ADVOCATES FOR COMMUNITY HEALTH

Robert F. Kennedy, Jr.
Secretary
Department of Health and Human Services

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services

Attention: CMS-9884-P, P.O. Box 8016
7500 Security Boulevard
Baltimore, MD 21244-8016

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

Dear Secretary Kennedy,

Thank you for the opportunity to comment on the Marketplace Integrity and Affordability rule.

Advocates for Community Health (ACH) is comprised of leading federally qualified health centers (FQHCs) driving innovation in our health care systems, policies, and health programs. ACH focuses on advocacy initiatives to affect positive change for FQHCs, the patients they serve, and the entire nation's health care system. Our 44 members serve 3.6 million people in 21 states, Puerto Rico, and the District of Columbia. Together, our membership employs over 50,000 Americans who provide high-quality, comprehensive primary health care, mental health services, preventive care, and social services to patients most in need.

FQHCs, by law, serve all patients regardless of ability to pay. While it varies by state, an average of 12% of health center patients are covered by private insurance, and many of these individuals have purchased insurance through Health Insurance Marketplaces. These families are low to middle income, working-class Americans who often live paycheck to paycheck, and cannot withstand significant changes to their health care costs. Unfortunately, some of the policies proposed would put them in this precarious position, raising the cost of health coverage by hundreds of dollars for most of the 20 million people who get coverage through the Health Insurance Marketplaces.[1] We would like to highlight four policy changes that may be potentially damaging to health center patients and their families.

[1] CMS, Marketplace 2025 "Open Enrollment Period Report: National Snapshot," January 17, 2025, https://www.cms.gov/newsroom/fact-sheets/marketplace-2025-open-enrollment-period-report-national-snapshot-2.

1. **Do not finalize the proposal to change the premium adjustment percentage**. *(Sec. 156.130(e))*

In the proposed rule, CMS proposes to change the rules for calculating the "premium adjustment percentage," a measure of premium growth that is used to make annual updates to several Affordable Care Act ("ACA") coverage parameters. This would result in higher out-of-pocket costs for individuals with commercial health insurance (including the 160 million people with employer-based insurance), lower premium tax credits ("PTC") for Marketplace enrollees, and larger payments under the ACA's employer shared responsibility provision. The proposed changes would expose a typical family to an additional $900 in cost-sharing and $313 in premiums. CMS estimates that this would reduce federal PTC spending by $1.27 billion and enrollment by 80,000 individuals in 2026.

Health centers see many patients with insurance who struggle to afford health care and are obligated by regulation to provide sliding fee programs. In the case of patients with third party coverage, health centers cannot charge more than they otherwise would have paid if they did not have insurance.[2] However, the more patients who need help and support for their cost sharing obligations, the higher the financial burden for the health center. Health centers operate on extremely small margins, and this could create financial risk for America's FQHCs.

2. **Do not finalize the proposal to widen de minimis ranges**. *(Sec. 156.140, 156.200, 156.400)*

CMS proposes to widen the de minimis ranges for health plans' actuarial values, arguing that the change would provide issuers with greater flexibility to increase cost-sharing for consumers, reduce premiums, improve the risk pool, and reduce the likelihood that issuers exit the market. However, the proposed change will result in higher costs for the vast majority of Marketplace enrollees, due to the reduction in advanced premium tax credits (APTCs). That is, due to smaller APTCs, recipients will have to choose either purchasing less comprehensive coverage or paying more in premiums for comparable coverage. CMS's own analysis acknowledges that the expanded de minimis ranges will effectively transfer costs from the government to consumers, by reducing APTCs in 2026 by $1.22 billion, growing to $1.4 billion in plan year 2029.

If the government were to weaken the quality of health plan offerings in the Marketplace, once again, it would increase costs for consumers and for health centers. As providers that treat all patients who walk through the doors, less generous health insurance simply means a greater burden falling on health center providers and frontline staff.

