**No. 26-1938**

**IN THE UNITED STATES COURT OF APPEALS**
**FOR THE FOURTH CIRCUIT**

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CITY OF COLUMBUS, *et al.*,
*Plaintiffs-Appellees*,

v.

ROBERT F. KENNEDY, JR., *in his official capacity as Secretary of the United States Department of Health and Human Services, et al*,
*Defendants-Appellants*.

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On Appeal from the United States District Court
for the District of Maryland

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# JOINT APPENDIX
# VOLUME I OF III

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**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

| | | |
|---|---|---|
| CITY OF COLUMBUS ET AL., | * | |
| Plaintiffs, | * | |
| v. | * | |
| ROBERT F. KENNEDY, JR. ET AL., | * | Civil No. 25-2114-BAH |
| Defendants. | * | |

* * * * * * * * * * * * * *

**MEMORANDUM OPINION**

Plaintiffs filed suit under the Administrative Procedure Act ("APA") seeking to prevent Defendants from implementing changes to federal regulations enforcing the Patient Protection and Affordable Care Act (the "ACA," or the "Act"). ECF 1 (complaint). These changes, embodied in the Marketplace Integrity and Affordability Rule (the "Rule"), were set to take effect on August 25, 2025. *See* Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 27,074 (June 25, 2025). Plaintiffs—three cities, a coalition of doctors, and an interest group representing small business owners—allege they will shoulder increased costs or see their members lose health insurance coverage if these changes are implemented. *See* ECF 1; ECF 65 (motion for summary judgment). Defendants, the Secretary of the Department of Health and Human Services ("HHS") and many in his employ charged with crafting and implementing the Rule,[1] counter that changes to ACA-related regulations are needed to prevent

[1] Throughout this opinion, the Court occasionally refers to the taker of the administrative actions on review as "the agency," following the example of the parties. *See, e.g.*, ECF 65-1, at 30; ECF 68-1, at 18.

fraud and to readjust the cost of health insurance. *See* ECF 68 (cross-motion for summary judgment).

The Court previously granted in part and denied in part Plaintiffs' motion to stay the Rule pursuant to 5 U.S.C. § 705 pending a final ruling on the merits of the instant matter. *See* ECF 11 (motion to stay); ECF 35 (memorandum opinion); ECF 36 (order); ECF 38 (amended order). The Court found that Plaintiffs had shown a likelihood of success on the merits of their challenge to seven provisions of the Rule. *See* ECF 38. Defendants have appealed the Court's decision to the United States Court of Appeals for the Fourth Circuit, arguing that Plaintiffs lack standing and that the Court erred in finding that Plaintiffs demonstrated a likelihood of success on their challenges to two provisions of the Rule.[2] *See* ECF 39. That appeal remains pending, and Defendants have been denied a stay pending appeal by both this Court and the Fourth Circuit. *See* ECF 49; ECF 52.

In the interim, the parties jointly moved to proceed on the merits in this Court "to account for the rate filing season for 2027." *See* ECF 57, at 2. Both parties seek a decision on the merits through cross-motions for summary judgment based on the administrative record. *Id.* The Court entered the parties' proposed briefing schedule, and the cross-motions for summary judgment are now ripe for resolution. *See* ECF 65 (Plaintiffs' motion for summary judgment); ECF 68 (Defendants' cross-motion for summary judgment); ECF 70 (Plaintiffs' reply); ECF 71 (Defendants' reply). All filings include memoranda of law, and Plaintiffs' motion includes an addendum of administrative record materials.[3] Accordingly, for the reasons stated below,

[2] That appeal has been docketed as Case No. 25-2012.

[3] Defendants also produced the complete administrative record to Plaintiffs via a digital vile sharing service and to the Court by mailing a flash drive. ECF 62, at 1. From this complete record, Plaintiffs compiled their addendum of record materials in support of their motion. *See* ECF 65-2

Plaintiffs' motion for summary judgment is **GRANTED in part and DENIED in part** and Defendants' cross-motion for summary judgment is **GRANTED in part and DENIED in part.**[4]

## I. BACKGROUND

### A. The Affordable Care Act

In 2010; Congress enacted the ACA "to increase the number of Americans covered by health insurance and decrease the cost of health care." *NFIB v. Sebelius*, 567 U.S. 519, 538 (2012). "Prior to the enactment of the ACA, individual health insurance markets were dysfunctional." *City of Columbus v. Trump*, 453 F. Supp. 3d 770, 778 (D. Md. 2020) ("*City of Columbus I*").[5] The ACA "adopts a series of interlocking reforms designed to expand coverage in the individual health insurance market."[6] *King v. Burwell*, 576 U.S. 473, 478–79 (2015). Individual market health plans are referred to as qualified health plans ("QHPs"). Individuals primarily enroll in QHPs for

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(Volume 1); ECF 65-3 (Volume 2). The Court references all filings by their respective ECF numbers and page numbers by the ECF-generated page numbers at the top of the page.

[4] Given the Court's earlier decision on the motion to stay under 5 U.S.C. § 705, *see City of Columbus v. Kennedy*, 796 F. Supp. 3d 123 (D. Md. 2025) ("*City of Columbus III*"), the parties "essentially ask this Court to decide the same issues, on the same record, for a second time," *Am. Fed'n of Tchrs. v. Dep't of Educ.*, 796 F. Supp. 3d 66, 81 (D. Md. 2025). In the interests of judicial economy, where the Court reaches the same conclusion as it did in *City of Columbus III*, it repeats its prior analysis, often verbatim. However, the Court stresses that it reaches its conclusions anew after review of the full record and with the benefit of fulsome briefing. Moreover, since the facts are undisputed and the Court previously held a lengthy hearing on the prior motion at ECF 11 addressing the same rule change, no additional hearing is necessary. *See* Loc. R. 105.6 (D. Md. 2025).

[5] The Court frequently cites two prior opinions by Judge Chasanow, which included the same City Plaintiffs involved in this case. One opinion is from 2020 and addresses a motion to dismiss. *See City of Columbus*, 453 F. Supp. 3d at 770 ("*City of Columbus I*"). The other opinion, from the same case, addresses the parties' cross-motions for summary judgment. *See City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021) ("*City of Columbus II*").

[6] "Individual health insurance is insurance that individuals purchase themselves, in contrast to, for example, joining employer-sponsored group health plans." *City of Columbus I*, 453 F. Supp. 3d at 778 (citation omitted).

a given benefit year during an annual open enrollment period, or under specified special enrollment periods. 42 U.S.C. § 18031(c)(6). Ultimately, the ACA "aims to achieve systemic improvements in the individual health insurance market by means of certain key reforms[.]" *City of Columbus I*, 453 F. Supp. 3d at 778.

First, the ACA's "guaranteed issue" requirement specifies that every "health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage," 42 U.S.C. § 300gg-1(a), subject to exceptions specified in the statute, such as limiting sign-ups to the aforementioned enrollment periods, *id.* § 300gg-1(b); *see Me. Cmty. Health Options v. United States*, 590 U.S. 296, 301 (2020). "In other words, the Act 'ensure[s] that anyone can buy insurance.'" *Me. Cmty. Health Options*, 590 U.S. at 301 (quoting *King*, 576 U.S. at 493).

Second, the ACA's "guaranteed renewability" provision mandates that "the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual." 42 U.S.C. § 300gg-2(a). This provision, too, is subject to statutory exceptions, including an exception for persons who have failed to pay premiums owed on their policy. *Id.* § 300gg-2(b)(1); *see also id.* §§ 300gg-12, 300gg-42.

Third, the ACA requires all QHPs to cover "essential health benefits" and limits cost-sharing (in the form of deductibles and co-pays) by enrollees for these essential health benefits. 42 U.S.C. § 300gg-6(a); *id.* § 18022(a)(2). The limitation on cost-sharing is adjusted each year by a "premium adjustment percentage," which is "the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year . . . exceeds such average per capita premium for 2013," the year before the ACA's reforms to the individual health insurance market went into effect *Id.* § 18022(c)(1), (4).

Fourth, the ACA "requires the creation of an 'Exchange' in each State where people can shop for insurance, usually online." *King*, 576 U.S. at 479 (quoting 42 U.S.C. § 18031(b)(1)); *see also Me. Cmty. Health Options*, 590 U.S. at 301. The Act "gives each State the opportunity to establish its own Exchange, but provides that the Federal Government will establish the Exchange if the State does not." *King*, 576 U.S. at 479; *see also* 42 U.S.C. §§ 18031, 18041. The purpose of the Exchange is to serve as a "marketplace that allows people to compare and purchase" ACA-compliant plans.[7] *Id.*

Fifth, exchange plans are categorized into different "metal tiers"—bronze, silver, gold, and platinum—based on their "level of coverage." 42 U.S.C. § 18022(d) (setting the "level of coverage" for each of the plan types). For example, "silver plans," must have an actuarial value of 70%, meaning the plan is designed such that the issuer will pay around 70% of covered medical expenses, and the enrollee will pay the remaining 30% of expenses through out-of-pocket spending.[8] *Id.* Because actuarial predictions may be imprecise, the ACA specifies that the Centers for Medicare & Medicaid Services ("CMS"), an agency within HHS, may "provide for a de minimis variation . . . to account for differences in actuarial estimates." *Id.* § 18022(d)(3).

Sixth, the ACA "seeks to make insurance more affordable by giving refundable tax credits to individuals[.]" *King*, 576 U.S. at 482 (citing 26 U.S.C. § 36B). These "premium tax credits"

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[7] As Plaintiffs describe, "[s]ome states have elected to create Exchanges themselves (state-based Exchanges or SBEs), as is the case in Maryland, while others have created Exchanges that operate on the federal Healthcare.gov platform (state-based Exchanges on the federal platform, or SBE-FPs), such as the Exchange that Illinois used in 2025 while it transitioned to an SBE. The Exchange in other states, including Ohio, is operated by the Centers for Medicare & Medicaid Services (CMS) (federally facilitated Exchange, or the FFE)." ECF 65-1, at 11 (citing CMS, Consumer Info. & Ins. Oversight, *State-Based Exchanges*, https://perma.cc/JFT3-6EAK).

[8] Bronze, gold, and platinum plans are designed to provide benefits that are actuarially equivalent to 60%, 80%, and 90%, respectively, of the full value of benefits under the plan. 42 U.S.C. § 18022(d)(1).

("PTCs") vary depending on an individual's income—individuals who earn more must pay more toward the cost of their monthly premium—but are generally pegged to the cost of the so-called "benchmark silver plan," or the second-lowest-cost silver plan offered within a market. *See, e.g.*, 26 U.S.C. § 36B(b)(3)(B)–(C). The ACA initially made these tax credits available to individuals with incomes between 100% and 400% of the federal poverty level ("FPL"). 26 U.S.C. § 36B(c)(1)(A). However, during the COVID-19 pandemic, Congress—via the American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4 ("ARPA")—temporarily increased the generosity of the ACA's premium subsidies and expanded subsidy eligibility to enrollees with household incomes above 400% of the FPL. The 2022 Inflation Reduction Act, Pub. L. No. 117-169, 136 Stat. 1818 ("IRA"), extended these enhanced subsides through 2025.

