IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

CITY OF COLUMBUS *et al.*, *Plaintiffs*, v. ROBERT F. KENNEDY, JR. *et al.*, *Defendants*.	Case No. 25-cv-2114

PLAINTIFFS' SUBMISSION IN RESPONSE
TO COURT'S AUGUST 15, 2025 MINUTE ORDER

Pursuant to the Court's August 15, 2025 minute order "directing Plaintiffs to file updated perma.cc links by Monday, August 18, 2025 at 5pm in accordance with the instructions sent to the parties by the Court via email," ECF No. 32, Plaintiffs provide below updated perma.cc links to the Urban Institute comment and the National Association of Insurance Commissioners comment cited in Plaintiffs' reply brief, ECF No. 30, at 24. Out of an abundance of caution, Plaintiffs are also providing the original links to each comment from Regulations.gov as well as copies of each comment, which are attached as exhibits to this filing.

Exhibit A, Urban Institute comment (Apr. 11, 2025)

- Perma.cc link: https://perma.cc/R5UM-GDCQ
- Original link: https://www.regulations.gov/comment/CMS-2025-0020-24021

Exhibit B, National Association of Insurance Commissioners comment (April 10, 2025)

- Perma.cc link: https://perma.cc/C4PM-7QZ4
- Original link: https://www.regulations.gov/comment/CMS-2025-0020-19406

Dated: August 17, 2025

Respectfully submitted,

/s/ Joel McElvain
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URBAN INSTITUTE · ELEVATE · THE · DEBATE

April 11, 2025

Administrator Mehmet Oz, MD
Centers for Medicare & Medicaid Services
Attention: CMS-9884-P, PO 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 Administrator Oz:

I write to offer public comment on CMS-9884-P Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability published on March 19, 2025. I am a senior fellow at the Urban Institute, hold a PhD in economics from the University of Maryland at College Park, and have worked in the field of health care economics and policy for more than 30 years. Prior to my current position, I worked at the US Congressional Budget Office. I have published numerous peer-reviewed journal articles and web-based research reports. My current employer, the Urban Institute, is a nonprofit research and policy organization, but the views expressed here are my own and do not represent the Urban Institute, its trustees, or its funders.

In my comment, I provide evidence that the justification for these proposed rules is based on a biased and overstated estimate of improper exchange enrollment due to three serious methodological flaws in the CMS analysis: (1) failing to exclude children from the exchange enrollment data when comparing with a population of adults; (2) comparing 2023 American Community Survey (ACS) data with 2024 exchange enrollment data without accounting for substantial changes in Medicaid enrollment during this period; and (3) ignoring inconsistent measures of income when comparing ACS data with exchange enrollment.

For questions or to schedule a follow-up dialogue, please reach out to jdavenport@urban.org.

Sincerely,

Jessica Banthin, PhD
Senior Fellow
Urban Institute

The recent payment notice aims to increase program integrity in the exchange and reduce "improper enrollment." Many of the proposed changes will impose new administrative burdens on people who seek health insurance coverage through the exchange and, as a result, the Centers for Medicare & Medicaid Services (CMS) estimates that between 750,000 and 2 million fewer people would enroll.

In my comment, I provide evidence that the justification for these proposed rules is based on an overstated and biased estimate of improper enrollment due to three serious methodological flaws in their research.

Program integrity is an important goal. But the extent of improper enrollment in the exchange and the cost to taxpayers is substantially overstated by one of the key sources cited in the notice—a report by the Paragon Institute—due to methodological flaws and data limitations.[1] Moreover, updated research conducted by CMS and included in the payment notice recreates the same methodological errors. By overstating the extent of improper enrollment in the exchange, the administration is justifying an array of changes to the enrollment process that will deter many eligible people from enrolling in the program.

My own research produced jointly with colleagues, and also cited in the notice, provides evidence of some improper enrollment in the marketplace by people with incomes below the eligibility threshold of 100 percent of the federal poverty line (FPL) from 2015 to 2017.[2] However, we refrain from estimating the exact number of people who enroll improperly for two major reasons: (1) a conceptual inconsistency between the two data sources in how income is measured, as discussed below; and (2) it is not improper or fraudulent for people seeking coverage in the exchange, who are required to project their income for the coming year, to anticipate that it will be greater than that of the previous year. As we noted in that piece, "Given the high income volatility among low-income families, these results do not necessarily prove that ineligible people are signing up for marketplace coverage. Eligibility for advanced PTCs is based on an enrollee's expected annual MAGI [modified adjusted gross income] for the coming year rather than on point-in-time income at the time of enrollment. This amount is hard to estimate, especially for households whose members may work part-time or seasonally, expect to change jobs, or are self-employed." Given the level of imprecision in measuring income, we refrained from concluding there was improper enrollment, with the exception of one state (Florida) where the data told an overwhelming and clear story.

