April 11, 2025

Submitted via www.regulations.gov

Secretary Robert F. Kennedy, Jr.
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Acting Administrator Stephanie Carlton
Centers for Medicare and Medicaid Services
7500 Security Boulevard
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Re: Comment Regarding "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability" Proposed Rule, Docket No. CMS-9884-P, 90 FR 12942 (Mar. 19, 2025)

Dear Secretary Kennedy and Acting Administrator Carlton:

Governing for Impact ("GFI") submits this comment on a proposed rule, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability" ("the proposed rule"), issued by the Centers for Medicare and Medicaid Services ("CMS") of the Department of Health and Human Services ("HHS").[1] GFI is a regulatory policy organization dedicated to ensuring that the federal government operates more effectively for everyday working Americans.[2] We appreciate the opportunity to comment, and we write in opposition to several provisions within the proposed rule that fail to satisfy the Administrative Procedure Act's ("APA") rulemaking requirements and run afoul of the text and spirit of the Affordable Care Act's ("ACA") relevant statutory mandates.[3]

Additionally, in a separate comment,[4] we urged the agencies to extend the comment period (and adjust the effective date(s) of the rule, if finalized) to give stakeholders adequate time to consider and meaningfully respond to the proposed rule. Given the shortened comment period and–in some instances–inadequate agency justification and supporting record, we limit our comment to the following program categories and specific changes within those categories: (1) the Special Enrollment Period for certain low-income individuals, (2) re-enrollment and auto-enrollment, and (3) income verification requirements.

Together, these proposals would undoubtedly strip individuals and families of affordable healthcare, likely leaving many uninsured. As we argue in detail below, CMS has not met its burden to justify

[1] 90 FR 12942 (Mar. 19, 2025).
[2] Governing for Impact, https://governingforimpact.org/.
[3] *See generally* 5 U.S.C. § 551, *et seq.*, 42 U.S.C. § 18001, *et seq.*
[4] GFI Comment on Docket No. CMS-2025-0020-011, https://www.regulations.gov/comment/CMS-2025-0020-10625 (Posted April 4, 2025) (requesting an extension of the comment period).

these changes, including by relying on faulty or unexplained data, failing to meaningfully address important policy considerations, and preventing the public from fully engaging with its reasoning.

I. Special Enrollment Period for Certain Low-Income Individuals

To start, the proposed rule would eliminate the Special Enrollment Period ("SEP") for individuals with incomes at or below 150% of the Federal Poverty Level ("FPL") who qualify for the Advanced Premium Tax Credit (APTC) ("the 150% FPL SEP"), and related provisions.[5] The 150% FPL SEP has been available to consumers since 2021.[6] In the proposed rule, CMS argues that the 150% FPL SEP has increased improper enrollments and the risk of adverse selection and, for similar reasons, is not authorized by what CMS believes to be the "single, best interpretation of the statute" (citing Section 1311(c)(6)(C) and (D) of the ACA).[7]

Neither of CMS's overlapping justifications withstands scrutiny. Moreover, the availability of the 150% FPL SEP has created significant reliance interests for potential enrollees (or current enrollees who lose coverage but become eligible under the SEP) who would otherwise remain uninsured due to affordability, which will be heightened if Congress does not extend the health care subsidies in the Inflation Reduction Act ("IRA") before its sunset at the end of 2025.[8]

A. CMS's policy justification for eliminating the 150% FPL SEP does not satisfy APA requirements.

When agencies are considering a new policy or a change in existing policy, the APA requires agencies to "examine[] 'the relevant data'" and "articulat[e] 'a satisfactory explanation.'"[9] Among other things, agencies must "clearly disclose[] and adequately sustain[]" their basis for decisionmaking.[10] Further, when effectuating a policy change that relies on "factual findings that contradict those which underlay its prior policy," the agency must address those changed factual findings in a reasoned manner.[11]

CMS asserts that the 150% FPL SEP has increased improper enrollments and the risk of adverse selection, which may create higher premiums.[12] That justification suffers from several deficiencies.

First, CMS has not considered conflicting evidence showing that SEP enrollees generally do not negatively affect the risk pool, meaning that they also do not increase the rate of adverse selection. To support its argument that the 150% FPL SEP has increased adverse selection, CMS explains how

[5] 90 FR 12979. The 150% FPL SEP is currently codified at 45 C.F.R. § 155.420(d)(16).
[6] Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond, 86 FR 53412 (Sep. 27, 2021) ("PY 2022 Payment Notice"). The 150% FPL SEP rule became effective on November 26, 2021 for plan years starting in 2022. 86 FR 53418.
[7] 90 FR 12979.
[8] *See generally*, Pub. L. 117-169 (Aug. 16, 2022), 136 Stat. 1818, 1905, Sec. 12001, *et seq.*
[9] *See* 5 U. S. C. § 706(2)(A); *Dept. of Commerce v. New York*, 139 S. Ct. 2551, 2569 (2019), *citing Motor Vehicle Mfrs. Assn. of United States, Inc. v. State Farm Mut. Automobile Ins. Co.*, 463 U.S. 29, 43 (1983).
[10] *Sec. & Exch. Comm'n v. Chenery Corp.*, 318 U.S. 80, 94 (1943).
[11] *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009) (*hereinafter Fox*).
[12] 90 FR 12982.

