April 11, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9884-P
P.O. Box 8016
Baltimore, MD 21244-8016.

Submitted electronically via regulations.gov

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

Dear Administrator Oz,

As a long-time leading national, non-partisan voice for health care consumers, Families USA appreciates the opportunity to respond to the Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability proposed rule (herein after "Proposed Rule").

Families USA seeks to ensure that hard-working families across America obtain and maintain access to affordable, high-quality health insurance coverage. To date, CMS has made significant strides in the Federal Marketplace and State-Based Exchanges under the Affordable Care Act to enroll more than 23.6 million people in affordable marketplace coverage.
[1] However, many of the policies proposed in this rule would reverse this progress, directly undermining access to health care coverage and the health and financial security of our nation's families.

As such, Families USA urges you to reconsider CMS' proposed changes, and to redraft the rule with these comments in mind—especially pertaining to the harmful impact these changes would have on consumers seeking to purchase affordable health care coverage.

We offer detailed comments on individual sections of the Proposed Rule below, but must first raise deep concerns with the overarching frame of CMS' stated intentions, assumptions, and process: 1) While Families USA shares the concerns raised by CMS related to broker fraud, the rule does not offer targeted solutions but rather broad obstacles that will impact state-based marketplaces and the ability of consumers to access health care, even when there is no

documentation of fraud. 2) To the extent that part of the justification for this rule is to offset the impact of the potential lapse in enhanced premium tax credits on the insurance risk pools in the marketplace, the best approach would be for Congress to simply renew the tax credits, and for CMS to pull back this rule accordingly. 3) The scope of the changes in this Proposed Rule with its multiple components requires a longer public comment period with sufficient time to garner the perspectives and impact of all impacted stakeholders.

To be more detailed in our overarching concerns with the approach taken in this rule, Families USA agrees with CMS on the need to address the issue that some brokers, agents, and lead generators have been responsible for large-scale unauthorized enrollments and abuse of the marketplace in certain states.[2] A lawsuit alleging fraud and RICO violations by several web-brokers and lead generators is pending,[3] and the U.S. Department of Justice recently charged the president and CEO of an insurance broker firm with fraud.[4] In general, these brokers and agents change consumers' health plans without authorization in order to increase their commission. This directly harms consumers and families by weakening the quality of their health care coverage and increasing consumers' financial exposure to potentially uncovered health care services.[5] **But the Proposed Rule does not offer appropriate targeted solutions to address this real concern. Importantly, this unauthorized enrollment occurred *only* in certain states: states where brokers and agents are allowed to enroll people in plans using private websites, without the consumer visiting HealthCare.gov or a state-based marketplace.[6] Efforts to address this fraud and/or abuse should therefore be focused on the use of these private websites and on strengthening regulation and oversight of the brokers, agents, and lead generators who are driving the abuses. To that end, most of the proposed policy changes contained in this rule are misguided in addressing concerns about abuse within the marketplaces and fail to target real fraud in the program. Instead, if finalized, this Proposed Rule will only serve to create obstacles for everyday Americans seeking to enroll in subsidized marketplace coverage which will result in reductions in legitimate enrollment, especially for low-income applicants.**

The Proposed Rule also makes the premature assumption that the enhancements to premium tax credits will expire at the end of the year, as is the case under current law, and assumes that the higher costs of coverage will discourage healthy people from enrolling in the marketplace. The Proposed Rule uses this hypothesis to justify many of its changes. As such, the best solution to address these issues is to work with Congress to extend the tax credits beyond December 2025, which is actively being discussed by bipartisan lawmakers. Such an extension would obviate many of the concerns regarding possible changes to risk pools noted in the justification. **Either way, but especially if Congress acts to extend the enhanced premium tax credits, we urge CMS to significantly revise this rule to ensure stability in the ACA marketplace.**

Finally, we are deeply concerned that given the depth and breadth of changes being proposed to both the Federal Marketplace and State-Based Exchanges, including an aggressive timeline for implementation, CMS has not provided sufficient time for health care stakeholders to provide public comment. A mere 30-day public comment period is often insufficient in allowing

diverse stakeholders impacted by the proposed changes to provide meaningful feedback to the federal government. There has been a longstanding commitment from both Republican and Democratic administrations, including President Trump's first administration, to uphold meaningful public comment periods that are commensurate with the scope of the changes being proposed. **Given the importance of CMS policy changes on the health and wellbeing of millions of Americans, we urge CMS to provide more appropriate length comment periods that match the scope of the policy changes being proposed.**

Our additional detailed comments focus on the following sections of the Proposed Rule:

- III. A. 2. Coverage Denials for Failure to Pay Premiums for Prior Coverage
- III. B. 1. Definitions; Deferred Action for Childhood Arrivals
- III. B. 2. Standards for Termination of an Agent's, Broker's, or Web-broker's Exchange Agreements
- III. B. 3. Verification Process Related to Income Eligibility for Insurance Affordability Programs
- III. B. 4. Annual Eligibility Redetermination
- III. B. 7. Annual Open Enrollment Period
- III. B. 8. Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Projected Household Income at or Below 150 Percent of the Federal Poverty Level
- III. C. 1. Prohibition on Coverage of Sex-trait Modification as an EHB
- III. C. 2. Premium Adjustment Percentage

<u>III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule A. Part 147- Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets 2. Coverage Denials for Failure to Pay Premiums for Prior Coverage</u>

Families USA strongly opposes CMS' proposal to allow health insurance issuers to require applicants to pay past-due premiums from prior health care coverage before effectuating new coverage.

