The Commonwealth Fund
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April 11, 2025

Robert F. Kennedy, Jr.
Secretary
Department of Health and Human Services

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services

Attention: CMS-9884-P, P.O. Box 8016
7500 Security Boulevard
Baltimore, MD 21244-8016

RE: RIN 0938-AV61, CMS-9884-P Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability

Dear Secretary Kennedy:

Thank you for the opportunity to comment on the Patient Protection and Affordable Care Act: Marketplace Integrity and Affordability proposed rule. The Commonwealth Fund is a nonprofit, nonpartisan foundation dedicated to affordable, quality health care for everyone. We support independent research on health care issues and make grants to promote better access, improved quality, and greater efficiency in health care, particularly for society's most vulnerable — including people of color, people with low income, and those who are uninsured.

Decades of research demonstrates that health insurance is essential to getting timely health care in the United States. People who are uninsured get far less needed care and live sicker, less productive, and shorter lives. Access to care is critical to preventing chronic disease and improving health outcomes.

The reforms to the individual insurance market enacted by the Affordable Care Act (ACA), together with the law's premium tax credits for marketplace health plans, have transformed the ability of people who lack access to employer-based coverage or Medicaid to buy affordable, comprehensive coverage. Before these reforms were implemented, people with preexisting conditions were out of luck when they sought to buy insurance on their own. Millions of young adults became uninsured when they graduated from high school or college. And insurance companies charged young women much higher premiums than young men and rarely covered maternity care.

The marketplaces in 2025 are strong and competitive. Enrollment is at a historic high of 24 million people. Insurer participation is robust: 96 percent of HealthCare.gov enrollees had a choice of three or more plans in 2024. Enrollment is highest in states that have not expanded Medicaid, including Florida and Texas.

Working families and individuals with low and moderate incomes have been among the most important beneficiaries of the ACA's coverage expansions. They are the least likely to work for employers who

offer coverage and the most in need of a place to get good, affordable health insurance. In states that have not expanded Medicaid, marketplace coverage is now a lifeline for low-income working people.

Still, the United States can improve. An estimated 28 million Americans, or 8.5 percent of the U.S. population, lacked health insurance by the third quarter of 2024. While today's uninsured rate represents a sea change from the years prior to ACA, when twice as many people — 49 million, or 16 percent of the population — lacked health coverage, it is critical that we continue to make coverage gains.

Progress on coverage can be made without major expansions. The Congressional Budget Office (CBO) estimates that more than 60 percent of people who remain uninsured are eligible for subsidized health insurance. This includes more than 4 million uninsured people who were eligible for marketplace premium tax credits in 2023. Making enrollment simple and easing coverage transitions during life events like job loss could help people maintain seamless coverage and access to the health care they need.

Health care affordability is an ongoing concern for working families. A 2023 survey found that more than half of working-age adults said it was very or somewhat difficult to afford their health care costs, including 43 percent of adults with employer coverage and 57 percent of people in marketplace or individual market plans. A 2024 survey found that 23 percent of working-age adults who were insured all year had such high out-of-pocket costs and deductibles relative to their incomes that they were underinsured. Of those, two-thirds were enrolled in employer health plans and 14 percent had marketplace or individual market plans.

To achieve a productive workforce and a high-performing health care system, it is incumbent upon policymakers to ease coverage enrollment barriers and seek to improve the affordability and cost-protection of health plans across the commercial insurance markets that now cover nearly 190 million people. We cannot have a strong workforce if working people and their families lack affordable access to health care.

The following sections of the proposed rule would likely increase the number of people who are eligible for but not enrolled in subsidized coverage, reduce the affordability of health insurance, and increase the number of people who have coverage but are underinsured. Taken together, these effects could reduce access to needed health care, particularly among families with low and moderate incomes.