adverse selection may be incentivized by the 150% FPL SEP, but does not provide data supporting this assumption.[13]

To the contrary, research has shown that expanded SEPs do not increase adverse selection. The COVID-19 Pandemic and the related expanded use of SEPs led to a natural study for adverse selection. Researchers found that "more lenient enrollment did not result in adverse selection. In fact, it led to favorable selection, meaning that these states [with more lenient enrollment] saw almost double the improvement in their risk pools."[14] This is because SEP enrollees are typically younger than OEP enrollees.[15] CMS also has access to data specifically comparing SEP enrollees versus OEP enrollees but chose not to include its findings. For example, Covered California's data from recent years, including 2024, shows that SEP enrollees are either *healthier* or the same as OEP enrollees.[16] Massachusetts found that SEP enrollees were slightly younger than OEP enrollees in 2024.[17] The same data California and Massachusetts used is available to CMS for all states using Healthcare.gov.

Second, as the Paragon report states, and as CMS recognizes, improper enrollment is largely due to brokers' and agents' intentional manipulation of potential enrollees' applications, *not* potential enrollees' direct misuse of the SEP. This finding does not justify CMS's proposal to eliminate the 150% FPL SEP, but again shows that CMS is not meaningfully considering an important factor–brokers' and agents' intentional manipulation of the program–nor has it considered potential alternatives that might prevent brokers and agents from increasing improper enrollments under the SEP.[18] CMS should focus its efforts on regulating bad actors who broker insurance coverage, not punish low-income potential enrollees who need affordable healthcare coverage. While the proposed rule attempts to clarify the standard of evidence required in enforcement actions against brokers and agents,[19] CMS can do more to directly tackle the issue of improper enrollments by brokers and agents. Eliminating the 150% FPL SEP may indirectly cut down on improper enrollments by brokers and agents, but CMS can more effectively address broker and agent misconduct through existing enforcement authorities and additional consumer consent requirements, for example.[20]

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[13] 90 FR 12982 (discussing *Turner et al. v. Enhance Health et al.* to explain how instead of enrolling in fully subsidized plans during OEP, consumers may wait until they get sick). *Turner v. Enhance Heath* is still in the discovery phase and trial is not set until 2026. Case No. 24-60591-CIV-DAMIAN/Valle (S. D. Fla. Dec. 20, 2024) (order setting trial and pre-trial schedule), available at: https://litigationtracker.law.georgetown.edu/wp-content/uploads/2024/04/Turner_2024.12.20_ORDER-SETTING-TRIAL.pdf.

[14] Mark A. Hall and Michael J. McCue, "Does Making Health Insurance Enrollment Easier Cause Adverse Selection?," To the Point (blog), Commonwealth Fund, Apr. 4, 2022. https://doi.org/10.26099/affn-rb03.

[15] CMS, The Exchanges Trends Report (July 2, 2018), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-3.pdf, 11 (finding that the average age for SEP enrollees in 2017 was 35, compared to 41 for OEP enrollees).

[16] *See* State Health & Value Strategies, New CMS Proposed Rule: ACA Marketplace Integrity (April 1, 2025), https://www.shvs.org/wp-content/uploads/2025/04/New-CMS-Proposed-Rule-on-ACA-Marketplace-Integrity_Final.pdf, 28.

[17] *Id.* at 34.

[18] *Cf. Farmers Union Cent. Exch., Inc. v. FERC*, 734 F.2d 1486, 1511 (D.C. Cir. 1984) ("It is well established that an agency has a duty to consider responsible alternatives to its chosen policy and to give a reasoned explanation for its rejection of such alternatives.").

[19] 90 FR 13011 (clarifying that CMS will use the "preponderance of the evidence" standard for noncompliance enforcement actions against brokers and agents).

[20] *See*, *e.g.*, Commonwealth Fund, Policymakers Can Protect Against Fraud in the ACA Marketplaces Without Hiking Premiums (March 5, 2025),

Third, CMS has not provided adequate data to support its claim that improper enrollment rates have increased, nor has it addressed other significant factors that may contribute to any supposed increase before deciding to strip enrollees of coverage. To support CMS's argument that the 150% FPL SEP has led to increased improper enrollment, HHS relies on a Paragon Institute Report that compared income distributions in states to the 2024 Open Enrollment Period ("OEP") data gathered by CMS.[21] However, CMS fails to mention that the Paragon report relied on income distribution data by states from *2022*, compared to the *2024* OEP, rendering their analysis theoretical since it assumes that income distribution has not changed since 2022.[22]

While it is likely that CMS does not have income distribution data for 2024, it can and should at least use the best available data for 2023. For example, the American Community Survey estimates that while the rate of people with incomes between 100-199% of the FPL has remained relatively constant from 2022 to 2023 in the U.S. on average, there is wide variation between states.[23] In almost half the states, the population of people with household incomes between 100 and 199% FPL increased between 2022 and 2023.[24] CMS's own analysis of income data from the Census Bureau simply *estimates* improper enrollment, again relying on 2022 income data and comparing it to 2024 OEP enrollment. While agencies can and should rely on available data to estimate policy effects, they should also recognize the limitations of that analysis before stripping coverage from millions of Americans who rely on Marketplace insurance.[25] By failing to account for potential changes in income distribution, CMS has not met its burden to consider the relevant data.

