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April 10, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-9884-P Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability

Submitted electronically via https://www.regulations.gov

Dear Administrator Oz:

Thank you for the opportunity to comment on the proposed Marketplace Integrity and Affordability rule.[1] This comment is submitted on behalf of the Center for American Progress (CAP), an independent, nonpartisan policy institute based in Washington, D.C. dedicated to improving the lives of all Americans through bold, progressive ideas, as well as strong leadership and concerted action.[2] CAP's policy experts and advocates have spearheaded and published research on ways to build on the Affordable Care Act (ACA), expand health coverage, strengthen access to care, and improve affordability.

We remind the Centers for Medicare & Medicaid Services (CMS) that under the Administrative Procedure Act, the agency must consider and respond to all significant and relevant comments submitted during the rulemaking process.[3] We urge CMS to give full and fair consideration to the concerns raised in this comment letter, which reflect many substantial ramifications of the proposed rule on marketplace affordability and access.

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

[1] Proposed Rule; Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, (published March 19, 2025), available at https://www.federalregister.gov/documents/2025/03/19/2025-04083/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability.
[2] Center for American Progress, "About Us," available at https://www.americanprogress.org/about-us/.
[3] Administrative Procedure Act, 5 U.S.C. § 553.

coverage to millions through the ACA marketplaces.[4] 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.[5]

In this letter, we outline our concerns with proposals to raise maximum out-of-pocket limits, erode the actuarial value of marketplace plans, prohibit gender-affirming care as an essential health benefit, exclude Deferred Action for Childhood Arrivals (DACA) recipients from marketplace eligibility, reinstate burdensome income verification requirements for enrollees, shorten the annual Open Enrollment Period, eliminate the Special Enrollment Period for low-income individuals, and reduce advance premium tax credits during automatic re-enrollment.

I. Premium Adjustment Percentage

CAP strongly opposes CMS's proposed revisions to the premium adjustment percentage methodology, which would increase out-of-pocket cost exposure and premiums for individuals and families. This change would create new and unnecessary financial burdens for millions of Americans with individual and small group marketplace plans, especially those middle-income consumers who already struggle to manage high out-of-pocket health costs. [6]

For example, the proposed 15 percent increase for 2026 maximum annual cost-sharing limits would raise the out-of-pocket maximum to $10,600 for individuals and $21,200 for families.[7] For a 45-year-old person who earns $42,000 a year (268 percent of the federal poverty level), this change would mean a $450 increase in their out-of-pocket maximum.[8] For an average family of four living on a $100,000 household income (311 percent of the

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[4] United States Department of Health and Human Services, "About the ACA," available at https://www.hhs.gov/healthcare/about-the-aca/index.html; United States Department of Health and Human Services, "About HHS," available at https://www.hhs.gov/about/index.html; Centers for Medicare and Medicaid Services, "About CMS," available at https://www.cms.gov/about-cms.

[5] KFF, "KFF Health Tracking Poll: The Public's Views on the ACA," January 17, 2025, available at https://www.kff.org/interactive/kff-health-tracking-poll-the-publics-views-on-the-aca/#?response=Favorable--Unfavorable&aRange=twoYear; Centers for Medicare and Medicaid Services, "Marketplace 2025 Open Enrollment Period Report: National Snapshot," January 17, 2025, available at https://www.cms.gov/newsroom/fact-sheets/marketplace-2025-open-enrollment-period-report-national-snapshot-2.

[6] Lunna Lopes and others, "Americans' Challenges with Health Care Costs," KFF, March 1, 2024, available at https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/; Katie Keith and Jason Levitis, "HHS Proposes To Restrict Marketplace Eligibility, Enrollment, And Affordability In First Major Rule Under Trump Administration (Part 1)," Health Affairs, March 12, 2025, available at https://www.healthaffairs.org/content/forefront/hhs-proposes-restrict-marketplace-eligibility-enrollment-and-affordability-first-major#:~:text=Under%20this%20new%20methodology%2C%20the,from%20about%201.4512%20for%202025.

[7] Proposed Rule; Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability.

[8] Gideon Lukens and Elizabeth Zhang, "Proposed ACA Marketplace Rule Would Raise Health Care Costs for Millions of Families," Center on Budget and Policy Priorities, April 1, 2025, available at https://www.cbpp.org/research/health/proposed-aca-marketplace-rule-would-raise-health-care-costs-for-millions-of.

federal poverty level), it would mean a $900 increase in their out-of-pocket maximum.[9] This change only serves to shift more health care costs onto consumers.

