MLRI MASSACHUSETTS LAW REFORM INSTITUTE

40 COURT STREET
SUITE 700
BOSTON, MA 02108

617-357-0700 PHONE
617-357-0777 FAX
WWW.MLRI.ORG

April 11, 2025

Centers for Medicare and Medicaid Services
Department of Health and Human

Submitted electronically through http://ww.regulations.gov

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

Thank you for the opportunity to comment on this proposed rule. The Massachusetts Law Reform Institute (MLRI) is a state-wide poverty law and policy center founded over 50 years ago to assist the residents of Massachusetts in obtaining access to health care and other essential services. These comments reflect MLRI's extensive experience with our state-based Marketplace, the Massachusetts Health Connector, currently providing affordable coverage to over 350,000 low- and moderate-income state residents. Massachusetts consistently ranks among the top states for health care with a high rate of health insurance coverage in no small part thanks to the Affordable Care Act and the Massachusetts Health Connector.[1] We have significant concerns that the proposed rule if finalized will undermine these achievements without advancing either integrity or affordability.

While the preamble states that the goal of the proposed rule is to provide relief from rising health care costs, the changes proposed will have the opposite effect. Virtually every provision will be harmful to consumers. Many of the proposals say they address the problem of individuals improperly obtaining coverage and incurring surprise tax liability. However, the restrictions on eligibility, affordability and access to care imposed by these proposals nationwide are not justified by the evidence.

It appears that the problem of broker fraud, widely reported in late 2024, was largely limited to the federal marketplace which has since taken steps to reduce the opportunities for fraud in the federal marketplace. While the federal marketplace heavily relies on brokers and authorizes them to use portals other than healthcare.gov, state-based marketplaces do not. According to the Massachusetts Health Connector, brokers are not active in the Massachusetts individual market and the Connector has received no consumer complaints of unauthorized enrollment or plan switching. Yet the preamble frequently invokes improper enrollment and surprise tax liability based on the evidence of broker fraud as if it were a widespread problem justifying rule changes making it harder to enroll. The one proposal directly addressing broker fraud, §155.220(g)(2), we support.

CMS also relies on evidence of excess payment of Advanced Premium Tax Credits as indicative of improper enrollment and specifically of applicants deliberately inflating their incomes. However, in the 41 states including DC which have adopted the Medicaid expansion, there is no incentive for applicants to deliberately inflate their income because low-income adults will be able to qualify for Medicaid.

[1] https://www.forbes.com/advisor/health-insurance/best-worst-states-for-healthcare/; https://www2.census.gov/library/publications/2024/demo/acsbr-021.pdf

Further, excess APTCs are not a good measure of improper enrollment. From our experience, excess APTCs are most often a reflection of the difficulty estimating expected annual income and expected tax filing status for a future period. Low-income workers are far more likely to experience fluctuations in income than people with higher incomes.[2] Accurately predicting future income using the MAGI methodology is even more difficult. Individuals who did not anticipate a loss of employment or a promotion, a marriage or divorce, an adult child who decides to leave school for work, or leave employment for school, particularly if it occurs late in the coverage year, may all find themselves with an excess payment of APTC. However, they were not improperly enrolled and estimating future income won't be made any more accurate by making the application and enrollment process more difficult.

We are also concerned that the proposed rule erodes the ability of state-based marketplaces to operate with the flexibility Congress intended which allows them to account for state differences with respect to population, insurance markets, provider networks and state laws. For these reasons, we oppose the rule as set out in more detail below.

Proposals reducing benefits and decreasing affordability

Reducing Affordability by Changing the Premium Adjustment Percentage (proposed change in methodology pursuant to § 156.130(e))

The proposed change in the methodology for calculating annual premium growth would increase maximum out of pocket cost-sharing for individuals with commercial insurance in both the individual and employer market by an estimated 15 percent in 2026.[3] The IRS also uses the "premium adjustment percentage" to update individual contribution percentages used to calculate the amount of the premium tax credit. The proposed change in methodology is estimated to increase premium contributions for consumers receiving PTCs by 4.5 percent.[4] We are opposed to these changes.