Relatedly, even using this data, both the Paragon report and CMS find that excess enrollments are more pronounced in states that have not adopted Medicaid expansion, since consumers and brokers have more incentives to manipulate income in order to qualify for low or no-cost health insurance that is otherwise unavailable.[26] Instead of directly addressing the purported excess enrollments in non-expansion states, CMS is proposing a universal policy applying to every state, even if no credible data suggests improper enrollments. CMS should instead query why consumers and brokers in non-expansion states may have increased incentives to manipulate income data. CMS has therefore failed to consider "responsible alternatives" to this policy, failing to meet its duty under the APA.[27]

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https://www.commonwealthfund.org/blog/2025/policymakers-can-protect-against-fraud-aca-marketplaces-without-hiking-premiums.

[21] 90 FR 12980, *citing* Blase, B.; Gonshorowski, D. (2024, June). The Great Obamacare Enrollment Fraud. Paragon Health Institute. https://paragoninstitute.org/ private-health/the-great-obamacare-enrollmentfraud.

[22] The proposed rule later uses CMS's 2024 Open Enrollment Public Use Files to estimate FPL distributions in each state, but it is important to note that CMS's data relies on unverified *self-reported* income, and HHS acknowledges some of the limitations of using this data. 90 FR 13022, citing https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files.

[23] KFF, Distribution of Total Population by Federal Poverty Level, 2022-2023, https://www.kff.org/other/state-indicator/distribution-by-fpl/?dataView=0&activeTab=graph&currentTimeframe=0&startTimeframe=1&selectedDistributions=100-199percent&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (accessed Apr. 4, 2025).

[24] 23 states had higher proportions of households with incomes between 100 and 199% FPL in 2023 than in 2022: Alaska, Arkansas, Connecticut, Delaware, Indiana, Iowa, Kansas, Kentucky, Michigan, Mississippi, Missouri, Nebraska, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, Virginia, Washington, West Virginia, and Wyoming. *Id.*

[25] 90 FR 12981.

[26] Blase, *supra*, fn. 21, at 13.

[27] *See generally Farmers Union Cent. Exch., Inc. v. FERC*, *supra* fn. 18, at 1511.

Fourth, CMS's analysis of the effect of repealing the 150% FPL SEP on premiums is contradictory. On the one hand, CMS finds that the PY 2025 Payment Notice overestimated the effect of the 150% FPL SEP on premiums;[28] rather than causing premiums to rise by 3-4% absent IRA subsidies, CMS now concludes that it increases premiums to rise by as little as 0.5%.[29] On the other hand, CMS relies on those same erroneous estimates in predicting that repealing the SEP "could decrease premiums by 3 to 4 percent compared to baseline premiums if this rule is finalized[.]"[30] The proposed rule therefore rests on an inflated understanding of how repeal might reduce premiums. At a minimum, CMS should clarify the discrepancies between these new estimates and the cost-savings CMS claims to support the elimination of the 150% SEP.

B. CMS has statutory authority to provide the low-income SEP.

CMS is also incorrect to assert that it lacks the authority to provide a 150% FPL SEP. Specifically, CMS argues that, by specifically enumerating certain types of SEPs, section 1311(c)(6)(C) and (D) of the ACA prohibits the agency from allowing other types of SEPs.[31] However, as we have detailed in a previous report, CMS has wide discretion when deciding which SEPs to include, and the statute contemplates the need to modify SEPs as circumstances change.[32]

The ACA requires Exchanges to provide SEPs "specified" under ERISA and other SEPs "under circumstances similar to" SEPs created under the Medicare Part D program.[33] The Medicare Part D program gives the agency significant discretion, and Congress directed the Secretary to establish a range of additional SEPs, including for low-income individuals.[34] By referring to this same authority under the Medicare statute, the ACA grants HHS wide discretion to require additional SEPs, including the 150% FPL SEP.

HHS's reliance upon *Texas Med. Ass'n v. HHS*, which interpreted a different statute, the No Surprises Act,[35] is off-base. Unlike that statute, which specifies certain factors arbitrators must consider before issuing payments, the ACA neither prescribes a "comprehensive" set of statutory factors nor "specifies in meticulous detail" a set of predetermined SEPs.[36] Instead, Congress required CMS to include SEPs as set in other programs, which routinely change over time. Further, the statutory language allowing CMS to include SEPs "under circumstances similar to" Medicare Part D SEPs implies situations where CMS will need to use its discretionary authority to address coverage gaps created by the Exchange program similar to the Medicare program.