This proposed policy change is a solution in search of a problem which, if finalized, would strip away health care coverage from our nation's families, threatening the health and financial security of more than 20 million Americans who rely on the ACA marketplace for health insurance. It is well-established that health insurance issuers already have various methods at their disposal to collect past-due premiums that cause less harm to consumers than directly denying coverage until payments are made. For example, CMS noted in its 2023 Notice of Benefit and Payment Parameters Final Rule that issuers have the ability to pursue such methods to recoup payments including through debt collection. CMS even went so far as to say that issuers are *not* permitted to forgive outstanding past-due premiums.[7] Given that issuers already have the ability to recoup these payments under current federal law, this proposal to allow issuers to collect these payments as a condition of enrolling in coverage can only be seen as a thinly veiled attempt to weaken access to the health coverage the American people rely on through the Affordable Care Act.

Reducing access to health coverage not only forces families to forgo needed medical care, often threatening their ability to manage chronic diseases,[8] but it also increases their financial exposure to expected and unexpected health care costs.[9] Given that nearly half of Americans have less than $500 in their savings account, any threats to health care coverage will only serve to force more people into medical debt and further threaten the health and financial security of our nation's families.[10] Not only do coverage losses place a significant financial burden on consumers and their access to care, they also directly increase the amount of uncompensated care that hospitals must deliver and may increase general health care spending in the long run.[11]

We are also concerned that this proposed change fails to include any requirements to notify consumers about past-due payment or propose a process that would enable consumers to dispute any liabilities or establish a payment plan. **We strongly recommend that for any proposal regarding a potential loss in coverage, CMS must take every available step to try to prevent that worst-case scenario. In a rule such as this, that would include requiring insurers and Exchanges to send multiple advance notices to consumers about any past-due premiums, providing time for consumers to dispute any liabilities, giving options for consumers to make a payment plan, and allowing consumers to reenroll in coverage while they are in the repayment process.**

Given that CMS already has options under federal law to pursue past-due premiums, and the extreme potential for coverage loss and resulting harm to families and providers under this provision of the Proposed Rule, Families USA urges CMS not to adopt this policy.

III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule B. Part 155-Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act 1. Definitions; Deferred Action for Childhood Arrivals

Families USA strongly opposes CMS' proposal to reverse the definition of "lawfully present" in 45 CFR 152.2 to exclude Deferred Action for Childhood Arrivals (DACA) recipients and make them ineligible to purchase health care coverage through the ACA Marketplace.

Under federal law, individuals who are "lawfully present" are eligible to purchase and enroll in health care coverage offered through the Affordable Care Act marketplace. Traditionally, "lawfully present" individuals included green card holders, asylees, refugees, and those with certain non-immigrant visas. In May 2024, the Department of Health and Human Services (HHS) finalized the 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', which included DACA recipients within the definition of "lawfully present." CMS estimated that roughly 100,000 DACA recipients would newly enroll in health insurance under this rule.[12] For this relatively small group of people who have only known the United States as

home, this would make a huge difference: They became eligible to purchase health insurance with their own money, and thus become enrolled in ACA marketplace coverage, as well as qualify for tax credits to make premiums more affordable.

This change was an essential improvement: Ensuring that DACA recipients have access to health coverage can improve health care access and outcomes for this population and also prevents health systems from acquiring additional uncompensated care costs.[13] Since DACA was established in 2012, DACA recipients have been ineligible for federally-funded health insurance programs such as Medicaid and CHIP. Without access to affordable care through the marketplaces, the high cost of health care coverage is often inaccessible for low-income DACA recipients.[14] [15]

Chronic uninsured rates amongst DACA recipients can lead to worse health outcomes for this population and end up costing the health system, and those who pay into it, more in the long run. It is well established that uninsured adults often experience worse health outcomes due to forgoing necessary care or receiving poorer quality care.[16] Health care coverage enables people to seek regular preventive care and manage chronic conditions and disease, and ensures some level of protection against financial exposure to high health care costs.[17] Importantly, when uninsured individuals do seek care, they are often sicker and require more costly medical intervention. In addition, these sicker patients often seek care in emergency departments—the highest cost care settings—which can drive up.[18]

Moreover, the inclusion of DACA recipients into the health insurance market improves health care costs for all consumers, contributing to larger risk pools that establish greater predictability and stability around premium calculations.[19] Because the DACA population is young (under the age of 45) and considered to be in good overall health, it is likely that the inclusion of DACA recipients into insurer risk pools could help to lower insurance premiums.[20]

Families USA encourages CMS to maintain ACA Marketplace eligibility for DACA recipients to ensure this population is able to access necessary health care to stay healthy and continue contributing to the workforce and economy, all while improving health insurance risk pools by increasing the number of healthy beneficiaries.

