April 11, 2025

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability [CMS-9884-P]

Dear Administrator Oz,

The National Health Council (NHC) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services (CMS) proposed rule, CMS-9884-P, which aims to modify standards for eligibility, enrollment, and coverage protections under the Affordable Care Act (ACA) Marketplaces.

Created by and for patient organizations over 100 years ago, the NHC brings diverse organizations together to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, equitable, and sustainable health care. Made up of more than 170 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses and organizations representing biopharmaceuticals, devices, diagnostics, generics, and payers.

While we recognize CMS' intent to strengthen program integrity and reduce fraud, we are deeply concerned that several provisions in this rule will create obstacles to coverage, increase out-of-pocket costs, and disproportionately impact vulnerable populations.

Ensuring Program Integrity Without Increasing Long-Term Health Costs

The NHC shares CMS' goal of strengthening program integrity and recognizes the intent behind the proposed elimination of the monthly Special Enrollment Period (SEP) for individuals with household incomes at or below 150% of the Federal Poverty Level (FPL). 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. Although fiscal responsibility is essential, removing this SEP risks being counterproductive—potentially driving greater use of high-cost emergency services and worsening outcomes for those least able to afford care. Many

of these individuals experience frequent income fluctuations due to seasonal employment, part-time or gig work, or sudden job loss, making the monthly SEP a practical tool for preventing lapses in coverage and avoiding costlier interventions down the line.

Individuals below 150% FPL are significantly more likely to experience disruptions in their employment and income stability, leading to frequent shifts in their eligibility for Medicaid and Marketplace coverage.[1] Consequently, the current monthly SEP enables these individuals to quickly enroll in coverage when they lose Medicaid eligibility or experience income changes outside the annual Open Enrollment Period (OEP), thus reducing unnecessary reliance on costly emergency care and providing continuous coverage more efficiently.

Furthermore, removing this SEP could inadvertently lead to higher uninsured rates and ultimately higher long-term health care costs. Coverage gaps—particularly among chronically ill, low-income individuals—directly correlate with worsened health outcomes, increased emergency department utilization, and higher overall health care expenditures.[2,3,4] By retaining the monthly SEP for this population, CMS can achieve better health outcomes at lower costs by preventing unnecessary emergency care, reducing avoidable hospitalizations, and supporting continuity of preventive care.

Additionally, the proposed tightening of income verification requirements raises further concerns about access to coverage for low-income populations. The proposal to eliminate the automatic 60-day extension for providing income verification documentation could result in disenrollment of eligible individuals unable to promptly produce required documentation. NHC members frequently report that low-income patients face considerable logistical challenges—such as obtaining employment verification from multiple employers or gathering necessary documentation from the IRS or Social Security Administration.[5] Such obstacles often result in delayed or lost documentation submissions, jeopardizing continuous coverage despite genuine eligibility.

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[1] Sammy Cervantes et al., *How Many Uninsured Are in the Coverage Gap and How Many Could Be Eligible if All States Adopted the Medicaid Expansion?* (San Francisco: KFF, February 25, 2025), https://www.kff.org/medicaid/issue-brief/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/.

[2] Daniel M. Finkelstein et al., “Economic Well-Being and Health: The Role of Income Support Programs in Promoting Health and Advancing Health Equity,” Health Affairs 41, no. 12 (December 2022), https://doi.org/10.1377/hlthaff.2022.00846.

[3] National Academies of Sciences, Engineering, and Medicine, *Health-Care Utilization as a Proxy in Disability Determination* (Washington, DC: National Academies Press, March 1, 2018), chap. 2, “Factors That Affect Health-Care Utilization,” https://www.ncbi.nlm.nih.gov/books/NBK500097/.

[4] Coleman Drake et al., "Characteristics and Health Care Spending of Marketplace Enrollees Who Use Special Enrollment Periods," *Health Affairs* 39, no. 8 (August 2020): 1328–1336, https://doi.org/10.1377/hlthaff.2020.00107.

