FAMILIESUSA THE VOICE FOR HEALTH CARE CONSUMERS

What They Are Saying: HHS "Marketplace Integrity" Rule

Recently, Families USA submitted comments opposing a proposed federal rule that would drive up costs for people in marketplace plans, make it harder for people to enroll in coverage, remove DACA recipients' rights to coverage, and prohibit states from requiring gender-affirming care coverage. In addition to our comments, more than 25,700 comments were submitted to HHS on this proposed rule. Among them were a range of voices: consumer and patient advocatess, health plans, organizations representing providers and hospitals, and thousands of every day Americans who will be negatively impacted if the rule is finalized.

General Comments

America's Essential Hospitals: "Because of the financial challenges that our members face, they cannot afford to take on additional uncompensated care costs. As a result, we are very concerned about the proposals in this proposed rule that are expected to cause between 750,000 and 2 million people to lose health insurance coverage. Although we recognize the importance of ensuring program integrity, we urge the Centers for Medicare & Medicaid Services (CMS) to act to minimize the loss of coverage among individuals who are currently eligible for marketplace coverage."

American Cancer Society – Cancer Action Network: "Having comprehensive and affordable health insurance coverage is a key determinant for surviving cancer. Research from the American Cancer Society shows that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive. Studies show that uninsured patients had substantially higher risks of presenting with late-stage cancers at diagnosis, especially for screen-detectable cancers and cancers with early signs and symptoms, for which access to care is critical for early diagnosis. By CMS' own estimates between 750,000 to 2 million fewer individuals would enroll in qualified health plan (QHP) coverage in 2026 if this proposal was finalized. These estimates do not account for other recent agency actions such as the significant cuts to navigator grant funding and the reduction of CMS personnel which are likely to result in decreased enrollment. Nor do CMS estimates account for the potential expiration of the enhanced Affordable Care Act (ACA) tax credits which have contributed to the record-breaking enrollment in Marketplace plans since they were enacted by Congress in 2021. ACS CAN is concerned that these cumulative policies will result in fewer individuals having access to affordable, comprehensive coverage."

American Hospital Association: **"Taken with other policies in the rule, CMS estimates that between 750,000 to 2 million consumers could lose their coverage.** We are deeply concerned by these estimates of coverage loss, particularly as we have seen no credible evidence to support that such a high number of individuals have been impacted by inappropriate broker enrollments. **Coverage loss of this magnitude would have substantial consequences for patient access to care, as well as the financial stability of hospitals, health systems, and other providers."**

American Lung Association: "People with lung disease have seen lifesaving benefits from marketplace coverage. For example, here is Daniel's story: Daniel lost his job due to his COPD, just nine days before his appointment to discuss getting a lung transplant. This meant losing his insurance coverage too. He tried to find new employment and worked part-time jobs to help pay for his care, but having a chronic condition made it difficult to get hired. It took two years to get on Medicare due to his disability, and in the meantime, he was told he didn't qualify for Medicaid. That's when he learned about a lifesaving option: the marketplace. He found a great plan, with subsidies that covered 90% of his premium costs. That meant his plan was affordable, at $120 per month. The coverage was excellent. He had no copayments for doctors' visits, and his medication costs went down to $15 a month. Without coverage for his medication, he isn't sure he would have had money to eat or if he would have survived."

Brookings Institution, Urban Institute, and Georgetown University: "This proposed rule represents a sharp reversal of previous policy without sufficient new evidence, without a reasonable connection to the justifications provided, and without considering key reliance interests.

Virtually every provision individually is harmful to consumers and/or inconsistent with the best reading of the statute. In addition, the proposals are justified with flawed analysis with respect to the major goals cited: reducing improper enrollment and improving the risk pool. And even to the extent that real problems exist under current policy (including evidence of fraud by brokers), the proposals bear no reasonable relationship to solutions that would address these problems. There are ways to address concerns about fraud by agents and brokers, but the rule omits such measures.

The rule also undermines state autonomy, imposes needless costs on states, and requires states to make changes on infeasible timelines, often in ways that would reverse policies on which they have relied for years.

Finally, the rule fails to provide a meaningful opportunity to comment, due to both the short comment period and the Centers for Medicare and Medicaid Services' ("CMS") failure to make publicly available key data that the agency has access to."