The Paragon report compares the number of people enrolled in the exchange according to administrative enrollment data, the numerator, with the number of people with similar incomes who live in the same state according to household survey data from the American Community Survey (ACS), the denominator. Examining data for each state and focusing on a narrow income range (incomes between 100 and 150 percent of the FPL), Paragon researchers conclude there is fraudulent enrollment in the exchange if the numerator exceeds the denominator. The CMS repeated this approach and has updated their analysis for 2024.

However, three major methodological flaws in the Paragon report and in the CMS's analysis are as follows:

- Researchers failed to define the numerator in a manner consistent with the denominator regarding the age of enrollees. By failing to exclude children from the exchange enrollment data, the estimate of "improper enrollment" is overstated, even more so in states with large shares of children in the exchange. For example, in Utah, children account for a larger share of total exchange enrollment than in any other state (28.4 percent versus 9.7 percent for all other states, according to open enrollment data for 2024).[3] The fact that Utah is listed by CMS as one of the top 10 states with

[1] Brian Blase and Drew Gonshorowski, *The Great Obamacare Enrollment Fraud* (Washington, DC: Paragon Health Institute, 2024).

[2] Benjamin Hopkins, Jessica Banthin, and Alexandra Minicozzi, "How Did Take-Up of Marketplace Plans Vary with Price, Income, and Gender?" *American Journal of Health Economics* 1 (11) (2025), https://doi.org/10.1086/727785.

[3] Author's tabulations of open enrollment period data for 2024. "2024 Marketplace Open Enrollment Period Public Use Files," Centers for Medicare & Medicaid Services, accessed April 10, 2025, https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files.

excess enrollment suggests that this inconsistency in age definition may be causing substantial bias in their estimates.

- There is a mismatch in the period of observation between data from the exchange and data from the ACS. Specifically, the notice uses 2023 ACS data to assess improper exchange enrollment in 2024, failing to account for substantial changes in Medicaid enrollment during this period due to the unwinding of the Medicaid continuous coverage requirement. The Medicaid unwinding substantially reduced the number of people enrolled in Medicaid, from about 94 million people in early 2023 to about 79 million people by late 2024—a decrease of roughly 15 million people.[4] The decrease in Medicaid enrollment thus increased the number of people potentially eligible for enrollment in the exchange. As a result, the denominator is too small when comparing 2023 ACS data with 2024 exchange enrollment and yields an overestimate of excess enrollment in 2024.
- There is a fundamental inconsistency in measures of income between the ACS and exchange enrollment data. The ACS asks one respondent to report income for the entire family or household for the current year. It is widely accepted that survey data tend to underestimate family and household income relative to tax data.[5] In contrast, the exchange enrollment process requires potential enrollees to predict their income for the next year to calculate premium tax credits rather than report their income for the current year. These two values can be quite different for legitimate reasons.

All three of these methodological flaws bias estimates of improper exchange enrollment in the same direction, leading to an overestimate. A more accurate estimate of improper exchange enrollment would be lower and would therefore reduce the need for so many new and burdensome changes in the exchange enrollment process.

[4] "Medicaid Enrollment and Unwinding Tracker," KFF, March 31, 2025, https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-enrollment-data/.

[5] John L. Czajka, "Income and Poverty Measurement in Surveys of Health Insurance Coverage," in *Databases for Estimating Health Insurance Coverage for Children: A Workshop Summary* (Washington, DC: National Academies Press, 2010), 109–40.

NAIC NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

April 10, 2025

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9884-P
P.O. Box 8016
Baltimore, MD 21244-8016

Via Regulations.gov

To whom it may concern:

The following comments on the proposed 2025 Marketplace Integrity and Affordability Proposed Rule (Proposed Rule), as published in the Federal Register on March 19, 2025, are submitted on behalf of the National Association of Insurance Commissioners (NAIC) which represents the chief insurance regulators in the 50 states, the District of Columbia, and 5 U.S. Territories.

Rule Timing Relative to Plan Year 2026

State regulators wish to express great concern about the timing of the Proposed Rule given that it proposes myriad changes to plan design and marketplace operations for plan year (PY) 2026. NAIC urges CMS to reconsider the timing of the implementation of at least some provisions of the Proposed Rule due to the additional burdens they place on regulators, marketplaces, health insurers, and consumers for PY 2026.