We offer comments on the following sections of the proposed rule:[1]

- III.B.3.c. Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (Section 155.320)
- III.B.3.d. Income Verification When Tax Data is Unavailable (Section 155.320)
- III.B.3.b. 60-Day Extension to Resolve Income Inconsistencies (Section 155.315)
- III.B.7. Annual Open Enrollment Period (Section 155.410)
- III.B.8. Monthly Special Enrollment Period for APTC-Qualified Individuals with a Projected Household Income at or Below 150 Percent of FPL (Section 155.420)
- III.B.9. Pre-enrollment Verification for Special Enrollment Period (Section 155.420(g))

[1] The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

- III.C.2. Premium Adjustment Percentage (Section 156.130(e))
- III.C.3. Levels of Coverage (Actuarial Value) (Sections 156.140, 156.200, 156.400).

Section III.B.3.c Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (Section 155.320)

Section III.B.3.d. Income Verification When Tax Data is Unavailable (Section 155.320)

These sections propose to cease accepting an applicant's attestation of income when tax data indicate their recent income is under 100 percent of the federal poverty level or tax data are unavailable.

When someone applies for an APTC, their eligibility is based on their projected income for the coming year and recent tax return data provided by the Internal Revenue Service (IRS). If their projected income is lower than that indicated in the tax data, the marketplace flags their application as a "data matching issue," or DMI. The applicant will then be asked to provide more information to support their income projection; otherwise, eligibility will be determined by the tax data. This is because the APTCs are larger the lower someone's income is.

The proposed rule would add a DMI for cases where an applicant's projected income is between 100 and 400 percent of the federal poverty level (FPL) and the tax data show their income to be less than 100 percent FPL. This is because in states that have not expanded Medicaid, the thought is that people who are caught in the Medicaid coverage gap (incomes too high to qualify for the state's existing Medicaid program and too low to qualify for an APTC) will have an incentive to inflate their income so they can get health insurance.

The Department of Health and Human Services (HHS) also adopted this rule in 2019. However, a Maryland district court overturned the rule in *City of Columbus, et al. v. Cochran*, finding that HHS had not provided adequate justification or response to public comments that had questioned the change.

HHS is proposing to reinstate the policy with this rule. This change will add a new burden on people with low income whose employers do not provide health insurance and who are not eligible for Medicaid in nonexpansion states. These individuals would be required to provide pay stubs and other information to support their income projections. Many people at this income level have multiple jobs and are in families working for multiple employers.

Because of multiple employment sources, variable hours, and seasonal employment, people with low income face unique challenges in estimating annual income. One analysis found that workers in the lowest income quintile had more than double the degree of income variability compared to workers in other income groups. This means that projected income and actual annual income are distinct concepts for families with lower incomes.

This policy runs at cross-purposes with the goal of enabling people to enroll in the coverage that, by law, they are eligible for. Experience with Medicaid and other federal programs shows that administrative hurdles decrease the likelihood of enrollment. HHS estimates that the two new policies would reduce enrollment by nearly 500,000 people. Based on earlier estimates of enrollment loss due to DMIs, the number of people blocked from coverage they are eligible for is likely to be higher.

HHS estimates these proposals will add more than 2 million DMIs per year, dramatically increasing administrative costs for the marketplaces – by more than $120 million, according to their own estimates.

If HHS is concerned about low-income people enrolling in coverage their incomes are too low for, the issue could be resolved, without erecting new barriers to coverage and care, in one of two ways:

- The 10 states that have not expanded Medicaid eligibility could move forward, eliminating the coverage gap and covering 1.4 million uninsured people.
- Congress could revise the ACA statute to allow people with incomes under 100 percent of poverty in nonexpansion states to become eligible for marketplace coverage.

Given the potential for coverage disruptions, particularly for those with low income, and the large administrative burden for the marketplaces, we recommend not moving forward with this proposal.

Section III.B.3.b. 60-Day Extension to Resolve Income Inconsistencies (Section 155.315)

CMS is also proposing to require applicants to submit a manual request for additional time to resolve a DMI rather than providing applicants with an automatic extension of 60 days, the current policy. This change would make DMIs harder to resolve. The automatic extension should be retained for the following reasons:

First, if the changes described above are adopted the exchanges will see a substantial increase in the number of applicants with DMIs and, consequently, a major burden on exchanges to review documents. As the agency sheds critical staff who monitor contractor performance in reviewing DMI documents, it seems prudent to retain the automatic 60 day extension to allow more time for applicants and the exchanges to resolve the DMI. Further, automatic extensions would relieve the exchanges of the additional paperwork burden of reviewing extension requests.