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[28] 89 FR 26323.
[29] 90 FR 12982. CMS now estimates that the 150% FPL SEP increases premiums by 0.5 to 3.6%. *Id.*
[30] 90 FR 13016.
[31] 90 FR 12982.
[32] Governing for Impact, Reversing Key Sabotage Efforts and Increasing Access to Affordable Care Act Coverage (Dec. 2020), https://govforimpact.wpengine.com/wp-content/uploads/2021/07/Public_04_Market-Modernization_HHS.pdf, 7-8.
[33] 42 U.S.C. § 18031 (c)(6)(C).
[34] *See* 42 U.S.C. § 1395w-101(b)(3); *see* 75 Fed. Reg. 19678, 19720 (Apr. 15, 2010) (the continuous low-income SEP for Medicare Part D). The continuous low-income SEP for Medicare was amended in 2018, allowing individuals to enroll via this SEP up to three times a year. 83 FR 16440, 16515 (2018). The Biden Administration modified this SEP, allowing consumers to enroll under the low-income Medicare Part D SEP up to once a month. 89 FR 30448, 30677-78 (2024), codified at 42 CFR 423.38(c)(4).
[35] 110 F.4th 762, 776 (5th Cir. 2024).
[36] *Id.* at 776, *quoting Tex. Med. Ass'n v. U.S. Dep't of Health & Hum. Servs.*, 654 F. Supp. 3d 575, 592 (E.D. Tex. 2023).

Indeed, CMS itself has previously recognized that it has broad authority under section 1321(a) of the ACA to implement the statutory requirements related to Exchanges, QHPs, and other standards under title I of the ACA.[37] CMS's rationale for changing its interpretation of the statutory authority is not convincing. CMS argues its experience with the 150% FLP SEP supports the agency's understanding that "Congress was prescient to provide the Secretary with a comprehensive statutory list of SEPs that omitted the 150 percent FPL SEP" in an effort to mitigate adverse selection.[38] As discussed above, however, the available evidence suggests that the 150% FPL SEP *mitigates* the risk of adverse selection. Nor has CMS provided any basis for concluding that any such risk outweighs the benefits of providing health care coverage for low-income individuals—the ACA's primary purpose.[39]

CMS also points to a 2025 Payment Notice commenter, who argued that the statute contemplates a set of SEPs that allow for mid-year eligibility if they experience a change in circumstances, unlike the 150% FPL SEP, which allows individuals to enroll at any time during the year based on their existing income, not a change in their income.[40] However, the 150% FPL SEP is naturally tied to changes in circumstances, since the SEP allows individuals to enroll who have been deemed ineligible for other programs, like Medicaid and CHIP, or have had changes in their income that qualify them for the SEP.

C. The availability of the 150% FPL SEP has created significant reliance interests.

When changing policy, agencies must provide a "more detailed justification than what would suffice for a new policy" if the "prior policy has engendered serious reliance interests that must be taken into account."[41] The 150% FPL SEP has been available to consumers since 2021, creating significant reliance interests that the proposed rule does not address.

The 150% FPL SEP has been used by millions of consumers since its codification in 2021. When the 2025 Notice of Benefit and Payment Parameters rule removed certain restrictions from the 150% FPL SEP, making the SEP permanent, CMS noted the policy had been successful, finding that 1.3 million consumers enrolled under the 150% FPL SEP between October 2022 and 2023.[42] The proposed rule does not address the significant number of consumers that will undoubtedly lose out on coverage if the SEP is removed (instead having to wait until the OEP to enroll, unless they

[37] *See*, *e.g.*, Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program, 89 FR 26218, 26323 (making the 150% FPL SEP permanent) (April 15, 2024) ("PY 2025 Payment Notice"); PY 2022 Payment Notice, 86 FR 53438 (implementing the monthly 150% FPL SEP), Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment, 78 FR 42160, 42162 (July 15, 2013) (citing § 1321(a)(1) to set minimum functions of an Exchange); Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 FR 18310, 18341 and 18359 (March 27, 2012) (citing § 1321(a)(1) to change verification methods and privacy standards for Exchanges).

[38] 90 FR 12982.

[39] *See*, *e.g.*, *King v. Burwell*, 759 F.3d 358, 373–374 (4th Cir. 2014), aff'd, 576 U.S. 473 (2015) ("The Supreme Court has recognized the broad policy goals of the Act: "to increase the number of Americans covered by health insurance and decrease the cost of health care." *NFIB*, 132 S.Ct. at 2580.).

[40] 90 FR 12982.

[41] *Fox*, 556 U.S. at 515 (*citing Smiley v. Citibank (S.D.), N.A.*, 517 U.S. 735, 742 (1996)).

[42] 89 FR 26321.

qualify for a different SEP). Recent data shows that almost 16% of the uninsured population has a household income under 200% FPL, meaning they are likely eligible for Medicaid or Marketplace coverage.[43] In many cases, eligible consumers may not enroll in Marketplace coverage because they are not aware of their eligibility or miss the OEP.[44] The 150% FPL SEP allows these consumers an additional opportunity to enroll in coverage, closing the coverage gap. Without it, eligible enrollees have fewer options to apply for coverage and miss out on months of subsidized coverage, leaving many uninsured.

Further, CMS would eliminate the 150% FPL SEP immediately upon the effective date of the final rule, unlike many of the proposed rule's other proposals, which would be effective starting in PY 2026.[45] This gives extremely limited time for public education, notification to low-income consumers, or Exchanges to implement the change. As highlighted above, with looming cuts to program funding, Navigators will undoubtedly have diminished resources to reach eligible consumers and assist with applications before the general OEP deadline, which will lead to many being uninsured unless they qualify under a different SEP or until next year's OEP. Without this time, there would also be significant confusion for consumers, issuers, and brokers, which would undoubtedly create added administrative burdens and loss of coverage for consumers who may qualify under a different SEP. CMS provides no guidance in the proposed rule as to how consumers and Marketplaces can remain in compliance with the proposed rule if finalized unchanged.