PTCs are claimed on an individual's tax return after the end of the year, and are paid by the Internal Revenue Service ("IRS"). 26 U.S.C. § 36B(h). Rather than an enrollee paying the entire insurance premium up front and then later claiming a credit toward that amount on the taxpayer's tax return, HHS—the federal agency that largely administers the ACA—may also make an advance payment of the premium tax credit amount directly to the enrollee's insurance provider. 42 U.S.C. §§ 18081, 18082. Such credits are known as advance premium tax credits ("APTCs"). "APTCs act as a subsidy for low-income individuals who could not afford to purchase insurance outright." *City of Columbus II*, 523 F. Supp. 3d at 741. CMS is responsible for determining whether individuals meet the statutory eligibility requirements for APTCs, as well as for "redetermin[ing] eligibility on a periodic basis in appropriate circumstances." 42 U.S.C. § 18081(f)(1)(B). The amount of the APTC owed ultimately depends on the individual's income at the end of the year. Thus, individuals must file a federal tax return each year to "reconcile" the

APTCs they received with the PTC amount they qualify for based on their actual income during the applicable tax year. *See* 26 U.S.C. § 36B(f)(1).

"Each year, HHS promulgates rules pursuant to its rulemaking authority under the ACA and the Public Health Service Act ('PHS Act'). Such rules are the mechanisms by which HHS makes ongoing adjustments to the regulations and processes surrounding ACA insurance markets." *City of Columbus II*, 523 F. Supp. 3d at 741.

**B. The Marketplace Integrity and Affordability Rule**

On March 19, 2025, CMS issued a Notice of Proposed Rulemaking for a proposed rule that would implement "several regulatory actions aimed at strengthening the integrity of the [ACA] eligibility and enrollment systems to reduce waste, fraud, and abuse." 90 Fed. Reg. 12,942 (Mar. 19, 2025). CMS explained that it "expect[ed] these actions would provide premium relief to families who do not qualify for [ACA] subsidies and reduce the burden of . . . [ACA] subsidy expenditures on the Federal taxpayer." *Id.* CMS received more than 26,000 comments on the proposed rule. After reviewing those comments and revising certain provisions of the proposed rule, HHS issued (and publicly released) the Rule on June 20, 2025, and it was published in the Federal Register on June 25. 90 Fed. Reg. 27,074.

As relevant here, the Rule implements policies concerning the effectuation of new Exchange coverage when a customer owes past-due premiums to an issuer, *id.* at 27,084–91; the requirement that recipients of APTCs file a federal tax return and reconcile those APTCs with the recipient's PTC amount, *id.* at 27,113–17; and the procedures HHS uses to annually redetermine Exchange enrollees' eligibility to receive APTCs, *id.* at 27,102–10. The Rule additionally makes changes to the procedures that HHS uses to verify enrollees' eligibility for APTCs, *id.* at 27,118–32; pauses an income-based special enrollment period ("SEP"), *id.* at 27,140–48; and amends

certain verification procedures that apply to SEPs, *id.* at 27,148–52. The Rule also updates the methodology used to calculate the "premium adjustment percentage," *id.* at 27,166–74, and makes adjustments to the allowable ranges of actuarial values applicable to the different plan types sold on Exchanges, *id.* at 27,174–78.

HHS explained in the Rule's preamble that, "[b]ased on [its] review of enrollment data and [its] experience fielding consumer complaints," it believes that the "temporary expansion of ACA premium subsidies" via the ARPA and the IRA "resulted in conditions that were exploited to improperly gain access to fully-subsidized coverage" on Exchanges. *Id.* at 27,074. More specifically, "the widespread availability" of fully subsidized plans—*i.e.*, plans with post-subsidy net premiums of $0—"created the incentive and opportunity for fraudulent and improper enrollments at scale," either by individual enrollees wanting no-cost Exchange coverage or by third-party brokers that collected commissions on improper enrollments made without customers' knowledge. *Id.* The Rule purports to "take[] a carefully curated set of temporary actions to immediately reduce the crisis-levels of improper enrollments over the short-term as the market readjusts to the new subsidy environment in which enhanced subsidies are no longer available." *Id.* The Rule also implements a number of "permanent reforms to help the markets reset to the changing subsidy environment to improve affordability and stability over the long-term." *Id.*

Plaintiffs contend that the Rule "contains a number of provisions that, in their individual and collective effect, would raise consumers' premiums for plans on the Exchanges, limit coverage under those plans, and deter millions of individuals from enrolling in coverage, leading to higher uncompensated care costs for providers of last resort." ECF 65-1, at 13–14. According to Plaintiffs, the Rule "will lead to at least 1.8 million fewer people enrolling on the Exchanges." *Id.* at 14 (citing Young Decl. ¶ 4). Plaintiffs argue that the Rule "accomplishes this result through

measures that erode the value of coverage obtained through the Exchanges, impose barriers designed to depress enrollment in the Exchanges, and impose further barriers limiting the availability of subsidized insurance even for those enrollees that do successfully enroll." *Id.*

The Rule was originally set to take effect on August 25, 2025, 90 Fed. Reg. 27,074, but many of its provisions would have applied to Exchange plans that would first become available in 2026, *see id.* at 27,178–79.

**C. Procedural History**

Plaintiffs are three city governments—the City of Columbus, Ohio; the Mayor and City Council of Baltimore, Maryland; and the City of Chicago, Illinois (collectively the "City Plaintiffs")—and two nonprofit organizations, Main Street Alliance ("MSA"), a "national network of small businesses," and Doctors for America ("DFA"), an advocacy organization consisting of "member physicians and medical trainees . . . in all 50 states." ECF 1, at 5–6 ¶¶ 8–12. Plaintiffs seek review of agency action under the APA, claiming that several of the Rule's provisions are contrary to law (Count I), and that those same provisions plus several others are arbitrary and capricious (Count II). *Id.* at 26 ¶¶ 74–82.

On July 2, 2025, Plaintiffs filed a motion for preliminary relief, in which they sought a stay of the August 25, 2025 effective date of the challenged Rule provisions under 5 U.S.C. § 705 or, in the alternative, a preliminary injunction. *See* ECF 11. The Court held a hearing on the Motion on August 14, 2025. *See* ECF 34 (Tr. of Hearing). On August 22, 2025, the Court issued a memorandum opinion and order granting in part and denying in part Plaintiffs' motion, construed as a motion for a stay under 5 U.S.C. § 705. *See* ECF 35 (memorandum opinion); ECF 36 (order). The Court's order stayed the effective dates of certain provisions of the Rule pursuant to 5 U.S.C. § 705 while this litigation remains pending. *See* ECF 38. Now the parties seek to resolve the litigation through cross-motions for summary judgment.

## II. JURISDICTION

As an initial matter, the Court assures itself of jurisdiction. The proposition that an "interlocutory appeal does not divest the district court of jurisdiction to resolve the *merits* of a suit" has been described as an "unremarkable" one. *CASA, Inc. v. Trump*, 791 F. Supp. 3d 606, 612 (D. Md. 2025) (emphasis in original). Taking such a course is widely understood to comport with the *Griggs* principle, or the principle that "[a]n appeal, including an interlocutory appeal, 'divests the district court of its control over those aspects of the case involved in the appeal.'" *Coinbase, Inc. v. Bielski*, 599 U.S. 736, 740 (2023) (quoting *Griggs v. Provident Consumer Discount Co.*, 459 U.S. 56, 58 (1982)). Ordinarily, the Court would have no pause in concluding that its resolution of the pending motions accords with *Griggs*, especially considering that Defendants only challenge two of the Court's holdings as to Plaintiffs' likelihood of success on the merits in the interlocutory appeal. *See* USCA4 Case No. 25-2012, at ECF 28.

However, the issue of Plaintiffs' standing is also on appeal, which may present some question about this Court's jurisdiction to proceed with the merits given the concerns expressed by dissenters in the Supreme Court's relatively recent opinion in *Coinbase, Inc. v. Bielski*. In that case, which concerned the denial of a motion to compel arbitration, the dissent expressed concern that the majority's reasoning concluding that *Griggs* required an automatic stay of proceedings when such a motion is appealed could be extended to "any interlocutory appeal on a dispositive issue." *Coinbase, Inc.*, 599 U.S. at 760–61 (Jackson, J., dissenting, joined by Sotomayor & Kagan, JJ., in full & Thomas, J., in part). "How far *Coinbase* extends is an active subject in the federal appellate courts." *City of Martinsville v. Express Scripts, Inc.*, 128 F.4th 265, 269 (4th Cir. 2025). And the Fourth Circuit recently concluded that *Coinbase*'s logic encompasses appeals taken pursuant to the federal officer removal statute. *See id.* at 271.

Nevertheless, in *City of Martinsville*, the Fourth Circuit cautioned in a footnote that its decision should not be read to "imply that the *Griggs* principle will sweep broadly in other interlocutory appeals." *Id.* at 270 n.3. "Interlocutory appeals taken from collateral orders," the Fourth Circuit explained, "will ordinarily come with narrow automatic stays because a collateral order must, by definition, be 'completely separate from the merits of the action.'" *Id.* (quoting *Flanagan v. United States*, 465 U.S. 259, 265 (1984)). The Court concludes that it has jurisdiction to proceed with the merits here, in accordance with the well-recognized proposition that an interlocutory appeal of preliminary injunctive relief analogous to a § 705 stay does not deprive a Court of jurisdiction to proceed on the merits. Moreover, the parties filed a joint motion at the Fourth Circuit to enter a briefing schedule that ripens after this Court's resolution of the pending motions for summary judgment, which the Fourth Circuit granted, perhaps suggesting that the Fourth Circuit agrees (or at least is not alarmed by) a resolution on the merits in this Court while the appeal is pending. *See* USCA4 Case No. 25-2012, at ECF 36 (motion for extension), at ECF 37 (order granting motion to extend filing time and noting no further extensions will be granted).

But consistent with the *Griggs* principle, the Court will not address Defendants' renewed contention in their cross-motion for summary judgment that "Plaintiff Doctors for America [ ] does not have standing." ECF 68-1, at 13. That issue is an aspect of the case involved in the pending appeal. Should the Fourth Circuit have reason to conclude that this Court does not have jurisdiction to resolve the pending motions for summary judgment, the Court notes that it would have issued this opinion as an indicative ruling pursuant to Fed. R. Civ. P. 62.1 in order to facilitate the expeditious resolution of this case as the parties have requested. *Cf. CASA, Inc.*, 791 F. Supp. 3d at 614 (using an indicative ruling to indicate how the Court would decide a pending motion it could not rule on in light of a pending interlocutory appeal).

## III. LEGAL STANDARD

### A. Summary Judgment

Plaintiffs have brought their claims as an APA challenge. *See* ECF 1. "Because claims brought under the APA are adjudicated without a trial or discovery, on the basis of an existing administrative record, such claims are properly decided on summary judgment." *Audubon Naturalist Soc. of the Cent. Atl. States, Inc. v. Dep't of Transp.*, 524 F. Supp. 2d 642, 660 (D. Md. 2007) (citing *Citizens for the Scenic Severn River Bridge, Inc. v. Skinner*, 802 F. Supp. 1325, 1332 (D. Md. 1991), *aff'd*, 972 F.2d 338 (4th Cir. 1992)). "From this review, the Court must determine whether the plaintiff has demonstrated that the agency action should be set aside as arbitrary, capricious, contrary to law, or unsupported by substantial evidence." *Williams v. Roth*, Civ. No. 21-2135-PX, 2022 WL 4134316, at *6 (D. Md. Sept. 12, 2022) (citing 5 U.S.C. § 706(2)(A)). "[T]he ordinary summary judgment standard set forth in Rule 56 'does not apply because of the limited role of a court in reviewing the administrative record.'" *Am. Fed'n of Tchrs.*, 796 F. Supp. 3d at 89 (quoting *Deese v. Esper*, 483 F. Supp. 3d 290, 304 (D. Md. 2020)).

