POLICY BRIEF

New Federal Health Insurance Rule to Impact Coverage in New York

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August 2025

Rockefeller SUNY Institute of Government

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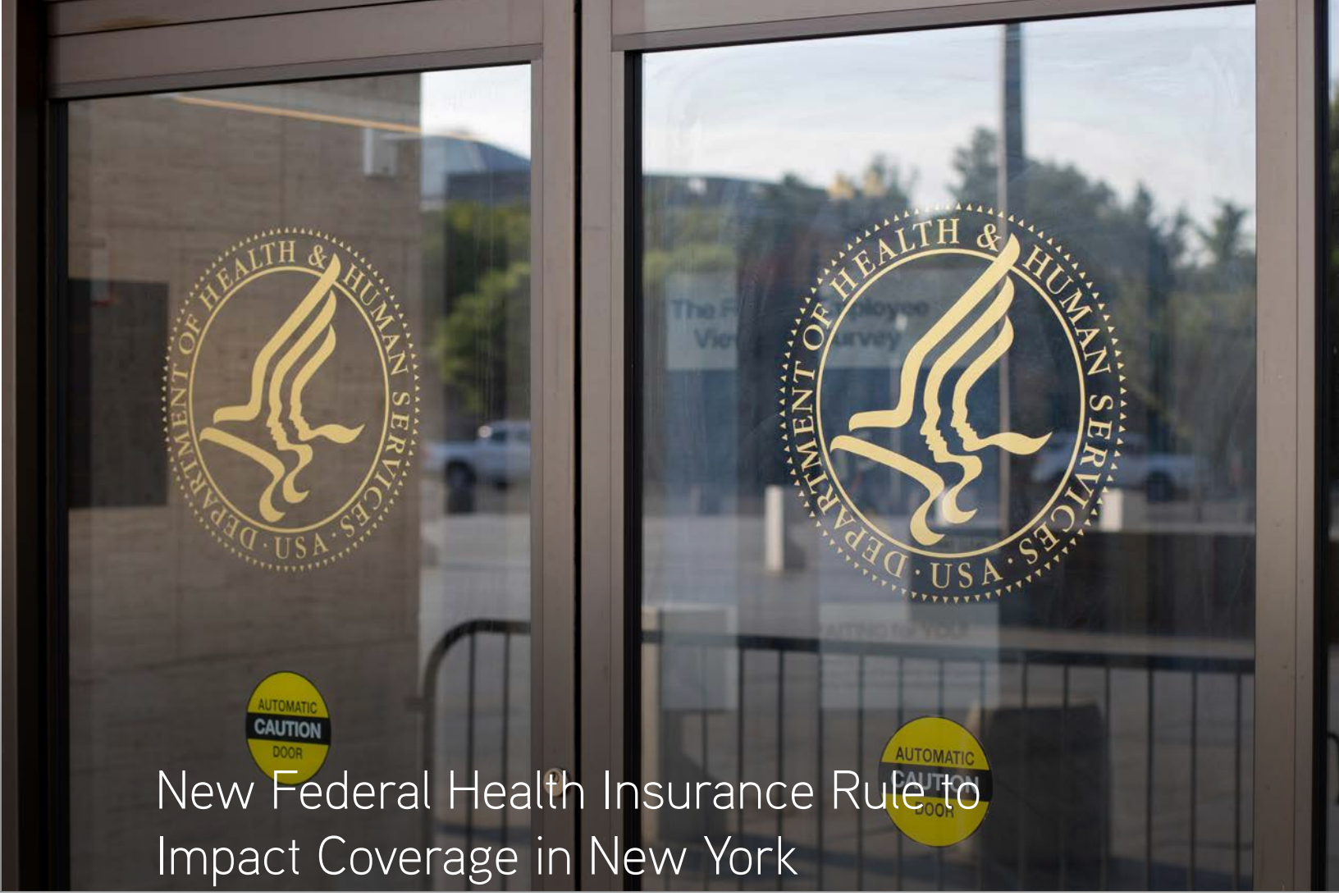


New Federal Health Insurance Rule to Impact Coverage in New York

Introduction

The Rockefeller Institute of Government is monitoring activity at the federal level that may have implications for New York's healthcare system. In addition to the enactment of the One Big Beautiful Bill Act (OBBBA), analyzed in a recent blog post,[1] this brief summarizes a new federal regulation from the US Department of Health and Human Services (HHS) that would alter regulations implementing the Affordable Care Act (ACA).[2] The Rule, titled "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability,"[3] which is scheduled to become final on August 25, 2025, is being challenged in a lawsuit by California, New York, and 19 other states.[4]

Many of the changes in the Rule include provisions that were struck from OBBBA by the Senate parliamentarian because they did not comply with the rules for passing a budget reconciliation bill with a simple majority.[5] The Rule allows the Trump administration to accomplish a similar result, despite the ruling by the parliamentarian; however, because rulemaking is generally easier to modify than statute, the Rule's provisions could be modified by a future administration without consent from Congress.

The Rule imposes a series of restrictions that HHS estimates will result in up to 1.8 million enrollees losing coverage nationally in plan year 2026.[6, 7] Because New York is both a state that has expanded Medicaid coverage eligibility under the ACA and currently operates a basic health plan (BHP) option,[8] known as the Essential Plan, New Yorkers with incomes up to 250 percent of the federal poverty level (FPL), equal to $80,375 for a family of four in 2005,[9] may be less significantly impacted. The estimated number of New Yorkers impacted by the Rule is roughly 226,000.[10] These are people who are enrolled in a qualified health plan (QHP)[11] through the NY State of Health (NYSOH)[12]—the state's official state-based ACA marketplace—where they can receive federal tax credits (known as "advanced premium tax credits" or shortened to "premium tax credits (PTC)")[13] that help reduce their premium payments on a sliding scale up to earning 400 percent of the FPL or $128,600 for a family of four in 2025.[14]

The Affordable Care Act in New York State

- **Medicaid Expansion**. The ACA offers states the ability to expand Medicaid eligibility to cover low-income adults up to 138 percent of the federal poverty level (FPL), which in 2025 is $21,597 for a single person and $44,367 for a household of four. Under the ACA, states that expand their Medicaid coverage are entitled to an enhanced federal match. Medicaid is supported by shared federal and state funding. Thus, for a Medicaid expansion state like New York, the federal funding share for the expansion population is greater than for the non-expansion population.
- **The Essential Plan**. New York's Basic Health Plan (BHP). New Yorkers with incomes up to 250 percent of the federal poverty level ($80,375 for a family of four in 2025) can enroll in this zero-premium, low-cost-sharing plan. The plan has no deductible and continuous enrollment.
- **The NY State of Health (NYSOH)**. In addition to being the gateway for enrollment in Medicaid, Child Health Plus, and the Essential Plan, NYSOH is New York's official state-based ACA marketplace for both individual and small group health plans. New Yorkers can enroll in qualified health plans (QHPs) through this marketplace and may receive subsidies called premium tax credits (PTCs) on a sliding scale based on income up to 400 percent of the FPL or $128,600 for a family of four in 2025. QHPs are offered by insurers in different "metal levels" determined by the ratio of plan coverage to out-of-pocket costs. Marketplace QHPs must follow various rules pertaining to the coverage offered and maximum out-of-pocket costs. NYSOH has an open enrollment period that is currently November 1 through January 31, with coverage starting January 1 for enrollment by December 15. Special enrollment periods allow those with a qualifying life event to enroll in QHPs at other times during the year.

