Suburban Hospital Alliance of New York State, LLC

Nassau-Suffolk Hospital Council

Northern Metropolitan Hospital Association

April 7, 2025

Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

RE: CMS-9884-P: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability

Dear Administrator Oz:

The Suburban Hospital Alliance of New York State, which represents hospitals and health systems in New York's Hudson Valley and on Long Island, appreciates the opportunity to comment on the proposed rule referenced above.

The Suburban Hospital Alliance and its members are committed to ensuring that all New Yorkers have meaningful access to care, which requires access to affordable health coverage. We share CMS's stated goal of lowering insurance costs for consumers and ensuring that both the federal and state-based marketplaces operate efficiently. We also support reasonable measures that protect consumers from unauthorized enrollments or plan changes.

In partnership with the federal government, New York has been very successful in its efforts to expand low-cost coverage, resulting in an uninsured rate lower than all but eight other states. Currently 226,505 individuals are enrolled in qualified health plans in New York and 1.6 million in the state's Basic Health Plan. The Basic Health Plan, enhanced federal QHP premium tax credits, cost sharing reductions and Medicaid expansion together have ensured more robust health insurance coverage options for New Yorkers at lower cost.

Our Long Island branch, the Nassau-Suffolk Hospital Council, has been providing enrollment assistance for more than 20 years, starting with the creation of the Children's Health Insurance Program. Our team of facilitated enrollers are experienced in assisting families with navigating the rules and requirements of enrollment in all the public health insurance programs and have a deep understanding of the challenges that consumers face in qualifying for, enrolling in and affording health insurance. As a hospital association, we are also keenly aware of the consequences of lack of insurance coverage: patients who only seek care on an emergency basis, when their conditions are more expensive to treat; poor long-term prognosis of patients who lack routine and preventative care; and higher percentages of patients who require charity care from hospitals, which jeopardizes their financial stability and ultimately limits the services they can offer to all patients.

We are deeply concerned about many of the changes in the proposed Marketplace Integrity and Affordability Rule. Our experience working directly with consumers tells us that many of these proposals will result in fewer enrollees, more disruption in coverage, and less diverse risk pools, adding more costs to our health system, not fewer. This would be the opposite of the agency's stated intent in propagating the rule.

At minimum, we urge that state-based marketplaces (SBM) be excluded from the rule where there has been no indication of fraud or unauthorized enrollments. New York's SBM, the New York State of Health (NYSOH), for example, requires all enrollment to be completed through its own official website with enhanced security measures, stricter access protocols and consumer protections that reduce the risk of fraud. Whereas the federal marketplace allows enhanced direct enrollment (EDE), which permits approved insurers and web brokers to enroll consumers using private websites without the consumer needing to visit HealthCare.gov, this is not permitted in New York. If the risk of broker fraud is due to security flaws in the interface between EDE platforms and the federal marketplace, that certainly should be addressed for the benefit of consumers and for the integrity of the program. However, we respectfully urge that CMS defer to the experience and role of states that have created and run successful state marketplaces.

Shorter Open Enrollment Period (OEP)
CMS proposes to shorten the open enrollment period to Nov. 1 through Dec. 15 for all individual market coverage, on and off the marketplaces, including those operated by individual states, beginning in 2025 for the 2026 coverage year.

Currently, New York's open enrollment period runs from Nov. 1 through Jan. 31. A shortened OEP would result in significant operational challenges to New York and require a considerable number of hours to implement at a substantial cost to the state. Shortening the annual enrollment period also would put tremendous strain on NYSOH's navigators and assistors, making it harder for them to provide timely assistance and increasing the risk of eligible individuals losing coverage, particularly those with complex financial situations and life changes. In addition, data shows that later enrollees tend to be younger and healthier. A shortened time frame would result in healthy enrollees missing the enrollment period and going without coverage. Fewer young adult enrollees would have an adverse impact on the remaining risk pool, making coverage more expensive for all.

Suburban Hospital Alliance recommends that CMS maintain the current open enrollment dates. Should CMS finalize the proposed changes to shorten the 2026 open enrollment period, we strongly urge CMS to continue to allow SBMs the flexibility to set their own open enrollment periods.

Eliminating the Low-Income Monthly Special Enrollment Period (SEP)
CMS proposes to end the monthly SEP for those with projected household incomes at or below 150 percent of the federal poverty level (FPL).

Our staff have supported individuals enrolling through the SEP since its inception. In our experience, offering additional opportunities to enroll in coverage is essential for populations that experience high levels of coverage instability. The SEP is a safety net for those transitioning from Medicaid or CHIP into other coverage without markedly increasing adverse

selection. If finalized, this proposal would be effective 60 days after. This will lead to a significant number of individuals experiencing gaps in coverage and higher costs for care.