In addition to higher cost-sharing limits, the proposed methodology would raise the premium adjustment percentage used to set advance premium tax credit (APTC) benchmarks. If finalized as proposed, benchmark premiums could increase by up to 4.5 percent.[10] With enhanced premium tax credits under the American Rescue Plan Act and Inflation Reduction Act set to expire at the end of 2025, this increase would coincide with an already projected average premium increase of $705 for more than 20 million marketplace enrollees.[11] Layering this change on top of expiring tax credits would push health coverage entirely out of reach for many consumers, reversing recent historic enrollment gains and increasing the number of uninsured Americans.

We encourage CMS not to finalize the proposed changes, and to carefully consider affordability impacts before altering the premium adjustment percentage methodology.

II. Levels of Coverage (Actuarial Value)

CAP strongly opposes the proposed changes to the actuarial value (AV) and de minimis range requirements because of their likelihood to reduce affordability and increase the risk of underinsurance.

The proposal to expand the de minimis ranges to +5/−4 percentage points for expanded bronze plans and +2/−4 percentage points for other metal levels would erode the value of coverage. Under the proposal, a silver plan (which should cover 70 percent of expected health care costs) could instead have an AV as low as 66 percent. By allowing broader variation in AV, the proposed rule would leave enrollees exposed to higher deductibles and increased out-of-pocket costs. This not only widens the gap in consumer cost-sharing responsibilities but also blurs the distinction between adjacent metal levels. A silver plan with 66 percent AV would offer nearly identical coverage to a bronze plan at 65 percent AV, making it more difficult for consumers to understand what they are purchasing and to select a plan that best meets their health and financial needs.

Expanding the de minimis range for silver plans would also negatively affect affordability. Because the second-lowest-cost silver plan determines the benchmark for premium tax credits, allowing low-AV silver plans to qualify would reduce the benchmark premium and subsequently lower premium tax credits for all consumers. As a result, consumers would either face higher net premiums to maintain adequate coverage or be pushed into lower-value plans with significantly higher cost-sharing.

This policy moves in the wrong direction. Instead of weakening AV standards, CMS should focus on increasing the generosity of marketplace coverage to ensure consumers can afford the care they need. A 2024 Commonwealth Fund survey found that 14 percent

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[9] Ibid.

[10] Proposed Rule; Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability

[11] Jared Ortaliza and others, “Inflation Reduction Act Health Insurance Subsidies: What is Their Impact and What Would Happen if They Expire?,” KFF, July 26, 2024, available at https://www.kff.org/affordable-care-act/issue-brief/inflation-reduction-act-health-insurance-subsidies-what-is-their-impact-and-what-would-happen-if-they-expire/.

of people who were considered underinsured had either marketplace or individual market coverage.[12] Changing the de minimis and lowering AV thresholds would only exacerbate this issue by shifting costs to consumers. Now is the time to strengthen, not dilute the marketplace coverage that millions of Americans rely on.

We urge CMS to maintain existing requirements, preserve the integrity of the metal tier structure, and protect consumers from higher out-of-pocket costs.

III. Provision of Essential Health Benefits

CAP strongly opposes the proposed revision to prohibit marketplace plans from covering medically necessary gender-affirming care as part of their essential health benefits (EHB). This proposal is discriminatory and would impose serious harm on transgender individuals and the broader health care system.[13]

Title I of the ACA grants HHS the authority to develop regulations and set standards for health insurance plans that improve health outcomes and patient safety, but the proposed exclusion of transgender health care directly contradicts this responsibility by ignoring the vast body of medical evidence that shows the positive health impacts for these services.[14] The services CMS seeks to prohibit also include hormone therapy, surgery, or mental health treatment which are medically necessary interventions for individuals diagnosed with gender dysphoria.[15] These treatments are widely recognized as the standard of care by all leading professional organizations in the United States, including the American Medical Association.[16]

In addition, the treatments CMS proposes to exclude are widely used in medical care and are not exclusive to transgender individuals. For example, mastectomies and reconstructive surgeries are routinely performed for breast cancer patients or individuals with genetic risk factors.[17] Because the proposed rule prohibits or allows certain medical services on the basis of sex, it is blatantly discriminatory and does not conform to the statutory language of the ACA. For example, Section 155.120 prohibits state-based exchanges from discriminating "on the basis of sex characteristics, including intersex