As summarized below and discussed in our other analyses[15] the Rule includes both permanent and temporary changes or impacts[16] Permanent ones include:

1. less generous benefits;
2. more expensive coverage;
3. shorter enrollment periods;
4. limiting automatic reenrollment for certain enrollees;
5. eliminating coverage for certain deferred action for childhood arrivals (DACA) individuals; and
6. limiting coverage for gender-affirming care.

Temporary changes, which generally sunset at the end of the 2026 plan year, include:

1. significant new paperwork verification requirements;
2. newly allowing insurers to deny coverage for past-due premiums;
3. adopting a $5 monthly premium payment for certain enrollees who are eligible for a $0 premium; and
4. requiring the Federally Facilitated Marketplace (FFM) to verify eligibility for new special enrollment period (SEP) enrollments.

HHS justifies these changes largely to address a perceived improper enrollment problem. These changes (both permanent and temporary) raise several questions about the future of coverage nationally and in New York State. Like with the changes authorized in the OBBBA, the ramifications for New Yorkers are significant. The impacts on New York may be mitigated by the state's adoption of a basic health program option known as the Essential Plan, but the full scope of change is unknown. Below are some critical questions raised by the Rule and the OBBBA that will be discussed in depth:

- **How much are consumers paying for coverage?** Coverage costs include payments for premiums and out-of-pocket costs, as well as cost decreases due to the availability of subsidies. The Rule is likely to increase costs for consumers and businesses.
- **What benefits will be covered?** The Rule may affect coverage of the minimum essential benefits currently required under the ACA and the federal executive's authority to limit coverage through regulation. The Rule will likely reduce benefits currently required by the ACA to provide a minimum of comprehensive coverage.
- **Where does the Rule apply?** Will states that have developed their own marketplaces face different coverage requirements compared to states that use the federal marketplace? The Rule will likely result in uneven requirements in different states, contrary to the ACA's goal of establishing minimum national standards.
- **Who is covered?** Will the Rule affect coverage for noncitizens and alter the definition of "lawfully present" for the purposes of eligibility for health

insurance programs? The Rule will likely result in fewer New Yorkers eligible for ACA coverage.

- **How to impose checks against improper payments or enrollments without limiting appropriate coverage?** The Rule will likely impose new impediments to enrollment, while potentially addressing at least one concern about individuals remaining enrolled in an ACA subsidized plan without their knowledge.

The Rule

As noted above, the Rule includes a number of both permanent and temporary changes and their impacts.[17] Here, we summarize many of the key changes to further analyze their potential impacts on coverage in New York and to New Yorkers.

Permanent Changes

These are changes that will be permanent unless changed by a subsequent new regulation, statute, or court ruling.

Less Generous Benefits[18]

Currently under the ACA, insurers must offer plans at four "metal levels"—bronze, silver, gold, and platinum—each of which is defined by how much of the average enrollee's medical costs the plan covers, known as "actuarial values." For example, silver plans are supposed to cover 70 percent of average costs, with the remaining 30 percent of average costs paid by enrollees in aggregate through deductibles, copayments, and coinsurance. Currently, insurers are allowed to vary slightly from these percentages within a limited range (known as the *de minimis* range). For most plans, the current range is plus or minus 2 percent, but Marketplace silver plans, which are used to determine the value of premium tax credits (PTCs), are held to a tighter standard: +2 percent to 0 percent. This narrower range ensures that the silver plan used to calculate subsidies remains fairly generous, so consumers receive the full value of the financial assistance they are entitled to. However, under the Rule, HHS would widen these ranges to give insurers more flexibility. All individual and small-group market plans—except expanded bronze plans—would be allowed a range of +2 percent to -4 percent. Expanded bronze plans would have a wider range of +5 percent to -4 percent. Silver plans that include additional cost-sharing reductions for lower-income enrollees would be allowed a slightly narrower range of +1 percent to -1 percent. Essentially, this change in permitted plan coverage lowers the price of that standard plan to which federal PTCs for all consumers are anchored, inasmuch as the federal PTCs are calculated based on the second-lowest-cost silver plan available in a given area.[19] Therefore, introducing less generous plans reduces federal subsidies for consumers who want to keep their current plan. As a result, consumers pay more or enroll in less generous benefit designs.

- **HHS Rationale**. HHS notes that insurers have asked for this added flexibility to help them design plans with lower premiums. The agency also suggests that allowing less-generous silver plans could benefit unsubsidized consumers

(those who do not qualify for PTCs because their income is too high) by giving them access to cheaper options. However, the flip side is that these lower-value silver plans would become the new benchmark for calculating PTCs. PTCs are a subsidy provided to certain income-eligible individuals purchasing insurance in the individual and small group markets on a federal or state-based exchange. Accordingly, if cheaper silver plans are available, the value of the tax credit for everyone would go down, requiring subsidized enrollees to pay more out-of-pocket for similar coverage or choose a less generous benefit package to mitigate the lower subsidy. HHS estimates that rate of increase in premiums would decrease slightly—by about 1 percent overall—but that this policy change would reduce the total amount of premium tax credits by $1.22 billion in 2026 nationally.[20] Together, these changes reflect a shift toward reducing federal spending on subsidies and increasing insurers' flexibility, but they also raise concerns that consumers—especially those with lower incomes—will end up paying more for less coverage.

- **Impact on NY**. This change is likely to impact New Yorkers who purchase coverage in the individual and small group markets on NY State of Health, including the self-employed, gig workers, and employees of firms with fewer than 100 employees. The Rule will likely decrease the rate of increase in premiums and decrease the PTCs. The Kaiser Family Foundation estimates that in 2024, more than $124 billion in PTCs were distributed nationally, so HHS's estimated $1.22 billion in lower tax credits in 2026 would represent about a 1 percent decrease in premium tax credits available nationally. Kaiser also estimates that New Yorkers received about $933 million in PTCs (7.5 percent of the national total), but this excludes the approximately $13 billion, according to the New York State *2026 Enacted Budget Financial Plan*, that New York State receives through subsidies for the Essential Plan.[21] The exact amount that New Yorkers will lose in these tax credits is unknown. However, we can apply HHS's estimates to the Kaiser estimates and infer that a 1 percent reduction to premium tax credits received by New Yorkers would reduce subsidies by approximately $9 million for the 226,000 individuals purchasing coverage in NYSOH. Additionally, since PTCs support coverage provided through the Essential Plan, a 1 percent reduction to such subsidies could reduce federal subsidies by approximately $130 million annually. Therefore, the combined impact of allowing lower-value plans in the marketplace could reduce federal premium tax credits by approximately $140 million.

Increased Premium and Out-of-Pocket Costs for Consumers

Another permanent change in the Rule is expected to increase costs for private health insurance, including those who get coverage through their employer or through the ACA Marketplace. At the heart of this change is a revision to something called the "premium adjustment percentage," a measure used to set key ACA parameters such as the maximum out-of-pocket (MOOP) costs a person can face in a year,[22] and the level of subsidy consumers get through premium tax credits.

- **HHS Rationale**. HHS acknowledges the concerns expressed in many public comments on the Rule, including that the change may result in higher net premiums and out-of-pocket costs that will result in coverage losses, adverse selection, worse health outcomes, medical debt, and uncompensated care. Nevertheless, HHS defends the change, noting that it will result in reduced federal spending.
- **Impact on New York**. The Rule is expected to increase out-of-pocket costs as well as premiums for those with private insurance coverage through their employer or through NYSOH. This change would result in a premium adjustment percentage that's about 4.5 percent higher for 2026 than it would be under the current method.[23] The effects of this change could be felt in several ways.
    - First, the MOOP for people with commercial insurance—including Marketplace and employer-based plans—would increase by about 15 percent compared to 2025. In practical terms, that means consumers could be responsible for thousands of dollars more in medical bills before their insurance fully kicks in.
    - Second, according to the comments provided by New York State on the Rule,[24] people who receive premium tax credits to help pay for their Marketplace coverage could see their monthly premium costs increase by 4.5 percent (more than $300 per month for a family of four), because the government would contribute less toward the cost of a benchmark silver plan.
    - HHS expects this change to result in higher net premiums of about $530 million per year, and at least 80,000 Marketplace enrollees nationally would lose their health insurance coverage. Excluding the impact of DACA, New York expects the Rule would result in 6,000 fewer qualified health plan enrollments.