[5] Lillian Witting, “Limited Access: Poverty and Barriers to Accessible Health Care,” *National Health Council*, January 20, 2023, https://nationalhealthcouncil.org/blog/limited-access-poverty-and-barriers-to-accessible-health-care/.

Evidence from previous CMS implementations suggests that imposing stricter documentation deadlines disproportionately disenrolls eligible individuals. An evaluation conducted by CMS during the initial implementation of pre-enrollment verification requirements in 2017 found that enrollment delays and disenrollments increased significantly without achieving meaningful reductions in improper enrollments.[6] Instead, the introduction of additional administrative burdens primarily affected genuine applicants rather than those attempting fraudulent enrollments. Moreover, higher premiums and stricter cost-sharing mechanisms, rather than SEPs themselves, are more likely to contribute to adverse selections given that as premiums increase, healthier individuals disproportionately drop coverage, leaving a more expensive risk pool.[7,8]

In recognition of these realities, the NHC recommends that CMS reconsider both the elimination of the monthly SEP for individuals below 150% FPL and the removal of the 60-day documentation submission extension. If CMS intends to address concerns around adverse selection or fraud, targeted audit strategies and enhanced consumer education should be employed to efficiently detect and reduce fraud, while minimizing administrative burdens on genuine, eligible enrollees. Maintaining the existing SEP structure and reasonable documentation timelines is essential to ensuring effective, fiscally responsible, and administratively efficient access to affordable health care coverage, aligning with the ACA's original intent and minimizing unnecessary costs to taxpayers by protecting economically vulnerable Americans from preventable health crises.

Minimizing Coverage Disruptions to Ensure Efficient Use of Taxpayer Funds

The NHC appreciates CMS' efforts to enhance accountability in the use of taxpayer resources through the proposal to reinstate the immediate ineligibility for premium tax credits (PTCs) for individuals who fail to reconcile advance payments of the premium tax credit (APTC) after just one year, replacing the existing two-year grace period. While the intent of this measure—to ensure accurate tax reconciliation and prevent improper subsidy payments—is understandable, we are concerned it may inadvertently lead to increased administrative costs and unnecessary coverage disruptions, particularly among individuals who may unintentionally fail to meet complex tax reconciliation requirements. At a time when some policy frameworks emphasize empowering states and promoting administrative efficiency, a federal-level mandate to shorten the reconciliation grace period could undercut those goals—reducing flexibility and increasing burdens on both enrollees and program administrators.

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[6] Centers for Medicare & Medicaid Services, *Patient Protection and Affordable Care Act: Market Stabilization*, 82 Fed. Reg. 18346 (April 18, 2017), https://www.federalregister.gov/documents/2017/04/18/2017-07712/patient-protection-and-affordable-care-act-market-stabilization.

[7] Benjamin D. Sommers et al., "The Role of Premiums and Cost Sharing on Take-Up and Coverage: Evidence from the Healthy Indiana Plan," *American Journal of Health Economics* 8, no. 3 (Summer 2022): 270–296, https://www.journals.uchicago.edu/doi/full/10.1086/716464.

[8] Centers for Medicare & Medicaid Services, *Patient Protection and Affordable Care Act: Market Stabilization*, 82 Fed. Reg. 18346 (April 18, 2017), https://www.federalregister.gov/documents/2017/04/18/2017-07712/patient-protection-and-affordable-care-act-market-stabilization.

The ACA and its associated tax credits have substantially reduced uninsured rates nationwide, resulting in significant savings through decreased emergency care use. However, 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.

Historical evidence from CMS' own experiences suggests that short reconciliation timelines often result in unintentional disenrollment of eligible individuals, undermining program efficiency and increasing administrative burdens. A Government Accountability Office (GAO) report from 2021 revealed that over half of the individuals who lost tax credits due to reconciliation issues remained eligible, but simply lacked understanding or support to navigate the reconciliation process effectively.[9] These individuals experienced harmful interruptions in coverage, creating significant stress and obstacles to accessing necessary care, and ultimately driving up avoidable health care expenditures.