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[12] Sara Collins and Avni Gupta, "The State of Health Insurance Coverage in the U.S.: The Commonwealth Fund, November 21, 2024, available at https://www.commonwealthfund.org/publications/surveys/2024/nov/state-health-insurance-coverage-us-2024-biennial-survey

[13] Lindsey Dawson, Kaye Pestaina, and Matthew Raye, "New Rule Proposes Changes to ACA Coverage of Gender-Affirming Care, Potentially Increasing Costs for Consumers," KFF, March 24, 2025, available at https://www.kff.org/private-insurance/issue-brief/new-rule-proposes-changes-to-aca-coverage-of-gender-affirming-care-potentially-increasing-costs-for-consumers/#footnote-657006-1.

[14] Patient Protection and Affordable Care Act, Public Law 111–148, 111th Congress, March 23, 2010, available at https://www.congress.gov/111/plaws/publ148/PLAW-111publ148.pdf.

[15] American Medical Association, "Advocating for the LGBTQ community," available at https://www.ama-assn.org/delivering-care/population-care/advocating-lgbtq-community (last accessed April 2025).

[16] Ibid; Coleman and others, "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8," International Journal of Transgender Health 23(2022): 1-59, available at https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644.

[17] American Cancer Society, "Breast Reconstruction After Mastectomy," available at https://www.cancer.org/content/dam/CRC/PDF/Public/8582.00.pdf (last accessed April 2025).

traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes."[18]

The agency's assertion that such gender-affirming care is not typically covered by employer-sponsored insurance is incorrect. According to the Human Rights Campaign, 72 percent of Fortune 500 companies offer coverage for gender-affirming care.[19] In total, more than 1,300 major employers nationwide currently provide this coverage, nearly 30 times the number from 2009.[20] An analysis of commercial insurance usage for hormone replacement therapy between 2011 and 2019 also shows that insurance coverage has increased over time, with 65 percent of transgender patients receiving HRT that was covered by their insurance in 2019 compared to 17 percent in 2011.[21]

Further, the entirety of the proposed rule seeks to address costs associated with commercial plans but the average cost of both hormones and surgeries in 2019 was only $0.06 per member per month.[22] According to a Center for American Progress survey, transgender adults were enrolled in marketplace insurance plans at the same rate as the total population in 2024, making it clear that excluding these services from coverage is not an effective cost-saving strategy.[23]

Additionally, 24 states and D.C. prohibit exclusions of gender-affirming care in state-regulated plans, and 27 states, Puerto Rico, and D.C. cover these services through Medicaid.[24] CMS's own data show that more than half of marketplace plans currently cover gender-affirming care in at least some capacity.[25]

If this proposal were implemented, it would set a dangerous precedent that could open the door to future categorical exclusions based on stigma instead of medical evidence. Section 156.115 of the Affordable Care Act currently establishes minimum requirements for marketplace plans and specifically states that they must "provide benefits for diverse segments of the population."[26] As written, the proposed rule offers no reasonable

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[18] Patient Protection and Affordable Care Act, Public Law 111–148.
[19] Human Rights Campaign, "Corporate Equality Index 2025," January 2025, available at https://reports.hrc.org/corporate-equality-index-2025.
[20] Ibid.
[21] Kellan Baker and Arjee Restar, "Utilization and Costs of Gender-Affirming Care in a Commercially Insured Transgender Population," Journal of Law, Medicine & Ethics 50(3)(2022): 456 – 470, available at https://www.cambridge.org/core/journals/journal-of-law-medicine-and-ethics/article/utilization-and-costs-of-genderaffirming-care-in-a-commercially-insured-transgender-population/94BEB47F534266132053E7F96382B801.
[22] Ibid.
[23] The authors calculated this figure by utilizing data from an online survey developed by the Center for American Progress and NORC at the University of Chicago, conducted from June 2024 to July 2024. The original data are on file with the authors.
[24] Movement Advancement Project, "Healthcare Laws and Policies: State Employee Benefits Coverage for Transgender-Related Care," July 1, 2024, available at https://www.mapresearch.org/equality-maps/healthcare_laws_and_policies; Movement Advancement Project, "Medicaid Coverage of Transgender-Related Health Care," April 9, 2025, available at https://www.lgbtmap.org/equality-maps/healthcare/medicaid.
[25] Movement Advancement Project, "Healthcare Laws and Policies: State Employee Benefits Coverage for Transgender-Related Care," July 1, 2024, available at https://www.lgbtmap.org/img/maps/citations-healthcare-state-employees.pdf.
[26] 45 CFR § 156.115, available at https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-156/subpart-B/section-156.115.

justification to exclude transgender people from the definition of "diverse populations" and the application of this statute. States must retain the ability to address the unique health needs of their residents.