Shortened Open Enrollment Periods[25]

Beginning in 2027, the open enrollment period, which is the annual time period for consumers to enroll in new coverage, will be shortened. Currently, and since 2021, consumers have 76 days—from November 1 to January 15—to select or change coverage.[26] Under the Rule, that period will shrink to 45 days, ending on December 15.[27] There will be no change to the open enrollment period for plan year 2026.

- **HHS Rationale**. HHS argues the change promotes timely enrollment, prevents a month of lapsed coverage, and harmonizes ACA marketplaces with typical employer-based insurance timelines. HHS supports this position with the observation that inadvertent dual enrollment decreased in years when the deadline was December 15, and the assertion that the shortened timeframe poses less stress on enrollment assistors' budgets.
- **Impact on New York**. The precise impact on New York enrollment is yet to be determined. Because New York offers the Essential Plan, which has continuous

enrollment, consumers with incomes up to 250 percent of FPL would not be affected. However, this change would apply to the roughly 226,000 consumers who purchase coverage in the individual and small group market on NY State of Health in plan year 2027 and after. Consumer advocates caution that the reduced window could be difficult to comply with for individuals who need extra time to gather documentation, navigate technology, or understand complex plan options.[28], [29] Populations most at risk of unintentional coverage loss include those with limited English proficiency, those without internet access, and individuals with variable incomes.

Limits on Automatic Reenrollment

Another core element of the Rule is a new restriction on automatic reenrollment for certain types of plan enrollees. The change specifically limits the ability of bronze plan enrollees who are cost-sharing reduction (CSR)-eligible, meet certain criteria such as having the same provider network and benefits, and a lower or equivalent net premium to automatically enroll in a new plan without filing paperwork to opt in. The Biden administration previously extended authorization for consumers who failed to actively update their information to be automatically reenrolled in their current plan—or a similar one—and continue to receive subsidies based on prior-year data.[30] A CSR-eligible plan is a silver plan purchased through an ACA Health Insurance Marketplace that provides additional savings on out-of-pocket costs like deductibles, copayments, and coinsurance for individuals and families who qualify based on their income.[31] Bronze plans are not CSR-eligible.[32]

- **HHS Rationale**. HHS states that "implementing these policies for 2026 will strengthen the program integrity of the exchanges and protect consumers by ensuring that those fraudulently or improperly enrolled in fully-subsidized, zero-premium plans are not unknowingly enrolled in those plans for an additional year while the market readjusts to the expiration of the expanded subsidies" (Rule, at 15). HHS also argues that an opt-in step is necessary to address complaints received by HHS from consumers improperly enrolled in plans without their consent or knowledge. HHS contends that, in some instances, it created delays in care when such consumers were enrolled in Medicaid, but because of the QHP coverage, they were experiencing difficulty in obtaining provider reimbursements.
- **Impact on New York**. Presumably, the NY State of Health will choose to request HHS permission to opt out and retain a form of automatic reenrollment for the roughly 226,000 consumers purchasing coverage in its individual and small group markets. Whether HHS will grant such requests remains to be seen. Nonetheless, this shift marks a major departure from previous guidance issued by HHS to expand opportunities for individuals to maintain coverage. This earlier guidance was issued during the COVID-19 pandemic and subsequently renewed in 2024,[33] with a finalized rule, to allow automatic enrollment shifts between bronze and silver plans when cost-sharing reduction payments would cover the cost of premiums.

Deferred Action for Childhood Arrivals (DACA)[34]

Effective with the implementation of the Rule on August 25, 2025, DACA individuals enrolled in Marketplace and Basic Health Plan (Essential Plan in New York) coverage will be ineligible for subsidies through federal or state-based exchanges and individuals whose immigration status is categorized as DACA will no longer be considered "lawfully present" for the purposes of determining coverage in either program. While the ACA currently authorizes coverage in the marketplace and basic health program for those who are lawfully present, upon enactment of the Rule, DACA individuals will no longer be classified as lawfully present. A 2024 Biden administration regulation made DACA individuals eligible for Marketplace coverage and Basic Health Plans by removing their previous exclusion from the definition of lawfully present.[35], [36] The definition of lawfully present has evolved over time,[37] and the question of whether DACA individuals are eligible for subsidized health insurance coverage through PTCs has been litigated extensively, including in *Kansas et al. v the United States et al*.[38]

- **HHS Rationale**. HHS states that Congress has "expressed a clear immigration policy that 'aliens' within the Nation's borders not depend on public resources to meet their needs" and public benefits should "not constitute an incentive for immigration to the United States" (8 U.S.C. 1601(2)).[39] Therefore, HHS believes it was improper for the Biden administration to advance a policy that expanded coverage and the ACA risk pools despite Congressionally enacted limitations, including in the ACA.
- **Impact on New York**. New York's approved 1332 waiver application (the successor to the Essential Plan)[40] included covering an estimated 16,000 DACA recipients, effective August 1, 2024. Previous estimates suggest the cost of providing coverage for the Essential Plan DACA population, should the state provide equivalent coverage in a state-only Medicaid program, is around $80 million annually. The number of DACA individuals with incomes above 250 percent and below 400 percent of the FPL enrolled in subsidized marketplace coverage does not appear discretely identifiable. As a result of this change and other changes included in the OBBBA, New York will have decisions to make regarding coverage of DACA individuals and other noncitizens. The circumstances surrounding previous litigation may have materially changed the facts in prior litigation, as detailed in other recent Rockefeller Institute of Government writings.[41]

Eliminating Coverage of Gender Affirming Care[42]

The Rule specifically forbids coverage of "sex-trait modification procedures" by insurers subject to the ACA's requirements to provide a minimum set of covered benefits, also known as Essential Health Benefits (EHB). This provision applies to all individual and small group market health insurance coverage beginning in the 2026 plan year, with the exception of an increasingly narrow number of certain grandfathered plans that existed prior to the enactment of the ACA. Under the ACA, HHS is required to ensure that the scope of EHBs "is equal to the scope of benefits provided under a typical employer plan" (42 USC 18022(b)(2)(A)). The ACA requires

the US Department of Labor to conduct a survey of employer coverage to determine the "typical" benefits provided. In implementing regulations, HHS had previously given states some flexibility in choosing or defaulting into certain EHB benchmark plans that serve to set the standard for required benefits.