Coverage disruptions due to reconciliation issues can lead to immediate health consequences and impose significant long-term costs on the health care system. Individuals experiencing coverage gaps often forgo preventive and chronic disease management services, resulting in deteriorating health outcomes and increased reliance on expensive emergency department care. Studies have shown that even short-term coverage interruptions are associated with a substantial increase in hospitalizations for ambulatory care-sensitive conditions (ACSCs), leading to preventable hospital costs and shifting financial burdens onto providers and public programs, ultimately resulting in unnecessary taxpayer expenses.[10]

Given the complexity inherent in ACA tax reconciliation requirements, the current two-year grace period offers essential flexibility for patients and families to correct and address inadvertent errors or delays without immediate penalty. Rather than imposing stringent reconciliation deadlines, CMS should instead focus on enhancing consumer education and outreach efforts, providing greater access to free tax-preparation assistance, and improving clear, timely communications to help eligible individuals maintain compliance and avoid unnecessary disenrollment. These steps can significantly reduce errors, improve overall compliance, and ensure responsible stewardship of public funds.

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[9] U.S. Government Accountability Office, *Advance Premium Tax Credit Payment Integrity* (Washington, DC: U.S. Government Accountability Office, November 2022), https://www.gao.gov/assets/gao-23-105577.pdf.

[10] Medicaid and CHIP Payment and Access Commission (MACPAC), *Effects of Churn on Hospital Use* (Washington, DC: MACPAC, July 2022), https://www.macpac.gov/wp-content/uploads/2022/07/Effects-of-churn-on-hospital-use_issue-brief.pdf.

The NHC recommends that CMS retain the existing two-year reconciliation grace period. Additionally, we encourage CMS to proactively identify opportunities to simplify reconciliation processes, develop clearer guidance for consumers, and expand access to enrollment assisters, navigators, and community-based organizations that can provide essential support. These targeted improvements can more effectively reduce improper payments and administrative burdens without risking harmful disruptions in coverage while maintaining fiscal responsibility and minimizing unnecessary health care costs to taxpayers.

Preserving Consumer Choice and Avoiding Unintended Cost Increases

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. Recent policy discussions have underscored the importance of increasing consumer autonomy in health care decision-making. Restricting AV flexibility and modifying EHBs may limit consumer options, contradicting the principle of consumer empowerment and potentially leading to higher out-of-pocket costs.

First, the proposed adjustments to AV thresholds—narrowing allowable variation in actuarial value—will likely result in higher deductibles, copayments, and coinsurance for consumers. While CMS frames this proposal as a measure intended to standardize benefit designs, it would, in practice, significantly restrict insurers' ability to offer competitively priced plans tailored to consumer needs. Higher cost-sharing obligations disproportionately burden patients with chronic illnesses or complex health conditions who require frequent and ongoing health care services. Even modest increases in cost-sharing lead to delays in care, skipped medications, and reduced adherence to treatment regimens. These delays are associated with worsening health outcomes, greater likelihood of hospitalization, and increased long-term costs for health systems, insurers, and taxpayers. Higher out-of-pocket costs also disproportionately affect low-income individuals, who are more likely to forgo care due to financial barriers.[11,12,13]

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[11] Peter J. Neumann et al., "The Impact of Cost Sharing on Specialty Drug Utilization and Outcomes: A Review of the Evidence," *American Journal of Managed Care* 27, no. 4 (2021), https://www.ajmc.com/view/impact-of-cost-sharing-on-specialty-drug-utilization-and-outcomes-a-review-of-the-evidence-and-future-directions.

[12] Robert Dubois et al., *High Patient Cost-Sharing and the Impact on Medication Adherence: A Review of the Literature*, National Pharmaceutical Council, 2018, https://www.npcnow.org/resources/high-patient-out-pocket-costs-lead-worse-medication-adherence-without-overall-health-care.

