Friday, March 13, 2026

Robert F, Kennedy, Jr., Secretary
Department of Health and Human Services
Centers for Medicare & Medicaid Services
Office of the Secretary
Attention: CMS-9883-P, P.O. Box 8016
Baltimore, MD 21244-8016

Re: RIN 0938-AV62; CMS-9883-P - Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2027

Submitted to: **https://www.regulations.gov/commenton/CMS-2026-0496-0002**

Dear Secretary Kennedy:

Fenway Health takes this opportunity to comment on the Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) proposed rule, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2027 (hereinafter NBPP 2027 or Proposed Rule).

Before turning to the substance of the 2027 NBPP, which requests comments on a myriad of issues, each with complex impacts on markets, consumers, providers, and issuers, we comment that HHS's decision to publish the Proposed Rule with a 30-day comment period leaves researchers and practitioners with too little time to properly consider and analyze the impact of the proposals. We recommend that HHS withdraw the proposed rule and reissue an NPRM with sufficient time for notice and comment.

Several provisions in the Proposed Rule would increase administration and operational burdens for consumers, health plan administrators, and regulators, burdens which can result in delays in coverage, increased coverage turnover, and greater operational burden for providers assisting

consumers with marketplace enrollment. Many portions of the proposed rule run counter to the statutory text of the ACA and counter to public policy.

I. Effective ECP Review Program Requirements for Non-Network Plans and Implementation of an Effective ECP Review Program (§ 155.1051 and § 156.235)

Fenway Health strongly opposes the proposal to reduce the minimum percentage of Essential Community Providers (ECPs) that issuers must contract within each plan's service area from 35 percent to 20 percent, including the separate threshold applicable to community health centers. As HHS is aware, the increase to 35 percent for plan year 2026 has only recently been enacted. It is premature to reverse course before HHS, states, and stakeholders have had the opportunity to assess the impact of the higher threshold on access, plan participation, and enrollee outcomes. Reducing the threshold to 20 percent would substantially weaken requirements for Qualified Health Plans (QHPs) to contract with ECPs that serve predominantly low-income and medically underserved individuals. Section 1311 of the Affordable Care Act (ACA) provides that QHPs "shall … include within health insurance plan networks those essential community providers, where available, that serve predominantly low-income, medically underserved individuals." This language reflects Congress's clear intent that issuers engage in good-faith contracting with ECPs located in their service areas. Reducing the participation standard, particularly when paired with the proposed removal of the narrative justification requirement, would diminish transparency and erode accountability mechanisms that help ensure compliance with this obligation.

The proposed reduction would not provide any meaningful reduction in issuer costs but would harm beneficiaries; indeed, the reduction may increase issuer costs by disrupting beneficiary care, resulting in higher cost services. Issuers have clearly been able to establish networks with 35 percent of ECPs – as the proposed rule notes. We are deeply concerned that the proposed reduction in ECP coverage would harm consumers through restricted access to the appropriate specialty care, dangerous and costly treatment interruptions and poor access to culturally responsive care providers. Many beneficiaries who use ECPs have long-standing relationships with these providers and have built relationships that are a key component of successful

management of chronic illnesses and disabilities. Allowing issuers to remove these providers from their networks will lead to care interruptions and may cause beneficiaries to forgo care entirely, rather than visit an unfamiliar provider without experience caring for disadvantaged or complex care populations.

II. Allowing Federally Facilitated Exchange (FFE) states to conduct their own provider access and ECP certification reviews

Fenway Health also opposes allowing Federally Facilitated Exchange (FFE) states to conduct their own provider access and ECP certification reviews. The Secretary should not relinquish to the states his duty to monitor network adequacy; the result would undermine Congress's intent to subject health plans to uniform standards that apply in all Exchanges, rather than varying standards across the country. States may lack the resources to establish their review processes, draining already strained budgets. Variability in how states interpret or operationalize "effective" review programs, particularly in the absence of a clear federal floor, risks inconsistent application and enforcement of ECP standards. Strong federal oversight of ECP participation standards ensures that families have adequate access to affordable, quality care delivered within their own communities. Congress designed the ECP provision to guarantee that consumers purchasing coverage through the Marketplace have access to trusted providers. We urge HHS to establish clear, uniform criteria and publicly available benchmarks that states must satisfy to qualify as having an effective ECP Review Program. Without safeguards, there is a risk that ECP contracting requirements will be interpreted or enforced less rigorously, potentially limiting safety net providers inclusion in QHP networks.