### B. Review Under the APA

The APA requires courts to "hold unlawful and set aside agency action, findings, and conclusions" that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). Previously, "[w]hen a challenger assert[ed] that an agency action conflicts with the language of a statute, [the reviewing court] generally appl[ied] the two-step analytical framework set forth in *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842–43 (1984)." *City of Columbus II*, 523 F. Supp. 3d at 744. However, *Loper Bright* overturned *Chevron* and changed this Court's role in reviewing an administrative agency's interpretation of a statute. *See Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 412 (2024). Section 706 of the APA requires courts to decide "'all relevant questions of law' arising on review

of agency action." *Id.* at 392 (quoting 5 U.S.C. § 706). "A court may give weight to an agency's authoritative interpretation but ultimately must rule on matters of law." *Molina-Diaz v. Bondi*, 128 F.4th 568, 574–75 (4th Cir. 2025) (first citing *Loper Bright*, 603 U.S. at 2262; and then citing *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944)); *see also Loper Bright*, 603 U.S. at 400–01 ("[A]gencies have no special competence in resolving statutory ambiguities. Courts do.").

"The scope of review under the 'arbitrary and capricious' standard is narrow and a court is not to substitute its judgment for that of the agency." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). However, the agency must "articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.'" *Id.* (quoting *Burlington Truck Lines v. United States*, 371 U.S. 156, 168 (1962)). Agency action is generally considered arbitrary or capricious if the agency "has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Id.*

## IV. ANALYSIS

As noted above, Plaintiffs challenge several provisions of the Rule as either contrary to law, arbitrary and capricious, or both.[9] *See* ECF 1, at 26–29. Plaintiffs separate their challenges into three categories: challenges to provisions that erode the value of coverage, challenges to

[9] With respect to the motion to stay, "Plaintiffs initially challenged the revocation of the low-income SEP in their opening brief but abandoned that claim on Reply." *City of Columbus III*, 796 F. Supp. at 148. Plaintiffs do not advance or defend that challenge at summary judgment either, and thus the Court considers Plaintiffs to have abandoned the claim. *See, e.g.*, *Tartaro-mcGowan v. Inova Home Health, LLC*, Civ. No. 121-298RDATCB, 2022 WL 2232190, at *3 (E.D. Va. June 21, 2022) ("Generally, a party abandons claims when she fails to defend them in opposition to a motion for summary judgment.") (collecting cases), *aff'd*, 91 F.4th 158 (4th Cir. 2024).

provisions that impose barriers on enrollment, and challenges to provisions that limit the availability of subsidized coverage. *See* ECF 65-1, at 14.

Plaintiffs' initial challenges raised in the "erosion of the value coverage" section of their brief seek relief from a provision imposing a monthly surcharge of $5 on enrollees to reconfirm eligibility, a provision revising the premium adjustment methodology, and a provision revising the actuarial value policy. *See id.* at 14–15. Plaintiffs' next three challenges are raised in the "barriers to enrollment" section and seek relief from a provision requiring enrollees to pay past-due premiums before receiving new coverage, a provision shortening the open enrollment period, and a provision adding verification requirements for SEP enrollments. *See id.* at 16–17. Plaintiffs' final challenges are included in the "limiting the availability of subsidized coverage" section and seek relief from a provision re-instituting a policy regarding failure-to-reconcile tax data and two provisions requiring heightened income verification when a person's projected annual income does not match IRS data or when tax data is unavailable. *See id.* at 17–18. The Court will address each challenge in turn.

**A. Eligibility Redetermination / Imposition of a "Junk Fee"**

As noted, a taxpayer is eligible for tax credits to cover the cost of premiums if he or she enrolls in coverage through the Exchange, falls within the specified income thresholds, and lacks an offer for other affordable health insurance. 26 U.S.C. § 36B(c)(1), (2). As Plaintiffs describe, "[t]he amount of the tax credit is determined by the taxpayer's income and the cost of a benchmark plan offered through the Exchange." ECF 65-1, at 28. Additionally, "[e]ligibility for, and the amount of, APTCs turn on the same statutory criteria." *Id.* (first citing 42 U.S.C. § 18081(a)(2); and then citing *id.* § 18082(a)(1)). The Rule provides that (1) if an enrollee does not submit an application for an updated APTC eligibility determination for plan year 2026 on or before the deadline to select Exchange coverage and (2) that enrollee's post-APTC premium will be zero

dollars (*i.e.*, the enrollee's coverage will be fully subsidized), then (3) the Exchange "must decrease the amount of" the APTC "applied to the [enrollee's] policy such that the remaining monthly premium owed for the policy equals $5." 90 Fed. Reg. at 13,031. Plaintiffs colorfully describe this requirement to reduce the value of the APTC by at least $5.00 a month as a "junk fee." ECF 65-1, at 28.

In response, Defendants argue that the fee is merely "a tool to facilitate HHS's ability to redetermine enrollees' eligibility to remain enrolled in fully subsidized Exchange plans." ECF 68-1, at 17. "The unusually high level of improper enrollment in fully subsidized Exchange coverage stemming from a soon-to-expire enhanced subsidy regime," Defendants argue, "presented the 'appropriate circumstances' for implementing this temporary nominal-premium procedure." *Id.* (first citing 90 Fed. Reg. at 27,103; and then quoting 42 U.S.C. § 18081(f)(1)(B)).

As the basis for the agency's authority, Defendants argue that the "ACA grants the HHS Secretary the authority to 'establish a program' for making these eligibility determinations and to 'establish procedures' for 'redetermin[ing] eligibility on a periodic basis in appropriate circumstances.'" *Id.* (alterations in original) (first quoting 42 U.S.C. § 18081(a)(1); and then quoting *id.* § 18081(f)(1)(B)). Plaintiffs acknowledge the agency's obligation to redetermine eligibility on a periodic basis in appropriate circumstances. *See* ECF 65-1, at 12, at 28–29. However, they argue that "CMS's authority under the statute is to determine *whether* the statutory criteria for APTC eligibility are met, not to *alter* those criteria." *Id.* at 29 (emphasis added) (citing *Neumann v. Prudential Ins. Co. of Am.*, 367 F. Supp. 2d 969, 975 (E.D. Va. 2005)). Plaintiffs contend that "[n]othing in section 18081 or the remainder of the Act grants CMS the 'authority to tinker with the premium cost structure outlined in 26 U.S.C. § 36B'" by reducing APTCs by $5

per month for applicants who automatically re-enroll in a plan that would otherwise be fully subsidized. *Id.*

Relying on 42 U.S.C. § 18081(a)(2), Defendants counter that "the ACA tasks HHS with 'determining' whether individuals enrolled in Exchange plans 'meet[] the income and coverage requirements' for claiming PTCs, as well as with determining 'the amount' of those tax credits." ECF 68-1, at 17 (quoting 42 U.S.C. § 18081(a)(2)). Defendants further argue that it is "likewise HHS's responsibility to determine an Exchange enrollee's eligibility for APTCs (which mirrors the applicable requirements for PTC eligibility) and to calculate the amount of those APTCs." *Id.* (first citing 42 U.S.C. § 18082(a)(1), (3); and then citing 45 C.F.R. § 155.305(f)(5)).

Importantly, however, 26 U.S.C. § 36B provides a formula for calculation of tax credits, which is determined by income and the cost of a benchmark plan offered through the Exchange. That statutory provision states:

> 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 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.

26 U.S.C. § 36B(b)(2). The agency cannot utilize its general rulemaking authority to override explicit statutory provisions. *See Air All. Hous. v. EPA*, 906 F.3d 1049, 1061 (D.C. Cir. 2018) ("[I]t is well established that an agency may not circumvent specific statutory limits on its actions

by relying on separate, general rulemaking authority."). As such, CMS lacks authority to tinker with the premium cost structure outlined in 26 U.S.C. § 36B.

Relatedly, CMS does not have the authority to change the statutory formula for APTCs under 42 U.S.C. § 18081(f)(1)(B). That section provides that the Secretary of HHS "shall establish procedures by which the Secretary or one of such other Federal officers . . . redetermines eligibility on a periodic basis in appropriate circumstances." 42 U.S.C. § 18081(f)(1)(B). The Court finds that the relatively limited grant of authority to "redetermine[] eligibility" for APTCs under "appropriate circumstances" does not encompass broad power to adjust the amount of APTCs, which are set according to a statutory formula. *Id.*

According to Defendants, the purpose of that provision corresponds with the purpose of the $5 fee—to "facilitate HHS's ability to *redetermine* enrollees' *eligibility* to remain enrolled in fully subsidized Exchange plans." ECF 68-1, at 17 (emphasis in original). Defendants thus argue "the 'procedure[]' HHS opted for in the Rule is the application of a nominal premium that is designed to prompt certain enrollees to affirmatively reconfirm their eligibility." *Id.* (quoting 42 U.S.C. § 18081(f)(1)(B)). But "an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate." *Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 328 (2014). Merely suggesting that the purpose of the provision comports with the agency's general rulemaking authority to "redetermine eligibility" does nothing to address Plaintiffs' argument that Defendants were not free to choose a procedure that changed the statutory formula. *See* ECF 65-1, at 28–29. Defendants' interpretation of its authority stretches the "redetermine eligibility" language beyond its plausible meaning and scope. *See Util. Air Regul. Grp.*, 573 U.S. at 328 ("Agencies are not free to 'adopt . . . unreasonable interpretations of statutory provisions and then edit other statutory provisions to mitigate the unreasonableness.'" (citation omitted)). In short, the

authority to verify eligibility does not infuse the agency with authority to re-write Congress's unambiguous statutory formulas.

The Court finds that HHS lacks the authority to impose a fee on plans that would otherwise be fully subsidized through APTCs via the formula prescribed by Congress. There are explicit formulas in the statutes for calculating APTCs, and Defendants do not have authority to re-write those formulas by reading broad authority into the limited statutory directive allowing HHS to "redetermine[] eligibility" for enrollment under "appropriate circumstances." 42 U.S.C. § 18081(f)(1)(B). Additionally, the Court agrees that the "Treasury's obligation is to pay the amount that would be owed under the section 36B formula, not a different amount arbitrarily selected by CMS." ECF 65-1, at 29. In short, the Court concludes that the Rule's "junk fee" provision is contrary to law because applicants cannot be compelled to pay a fee that is untethered to the statutory formula.[10] Accordingly, Plaintiffs are entitled to summary judgment on their challenge against this provision.

**B. Revised Premium Adjustment Percentage Methodology**

The ACA directs the HHS Secretary to determine an annual "premium adjustment percentage" based on "the average per capita premium for health insurance coverage in the United States for the preceding calendar year." 42 U.S.C. § 18022(c)(4). This measure of premium growth is then used to set the rate of increase for a number of parameters defined in the ACA, such as the maximum annual limitation on cost sharing under Exchange plans. *See* 45 C.F.R. § 156.130(a). Because the IRS traditionally adopts the same premium growth indexing methodology as HHS, the methodology used to calculate the premium adjustment percentage also

[10] Because the Court finds that this provision of the Rule is contrary to law, the Court does not reach Plaintiffs' alternative argument that adopting the provision was arbitrary and capricious.

affects how PTC and APTC amounts are calculated and, by extension, the cost of health care coverage on Exchanges. *See* 90 Fed. Reg. at 27,171.