3. **Do not finalize the proposal to shorten open enrollment periods.**

[2] Health Resources and Services Administration. Health Center Program Compliance Manual, Chapter 9: Sliding Fee Discount Program. https://bphc.hrsa.gov/compliance/compliance-manual/chapter9

*(Section 155.410)*

ACH opposes the proposal to shorten the annual open enrollment period (OEP). CMS is proposing to reduce the federally facilitated Marketplace exchange ("FFE")'s enrollment period from 76 to 45 days and prohibit the state-based Marketplace exchanges ("SBEs") from having a longer enrollment period. If finalized, all Marketplace OEPs would be required to run from November 1-December 15. CMS supports this proposed change by suggesting that extending the OEP past December 15 contributes to adverse selection, does not help boost enrollment, and contributes to "consumer confusion." However, the experience of SBEs suggests that longer OEP durations encourage greater enrollment among younger, healthier individuals, thereby strengthening the Marketplace risk pool. For example, average risk scores for individuals enrolling early in Covered California's OEP (before Dec. 15) have consistently been higher than those enrolling after January 1. The trend is striking and consistent across all years and time periods; the later in the OEP consumers enroll, the healthier they are.

At the same time, CMS has slashed Navigator grants by 90%, leaving them without the resources to educate consumers about changing Marketplace policies and with limited capacity to help during the shortened enrollment window. Indeed, CMS acknowledges that it has received concerns from Navigators, agents and brokers, and other consumer assisters that a 45-day OEP is insufficient time for them to fully assist Marketplace applicants with comparing their plan choices. Thus, rather than reducing burdens on Navigators, the proposed shortened OEP will only make it harder for them to provide quality support for their clients. Similarly, shortening the OEP by half will place considerable strain on Marketplace call centers, resulting in longer wait times and a degraded customer experience.

Health centers have long served as a trusted access point for health insurance coverage, working tirelessly to ensure that Americans can access the health care system and obtain the coverage they need. Health centers have vast experience serving many patients who are transient due to changing work locations or financial conditions. An enrollment period of 45 days simply isn't enough time to reach all eligible health center patients and help them navigate the paperwork necessary to enroll. This change will undoubtedly result in a loss of coverage for some of the most vulnerable consumers.

ACH therefore urges CMS not to finalize this proposal, to maintain the current OEP duration of November 1-January 15, and to continue to provide SBEs with the flexibility to determine their own OEP dates. Finalizing this proposal will result in reduced enrollment, a less-healthy risk pool, and higher premiums for Marketplace enrollees. At a minimum, the proposed change to the OEP dates should be delayed until 2027, to mitigate the likely harms consumers will face if Congress does not extend the currently available enhanced APTCs, which will expire in December 2025 without Congressional action.

4. **Do not repeal the special enrollment period for families below the federal poverty level.**
   *(Sec. 155.420)*

CMS proposes to repeal the special enrollment period ("SEP") made available to individuals at or below 150 percent of the federal poverty level ("FPL"), which equals an annual income of $23,475 for an individual, or $48,225 for a family of four. The availability of this SEP has helped low-income consumers access affordable health insurance coverage and maintain access to care. We urge CMS not to finalize this proposal. The low-income SEP has helped millions of individuals overcome challenges enrolling in health coverage. These challenges are particularly acute for lower-income individuals who may lack access to necessary information, face greater employment and household volatility, or reside in areas without sufficient enrollment assistance. These obstacles to health coverage will only be exacerbated if CMS finalizes its proposal to shorten the OEP by almost half, from 76 to 45 days.

The SEP for low-income Americans has been a critically important opportunity for beneficiaries who lose access to health insurance during the calendar year, but whose health needs cannot take a pause. This kind of elimination will undoubtedly lead to worsening health incomes and increased financial burdens for millions of Americans.

## Conclusion

We appreciate the opportunity to provide feedback on the Marketplace Integrity and Affordability rule. For more information, please contact me at apearskelly@advocatesforcommunityhealth.org and/or Stephanie Krenrich, Senior Vice President of Policy and Government Affairs, at skrenrich@advocatesforcommunityhealth.org.

Sincerely,

Amanda Pears Kelly
Chief Executive Officer
Advocates for Community Health