The financial and operational implications for health centers and ECPs are significant and directly affect consumer access to care. ECPs contract with marketplace plans to expand access for consumers that need access to affordable and accessible primary care services in their communities. If ECPs become out of network due to contractual changes with marketplace plans, this will cause financial harm to ECPs by increasing their uncompensated care costs or losing patients with established relationships due to changes in coverage. Reducing the number of in-

network providers has been shown to lower plan costs but also to limit enrollee choice, increase waiting times, and complicate continuity of care for individuals who must switch plans to stay with their provider of choice. Additionally, enrollees who receive care from out-of-network providers frequently face coverage denials or substantially higher out-of-pocket costs, undermining the financial protection that coverage is intended to provide. These findings underscore that the size and composition of provider networks directly affect both access to care and the degree of financial security afforded to enrollees.

Reducing the ECP contracting threshold would increase the risk that issuers would contract with fewer community health centers. This change could lead to narrower Marketplace networks and greater likelihood of ECPs exclusion, which would disrupt established care relationships and increase out-of-network costs for consumers with limited access to health care. Such disruptions to established patient-provider relationships undermine continuity of care and may further limit access in rural and medically underserved communities.

We strongly urge HHS to maintain the current 35% standard to provide issuers' most vulnerable members access to care and the ability to continued service at the community health centers which for many years were the only places willing to see them without insurance. Removing ECPs from issuer networks reduces enrollees' ability to access care and remain healthy.

III. Eligibility Verification and Income Determinations

Failure to File and Reconcile (§ 155.305)

Fenway Health recommends that HHS withdraw the proposal to amend § 155.305(f)(4) to deny Advance Premium Tax Credits (APTCs) to tax filers who have failed to file and reconcile their APTCs for a single year. Implementation on the federal platform in FY 2027, along with optional earlier adoption by SBEs, would negatively impact enrollees who disproportionately

encounter health-harming legal problems and other social drivers of health, like poverty. In 2025, one in four Americans waited until the last minute to file their taxes, with 21% of respondents stating they do not feel prepared and feel the tax filing process is too complicated and stressful. Additionally, a 2024 survey of over 2,000 people aged 18 or older found that more than half lacked basic tax knowledge, with only 2% possessing "proficient" tax knowledge. With the median household income reported at $83,730 in 2024, access to APTCs can be crucial for affording comprehensive health insurance coverage.

Of the 35,000 patients whom Fenway Health serves, 7% are uninsured altogether, and 36% are at or below 200% of the federal poverty level (FPL), which makes them eligible for our sliding fee discount program. We serve some of the most financially vulnerable patients. This provision would make it harder for them to afford Marketplace insurance, if eligible.

We also know that failing to file APTCs properly is not always the consumer's fault. This proposed rule and the 2025 Marketplace Final Rule acknowledge that delays and errors in the Internal Revenue Service (IRS) processing of tax returns, as well as issues with sharing tax return information with the Exchanges, can cause the IRS to incorrectly note an enrollee with a Failure to File and Reconcile (FTR) status. We urge HHS to continue the current policy of denying APTC only after a tax filer fails to file and reconcile their APTC for two consecutive years. This will help balance competing concerns and better understand the potential impacts of the new policy on improper APTC payments in Exchanges.

Income Verification When Data Indicates Income <100% FPL (§ 155.320(c)(3)(iii))

Fenway Health recommends that HHS withdraw the proposal at § 155.320(c)(3)(iii) to require all Exchanges to generate annual household income inconsistencies in certain circumstances when applicants report a household income that is *greater than* the income amount represented by income data from trusted sources. We anticipate that this proposal will negatively affect Exchange operations and ultimately have negative ramifications for the lowest-income enrollees. The provision directs verifiers to use both the applicant's projected income for the coming year and recent IRS tax return data to determine whether the applicant qualifies for APTCs. If

projected income is inconsistent with what is shown in tax data, the Exchange generates a "data matching issue," or DMI. The consumer must then provide additional information to substantiate their projection; if they do not, APTC eligibility is determined based on tax data.

This proposal will disproportionately impact very low-income consumers. It will create a substantial administrative burden on these enrollees, who would be required to respond to the DMIs by submitting pay stubs or additional information, which could be difficult to gather to support their income projections, or risk losing tax credits. The proposed rule estimates that 81,000 people annually would be denied tax credits, reducing APTC payments by $213 million, and will create nearly 550,000 DMIs a year. Fenway Health is also concerned that this provision will divert valuable time and money at the Exchanges away from other pertinent enrollment and eligibility issues. The proposed rule states that the increased DMIs will cost over $32 million per year to both Federal and State-Based Exchanges. Additionally, these Exchanges will incur one-time costs to perform technical updates to eligibility systems, amounting to almost $776,000 for FFE and more than S16.3 million for SBEs in 2026.

