American Association on Health & Disability

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LAKESHORE

April 11, 2025

Re: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability

Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9884-P
P.O. Box 8016
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Submitted via: www.regulations.gov

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The American Association on Health and Disability and the Lakeshore Foundation appreciate the opportunity to provide comments.

The American Association on Health & Disability (www.aahd.us) is a national cross-disability organization that conducts research, engages the community, and facilitates the development and implementation of programs to advance public health and healthcare policy for the health and wellness of people with disabilities. Through these actions, AAHD is committed to eliminating systemic barriers to healthcare and drive health equity for people across all disabilities, valuing the diverse and intersecting identities within the disability community. AAHD connects people with disabilities, disability advocates, health practitioners, researchers, and policy makers to accessible cross-disability health data and resources—creating a more inclusive society where data-driven healthcare leads to more equitable health outcomes.

The Lakeshore Foundation (www.lakeshore.org) mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation and research. Lakeshore is a U.S. Olympic and Paralympic Training Site; the UAB/Lakeshore Research Collaborative is a world-class research program in physical activity, health promotion and disability linking Lakeshore's programs with the University of Alabama, Birmingham's research expertise.

These proposed rules come at a critical time for the Affordable Care Act (ACA) marketplaces as they have seen significant increases in enrollment over the last several years reaching record enrollment of 24.2 million people for 2025. While it is unknown exactly how many people with disabilities utilize the marketplace for obtaining health insurance, it was estimated that at the time of the ACA's passage that 3.5 million people with disabilities were of working age but did not have coverage either publicly or through a private plan. We also know that statistics show that 20-25% of the population has a disability, meaning there could be as many as 8 million people with disabilities covered through the ACA marketplace. Given the fact that the proposed rules would potentially create barriers to all individuals getting the coverage they need or having difficulty in utilizing their coverage to pay for essential health care, we write to express our concern with the proposed rules and urge that they are not finalized in their present form. One of the key purposes of the ACA is promoting eligibility, affordability, and access to health insurance coverage. This is especially true for people with disabilities who have unique health care needs and rely on coverage to access trusted providers, services and a continuity of care to maintain their health and well-being.

Coverage Denials for Failure to Pay Premiums for Prior Coverage (§ 147.104(i))

Under the proposed rules, carriers would be permitted to essentially deny coverage to any enrollee who owes the company for unpaid premiums in prior years. Previously, any requirements to pay unpaid premiums only looked back for the past year, but this rule would extend that look back to an indefinite time. Many of these individuals may not even realize that there are unpaid premiums, meaning that individuals could sign up for coverage thinking that they were insured for the coming year without realizing that there was an unpaid bill that could potentially prevent that coverage from effectuating. No data has been provided which demonstrates why such a proposal would be needed and denying people coverage for this reason will only serve to add to the issues of medical debt in this country. According to a 2024 report from the Peterson Center on Health Care and the Kaiser Family Foundation, 20 million Americans own medical debt totaling at least $220 billion.[1] This is equal to 8% of the US adult population and the percentage is even higher for people with disabilities as 13% of the disabled population has some sort of medical debt. By making it harder for these people to get coverage, this will only compound the problem and if they are forced to go without coverage, it will only add on to this debt as they will be forced to seek care which goes uncompensated. The intention of the ACA was to reduce the amount of uncompensated care provided in this country and this rule would undermine that intention and the purpose of the law.

Limited Open Enrollment Periods (§ 147.104(b)(2))
Annual Open Enrollment Period (§ 155.410)

Under the previous Administration, open enrollment was from November 1 to January 15. The proposed rules would shorten the open enrollment period from November 1 to December 15. A larger window for the open enrollment period allows for an increase in access and fair health outcomes for millions of Americans, especially the disability population. An overall change in the open enrollment period can lead to confusion among enrollees which requires additional education in outreach, which might not be as feasible as it was in previous years, due to the drastic cuts in Navigator funding. This also creates unnecessary constraints for enrollees as many enrollees get automatically reenrolled and then may want to make changes. An extended open

[1] https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/

enrollment period allows those who automatically reenroll time to make changes so that they can be in a plan for the remainder of the year that actually meets their needs. This is especially needed when you consider that the bulk of the open enrollment period is during the holiday season when people are preoccupied with other priorities.

