditions and have been demonstrated to outperform other provider types across access and outcome measures.^{18,19}

The Health Department firmly believes in investing in primary care institutions as a means of improving health outcomes and lowering health care costs. These values reflect longstanding policy established by the ACA and meaningfully improved under CMS' 2023 and 2024 payment rules. For these reasons, and in alignment with CMS' long history of supporting such institutions, CMS should also withdraw this proposal.

H.R. 1 Implementation

In the Payment Notice, CMS proposes to implement several provisions of H.R. 1, including changes related to eligibility for APTCs based on immigration status. While we recognize that CMS is obligated to carry into effect the laws passed by Congress and signed by the President, the Health Department once again strongly objects to these changes, which will hurt New Yorkers by making health insurance less readily available and affordable. As a result of H.R. 1, New York State intends to revert back to its operation of a Basic Health Program, which has been suspended since 2024 in favor of a 1332 State Demonstration Waiver. While this choice will preserve access for many lower-income New Yorkers who rely on our Basic Health Program (known in New York as the Essential Plan), it will result in 450,000 New Yorkers statewide losing access to a low-cost, high-quality insurance option. The state did not make the choice to terminate its waiver lightly, but was forced to make difficult decisions based on the significant funding cuts present in H.R. 1. The Health Department will continue to fulfill its mission of protecting and promoting the health of all New Yorkers, despite this federal administration's actions to the contrary.

The Health Department appreciates the opportunity to submit these comments.

¹⁶ Health Resources & Services Administration. *Impact of the Health Center Program*. Updated August 2025. Retrieved at: <https://bphc.hrsa.gov/about-health-center-program/impact-health-center-program>

¹⁷ Vicki Fung, Damian Archer, Jennifer S. Haas, Terrence Shirley, Rajan A. Sonik, Cheryl Clark. 2025. Opportunities and Challenges for the Federally Qualified Health Center Program: A Critical Review. *Annual Review Public Health*. 47:In press. <https://doi.org/10.1146/annurev-publhealth-082224-022250>

¹⁸ Wells, R., Smith, N. K., & Rodriguez, M. I. (2024). *Contraception use by Title X clients and clients of other providers, 2015–2019*. *Women's Health Issues*, 34(1), 59–65. <https://doi.org/10.1016/j.whi.2023.10.001>

¹⁹ Weiser, J., Beer, L., Frazier, E. L., Patel, R., Dempsey, A., Hauck, H., & Skarbinski, J. (2015). Service Delivery and Patient Outcomes in Ryan White HIV/AIDS Program-Funded and -Nonfunded Health Care Facilities in the United States. *JAMA internal medicine*, 175(10), 1650–1659. <https://doi.org/10.1001/jamainternmed.2015.4095>