HHS presently only considers premiums for *employer*-sponsored coverage in the premium adjustment percentage calculation, not insurance purchased by *individuals* on the marketplace. The Rule, however, incorporates individual insurance market data into this measure. *Id.* at 27,169. Section 1302(c)(4) of the ACA and § 156.130(e) provide that the premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013. *Id.* at 27,166. In response to the proposed rule, commenters expressed concern that "individual market premiums should not be used to measure premium growth since 2013 because premiums in the early years of ACA were volatile[.]" *Id.* at 27,173.

Plaintiffs contend that "[a]s a result" of the Rule's incorporation of individual plan prices into the premium growth indexing methodology, "the maximum out-of-pocket limit in 2026 will be about $450 higher for an individual and $900 higher for a family than it otherwise would have been." ECF 65-1, at 33 (citing 90 Fed. Reg. at 27,206). According to Plaintiffs, "[t]his will lead to about a 4.5% increase in premiums across the board and 80,000 fewer enrollments in the Exchanges under CMS's own estimates, running the risk of a spiral of a worsening risk pool and increased premiums, as well as higher volumes of uninsured patients being seen by health centers." *Id.* (internal quotation marks and citations omitted).

1. Contrary to Law

Plaintiffs now argue that the revised premium adjustment percentage methodology is contrary to law and emphasize that "[t]he statute requires the agency to compare the most recent 'average per capita premium for health insurance coverage' with 'such average per capita premium for 2013,' the year before the Act's reforms to the individual health insurance market went into

effect." *Id.* at 33 (quoting 42 U.S.C. § 18022(c)(4)). "By using the term 'such,'" Plaintiffs argue that "Congress directed the agency to compare average premiums in the two years for the 'same,' or 'equivalent,' coverage." *Id.* at 33–34 (citing *King*, 576 U.S. at 487). "But premiums on the individual market in 2013 were not premiums for policies that met the Act's standards for 'health insurance coverage,'" say Plaintiffs. *Id.* at 34 (first citing 42 U.S.C. §§ 300gg-91(b), 18021(b)(2); and then citing 42 U.S.C. § 300gg et seq.). "So any measurements of premiums for individual policies in 2013 wouldn't capture the cost of 'health insurance coverage,' as the Affordable Care Act uses that phrase." *Id.*

Defendants respond that Plaintiffs' "argument places far more weight on the word 'such' than it can bear." ECF 68-1, at 21. According to Defendants, "[h]ad Congress wished to constrain the agency in the highly specific manner that Plaintiffs suggest"—i.e., "to include the group market only"—"it could easily have been more specific." *Id.* at 21–22. In addition to arguing that the plain text of the statute does not naturally accommodate Plaintiffs' reading, Defendants contend that "Plaintiffs' argument relies on an incorrect premise that demands an impossibly pristine market comparison from 2013" when both "individual and small group markets" were "restricted to calculate premium costs based only on certain factors." *Id.* at 22 (citing 45 C.F.R. § 147.102).

The Court begins and ends with the text of the ACA. The provision at issue, 42 U.S.C. § 18022(c)(4), provides:

> For purposes of paragraph (1)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

42 U.S.C. § 18022(c)(4). The ACA defines "health insurance coverage" to mean "benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise

and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer." 42 U.S.C. § 300gg-91(b)(1); *see also id.* § 18021(b)(2). Plaintiffs read this definition together with the other provisions of the ACA "setting standards, as of 2014, for health insurance coverage in the individual market" to give meaning to the phrase "health insurance coverage" as it is used in § 18022(c)(4). ECF 65-1, at 34 (citing 42 U.S.C. § 300gg et seq.).

The Court observes that the term "health insurance coverage" only appears in the first half of (c)(4), relating to the "average per capita premium . . . for the preceding calendar year"; it is not used to describe the "average per capita premium for 2013." 42 U.S.C. § 18022(c)(4). Moreover, the provision expressly grants the Secretary the authority to "determine[]" the "average per capita premium for 2013." *Id.* ("as determined by the Secretary"). By way of contrast, the first half of the provision permits the Secretary to "estimate[]" the "average per capita premium for health insurance coverage in the United States for the preceding calendar year." *Id.* Defendants argue that there is a meaningful difference between estimation and determination, in that "[a]n estimate of a value is implicitly constrained by metrics and formulas, whereas determination of a value is not." ECF 68-1, at 23. Where a statute "has used one term in one place, and a materially different term in another, the presumption is that the different term denotes a different idea." *Sw. Airlines Co. v. Saxon*, 596 U.S. 450, 457–58 (2022) (quoting A. Scalia & B. Garner, Reading Law 170 (2012)). However, it is not clear to the Court whether "estimated" and "determined" in this context are materially different, and Defendants do not cite a source for defining either term in support of their reading.

More useful to the Court is the use of the word "such" in the provision. Within (c)(4), Congress used "such" twice—once to refer back to the preceding calendar year ("such preceding calendar year") and once to refer back to the average per capita premium ("such average per capita premium"). 42 U.S.C. § 18022(c)(4). Plaintiffs suggest that "such" means the same kind or degree already described. *See* ECF 70, at 8; *Culbertson v. Berryhill*, 586 U.S. 53, 59 (2019) ("Both at the time of enactment and today, the adjective 'such' means '[o]f the kind or degree already described or implied.'" (alteration in original) (first quoting H. Fowler & F. Fowler, Concise Oxford Dictionary of Current English 1289 (5th ed. 1964); and then citing Black's Law Dictionary 1661 (10th ed. 2014))). In the first usage in this subsection, the Court observes that Congress has used "such" to effectively mean "the same as stated prior." In other words, the Secretary must estimate "the average per capita premium for health insurance coverage in the United States for the preceding calendar year [ ] as estimated by the Secretary no later than October 1 of [the same] preceding year." 42 U.S.C. § 18022(c)(4) (alteration added).

The second clause, however, resists that precise meaning for "such," because the "average per capita premium for 2013" will (of course) not necessarily be "the same" as that of the average for the year of comparison. But the *kind* of average taken can be made identical to the calculation described prior. In other words, the Secretary must determine the average per capita premium of the kind described—i.e., "for health insurance coverage"—but "for 2013." *Id.* (alteration added). The question the Court must answer, then, is whether the meaning of "health insurance coverage" is coverage that comports with the "standards, as of 2014, for health insurance coverage in the individual market" set by the ACA, *see* ECF 65-1, at 34, or whether such coverage must simply meet the definition provided for in § 300gg-91(b). The text of the statute compels the latter reading, even if the former may be of sounder policy.

As discussed, the ACA defines "health insurance coverage" to mean "benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer." 42 U.S.C. § 300gg-91(b)(1). That definition alone does not include a requirement that the benefits provided comply with the other standards established by the ACA. Plaintiffs urge the Court to read the definition of "health insurance coverage" in connection with the other provisions of the ACA that set standards for such coverage, *see* ECF 65-1, at 34, so that § 18022(c)(4) must be read to involve an average per capita premium of "health insurance coverage" *that comports with the ACA* "for 2013," *see* 42 U.S.C. § 18022(c)(4). But to do so would require the Court to effectively add words to §§ 300gg-91(b)(1) or 18022(c)(4), which ordinary principles of statutory interpretation counsel against. *See Stockley v. United States*, 260 U.S. 532, 540 (1923) ("We are not at liberty to add to or take from the language of the statute.").

Plaintiffs are likely correct that "the coverage available on the individual market in 2013 'differ[ed] in [a] meaningful way,' from the coverage available on that market now." ECF 70, at 6–7 (alterations in original) (quoting *King*, 576 U.S. at 487). But the Court finds no statutory authority to compel the agency to use a particular formulation in its determination of the "average per capita premium for 2013" under § 18022(c)(4).

2. Arbitrary and Capricious

Plaintiffs also argue that the revised premium adjustment percentage methodology was arbitrary. *See* ECF 65-1, at 34. "CMS acknowledged that its choice ran contrary to the Act's goals, but it brushed this concern aside, reasoning that it didn't need to take these issues into account when it exercised its discretion under section 18022(c)(4) to adopt an 'appropriate'

methodology." *Id.* at 34 (first citing 90 Fed. Reg. at 27,172; and then citing 90 Fed. Reg. 12,942, 12,990 (Mar. 19, 2025)).

Defendants do not dispute that the new Rule will affect the cost of Exchange plans. *See* ECF 68-1, at 23 ("HHS acknowledges that the new methodology will increase the maximum annual limitation on cost sharing and net premiums for enrollees with incomes under 400 percent of the FPL, which could in turn negatively impact the cost of Exchange coverage and enrollment." (citing 90 Fed. Reg. at 27,171, at 27,206–07)). However, Defendants maintain that "any such impact would be a consequence of Congress's decision to tie the value of certain forms of financial assistance under the ACA to the premium adjustment percentage." *Id.* at 24 (emphasis in original). Defendants argue that "HHS therefore concluded—and reasonably so—that a premium adjustment percentage methodology that considers 'all private health insurance premiums' is 'more consistent with' that congressional intent and the ACA's text." *Id.* (quoting 90 Fed. Reg. at 27,172). In the Rule, CMS explained that "[b]ecause the role of the premium adjustment percentage is to appropriately index various parameters defined in the ACA, the primary consideration for setting the value of the premium adjustment percentage should be whether it accurately and comprehensively captures the rate of premium growth in the United States rather than the impact of the indexing methodology on net premiums, enrollment, access to health care, health outcomes, or out-of-pocket costs for those who receive non-covered or out-of-network care." 90 Fed. Reg. at 27,172. According to the agency, "[c]onsidering these other impacts when setting the premium adjustment percentage may result in a measure of premium growth that does not accurately reflect actual premium growth in the United States, artificially inflating the generosity of provisions of the ACA beyond the intent of Congress." *Id.*

That the agency changed its view on how to set the premium adjustment percentage does not mean its position was not substantially justified. "Agencies are free to change their existing policies as long as they provide a reasoned explanation for the change." *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 221 (2016). "In such cases it is not that further justification is demanded by the mere fact of policy change; but that a reasoned explanation is needed for disregarding facts and circumstances that underlay or were engendered by the prior policy." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515–16 (2009). "We defer to the agency's new position no less than the old, so long as we are satisfied that the agency's change in position was intentional and considered." *Philip Morris USA, Inc. v. Vilsack*, 736 F.3d 284, 290 (4th Cir. 2013).