A longer open enrollment period would improve access for marginalized and working populations, especially those with multiple jobs, caregivers, or those who face unstable housing. This would also address individuals who experience life changes outside of this narrow window in being able to sign up for coverage. It would also decrease administrative errors and mistakes that were seen during the Medicaid unwinding,[2] such as online portal issues, automatic coverage termination when redeterminations were not logged into state systems, and incorrect housing information. A focus should be placed on improving these eligibility and administrative systems instead of decreasing this critical window that people with disabilities use to maintain and update their healthcare coverage. Longer open enrollment periods increase enrollment and coverage rates, which were seen in the last open enrollment period with over 24 million people choosing a Marketplace plan for 2025. From 2016 to 2019, the number of individuals who chose a Marketplace plan was, on average, 11.9 million. From 2020 to 2024, this number, on average, became 15.1 million.[3] An increase in enrollment would lead to better health outcomes for vulnerable populations that utilize these healthcare systems more than the average person, such as a person with a disability. These populations often require longer outreach and education periods to decrease healthcare disparities. Finally, longer open enrollment periods decrease the cost of uncompensated and high-cost care, as those who are uninsured often wait until their health issue is no longer in preventative or primary care, relying on emergency care and further high-cost specialized care.

It is important to also note that once enhanced subsidies that aided the Marketplace's tax credits expire on January 1, 2026, monthly premium payments for most enrollees will increase significantly and the Marketplace will most likely see a drop-off in enrollment due to higher costs.[4] This issue combined with a reduction in funding for the ACA Navigator program from $98 million to $10 million will pose multiple issues for people with disabilities.[5] Without Navigators to adequately conduct outreach and provide enrollment assistance, people with disabilities will need more time to go through healthcare plans on the Marketplace themselves to ensure that they are choosing the right coverage. They will also need to plan further ahead of time to compensate for higher costs without enhanced premium tax credits that were previously available. Instead, we would urge CMS to reconsider shortening the open enrollment period and leaving it at November 1 – January 15.

Verification Process Related to Income Eligibility for Insurance Affordability Programs (§§ 155.305, 155.315, and 155.320)

Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii))

The proposed rules add new requirements for individuals to verify their income to demonstrate their eligibility for financial assistance and require those with $0 premiums to pay $5 per month

[2] https://healthlaw.org/unwinding-issues-show-medicaid-eligibility-systems-need-better-oversight-to-ensure-coverage/

[3] https://www.kff.org/affordable-care-act/state-indicator/marketplace-enrollment/

[4] https://www.kff.org/affordable-care-act/issue-brief/congressional-district-interactive-map-how-much-will-aca-premium-payments-rise-if-enhanced-subsidies-expire/

[5] https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding

until they do. The rationale provided for these requirements is that it will help reduce fraud for those who are being enrolled in plans and are between 100-150% of the Federal Poverty Level (FPL). However, there is no evidence that this issue is widespread. The report cited in the proposed rules suggests that a huge increase in enrollment for those between 100-150% FPL is evidence that people are misreporting their income. This conclusion is illogical without definitive proof that this is happening as it assumes its conclusion. In fact, the methodology used by the Paragon Health Institute cited in the proposed rules has been questioned and suggests that the estimate that 4-5 million people are fraudulently enrolled is inaccurate.[6] Instead, a more likely explanation is that the enhanced tax subsidies made available through the Inflation Reduction Act made it more affordable for these individuals to sign-up for a health care plan through the marketplace and people took advantage.

We believe this is a solution looking for a problem. This requirement will add an extra burden on consumers who desperately need health insurance coverage and risks those individuals not getting the coverage they need. The proposed rules state that they are trying to prevent people from gaming the system and causing the risk pool to become unbalanced, but we believe these proposed rules will cause the exact thing they claim to be trying to prevent. Making it harder for people to enroll in coverage and get the financial help to which they are entitled will cause an effect where healthy people may not be motivated to jump over all the administrative hurdles and only those who are "sicker" and need the guarantee of coverage will be the ones who go through the gauntlet to effectuate enrollment.

Finally, it should be pointed out that if fraud does exist and people are being enrolled without their knowledge, then the rules to prevent this should be focused on the agents and brokers that are enrolling people without their consent in the name of increasing their commissions. To make it more burdensome on individuals seems to misplace the blame for such fraud.

Pre-enrollment Verification for Special Enrollment Periods (SEPs) (§ 155.420(g))

Similar to the income verification rules, the proposed rules on SEPs add new requirements for individuals to prove their eligibility for a SEP. The rationale for these changes is that it will prevent individuals from waiting to enroll until they have a medical need and it will ensure that only those who are eligible for a SEP receive one. However, there is no evidence that people approach health insurance this way. Adding new administrative burdens on individuals who are attempting to enroll will only discourage people from getting coverage. Similar to the income verification requirements that we reference above, this could lead to the unbalancing of the risk pool as only those who really need coverage will go through with meeting the requirements while healthy individuals decide it's not worth the effort and sit out. Long term this will lead to price increases and people with disabilities who do rely on health insurance could be forced to pay more.