III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule B. Part 155-Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act 2. Standards for Termination of an Agent's, Broker's, or Web-broker's Exchange Agreements

Families USA agrees that fraudulent and unauthorized enrollments by agents, brokers, and web-brokers must be stopped, and supports the provision in the Proposed Rule that would apply a "preponderance of evidence" standard as proof for establishing a reason for terminating agent/broker/web-broker Exchange agreements. This provision builds on current rules that allow the federally facilitated marketplace to immediately *suspend* an agent or broker

for suspected fraud that may cause imminent or ongoing harm to consumers or that risks the accuracy of eligibility determinations, and then to *terminate* the agent's, broker's, or web-broker's agreement upon finding a violation of HHS standards or agreements, if the matter is not resolved within 30 days from the date of notice (45 CFR 155.220(g)(5) and (k)(3)). Setting an explicit evidentiary standard, as proposed, will further help CMS protect consumers from bad actors.

This provision builds on important policy change finalized by CMS in the 2026 Notice of Benefit and Payment Parameters, in which CMS strengthened its compliance reviews, established greater authority to suspend the ability of an agent or broker to transact business with the Exchange (45 CFR 155.220(k)), and updated model consent forms that can be used to document consumer review and confirmation of enrollment changes. Taken together, these changes mark an important step forward in strengthening oversight and accountability over the fraud and abuse driven by brokers and agents in the marketplace.

Importantly, CMS asks for input on other approaches to assist consumers who were switched to a different health plan by brokers or agents without their consent. Families USA offers the following:

- **If CMS continues to allow enhanced direct enrollment, rules should:** obligate brokers to act in the best interest of consumers, require documentation of consumer consent before a broker receives a commission, and require lead generators to register with the marketplace and meet marketing standards.[21] [22]
- To prevent unauthorized plan switches, Families USA further recommends that, once tested, **CMS *require* use of its updated model consent form and its scripts for documenting consumers' review and confirmation of enrollment changes**.
- When consumers are wrongfully switched into a different plan, **CMS should retroactively enroll the consumer in their original plan and/or provide an exceptional circumstances special enrollment period**, beginning the date that the consumer learns of an unauthorized switch, to enroll in the plan of their choice. Rules should assure that the consumer is held harmless for any medical bills that might exceed the cost-sharing amount the consumer would have otherwise incurred in the plan they chose.

- **CMS should consider ways to better regulate health plan gifts and wellness rewards programs.** We understand from one informant that some agents or brokers use promises of gifts, such as groceries or prepaid cash cards, as inducements for consumers to change their plans.[23] Such gifts are offered by some health plans as an incentive to participate in wellness activities, such as participating in a wellness screening or "learning new ways to be healthy."[24] However, malicious agents or brokers may misrepresent those rewards programs, disappointing consumers who do not actually qualify and potentially leaving them in a plan that does not meet their needs.[25]

III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule B. Part 155-Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act 3. Verification Process Related to Income Eligibility for Insurance Affordability Programs

a. Failure to File Taxes and Reconcile APTC Process

Families USA strongly opposes CMS' proposal to reinstate a policy that ended in 2023, which would require Exchanges to determine a tax filer ineligible for a premium tax credit if: (1) HHS notifies the Exchange that the tax filer (or their spouse, if the tax filer is a married couple) received an APTC for a prior year for which tax data would be utilized for verification of income, and (2) the tax filer or tax filer's spouse did not comply with the requirement to file a federal income tax return and reconcile APTC for that year. Under current rules, this process uses two consecutive years rather than the proposed one year as the period of time assessed for reconciling noncompliance with filing federal income tax returns and the receipt of premium tax credits. If finalized, this rule would make it hard—and in some cases impossible—for many self-employed marketplace enrollees to retain coverage.

Many marketplace enrollees are self-employed, independent contractors or small business owners with complicated tax returns due to many income sources and expenses.[26] The Department of Treasury reported that 3.3 million self-employed workers and small business owners were covered by the marketplace at some point during the year in 2022, amounting to 28% of all 21–64-year-old marketplace enrollees.[27] Many self-employed workers pay taxes by April 15, but utilize the standard extension to October to file tax return paperwork, which is specifically allowed for sole proprietorships.[28] IRS data shows that in the 2024 tax filing season, 24 million returns were filed between April 19 and December 27, which does not leave sufficient time to be processed prior to the November 1-December 15 open enrollment period for marketplace verification.[29]

Further, amidst current federal worker layoffs unfolding on a massive scale, it is unclear whether IRS and HHS will retain sufficient staff capacity to provide accurate and timely notices about failure to reconcile tax returns with APTCs, or be able to promptly resolve questions and disputes that might arise to adequately support employees in navigating these tax complexities, particularly as it pertains to health care. The two-year deadline for reconciliation was originally established to address the operational challenges that marketplaces faced in receiving accurate and timely information about tax filing status,[30] and to prevent the occurrence of those problems in the coming year. We are deeply troubled that CMS does not provide sufficient data to justify reducing the length of time for reconciliation. While the rule does cite to enrollment public use files, [31] the rule fails to provide any data about the number of enrollees who do not reconcile and are ineligible for APTCs. The 2025 and 2026 Notices of Benefits and Payment Parameters have already required marketplaces to send further notice to marketplace enrollees who fail to reconcile their APTC, informing them that they are at risk of losing their

premium tax credits.[32] It is too early to determine whether these measures alone will be sufficient to address the problems that are the stated concern of this proposed provision.