Section III.B.7. Annual Open Enrollment Period (Section 155.410)

CMS proposes to shorten the annual open enrollment period (OEP) for the federally facilitated marketplace exchange (FFE) from 76 to 45 days. Further, in a break from historic deference to state flexibility, the proposed rule would prohibit the state-based marketplace exchanges (SBE) from using a longer OEP. 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.

For example, average risk scores for individuals enrolling early in Covered California's OEP (before Dec. 15) have consistently been higher than those enrolling after January 1. The trend is consistent across all years and time periods: the later in the OEP that consumers enroll, the healthier they are.

New York's SBE has had similar results. In the final month of New York State of Health's 2017 OEP, which ended January 31, more than 135,000 individuals enrolled in marketplace health plans. New York found that younger enrollees made up a higher share of total enrollment than they did earlier in the OEP.

This proposed change in OEP dates will also impose significant costs on the FFE and SBEs. By CMS's own estimates, it would take each SBE 4,000 hours to develop and code changes to their IT systems, at a cost of almost $7.8 million. This estimate does not include the costs of outreach to consumers.

Reducing the length of OEPs will lower enrollment among the healthiest and youngest enrollees. Doing this could cause premiums to rise and federal expenditure on tax credits to climb, while also increasing administrative costs for the marketplaces.

Rather than finalize this proposal, we recommend maintaining the current OEP duration of November 1 through January 15 and continuing to provide SBEs with flexibility to determine their own OEP dates.

Section III.B.8. Monthly Special Enrollment Period for APTC-Qualified Individuals with a Projected Household Income at or Below 150 Percent of FPL (Section 155.420)

CBO estimates there were 4.4 million uninsured people in 2023 who were eligible for premium tax credits for coverage purchased through the marketplaces. To help these individuals, HHS in 2021 established a monthly special enrollment period (SEP) for people at or below 150 percent of poverty ($23,475 for an individual, $48,225 for a family of four). The availability of this SEP has helped low-income working people enroll in affordable health insurance coverage and get access to needed health care.

However, CMS suggests that this SEP (referred to here as the "low-income SEP") has contributed to improper enrollments, driven largely by unscrupulous brokers and web brokers seeking commissions. CMS also suggests that this SEP has increased adverse selection, leading to a less healthy risk pool. The agency also suggests that the low-income SEP lacks a statutory basis.

Federal officials have broad authority to create SEPs in the ACA marketplaces and have established several over time. These include SEPs for when people lose jobs along with their employer health insurance, become ineligible for Medicaid, or experience a life-changing event like marriage or divorce. While the proposed rule suggests that SEPs have been fraudulently used, the evidence shows that they have been chronically underutilized. One study found that each year an estimated 33.5 million people experience a life-changing event that ends their coverage and makes them eligible for an SEP, but fewer than 15 percent enroll in marketplace plans.

There isn't evidence that the low-income SEP has caused the increase in fraudulent enrollments experienced by the FFE in 2024. The cause of enrollments made without consumer consent can be traced to brokers and agents in the FFE who are taking advantage of system vulnerabilities that are unique to the FFE. Federal regulators have taken numerous steps to close system loopholes, increase oversight and enforcement, tighten verification procedures, and ameliorate harm to consumers. And there are more steps that can be taken. But preventing enrollment fraud by making it harder to enroll throws the baby out with the bathwater and fails to address the real source of the problem.