Income Verification When Tax Data is Unavailable (§ 155.320(c)(5))

Fenway Health recommends that HHS continue accepting enrollee self-attestation of income and withdraw the proposal to modify § 155.320(c)(5).

This proposal appears to treat Exchanges with incomplete information as a data matching issue (DMI), placing the onus on enrollees to help alleviate the burden. This proposal also does not account for why a person's tax data is unavailable, beyond DMI. For instance, low-income taxpayers do not have to file a tax return or pay taxes if their income falls below the standard deduction amount for their filing status. For tax year 2026, for a single tax filer, it is $16,100, and for a married couple, $32,200. Instead, HHS should only implement income-verification requirements when there is actual reason to believe that fraud is occurring. The costs associated with income-verification are high for both consumers and administrators, without providing commensurate benefits.

There are many legitimate reasons for not having tax data available, like marriage, the birth of a child, name changes, and other demographic updates, but are others are not included in this proposed rule. Verification through other trusted data sources should apply to all enrollees, not just those with cases that fall under the reasons favored by HHS. Additionally, we believe the Administration underestimates that enrollees may need only one hour to submit documentation for this income verification requirement. In instances where the enrollee is experiencing homelessness or falls below the income threshold, gathering adequate documentation showcasing their situation would be difficult. They may need to work with case workers, their healthcare team, and others to gather sufficient evidence to demonstrate their potential income. This reality faced by enrollees makes self-attestation of income so crucial to prevent undue denial of affordable health insurance.

Pre-Enrollment SEP Verification (§ 155.420(g))

Fenway Health recommends that HHS withdraw the proposal requiring all Federal Exchanges to conduct pre-enrollment eligibility verification for at least 75% of new special enrollment period (SEP) enrollments. The proposed changes seek to curb alleged abuses of SEPs by requiring individuals to provide evidentiary proof and seek to limit enrollment by restricting SEPs. We believe these changes undermine the intent of the Affordable Care Act by restricting access to insurance coverage. Currently, it is widely accepted that self-attestation is a reliable standard. Requiring individuals to have pre-enrollment verification will prevent or significantly delay potential consumers from applying and enrolling in coverage, as often evidence is not readily available.

The administrative burden placed on State-Based Exchanges (SBEs) to perform pre-enrollment verifications will delay insurance coverage for enrollees. Applicants must submit additional documentation to verify the SEP, and while they can select a plan before submitting proof, their enrollment is “pended” until verification. Although SBEs may request the use of alternative SEP verification methods, doing so may impose substantial implementation costs. The estimates in the 2025 Marketplace Final Rule indicate that most SBEs would incur approximately $12 million

in one-time costs to implement alternative verification approaches, while five SBEs are estimated to incur about $60 million in one-time costs. Pre-enrollment verification would be required in advance of making a plan selection. Further, very few individuals who are eligible to enroll for coverage using a SEP actually enroll in coverage through this process. Assisters believe this is because individuals do not know about SEPs or do not realize they may be eligible for a SEP. This is in addition to ongoing annual costs to implement and operationalize SEP verification requirements.

The pre-enrollment process will likely delay coverage and access to life-saving medication and care. This could especially affect people moving from one part of the country to another. People who lose employer-provided coverage or are reentering society after being incarcerated often find it difficult to secure the necessary documentation. Delays in determining eligibility may also cause an individual to not be able to access insurance coverage or select a Qualified Health Plan within the 60-day period required. For uninsured individuals with expensive chronic conditions such as HIV, they many not be able to afford the out-of-pocket costs and may stop taking their medications as a result. This can lead to becoming ill and drug resistance.

We strongly urge HHS to eliminate the pre-enrollment verification requirement, as it will create delays in accessing new coverage. We believe that HHS should continue to randomly audit individuals to determine if there is a trend of abuse. For SEP periods that do not easily lend themselves to verification other than self-attestation, HHS should accept self-attestation or alternative documents as the proposed changes may disproportionately impact specific demographic groups. The proposed changes would increase administrative workload for enrollment assistance programs and could delay coverage effectuation and increase the risk of coverage gaps for consumers with unstable income, limited documentation, or housing instability. Instead of a burdensome and costly pre-enrollment verification, we recommend a streamlined implementation approach to minimize delays for populations with limited access to health care.