II. Re-enrollment and auto-enrollment

The proposed rule would modify re-enrollment and auto-enrollment procedures, impermissibly barring people from affordable coverage because of past-due premiums or failure to reconcile ("FTR") their receipt of Advanced Premium Tax Credits ("APTC"). Both proposals fail to meet the APA's requirement for reasoned decision-making, and the automatic $5 monthly premium for certain APTC-eligible enrollees proposal goes beyond CMS's authority under the ACA.

A. *Past-Due Premiums*

The proposed rule would remove § 147.104(i), reversing the policy restricting issuers from requiring enrollees to pay past-due premiums to start new coverage.[46] The proposed rule goes beyond changes made by CMS during the first Trump administration,[47] and would allow Exchanges to deny coverage if enrollees have *any* past-due premiums, not just past-due premiums within the last 12 months.[48] Both CMS's initial reversal of § 147.104(i) and its current proposal do not meaningfully address the initial concerns that spurred the agency to adopt the 2014 guaranteed availability requirement, nor does CMS provide the public with adequate data to support its decision. And, as we have outlined in a previous report, the ACA's guaranteed availability provision requires insurers to accept every

[43] Jennifer Tolbert, *et al.*, KFF, Key Facts about the Uninsured Population (Dec. 18, 2024), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.
[44] *See, e.g.*, Sarah Luek, Center on Budget and Policy Priorities, Broadening Marketplace Enrollment Periods Would Boost Access to Health Coverage (Apr. 19, 2021), https://www.cbpp.org/research/health/broadening-marketplace-enrollment-periods-would-boost-access-to-health-coverage#_ftn6.
[45] 90 FR 12980.
[46] 90 FR 12950.
[47] 82 FR 18346.
[48] *Id.*

employer and individual that applies for coverage, regardless of their health status or other factors;[49] meaning that CMS does not have the authority to make a blanket exception for past-due premium payments.

In 2022, CMS found that the Trump administration's initial policy (allowing Exchanges to deny coverage to enrollees who failed to pay past-due premiums within the last year), "had the unintended consequence of creating barriers to health coverage that disproportionally affect low-income individuals."[50] Allowing Exchanges to deny coverage for past-due premiums even beyond the 12 months contemplated by the initial Trump administration policy would undeniably create even more significant barriers for low-income consumers. To rebut CMS's earlier findings, CMS now asserts that low-income consumers would not be significantly impacted "[g]iven the availability of premium support for many who experience financial hardship[.]"[51] Without any data, CMS acknowledges the harm posed by the initial (more limited) premium requirement but concludes that the disproportionate effect on low-income consumers is somehow less salient now. This is hardly the "reasoned explanation" required by the APA.

Further, the proposal does not address a significant concern: the elimination of the enhanced subsidies in the IRA, which sunset at the end of 2025. If Congress does not renew the subsidies in the IRA, lower-income enrollees would face significant increases in premium payments. For example, a 45-year old enrollee at 166% FPL would experience an increase of $917 in premium payments for a benchmark silver plan without enhanced subsidies; nearly six times their current payment of $160.[52] More than half of consumers enrolled in individual or Marketplace plans in 2023 reported that it was already "very or somewhat difficult" to afford health care costs.[53] And because of these costs, many have delayed care or become uninsured. Imposing even higher financial barriers to coverage (including the payment of potentially all past-due premiums and the increased premiums expected in 2026) is likely to lead to significant rates of uninsurance in this population. Most uninsured people cite the high cost of insurance as the primary reason they lack coverage,[54] and the added costs of paying past-due premiums to effectuate coverage will only exacerbate this problem. By increasing the rate of uninsurance, it is also likely that the risk pool will worsen, creating higher premiums for enrollees.[55]

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[49] GFI, Proposed Action Memorandum: Reversing Key Sabotage Efforts and Increasing Access to Affordable Care Act Coverage (Dec. 2020), https://govforimpact.wpengine.com/wp-content/uploads/2021/07/Public_04_Market-Modernization_HHS.pdf, 11.

[50] 87 FR 27218.

[51] 90 FR 12952. The agency also argues that loss would be minimal because individuals with past-due premiums who receive APTC would "generally owe no more than 1 to 3 months" of past-de premiums. *Id.*

[52] Jared Ortaliza, *et al.*, KFF, *Inflation Reduction Act Health Insurance Subsidies: What is Their Impact and What Would Happen if They Expire?* (Jul. 26, 2024), 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/#:~:text=The%20enhanced%20subsidies%20in%20the%20Inflation%20Reduction%20Act%20reduce%20net%20premium%20costs%20by%2044%25%2C%20on%20average%2C%20for%20enrollees%20receiving%20premium%20tax%20credits%2C%20though%20the%20amount%20of%20savings%20varies%20by%20person.

[53] Sara R. Collins, *et al.*, Commonwealth Fund, *Paying for It: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer* (Oct. 26, 2023), https://www.commonwealthfund.org/publications/surveys/2023/oct/paying-for-it-costs-debt-americans-sicker-poorer-2023-affordability-survey.

[54] *See*, e.g., Tolbert, *supra* fn. 43.