Center for American Progress(CAP): "While CMS frames the proposed rule as advancing program integrity and lowering premiums, numerous provisions therein would instead restrict eligibility, limit enrollment opportunities and increase enrollee costs. Such changes would also conflict with the intent of the Affordable Care Act to "make affordable health insurance available to more people," the Department of Health and Human Services (HHS)'s mission to "enhance the health and well-being of all Americans," and CMS's mission to provide health coverage to millions through the ACA marketplaces. This is particularly concerning given the popularity of the ACA and the number of Americans who rely on it for coverage, including more than 24 million people who selected a marketplace plan for 2025."

Center on Budget and Policy Priorities (CBPP): The Administration seeks to justify these new burdens on applicants by claiming that millions of people have been improperly enrolled by agents and brokers. Yet it does little to build on prior actions directed at unscrupulous agents and brokers, and it instead increases red tape and administrative burdens for people seeking coverage. CMS itself admits that "eligible enrollees may lose coverage as a result of the administrative burdens imposed by the provisions of this rule."

Cigna: "As CMS is aware, issuers will be in the middle of plan filing timeframes when this rule is finalized, which will not leave sufficient time to update plan designs and rates. Issuers also interact with other stakeholders, including states, vendors, agents, and brokers, who need adequate time to update systems, processes, and resources to communicate and comply with the proposed changes. Most importantly, consumers need time to understand the new policies and their impacts."

Colorado Consumer Health Initiative: "We have significant concerns that the proposed rule undermines both the stated goal of the Affordable Care Act to provide quality, affordable health care for all, and over a decade of improvements and achievements resulting in access to care for 50 million people- including Plan Year 2025's record-breaking enrollment of more than 24 million individuals across the nation. [...] We feel this rule overall largely adds burden to consumers attempting to enroll, arbitrarily eliminates flexibility for State Based Marketplaces, is premised on faulty or lagged data, and incorrectly addresses the fraud CMS intends to resolve. The Paragon Health Institute report referenced several times in the proposed rule relies on problematic data, fails to account for income misestimations, and exaggerates the extent of possible enrollment fraud."

Community Catalyst: "Federal law has long recognized the importance of state regulation of their own health insurance markets and the importance of supporting state innovation in that regulation. This proposed rule threatens to limit states' rights to manage their own unique insurance markets in the ways that work best for them."

Families USA: “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.”

Legal Action Center: “We are also concerned that people who are no longer able to access affordable Marketplace coverage would not have any alternatives for health insurance, especially with the ongoing discussions about cuts and substantial changes to Medicaid. Similarly, people who lose their Medicaid coverage would have limited alternatives to purchase coverage as a result of these proposed changes. Other than the proposals that directly target agents and brokers, the Administration has failed to demonstrate in this proposed rule how making it harder for people to access insurance coverage is an appropriately tailored or effective way to prevent or reduce fraud.”

The Leukemia & Lymphoma Society: “Even though the Department observes repeatedly (and correctly) that bad-actor agents and brokers are the drivers of fraud and improper enrollment, it is striking to us that the proposed rule would do nothing to increase oversight or to improve compliance, and in fact, it proposes nothing to crack down on those bad actors. Instead, the Department proposes to crack down on consumers – depriving up to 2 million people of coverage by its own account. Simultaneously, the Department has quietly reinstated many of the agents and brokers it previously suspended due to program integrity concerns.

It is difficult to reconcile the Department’s reversal with states’ actual experiences. SBMs that have allowed open enrollment into January see consumer interest but have not faced adverse selection. On the contrary, they have found that consumers who enroll later tend to be younger and healthier than those who enroll early.”

Multnomah County Community Health Center, Ohio Association of Community Health Centers, Wright Center for Community Health: “Community health centers (CHCs) are already facing intense financial pressure while operating on little to no margin, and a decrease in insured patients may force CHCs to reduce services or close their doors completely - which would negatively impact access for the low-income population that we serve, particularly in rural areas.”

National Health Law Program (NHeLP): “Severe health consequences may arise when policy-makers impose barriers to affordable care. HHS’s proposal will hold individuals’ health hostage in an attempt to resolve administrative problems.”