We urge CMS to withdraw this harmful provision. The proposed exclusion of gender-affirming care would cause lasting harm to transgender individuals, reduce access to necessary medical treatment, and conflict with CMS's own mission to enhance the health and well-being of all Americans.

IV. Eligibility Definitions

CAP opposes the proposal to reverse the 2024 final rule and reinstate the exclusion of DACA recipients from the definition of "lawfully present," making them ineligible for marketplace coverage.[27]

CMS has not provided adequate justification for this exclusion, especially given the disproportionately high uninsurance rates among this population.[28] Based on 2022 data, 47 percent of DACA recipients were uninsured, nearly five times the national uninsurance rate of U.S.-born individuals.[29] This is a striking policy failure for a legally protected population that lives, works, and contributes to communities across the country.[30]

Excluding DACA recipients from marketplace eligibility not only ignores their urgent coverage needs, but also the potential benefits of including this population in the marketplace risk pool. According to a 2024 KFF analysis, the majority of DACA recipients are under age 36, over half are female, and 64 percent report their health as excellent or very good, with another 28 percent reporting good health.[31] Their inclusion in the marketplace risk pool could lower overall risk and potentially reduce premiums, advancing CMS's goals of affordability and marketplace stability.

If finalized, this proposal would also terminate coverage mid-year for approximately 11,000 DACA recipients who selected a 2025 marketplace plan.[32] The proposed timeline, which aligns the policy change with the final rule's effective date, would further provide state-based marketplaces (SBMs) with insufficient time to prepare and respond

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[27] Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, and a Basic Health Program (published May 8, 2024), available at https://www.federalregister.gov/documents/2024/05/08/2024-09661/clarifying-the-eligibility-of-deferred-action-for-childhood-arrivals-daca-recipients-and-certain.

[28] KFF, "Key Facts on Deferred Action for Childhood Arrivals (DACA)," February 11, 2025, available at https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/.

[29] Ibid.

[30] Tom K. Wong and others, "2023 Survey of DACA Recipients Highlights Economic Advancement, Continued Uncertainty Amid Legal Limbo," Center for American Progress, March 25, 2024, available at https://www.americanprogress.org/article/2023-survey-of-daca-recipients-highlights-economic-advancement-continued-uncertainty-amid-legal-limbo/.

[31] KFF, "Key Facts on Deferred Action for Childhood Arrivals (DACA)."

[32] Proposed Rule; Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability.

operationally. While CMS acknowledges that SBMs would need to make IT system changes to process mid-year terminations, the agency did not account for the full scope of associated costs such as retraining staff, revising consumer-facing materials, and expanding call center capacity. These operational demands on a compressed timeline risk destabilizing state systems and undermining the enrollee experience. CMS's failure to estimate these additional burdens raises serious questions about the administrative feasibility of the proposal.

V. Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL

CAP opposes the proposed requirement to impose additional verification documentation when IRS income data does not align with projected income for consumers with incomes below 100 percent of the FPL ($15,650 for an individual).[33] This proposal introduces unnecessary administrative burdens for low-income individuals.

Despite CMS's stated concerns, the agency has not provided evidence that these income discrepancies are indicative of fraud or abuse. Income among low-wage workers often fluctuates.[34] According to KFF, from 2013 to 2014, roughly half of low-income ACA enrollees experienced year-over-year income changes of 20 percent or more.[35] Requiring verification based on outdated IRS data ignores this real-world volatility and could penalize consumers for making income estimates. Marketplace eligibility is based on a good-faith estimate of annual income, and recent CMS enforcement efforts have already strengthened program integrity.[36]

This policy would disproportionately harm marketplace enrollees who work in gig, contract, or self-employed roles whose income often varies and may have difficulty providing verifying documentation.[37] In 2022, self-employed workers and small-business

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[33] U.S. Department of Health and Human Services, "2025 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii)," available at https://aspe.hhs.gov/sites/default/files/documents/dd73d4f00d8a819d10b2fdb70d254f7b/detailed-guidelines-2025.pdf (last accessed April 2025).

[34] The Aspen Institute, "Income Volatility: A Primer," March 2016, available at https://www.aspeninstitute.org/wp-content/uploads/2016/05/IncomeVolatility-APrimerMay.pdf.