Here, the agency's change in position was not arbitrary and capricious because it provided the necessary reasoned explanation for the change. In the Rule, HHS clarified that premiums from the individual market were previously excluded because they were "most affected by the significant changes in benefit design and market composition in the early years of implementation of the ACA market rules and were most likely to be subject to risk premium pricing," and later, in 2022, the agency "anticipated that these premiums would be more volatile in response to the COVID-19 PHE than employer-sponsored premiums." 90 Fed. Reg. at 27,173. However, the agency reasoned that "the ACA is now past the initial years of implementation and issuers have had the opportunity to collect data on the risk composition of the individual market and adjust pricing accordingly . . . [a]dditionally . . . premiums in the employer-sponsored market increased more rapidly than premiums in the individual market during the COVID-19 PHE, the impact of which has led to a decreasing gap in premium growth between the individual market and employer-sponsored market." *Id.* In light of those findings, the agency determined that "a comprehensive

measure incorporating both individual market and employer-sponsored premiums will more accurately reflect true premium growth going forward." *Id.*

While Plaintiffs argue that the agency "disregarded commenters who noted that the new measure would be less accurate if it included the volatility of the individual insurance market in the early years of the ACA's implementation," ECF 65-1, at 34, the Rule reflects that the agency explicitly responded to this concern by commenters:

> We acknowledge that the premium adjustment percentage is a cumulative measure and, as such, the market fluctuations in the early years of ACA implementation are included in the calculation when using private health insurance premiums (excluding Medigap and property and casualty insurance) as the data source for indexing. However, because it is a cumulative measure, the impact of these early years decreases as more time elapses between the applicable plan year and the benchmark year (2013). For example, for PY 2018, PY 2014 was 1 of 4 years of growth included in the premium adjustment percentage measure and therefore the weight of PY 2014 premium growth was approximately one quarter of the overall measure. For PY 2026, PY 2014 is 1 of 12 years of growth included in the measure. Therefore, for PY 2026, the weight of PY 2014 is only one twelfth of the overall measure. As such, the greater time between the benchmark year and the applicable plan year reduces the impacts of any individual year, even if the premium growth in that year is unusual.

90 Fed. Reg. at 27,173. HHS both explained the reasoning behind the policy change and addressed commenters' concerns that the new methodology would lead to less accurate measures of premium growth. While this policy change will undoubtedly have effects on the broader insurance market, including, as HHS concedes, an increase in premiums and a worsening risk pool, the Court is constrained to conclude that HHS did not act without explanation or rationale in making this decision. In fact, the agency took these negative effects into account when responding to comments in the final Rule, but ultimately concluded that the new methodology was more closely aligned with Congressional intent and the text of the ACA, and therefore should nonetheless be adopted despite its likely impact on premiums and enrollment. *See id.* at 27,172 (acknowledging

commenters' concern that healthy enrollees "may be less likely to enroll due to the higher net premiums that result from the change in the premium adjustment methodology" but ultimately finding "consideration of the impact of this proposal on the risk pool to be outside the scope of the indexing provisions of the ACA because the purpose of the premium adjustment percentage is to accurately index program parameters against the growth in premiums, not to control the growth of those premiums").

"The role of courts is not to assess whether executive decisions are wise." *Am. Fed'n of Tchrs.*, 796 F. Supp. 3d at 81 (citing *Dep't of Homeland Sec. v. Regents of the Univ. of Calif.*, 591 U.S. 1, 35 (2020)). As such, the Court is satisfied that "such a change in course was made as a genuine exercise of the agency's judgment." *Philip Morris*, 736 F.3d at 290; *see also City of Columbus II*, 523 F. Supp. 3d at 758 ("The court may not supplant the agency's view that the new policy is better than the old one simply because Plaintiffs prefer the old policy.").[11] Consequently, the Court concludes that the provision was not arbitrary and capricious, and that Defendants are entitled to summary judgment as to this provision.

### C. Actuarial Value Policy

Under the ACA, health insurance plans offered on Exchanges must cover certain "essential health benefits" and adhere to certain "level[s] of coverage" specified in the statute. 42 U.S.C. § 18022(a). A plan's "level of coverage," or actuarial value, reflects the estimated average percentage of covered health care expenses that will be paid by the insurance plan. For example, under a plan with an actuarial value of 80%, the insurer will pay, on average, 80% of covered

[11] In light of the Court's finding on this point, the Court is unconvinced that Plaintiffs' argument that the agency had an "unalterably closed mind" during rulemaking could provide an independent basis for relief on this claim. ECF 65-1, at 35. The examples put forth by Plaintiffs, *see id.* at 35–36, are insufficient to show that Defendants were "unwilling or unable to rationally consider arguments." *Mississippi Comm'n on Env't Quality v. EPA*, 790 F.3d 138, 183 (D.C. Cir. 2015) (quotation marks and citations omitted).

medical expenses, and the enrollee will pay the remaining 20% of expenses through a combination of deductibles, coinsurance, co-payments, and maximum out-of-pocket limits. Consequently, the higher a plan's actuarial value, the lower an enrollee's out-of-pocket costs, on average. Plans that have a higher actuarial value also have higher premiums.

The statute instructs the Secretary to "develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates." 42 U.S.C. § 18022(d)(3). As relevant here, current regulations provide that the "allowable variation" in the actuarial value of silver, gold, and platinum plans is two percentage points above and below their respective benchmark actuarial values (*i.e.*, +2/-2 percentage points). 45 C.F.R. § 156.140(c)(2). The Rule will change this range to +2/-4 percentage points. *See* 90 Fed. Reg. at 27,174. And for bronze plans, current regulations allow for a +5/-2 percentage point range, which the Rule will change to +5/-4 percentage points. *Id.*

Plaintiffs explain that "[t]he formula for PTCs turns on the cost of the second-lowest-cost silver plans available on the Exchange." ECF 65-1, at 36 (citing 26 U.S.C. § 36B(b)(2)(B)(i)–(ii)). Thus, "[b]y permitting insurers to sell cheaper, but less comprehensive, silver plans, CMS will therefore decrease the value of the tax credits for all enrollees, leading to a reduction in PTCs by $1.22 billion overall for 2026 alone, by CMS's own calculation." *Id.* (citing 90 Fed. Reg. at 27,208). Plaintiffs argue that "[t]he rule does not even attempt to justify the new policy as an effort to account for differences in actuarial estimates." *Id.* at 37–38 (citation omitted). Defendants counter that "CMS [ ] made the reasoned judgment that such 'short-term' concerns about how wider ranges would affect subsidized enrollees should not necessarily take priority over the longer-term prospect of plans with lower premiums and competitive cost-sharing structures drawing

unsubsidized consumers to Exchanges, 'potentially improv[ing] the risk pool as coverage becomes more affordable for generally healthy people who currently may opt to forgo coverage altogether.'" ECF 68-1, at 28 (quoting 90 Fed. Reg. at 27,175).

Generally, "an agency decision is arbitrary and capricious if 'the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.'" *Sierra Club*, 899 F.3d at 293 (quoting *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 43). So too, here, as the agency was constrained to rely only "on factors which Congress has [] intended it to consider" when exercising its authority under the statute. *Sierra Club*, 899 F.3d at 293. Here, as Plaintiffs point out, "[t]he purpose of the standard is set forth in section 18022(d)(3) itself and the only permissible 'de minimis' variations are those that account for uncertainties in 'differences in actuarial estimates,' not variations to reflect a new Administration's policy preference for less generous subsidies." ECF 65-1, at 37 (citation omitted).

Moreover, the agency was obligated to establish a "rational connection between the facts found and the choice made." *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 43. The Rule reflects that HHS believed "lower AVs would lead to lower premiums, and in turn potentially improve the risk pool as coverage becomes more affordable for generally healthy people who currently may opt to forgo coverage altogether." 90 Fed. Reg. at 27,175. HHS acknowledged that "although this may mean that those eligible for APTCs receive less money in tax credits, [the agency] believe[s] that in the long term there would be a sufficient choice of affordable plans." *Id.* Similarly, in response to commenters' concerns that the provision would "lead to increased out-of-pocket consumer costs

as plan cost-sharing generosity decreases and higher overall premiums for some consumers given a potential impact on the generosity of the SLCSP, the benchmark plan used to determine an individual's PTC," *id.* at 27,176, the agency merely stated that the "change is essential to restoring greater balance between access and affordability in the long term," and "the overall benefits to the risk pool as a result of this change will better incentivize unsubsidized enrollees to enroll in coverage, which we expect to lower overall costs and further drive down premiums as the risk pool improves," *id.* at 27,176–77.

This reasoning is conclusory and unsupported by evidence. Defendants cannot merely label something a "short-term" trade-off to avoid engaging with data and justifying the change during the rulemaking process. *See* ECF 68-1, at 28. There is no data to back up the claim and reasoning that coverage would become "more affordable" over time, which is understandable considering that *even CMS itself* estimates that the policy change widening the de minims range will reduce aggregate PTCs by $1.2 billion in 2026. *See* 90 Fed. Reg. at 27,208. And, as Plaintiffs note, data shows that "[a] typical family of four would see their subsidies decrease, and their cost of coverage rise, by up to $714 for the year." ECF 65-1, at 36 (citing Ctr. for Budget & Policy Priorities comment at 34–35 (Apr. 11, 2025), https://perma.cc/KP9W-J63N, *also available at* ECF 65-2, at 185–86). Plaintiffs argue, and the Court agrees, that the relationship between subsidies and the strength of the risk pool is well established by empirical research, but CMS simply stated that it 'expect[ed]' its rule to have the opposite effect, without citing any evidence to support this subjective belief or engaging with the record." *Id.* at 37 (quoting 90 Fed. Reg. at 27,107). Such "nodding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decisionmaking." *Gresham v. Azar*, 950 F.3d 93, 103 (D.C. Cir. 2020). Thus, the Court finds that Defendants provided an insufficient and conclusory rationale for altering

the de minims variation, and that the agency acted in an arbitrary and capricious manner.[12] Plaintiffs are thus entitled to summary judgment on their challenge of this provision.

**D. Revocation of Guaranteed-Issue / Past Due Premium**

The next challenged provision will allow issuers to require a customer to pay (1) any past-due premiums the customer owes the issuer (or related issuers) for prior coverage *and* (2) the initial premium amount (also known as a "binder payment") required for new coverage before the latter coverage is effectuated. *See* 90 Fed. Reg. at 27,084, at 27,220. If the customer fails to pay that combined amount in full, the issuer can decline to effectuate the new coverage. *Id.* at 27,084.

Defendants argue that "an issuer's provision of coverage is of course contingent on the enrollee's payment of premiums." ECF 68-1, at 31 (citing 42 U.S.C. § 300gg-2(b)(1) (providing that an issuer may "nonrenew or discontinue health insurance coverage" if an enrollee "has failed to pay premiums")). Defendants also cite 45 C.F.R. § 155.400(e) in support of their argument, which provides that federally facilitated Exchanges and State-based Exchanges on the federal platform "will[] require payment of a binder payment" equivalent to "the first month's premium" to "effectuate an enrollment" in an Exchange plan. *Id.* According to Defendants, "[t]he Rule simply allows an issuer who is owed past-due premiums from a particular customer to credit any payments made by that customer for new coverage to the past-due balance before crediting any payments to the initial premium amount for the new coverage." *Id.* at 31–32. In doing so, "if, because of such an allocation policy, the consumer still has an outstanding balance on the initial premium amount, then the issuer can decline to effectuate the new policy for failure to pay the requisite initial premium." *Id.* at 32 (citations omitted). Plaintiffs maintain that the agency "was

[12] However, the Court is likewise unconvinced by Plaintiffs' argument that the agency had an "unalterably closed mind" during rulemaking with respect to this provision. ECF 65-1, at 38; *see supra* note 11.

not free to rewrite the text of Section 300gg-1(a) to carve out a new exception to the statute's categorical [guaranteed-issue] rule." ECF 65-1, at 39.