NorthWest Health Law Advocates (NoHLA): “While we acknowledge that there is significant room for improvement in United States health care and coverage, this proposed rule represents an abrupt reversal of previous policy – without sufficient new evidence to justify the changes; a nexus to the explanations provided; consideration of key reliance interests; or, in some cases, without waiting for previous policies to take effect. In addition, the proposals are often justified with flawed analysis with respect to the stated goals, such as reducing improper enrollment and improving the risk pool. To the extent that real problems exist under current policy (such as evidence of fraud by brokers), the proposals do not bear a reasonable relationship to solutions that would address these problems. There are better ways to address concerns about fraud, such as the program integrity safeguards used in Washington State.”

Pennsylvania Health Insurance Exchange Authority: “The proposed rule represents an overreach in mandating policies to all states – even those without these issues – in an unprecedented usurpation of state governance and at a significant operational cost. Meanwhile, the logical conclusion from the data laid out in the proposed rule argues that states should be given more flexibility, not less, given the responsible state approaches. Pennie and other state-based marketplaces have managed more stable programs with better outcomes that have largely avoided the concerning issues seen in the federal marketplace. In short, Pennsylvanians should not be penalized for issues in other states that do not apply in the Commonwealth.”

Robert Wood Johnson Foundation: “Instead of creating enrollment barriers for individuals who are eligible for Marketplace coverage, premium subsidies, and cost-sharing assistance, CMS should focus its regulatory and oversight efforts on rogue brokers and agents that conduct unauthorized plan switching and improper enrollment activity.”

US Of Care: “We are concerned that these changes, if finalized, would result in inefficiencies and increased costs across the system, largely driven by policies that could jeopardize people’s access to care and drive up uncompensated care in the process.”

Gender Affirming Care and Restricting State Flexibility for Defining Essential Health Benefits

Sign-on letter from the following physician groups: Academic Pediatric Association, American Academy of Child and Adolescent Psychiatry, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Pediatric Society, American Psychiatric Association, Association of Medical School Pediatric Department Chairs, National Association of Pediatric Nurse Practitioners, and Pediatric Policy Council Society for Adolescent Health and Medicine:

"This proposal also threatens access to best-practice medical care for transgender young people and adults. Health care for transgender people is individualized, age-appropriate, and provided according to longstanding expert clinical guidelines. This evidence-based care is supported by every major American medical organization. Preventing anyone from obtaining medically necessary care threatens their health, mental health, and well-being and that of their families. This proposal specifically excludes medically necessary health care services for individuals with gender dysphoria while explicitly including the same services for patients with other clinical indications. As such, the proposal discriminates against transgender individuals. While CMS does not propose to prohibit any coverage of this care, excluding these services from the EHB package will have the effect of limiting the plans with benefit packages that include medically necessary services and increasing the cost of premiums and care for this population. We oppose any proposals that make it more difficult for patients to access the care they need to lead healthy lives. Clinicians, not CMS, are best positioned to work with patients and their families to address their medical and mental health care needs. By inserting CMS between patients and health care providers, this proposal represents a harmful intrusion into the patient-clinician relationship. It serves no purpose other than to target individuals whose families rely on life-saving medical care."

Blue Cross and Blue Shield of America: "Some services used in the context of "sex-trait modification," such as mastectomies, are a routine part of medical care for diseases such as cancer. As such, they are one component of the medical/surgical benefits that provide a baseline for a parity analysis under the Mental Health Parity and Addiction Equity Act (MHPAEA). The rule implementing ACA Section 1557 also prohibits discrimination in benefits based on sex and gender. BCBSA recommends that CMS clarify any potential interactions between the proposed policy and the requirements of MHPAEA and ACA Section 1557. Specifically, would coverage of a procedure such as mastectomies as an EHB for purposes other than "sex-trait modification" trigger a requirement under MHPAEA to also cover them for the purposes of "sex-trait modification" as a treatment for gender dysphoria?"

Cigna: "We recommend CMS preserve the existing EHB framework that allows state benefit flexibility and innovation to meet consumer needs within a broad federal guardrail. "

National Health Council: "The NHC recognizes CMS' intent to promote standardized and clear health plan options through CMS' proposal to adjust actuarial value (AV) thresholds for plans in the ACA Marketplaces, as well as the decision to modify certain Essential Health Benefits (EHBs). These changes could inadvertently limit consumer choice and market flexibility, increase out-of-pocket costs, and limit patient access to critical health care services, particularly affecting those managing chronic conditions, disabilities, and complex health needs."