IV. Changes to Catastrophic Plans (§ 156.155)

Fenway Health also strongly opposes the proposed expansion of catastrophic plans. We believe this change would shift many low- and moderate-income individuals into coverage with extremely high cost-sharing and limited benefits, potentially destabilizing enrollment patterns. By broadening eligibility for these plans and increasing the maximum out-of-pocket limits to unprecedented levels, HHS risks encouraging enrollment in multi-year plans that lock consumers into high-deductible coverage that does not meet their evolving health care needs.

Expanding non-network plans and multi-year catastrophic plans could increase complexity for consumers navigating Marketplace coverage, and additional plan variability may make it more difficult for consumers to identify plans that include their providers and support continuity of care. Additionally, because APTCs cannot be applied to catastrophic plans, consumers who would otherwise qualify for subsidized bronze or silver coverage may instead enroll in lower-premium catastrophic plans, undermining continuity of care and resulting in forgone or delayed treatment.

Expanded use of catastrophic plans will be a catastrophe for public health. Costs for individuals and networks will rise, as these plans will not cover essential services. High deductibles copays will cause patients to not access health care. This will increase uncompensated care costs and financial burdens for safety net providers, including community health centers, who care for 34 million patients. The nation's health will suffer as a result.

Expansion of Hardship Exemption Eligibility (§ 155.605(d)(1))

HHS proposes expanding hardship exemption eligibility at § 155.605(d)(1) to consumers above 30 years old who are ineligible for APTC or cost-sharing reductions (CSRs) who are unable to purchase marketplace insurance to purchase catastrophic coverage. If finalized, this proposal is likely to weaken the broader marketplaces by drawing away younger consumers from the high-

actuarial value (AV) plans to low-value plans. It is counter to good public health policy and should be withdrawn.

Catastrophic coverage often has lower premiums, but results in higher costs to consumers. While this expansion aims to give certain individuals access to more affordable options, the policy may produce unintended consequences for enrollees, providers, and Marketplace stability. Under the proposal, individuals otherwise ineligible for APTCs or CSRs would qualify for a hardship exemption and thus be eligible for catastrophic plans—coverage with low premiums and high deductibles designed to protect against major medical costs, limited to a minimum of three primary care visits before the deductible. Although this may reduce premium costs on the front end, catastrophic plans expose consumers to far greater out-of-pocket expenses for most services, which can deter patients from receiving the care they need, including patients managing chronic disease or multiple comorbidities, a population ECPs serve in large numbers.

HHS should not finalize either of these regulatory proposals. The most direct way to achieve HHS' goal of supporting access to affordable, high-value coverage is to expand eligibility and generosity of the APTC for higher AV metals and higher income workers purchasing Marketplace Plans.

In context of other proposed changes that expand access to catastrophic coverage, the expanded hardship exemption may make such relatively unregulated insurance options more attractive relative to comprehensive Marketplace plans. HHS proposes to broaden access to catastrophic plans and even allow multi-year catastrophic plan terms at § 156.155, intended to increase consumer choice and affordability. However, analysis of the proposed changes suggests that increasing reliance on high-deductible catastrophic coverage could cause healthier individuals to abandon more comprehensive coverage, raising premiums across the remaining risk pool and reducing affordability for enrollees who need robust benefits. For consumers these dynamics risk creating dual harms: consumers enrolled in catastrophic plans may delay or avoid needed care because of high-deductible barriers, which undermines continuity of care and worsens health outcomes. Additionally, providers are likely to experience revenue loss as a larger proportion of

their patient population has less comprehensive coverage with significant cost-sharing obligations. Revenue volatility, administrative burdens, and increased uncompensated care burden strain safety-net provider capacity, just as affordability challenges elsewhere in the Marketplace may increase overall uninsurance rates. Fenway Health opposes these proposals.

HHS presents very little evidence or analysis on the potential interaction between the expanded hardship exemptions and changes to catastrophic plans. HHS should conduct and publish an actuarial analysis quantifying the projected impact of this hardship exemption on Marketplace risk pools, premiums, and federal subsidy costs before implementation of a policy of this scale.

V.Revised Standards for Broker Conduct and Marketing

Redefining sex discrimination

Fenway Health strongly opposes the proposal to amend § 155.220(j)(2)(i), which articulates nondiscrimination requirements among the standards of conduct that individuals who assist with or facilitate health insurance enrollment must meet. HHS proposes to strike a parenthetical clarifying that prohibited sex discrimination includes discrimination based on sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes, erroneously claiming the text at issue addresses "ancillary issues of gender ideology." We urge HHS to maintain this regulatory text, which protects consumers, and particularly women and LGBTQI+ people, from consequential barriers to health insurance.