With enhanced premium tax credits set to expire at the end of 2025 and potential Congressional action on health programs like Medicaid, significant uncertainty already surrounds the 2026 markets. Several provisions proposed in this rule only add to that uncertainty. At this point in the year, health insurers have already completed their PY 2026 plan designs and must soon submit rates to their state regulators. Insurers need to know the rules under which they will be operating to fully weigh their options and develop appropriate plans and rates. They will not know the rules until this proposal is finalized, so we expect rate increases to result from the uncertainty generated by these late rule changes, as well as uncertainty over enhanced premium tax credits. To implement these changes for PY 2026 will present significant challenges and could add to consumer and federal costs.

The changes such as increasing consumers' maximum out-of-pocket costs, allowing issuers to design plans with reduced actuarial values, and adding a $5 monthly penalty for consumers who do not actively re-enroll in coverage could encourage consumers to leave the market. The impact of these changes could result in fewer individuals enrolled in coverage in 2026 than in 2025, with those who are youngest and healthiest being most likely to drop or not pursue coverage in 2026. Resulting

coverage losses would compromise the integrity and health of the risk pool, discourage carrier participation, lead to higher premiums, and destabilize state insurance markets. The possible extent of these changes and their impact on individual market risk pools needs to be known before plans and rates can be established for PY 2026.

The Proposed Rule would place new requirements on consumers, as well, such as additional paperwork submissions and the new $5 premium for some. It is critical that consumers understand these requirements before they go into effect. The required implementation of these changes for PY 2026 will present substantial consumer education challenges, especially in light of the substantial reductions in Navigator funding and the proposed open enrollment period reduction.

Finally, the additional administrative and systems changes that would be required of State-Based Marketplaces (SBMs) under this Proposed Rule will be burdensome and costly if they need to be implemented for PY 2026.

Given the concerns expressed above, we encourage CMS to move the implementation date of the new rules to PY 2027. If any changes are to be effective for PY 2026, the final rule must be published as soon as possible, preferably within a month of the comment deadline.

Comment Deadline

As we have noted with respect to past proposed rules, a 30-day comment period is too brief for a rule that proposes these many changes to complex policies applicable to health insurance issuers, regulators, marketplaces, and consumers. We urge CMS to provide a longer comment period in the future to allow stakeholders an adequate opportunity to analyze the proposed changes and formulate useful comments.

State Flexibility on the Open Enrollment Period

The Proposed Rule would require all states to run their Annual Open Enrollment period (OEP) exclusively from November 1 to December 15, with coverage beginning January 1 of the following year. There are valid operational and consumer protection reasons for states setting an OEP that varies from the Federal dates, such as providing additional time for consumers to make informed decisions about their coverage and allowing for flexibility in plans' start dates.

NAIC encourages CMS to allow SBMs to set OEP dates that best meet the needs of their consumers and markets, beginning before November 1 if the state chooses, or ending after December 15. Indeed, many SBMs have maintained consistent OEP dates that consumers and stakeholders have come to know and expect, providing market stability. Regulators do not believe that requiring SBMs to abandon existing consistency within their states to align with federal OEP dates provides any tangible benefits for consumers. Extending the Open Enrollment Period into January provides consumers with more time to choose a plan and provides the opportunity for plan switching for a brief period after the benefit year begins. A majority of SBMs have used their authority to extend open enrollment beyond December 15 but not all have chosen to do so. Some have chosen to extend later in December, but not into January. To avoid disruption in these states and preserve state flexibility, we urge this change to be made optional for SBMs.

State Flexibility on Other Proposals

A number of other provisions in the Proposed Rule would limit the ability of SBMs to make their own choices and require them to adopt changes to their operations for PY 2026. The Proposed Rule would require SBMs to take action based on a single fail-to-reconcile notice; end extensions of the deadline for consumers to file paperwork to resolve income inconsistencies; stop the practice of reenrolling consumers into plans that save them money; and verify a greater share of special enrollment periods. The Proposed Rule also includes new limitations on the ability of states to establish their Essential Health Benefits (EHB), which impacted states will not have enough time to comply with if this provision goes into effect for PY 2026.

State regulators object to these limits to state authority. We urge CMS to maintain state flexibility in these areas permanently. If state flexibility is removed in these areas, states should be given sufficient time to make the necessary changes.