Even modest increases in point-of-service cost-sharing deter low-income consumers from using medically necessary care. We have seen how this affects our clients whose fear of incurring a $50 copayment for an emergency room visit has kept them from getting timely emergency care, or who split their prescriptions to make them last longer. Similarly, small increases in premiums deter enrollment particularly among people in good health with low-risk profiles who are weighing the costs of insurance against the rising costs of food and housing. In the Massachusetts merged individual and small group market, individuals receiving APTCs have a lower risk profile and use fewer health services than unsubsidized individuals.[5] Decreasing enrollment of subsidized members will increase premium costs for unsubsidized members. CMS estimates that its proposal will decrease enrollment by 80 million members.

Prohibiting Coverage of Medically Necessary Gender Affirming Care ("Sex Trait Modification") as an Essential Health Benefit (§ 156.115(d))

[2] Brookings Institution, Low-income workers experience—by far—the most earnings and work hours instability, January 2025, https://www.brookings.edu/articles/low-income-workers-experience-by-far-the-most-earnings-and-work-hours-instability/

[3] Health Affairs (March 20, 2025) https://www.healthaffairs.org/content/forefront/hhs-proposes-restrict-marketplace-eligibility-enrollment-and-affordability-first-major

[4] Op. cit.

[5] Final Report of Merged Market Advisory Council, https://www.mass.gov/doc/final-report-of-the-merged-market-advisory-council/download

CMS proposes to prohibit "sex trait modification," more commonly referred to as gender-affirming care or gender dysphoria, as part of essential health benefits (EHB), beginning in 2026. We oppose this change both because there is no legitimate basis for it, and because it constitutes unlawful discrimination.

The ACA requires the Secretary to ensure that the scope of EHB is equal to the scope of benefits under a typical employer plan. According to CMS, the treatment of gender dysphoria is not typically covered in employer-sponsored health plans. However, the evidence proves just the opposite. Employer survey data shows that coverage of gender affirming care is common.[6] Massachusetts is one of 24 states and D.C. where state insurance laws prohibit exclusion of gender-affirming care.[7]

Further, the specific services used in providing gender-affirming care are covered for a wide range of diagnoses and recognized as medically necessary services for the treatment of gender dysphoria by virtually all major medical associations.[8] Excluding these services for gender dysphoria would be difficult to implement as well as discriminatory.

Excluding gender dysphoria from EHB is contrary to the requirement that EHBs be defined in a way that protects individuals from discriminatory benefit design. It is also inconsistent with Section 1557 of the ACA, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act—laws that courts have interpreted to prohibit discrimination against people with gender dysphoria.

Proposals making it harder for eligible consumers to enroll in coverage

Reducing the Annual Open Enrollment Period (§ 155.410)

CMS proposes to shorten the annual open enrollment period (OEP) for the federal marketplace to 45 days from November 1 to December 15, and to prohibit the state-based Marketplaces like the Massachusetts Health Connector from having a longer OEP. If finalized, all Marketplace OEPs would be limited to the period from November 1-December 15. According to CMS this change will reduce adverse selection and reduce consumer confusion. However, the experience of Massachusetts and other state-based Marketplaces proves just the opposite.