The ACA's guaranteed-issue requirement provides that "each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept *every* employer and individual in the State that applies for such coverage," subject only to specified exceptions. 42 U.S.C. § 300gg-1(a) (emphasis added). Defendants invoke separate statutory provisions that relate to renewability and termination of coverage, rather than issuance, to justify the new past-due premium policy. *See* 42 U.S.C. § 300gg-2(b)(1).

The Court finds no authority in the text of the statute for the agency's decision to "credit any payments made by that customer for new coverage to the past-due balance before crediting any payments to the initial premium amount for the new coverage." ECF 68-1, at 32. As CMS itself has long understood, an exception for past-due premiums is not one of the Act's enumerated exceptions to the guaranteed-issue requirement. *See* 77 Fed. Reg. 70,584, 70,599 (Nov. 26, 2012); *see also* ECF 65-1, at 38–39. Plaintiffs clarify that "[t]here is such an exception for past-due premiums in the Act's parallel provision that guarantees the *renewability* of policies." ECF 65-1, at 39 (emphasis added) (citing 42 U.S.C. § 300gg-2(b)(1)). This demonstrates "Congress's understanding that an outstanding debt could prevent an enrollee from maintaining the policy he or she currently has, but that the debt wouldn't lock the enrollee out of the market altogether." *Id.* (citations omitted). Had Congress wanted to condition issuance of a new policy on payment of past premiums, it clearly knew how to do so expressly. *See* 42 U.S.C. § 300gg-2(b)(1) (providing that an issuer may "nonrenew or discontinue health insurance coverage" if an enrollee "has failed to pay premiums"). In the absence of an enumerated exception to the guaranteed-issue requirement, the agency "has no power to tailor legislation to bureaucratic policy goals by

rewriting unambiguous statutory terms." *Util. Air Regul. Grp.*, 573 U.S. at 325 (internal quotation marks omitted); *see also TRW, Inc. v. Andrews*, 534 U.S. 19, 28 (2001) ("Where Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied, in the absence of evidence of a contrary legislative intent" (cleaned up)); *Polselli v. IRS*, 598 U.S. 432, 439 (2023) ("We assume that Congress acts intentionally and purposely when it includes particular language in one section of a statute but omits it in another section of the same Act." (internal quotation marks and citations omitted)).

According to Defendants, the Rule's past-due premium policy will "help to promote continuous coverage, reduce gaming and adverse selection,[13] ensure that ACA subsidies are targeted to those who are eligible, and allow issuers to more accurately predict costs and prices." ECF 68-1, at 30 (quoting 90 Fed. Reg. at 27,084). Regardless of the merits of those arguments, they are best directed to Congress, as it is only Congress who can add enumerated exceptions to the guaranteed-issue requirement. *See Brown & Williamson Tobacco Corp. v. Food & Drug Admin.*, 153 F.3d 155, 161 (4th Cir. 1998), *aff'd*, 529 U.S. 120 (2000) ("[N]either federal agencies nor the courts can substitute their policy judgments for those of Congress."). The Court is bound by the plain text of the statute in its current form, which contains a guaranteed-issue requirement, subject only to specific, enumerated exceptions. The exceptions do not include a provision permitting insurers to deny issuance of coverage based on failure to pay a past-due premium.

[13] The risk of "adverse selection" that Defendants refer to in the insurance context is "a situation where individuals with higher risk are more likely to select coverage than healthy individuals[.]" 90 Fed. Reg. at 27,075.

Accordingly, the Court concludes that the provision is contrary to law and will award summary judgment to Plaintiffs as to that provision.[14]

**E. SEP Eligibility Verification Requirements**

The ACA requires Exchanges to provide for SEPs during which qualifying individuals may enroll for coverage in between the annual open enrollment periods. 42 U.S.C. § 18031(c)(6)(C). Under current regulations, federally facilitated Exchanges are required to conduct pre-enrollment eligibility verification only for applicants seeking to enroll in an Exchange plan under the loss-of-minimum-essential-coverage SEP; they are not permitted to conduct such pre-enrollment eligibility verification in conjunction with any other category of SEP. *See* 45 C.F.R. § 155.420(g). Under the Rule, federally facilitated Exchanges will instead be required to conduct pre-enrollment eligibility verification for other categories of SEPs as well (permanent move, marriage, etc.), which is consistent with the eligibility verification policy that was in place between 2017 and 2022. *See* 90 Fed. Reg. at 27,148–49. The Rule further requires those federal Exchanges to conduct pre-enrollment eligibility verification "for at least 75 percent of new enrollments through SEPs." *Id.* at 27,148, at 27,223. The Rule is time-limited and will sunset at the end of 2026, and the eligibility verification requirements do not apply to State Exchanges.[15] *Id.* at 27,151.

Plaintiffs maintain that "[t]his rule will generate 293,000 verification issues to resolve in the coming year, resulting in a further barrier to coverage, through additional paperwork and administrative burdens, and costing consumers more than $7 million in 2026." ECF 65-1, at 43

[14] Because the Court finds that this provision of the Rule is contrary to law, the Court does not reach Plaintiffs' alternative argument that adopting the provision was arbitrary and capricious.

[15] States are given the "option" to conduct pre-enrollment eligibility verification for SEP enrollment, but they are not required to do so, a policy unchanged by the Rule. *See* 90 Fed. Reg. at 27,151 ("[T]he program integrity issues are largely concentrated in Exchanges utilizing the Federal platform.").

(citing 90 Fed. Reg. at 27,186). According to Plaintiffs, "[y]ounger and healthier people are more likely to drop coverage as a result, leading to a worsening of the risk pool, as CMS itself realized the last time it considered (and rejected) a similar policy." *Id.* (citations omitted). Plaintiffs argue that Defendants failed to provide "an adequate explanation for why the agency acted at all," and that there was a "fundamental mismatch between this rule and the problem that CMS claims it is trying to solve." *Id.* at 44, 47. Specifically, "CMS attempted to justify this policy as a response to the problem of improper enrollments by brokers," but according to Plaintiffs, "the agency fundamentally misconceived the scope of that problem and ignored the success of recent efforts to address broker misconduct." *Id.* at 44.

Defendants respond that "because of their limited scope, the regulations 'do not provide enough protection against misuse and abuse' of SEPs, which enables otherwise ineligible individuals to enroll in Exchange plans 'only after they become sick or . . . need expensive health care services,' which in turn 'negatively impacts both the risk pool and program integrity around determining eligibility for' APTCs and other subsidies." ECF 68-1, at 35–36 (quoting 90 Fed. Reg. at 27,148). According to the Rule, requiring pre-enrollment eligibility verification for all SEP categories "improves the risk pool by restricting people from gaming SEPs to wait to enroll until they need health care services."[16] 90 Fed. Reg. at 27,150. Additionally, CMS reasons that "pre-enrollment verification for SEPs strengthens program integrity by denying ineligible enrollments and discouraging ineligible enrollees who know they cannot meet verification

[16] CMS suggested that pre-enrollment verification requirements that previously applied to SEPs did not create substantial barriers to Exchange enrollment, and that such requirements had the effect of "encourag[ing] continuous enrollment by making it more difficult to engage in strategic enrollment and disenrollment" based on customers' changing health status. 90 Fed. Reg. at 27,149.

standards from attempting to enroll which, in turn, reduces Federal subsidies to ineligible consumers who would otherwise enroll and receive APTC and CSR subsidies." *Id.*

While an agency "is not required to choose the best solution, only a reasonable one," *Petal Gas Storage, LLC v. FERC*, 496 F.3d 695, 703 (D.C. Cir. 2007), it is required to "provide[] an explanation of its decision that includes a rational connection between the facts found and the choice made," *Nat'l Audubon Soc'y v. U.S. Army Corps of Eng'rs*, 991 F.3d 577, 583 (4th Cir. 2021). Importantly, courts are not free to "ignore the disconnect between the decision made and the explanation given." *Dep't of Com. v. New York*, 588 U.S. 752, 785 (2019). "The reasoned explanation requirement of administrative law, after all, is meant to ensure that agencies offer genuine justifications for important decisions, reasons that can be scrutinized by courts and the interested public." *Id.*

Here, the Court finds that the agency's chosen solution is unmoored from the problem it seeks to address. The provision purports to address "urgent program integrity concerns," 90 Fed. Reg. at 27,151, and alleged "gaming" of SEPs through enrollees waiting until they are sick to enroll in coverage, *id.* at 27,150, in an effort to "discourag[e] ineligible enrollees who know they cannot meet verification standards from attempting to enroll," *id.* But Defendants have offered no current data, reports, or evidence establishing that any "misuse and abuse" of SEPs, 90 Fed Reg. at 27,148, stems from SEP enrollment *in particular*. In the Rule, the agency cites to a "GAO undercover testing study of SEPs" from 2016, which found that "9 of 12 of GAO's fictitious applicants were approved for coverage on the Federal and selected State Exchanges." *Id.* But as noted, that study was from 2016, and the parties have not identified, nor can the Court locate, any evidence in the Rule to corroborate Defendants' conclusory assertion that abuse of SEPs is *currently* contributing to the "program integrity concerns" the agency seeks to address through this

provision. Accordingly, it remains merely a theory that the "temporary policy will help stabilize the marketplace in [Plan Year] 2026 as the subsidy environment normalizes and the high levels of improper enrollments are reduced before reverting back in PY 2027." 90 Fed. Reg. at 27,152. Further, the agency's conclusion that "the additional burden [on enrollees] is not significant enough to outweigh the merits of SEP verification and the increases in program integrity that it provides," *id.* at 27,151, is insufficient to address the very real concern raised by numerous commenters that the Rule change will improperly hinder the enrollment of eligible individuals.[17] Defendants similarly fail to articulate how an audit of 75% of new enrollments will curb the alleged problem. And they offer no new evidence or reasons at this stage of litigation. *See* ECF 68-1, at 36–37.

After reviewing the record, the Court finds that Plaintiffs' disagreement with CMS is more than a mere policy debate on the merits of the provision. Plaintiffs have established that Defendants' rationale was not indicative of reasoned decision-making. In short, the hypothesis that such "gaming" and "abuse" of subsidized coverage stems from enrollees and brokers fabricating events triggering SEPs is without support. *See Dep't of Com.*, 588 U.S. at 783 (remanding rule to agency where the record "reveal[ed] a significant mismatch between the decision the Secretary made and the rationale he provided"). The Court agrees with Plaintiffs' principal argument that "CMS acted arbitrarily in imposing these new burdens for 2026." ECF

[17] Indeed, one commenter noted that "a study published by the American Economic Association found that adding one single additional step to the enrollment process prompted a 33 percent decline in enrollment, predominantly among young, healthy, and economically disadvantaged people." *See* Ctr. for Budget & Policy Priorities comment at 29 (Apr. 11, 2025), https://perma.cc/KP9W-J63N (citing Mark Shepard & Myles Wagner, *Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment*, 115 Am. Econ. Rev. 772 (2025), doi: 10.1257/aer.20231133), *also available at* ECF 65-2, at 180.

65-1, at 44. As such, the Court finds that instituting SEP pre-enrollment verification procedures was arbitrary and capricious, and will enter judgment in favor of Plaintiffs as to that provision.