Whitman-Walker Institute: “This definitional issue is a huge problem for defending the Secretary’s authority to finalize this rule. After CMS specifically tries to carve out a discrete, identifiable set of procedures based on E.O. 14187, they then also cite “some stakeholders” (who are not identified) who “do not believe that [healthcare services for transgender people] fit into any of the 10 categories of EHB, and, therefore, do not fit within the EHB framework even if some employers cover such services.” The agency proposes to deal with its definitional problem by resorting to a purpose-based definition (“services performed to align or transform an individual’s physical appearance with an identity that differs from his or her sex”), which veers into prohibited discrimination if CMS is suggesting, as they seem to be, that the same services they propose to prohibit for transgender people should be provided for non-transgender people. In response to CMS’s solicitation for comments about “whether we should define explicit exceptions to permit coverage…for other conditions,” the answer should be a strong no, because such a schema discriminates on the basis of health conditions as well as transgender status, as further detailed below.”

Anonymous Individual: “Not only is it cruel, but not providing healthcare early on has been proven to result in increased costs economically. If we don’t provide healthcare to everyone in the US, we lose revenue due to lost productivity. [...] There are many things that fall under this broad category that will have effects on more than just transgender individuals, the ones that are being politically persecuted with this rule. However, transgender people have existed for centuries and this rule will do nothing to change that aside from making life worse for average Americans that are just trying to live in peace. Gender affirming healthcare has been proven through research to have positive outcomes and we could continue to build on this foundation. However, we have defunded studies meant to improve gender affirming care and now use the “lack of available information” to detract from the effectiveness of gender affirming care. Stop using CMS as a political tool to intimidate vulnerable populations. Everyone deserves equal access to healthcare.”

Alison M.: “As the parent of a transgender daughter I have witnessed firsthand the challenges that the transgender community face in accessing medical care. My daughter was on a waitlist to get an appointment at a transgender clinic for over a year, and then it took a further 6 months before she had her first appointment. Accessing care in a facility that is familiar with the unique needs facing transgender people has made such a huge difference to my daughter. Even though she has to travel 1.5 hours each way to visit the clinic receiving comprehensive and compassionate care has ensured that she is comfortable getting the medical care that she needs.”

Xian M: “As a trans doctor, I have the unique privilege of seeing both sides of this struggle. I remember not even ten years ago, the main path to paying for gender affirming care was through crowdfunded donations. For many, hormone therapy and gender affirming surgeries were distant dreams and the reality was living with body dysphoria that drove many to depression, substance use, and suicide. As a doctor, it pains me that there is something that I can do to not only prevent suicide, but to bring joy to someone's life. To withhold medicine that has been around for decades and has been scientifically shown to be safe and effective, and hide them behind a financial barrier, is a travesty to my oath to do no harm and to protect life."

William Z.: "I am trans and getting access to healthcare for some concerns that are somewhat unique to my kind was extremely challenging, however when I finally did get access, at age 44, it was life-changing. I had previously been visited by strong suicidal ideation quite regularly, at least once every 3 months for decades. I'm happy to have made it that far and now this far. I am also happy to report that I am so happy to be me and that I can't recall the last time I seriously considered suicide."

Marketplace Coverage for DACA Recipients

American Academy of Family Physicians(AAFP): "If excluded from ACA coverage, thousands of DACA recipients will not only lose coverage but also shift health care costs to state and community programs, safety-net providers, and emergency rooms. This exclusion could lead to delays in preventative care and reliance on costly acute interventions. Such outcomes would harm the health of DACA recipients while driving up overall costs for the healthcare system. Additionally, CMS estimates that the implementation of this provision would cost each SBM [State Based Marketplace] at least 1,000 hours, with an additional 1,000 hours to terminate coverage for current DACA enrollees. CMS notes that this estimate does not account for the consumer outreach and education necessary to notify beneficiaries of this change. This significant administrative burden would waste critical CMS resources, while also disproportionately increasing health care costs for communities with DACA residents."

American Association of American Medical Colleges (AAMC): "If finalized as proposed, these changes could result in approximately 750,000 to 2,000,000 individuals losing coverage, eliminating advancements in lowering the uninsured rate in the United States. Rather than creating additional barriers to coverage, CMS should focus on policies that incentivize healthy individuals to select and maintain coverage to prevent adverse selection" "The AAMC urges the agency not to finalize its proposal to alter its interpretation of "lawfully present" for the purposes of determining eligibility in a QHP or insurance affordability programs to exclude DACA recipients. [.....] Lack of coverage for this population may also drive a reliance on emergency departments and community health centers for routine health care, rather than receiving more effective and efficient care in other settings."