As a result, Families USA strongly opposes the proposal to reduce the length of time for reconciliation. While we urge CMS not to finalize this provision, out of deep concern for the impact this change would have on consumers, we offer the following recommendations to mitigate harm, should this provision be finalized:

1) Establish a termination clause in the rule which would revert to the two-year file and reconciliation period if operational challenges make it difficult to provide timely notice and dispute resolution to enrollees.
2) At a minimum, people terminated due to failure to reconcile must be provided an exceptional circumstance special enrollment period to reenroll in marketplace coverage with current income information.

Further, Families USA understands the need to protect enrollees from an extended tax liability. To do that, Families USA urges CMS and IRS to provide more outreach about the need to update income information and revisit plan selections annually. For example, CMS and IRS should work together to provide clear information in large font with 1095-A forms stating that if you receive this form, you are required to file or may lose access to advance credits in the future. CMS and IRS should work with tax software providers to ensure that further information is provided on all major platforms that people use to file their taxes and to file for extensions. Information should also be provided in materials sent by health plans to enrollees. Free help should be provided with the complicated tax form 8962 which is used to reconcile APTCs. **Reinstating navigator funding that was cut by the administration earlier this year would help with such outreach.**

b. 60-Day Extension to Resolve Income Inconsistency (§ 155.315); c. Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii)); and d. Income Verification When Tax Data is Unavailable (§ 155.320(c)(5))

Separately, CMS also proposes removing the automatic 60-day extension for applicants to resolve data matching issues (DMIs) for income inconsistency, and requires marketplaces to generate DMIs when tax data shows an applicant's income is below 100% of the Federal Poverty Level or when tax data is unavailable. When a marketplace generates a DMI related to income inconsistency for an applicant, the marketplace sends that applicant a notice to submit required documents to verify their income.

Families USA urges CMS not to adopt the proposed policy changes to the income eligibility verification process. We strongly believe that the changes will harm a significant portion of low-income enrollees with volatile income. CMS estimates that these policies could deny nearly 500,000 enrollees access to subsidized health coverage, and would afford little flexibility for consumers while imposing significant administrative burdens on the Federal and State-Based

Exchanges.[33] This policy change is likely to disproportionately impact lower-income enrollees, who are more likely to experience high income volatility (a "change in circumstances" under the law), which make prior year tax returns an inaccurate prediction of their current income.[34] This same income volatility may present a significant burden on lower-income individuals in presenting the requisite income documentation in a timely fashion. For these individuals, proper income documentation may require collecting dozens of individual paystubs to substantiate their income projection.

III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule B. Part 155-Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act 4. Annual Eligibility Redetermination

CMS is proposing to amend the annual eligibility determination process to prevent enrollees from being automatically re-enrolled in fully subsidized coverage with advanced premium tax credits without taking additional action to confirm their eligibility. Beginning with annual redeterminations for 2026 for Federal Exchange plans and 2027 for State Exchanges, individuals who would be automatically re-enrolled in fully subsidized coverage and have not submitted updated eligibility documents would instead be billed a premium of $5 per month until they submit such documentation, at which point the full subsidization of their coverage through enhanced tax credits would resume. CMS is also considering whether to automatically re-enroll this subset of enrollees without any APTC to push attendees to submit updated eligibility documentation.

Families USA strongly opposes the proposal to require $5 premium payment for automatically re-enrolled enrollees who have not yet submitted updated eligibility documentation to receive advanced premium tax credits.

Rather than substantially improving the enrollment process, this proposed policy change will create additional obstacles for consumers seeking to purchase affordable coverage through the federal and state-based marketplaces. While CMS suggests in the Proposed Rule that existing automatic re-enrollment processes may increase the risk of improper enrollments, CMS does not provide sufficient evidence to substantiate this claim. Instead, CMS acknowledges in the Proposed Rule that the change to automatic renewals would increase paperwork for many low-income people, creating additional enrollment barriers. In fact, CMS estimates that 2.68 million marketplace enrollees in the federal marketplace, and an unknown number in state marketplaces, would have been impacted during the most recent annual redeterminations period for 2025 coverage if this policy was in place.[35]