- **HHS Rationale**. HHS asserts that "sex-trait modification is not typically included in employer-sponsored plans" (Rule, 268). HHS went to great lengths to emphasize that it made its determination independent of President Trump's executive orders barring federal funding for gender-affirming medical care, which has been subject to court injunction. HHS noted that some 42 states chose or defaulted to EHB benchmark plans that did not include coverage for gender-affirming care. Further, HHS contended that there was inconsistency in the level of coverage for those states that do have EHB benchmark plans that cover gender-affirming care.
- **Impact on New York**. The New York State Department of Financial Services (DFS) has directed that all fully-insured health plans cover medically necessary gender-affirming care.[43] States are federally preempted from most regulation of self-funded plans—over half of New Yorkers are in these plans, where their employer pays the medical bills and a third party (often an insurer) administers the plan. Even if New York applies state laws to protect coverage of gender-affirming care for fully-insured plans, federal premium tax credits would not be available under the Rule. The state could arguably pay for the care out of state-only funds, known as defrayal,[44] but that could bring federal attention to other state-mandated benefits that the state argues are not benefit expansions. Any reductions in federal subsidies for coverage would shift health insurance costs to consumers in New York or require a commensurate reduction in benefits for regulated plans. This would include products sold to the roughly 226,000 consumers purchasing coverage in the individual and small group markets. A brief exploration of options for New York to adopt new EHB benefits is explored in a prior Rockefeller Institute blog post.[45] A challenge to this portion of the Rule is included in the lawsuit brought by California, New York, and 19 other states.

Temporary Changes

These changes are temporary, generally expiring at the end of the 2026 plan year (December 31, 2026).

Stricter Paperwork and Verification Requirements[46]

The Rule also imposes significant modifications to paperwork burdens on applicants, effective through plan year 2026.[47],[48] Prior rules, finalized in 2023 during the Biden administration, allowed "attestation" in many cases where individuals could certify their income, residency, or immigration status subject to later verification primarily through automated links with relevant agencies such as the Internal Revenue Service and Homeland Security.[49] Under the Rule, by contrast, applicants with a broad range of eligibility verification inconsistencies[50] will now be required to electronically submit

hard-copy documentation upfront. Under the new framework, enrollment systems will automatically "pend" an application until the necessary documents are uploaded. Consumers have 90 days to submit documents. Conditional enrollment will no longer be granted while verifications are pending, which could create coverage gaps for those who qualify, but due to income variability or other circumstances, were required to submit supporting documentation to verify coverage.[51] Therefore, these procedural changes may delay or prevent coverage for individuals whose eligibility requires additional documentation, especially those who cannot quickly provide items such as employer letters, tax documents, or utility bills. Marketplaces and enrollment assisters may struggle to manage the influx of document review requirements, increasing wait times and confusion during busy enrollment periods.

- **HHS Rationale**. HHS argues that the additional paperwork requirements are necessary to ensure proper enrollments in federally subsidized coverage.[52] HHS estimates the impact of the Rule will be most notable in states whose enrollment on the exchange exceeds 100 percent of the population estimated to be eligible for such coverage.
- **Impact on New York**. The Rule applies for 2026 to both the Federally Facilitated Marketplaces (FFM) and State-Based Marketplaces (SBMs), like New York. New York is notably excluded from HHS's estimates on the impact of loss of enrollment, along with Minnesota and Oregon, due to "the presence of a [Basic Health Plan] BHP during at least some portion of the analysis period." Whether the exclusion of New York as a BHP state accurately reflects the relative lack of harm to the BHP-eligible population remains to be seen. Moreover, those earning too much for eligibility in New York's BHP (again, called the "Essential Plan") but still eligible to purchase a Qualified Health Plan (QHP) through the NY State of Health (NYSOH) will likely be impacted. However, as of 2024, New York is one of relatively few states that provide access to a mobile application to submit documentation,[53] in addition to the online website and in-person enrollment assistance, which may ease the administrative burden of document submission for New York residents.[54]

Insurer Discretion to Deny New Coverage Based on Past-Due Premiums[55]

The Rule newly authorizes insurers to temporarily deny coverage for the upcoming plan year if a consumer owes premiums from a previous coverage period. Once the grace period is exhausted, this authority extends to situations where prior nonpayment was due to hardship, administrative error, or temporary job loss. The policy effectively allows insurers to bar reentry into the ACA marketplace for individuals who missed payments, regardless of the reason.

- **HHS Rationale**. Due to a perceived problem with potential duplicate enrollment in non-expansion states (those states that did not increase the income eligibility threshold for Medicaid),[56] HHS argues this measure is necessary to temporarily "protect consumers from accruing large tax liabilities and ensure program integrity." HHS estimates that just over 184,000 policies are likely to

be terminated for nonpayment in which $10 or less is owed by the enrollee, representing approximately 12.25 percent of the total number of policies terminated.

- **Impact on New York**. This could apply to up to 150,000 consumers purchasing coverage in the individual and small group markets on NY State of Health. This means that a consumer who owed a *de minimis* amount of $5 or $10 in premium from the prior year could be blocked by the insurer from enrolling in the current year, even if—due to fluctuating income for a gig worker or independent contracts, for example—the consumer qualifies for a zero premium in the current year. In New York, nearly 76,000—or approximately 33 percent—of total qualified health plan enrollees have no premiums after application of premium tax credits. Because New York is both a Medicaid expansion state and has a Basic Health Plan,[57] this percentage is lower in New York as eligibility for QHP coverage begins at 250 percent of the FPL, rather than 100 percent in Medicaid non-expansion states. Critics of the Rule note this provision could trap people in cycles of uninsurance, particularly those who experience temporary financial distress. While insurers welcome the provision as a mechanism to encourage timely premium payment, consumer protection advocates argue it undermines the core ACA goal of ensuring continuous and affordable access to health coverage.

New Monthly Fee for $0 Premium Plans[58]

In a particularly controversial move, the Rule introduces a new monthly $5 charge for enrollees automatically reenrolled in $0 premium plans. Failure to pay this new fee—despite the plan having a premium of $0—will likely result in disenrollment. While this component of the Rule is temporary, the One Big Beautiful Bill Act (OBBBA) bars auto renewal beginning in 2027.

- **HHS Rationale**. HHS defends the change as necessary to ensure that consumers are aware of their coverage and actively intend to use it. HHS expresses concern that some enrollees with $0 premiums may have alternative coverage and not even realize they have coverage through the Marketplace. If so, federal funds are being wasted on premiums for coverage that is not used, leaving insurers with a windfall.
- **Impact on New York**. This fee is mandated for the Federally Facilitated Marketplace (FFM), but not for State-Based Marketplaces (SBMs). As a result, New York is unlikely to impose this fee through NYSOH to the 76,000 enrollees who currently have no premium obligation in the individual and small group market. Even if New York did adopt this provision, the impact would be focused on those with incomes above 250 percent FPL who are not eligible for the state's BHP (the Essential Plan), which separately has no premiums. For those states where the Rule applies, critics argue that this policy undermines the intended coverage support in the ACA. It may also lead to unnecessary coverage loss over a seemingly trivial payment, especially for those with limited banking access or who are unaware of the new provision.

Tighter Special Enrollment Period (SEP) Rules[59]

An SEP allows individuals to enroll or change their coverage outside the regular Open Enrollment Period due to specific life changes such as job loss, marriage, birth of a child, or moving to a new area. New documentation requirements make it more difficult to enroll in an SEP. In particular, the Rule requires the FFM to make a preenrollment verification for all types of SEPs and for at least 75 percent of new SEP enrollments. Thus, prior to enrollment, prospective enrollees through the FFM will have their SEP eligibility electronically verified or must submit documents to confirm SEP eligibility. This change reverses Biden-era rules, based on the concern that preenrollment verification can undermine the marketplace risk pool—dissuading healthy individuals from enrolling and making the covered lives older, sicker, and, therefore, more expensive.

- **HHS Rationale**. HHS recognized the burden on consumers and that young persons are less likely to address SEP verification issues. However, HHS does not consider the impact significant enough to outweigh the merits of the Rule's ability to ensure the integrity of the SEP system. HHS estimates that the new SEP provisions will result in federal savings of over $105 million.
- **Impact on New York**. This change in the Rule applies only to FFM enrollment. Because New York has an SBM, the impact on our state is likely to be minimal.