CareFirst BCBS: “CareFirst is concerned about operational challenges with the proposed effective date for implementing changes related to the definition of “lawfully present” and its impact on DACA recipients’ eligibility to enroll in a Qualified Health Plan through the Exchange. The proposed rule does not provide sufficient time for SBEs to accurately identify impacted individuals and share the necessary files and documentation with carriers, carriers to process the terminations, and Exchanges to send the termination notices to consumers.”

Center for Law and Social Policy: “Eliminating DACA recipients from the definition of “lawfully present” for the purposes of marketplace coverage would significantly harm DACA recipients themselves and their families, worsening access public health, access to health coverage, and healthy outcomes for immigrant families. HHS should retain DACA recipients’ current eligibility for the marketplace and BHP.”

Cystic Fibrosis Foundation: “DACA recipients are young and relatively healthy. As they enter their states’ individual market and BHP risk pools, those pools will become younger and healthier than they would have been in the absence of this rule. Stronger risk pools can be expected to exert downward pressure on plan premiums and enhance market stability, improving coverage options for all.”

Covered California: “With a mutual commitment to the well-being of all communities, Covered California advocates for CMS to keep DACA recipients within the lawful presence definition, preserving their access to marketplace coverage and financial assistance… Covered California is deeply committed to ensuring that all individuals and communities have access to comprehensive, equitable healthcare, reflecting our state’s core values of equity and accessibility. By embracing the diversity of our state and recognizing healthcare as a fundamental right, we work towards a healthier California. Including DACA recipients in marketplace coverage reduces uninsured rates, brings younger enrollees into the market and connects Californians to coverage they need and deserve. We strongly oppose removing DACA recipients from the definition of lawfully present.”

The Leukemia & Lymphoma Society: “LLS strongly disagrees with this position. The lack of treatment options facing DACA recipients includes people diagnosed with blood cancers who have nowhere else to turn without Affordable Care Act (ACA) coverage. Further, by revoking this eligibility, the Department likely increases the number of individuals who will have to rely on expensive, uncompensated care, harming existing enrollees and increasing costs for hospitals as well. LLS urges the Department not to finalize this proposal.”

Hayley L.: “Healthcare is a basic human right! My husband is a DACA recipient, he and his family and every person that is legal in this country deserves the constitutional right to life! Healthcare saves lives!!

To think that something that would add new, unnecessary barriers to enrollment in ACA plans, make it harder for low-income people to access subsidized care, and strip legal DACA recipients of healthcare coverage would even be considered, is absolutely immoral unconstitutional and downright disgusting."

Jennifer M.: "To the committee working on the Marketplace Integrity and Affordability rules, I find that it would be anti-humanitarian to disallow DACA children from being able to participate in the Affordable Care Act. These children came here with their families and did not have a choice to be here. Not having insurance in the US today is a major barrier to any ways to better one's life. These children, and their families, contribute millions of dollars to the US tax base and deserve protection. I am a college professor and I teach a significant number of DACA students. They are driven, bright, and hard-working students who want to make their life in the US, and DACA gives them a path to citizenship. Without health insurance, which is largely unaffordable without ACA protections, these students will suffer unduly. In addition, uninsured patients in the US cost approximately 35 Billion Dollars annually. It would be short-sighted and faulty to eliminate health insurance for any group of people, especially DACA recipients."

Marcia Z.: "When I worked as a volunteer with SIREN (Services, Immigrant Rights & Education Network) in San Jose, I met DACA recipients who needed help submitting their renewal requests. I was happy to assist them with the process, and while doing so, I learned a little about their lives and struggles to work, study and raise families. I am glad I live in the State of California where DACA recipients have the rights and benefits they deserve, including Medi-cal if they are low income, and eligibility for in-state college tuition.

I was distressed to learn how harmful CMS-9884 would be to DACA recipients. Every resident has the right to buy an affordable health insurance plan! It's unthinkable to me as a senior on Medicare that these residents would lose both their existing ACA coverage and no longer be eligible to purchase insurance on the ACA Marketplace."