**F. Shortened Open Enrollment Period**

Under the ACA, the Secretary must require Exchanges to provide for "an initial open enrollment, as determined by the Secretary," "annual open enrollment periods, as determined by the Secretary for calendar years after the initial enrollment period," and "special enrollment periods specified in section 9801 of title 26 and other special enrollment periods" under certain circumstances. 42 U.S.C. § 18031(c)(6). Under the current policy, the open enrollment period for the Exchanges begins on November 1 and ends (at the earliest) on January 15. *See* 45 C.F.R. § 155.410(e); ECF 65-1, at 16. Starting in 2027, however, the Rule will require Exchanges to hold an open enrollment period that begins no later than November 1, and ends no later than December 31, a 60-day period in total. *See* 90 Fed. Reg. at 27,135–40. The Rule would thus rescind the extended open enrollment period which was in effect over the last four years in favor of a shorter one.

Plaintiffs argue that in attempting to enact such a Rule, "CMS ignored a wealth of evidence showing that January enrollments have been beneficial both for enrollees and for the financial health of the Exchanges." ECF 65-1, at 41. According to Plaintiffs, "CMS opined that it needed to balance the need to allow sufficient time for consumers to enroll in the Exchanges against the possibility that a longer open enrollment period would create a risk of adverse selection," but "such a trade-off is entirely illusory." *Id.* Plaintiffs assert that "[a]ll . . . available evidence from the state-based Exchanges shows that January enrollees are younger and healthier, and that their enrollments accordingly lower premiums overall." *Id.* (citations omitted). Although "[d]ata from the federally facilitated Exchange is solely in the possession of CMS," Plaintiffs maintain that "there is no reason to believe (and the agency offered none) that the result would be different in

states on that Exchange," so "by shortening the open enrollment period, the agency exacerbated the problem of adverse selection that it claimed it was trying to solve." *Id.* (citations omitted).

As discussed, "[a]gencies are free to change their existing policies as long as they provide a reasoned explanation for the change." *Encino Motorcars, LLC*, 579 U.S. at 221. Here, the agency explained that in setting the open enrollment period, it generally "attempt[s] to balance the risk of adverse selection—a situation where individuals with higher risk are more likely to select coverage than health individuals—with the need to ensure that consumers have adequate opportunity to enroll in QHPs through an Exchange." 90 Fed. Reg. at 27,136. Accordingly, in different years, the open enrollment period has varied, opening in 2014, for example, as early as October 1, 2013, and closing in March 31, 2014. *See id.* (chart providing summary of open enrollment periods starting in 2014). At other times, such as in 2018, the open enrollment period has been shorter, starting on November 1 and ending on December 15, 45 days total. *See id.* (noting that period existed in 2018, 2019, 2020, and 2021).

However, the Rule reflects that HHS failed to explain why the adverse selection problem would be remedied by the open enrollment period it chose. It is possible that a reasoned explanation for shortening the period to 60 days exists, or could exist, as evidenced by the fact that the open enrollment period has changed over time, and indeed has been shorter than the Rule would now require. *See id.* But HHS did not provide such an explanation. Instead, it stated that although HHS formerly concluded that the "risk of adverse selection was outweighed by the benefits of increased consumer enrollments and opportunities to switch plans for consumers with unexpected plan costs," the agency's "new analysis of this experience extending the OEP to end January 15 suggests that these benefits did not materialize," and thus the "risk of adverse selection was outweighed" by those benefits. *Id.* at 27,137. However, HHS provides no specifics as to its

"new analysis," and it offers no current data, reports, or evidence establishing its conclusion. The closest HHS comes is reflected in the mention of HHS's "experience implementing" the prior open enrollment period, in which HHS observed that "fewer than 3 percent of enrollees (470,000 individuals) ended" coverage "between December 15, 2024, and January 15, 2025[.]" *Id.* But that observation fails to map, without more, onto the risk of adverse selection supposedly motivating the adoption of a shorter period, nor does it explain *why* the risk of adverse selection drives the *particular length* of open enrollment ultimately selected. *See id.*; *see also* 90 Fed. Reg. at 12,979. The absence of reasoned decision-making is particularly troubling given that this provision of the Rule will take the described timeframe for enrollment "away from the 470,000 individuals who relied on the opportunity" in the past. ECF 70, at 22. Because the Court is unable to discern a "rational connection between the facts found and the choice made," *Nat'l Audubon Soc'y*, 991 F.3d at 583, it concludes that the agency's decision to shorten the open enrollment period was arbitrary and capricious, and will award summary judgment to Plaintiffs as to this provision.[18]

**G. Failure-to-Reconcile Provision**

This provision reinstates a prior Failure to File and Reconcile ("FTR") policy that requires an Exchange to determine that a "tax filer" is ineligible for APTCs under the ACA if the applicant (1) received APTCs the prior year and (2) failed to comply with the statutory requirement to file a tax return and "reconcile APTC" for that year. *See* 90 Fed. Reg. at 27,113, at 27,221. This provision, which will apply only through the end of 2026 should it go into effect, *see id.* at 27,115,

[18] Plaintiffs also argue that the agency failed to respond to several categories of comments. *See* ECF 65-1, at 41–43. The Court does not rest its holding on these arguments, however, and notes that with respect to this provision, the agency was responsive to some commenters' concerns. *See, e.g.*, 90 Fed. Reg. at 27,138 (delaying the implementation date of this provision to 2027 in light of commenters' concerns about Navigators' ability to assist individuals due to recent cuts to the Navigators program). In short, this case appears to present the likely rare scenario where an agency was responsive to comments related to a rule change, but never provided a fundamental justification for the change in the first place.

amends the current requirement that such a determination be made only after a tax filer fails to reconcile for two consecutive tax years. *See* 45 C.F.R. § 155.305(f)(4).

The IRS requires taxpayers who receive APTCs—which are typically scaled to the recipient's projected annual household income—to reconcile those advanced payments with the PTC amount they otherwise qualify for in the applicable tax year, as determined by their actual annual household income in that year. *See* 26 U.S.C. § 36B(f). If the APTCs the taxpayer received exceed that allowable PTC amount, then the taxpayer may incur a tax liability, subject to certain income-based caps. *Id.* § 36B(f)(2). Since 2012, HHS has prohibited an Exchange from "determin[ing] a tax filer eligible for" APTCs if the filer (1) received APTCs the prior year and (2) failed to comply with the requirement to file a federal income tax return and reconcile those APTCs for that year. 45 C.F.R. § 155.305(f)(4). Taxpayers who are determined ineligible for APTCs due to their failure to reconcile can still claim on their tax returns the full amount of the PTC they are otherwise eligible for; such taxpayers just would not be able to receive that PTC amount in advance. *Id.*

In 2023, CMS amended the failure-to-reconcile regulations such that a taxpayer becomes ineligible for APTCs only after failing to file a federal income tax return and reconcile their APTCs for *two* consecutive tax years. *See* 90 Fed. Reg. at 27,113. The current Rule provision reverts back to the requirement that a taxpayer be deemed ineligible for APTCs after one year of failing to reconcile, and that change applies only through plan year 2026. *Id.*

In their contrary to law claim, Plaintiffs challenge the agency's authority to "condition eligibility for a tax credit on the reconciliation of old debts." ECF 65-1, at 46. Plaintiffs posit that although "CMS has authority to determine if the statutory standards for APTC eligibility are met, [ ] it does not have authority to alter those standards." *Id.* at 45 (citing 42 U.S.C. § 18081(a), (f)).

According to Plaintiffs, "[t]he statute does not contemplate that a prior tax debt affects an applicant's eligibility for APTCs in any way." *Id.* at 46.

As an initial matter, the Court observes that the parties do not relitigate their statute of limitations concern as to this claim at summary judgment. *See* ECF 65-1, at 45–47; ECF 68-1, at 37–41. The Court reiterates its prior conclusion here that Plaintiffs' challenge is not barred on account of the "reopening doctrine," which "allows an otherwise stale challenge to proceed because the agency opened the issue up anew, and then reexamined and reaffirmed its prior decision." *Wash. All. of Tech. Workers v. U.S. Dep't of Homeland Sec.*, 892 F.3d 332, 346 (D.C. Cir. 2018) (internal quotation marks and citation omitted). Specifically, the "doctrine arises where an agency conducts a rulemaking or adopts a policy on an issue at one time, and then in a later rulemaking restates the policy or otherwise addresses the issue again without altering the original decision." *CTIA–Wireless Ass'n v. FCC*, 466 F.3d 105, 110 (D.C. Cir. 2006) (internal quotation and alterations omitted). "The doctrine only applies, however, where the entire context demonstrates that the agency has undertaken a serious, substantive reconsideration of the existing rule." *All. for Safe, Efficient & Competitive Truck Transp. v. Fed. Motor Carrier Safety Admin.*, 755 F.3d 946, 954 (D.C. Cir. 2014) (internal quotation marks and citation omitted).

In 2017, another trial court in this Circuit noted that it "[could not] find [any] Supreme Court or Fourth Circuit precedent recognizing the reopening doctrine." *Indep. Cmty. Bankers of Am. v. Nat'l Credit Union Admin.*, No. 16-cv-1141, 2017 WL 346136, at *4 (E.D. Va. Jan. 24, 2017). This Court has similarly not been able to find any in-circuit case law addressing this doctrine. *See Outdoor Amusement Bus. Ass'n, Inc. v. Dep't of Homeland Sec.*, 983 F.3d 671, 682 n.5 (4th Cir. 2020) (not reaching the issue of whether to adopt the reopening doctrine, but recognizing its application in the D.C. Circuit); *see also Biden v. Texas*, 597 U.S. 785, 809 n.8

(2022) (noting that the Supreme Court has never adopted the reopening doctrine). However, the reopening doctrine remains well-established in the D.C. Circuit, which regularly hears APA claims. *See, e.g.*, *Growth Energy v. EPA*, 5 F.4th 1, 21 (D.C. Cir. 2021) ("When a later proceeding explicitly or implicitly shows that the agency actually reconsidered the rule, the matter has been reopened and the time period for seeking judicial review begins anew." (internal quotation marks and citations omitted)). As such, despite the lack of in-circuit precedent, the Court cannot identify a reason the reopening doctrine would not apply and thus applies it here, for the reasons stated in its prior opinion.[19] *See City of Columbus III*, 796 F. Supp. 3d at 161–62 ("By explicitly re-evaluating and subsequently affirming its statutory authority to issue the failure-to-reconcile provision during the notice and comment rulemaking process, CMS reopened the issue of Congressional authorization for the provision.").