[35] Cynthia Cox and others, "Repayments and Refunds: Estimating the Effects of 2014 Premium Tax Credit Reconciliation," KFF, March 14, 2015, available at https://www.kff.org/affordable-care-act/issue-brief/repayments-and-refunds-estimating-the-effects-of-2014-premium-tax-credit-reconciliation/.

[36] Centers for Medicare and Medicaid Services, "CMS Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity," October 17, 2024, available at https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity#:~:text=From%20June%202024%20through%20October,enrollments%20or%20unauthorized%20plan%20switches.

[37] Consumer Financial Protection Bureau, "The Financial Security of Small Business Owners: Evidence from the Making Ends Meet Survey," January 3, 2025, available at https://www.consumerfinance.gov/data-research/research-reports/the-financial-security-of-small-business-owners-evidence-from-the-making-ends-meet-survey/#:~:text=The%20results%20of%20the%20analysis,varied%20from%20month%20to%20month; Daniel Auguste and others, "The Precarity of Self-Employment among Low- and Moderate-Income Households," *Social Forces* 101 (3)(2022): 1081–1115, available at

owners ages 21-64 made up 28 percent of total marketplace enrollees. [38] In states such as Florida, Georgia, Maine, North Carolina, Nebraska, New Hampshire, South Carolina, Utah, and Wyoming, more than one in five small-business owners and self-employed individuals relied on marketplace coverage in 2022.[39]

According to CMS estimates, the proposal would generate approximately 550,000 additional data matching issues (DMIs) annually, creating $66 million in annual burdens for consumers and $155 million in administrative costs for SBMs and Healthcare.gov.[40]

We urge CMS to maintain current income verification policies and avoid imposing unnecessary barriers that limit access to affordable coverage.

VI. Income Verification When Tax Data is Unavailable

CAP opposes the proposal to remove the option for self-attestation of projected income when IRS records return no income information, generating a dating matching issue (DMI) and requiring additional income verification.

CMS estimates the proposed change would result in 2.1 million additional DMIs per year.[41] Consumers subject to unresolved DMIs are typically required to pay the full, unsubsidized premium after the inconsistency period ends, even if they are actively appealing the decision. For individuals who were initially determined eligible for premium tax credits, this sudden shift to full-cost premiums can create a significant financial hardship.

The experience of the Massachusetts Health Connector provides compelling evidence of the harm this policy would cause. After implementing a rule allowing self-attestation of income when IRS data was unavailable, the Connector saw a 40 percent reduction in the number of applicants subject to verification requirements and a 33 percent decrease in tax credit losses at renewal, without evidence of widespread ineligible individuals receiving subsidies.[42] This highlights the value of self-attestation in minimizing disruption and ensuring continuity of coverage.

Rather than improving accuracy, this proposal would increase administrative complexity, drive eligible enrollees out of coverage, and undermine the stability of the individual market risk pool. We urge CMS to preserve the current self-attestation policy.

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https://academic.oup.com/sf/article-abstract/101/3/1081/6523445?redirectedFrom=fulltext&login=false.

[38] U.S. Department of Treasury, "Affordable Care Act Marketplace Coverage for the Self-Employed and Small Business Owners," September 20, 2024, available at https://home.treasury.gov/system/files/131/ACA-Mkt-Coverage-Self-Employed-Small-Business-Owners-09232024.pdf.

[39] Ibid.

[40] Proposed Rule; Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability.

[41] Ibid.

[42] Audrey Morse Gasteier, "Data for Response to CCIIO Rule: Perspectives from Massachusetts," April 1, 2025, available at https://www.shvs.org/wp-content/uploads/2025/04/New-CMS-Proposed-Rule-on-ACA-Marketplace-Integrity_Final.pdf.

VII. Advance Premium Tax Credit Calculation During Automatic Re-enrollment

CAP opposes the proposal to reduce advance premium tax credits during automatic re-enrollment, even when consumers qualify for a higher amount under the law. Withholding part of the APTC to impose a minimum $5 premium unless consumers actively return to the marketplace is unlawful.

The ACA clearly outlines how APTCs are calculated and applied. Section 36B of the Internal Revenue Code governs the formula, while Sections 1411 and 1412 of the ACA direct the Secretary of Health and Human Services to determine eligibility and ensure payment of the full credit amount.[43] The statute does not authorize CMS to arbitrarily withhold part of an enrollee's APTC as a means of encouraging marketplace engagement.