[13] Samantha Artiga et al., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings*, Kaiser Family Foundation, June 1, 2017, https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

Increased out-of-pocket expenses are closely associated with avoidance of essential preventive care and chronic disease management.[14] One-third of adults with chronic conditions report skipping or delaying care specifically due to cost concerns associated with higher deductibles or copays.[15] Slight adjustments to AV thresholds can increase annual deductibles by several hundred dollars—amount significant enough to cause individuals, particularly those at lower income levels, to forgo care, leading to worse health outcomes and higher long-term costs for the health care system as a whole.[16]

Additionally, CMS' proposed removal of certain health benefits previously covered from EHBs significantly reduces clarity and consistency in insurance markets across states. While the proposal ostensibly seeks to clarify coverage requirements, it creates inconsistency and confusion, potentially conflicting with nondiscrimination protections outlined under Section 1557 of the ACA.

The NHC believes maintaining flexibility within the EHB framework allows states and insurers to offer market-driven plans that reflect local preferences and consumer choice, ultimately controlling costs and promoting efficient health care spending.
The NHC urges CMS to maintain current AV flexibility and support approaches that enhance consumer-driven market competition and reduce unnecessary financial burdens on patients and taxpayers. CMS should preserve existing protections that ensure affordable, accessible coverage for individuals with complex health care needs. Furthermore, CMS should ensure EHB definitions remain clear, flexible, and responsive to state-level innovation, maintaining consistency and avoiding confusion among insurers and consumers.

Instead of pursuing restrictive AV and EHB policies, CMS should prioritize initiatives to increase affordability, strengthen patient protections, and address existing gaps in coverage through enhanced competition, innovation, and consumer choice. We recommend exploring alternative approaches such as enhancing consumer education, improving transparency around coverage and costs, and promoting innovative plan designs that enhance patient value without increasing financial obstacles, aligning with the Administration's goals of market-based solutions, fiscal responsibility, and state-driven flexibility.

Supporting Market Stability and Reducing Administrative Burdens

The NHC appreciates CMS' commitment to strengthening program integrity and reducing improper enrollments but urges caution regarding several aspects of CMS' proposed rule changes, notably around increased administrative requirements for insurers, reductions in automatic reenrollment, and stricter eligibility verification

[14] Munira Z. Gunja et al., "The Cost of Not Getting Care: Income Disparities in the Affordability of Health Services Across High-Income Countries," *The Commonwealth Fund*, November 2023, https://www.commonwealthfund.org/publications/surveys/2023/nov/cost-not-getting-care-income-disparities-affordability-health.

[15] Kaiser Family Foundation, "Explaining Health Care Reform: Questions About Health Insurance Subsidies," *KFF*, October 2024, https://www.kff.org/affordable-care-act/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/.

[16] Kaiser Family Foundation, *Explaining Health Care Reform*.

standards. While CMS frames these proposed measures as essential for ensuring program integrity and reducing improper enrollments, the NHC is concerned these additional complexities could unintentionally introduce new costs and reduce market efficiency, ultimately raising premiums and reducing consumer choice. Such increased administrative requirements could result in greater inefficiencies and consumer confusion, working against broader calls for streamlined, citizen-centered governance.

Increased administrative burdens, particularly those associated with income-verification requirements and pre-enrollment eligibility checks for SEPs, impose substantial costs on insurers. Historical evidence suggests that administrative complexity and uncertainty directly increase operational costs for insurers, often resulting in premium increases passed directly onto consumers.[17] Implementing intensified verification requirements has previously led to notable increases in administrative spending, disproportionately affecting smaller insurers and those serving rural or low-income populations. Reinstating intensive pre-enrollment verification, impacting up to 75% of SEP enrollees, risks replicating these detrimental cost burdens, potentially reducing market competition by disproportionately impacting smaller insurers, including those serving rural and economically distressed regions.[18]

Moreover, the proposal requiring individuals previously eligible for zero-premium plans to pay a minimum $5 monthly premium for continued automatic reenrollment, although nominal, has significant implications for both insurers and consumers. CMS suggests this change may incentivize enrollee participation in eligibility verification; however, evidence from prior experiences indicates that introducing even minimal premiums can substantially reduce enrollment among low-income populations. A Commonwealth Fund analysis found that implementing nominal premiums among previously zero-premium enrollees can drive disenrollment rates upwards of 15-20%, disproportionately affecting the risk pool by excluding younger, healthier individuals who might forego coverage due to perceived minimal immediate need. This disruption can exacerbate adverse selection, increasing premiums for remaining enrollees and destabilizing market conditions, ultimately raising federal costs and placing unnecessary burdens on taxpayers.

