National Patient Advocate Foundation

March 13, 2026

Centers for Medicare and Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

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

Submitted electronically via www.regulations.gov

National Patient Advocate Foundation (NPAF) appreciates the opportunity to submit comments on this proposed NBPP.

Background

NPAF prioritizes policies responsive to unmet financial needs articulated by patients and caregivers coping with complex and chronic conditions. For most of them, financial distress is a common consequence of serious illness. This is true even for individuals with health insurance. Costs of medical and other care escalate quickly and often overwhelm even the best planned household budgets, hurting individuals' economies, health, and quality of life. Patients and family caregivers in our vast national network consistently tell us that preserving financial stability alongside medical and mental health must be considered as integral aspects of high-quality healthcare, and NPAF is positioned to pursue this objective through evidence-supported, system-level reforms.

Our direct patient services counterpart, Patient Advocate Foundation (PAF), delivers a hands-on, skilled "Needs Navigation" model with and on behalf of patients experiencing financial hardship to help reduce the stress they and their caregivers experience in successfully completing the time-consuming administrative processes needed to access care and benefits. In 2024, PAF reached more than 3.1 million people via direct services, education, and outreach, distributing over $335 million in financial support and providing direct, sustained assistance to more than 193,000 patients. The population PAF served last year alone represented 804 distinct diagnoses and 454 rare diseases from all 50 states and 91% of all US counties.

Needs navigation aims to ease healthcare cost concerns that are a common condition across patient populations. NPAF worked with patients and caregivers to define and describe the need for it in terms that are resonant and responsive to their challenges as they've identified them:

> *Needs Navigation provides hand-on support that helps people find and use resources that ease cost concerns.*

NPAF recognizes the importance of making Needs Navigation models reliably available to help people with cost concerns in every care setting – hospitals, outpatient offices, skilled nursing facilities, community health centers and more. This is one of our top policy priorities for improving quality in the context of advancing person-centered, value-based care. A variety of clinical and non-clinical navigation models have evolved over the past decades in different care settings as a critical component of providing person-centered care, including Needs Navigation to help patients and families make ends meet and maintain their financial health while contending with their complex and chronic conditions.

Evidence indicates the striking necessity of expanding the availability of Needs Navigation models now, with a 2024 Gallup poll showing more than one-third of Americans (35%) reporting that they are unable to access quality, affordable healthcare – findings that are four points higher than in 2023 and a new high since 2021. A 2025 national survey of 2,510 patients and caregivers fielded by our PAF Patient Insight Institute found 82% of them experienced financial difficulties in the past year because of expenditures related to medical care, insurance, cost of living challenges, lost wages, and more. The majority of this cohort also confirmed that Needs Navigation should be available for everyone (89%), with 95% responding that they valued Needs Navigation as a vital part of healthcare.

Recognizing the rising prevalence of financial hardship across patient populations, Needs Navigation should now be expanded and integrated as a care model across all Medicare programs to provide real-time relief and practical help for patients and families at risk for medical debt, other health-related financial hardships, and social strains that contribute to poorer health outcomes.

With this background, here are our comments on this proposed NBPP:

Hardship Exemptions and Catastrophic Coverage

We support the proposed hardship exemption changes and appreciate the recognition that some individuals fall into "subsidy gaps" and face unaffordable premiums for comprehensive coverage. The proposal to expand these exemptions offers an important backstop for many at risk of becoming uninsured. For these individuals, this change can open a lower-premium option when they otherwise cannot access subsidized coverage—for example, workers with variable hours whose projected income falls just outside the range for APTC or individuals in the so-called "family glitch" situations.

However, we do not support the promotion of catastrophic plans in this NBPP. These are high-deductible products that shift substantial costs to enrollees at the point of care. For low-income patients living paycheck to paycheck, large deductibles and coinsurance are a barrier to accessing needed services such as primary or preventive care, behavioral health, or prescription drugs.

We therefore recommend that HHS emphasize to the Exchanges and issuers that hardship-based access to catastrophic plans should not be seen as a substitute for pursuing or maintaining eligibility for APTC/CSR-eligible coverage where possible. Clear, standardized consumer disclosures at the point of plan selection that explain, in plain language, the high-deductible nature of catastrophic coverage and provide concrete examples of expected out-of-pocket costs for common services would also be helpful. Our Patient Insight Institute would be happy to work with the agency on crafting such disclosures.