For consumers impacted by this proposed change, the proposed $5 premiums on an anticipated $0 premium plan may cause confusion. This would be compounded by the likelihood that some consumers will miss notices or have difficulty paying electronically.[36] Families USA believes this policy will ultimately cause great harm to health care consumers by reducing enrollment, creating unnecessary confusion for enrollees, and increasing premiums in

the both the short- and long-term. **As such, we strongly urge CMS not to finalize this proposed change.**

III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule B. Part 155 – Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act 7. Annual Open Enrollment Period

CMS is proposing to amend the duration of the annual Open Enrollment Period (OEP) in which qualified individuals may apply for or change coverage in a Qualified Health Plan (QHP) through the Federal Health Care Marketplace or State-Based Exchanges. If finalized, the OEP would begin on November 1 and end on December 15, a total of 45 days, shortening the current duration of the OEP by 31 days. This proposed change would also prevent states from establishing longer enrollment periods as determined by their own population needs.

This proposed policy change marks a return to policy finalized in the Notice of Benefit and Payment Parameters for 2017, which also established a 45-day OEP from November 1 to December 15, which remained in effect for 2018, 2019, 2020, and 2021. In the Notice of Benefit and Payment Parameters for 2022, CMS finalized a change which extended the OEP to 76 days, lasting from November 1 to January 15, which remains in effect today.

Families USA opposes this reversal of current policy, and recommends that CMS maintain the current Open Enrollment Period duration of November 1 to January 15, without change, and continue to allow state-based marketplaces to provide open enrollment periods that best serve residents in their states. Many consumers who purchase coverage through the federal or state-based Exchanges benefit from the current 75-day duration of the OEP, or for longer periods in some states, as we detail below. For instance, given the additional financial challenges and time constraints faced by many parents, families, and small business owners during the holiday season, many people might find it much easier to shop for and compare plans after the holidays.

On adverse selection during Open Enrollment

To the extent that CMS proposes this change out of concerns around mitigating adverse selection in a longer OEP, the data tells a different story. Data from CMS shows that nearly 800,000 new consumers purchased coverage on the marketplace between January 4 and January 15 of 2025, almost one-fifth of all new marketplace consumers.[37] This may include younger, healthy, first-time enrollees who might use additional time to learn about their coverage options from family, friends, or professional services, and whose enrollment serves to improve the risk pool and decrease premium costs. This is evidenced by data from Covered California which shows that people who enroll in January have the lowest risk scores among new sign-ups.[38] In 2025, roughly 470,000 existing enrollees nationally utilized this 31-day period to switch plans or end coverage, which includes individuals automatically re-enrolled into unexpectedly expensive coverage. A longer enrollment period also allows people more time to get assistance from navigators: In the federal marketplace, navigators helped more than 90,000

people enroll in QHPs in 2024 while also helping nearly 86,000 people resolve problems with marketplace coverage or Medicaid.[39] Consumer Assistance Programs, certified assisters, and navigators in state-based Exchanges can also assist more consumers during a longer OEP.[40]

In addition, other proposed policies in this rule (discussed in section III. B. 3.), if adopted, would establish tighter enrollment and income verification requirements that may result in changes to the expected monthly contribution for coverage for some marketplace enrollees. Increases to expected monthly contributions may motivate these enrollees to switch to a less expensive plan during the longer OEP. By ending the OEP on December 15, some of these enrollees may not have enough time to shop for alternative options for affordable coverage.

Evidence from state-based marketplaces as well as prior premium data does not validate adverse selection concerns. As mentioned above, the OEP lasted 45 days between 2018 and 2021, and was extended to 76 days in 2022. However, the average benchmark premium decreased from $452 to $438 between 2021 and 2022, and the average lowest-cost silver and gold premiums also decreased over the same period.[41]

It stands to reason that consumers living with chronic illnesses or who rely on expensive medications will be more motivated to proactively enroll in the marketplace, while relatively healthy consumers may wait to enroll at their convenience. Indeed, a study showed that extending enrollment periods during 2021 improved risk scores across the market.[42] For small business owners or the self-employed, the holiday season may be a particularly busy time of year. Offering an additional 31 days to research different plans or contact navigators for assistance is crucial to maintaining affordable coverage. Similarly, young adults may wait until after school semesters end to enroll in coverage—in fact, in 2025, CMS' young adult "week of action" to encourage enrollment took place the first week of January.[43]

Taken together the evidence is clear: Rather than primarily addressing improper plan switching and adverse selection, this policy change may inadvertently result in reductions to enrollment and cost-conscious plan switching.

III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule B. Part 155-Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act 8. Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Projected Household Income at or Below 150 Percent of the Federal Poverty Level

Similarly, Families USA strongly opposes CMS' proposal to remove the monthly Special Enrollment Period (SEP) for qualified individuals with a projected annual income at or below 150% of the Federal Poverty Level (FPL). We strongly disagree with CMS' justification that this SEP ("the 150 percent FPL SEP") has increased the level of improper enrollments and increased the risk for adverse selection by incentivizing consumers to wait until they are sick to enroll in coverage. Data from Covered California shows that the prospective risk scores of SEP enrollees

are equal to or lower than those of Open Enrollment enrollees, and that SEP enrollees tend to be younger than their Open Enrollment counterparts.[44] This evidence does not substantiate the risk of adverse selection cited by CMS in the Proposed Rule.[45] Rather, it suggests that SEP enrollment may actually improve the risk pool.