Auto-Reenrollment

The Proposed Rule would require two substantive changes to the auto-reenrollment process. It would establish a $5 monthly premium for consumers who are automatically re-enrolled and previously qualified for a monthly premium of $0 until the consumer actively confirms eligibility and enrollment. It also would remove the option for Marketplaces to re-enroll consumers who had selected a bronze plan into a silver plan, when that silver plan costs them the same or less and includes the same provider network. Both of these changes would be most burdensome on those who can afford it the least.

State regulators share the goal of ensuring that only eligible consumers receive premium tax credits. At the same time, we do not believe Marketplaces should establish unnecessary barriers to enrollment or continued enrollment. Current practices seek to ensure continued eligibility: consumers are required to report changes in their eligibility information to Marketplaces; the auto-reenrollment process includes checks of income and other eligibility data; and the reconciliation requirement at tax filing serves as a backstop to recoup improper APTCs. Adding the $5 premium as a barrier to continued enrollment would help to encourage some enrollees to update their information. However, it is also likely to lead some eligible enrollees to lose coverage, as a state entity would be required to withhold a federal tax benefit from its consumers, potentially without the consumer's awareness. We urge CMS to make this policy optional for SBMs, at the very least.

Re-enrolling consumers with bronze plans into silver can be very beneficial for consumers who qualify for cost-sharing reductions. State regulators recognize that some consumers lack understanding of the elements of health insurance cost-sharing, such as co-pays and deductibles. The concept of actuarial value is even less well understood, let alone that cost-sharing reductions are available only in silver plans. Consumers may enroll in bronze plans because they are unaware of the benefits of silver plans, invested too little time in choosing a plan and made their plan choice based exclusively on premium without fully understanding their total financial exposure when deductibles and cost-sharing are included, or received incomplete advice from a producer or assister. Nonetheless, some consumers may choose bronze plans knowing the benefits they are forgoing—current policy allows them to change back to a bronze plan if they are auto-reenrolled into silver. We support giving Marketplaces the option of retaining this feature of the reenrollment hierarchies so that SBMs can choose whether the revised hierarchy is in the best interests of consumers and insurance markets in their states.

Special Enrollment Period for Consumers with Low Income

The Proposed Rule would end the monthly Special Enrollment Period for consumers eligible for APTC with income below 150% of the federal poverty level. As we pointed out in our comments when the policy was codified in the 2022 Notice of Benefit and Payment Parameters, the ongoing SEP creates some risk of adverse selection and increased premiums. However, we supported the option for SBMs to implement the policy and we continue to believe SBMs should have the choice.

We also urge CMS to take additional steps to combat unauthorized enrollments or plan transfers. We do not believe that the under 150% SEP is a major contributor to such improper practices – it was not a major problem for SBMs, which seems to indicate that FFM procedures are the key issue. CMS has already implemented system changes to limit unauthorized enrollments and has taken a more timely approach to suspending and terminating producers suspected of improper practices. We urge continued and expanded efforts in these areas to address vulnerabilities in the federal marketplaces, regardless of the final policy on special enrollments for low-income consumers.

Co-Pay Accumulator Enforcement

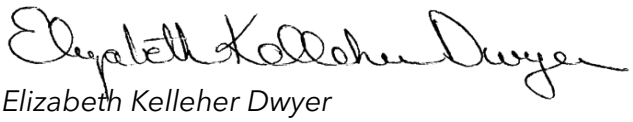
State insurance regulators urge CMS to move forward with rulemaking to clarify whether health insurers may operate co-pay accumulator programs and disregard the value of co-pay assistance provided by drug manufacturers or other third parties. After its co-pay accumulator rule was invalidated by judicial action in 2023, CMS has chosen not to enforce the previous rule. Some states have chosen to do so, but the lack of enforcement or clarity from federal regulators has introduced challenges. We ask CMS to publish a new rule on this topic as soon as possible and we would welcome the opportunity to share more state perspectives on enforcement.

Thank you for your consideration of these comments. We again strongly urge you to continue the historical position of state deference as you look to finalize this Proposed Rule. The flexibility afforded states in developing their Marketplaces has led to record enrollment across many of the SBMs and states have continued to develop innovative programs for the benefit of their constituencies. We welcome continued collaboration with CMS on our shared goals of healthy markets and consumer protection.

Sincerely,

Jon Godfread
NAIC President
Commissioner
North Dakota Insurance Department

Scott White
NAIC President-Elect
Commissioner
Virginia Bureau of Insurance



Elizabeth Kelleher Dwyer
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