Conclusion

HHS broadly justified the Rule as necessary to prevent fraud, reduce improper payments, and ensure program integrity[60]—a lens through which many of the health-related changes have been framed by Congress and the Trump administration. As such, the Rule will have numerous impacts on coverage in New York. As discussed above, some of the permanent changes most likely to affect New York include: (1) less generous benefits; (2) more expensive coverage; (3) shorter open enrollment periods; (4) the elimination of coverage for certain deferred action for childhood arrivals (DACA) individuals; and (5) significant limitations on coverage for gender affirming care. Temporary changes, which generally sunset at the end of the 2026 plan year, which may impact New York include: (1) significant new paperwork verification requirements; and (2) newly allowing insurers to deny coverage for past-due premiums.

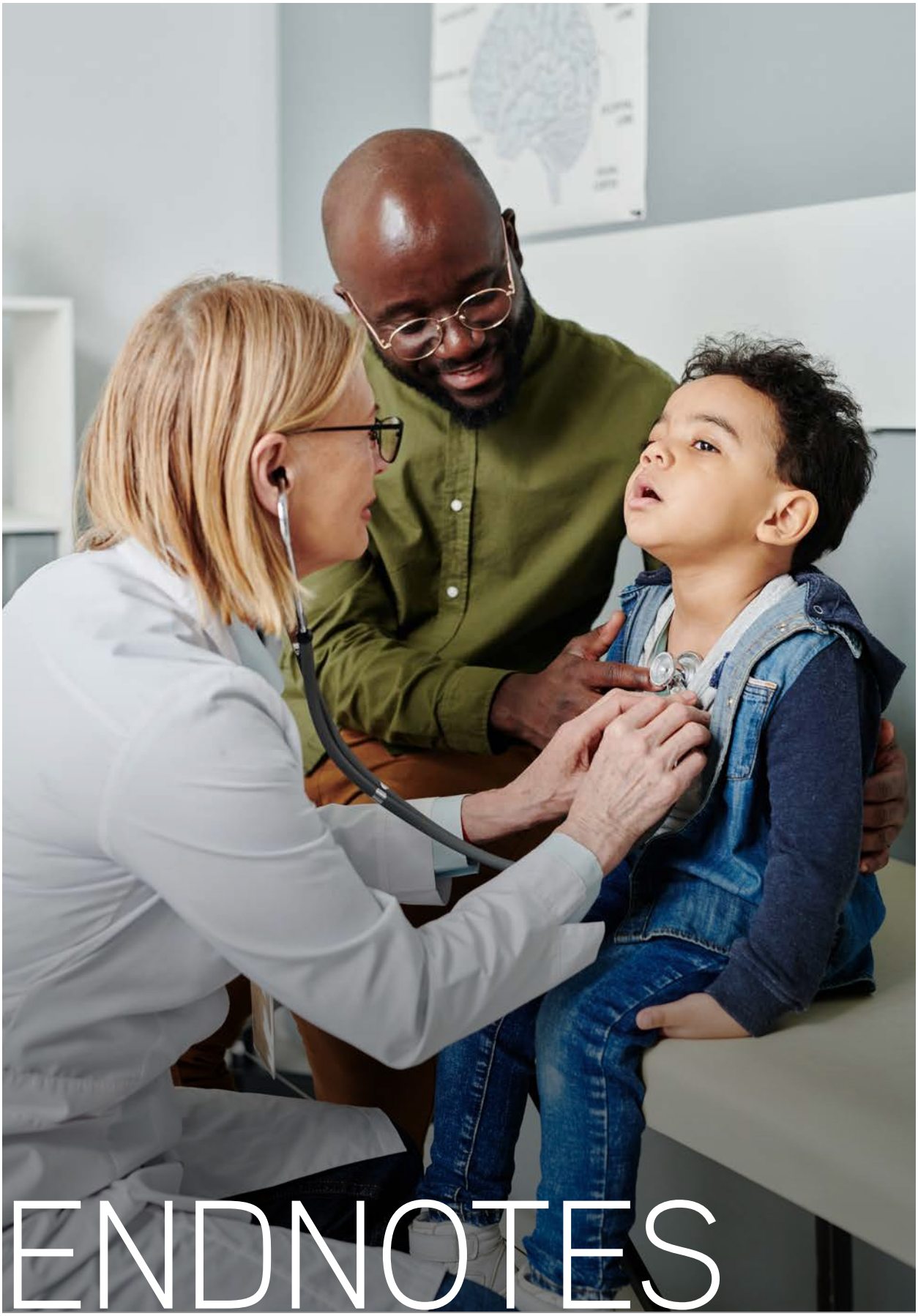
In addition to potentially restricting enrollment and increasing the cost of coverage in New York, the DACA change could cost the state approximately $80 million annually, should the state decide to provide equivalent care to such persons. How to handle the impact of the DACA provision in the Rule will be among the early decisions facing policymakers, given the Rule's August 25 effective date.[61]

Further consideration will be needed to fully explore state options to mitigate the consequences from the Rule as the negative impacts increase, including lower benefits, higher costs, and a variety of other barriers to enrollment for New Yorkers. New York's individual and small group health insurance market is already likely to

experience adverse selection, where younger and healthier individuals are not purchasing coverage, and an older, sicker population is making the insurance risk pool more expensive.

The Rockefeller Institute is continuing to analyze federal healthcare changes and the associated impacts on healthcare coverage, financing, and providers in New York. This piece, along with prior and future writings, will continue to address the questions and tensions in coverage as the state and nation navigate and respond to the changes at the federal level.

For more information about the programs described in this brief, see *How Healthcare Changes in Washington Could Affect New York*.[62]



ENDNOTES

1 Jillian Kirby Bronner, "An Analysis of the One Big Beautiful Bill Act (OBBBA's) Impact on Healthcare for New York," Rockefeller Institute of Government, July 10, 2025, https://www.rockinst.org/blog/an-analysis-of-the-one-big-beautiful-bill-act-obbbas-impact-on-healthcare-for-new-york/,

2 "About the Affordable Care Act," US Department of Health Human Services, updated March 17, 2022, https://www.hhs.gov/healthcare/about-the-aca/index.html.

3 US Health and Human Services Department Rule, "Patient Protection and Affordable Act; Marketplace Integrity and Affordability," *Federal Register* 90, no. 120 (June 25, 2025): 27074–224, https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability.

4 *California Bank v. Kennedy*, 167 US 362 (1897), https://supreme.justia.com/cases/federal/us/167/362/.

5 See, "Health Provisions in the 2025 Federal Budget Reconciliation Bill," Kaiser Family Foundation, undated July 8, 025, https://www.kff.org/tracking-the-affordable-care-act-provisions-in-the-2025-budget-bill/ ; see also, "Health Care Week in Review | Senate Parliamentarian Issues Rulings on Budget Reconciliation Provisions; Supreme Court Upholds the Role of the USPSTF under the Affordable Care Act," JD Supra, June 30, 2025, https://www.jdsupra.com/legalnews/health-care-week-in-review-senate-9720433/.

6 US Department of Health and Human Services Rule, "Patient Protection and Affordable Act; Marketplace Integrity and Affordability."

7 HHS estimates a reduction in marketplace coverage between 725 million (lower bound) to 1.8 billion (upper bound) individuals. HHS details the complexity in estimating the impact of the Rule (US Department of Health and Human Services Rule, "Patient Protection and Affordable Act; Marketplace Integrity and Affordability, https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability#p-1476), but in short, they note that they believe a significant amount of the impact is concentrated in Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Utah, where they believe there "improper enrollments."