[55] *See*, *e.g.*, Commonwealth Fund, Options to Expand Health Insurance Enrollment in the Individual Market (Oct. 19, 2027),

For these reasons, it is unclear what cost-savings, if any, could be expected from the proposed rule's past-due premium policy, especially if CMS chooses to require Exchanges to demand past-due premiums, as the proposed rule suggests.[56]

B. $5 Monthly Premiums for Certain APTC-eligible Enrollees

The proposed rule would modify § 155.335(a)(3) and (n), requiring Exchanges to force fully subsidized enrollees who fail to select a plan on time to pay a $5 monthly premium until they update their eligibility determination.[57] It would do so by lowering the amount of APTC applied to those policies. However, CMS does not have statutory authority under the ACA to set APTC amounts in that manner. Even if it did, CMS has not met its burden under the APA to justify its change in policy where enrollees possess significant reliance interests in their continued access to health coverage.

First, CMS does not have the authority to set APTC amounts under section 1411(f)(1)(B) of the ACA. 42 U.S.C. § 18081(f)(1) allows the Secretary, in consultation with Treasury, Homeland Security, and the Commissioner of Social Security, to establish procedures by which the agency (1) hears and makes decisions about appeals of eligibility determinations and (2) redetermines eligibility on a periodic basis. Both of these authorities speak to the Secretary's power to set standards around determining and re-determining eligibility, *not* calculations as to what the premium tax credit or APTC should be. The authority to set APTC lies with the IRS at 26 U.S.C. § 36B, which requires the IRS to use a specific method of calculating those credits. Neither CMS nor IRS has the discretion to alter that statutorily mandated calculation.[58]

To the contrary, CMS is mandated by statute to establish a program that makes advance determinations based on the IRS's calculation of PTCs at the Exchanges' request. 42 U.S.C. § 18082(a)(1).[59] The advance determination of eligibility must be made "on the basis of the individual's household income for the most recent taxable year" when that information is available. *Id.* § 18082(b)(1)(B). Nowhere in the text does Congress give CMS the authority to modify the IRS's calculation of the PTC. Further, the ACA *requires* the Treasury to make the advanced payments

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https://www.commonwealthfund.org/publications/fund-reports/2017/oct/options-expand-health-insurance-enrollment-individual-market (finding that increasing the risk pool makes it easier for insurers to set premiums and spread administrative costs over a large base and that people who are on the fence about enrolling tend to be healthier than average).

[56] 90 FR 12953.

[57] 90 FR 12969.

[58] 26 USC § 36B(b)(2) ("...Premium assistance amount. The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of— (A)the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under 1311 [1] of the Patient Protection and Affordable Care Act, or (B)the excess (if any) of—(i)the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over (ii)an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.")

[59] The Secretary, in consultation with the Treasury, will establish a program where: "...upon request of an Exchange, advance determinations are made under section 18081 of this title with respect to the income eligibility of individuals enrolling in a qualified health plan in the individual market through the Exchange for the premium tax credit allowable under section 36B of title 26 and the cost-sharing reductions under section 18071 of this title[.]" *Id.*

determined by the APTC to health issuers,[60] CMS cannot prevent the Treasury from making those payments nor the Exchanges from receiving those payments.

Second, as noted above, courts generally require the agency to provide a more detailed justification when it changes a policy that has created serious reliance interests.[61] At no point since the ACA's implementation have enrollees who qualify for fully subsidized plans through APTC been required to pay a penalty of $5 a month for failing to make a plan selection during their enrollment period or failing to redetermine their eligibility. And research has shown that even modest increases in premiums lead to increased disenrollment among low-income consumers.[62] As the proposed rule states, and the 2021 Payment Notice proposed rule also found, commenters then and now "believ[e] that adopting the proposed changes could disadvantage the lowest income group of Exchange enrollees by taking away financial assistance for which they are eligible without evidence that they are at greater risk of incurring overpayments of APTC."[63] CMS makes no attempt to contend with these reliance interests nor commenters' fear that the $5 monthly premium would disproportionately harm low-income consumers who are likely eligible for the previously determined APTC. CMS also fails to fully consider the added administrative burdens and confusion that this change would create for consumers, issuers, brokers, and Exchanges.

III. Income verification

The proposed rule also makes several changes to the income verification process, making it more burdensome for consumers to enroll or re-enroll in healthcare coverage. These policies are magnified by CMS's recent 90% cut to the Navigator program, which provides a necessary resource for helping consumers, particularly low-income consumers, determine their eligibility for Marketplace coverage or other programs and enroll in that coverage.[64] Not only will these added income verification requirements have disastrous effects on enrollment, CMS again fails to justify the policy changes in accordance with the APA's requirements.