By CMS's own estimates, fraud associated with unauthorized enrollments and plan-switching for people with incomes under 150 percent of poverty is concentrated in states that have chosen not to expand Medicaid eligibility. There isn't evidence of any meaningful fraud in the SBE states, all but two of which have implemented the low-income SEP and made it available to consumers for a number of years. None of these SBEs have reported problems with fraud. Indeed, Covered California reports that SEPs have become a critical source of enrollment, with more consumers signing up via the SEP than during the annual OEP. Yet there is no evidence of any meaningful fraud, as Covered California has in place

comprehensive safeguards to ensure that brokers obtain consumer consent before completing an enrollment. Similarly, the Massachusetts Connector, which has long had a year-round SEP for low- and moderate-income individuals, has identified "zero consumer reports among the 1.2 million calls to its customer service center in 2024" of unauthorized enrollments.

The experience of SBEs suggests that the low-income SEP has not contributed to adverse selection. For example, Massachusetts has long offered year-round enrollment to people who qualify for Connector Care, their marketplace for low- and moderate-income individuals. Massachusetts Health Connector officials report they have "not experienced adverse selection within the program," and their "risk scores have been healthier than for insurers off-Marketplace."

The low-income SEP provides a path to coverage for millions of uninsured people who are eligible for subsidized coverage and need timely access to health care. Owing to the potential for this proposal to pose a barrier to people enrolling in coverage and obtaining needed care, we recommend not finalizing this proposal.

Section III.B.9. Pre-enrollment Verification for Special Enrollment Period (Section 155.420(g))

Given the multiple sources of health insurance coverage in the U.S., transitions in coverage are inevitable. Unfortunately, many people who experience life events that trigger a coverage transition, such as a job loss, spend time uninsured. In 2024, 12 percent of the U.S. adult working-age population experienced a gap in their health insurance.

SEPs are aimed at preventing such gaps in coverage, and federal and state policy ideally would aim to increase, rather than decrease, their use. As noted above, just 15 percent of the 33.5 million people who experience life-altering events that qualify them for a SEP actually use them.

Yet CMS proposes to impose additional documentation requirements on consumers seeking to enroll in marketplace coverage through a SEP. Additionally, although CMS has traditionally deferred to the SBE's knowledge of their local markets in their creation and use of SEPs, the proposed rule would require all marketplaces, including SBEs, to conduct pre-enrollment eligibility verification for at least 75 percent of new enrollments through SEPs.

The policy risks triggering further declines in Americans' use of the SEPs and driving up coverage gaps and uninsured rates. This would leave millions of people unable to pay for health care should they need it and expose them to catastrophic medical debt. A study of the Massachusetts health insurance exchange found that adding one additional step to the enrollment process prompted a 33 percent decline in enrollment, predominantly among young, healthy, and economically disadvantaged people. The effect was equivalent to a 57 percent increase in the annual premium. Removing paperwork burdens, on the other hand, has been found to significantly increase enrollment and continuity of coverage among healthy, younger individuals.

CMS projects $7.2 million in new costs to consumers complying with the new SEP verification standards. It projects one-time costs of $60 million for five SBEs to add verification standards and an annual new cost of $1,736,615 per SBE, not including costs associated with consumer communications, outreach, and assister training.

Given the persistence of coverage gaps in our health insurance system and the chronic underutilization of SEPs by the millions of people who are eligible for them, the proposed change would be administratively costly for little expected benefit.

Section III.C.2. Premium Adjustment Percentage (Section 156.130(e))

Section III.C.3. Levels of Coverage (Actuarial Value) (Sections 156.140, 156.200, 156.400)

Health care affordability is an ongoing concern for American working families. A 2023 survey found that more than half of working age adults said it was very or somewhat difficult to afford their health care costs, including 43 percent of adults with employer coverage and 57 percent of people in marketplace or individual market plans. A 2024 survey found that 23 percent of working age adults who were insured all year had such high out-of-pocket costs and deductibles relative to their incomes that they were underinsured. Of those, two-thirds were enrolled in employer health plans and 14 percent were in marketplace or individual market plans.

Rather than trying to improve the affordability and cost protection of commercial health insurance plans, which cover nearly 190 million people, the proposed rule makes changes that will raise premiums and out-of-pocket costs for consumers.