8 "Basic Health Program," Medicaid.gov, Centers for Medicare & Medicaid Services, accessed August 21, 2025, https://www.medicaid.gov/basic-health-program.

9 The Federal Poverty Level (FPL) in 2025 is $15,650 for an individual and $32,150 for a family of four ("2025 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii)," US Department of Health and Human Services, 2025, https://aspe.hhs.gov/sites/default/files/documents/dd73d4f00d8a819d10b2fdb70d254f7b/detailed-guidelines-2025.pdf).

10 According to the *2024 NY State Health Coverage Update* (Albany: NY State of Health, 2024), https://info.nystateofhealth.ny.gov/sites/default/files/EnrollmentReport2024a.pdf.

11 "Qualified Health Plans Information," NY State of Health, accessed August 21, 2025, https://info.nystateofhealth.ny.gov/QualifiedHealthPlans.

12 *Ibid*.

13 "Advance premium tax credit (APTC)," HealthCare.gov, US Centers for Medicare & Medicaid Services, accessed August 21, 2025, https://www.healthcare.gov/glossary/advanced-premium-tax-credit/.

14 Enacted in 2010, the Affordable Care Act (ACT) created sweeping reforms in the private health insurance market, including the creation of health insurance exchanges, advance premium tax credits advance premium tax credits, and protections for individuals with preexisting conditions. In addition to the ACA, subsequent companion federal regulations have filled in critical administrative details, governing everything from eligibility verification to enrollment timing and grace periods for lapsed coverage.

15 See also recent Rockefeller Institute of Government publications: Jillian Kirby Bronner, *How Health Policy Changes In Washington Could Affect New York* (Albany, NY: Rockefeller Institute of Government, June 2025), https://rockinst.org/issue-area/how-health-policy-changes-in-washington-could-affect-new-york/, and Kirby Bronner, "An Analysis of the One Big Beautiful Bill Act (OBBBA's) Impact on Healthcare for New York."

16 US Department of Health and Human Services Rule, "Patient Protection and Affordable Act; Marketplace Integrity and Affordability."

17 *Ibid*.

18 *Ibid*, https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability#p-1080.

19 "Questions and answers on the Premium Tax Credit," US Internal Revenue Service, updated May 29, 2025, https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit.

20 The Kaiser Family Foundation estimates that in 2024 more than $124 billion in premium tax credits were distributed nationally, so this would represent about a 1 percent decrease in advanced premium tax credits available nationally. Kaiser also estimates that New Yorkers received about $933 million in premium tax subsidies (7.5 percent of the national total), but this excludes the approximately $13 billion, according to the New York State *2026 Enacted Budget Financial Plan*, New York State receives through subsidies for the Essential Plan. "Estimated Total Premium Tax Credits Received by Marketplace Enrollees, Kaiser Family Foundation, accessed August 22, 2025, https://www.kff.org/affordable-care-act/state-indicator/average-monthly-advance-premium-tax-credit-aptc/.

21 Effective April 1, 2024, New York's fully federally funded Section 1332 Waiver mirrors the initial 1331 Essential Plan waiver with expanded eligibility to household incomes up to 250 percent of the federal poverty limit (FPL).

22 "Out-of-pocket maximum/limit," HealthCare.gov, US Centers for Medicare & Medicaid Services, accessed August 21, 2025, https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/.

23 US Department of Health and Human Services, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," 45 CFR Parts 147, 155, and 156 (CMS 9884-F), RIN 0938-AV61, p. 257, https://www.cms.gov/files/document/cms-9884-f-2025-pi-rule-master-5cr-062025.pdf.

24 "NY State of Health and the New York State Department of Financial Services Comments on 90 FR 12942, Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," NY State of Health, March 19, 2025, https://info.nystateofhealth.ny.gov/sites/default/files/NY%20State%20of%20Health%20Comment%20Marketplace%20Integrity.pdf/.

25 US Department of Health and Human Services Rule, "Patient Protection and Affordable Act; Marketplace Integrity and Affordability," https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability#p-688.

26 OEP duration by plan year (in days): 2014 – 182; 2015 -93; 2016 and 2017 – 92; 2018 -2021 – 45; 2022 and 2023 – 76; 2024 – 77; 2025 and 2026 – 76; 2027 – 45.

27 See also a timeline of key dates, "A quick guide to the Health Insurance Marketplace," HealthCare.gov, US Centers for Medicare & Medicaid Services, accessed August 22, 2025, https://www.healthcare.gov/quick-guide/dates-and-deadlines/.

28 Katie Keith, "HHS Finalizes ACA Marketplace Rule, Part 2: Income and SEP Verification, 'Failure to Reconcile,' And More," *Health Affairs*, June 27, 2025, https://www.healthaffairs.org/content/forefront/hhs-finalizes-aca-marketplace-rule-part-2-income-and-sep-verification-failure-reconcile.

29 *Ibid*.

30 US Department of Health and Human Services, "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment," 45 CFR Parts 153, 155, and 156 (CMS 9899-F), RIN 0938-AU97, https://www.cms.gov/files/document/cms-9899-f-patient-protection-final.pdf.

31 "Saving money on health insurance," HealthCare.gov, US Centers for Medicare & Medicaid Services, accessed August 22, 2025, https://www.healthcare.gov/lower-costs/save-on-out-of-pocket-costs/.

32 *Ibid*.

33 US Department of Health and Human Services, "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment," 45 CFR Parts 153, 155, and 156 (CMS 9899-F), RIN 0938-AU97.

34 US Department of Health and Human Services Rule, "Patient Protection and Affordable Act; Marketplace Integrity and Affordability," https://www.federalregister.gov/d/2025-11606/p-202.

35 US Centers for Medicare & Medicaid Services Rule, "Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, and a Basic Health Program," *Federal Register* 89, no. 90 (May 8, 2024): 39392-437, https://www.federalregister.gov/documents/2024/05/08/2024-09661/clarifying-the-eligibility-of-deferred-action-for-childhood-arrivals-daca-recipients-and-certain.

36 The Biden administration proposed to extend such coverages to Medicaid and Child Health Plus in the initial rule, but opted not to make such change in the final rule, ultimately based on feedback from States for administrative reasons. (US Centers for Medicare & Medicaid Services, "Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, and a Basic Health Program," https://www.federalregister.gov/documents/2024/05/08/2024-09661/clarifying-the-eligibility-of-deferred-action-for-childhood-arrivals-daca-recipients-and-certain#p-26).

37 According to HHS, they issued an interim final rule in the July 30, 2010, *Federal Register* (US Department of Health and Human Services Rule, "Pre-Existing Condition Insurance Plan Program," *Federal Register* 75, no. 146 (July 30, 2010): 45014-33, https://www.federalregister.gov/documents/2010/07/30/2010-18691/pre-existing-condition-insurance-plan-program) to define "lawfully present" for the purposes of determining eligibility for the Pre-Existing Condition Insurance Plan (PCIP) program.

In the March 27, 2012, *Federal Register* (US Department of Health and Human Services Rule, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers," *Federal Register* 77, no. 59 (March 27, 2012): 18310-475, https://www.federalregister.gov/documents/2012/03/27/2012-6125/patient-protection-and-affordable-care-act-establishment-of-exchanges-and-qualified-health-plans) (Exchange Establishment Rule), HHS defined lawfully present for purposes of determining eligibility to enroll in a QHP through an exchange by cross-referencing the existing PCIP definition.