Importantly, the 150 percent FPL SEP was established in the 2022 Notice of Benefit and Payment Parameters Final Rule, and was then made available without limitation for individuals making equal to or less than 150% of the Federal Poverty Level in the Notice of Benefit and Payment Parameters Final Rule for 2025.[46] Currently, more than 9.4 million people—more than 40% of all marketplace enrollees—report income between 100 and 150% of the FPL.[47] This special enrollment period for individuals at 150% FPL is a critical safety net for vulnerable populations including those living in the "coverage gap" in states that have not expanded Medicaid, as well as those in expansion states with volatile income who churn between Medicaid and marketplace coverage.[48]

Medicaid Churn

Consistent access to enrollment periods is especially important for individuals who churn between Medicaid and marketplace coverage. Enrollees can become ineligible for Medicaid when they experience changes in income or circumstances: a new job, a moderate wage increase, or changes to household dependents. Churn has been estimated to impact as many as 21% of Medicaid enrollees annually.[49] In states that have expanded Medicaid eligibility, people are eligible for Medicaid with incomes up to 138% of the FPL. When their incomes rise above this level, they need to be able to enroll in the marketplace. When people realize they have lost Medicaid coverage due to churn, which may not occur until they seek care, many will look to enroll in subsidized marketplace coverage.

Federal regulations give people up to 90 days following termination of their Medicaid coverage to enroll in marketplace coverage, but this period is not sufficient for many. Therefore, the 150 percent FPL SEP has been crucial to maintain access to health care coverage.[50] Prior to the existence of the 150 percent FPL SEP, just 3-4% of people losing Medicaid were able to transition to a federal or state marketplace plan.[51] While some transfers of information between Medicaid and the marketplace are automatic, people moving between these two programs must still submit additional information to the marketplace, such as documenting they have no affordable offer of employer-based coverage, which may delay marketplace enrollment.[52]

Delayed determinations of Medicaid ineligibility also cause people to delay marketplace applications. Though Medicaid applicants are supposed to receive determinations about their eligibility within 45 days of submitting an application, data shows that many determinations take longer across most states.[53] Issues with mailed notices[54] as well as electronic ones[55] also prevent people from learning about Medicaid terminations promptly. A survey of adults who had Medicaid coverage prior to April 2023 showed that 58% of those who tried to renew their coverage experienced some problem, such as long call center wait times or problems

submitting and processing documents.[56] These sorts of barriers delay Medicaid eligibility decisions, and therefore delay marketplace applications for those found to be just above Medicaid income guidelines. Additionally, continuous enrollment through the 150% FPL SEP is essential to ensuring that people affected by delays in eligibility determinations are able to access a new source of affordable coverage, regardless of receiving short notice about termination of Medicaid coverage. If passed, the proposed change to eliminate the 150 FPL SEP would result in many of these people becoming uninsured, leading many to skip needed primary and preventive care and ultimately imposing a higher burden on the health care system when they need to seek complex care in more expensive settings down the line.[57]

"Coverage Gap" Populations in Non-Expansion States

This SEP is of particular importance for individuals below 150% of the FPL in the 10 states that have not expanded Medicaid coverage to adults up to 138% of the FPL. Following adoption of this special enrollment period, enrollment in marketplace plans increased by 100% or more between 2020 and 2024 in seven states that have not yet expanded Medicaid: South Carolina, Kansas, Georgia, Florida, Mississippi, Alabama, and Texas.[58] People at this income level often work in jobs that do not provide health insurance. They therefore do not get notices from employers about their option to enroll in the marketplace and they receive no other notice similar to the model notices that employees receive.[59] Further, if their incomes rise above the poverty line in the middle of the year, no notice informs either them or the marketplace that their change of income qualifies them for a special enrollment period or for marketplace coverage—thus, they would not be adequately served by the 60-day special enrollment period for people newly eligible for premium tax credits.

Families USA recommends that CMS do not finalize the proposed changes that would eliminate the Special Enrollment Period for APTC-eligible individuals with a projected household income at or below 150% of the Federal Poverty Level.

III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule C. Part 156-Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges 1. Prohibition on Coverage of Sex-trait Modification as an EHB

Families USA strongly opposes the prohibition on coverage of "sex-trait modification" as an essential health benefit (156.115 (D)). These essential health care services provide Americans with care that improves mental health outcomes and quality of life.

CMS proposes that states would be prohibited from including "sex-trait modification" as essential health benefits (EHBs) for ACA marketplace plans starting in Plan Year 2026. This Proposed Rule would limit transgender individuals' access to the health care they need—care that improves mental health, including by reducing rates of depression, and overall improved wellbeing.[60] If finalized, this rule would be a major step backward from existing CMS policy

which has given states discretion to include gender-affirming care as part of their EHB benchmark plans, and would undermine evidence-based medicine and current standards of care as determined by a diverse range of medical societies and associations.[61] [62]

Section 1554 of the Affordable Care Act denies the Secretary of Health and Human Services from promulgating any regulation that creates unreasonable barriers to individuals to obtain appropriate medical care.[63] The American Medical Association, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Psychiatric Association consider gender-affirming care as a standard level of care.[64] Blocking states from listing these services as an EHB would create an unreasonable barrier to appropriate care.