Additionally, CMS proposes shortening the OEP from January 15 to December 15. While intended to reduce adverse selection, shortening the enrollment window limits the time available for insurers, navigators, and community organizations to reach and educate potential enrollees effectively. This change risks lowering total enrollment numbers, particularly among populations who require more assistance navigating complex enrollment processes, including elderly individuals, those with disabilities, non-English speakers, and individuals without internet access. Reduced enrollment periods historically correlate with fewer healthy participants enrolling, further destabilizing the insurance risk pools and driving up premiums as insurers struggle to balance coverage costs across a smaller, sicker population. A shorter enrollment window could also

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[17] Baird Webel, *The Factors Influencing the High Cost of Insurance for Consumers*, CRS Testimony, Congressional Research Service, November 2, 2023.

[18] Dan Durham, *Testimony on Administrative Simplification in the Health Care System*, America's Health Insurance Plans, September 2009, https://www.kff.org/wp-content/uploads/sites/2/2012/09/durham_testimony_final_hl912.pdf.

inadvertently reduce market competition, as consumers may have less opportunity to evaluate and select the most cost-effective plan for their needs.

Furthermore, the proposed rule suggests removing automatic reenrollment mechanisms or significantly restricting their use. While auto-reenrollment has been criticized for occasionally maintaining incorrect subsidy payments, it nonetheless remains a critical mechanism for retaining enrollment stability year-to-year. Data from the Kaiser Family Foundation indicates automatic reenrollment annually accounts for approximately 40% to 50% of Marketplace renewals. Eliminating or severely restricting automatic reenrollment will inevitably lead to significant coverage disruptions for individuals who, due to lack of awareness or logistical obstacles, fail to actively reenroll annually. The ensuing instability and coverage losses disproportionately harm patients with chronic illnesses or disabilities who require consistent access to health care services. Disrupting continuity of coverage also risks increased health care expenditures due to delayed preventive care and higher utilization of emergency services, ultimately increasing overall health care costs for taxpayers.

Rather than imposing restrictive administrative policies that risk market destabilization, CMS should prioritize policy solutions that support patient retention and insurer stability. Streamlined eligibility processes, combined with targeted auditing and verification protocols that identify high-risk areas without broad-based enrollment obstacles, could more effectively improve program integrity without unintentionally excluding eligible patients. Furthermore, enhancing public outreach, consumer education, and assistance resources to support compliance and informed decision-making would significantly improve market stability, coverage continuity, and affordability without compromising program integrity, thereby promoting efficient use of federal resources, protecting taxpayer investments, and preserving a competitive, consumer-focused marketplace.

Ensuring Consumer Choice and Value in Automatic Re-enrollment

The NHC recommends that CMS reconsider its proposal to remove the existing mechanism that allows ACA Exchanges to automatically re-enroll eligible individuals from bronze-level plans into silver-level plans when doing so results in lower net premiums after subsidies. While CMS indicates this proposal aims to simplify enrollment processes and reduce complexity, this change could inadvertently reduce consumer choice and increase unnecessary costs to both individuals and the health system.

Automatic re-enrollment from bronze to silver plans currently represents an essential safeguard for consumers, especially working families and individuals who benefit significantly from clear and efficient automatic processes to maintain coverage that best suits their economic circumstances. Historically, the automatic upgrade from bronze to silver coverage has ensured that individuals eligible for cost-sharing reductions (CSRs) receive the financial protection and coverage comprehensiveness designed by the ACA to maximize taxpayer investment in effective, value-driven health care. Without this safeguard, consumers who fail to actively review and select their plans annually risk remaining in bronze plans that impose significantly higher deductibles and out-of-pocket costs, potentially leading to inefficient health care spending and higher long-term costs.