In the August 30, 2012, *Federal Register* (US Department of Health and Human Services Rule, "Pre-Existing Condition Insurance Plan Program," *Federal Register* 77, no. 168 (August 30, 2012): 52614-16, https://www.federalregister.gov/documents/2012/08/30/2012-21519/pre-existing-condition-insurance-plan-program), HHS adjusted the previous definition of "lawfully present" used for PCIP and QHP eligibility, which had considered all recipients of "deferred action" to be lawfully present, to add an exception that excluded DACA recipients from the definition.

In the March 12, 2014, *Federal Register* (US Centers for Medicare & Medicaid Services Rule, "Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic health Programs; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process;Trust Fund and Financial Integrity," *Federal Register* 79, no. 48 (March 12, 2014): 14112-51, https://www.federalregister.gov/documents/2014/03/12/2014-05299/basic-health-program-state-administration-of-basic-health-programs-eligibility-and-enrollment-in), HHS established the framework for governing a BHP, which also adopted the definition of "lawfully present" for the purpose of determining eligibility to enroll in a BHP through a cross-reference to §155.20.

In the May 8, 2024, *Federal Register* (US Centers for Medicare & Medicaid Services, "Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, and a Basic Health Program") (DACA Rule), HHS reinterpreted "lawfully present" to include DACA recipients and certain other noncitizens for the purposes of determining eligibility to enroll in a QHP through an Exchange, PTC, APTC, CSRs, and to enroll in a BHP in states that elect to operate a BHP.

38 This case challenges the Biden administration rule extending coverage to DACA individuals. The Rule would invalidate the case, but should the pending challenge to the Rule, in *State of California et al. v. Kennedy et al.*, be successful, the Kansas case, which is currently pending implementation of the rule, would be reactivated. ("*State of California et al. v. Kennedy et al.*," Health Care Litigation Tracker, O'Neill Institute, updated August 15, 2025, https://litigationtracker.law.georgetown.edu/litigation/kansas-et-al-v-united-states-of-america-et-al/.)

39 "Statements of national policy concerning welfare and immigration," U.S.C. § 601, 2 (2024), https://www.govinfo.gov/link/uscode/8/1601.

40 "NY State of Health 1332 Waiver Information Page," NY State of Health, accessed August 22, 2025, https://info.nystateofhealth.ny.gov/1332.

41 For more information see: Kirby Bronner, *How Health Policy Changes in Washington Could Affect New York* and "An Analysis of the One Big Beautiful Bill Act (OBBBA's) Impact on Healthcare for New York."

42 US Department of Health and Human Services Rule, "Patient Protection and Affordable Act; Marketplace Integrity and Affordability,"https://www.federalregister.gov/d/2025-11606/p-1387.

43 "Health Coverage Information for Transgender New Yorkers," New York State Department of Financial Services, accessed August 22, 2025, https://www.dfs.ny.gov/consumers/health_insurance/transgender_healthcare.

44 See 2018 guidance on Defrayal of State Additional Required Benefits: "Frequently Asked Question on Defrayal of State Additional Required Benefits," US Centers for Medicare & Medicaid Services, October 23, 2018, https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/faq-defrayal-state-benefits.pdf.

45 Troy Oechsner and Courtney Burke, "State Options for Preserving Preventive Coverage after Supreme Court Decision in *Kennedy v. Braidwood Management Inc.*," Rockefeller Institute of Government, July 9, 2025, https://www.rockinst.org/blog/state-options-for-preserving-preventive-coverage-after-supreme-court-decision-in-kennedy-v-braidwood-management-inc/.

46 US Department of Health and Human Services Rule, "Patient Protection and Affordable Act; Marketplace Integrity and Affordability," https://www.federalregister.gov/d/2025-11606/p-188.

47 According to HHS: "In the April 17, 2018, *Federal Register* (US Department of Health and Human Services Rule, "Patient Protection and Affordable Care Act; HHS Notice of Benefit Payment Parameters for 2019," *Federal Register* 83, no. 74 (April 17 2018): 16930-17071, https://www.federalregister.gov/documents/2018/04/17/2018-07355/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2019), we revised income verification provisions in §155.320(c)(3)(iii) to require the Exchange to generate annual household income inconsistencies in certain circumstances when a tax filer's attested projected annual household income is greater than the income amount represented by income data returned by IRS and the Social Security Administration (SSA) and current income data sources. On March 4, 2021, the United States District Court for the District of Maryland decided *City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021) and vacated these revisions to income verification. We then implemented the court's decision in the May 5, 2021, *Federal Register* (US Department of Health and Human Services Rule, "Patient Protection and Affordable Care Act; HHS Notice of Benefits and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards," *Federal Register* 86, no. 85 (May 5, 2021): 24140-295, https://www.federalregister.gov/documents/2021/05/05/2021-09102/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2022-and) and rescinded the income verification provisions in §155.320(c)(3)(iii) that the court invalidated.

In the March 27, 2012 *Federal Register* (US Department of Health and Human Services Rule, "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers," *Federal Register* 77, no. 59 (March 27, 2012): 18310-475, https://www.federalregister.gov/documents/2012/03/27/2012-6125/patient-protection-and-affordable-care-act-establishment-of-exchanges-and-qualified-health-plans), we established the alternative verification process in §155.320(c) for situations when a household income inconsistency occurs with IRS data or when tax return data is unavailable. This process required the Exchange to provide the applicant notice of the income inconsistency and requires applicants to provide documentary evidence to verify their income or otherwise resolve the inconsistency

within a period of 90 days from which notice is sent. In the April 27, 2023, *Federal Register* (US Department of Health and Human Services Rule, "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024," *Federal Register* 88, no 81 (April 27, 2023): 25740-923, https://www.federalregister.gov/documents/2023/04/27/2023-08368/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2024), we revised this process to require exchanges to accept an applicant's or enrollee's self-attestation of annual household income when a call to IRS is completed but tax return data is unavailable and add that household income inconsistencies must receive an automatic 60-day extension in addition to the 90 days provided to applicants to resolve their income inconsistency."

48 According to HHS (US Health and Human Services Department Rule, "Patient Protection and Affordable Act; Marketplace Integrity and Affordability," https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability#p-532), this change would "re-codify a provision the Department finalized in the 2019 Payment Notice (US Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice Benefit Payment Parameters for 2019," *Federal Register* 83, no. 74 (April 17, 2018): 16930-17071, https://www.federalregister.gov/documents/2018/04/17/2018-07355/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2019#page-16985), that was later vacated by the United States District Court for the District of Maryland in *City of Columbus* v. *Cochran,* 523 F. Supp. 3d 731 (D. Md. 2021), finding there was insufficient evidence of prevalent fraudulent behavior justifying the administrative burden and corresponding coverage impacts. In the proposed rule, we stated that though we believe we had a clear legal basis for finalizing the provisions in the 2019 Payment Notice, we also believe circumstances have changed substantially since the court vacated the prior rulemaking. The department, in the proposed rule and this final rule, has provided a reasoned justification to reinstate the policy, supported by data and related estimates documenting the consumer harm and significant losses of taxpayer dollars illustrating the reasons this income DMI is necessary. While we previously acknowledged in the 2019 Payment Notice that we did not have firm data on the number of applicants who might be inflating their income to gain APTC eligibility, there is now clear evidence from enrollment data that shows potentially millions of applicants are inflating their incomes or having applications submitted on their behalf with inflated incomes. Additionally, while concerns were raised in *City of Columbus* v. *Cochran* about consumers who may project a higher income than they receive due to the nature of low-wage work making it difficult to predict their annual household income, we stated that we believe enough consumers—and the agents, brokers, and web-brokers helping them apply—are intentionally inflating their incomes to qualify for fully-subsidized plans that justifies the creation of this income DMI type"

49 US Department of Health and Human Services Rule, "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024," Federal Register 88, no. 81 (April 27, 2023): 25740-923, https://www.federalregister.gov/documents/2023/04/27/2023-08368/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2024.