Additionally, Section 1557 of the Affordable Care Act serves as the civil rights enforcement provision under the law and prevents discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities.[65] Section 1557 sets certain statutory health care rights for patients and allows patients to file legal complaints when their rights are denied. Under law, Section 1557 provides patients with nondiscrimination protections based on gender identity and sexual orientation, including protections for transgender people's access to care and coverage.[66] The Proposed Rule denying "sex-trait modification" as an essential benefit opens up providers, insurers, and the Administration to legal challenges for violating nondiscrimination laws.

Care provided to transgender individuals is life-saving care, and in states that have chosen to include gender-affirming care as an EHB, costs have been insignificant. Less than 1% of the U.S. population seeks trans health care services and the costs of providing such care is negligible.[67] A review of commercial health insurance claims data found that only 0.11% of enrollees utilize trans health care services, and the cost of this care amounts to only $0.06 per member per month.[68]

This care is particularly important given that the transgender population in America suffers from high rates of depression, substance use disorder, and suicidal ideation, much of which is mitigated by gender-affirming health care.[69] The U.S. spends $13 billion on suicide-related medical care and over $35 billion on substance use disorder treatment each year.[70] Prevalence of lifetime suicide attempts and clinical depression among transgender individuals are 40% and 52%, respectively—rates that are nine and six times greater than the general U.S. population, respectively.[71] Access to gender-affirming health care, including both hormone therapy and surgical care, significantly reduces moderate to severe depression and suicidal ideation in young trans adults.[72] The health supporting benefits of gender-affirming care are widely recognized by the medical profession and should be accessible to all Americans.

Further, this proposal directly undermines the 2019 HHS Notice of Benefits and Payment Parameters which gives states the flexibility to establish new standards to update their EHB benchmark plans and is counter to this administration's stated goals of managing chronic illness and disease.[73] The authority granted to states to update their EHB benchmark plans allows them to respond to new medical information and scientific studies to inform best practices

around health care coverage and access for health care consumers in the state. For example, through Colorado's approved EHB request, the state was able to set clear standards around trans health care coverage for insurers and ensure comprehensive coverage for patients, based on evidence linking trans health care with statistically significant reductions in depression, anxiety, gender dysphoria, as well as improvements in quality of life.[74] [75]

Families USA strongly urges CMS to maintain states' authority to include gender-affirming and trans-specific health care in their EHB Benchmark plans, allowing plans to respond to and address new scientific research.

Additionally, Families USA opposes use of the term "sex-trait modification" in law or regulation. There are existing definitions and terminology for the health care services to treat gender dysphoria that transgender individuals commonly seek.[76] Likewise, we object to banning coverage for any specific health care services used to treat gender dysphoria such as hormone therapy and surgical care, which are also used to treat other conditions including cancer treatments and endocrine disorders.[77]

<u>III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule C. Part 156-Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges 2. Premium Adjustment Percentage</u>

Families USA opposes changing the premium adjustment methodology for Plan Year 2026 and beyond. As the preamble notes, a change in methodology would apply to the following, raising costs for consumers:

- The maximum annual limit on cost-sharing (MOOP), 156.130(a); and
- The cost at which employer-based coverage is considered unaffordable and people can instead use premium tax credits in the marketplace. (155.605 (d) and if likewise adopted by the Treasury department, 26 CFR Part 1)

Further, if the Department of Treasury/IRS uses the same methodology to update premium contributions for individuals receiving premium tax credits, as has been the practice, individuals receiving an APTC would be charged 4.5% more for premiums of a benchmark plan,[78] and that cost increase would be in addition to the increases they will receive if enhanced premium tax credits expire. **As a result, Families USA opposes this change, as detailed below.**

<u>CMS' Original Formula for Premium Adjustment</u>

CMS proposes to adjust premiums, maximum out-of-pocket-limits, and minimum essential coverage formulas based on the growth in both employer-sponsored insurance (ESI) and "direct payment" premiums, returning to a formula that it abandoned in 2022.

The preamble notes that in past years, CMS decided to adjust premiums and maximum out-of-pocket limits based only on the growth in ESI premiums because those would not be skewed by

premium fluctuations during initial implementation of the individual market. Later, after a brief period (2019-2021) in which the premium adjustment factor also included direct market premiums, CMS returned to its original formula for reasons that continue to hold true today:

a) A higher premium growth factor would lead to higher costs for consumers and lower enrollment. A lower premium growth factor makes health coverage more accessible and affordable for consumers of all income levels.
b) Premiums in the individual market are more influenced by economic uncertainty and predictions of risk than ESI premiums. As CMS wrote in 2021, "We believe using the NHEA ESI premium measure aligns with the statutory language at section 1302(c)(4) of the ACA, as ESI meets the definition of "health insurance coverage" and represents the vast majority of the market, overlapping very significantly with the private health insurance data used for benefit years 2020 and 2021."[79]
c) Medical loss ratio rebates in the individual market (totaling approximately $550 million in 2024[80]) indicate that individual market premium prices are still higher than the cost of care plus reasonable administrative costs.