Evidence from enrollment data demonstrates that automatic re-enrollment plays a critical role in maintaining Marketplace coverage. During the 2023 OEP, CMS reported

that approximately 80% of the 15.9 million plan selections were from individuals who had prior-year coverage and were either automatically re-enrolled or actively selected a plan.[19] Eliminating automatic upgrades could increase administrative burdens and uncertainty for consumers, potentially undermining efficient decision-making and diminishing the overall effectiveness of taxpayer-funded subsidies. Automatic re-enrollment serves as a vital backstop to prevent coverage disruptions for individuals who may face obstacles such as limited internet access, time constraints, or confusion about plan selection.[20]

Moreover, silver-level plans are specifically structured to maximize ACA benefits, including substantial CSRs designed to reduce out-of-pocket costs significantly. By maintaining bronze-level enrollment by default, the proposed rule risks increasing consumer financial burdens unnecessarily. According to analyses by the Urban Institute, individuals eligible for CSRs who remain enrolled in bronze plans often experience markedly higher out-of-pocket costs for basic health care services, including essential preventive care, prescription medications, and chronic disease management. This results in individuals forgoing necessary care, exacerbating chronic conditions, and ultimately driving up health care system costs due to increased hospitalizations and emergency department utilization, further burdening taxpayers.

The proposed change also presents challenges to insurers, potentially undermining market stability. Silver-level enrollment is critical in balancing the risk pools within ACA marketplaces, ensuring adequate representation of differing health statuses. Removing automatic upgrades threatens to skew enrollment toward plans that attract fewer healthy participants, potentially increasing premiums across plan tiers and destabilizing markets overall. Insurers rely on balanced enrollment across plan tiers to predict and manage financial risks; disrupting automatic re-enrollment could inadvertently increase market volatility and drive up premiums for consumers across the board, resulting in higher federal subsidy payments and greater financial exposure for taxpayers.

To mitigate these concerns, the NHC strongly recommends that CMS maintain the automatic re-enrollment policy from bronze to silver plans. If CMS is intent on improving consumer awareness or engagement in annual enrollment decisions, we encourage investment in enhanced consumer education and proactive enrollment outreach programs rather than eliminating existing automatic protections. Expanded efforts to educate consumers on the value of silver-level coverage and the benefits of annual plan review can promote informed enrollment decisions without sacrificing vital consumer protections, supporting market efficiency, individual choice, and responsible stewardship of federal resources.

Ensuring Predictability and Transparency in Premium Growth Measures and Subsidy Calculations

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[19] Centers for Medicare & Medicaid Services, *Nearly 16 Million People Have Signed Up for Affordable Health Coverage in ACA Marketplaces Since Start of Open Enrollment Period* (January 11, 2023), https://www.cms.gov/newsroom/press-releases/nearly-16-million-people-have-signed-up-affordable-health-coverage-aca-marketplaces-start-open.

[20] HealthCare.gov. If You Don't Act: How You'll Be Automatically Enrolled. Accessed March 31, 2025. https://www.healthcare.gov/keep-or-change-plan/automatically-enrolled.

The NHC recommends CMS reconsider or further evaluate its proposal to modify the premium growth measure used to calculate affordability benchmarks and subsidy amounts in the ACA Marketplace. While we acknowledge CMS' intent to refine premium adjustments to better reflect current market conditions, the proposed recalculations could inadvertently reduce subsidy amounts, significantly increasing out-of-pocket costs for lower-income and subsidy-eligible consumers, thereby limiting their ability to access affordable coverage and potentially increasing overall health care costs. Although recent policy proposals have emphasized the importance of cost-effectiveness and fiscal responsibility in federal health programs, reducing subsidies through recalibrated premium growth measures may unintentionally increase reliance on costly emergency care and uncompensated services—outcomes that conflict with the goal of achieving long-term system-wide savings.