The Massachusetts Open Enrollment period has run from November 1 to January 23 since 2018. (In Massachusetts, the 23d of the month has always been the last day to effectuate coverage for the first of the following month). The Health Connector's enrollment data show that higher risk individuals are

---

[6] Kaiser Family Foundation, New Rule Proposes Changes to ACA Coverage of Gender-Affirming Care, Potentially Increasing Costs for Consumers, (March 24, 2025) https://www.kff.org/private-insurance/issue-brief/new-rule-proposes-changes-to-aca-coverage-of-gender-affirming-care-potentially-increasing-costs-for-consumers/

[7] Massachusetts Dept. of Insurance Bulletin 2021-11; Prohibited Discrimination on the Basis of Gender Identity or Gender Dysphoria Including Medically Necessary Gender Affirming Care and Related Services; Issued September 9, 2021 https://www.mass.gov/news/bulletin-2021-11-prohibited-discrimination-on-the-basis-of-gender-identity-or-gender-dysphoria-including-medically-necessary-gender-affirming-care-and-related-services-issued-september-9-2021

[8] Kaiser Family Foundation, Health Policy 101: LGBTQ + Health Policy, https://www.kff.org/health-policy-101-lgbtq-health-policy/?entry=table-of-contents-gender-affirming-care

more likely to enroll before December 15, and lower risk individuals after December 15.[9] The longer OEP has enabled younger individuals to enroll in coverage and improve the overall risk pool for the merged market benefiting subsidized and unsubsidized individuals alike. Individuals 18-44 were the most likely to enroll after December 15 and those 55 and over the most likely to enroll early. Further, most people in Massachusetts completed their enrollment after December 15. During the most recent open enrollment two thirds of new enrollees enrolled after December 15.

A shorter open enrollment period will also make it more difficult and more costly for Call Centers to handle the volume of calls during open enrollment, and for certified application counselors and Navigators to handle the volume of people seeking assistance with applications and plan selection. During open enrollment 2025 the Health Connector Call Center handled a large volume of calls both before and after December 15. A shorter OE period will double the call volume and likely lead to reduced enrollment. This is particularly ill-timed if enhanced premium tax credits expire in 2025 in which case the number of calls and requests for assistance will be much higher for OE 2026.

For all these reasons we urge CMS not to shorten the open enrollment period and not to terminate the authority of state-based Marketplaces like the Massachusetts Health Connector to select longer OE periods in keeping with the needs and circumstances of the state.

Requiring Additional Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii)) and When Tax Data is Unavailable (§ 155.320(c)(5))

CMS proposes two policies that will require applicants to submit more paperwork for income verification when IRS data show income below 100% FPL and when a data match with IRS returns no response. These changes will make it more difficult for low-income people and those with fluctuating incomes or family circumstances to receive benefits to which they are qualified. When people are faced with requests for additional documentation, those who give up on the process at some point — and consequently lose coverage — are likely to be healthier-than-average people rather than sicker ones.[10] The result is that insurers end up with a less healthy, costlier group of enrollees just the result CMS states it is seeking to avoid.

According to CMS these proposals will generate an estimated 2.7 million new requests for information and an estimated 480,000 people, most of whom are likely eligible, will lose health insurance because they fail to successfully navigate the process.

The experience of Massachusetts shows just this pattern of adverse selection when paperwork requirements become burdensome with respect to tax data. It found that the IRS returns non-income response often and across income ranges, and that younger individuals were more likely to get non-income response than people 45 or older. With respect to the requirement for more paperwork for individuals with attested income under 100% FPL who CMS suspects of inflating their income. In Massachusetts and the other 40 jurisdictions that have expanded Medicaid, low-income applicants have no incentive to underreport their income.

Reducing the Effectiveness of Auto-enrollment Annual Eligibility Redeterminations (§ 155.335)

[9] This and other references to data compiled by the Health Connector can be found in its public comment letter posted on regulations.gov.

[10] Do Ordeals Work for Selection Markets: Evidence from Health Insurance Auto-Enrollment, American Economic Review 2025, 115(3): 772–822: https://pubs.aeaweb.org/doi/pdfplus/10.1257/aer.20231133

Currently, individuals can have their continuing eligibility verified based on electronic data matching and be auto enrolled in the same plan at annual redetermination without having to "return to the Marketplace" unless their circumstances have changed, or they want to change health plans. Based on concerns about broker fraud and improper enrollments, CMS proposes that all Marketplaces asses a $5 per month premium as a condition of reenrollment for certain low-income consumers who, based on their redetermination, do not owe a premium until they have returned to the Marketplace. This policy, like the other proposals making enrollment more difficult, is based on the faulty premise of widespread improper enrollment. It is also unlawful. It will be costly for Marketplaces to implement and further weaken the risk pool. We urge CMS to withdraw it.