Elimination of the 150% FPL Special Enrollment Period

We do not support the proposal to permanently eliminate the monthly special enrollment period (SEP) for individuals with income up to 150 percent FPL after the end of 2026. This SEP has functioned as a critical safety valve for financially vulnerable individuals, many of whom have highly volatile incomes due to contingent work, caregiving responsibilities, or health events.

For patients with financial hardship, income can fluctuate above and below key eligibility thresholds month to month. The 150% FPL SEP has allowed such individuals to enter the marketplace outside of open enrollment when their circumstances worsen, helping to avoid prolonged uninsurance. Removing this pathway will likely lead to more periods without coverage precisely when people are experiencing economic and often health crises.

Income Verification and Documentation Requirements Near Or Below Poverty

We do not support the proposal to require Exchanges to create data matching issues and request documentation when trusted data sources indicate household income below 100 percent FPL or eliminating the requirement that Exchanges accept self-attestation of income when IRS data are unavailable. While improving program integrity is important, these changes would pose substantial barriers for patients in poverty or facing chaotic financial lives.

Very low-income patients and families often lack stable mailing addresses, internet access, or ready access to pay stubs and other documentation. For patients with financial hardship who are also juggling serious illness, disability, caregiving, or unstable housing, the need to promptly respond to documentation requests can easily lead to loss or denial of coverage, even when they are fully eligible. We instead recommend that the agency:

- Create an explicit "financial hardship" or "good cause" pathway allowing Exchanges to grant temporary or conditional eligibility while applicants work with assisters to obtain documentation, particularly where available data already suggest low income rather than higher income.

- Direct Exchanges to use multiple communication modalities (text, email, phone, and trusted community-based partners) to notify consumers of documentation requests and imminent coverage terminations, recognizing that patients in hardship may not reliably receive mailed notices.

- Monitor, and publicly report, the impact of these documentation policies on enrollment and retention among households below 150% FPL, with a focus on whether eligible individuals are losing coverage due to paperwork rather than ineligibility.

APTC Loss for Failure to File and Reconcile

The forthcoming statutory requirement that Exchanges deny APTC for tax filers who fail to file and reconcile prior-year APTC, which the proposed NBPP would operationalize as a one-year lockout, raises serious concerns for patients experiencing financial hardship. Individuals with unstable finances, limited English proficiency, or limited access to tax preparation support are more likely to have difficulty completing complex filing and reconciliation requirements on time.

For patients in financial hardship, a one-year loss of APTC can make coverage entirely unaffordable, increasing uninsurance, delayed care, and catastrophic medical debt. A recent study in JAMA found "individuals diagnosed with cancer in the US during 2020 and 2021 experienced worse survival during the first year after their diagnosis than those diagnosed before the COVID-19 pandemic … suggesting substantial harms associated with cancer care

disruptions during the first 2 years of the COVID-19 pandemic" Similar poor health outcomes could happen as a result of individuals losing APTC coverage.

While the statute requires some form of consequence for failure to reconcile, the final rule can and should incorporate flexibility and mitigation strategies for vulnerable populations. Given this, we recommend the agency:

- Direct Exchanges to deploy robust pre-emptive outreach and assistance to at-risk enrollees—such as those with very low incomes or prior reconciliation issues—well before the tax filing deadline, including referrals to free tax assistance programs.

- Establish a clear and accessible "good cause" exception process for individuals who fail to file and reconcile due to circumstances related to financial hardship, serious illness, caregiving burdens, or natural disasters, allowing restoration of APTC once the filing obligation is fulfilled without imposing an automatic additional-year lockout.

- Require Exchanges to track the demographics and financial characteristics of those subject to the lockout and publicly report on coverage losses and subsequent coverage outcomes.

Conclusion

NPAF appreciates the opportunity to comment on this proposed NBPP. Engaging patients in NPAF's policy development practices and providing a Needs Navigation model addressing financial hardship concerns prioritized by patients and caregivers is a hallmark of our nearly 30 years of organizational experience, expertise, and history. We are happy to share lessons learned and welcome the opportunity to meet with agency staff to discuss these recommendations to scale Needs Navigation and skilled clinical communication that is person-centered in all reform efforts to make the healthcare system work for everyone. Please contact me at Rebecca.kirch@npaf.org if NPAF can provide further details.

Respectfully submitted,

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