Elimination of the Low-Income Special Enrollment Period (SEP) (§ 155.420)

The proposed rule would eliminate a new SEP that was introduced in 2022 which allowed people with incomes below 150% of the Federal Poverty Level (FPL) to enroll for coverage at any time. The rationale for eliminating this SEP is faulty in that it assumes this population will wait until they need coverage before enrolling thereby unbalancing the risk pool. However, the premium tax credits available to these individuals would mean they would have little to no reason to try and "game the system" as the premiums paid by these individuals are usually $0. They gain

[6] https://americanscovered.org/wp-content/uploads/2025/02/Paragon-Response-Report-FINAL.pdf

nothing by waiting to enroll. Instead, preventing individuals who learn of the availability of tax credits that cover all or most of their monthly premiums would actually have the opposite effect as it could prevent healthy people from enrolling after they learn that they could be eligible for insurance at no cost to them. This is especially true when navigator funding is being decreased by 90% so that individuals will have a harder time learning about the availability of financial assistance and getting the consumer assistance, they need in enrolling for coverage during the open enrollment period.

Health care disparities greatly affect people with disabilities, with access to health care services and coverage being at the forefront of this issue. Since access to healthcare is typically linked with income status, coverage for those in marginalized groups often comes with many hurdles and this SEP made it easier for people with disabilities to enroll in coverage if they needed it. We are concerned that elimination of this SEP will make it that much harder for people with disabilities to get the coverage they need.

Definitions; Deferred Action for Childhood Arrivals (§ 155.20)

There are over 538,000 young adults who fall under the Deferred Action for Childhood Arrivals (DACA) program, many of whom are working and pay taxes to fund programs like the tax subsidies in the ACA Marketplace. DACA recipients also identify as having some form of a disability, with survey data showing that 3% identify as having one or more disabilities.[7] DACA recipients have paid nearly $2.1 billion to social security and Medicare annually, highlighting tax contributions that allow millions of Americans to access healthcare coverage. The previous Administration allowed for this population to be eligible to sign up for healthcare coverage through the Marketplace and receive tax credits that would make coverage more affordable.

The current proposal to no longer make this population "lawfully present" immediately would negatively impact DACA recipient's mental and physical health outcomes. DACA recipients would no longer have easy access to employer-sponsored healthcare or expanded coverage. This change could also increase unemployment rates and have negative impacts to the workforce, with DACA recipients accounting for 45,000 healthcare professionals and 20,000 educators, as DACA recipients would face adverse health outcomes due to lack of healthcare coverage.[8] Making sure that all Americans, especially DACA recipients who have one or more disabilities, have healthcare and focus on decreasing any coverage gaps are both public health issues and main objectives of the ACA in terms of eligibility, affordability, coverage, and access, as lack of coverage and preventative care would lead to more serious, negative health outcomes and higher costs that will only exacerbate an already burnt-out healthcare system.

Prohibition on Coverage of Sex-trait Modification as an EHB (§ 156.115(d))

This proposal would negatively impact the LGBTQ+ community and increase costs for states and other enrollees.[9] It also incorrectly uses the phrase "sex-trait modification," which has not been used in policy, law, or medicine, with the correct term being gender dysphoria. By removing gender affirming care as an essential health benefit (EHB), enrollees in the Marketplace would not be receiving cost-sharing and benefit design protections that would

[7] https://www.nccp.org/wp-content/uploads/2021/07/DACA-Health-Insurance_7.6.21.pdf
[8] https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-%20daca-recipients-fall-2021-edition/
[9] https://www.kff.org/private-insurance/issue-brief/new-rule-proposes-changes-to-aca-coverage-of-gender-affirming-care-potentially-increasing-costs-for-consumers/

normally be in place for other essential health benefits. This would increase the amount of out-of-pocket costs for those who need gender affirming care. This exclusion from being an EHB will directly raise health care costs for persons diagnosed with gender dysphoria. Gender dysphoria is defined as "discomfort or distress related to incongruence between a person's gender identity, sex assigned at birth, gender identity, and/or primary and secondary sex characteristics.[10]" Those who are diagnosed with this would require this EHB and would have positive health outcomes from this treatment, specifically positive health outcomes and an overall better quality of life.

This proposal would disrupt continuous and accessible coverage and access to care for all consumers, regardless of their diagnosis, as this treatment is not exclusive to transgender people and can work as treatment of other conditions. Overall, this rule would yield higher costs, limit access to care, and negatively impact transgender people, especially those with disabilities. Transgender adults have a 27% chance of having at least one disability by the age of 20 and a 39% chance once they reach the age of 55 and will consistently experience decreased health outcomes at higher rates than most populations.[11] Removing gender affirming care from the EHBs will only exacerbate these poor outcomes and decrease affordability, which goes against a key goal of the ACA.

Conclusion

As we mentioned, the ACA is meant to promote eligibility, affordability, and access to health insurance coverage. For the reasons stated above, we are opposed to the changes in the proposed rules and urge that CMS does not adopt them as we believe they would stand in opposition to the goals of the ACA.

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[10] https://dictionary.apa.org/gender-dysphoria
[11] https://pubmed.ncbi.nlm.nih.gov/36190882/