Sexual and gender minority people experience significant barriers to culturally and clinically competent care. Comprehensive health insurance, with strong non-discrimination protections, is a key tool used to gain access. The removal of the explicit prohibition on sexual orientation, gender identity, and sex characteristics (SOGISC) nondiscrimination would make it harder for LGBTQI+ people to access health care. Anti-LGBTQI+ discrimination remains widespread in the United States. Thirty-six percent of LGBTQI+ Americans experienced discrimination in

2024, according to a national survey by NORC and the Center for American Progress.[1] Experiencing discrimination in health care causes LGBTQI+ people to delay or avoid medical care.[2] Anti-LGBTQI+ discrimination negatively affects the health and well-being of LGBTQI+ people.[3] It also correlates with disparities in risk factors. For example, a study of LGBT veterans found that those who experienced discrimination in health care reported higher rates of tobacco use and lower rates of disclosure of their LGBT identity to health care providers.[4]

Brokers, agents, and web-brokers exercise significant gatekeeping power in plan selection, benefit design, and access to enrollment assistance. Without explicit regulatory language clarifying prohibited grounds of sex discrimination, discriminatory steering, misinformation, and hostile treatment can persist under the guise of professional discretion or market practice, widening sex-related health inequities. Retaining the parenthetical language on prohibited sex discrimination grounds in the regulatory text is essential both to place covered entities on notice regarding their obligations and to support meaningful enforcement of § 1557 of the Affordable Care Act in a health insurance context.

Conclusion

The Affordable Care Act dramatically expanded coverage options and created patient protections. This led to some 44 million Americans accessing health insurance who would

[1] Smith C, Norris H. *The LGBTQI+ Community Reported High Rates of Discrimination in 2024.* Washington, DC: Center for American Progress. March 12, 2025. https://www.americanprogress.org/article/the-lgbtqi-community-reported-high-rates-of-discrimination-in-2024/

[2] Medina C, Mahowald L. *Discrimination and barriers to well-being: The state of the LGBTQI+ community in 2022.* Center for American Progress, Washington, DC. 2023. https://www.americanprogress.org/article/discrimination-and-barriers-to-well-being-the-state-of-the-lgbtqi-community-in-2022/

[3] Gruberg S, Mahowald L, Halpin J. *The state of the LGBTQ community in 2020. A national public opinion study.* Washington, DC: Center for American Progress, 2020, October 6. Available at https://www.americanprogress.org/issues/lgbtq-rights/reports/2020/10/06/491052/state-lgbtq-community-2020/

[4] Ruben MA, Livingston NA, Berke DS, Matza AR, Shipherd JC. Lesbian, Gay, Bisexual, and Transgender Veterans' Experiences of Discrimination in Health Care and Their Relation to Health Outcomes: A Pilot Study Examining the Moderating Role of Provider Communication. *Health Equity*. 2019 Sep 26;3(1):480-488.

otherwise have been unable to access it.[5][6] This represents a great advance for public health and health justice in our country. The ACA made it possible for many consumers to enroll in insurance when they previously had been denied because of pre-existing conditions. The patient protections in the ACA, such as the non-discrimination regulations, promoted equality, enhanced access, and saved lives—particularly for those who are most vulnerable. We are deeply concerned that the proposed rules will hurt the progress that has been made and will harm individuals in addition to leading to poor health outcomes, health disparities, and contribute to lower levels of public health across the nation.

For the reasons stated above, we strongly urge HHS to consider our comments, and reject the provisions described above, as you develop the final rule. If you have any questions, please contact information@fenwayhealth.org.

Sincerely,

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[5] KFF. "Affordable Care Act Marketplace and Medicaid Expansion Enrollment Reached a Combined 44 Million in 2024." January 15, 2025. Press release. https://www.kff.org/affordable-care-act/affordable-care-act-marketplace-and-medicaid-expansion-enrollment-reached-a-combined-44-million-in-2024/

[6] Lo J, Levitt L, Ortaliza J, Cox C. "ACA Marketplace premium payments would more than double on average next year if enhanced premium tax credits expire." KFF: September 30, 2025. https://www.kff.org/affordable-care-act/aca-marketplace-premium-payments-would-more-than-double-on-average-next-year-if-enhanced-premium-tax-credits-expire/

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