First, CMS proposes to change the rules for calculating the "premium adjustment percentage," a measure of premium growth used to make annual updates to several ACA coverage parameters. The change would result in higher out-of-pocket costs for individuals with commercial health insurance (including the estimated 160 million people with employer-based insurance), smaller premium tax credits for marketplace enrollees, and larger payments under the ACA's employer shared responsibility provision.

Under the ACA, the premium adjustment percentage is used to update the maximum annual limit on out-of-pocket costs under employer, marketplace, and individual market health plans. The Internal Revenue Service uses the premium adjustment percentage to update individual contributions for marketplace enrollees receiving the APTCs. It is also used for updating other ACA parameters, like the employer shared responsibility payment.

Under current regulations, the premium adjustment percentage measures premium growth by looking at changes in the cost of employer-sponsored coverage. CMS proposes changing the calculation to also include coverage in the individual market. But the premium adjustment percentage is intended to measure underlying trends in health insurance premiums, not the effect of the policy changes made in the individual market.

The change would result in a premium adjustment percentage that would be about 4.5 percent higher in 2026. This would result in higher annual limits on out-of-pocket costs for people in employer and marketplace plans and higher premiums for people who receive tax credits in the marketplaces compared to current policy. In 2026, the new approach would increase the annual out-of-pocket limit to $10,600 for self-only coverage and $21,200 for family coverage, a 15 percent increase over 2025, and a 4 percent increase over 2026 using the current methodology.

One study estimates that a family of four earning $85,000 a year would pay $313 more in premiums under the policy change, and $900 more in out-of-pocket costs, were it to reach the out-of-pocket maximum. This means that this family would pay more for less coverage.

The proposed rule could also increase out-of-pocket costs for marketplace enrollees by providing insurers with greater flexibility in meeting the actuarial value (AV) requirements for plans sold in the marketplaces. The AV of a plan is the average share of medical spending paid by the plan; it reflects a plan's cost-sharing elements, such as deductible size, copayments, coinsurance, and out-of-pocket limits. Plans sold in the marketplaces can fall into four AV tiers: bronze (60% AV), silver (70% AV), gold (80% AV), or platinum (90% AV). In addition, people with income under 250 percent of poverty are eligible for cost-sharing-reduction silver plans with AVs of 94 percent, 87 percent, and 73 percent. depending on income.

Because there may be differences in AV estimates for plans, the ACA grants HHS the flexibility to allow variation around these levels, or de minimis variation. Under the original regulations post-ACA, HHS limited de minimis variation to +2/–2 percentage points. During the first Trump administration, HHS changed the limits to +2/–4 for all plans and +5/–4 for bronze plans. The Biden administration subsequently changed the limits back to +2/–2 and, to better protect consumers in plans with the highest cost sharing, HHS changed the de minimis limits for bronze plans to +5/–2. In addition, HHS set limits on silver level plans of +2/0 and CRS silver plans of +1/0. This was to ensure that people enrolling in these plans received the full value of marketplace tax credits entitled to them by law.

Now HHS is proposing to revert to the limits of +5/–4 for bronze plans and +2/–4 for all plans beginning in 2026. In addition, it would drop the limit of +2/0 on silver plans and allow de minimis variation of +1/–1 for CSR plans. The rule acknowledges that these latter changes could decrease the amount of APTCs for some consumers, as well as increase out-of-pocket cost exposure across the marketplaces.

One study estimates that a silver plan with an AV of 66 percent, as opposed to 70 percent, would increase out-of-pocket costs for a family of four earning $85,000 by $714.

Given the likelihood of the proposed rule raising premiums and out-of-pocket costs for consumers, we recommend not finalizing this proposal.

We appreciate CMS's efforts to gain and respond to stakeholder input for this proposed rule. We encourage CMS to continue to seek input from a broad set of stakeholders, including state-based marketplaces, insurers, and researchers.

Please contact Sara R. Collins (src@cmwf.org) with any questions regarding our comments on the Marketplace Integrity and Affordability Proposed Rule. For general questions about this response or inquiries for the Commonwealth Fund, please contact Christina Ramsay (cr@cmwf.org).

Sincerely,

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