50 For example, HHS identifies income inconsistencies as follows: "(1) The consumer attested to projected annual household income that is greater than or equal to 100 percent but not more than 400 percent of the FPL; (2) the Exchange has data from IRS and SSA that indicates household income is below 100 percent of the FPL; (3) the Exchange has not assessed or determined the consumer to have income within the Medicaid or CHIP eligibility standard; and (4) the consumer's attested projected annual household income exceeds the income reflected in the data available from electronic data sources by a reasonable threshold [not less than 10 percent and may include a dollar amount] established by the Exchange and approved by HHS."

51 HHS estimates the additional documentation would take approximately one hour to gather, which may underestimate the time commitment necessary to verify coverage. HHS argues "the Department is of the view that younger individuals generally are accustomed to requirements to prove their eligibility for a variety of benefits and activities, including proving their identities and incomes, such that dedicating a single hour to verification activities is unlikely to lead to significant numbers of young persons abandoning their insurance applications once the process is started."

52 According to HHS, an "analysis of 2024 open enrollment data shows plan selections on HealthCare.gov among people ages 19-64 who reported household income between 100 percent and 150 percent of the FPL in non-Medicaid expansion States were 70 percent higher than potential enrollments estimated from Census data at that same income level. Based on this mismatch between enrollment and the eligible population, this study estimates four to five million people improperly enrolled in QHP coverage with APTC in 2024 at a cost of $15 to $20 billion."

53 "Accelerating New York's enrollment process with digital document uploads," Maximus, April 18, 2024, https://maximus.com/case-studies/accelerating-new-york-enrollments-with-document-uploads

54 NYSOH webpage on how to submit documents: "Submit Documents," NY State of Health, accessed August 22, 2025, https://info.nystateofhealth.ny.gov/submit-documents.

55 US Department of Health and Human Services Rule, "Patient Protection and Affordable Act; Marketplace Integrity and Affordability," https://www.federalregister.gov/d/2025-11606/p-648

56 The ACA provided an option for states to expanded Medicaid coverage to most adults with incomes up to 138 percent of the FPL ($21,597 for an individual in 2025). Those states that adopt expansion are entitled to receive an enhanced federal matching rate (FMAP) for their expansion populations. Currently, 41 states (including New York and District of Columbia) have adopted Medicaid expansion and 10 states have not adopted the expansion. (See, "Status of Medicaid Expansion Decisions," Kaiser Family Foundation, May 9, 2025, https://www.kff.org/status-of-state-medicaid-expansion-decisions/).

57 "Basic Health Program," Medicaid.gov, US Centers for Medicare and Medicaid Services, accessed August 22, 2025, https://www.medicaid.gov/basic-health-program.

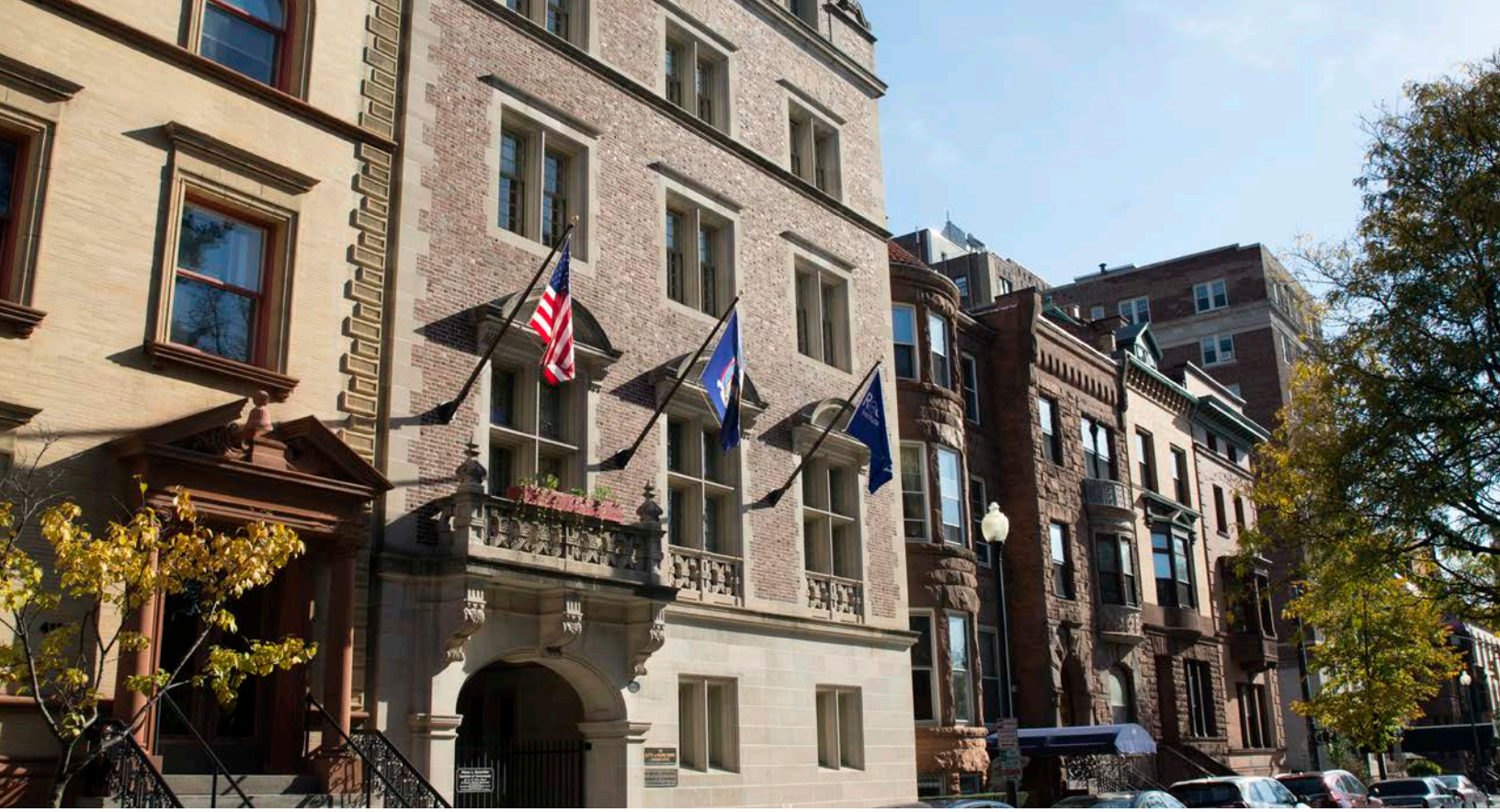
58 US Department of Health and Human Services Rule, "Patient Protection and Affordable Act; Marketplace Integrity and Affordability," https://www.federalregister.gov/d/2025-11606/p-1028.

59 *Ibid*, https://www.federalregister.gov/d/2025-11606/p-1377.

60 US Department of Health and Human Services, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," 45 CFR Parts 147, 155, and 156 (CMS 9884-F), RIN 0938-AV61.

61 The case of *Kansas v. United States,* 19 Republican states sued the Biden administration on administrative procedure act claims; the case is expected to be nullified by implementation of the rule, but should injunctive relief be provided in *California v Kennedy*, *Kansas v United States* would proceed.

62 Kirby Bronner, *How Health Policy Changes In Washington Could Affect New York*.



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