We support maintaining the current monthly SEP for individuals with modest incomes.

Requiring Additional Documentation of SEP Triggering Events
During President Trump's first term, consumers in the federal marketplace were required to submit documentation proving their eligibility for most SEPs -- such as loss of employer-based health insurance, marriage, pregnancy, birth, adoption, etc. — as a condition of enrollment. Prior to this, individuals were largely allowed to self-attest that they had experienced a life-changing event, allowing them to enroll in coverage outside of the OEP. The Biden Administration relaxed the documentation requirements after reviewing evidence that the additional requirements were primarily discouraging younger, and often healthier, consumers from enrolling. Here again, this would have a negative impact on the diversity of the risk pool, leading to less affordable coverage for all.

CMS is proposing to reverse the Biden policy and re-instate pre-enrollment verification for most SEPs. The rule would further require all marketplaces, including SBMs, to conduct eligibility verification for at least 75 percent of new enrollments through SEPs beginning with the 2026 plan year. This change would increase the administrative expense of enrollment for the federal marketplace and SBMs.

Additional administrative barriers for those seeking enrollment ultimately leads to an increase in individuals without insurance. For that reason, Suburban Hospital Alliance opposes this provision and recommends that CMS continue to allow self-attestation of SEPs.

Updating Premium Adjustment Percentage (PAPI) Methodology
CMS proposes to update the methodology for calculating the premium adjustment percentage, using private insurance premiums to help set the annual limitation on enrollee cost sharing.

This proposed rule would sharply increase the share of income that individuals pay for premiums after tax credits and the maximum out-of-pocket limit. People with low incomes who enroll in plans with cost-sharing reductions that reduce deductibles, and other out-of-pocket costs also would face higher out-of-pocket maximums. This means sick individuals would face out-of-pocket expenses roughly 15 percent higher in 2026 for necessary treatment; some percentage of healthy individuals would likely forgo coverage altogether due to increased costs.

At minimum, we recommend that CMS gradually phase in the revised methodology to mitigate the impact on consumers and reduce the likelihood that fewer individuals will obtain or retain coverage.

Deferred Action for Childhood Arrivals (DACA) Recipients
CMS proposes to change the definition of "lawfully present" so that DACA recipients would no longer be eligible to enroll in the marketplace or Basic Health Plans or receive premium tax credits or cost-sharing reductions. There are approximately 8,000 DACA individuals covered in New York State under a QHP or New York's Basic Health Plan.

New York historically supported coverage for this population by enrolling income-eligible enrollees in either fully state-funded Medicaid or Child Health Plus insurance prior to the 2024

rule that declared these individuals to be lawfully present for the purposes of coverage. Rescinding the 2024 regulation and extending this restriction to coverage provided with state-only dollars will impair access to health care, increase the number of uninsured, and drive-up spending on emergency medical care. For these reasons, we urge that CMS retain eligibility for DACA recipients.

Canceling Advance Premium Tax Credits (APTC) for Failure to Reconcile
Marketplace enrollees are eligible for APTCs based on their projected income for the year. If they received APTCs, they must file a tax return for that year; if there is a difference between the projected income and their actual income, they must reconcile those amounts and pay back any excess APTCs for which they were ultimately ineligible. Under current regulation, if an enrollee fails to file a tax return and reconcile their APTCs for two consecutive years, they will lose eligibility for premium tax credits. The additional year was given to acknowledge the burden, confusion, and difficulty this process is for consumers, in addition to delays and errors by the IRS that impact eligibility and often take time to resolve.

CMS proposes to end eligibility for APTCs for those who fail to file and reconcile after just one year, not two. The additional administrative burdens on enrollees will likely result in many dropping coverage they can no longer afford, increasing the number of uninsured. In addition, it is not clear that SBMs or the IRS have sufficient time to implement these changes in time for the 2026 plan year. We recommend that CMS retain the two-year reconciliation period.

In summary, the Suburban Hospital Alliance of New York State is extremely concerned that if finalized, this proposed rule would severely restrict marketplace eligibility, enrollment, and affordability, reversing decades-long improvements in health insurance coverage. **For all the reasons listed above, Suburban Hospital Alliance of New York State recommends that CMS withdraws this rule in its entirety and focus more narrowly on addressing the causes of broker fraud in the federal marketplace.**

Sincerely,

Stacy L. Villagran

Stacy L. Villagran
Chief Operating Officer