A. Failure to reconcile APTC

The proposed rule would amend § 155.305(f)(4) to reinstate CMS's previous policy making enrollees ineligible for APTC if the enrollee failed to reconcile their APTC in the previous tax year,[65] reversing the current policy, which allowed enrollees to maintain their APTC until the IRS reported a failure to reconcile ("FTR") for 2 consecutive years.[66]

This change in agency policy does not meet the APA's requirement for reasoned decision-making because it fails to provide the public with adequate data which CMS has relied on to propose this change. When agencies rely on specific data to underpin their reasoning for a change in policy (or

[60] 42 U.S.C. § 18082 (c)(2)(A)("The Secretary of the Treasury shall make the advance payment under this section of any premium tax credit allowed under section 36B of title 26 to the issuer of a qualified health plan on a monthly basis (or such other periodic basis as the Secretary may provide)").
[61] *See*, *supra*, fn. 41.
[62] *See*, *e.g.*, Betsy Q. Cliff, *et al.*, *Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules*, 8(1) Am. J. of Health Econ. 127, https://www.journals.uchicago.edu/doi/full/10.1086/716464 (2022).
[63] 90 FR 12970, citing 85 FR 7088
[64] CMS Newsroom, CMS Announcement on Federal Navigator Program Funding (Feb. 14, 2025), available at: https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding.
[65] 90 FR 12958.
[66] 88 FR 25814 (2024).

even in proposing a new policy), courts have found they must "identify and make available technical studies and data" the agency has relied on to reach its conclusion.[67] While CMS argues that the current FTR process facilitates improper enrollment, increasing potential tax liabilities for consumers, nowhere in the proposed rule does CMS present the specific data or methods used to reach its conclusions—thereby precluding the public from substantively responding to the agency's proposal, and indicating that the agency lacks adequate data to support its change.[68]

CMS points to general Marketplace Open Enrollment Period Public Use files to assert that "the new FTR process places a substantially higher number of tax filers at a greater risk of accumulating increased tax liabilities[]" without noting how the data was used to reach that conclusion.[69] Similarly, CMS asserts that "this new analysis of the enrollment and tax filing status suggests a large number of people with FTR status are ineligible for APTC and that pausing removal of APTC due to an FTR status allows ineligible enrollees to accumulate tax liabilities[,]" again citing to general Marketplace OEP data.[70] Without access to the underlying data, commenters cannot analyze CMS's conclusions.

B. Removing the 60-day extension to verify income

The proposed rule would remove § 155.315(f)(7), which gives applicants an automatic 60-day extension to the 90-day period to verify income under 1411(e)(4)(A) of the ACA.[71] Again, this proposal does not conform to the APA's requirement for reasoned decision-making because it fails to meaningfully consider significant concerns raised in previous rulemaking that underpinned the agency's initial decision to set the automatic extension.

CMS provides two primary justifications for removing the automatic extension: (1) the 60-day extension does not conform with the statute, since the ACA specifies that the 90-day period can be increased by 60-days in 2014,[72] (2) the "60-day extension did not provide a meaningful benefit to consumers and weakened program integrity[]" since data suggests that those that needed the 60-day extension before § 155.315(f)(7) was added could do so under § 155.315(f)(3).[73]

Again, this policy change fails to adequately consider an important factor. CMS admits in the proposed rule that: "90 days is often an insufficient amount of time for many applicants to provide income documentation, since it can require multiple documents from various household members

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[67] *Solite Corp. v. EPA*, 952 F.2d 473, 484 (D.C. Cir. 1991) ("Integral to the notice requirement is the agency's duty to identify and make available technical studies and data that it has employed in reaching the decisions to propose particular rules."); *see Window Covering Manufacturers Ass'n v. Consumer Prod. Safety Comm'n*, 82 F.4th 1273, 1283 (D.C. Cir. 2023); *Lloyd Noland Hosp. & Clinic*, 762 F.2d at 1565 ("The purpose of notice under the APA is to disclose the thinking of the agency and the data relied on."); *United States v. Nova Scotia Food Prod. Corp.*, 568 F.2d 240, 251-52 (2d Cir. 1977); *see also* Jennifer Nou, Edward H. Stiglitz, Strategic Rulemaking Disclosure, 89 S. Cal. L. Rev. 733, 745-46 (2016) (discussing empirical evidence that agencies, in response to this rule, have shifted to conduct more information-gathering before issuing the NPRM to reduce litigation risk).

[68] Additionally, as we have detailed before, the best reading of the statute does not require Exchanges to deny APTC due to failure to reconcile. *See*, *e.g.*, Governing for Impact, Proposed Action Memorandum: Eliminating the "Failure to Reconcile" Penalty (Dec. 2020), available at: https://govforimpact.wpengine.com/wp-content/uploads/2021/07/Public_07_Eliminating-22Failure-to-Reconcile22-Penalty_HHS.pdf, 4-5.

[69] 90 FR 12959.

[70] 90 FR 12961.

[71] 90 FR 12963.

[72] *Id.*

[73] *Id.*

along with an explanation of seasonal employment or self-employment, including multiple jobs."[74] However, the APA requires more than "nodding" to concerns to then dismiss them in a "conclusory manner" to constitute reasoned decisionmaking.[75] While CMS finds that those who need more time usually also qualify for a 60-day extension under § 155.315(f)(3) (which provides an extension if applicants show a good faith effort in obtaining documentation),[76] this still does not negate the fact that 90 days is known to be insufficient. Instead of relying on § 155.315(f)(3), which requires an application process and related administrative burdens, CMS can keep the automatic extension, giving consumers adequate time to gather documentation.

Further, CMS *does* have the authority to automate the extension. Under Section 1411(c)(4)(B) of the ACA, the Secretary has broad authority to modify the verification process, including by extending the verification timeline, as long as the Secretary finds that such modifications would "reduce the administrative costs and burdens on the applicant[.]"[77] If the Secretary finds that the original justification for the extension is still applicable–i.e. consumers either need more time to provide the required documentation or consumers' burden is reduced by extending the timeline–then CMS is authorized to provide the extension.