We do not yet know if enhanced premium tax credits will be extended by Congress, nor how enrollees and the marketplace will respond if it is the first year since 2021 that premium tax credits are unavailable to people over 400% of the FPL and reduced for others. Thus, there is compelling reason to reduce volatility in the market in order to retain a large enrollee base.

Further, the proposed formula would include short-term health plans, fixed indemnity plans, and other plans that do not provide full health insurance in the computation of premium growth. There is no justification for including these plans which have no benefit requirements and therefore could vary greatly in price from year to year.

As the preamble shows, the proposed changes to the formula would directly increase consumers' costs—even though affordability is an explicit purpose of the Affordable Care Act.

Families USA strongly opposes this change, which CMS acknowledges would increase the amount that marketplace enrollees pay for cost-sharing; and that if the IRS also adopts the change, would increase premiums for people with premium tax credits.

Large price increases for coverage

The maximum limit on cost sharing for self-only coverage would increase to $10,600, a 15.2% increase from Plan Year 2025; and for family coverage would increase to $21,200. As noted, this is $450 higher for individuals, and $900 higher for families, than would have been the case under the previously published methodology. Families with income up to 200% of federal poverty who faced major illness could have out-of-pocket expenses of $7,000 per year, in addition to the higher premiums they would face if the IRS follows the same premium adjustment methodology and enhanced premium tax credits expire.

If enhanced tax credits expire and the premium adjustment formula is simultaneously changed, people will immediately experience large price increases:[81] [82]

- Premiums for an individual earning about $34,000 (just over twice the poverty line) would increase $1,197 annually from the expiration of enhanced tax credits, plus another $157 (4.53%) from the change in the premium adjustment formula. Additionally, their maximum out-of-pocket cost in a silver plan would increase by $350.[83]
- Premiums for a 50-year-old individual earning just over $60,000 (411% of federal poverty) would increase $3,065 from the expiration of enhanced tax credits. Additionally, their maximum out-of-pocket cost in a silver plan would increase by $1,400 over 2025 levels, of which $550 is from the proposed change in the formula.[84]
- A family of four at an annual income of about $70,000 (twice the poverty line) would experience a premium increase of $2,769 from enhanced premium tax credits going away, plus an additional $211 from the change in the premium adjustment formula. On top of that, their maximum out-of-pocket cost in a silver plan would increase by $700.[85]

Families USA opposes decreases in allowed actuarial value that would compound problems with health care affordability (156.140, 156.200, and 156.400)

Proposed de minimis range changes

CMS proposes that the actuarial value of silver plans could vary between a de minimis range of +2/-4 percentage points from 70, an increase from the current range of +2/0. Since the second lowest cost silver plan is the "benchmark" for premium tax credits,[86] this means that people with premium tax credits would be faced with a plan that covers a far lower share of their costs than today. We strongly disagree with CMS' justification for decreasing the value of silver plans: CMS asserts in the preamble that unsubsidized enrollees will be discouraged from enrolling in higher actuarial value plans because these plans have higher premium costs and that this may negatively affect risk pools. However, this argument is a misleading justification for lowering the value of silver plans, since all enrollees continue to have options to buy lower value/lower cost bronze plans in the marketplace, and those plans are part of the same risk pool as silver, gold, and platinum plans.[87]

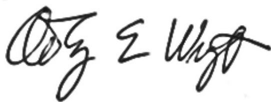
Increased cost burdens would fall heavily on low- to middle-income groups that can least afford additional expenses. Median wages have not increased in real dollars from 2020 to 2024.[88] Since 2000, rents have risen faster than median income in almost all parts of the country.[89] Large proportions of households report difficulties paying for utilities, food, housing, and medical expenses.[90] [91]Already, a third of marketplace enrollees report that they delay or skip care or drugs due to affordability, and increases in their cost sharing will worsen this problem.[92] If this Proposed Rule is finalized, people with income just over the federal poverty

line will face higher health care expenses at the same time that they may experience cuts in food assistance[93] or other benefits.

In conclusion, the Proposed Rule on Marketplace Integrity would force many Americans to pay more for health coverage, get less value from their health coverage, or lose health coverage altogether.

Families USA appreciates the opportunity to comment on this proposed Marketplace Integrity rule and urges CMS to reconsider the many proposals highlighted in our comments that would make marketplace coverage less affordable and less accessible for millions of Americans. If there are any further questions, please contact Cheryl Fish-Parcham, Director of Private Coverage at Families USA, at cparcham@familiesusa.org.

Sincerely,



Anthony Wright
Executive Director

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