Premium subsidies under the ACA have been critical to maintaining affordability for millions of Americans, particularly those with chronic illnesses, disabilities, and complex medical conditions, who often rely heavily on regular health care services. The ACA's original subsidy structure was intentionally designed to shield consumers from rapid premium increases and maintain predictable affordability. Any changes to the premium growth calculation methodology, especially those that could lower subsidy levels, risk undermining this fundamental objective and increasing financial obstacles to coverage. According to analysis conducted by the Kaiser Family Foundation, adjustments to subsidy calculation formulas directly impact the affordability and accessibility of Marketplace plans for subsidy-eligible populations. Even modest reductions in subsidies disproportionately affect lower-income individuals, who already allocate a higher proportion of their income toward health care-related expenses. Reduced subsidies result in higher net premiums, which can push coverage beyond affordability thresholds, leading to increased uninsured rates and diminished health care access, thereby increasing long-term costs to the health care system and federal taxpayers.

Historical data from previous changes in premium-growth calculation methodologies also demonstrate unintended negative consequences for enrollment stability and market dynamics. A Congressional Budget Office (CBO) analysis found that previous modifications to subsidy benchmarks that lowered subsidies resulted in decreased enrollment among younger, healthier individuals.[21] This dynamic can exacerbate adverse selection, raising premiums overall and further destabilizing Marketplace risk pools. Insurers rely on balanced enrollment to predict risk accurately and manage costs; destabilizing this balance increases overall premiums, making affordable coverage more elusive for all Marketplace consumers, potentially requiring greater federal expenditures to maintain affordability.

Given the complexity of subsidy calculations, transparency and predictability are critical components in maintaining consumer confidence and enrollment stability. CMS' proposed methodology changes lack sufficient clarity about how revised premium growth measures would precisely impact specific consumer segments. Without detailed, transparent modeling, stakeholders—including consumers, patient organizations, and insurers—cannot fully anticipate the implications of these methodological shifts. Greater transparency and detailed actuarial analyses should accompany any proposal to alter

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[21] Congressional Budget Office, *Federal Subsidies for Health Insurance: 2023 to 2033* (Washington, DC: CBO, September 2023), https://www.cbo.gov/publication/59613.

premium benchmarks, ensuring that stakeholders can thoroughly assess potential impacts and offer informed feedback, ensuring optimal use of federal funds and maintaining consumer confidence.

Instead of immediate adoption of the proposed premium growth recalculation, CMS should consider conducting comprehensive analyses to evaluate the specific impacts these changes may have across various consumer groups. We strongly recommend that CMS thoroughly model these proposed adjustments and publicly share detailed impact assessments, including how various income and demographic groups could be affected. Stakeholders, particularly patient advocacy groups and consumer representatives, should have ample opportunity to review this data and provide informed input to CMS before implementing significant alterations, thereby ensuring fiscal responsibility, market stability, and transparency.

Encouraging Effective Broker and Web-Broker Oversight Without Limiting Market Access

The NHC thanks CMS for its proposal to strengthen oversight of brokers, agents, and web-brokers operating within the ACA Marketplaces, including establishing clearer termination standards for misconduct. We fully support efforts to enhance marketplace integrity and ensure robust consumer protections, and believe that what is sometimes termed enrollee fraud is instead due to misconduct by brokers, agents, and web-brokers. However, we also wish to emphasize the importance of ensuring that oversight frameworks avoid unnecessary regulatory burdens that could restrict competition or limit consumer access to market-driven enrollment assistance.

Brokers and agents frequently serve as essential enrollment facilitators, offering personalized guidance, particularly for populations who face significant obstacles navigating complex coverage decisions. Patients with chronic illnesses, disabilities, or complex medical needs often rely on specialized brokers who understand their unique circumstances, helping them select plans that balance affordability, provider networks, medication coverage, and out-of-pocket costs. Evidence from previous enrollment periods indicates that brokers significantly enhance enrollment outcomes, with enrollees assisted by brokers demonstrating higher levels of coverage satisfaction and continuity year-over-year, thus ensuring efficient and effective use of taxpayer-funded subsidies.