Reducing Open and Special Enrollment Windows

American College of Physicians: "ACP is concerned that the proposed changes to the open enrollment period will confuse our patients, particularly those served by state-based exchanges (SBE) with an extended open enrollment period. A longer open enrollment affords patients additional time to change plans if, for example, they discover their plan's clinician directory included inaccurate information necessitating enrollment in a new plan that includes their preferred physician in the network. The extended enrollment period may provide an opportunity for individuals to shop for a different plan if their advance premium tax credit (APTC) amounts change and they need to enroll in a plan that better meets their needs."

American Lung Association: "Neither states with open enrollment periods from November 1 to January 15 nor HHS saw evidence of adverse selection into the marketplace as a result of the longer open enrollment period. On the contrary, those states found that individuals who enroll later tend to be younger and healthier than those who enroll early. Limiting the federal annual open enrollment period to November 1 through December 15 – and requiring state-based marketplaces to do this – would decrease access to quality, affordable healthcare coverage for individuals with lung disease. The Lung Association strongly urges HHS not to finalize this policy."

Association for Community Affiliated Plans: "It is our understanding that often healthier consumers wait to enroll, while sicker consumers have a greater incentive to enroll early, which suggests that shortening OEP risks degrading the risk pool. Analysis from Covered California, for example, shows a decreasing risk score of consumers enrolling in coverage prior to December 15 compared to those purchasing coverage from December 15 to December 31, and even lower risk scores for consumers purchasing coverage in January. ACAP urges CMS to retain the current OEP in order to support a balanced risk pool and lower premiums for all consumers."

Brookings: "Abundant evidence shows that, contrary to HHS' assumptions, administrative burdens created by HHS' changes to the Marketplace enrollment process would deter eligible people from enrolling, reducing insurance coverage and increasing insurance premiums... HHS does not meaningfully justify its claim that its proposed changes to special enrollment period (SEP) policies would sharply reduce premiums, and HHS is ignoring evidence that could allow it to make a more evidence-based assessment of these policies."

The Commonwealth Fund: "If finalized, all marketplace OEPs would be required to run from November 1 to December 15. CMS supports this proposed change by suggesting that extending the OEP past December 15 contributes to adverse selection. CMS also asserts that a longer OEP does not help boost enrollment and contributes to consumer confusion.

However, data from the SBEs suggest that longer open enrollment periods increase enrollment among younger and healthier enrollees and therefore strengthen marketplace risk pools. Stronger risk pools mean lower premiums and less cost to the federal government."

Governing for Impact: "When agencies are considering a new policy or a change in existing policy, the APA requires agencies to "examine 'the relevant data'" and "articulate 'a satisfactory explanation.'" Among other things, agencies must "clearly disclose and adequately sustain" their basis for decision making. Further, when effectuating a policy change that relies on "factual findings that contradict those which underlay its prior policy," the agency must address those changed factual findings in a reasoned manner.

CMS asserts that the 150% FPL SEP has increased improper enrollments and the risk of adverse selection, which may create higher premiums. That justification suffers from several deficiencies.

First, CMS has not considered conflicting evidence showing that SEP enrollees generally do not negatively affect the risk pool, meaning that they also do not increase the rate of adverse selection. To support its argument that the 150% FPL SEP has increased adverse selection, CMS explains how adverse selection may be incentivized by the 150% FPL SEP, but does not provide data supporting this assumption. [...]

Second, as the Paragon report states, and as CMS recognizes, improper enrollment is largely due to brokers' and agents' intentional manipulation of potential enrollees' applications, not potential enrollees' direct misuse of the SEP. This finding does not justify CMS's proposal to eliminate the 150% FPL SEP, but again shows that CMS is not meaningfully considering an important factor–brokers' and agents' intentional manipulation of the program[...]

Third, CMS has not provided adequate data to support its claim that improper enrollment rates have increased, nor has it addressed other significant factors that may contribute to any supposed increase before deciding to strip enrollees of coverage. To support CMS's argument that the 150% FPL SEP has led to increased improper enrollment, HHS relies on a Paragon Institute Report that compared income distributions in states to the 2024 Open Enrollment Period ("OEP") data gathered by CMS. 21 However, CMS fails to mention that the Paragon report relied on income distribution data by states from 2022, compared to the 2024 OEP, rendering their analysis theoretical since it assumes that income distribution has not changed since 2022. [...]