We urge CMS to withdraw this provision and uphold the statutory requirement that eligible consumers receive the full value of the APTC they qualify for, whether they are automatically renewed or automatically re-enrolled.

VIII. Annual Open Enrollment Period

CAP opposes the proposal to shorten the annual open enrollment period from November 1 to December 15. We also oppose any new restrictions that would prevent SBMs from maintaining or extending enrollment timelines to better serve their populations.

Shortening the enrollment window creates a clear barrier to coverage, as demonstrated during the first Trump administration. When CMS previously cut the open enrollment period, marketplace enrollment gains began to reverse.[44] A shorter enrollment timeframe reduces opportunities for outreach and education, a concern that is particularly relevant considering the recent 90 percent reduction in funding for the federal Navigator Program.[45] Navigators play a crucial role in reaching underserved populations, including people with limited English proficiency, rural residents, and those without internet access.[46] With drastically reduced resources, the ability to conduct robust outreach and enrollment assistance is already compromised.

CMS also claims that aligning enrollment periods across marketplaces will prevent adverse selection, but the agency provides no supporting evidence. In fact, data from Covered California shows that individuals who enroll after December 15 have *lower* risk

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[43] 26 U.S. Code § 36B; 42 U.S. Code § 18081

[44] Sara Collins and others, "First Look at Health Insurance Coverage in 2018 Finds ACA Gains Beginning to Reverse," The Commonwealth Fund, May 1, 2018, available at https://www.commonwealthfund.org/blog/2018/first-look-health-insurance-coverage-2018-finds-aca-gains-beginning-reverse.

[45] Centers for Medicare and Medicaid Services, "CMS Announcement on Federal Navigator Program Funding," February 14, 2025, available at https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding.

[46] Karen Pollitz and others, "Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need," Kaiser Family Foundation, August 7, 2020, available at https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-brief/.

scores than those who enroll earlier in the state's SBM enrollment period.[47] Shortening the enrollment window could worsen the risk pool by excluding healthier individuals who typically wait until January to enroll.

We recommend that CMS preserve the existing open enrollment period of November 1 to January 15 and allow SBMs to continue offering flexibility based on the needs of their populations and the realities of consumer behavior, especially when federal enrollment assistance infrastructure has been significantly diminished.[48]

IX. Special Enrollment Periods for Low-Income individuals

CAP opposes CMS's proposal to eliminate the special enrollment period (SEP) for people with incomes at or below 150 percent of the FPL (in other words, $23,475 for a family of one). This SEP has served as a critical tool for increasing health care access among people living in near-poverty.

CMS attributes an increase in fraudulent activity to this SEP but provides no supporting evidence. Notably, 18 out of the 20 SBMs have adopted this SEP and their experience does not indicate fraudulent enrollment.[49] In 2024, the Massachusetts Health Connector reported no consumer complaints of unauthorized enrollments among the more than 1 million calls to its customer service center.[50]

We encourage CMS to preserve the low-income SEP. Eliminating it would reverse coverage gains and impose unnecessary disruption without addressing the root causes of enrollment fraud.

Conclusion

The proposed rule would raise consumer premium and out-of-pocket costs, restrict eligibility, and impose unnecessary administrative barriers, threatening hard-won coverage gains and destabilizing the individual market. We strongly urge CMS to withdraw these provisions and realign the rule with its statutory mission to advance affordable, comprehensive coverage for Americans.

For any questions regarding this comment letter, please contact Natasha Murphy, Director of Health Policy, at nmurphy@americanprogress.org. CAP appreciates the opportunity to provide comment and thanks CMS for considering our recommendations.

Sincerely,

Center for American Progress

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[47] Katie Ravel, "Preliminary Analysis: Open and Special Enrollment Periods," Covered California, April 1, 2025, available at https://www.shvs.org/wp-content/uploads/2025/04/New-CMS-Proposed-Rule-on-ACA-Marketplace-Integrity_Final.pdf.

[48] Centers for Medicare and Medicaid Services, "CMS Announcement on Federal Navigator Program Funding."

[49] Rachel Swindle and others, "ACA State Marketplace Models and Key Policy Decisions," The Commonwealth Fund, March 14, 2025, available at https://www.commonwealthfund.org/publications/maps-and-interactives/aca-state-marketplace-models-and-key-policy-decisions.

[50] Audrey Morse Gasteier, "Data for Response to CCIIO Rule: Perspectives from Massachusetts."