Under the ACA, section 36B of the Internal Revenue Code governs calculation of a premium tax credit amount, and under section 1412(c) of the ACA the federal government "shall make the advanced payment under this section of any premium tax credit allowed under section 36B." CMS has no statutory authority to alter an eligibility determination made in accordance with the statute as it proposes to do in this rule-making.

Aside from the question of the legality of this proposal, any policy that limits auto-renewal or auto-enrollment will be very disruptive to states like Massachusetts. According to the Health Connector. Auto-enrollment and auto-renewal have played a major role in the state's universal coverage strategies and have not resulted in fraud or unexpected enrollment. Requiring thousands of people to take new and unnecessary actions to continue their coverage will result in significant added administrative costs with no added benefit. Maintaining the ability to auto-renew and auto-enroll is critical to supporting a strong risk pool and preventing premium increases for everyone.

Requiring More Pre-Enrollment Verification for Special Enrollment Period (SEP) and ending the low-income SEP (§ 155.420(g))

CMS proposes imposing additional documentation requirements on consumers seeking to enroll in Marketplace coverage through a SEP. The proposed rule would require state-based Marketplaces to conduct pre-enrollment eligibility verification for at least 75% of new enrollments through SEPs. It also proposes to end the low-income SEP. We oppose these changes.

CMS argues that requiring consumers to submit documents proving that they have experienced a SEP-triggering event will prevent people from enrolling only after they become sick or need health care services. However, the evidence from Massachusetts shows the opposite: in 2024, the average age of individuals who enrolled though a SEP was three years younger than the average age of all enrollees. The majority of SEP verifications are verified pre-enrollment, often with information from the integrated eligibility system used for both Medicaid (MassHealth) and APTCs, however it is important that state-based Marketplaces retain their flexibility to continue to allow post-enrollment verification.

Because CMS provides no evidence to support either the use of SEPs to commit fraud in the state-based Marketplaces, nor evidence of adverse selection, there is no rational basis to take away their traditional flexibility to determine the SEP verification processes that work for their issuers and markets. We urge CMS not to finalize this proposal.

CMS also proposes to repeal the SEP based on income at or below 150% FPL. CMS suggests that this SEP has contributed to improper enrollments and increased adverse selection. But as discussed earlier in these comments, improper enrollments driven by broker fraud were largely limited to the federal

marketplace and states that did not expand Medicaid, and there is little evidence that SEPs lead to adverse selection.

Proposals restricting eligibility to enroll in coverage

Excluding Deferred Action for Childhood Arrivals from the Definition of Lawful Presence (§ 155.20)

We oppose the proposal to exclude Deferred Action for Childhood Arrivals (DACA) recipients from the definition of lawfully present for the purposes of ACA eligibility. DACA recipients are immigrants who arrived in the United States without status as children. They have gone through extensive vetting and renewals to maintain their presence in the U.S. and like other individuals with deferred action are able to obtain work authorization and protection from removal. The ACA requires Advanced Premium Tax Credit eligibility for "lawfully present" immigrants. Last year, the administration removed DACA recipients' exclusion from the category. Less than a year later, there is no reason for CMS to cut thousands of people off their health insurance, much less to do it in the middle of a benefit year.

In 2012 when CMS initially excluded DACA from the definition of lawful presence for purposes of the ACA, it was wrong. Recipients of deferred action have always been considered lawfully present across federal agencies. DACA recipients are critical members of families and communities across the United States. More than 1.3 million people[11] live with a DACA recipient, including 300,000 U.S.-born children who have at least one parent with DACA. A majority of DACA recipients are employed, and three quarters of DACA recipients in the workforce are essential workers, including 45,000 healthcare professionals and 20,000 educators. Yet DACA recipients are disproportionately uninsured[12] due to their previous exclusion from the ACA and their continued exclusion from programs like Medicaid. CMS was right to recognize DACA as lawfully present in 2024. We oppose the proposal to exclude them from the definition.