C. *Income verification process for certain consumers whose income is between 100% and 400% FPL*

The proposed rule would modify § 155.320(c)(3)(iii)(D) and (c)(3)(vi)(C)(2), requiring Exchanges to follow the procedure set out in § 155.315(f)(1) through (4), if the following criteria are met: (1) the consumer attested to an income between 100 and 400% FPL, (2) the Exchange has conflicting data from the IRS and SSA that suggests the income is under 100% FPL, (3) the Exchange has not assessed or determined the consumer to be eligible for Medicaid or CHIP, and (4) the attested income exceeds the projected income gathered by IRS/SSA by more than a 10% threshold (or some set amount).[78] Again, CMS does not meaningfully address significant concerns raised in previous rulemaking and ensuing litigation.

A similar policy was vacated by *City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021). The court found that the 2019 income verification policy was arbitrary and capricious because CMS (1) failed to provide sufficient empirical evidence to support its policy change, (2) "improperly elevated the objective of fraud prevention, for which it had no evidence, above the ACA's primary purpose of providing health insurance[]"[79], and (3) failed to adequately address commenters' concern that providing additional income documentation would be difficult for certain low-income workers.[80] CMS now purports to point to a more detailed record, finding evidence that consumers and insurance brokers may be inflating income to qualify for APTC.[81] However, the proposed rule still does little to address concerns that low-income workers may not be able to provide required income documentation–due, in part, to the nature of low-wage jobs–and does not address how the policy

[74] *Id.*
[75] *Gresham v. Azar*, 950 F3d 93, 103 (D.C. Cir. 2020).
[76] 90 FR 12963.
[77] 42 U.S.C. § 18081(c)(4)(B).
[78] 90 FR 12966.
[79] Citing *King*, 759 F.3d at 373-74.
[80] 523 F. Supp. 3d at 763.
[81] *See*, *e.g.*, 90 FR 12964, *citing* Hopkins, B.; Banthin, J.; and Minicozzi, A. (2024, Dec. 19). How Did Take-Up of Marketplace Plans Vary with Price, Income, and Gender? American Journal of Health Economics, 1 (11). https://www.journals.uchicago.edu/doi/10.1086/727785.

would maintain ACA's primary purpose of providing access to coverage while maintaining program integrity. CMS's repeated failure to acknowledge these issues renders its change all the more arbitrary.

D. Self-attested income when IRS data is not available

The proposed rule would also remove § 155.320(c)(5), which makes an exception to the standard household income inconsistency process, requiring Exchanges to accept an applicant's attestation if the IRS does not have tax return data.[82] But CMS again fails to meaningfully address previous concerns with the availability of income documentation.

The agency asserts that its previous determination that the alternative verification process was punitive is no longer true.[83] CMS also appears to believe that the previous exception violated statutory requirements under the ACA for verification of eligibility when there are inconsistencies or lack of IRS data.[84]

But the proposed rule admits that there are legitimate reasons why an enrollee would not have IRS data– for example, because they were not required to file taxes for the previous year. By simply concluding that enrollees "would have the opportunity to be verified through other trusted data sources" or "take one hour [on average] to submit documentation,"[85] CMS has failed to reasonably address this concern. Indeed, the one-hour estimate simply relies on the 2024 Payment Notice's assumption that, on average, consumers spend about an hour to submit income documentation to calculate how much time consumers would save by being able to self-attest household income.[86] While an untested assumption may serve to illustrate the lowered burden for consumers, it cannot serve as a significant justification for eliminating the option to self-attest household income where documentation is not readily available or harder to compile, like in many low-wage jobs or when applicants have multiple part-time jobs.[87]

IV. Comment Period

Aside from these specific concerns, and as we explained in requesting an extension of the comment period, allowing 23 days from Federal Register publication for comment is insufficient to allow commenters an opportunity to substantively respond to the agency's proposals. To summarize, given the number, complexity, and scope of CMS' proposals, "interested persons," including GFI, need more than 23 days to consider the proposals, the rationales behind them, the consequences they would have if finalized, and—critically—the "written data, views, or arguments" that commenters can provide for CMS's consideration to improve its rulemaking.[88] Given more time, commenters like GFI and others could provide more detailed analysis and data for CMS to consider.

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[82] 90 FR 12967.
[83] *Id.*
[84] *Id.*
[85] *Id.*
[86] 88 FR 25893.
[87] *See*, *e.g.*, Suzanne Wikle, *et al.* States Can Reduce Medicaid's Administrative Burdens to Advance Health and Racial Equity, Center on Budget and Policy Priorities, 2022. JSTOR, http://www.jstor.org/stable/resrep43095, 7.
[88] 5 U.S.C. § 553(c).

V. Conclusion

As we have detailed above, several of CMS's proposals fail to satisfy even the most basic requirements for public participation, reasoned decision-making, and meaningful consideration of important factors. Moreover, several of those proposals are not authorized by the ACA or related statutory provisions. Given these serious insufficiencies in the proposed rule, GFI opposes these and other provisions.

Sincerely,

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