Fourth, CMS's analysis of the effect of repealing the 150% FPL SEP on premiums is contradictory. On the one hand, CMS finds that the PY 2025 Payment Notice overestimated the effect of the 150% FPL SEP on premiums;28 rather than causing premiums to rise by 3-4% absent IRA subsidies, CMS now concludes that it increases premiums to rise by as little as 0.5%.29 On the other hand, CMS relies on those same erroneous estimates in predicting that repealing the SEP "could decrease premiums by 3 to 4 percent compared to baseline premiums if this rule is finalized[.]" The proposed rule therefore rests on an inflated understanding of how repeal might reduce premiums."

International Community Health Services: "A shorter enrollment period will likely have significant impacts on health centers. Under federal law, health centers are mandated to provide care to every patient who comes to them regardless of their ability to pay. In 2023, health centers cared for 5.6 million uninsured individuals, one million more than in 2019; the total cost of care gap in 2023 exceeded $3.16 billion, $1 billion more than in 2019.viii Health centers rely heavily on reimbursements from their insured populations to ensure they can pay for the care they provide to their uninsured patients. This rise in costs for health centers will only be exacerbated by a decrease in health insurance enrollments."

National Health Council: "While we acknowledge CMS' concern that this SEP may lead to adverse selection, eliminating it may unintentionally increase health care costs and place unnecessary burdens on taxpayers by causing disruptions in coverage among economically vulnerable Americans."

Enrollment Problems for People with Premium Tax Credits

American College of Physicians: ACP supports access to evidence-based and clinically indicated gender-affirming care that is provided in line with the medically accepted standard of care using an informed-consent model. Policymakers should uphold access to evidence-based health care services, care, resources and information.[...] If finalized, this proposal would limit crucial coverage, cost-sharing, and other protections for patients with non-grandfathered individual and small group market plans. Without insurance coverage, the cost of treatment for persons with gender dysphoria may be prohibitively expensive."

HRA Council: "Existing PTCs help ensure the stability of the individual market with stable and competitive local plan selections for ICHRA. In the absence of PTCs, premium increases due to trend and morbidity would harm the important employer option to implement an ICHRA for their employees."

"An unintended consequence of individual past-due premium requirements could result in an employer being unable to make an ICHRA offer. This could have an adverse domino effect if it blocks an employer from making an otherwise legitimate ICHRA offering, subjecting the employer to a possible tax penalty if the employer has no way to make another offer of affordable health coverage to their employees."

The Leukemia & Lymphoma Society: "The Department of Health and Human Services (the Department) has put forward this new slate of proposals that will undermine coverage affordability and access patients while creating significant uncertainty in the market just as plans and state regulators are working to implement the current rule."

Multnomah County Community Health Center, Ohio Association of Community Health Centers, Wright Center for Community Health, California Primary Care Association, Southern West Virginia Health System: "Over 45% of health center patients are 100% below the FPL – meaning they make a little over $15,000 per year as a single person. It will create a substantial administrative burden on these enrollees who would be required to respond to the data-matching issues (DMIs) through submitting pay stubs or additional information, which could be difficult to gather to prove their income projection, or risk losing tax credits. The proposed rule estimates 81,000 people annually would be denied tax credits, reducing APTC payments by $189 million, and will create 550,000 DMIs a year."

National Association of Insurance Commissioners (NAIC): "The Proposed Rule would require two substantive changes to the auto-reenrollment process. It would establish a $5 monthly premium for consumers who are automatically re-enrolled and previously qualified for a monthly premium of $0 until the consumer actively confirms eligibility and enrollment. It also would remove the option for Marketplaces to re-enroll consumers who had selected a bronze plan into a silver plan, when that silver plan costs them the same or less and includes the same provider network. Both of these changes would be most burdensome on those who can afford it the least."

National Health Council: "the process for reconciling APTCs can be complex, often requiring detailed financial documentation, accurate income forecasting, and timely tax filing. Individuals who fail to reconcile often do so unintentionally, either due to a lack of understanding of the process, inadequate access to tax assistance resources, or changes in life circumstances that complicate timely filing. Reverting to a one-year reconciliation requirement substantially increases the risk that eligible individuals will lose their subsidies—and consequently, their coverage—due to administrative confusion rather than actual ineligibility, potentially increasing reliance on costly emergency services and raising overall health care expenses."