Excessively stringent regulatory standards—particularly those imposing punitive actions without clear, graduated penalties or remediation processes—could inadvertently drive brokers and agents away from ACA marketplaces, reducing overall consumer access to critical enrollment support. The American Academy of Actuaries previously noted that overly aggressive regulation without a balanced enforcement mechanism tends to disproportionately impact smaller brokerage firms, which are often key providers of specialized enrollment assistance to niche and underserved markets, thus potentially reducing market competition and choice.

Rather than broad punitive measures, CMS should focus on targeted oversight emphasizing education, compliance assistance, clear guidelines for acceptable practices, and proportional disciplinary procedures. Establishing clear expectations for brokers—paired with accessible compliance training and educational resources—can effectively mitigate misconduct risks without creating undue market obstacles.

Enhanced consumer education around broker roles and rights would also empower enrollees to effectively navigate interactions with brokers, reducing susceptibility to misconduct without broadly limiting broker availability, thus protecting consumers while preserving market choice and competition.

CMS should ensure the oversight framework preserves robust consumer access to brokers and web-brokers in rural areas, regions with limited internet access, and among populations with limited health insurance literacy. Regulations should explicitly encourage, rather than deter, brokers' active participation by balancing oversight rigor with practical supports that help brokers deliver high-quality enrollment assistance consistently, ultimately promoting market efficiency and responsible use of public resources.

Impact on Safety-Net Providers

The NHC notes that CMS' proposal to revise eligibility rules, specifically with respect to Deferred Action for Childhood Arrivals (DACA) recipients, may have unintended consequences on safety-net providers and health systems. Limiting ACA Marketplace coverage eligibility for certain groups can inadvertently increase the number of uninsured individuals seeking care through emergency departments and community health centers, which serve as critical health care resources, especially in economically vulnerable areas. Numerous studies have documented that reductions in marketplace coverage eligibility often result in increased reliance on emergency services and delayed medical treatment, which lead to higher health care costs.[22,23] Ultimately, these costs are absorbed by local hospitals, health care systems, and state and local governments.[24] Given the potential unintended impacts on safety-net providers and associated health care costs, the NHC respectfully encourages CMS to consider maintaining broad eligibility rules that help mitigate the financial and resource strain on safety-net institutions, thus preserving stable, affordable health care delivery across communities.

Conclusion

The NHC strongly urges CMS to reconsider the proposed restrictions that could disrupt coverage and increase financial hardship for low-income individuals, patients with chronic conditions, and underserved populations. Instead, CMS should focus on strengthening enrollment accessibility, affordability, and continuity of care.

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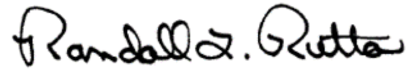
[22] Gerald F. Kominski, Narissa J. Nonzee, and Andrea Sorensen, "The Affordable Care Act's Impacts on Access to Insurance and Health Care for Low-Income Populations," *Annual Review of Public Health* 38 (December 15, 2016): 489–505, https://doi.org/10.1146/annurev-publhealth-031816-044555.

[23] Jennifer Tolbert et al., *Key Facts about the Uninsured Population* (San Francisco: KFF, December 18, 2024), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

[24] Leighton Ku et al., *How Potential Federal Cuts to Medicaid and SNAP Could Trigger the Loss of a Million-Plus Jobs, Reduced Economic Activity, and Less State Revenue* (New York: Commonwealth Fund, March 25, 2025), https://www.commonwealthfund.org/publications/issue-briefs/2025/mar/how-cuts-medicaid-snap-could-trigger-job-loss-state-revenue.

We appreciate the opportunity to provide input on this important rule and welcome further dialogue to ensure that Marketplace policies prioritize patient needs. Please feel free to Kimberly Beer, Senior Vice President of Policy and Government Affairs, at kbeer@nhcouncil.org or Shion Chang, Senior Director of Policy and Regulatory Affairs, at schang@nhcouncil.org for additional dialogue.

Sincerely,



Randall L. Rutta
Chief Executive Officer