Denying Coverage for Failure to Pay Past Debts for Prior Coverage (§ 147.104(i))

CMS proposes to allow issuers to condition new coverage on the repayment of outstanding premium debt for prior coverage. This policy violates the statute, will worsen Marketplace risk pools and may lead to more uninsured. For these reasons, we oppose it.

Pursuant to 42 USC 300gg-1 on Guaranteed availability of coverage, as amended by the ACA, the issuer "must accept every… individual in the state that applies" subject to limited exceptions with no exception related to past due premium collections. An issuer that refuses enrollment on the grounds that the funds have been applied to an old debt has violated the guaranteed availability requirements of this section.

Further, allowing these coverage denials will worsen Marketplace risk pools and raise premiums for all consumers, including the unsubsidized. Young and healthy individuals are more price sensitive and less likely to enroll if enrollment requires added payments for past due debts.

---

[11] Svajlenka, N., & Truong, T. Q. (2024, July 29). *The Demographic and Economic Impacts of DACA Recipients: Fall 2021 Edition*. Center for American Progress. https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-%20daca-recipients-fall-2021-edition/

[12] Published: Feb 11, 2025. (2025, March 12). *Key Facts on Deferred Action for Childhood Arrivals (DACA)*. KFF. https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/

In Massachusetts, the Health Connector conducts premium billing on behalf of carriers and reports that it has not seen abuse of grace period and guaranteed issue provisions. They report, and our experience confirms, that individuals who fail to pay for coverage were often assessed higher premiums based on household changes that occurred mid-year. If these individuals are left with no affordable options in the current year based on past debts, it will only increase the number of uninsured.

Denying coverage for Failure to File Taxes and Reconcile after One Year(§ 155.305(f)(4))

CMS proposes to revoke the recent policy waiting for two years before denying future APTC to consumers who may not have filed a tax return reconciling past APTC. Under the proposal, a consumer would lose APTC if the IRS reports that they had not reconciled APTC for a single year instead of the two years under the current rule.

Individuals who fail to reconcile are subject to all the IRS's normal enforcement tools for failing to properly file a return. Denying coverage for failure to reconcile is an added penalty that should not be undertaken lightly. One year's data is not sufficiently reliable considering delays at IRS which are likely to increase exponentially if agency staffing is reduced as planned.[13]Denials for failure to reconcile have also been challenging for consumers to resolve because IRS privacy rules prevent Marketplace notices and Call Center employees from clearly stating that the problem with enrollment is related to tax filing. The requirement effective in 2025 for two years of data from IRS strikes the right balance and should be retained.

As with other proposals making it more difficult to enroll, CMS calls it a corrective to broker fraud and improper enrollment. It states that "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 failure to reconcile status allows ineligible enrollees to accumulate tax liabilities." But the agency offers no data to support this claim. The experience of the Health Connector does not confirm this linkage.

This proposal would be implemented in fall 2025, beginning with the 2026 open enrollment period. Eligibility would be tied to filing a 2024 federal tax return and reconciling APTC to remain eligible for APTC in 2026. This implementation timeline is not feasible on this timeline. In Massachusetts, planning for OE 2026 is already well underway, nor does it seem feasible for the IRS. We urge CMS not to finalize this proposal.

Thank you again for the opportunity to comment.

Yours truly,

Victoria Pulos
Senior Health Law Attorney

[13] Treasury plans to cut up to 50% of IRS enforcement staff, 20% of other components, (April 9, 2025) https://federalnewsnetwork.com/reorganization/2025/04/treasury-plans-to-cut-up-to-50-of-irs-enforcement-staff-20-of-other-components/