Turning back to the merits of Plaintiffs' contrary to law challenge, the Court agrees with Plaintiffs that "[t]he statute does not contemplate that a prior tax debt affects an applicant's eligibility for APTCs in any way," and that "if Congress intended to condition eligibility for a tax credit on the reconciliation of old debts, it knew how to do so." ECF 65-1, at 46 (first citing 26 U.S.C. §§ 24(*l*), 32(k); and then citing *Nat'l Elec. Mfrs. Ass'n v. Dep't of Energy*, 654 F.3d 496, 507 (4th Cir. 2011)). Once again, Defendants' invocation of its general rulemaking authority under 42 U.S.C. § 18041(a)(1) does not authorize it to flout separate, express provisions of the statute. *See* ECF 68-1, at 37–39; *see NRDC v. Reilly*, 976 F.2d 36, 40 (D.C. Cir. 1992) (explaining that a "general grant of rulemaking power . . . [cannot] trump the specific provisions of the act"); *see also Air All. Hous.*, 906 F.3d at 1061 ("[I]t is well established that an agency may not circumvent

[19] Since the issuance of the Court's prior opinion in this matter, Judge Maddox has also applied the reopening doctrine. *See Von Gronefeld v. Kendall*, Civ. No. MJM-23-1407, 2026 WL 691641, at *8 (D. Md. Mar. 11, 2026).

specific statutory limits on its actions by relying on separate, general rulemaking authority."). CMS is not free to re-write the statutory formula to accomplish its policy goals, irrespective of the efficacy of such a policy. As the Court previously described in evaluating the provision addressing the $5 fee, PTCs (and thus, by extension, APTCs) are prescribed by statutory formula. *See* 26 U.S.C. § 36B(b)(2)–(3); *supra* Section III.A. Thus, the agency's decision to condition APTC eligibility on reconciling tax information reads an exception into the statutory formula that is simply not there. Because the plain text of the statute contradicts the agency's provision, the Court concludes that the failure-to-reconcile provision is contrary to law.[20] Plaintiffs will be awarded summary judgment as to that provision.

### H. Data-Matching Policies / Income Eligibility Verification

#### 1. Recission of Automatic 60-Day Extension

When an Exchange attempts to verify an applicant's income for purposes of determining an applicant's eligibility for APTCs, and it finds an inconsistency in that applicant's data, it notifies the applicant and provides the applicant with an opportunity to respond. 42 U.S.C. § 18081(e)(4). The statute provides a default period of 90 days for that response. *Id.* §§ 18081(c)(4), (e)(1), (e)(4). The current regulations provide for an additional 60 days where necessary. 45 C.F.R. § 155.315(f)(7). The final Rule revokes that 60-day extension. 90 Fed. Reg. at 27,120. Plaintiffs argue that "CMS wrongly reasoned that it was compelled by the statute to impose a 90-day policy." ECF 65-1, at 48. Defendants respond that "[i]t is Plaintiffs' flawed reading of the ACA's plain text that is arbitrary, not the Rule." ECF 68-1, at 44.

The Supreme Court recently held that "[c]ourts must exercise their independent judgment in deciding whether an agency has acted within its statutory authority, as the APA requires."

[20] Because the Court finds that this provision of the Rule is contrary to law, the Court does not reach Plaintiffs' alternative argument that adopting the provision was arbitrary and capricious.

*Loper Bright*, 603 U.S. at 412. The Court explained that "[c]areful attention to the judgment of the Executive Branch may help inform that inquiry," however, "courts need not and under the APA may not defer to an agency interpretation of the law simply because a statute is ambiguous." *Id.* at 412–13. "If a statute is ambiguous, courts exercise their independent judgment to determine the single, best meaning, but do so with the agency's body of experience and informed judgment . . . at [their] disposal." *Valladares v. Ray*, 130 F.4th 74, 83–84 (4th Cir. 2025) (alterations in original) (internal quotation marks and citations omitted).

According to Plaintiffs, 42 U.S.C. § 18081(e)(4)(A)(ii) and § 18081(c)(4)(B) grant the agency power to modify the timeline described in paragraph (e)(4)(A). *See* ECF 65-1, at 48. However, according to Defendants, "one of those provisions expressly states that the HHS Secretary 'may extend the 90-day period' for resolving income-related inconsistencies 'for enrollments *occurring during 2014*,' and makes no mention of extensions being available during any other year." ECF 68-1, at 43 (emphasis in original) (citing 42 U.S.C. § 18081(e)(4)(A)(ii)). Defendants contend that while § 18081 "provides that the HHS Secretary 'may modify' the 'methods' for verifying information prescribed by the ACA, that provision plainly limits such modifications to the methods by which HHS verifies information with trusted data sources and other federal agencies, not the methods by which Exchanges must try to resolve income-related inconsistencies *with applicants*." *Id.* (emphasis in original) (citing 42 U.S.C. § 18081(c)(4)(B)). Defendants further point out that "§ 18081(c) falls under a subsection titled 'Verification of information contained in records of specific Federal officials,' and the example of a permissible modification that the provision provides concerns the transfer of tax return information from a federal official (i.e., the Treasury Secretary) directly to another trusted data source." *Id.*

The Court begins, as it must, with the statutory text. 42 U.S.C. § 18081(c)(4)(B) provides that "[t]he Secretary may modify the methods used under the program established by this section for the Exchange and verification of information if the Secretary determines such modifications would reduce the administrative costs and burdens on the applicant." 42 U.S.C. § 18081(e)(4)(A)(ii) provides that the Exchange, in the case of an inconsistency or inability to verify, shall "provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with the person verifying the information under subsection (c) or (d) during the 90-day period beginning the date on which the notice required under subclause (I) is sent to the applicant." The section also states that "[t]he Secretary may extend the 90-day period under subclause (II) for enrollments occurring *during 2014*." 42 U.S.C. § 18081(e)(4)(A)(ii) (emphasis added).

In deciding Plaintiffs' motion for preliminary relief, it was not clear to the Court that Plaintiffs were "likely succeed on their argument that 'the agency misunderstood the scope of its authority on this score.'" *City of Columbus III*, 796 F. Supp. 3d at 164 (quoting ECF 30, at 23). As an initial matter, the Court agreed, and still does agree, that "the mere title of the subsection cannot alter the otherwise unambiguous meaning of the language in its text" and that "CMS's reading of 42 U.S.C. § 18081(c)(4)(B) is unreasonable given that the Section 'authorizes modification of methods in order to reduce administrative burdens on the applicant, and this language would make little sense if the statute permitted the agency only to modify the procedures it used with other federal agencies without the applicant's involvement.'" *Id.* at 164–65 (quoting ECF 30, at 23).

However, the 2014 limiting provision in 42 U.S.C. § 18081(e)(4)(A)(ii) expressly indicates that an agency could extend the 90-day deadline for enrollments occurring *during 2014*. Given

the statute's explicit reference to a specific year, the Court cannot interpret the statute to allow blanket modifications for enrollments *at any time*. "When Congress provides exceptions in a statute, it does not follow that courts have authority to create others. The proper inference . . . is that Congress considered the issue of exceptions and, in the end, limited the statute to the ones set forth." *United States v. Johnson*, 529 U.S. 53, 58 (2000). However, the matter is further complicated by the agency's internal inconsistency in applying its own modification authority. Curiously, the agency claims that its modification power is limited, but simultaneously uses that modification authority to allow extensions on a case-by-case basis to individual applicants in years other than 2014.

In an attempt to reconcile this inconsistency, Defendants argue that "any authority the HHS Secretary might have to '*modify*' a statutorily prescribed timeline in order to 'reduce the administrative costs and burdens' faced by a particular '*applicant*,' 42 U.S.C. § 18081(c)(4)(B) (emphasis added), cannot be reasonably understood to include the authority to promulgate a regulation that categorically *replaces* a statutorily prescribed timeline (90 days) with a different one (90 days plus an automatic 60-day extension) for all applicants." ECF 68-1, at 44 (emphasis in original) (first quoting 42 U.S.C. § 18081(c)(4)(B); then citing 45 C.F.R. § 155.315(f)(7); and then citing *Util. Air Regul. Grp.*, 573 U.S. at 328). The Court invited further briefing on this issue of statutory interpretation at the preliminary relief stage, *see City of Columbus III*, 796 F. Supp. 3d at 164, and the parties have offered additional arguments in their cross-motions for summary judgment, *see* ECF 65-1, at 48–49; ECF 68-1, at 44–45.

Plaintiffs now argue that the Court should not apply the *expressio unius est exclusio alterius* canon of statutory interpretation—a phrase which "means 'expressing one item of [an] associated group or series excludes another left unmentioned,'" *Children's Hosp. Ass'n of Texas*

*v. Azar*, 933 F.3d 764, 770 (D.C. Cir. 2019) (quoting *Chevron U.S.A. Inc. v. Echazabal*, 536 U.S. 73, 80 (2002))—to this close question. In support of its contention, Plaintiffs assert that "[t]his canon is a 'feeble helper in an administrative setting,' when a statute, such as this one, contains multiple overlapping grants of authority to an agency." ECF 65-1, at 49 (quoting *Children's Hosp. Ass'n of Texas*, 933 F.3d at 770–71). Plaintiffs further point out that "[e]ven outside of this setting, '[i]f there are other reasonable explanations for an omission in a statute, *expressio unius* may not be a useful tool.'" *Id.* (first quoting *Children's Hosp. Ass'n of Texas*, 933 F.3d at 771; then citing *NLRB v. SW Gen., Inc.*, 580 U.S. 288, 302 (2017); and then citing *United States v. Hawley*, 919 F.3d 252, 256 (4th Cir. 2019)). According to Plaintiffs, "[t]he most logical explanation for the phrasing of paragraph (e)(4)(A) is that Congress wished to remove any doubt as to the scope of CMS's authority in the first year of implementation for the ACA, when time was short and the agency faced numerous interpretive issues to resolve." *Id.* Plaintiffs continue that "[t]here was no reason for Congress to proceed further to reiterate the 'methods' authority it had already granted the agency under paragraph (c)(4)(B) for later years." *Id.*

Defendants acknowledge that the *expressio unius* "canon can be overcome by 'contrary indications that adopting a particular rule or statute was probably not meant to signal any exclusion.'" ECF 68-1, at 44 (quoting *Marx v. Gen. Revenue Corp.*, 568 U.S. 371, 381 (2013)). But Defendants contend that "there is no warrant for that here," because despite Plaintiffs contention that *expressio unius* is a "feeble helper in an administrative setting," "that is not true where Congress has 'directly resolved' the scope of an agency's authority." *Id.* (quoting *Cheney R.R. Co. v. Interstate Com. Comm'n*, 902 F.2d 66, 69 (D.C. Cir. 1990)). According to Defendants, "[t]here is simply no ambiguity in the plain text of the statute: automatic 60-day extensions

countermand the ACA's limited grant of extension authority in 42 U.S.C. § 18081(e)(4)(A)(ii)." *Id.*

Although the Court still believes this issue is a close call, it concludes that Plaintiffs have the better interpretation of 42 U.S.C. § 18081(e)(4)(A)(ii) and § 18081(c)(4)(B). In reaching that conclusion, the Court examines the structure of the section. *Peltier v. Charter Day Sch., Inc.*, 37 F.4th 104, 128 (4th Cir. 2022) ("Our inquiry begins with the text and the *structure* of the statute." (emphasis added)). Section 18081 begins by laying out the scope of the program, *see id.* § 18081(a), before laying out the requisite information applicants must provide, *see id.* § 18081(b). In the next section related to the verification of such information, the statute states that "[t]he Secretary . . . shall provide that verifications and determinations under this subsection shall be done . . . through use of an on-line system" or otherwise through "electronic submission" or "through such other method as is approved by the Secretary." *Id.* § 18081(c)(4)(A). It is in the context of methods for verification of information that (c)(4)(B) then provides that "[t]he Secretary may modify the *methods* used under the program established by this section for the Exchange and verification of information *if* the Secretary determines such modifications *would reduce the administrative costs and burdens on the applicant*[.]" *Id.* § 18081(c)(4)(B) (emphasis added). In addition to limiting such authority to modify to "methods" of verification, the other limiting principle applicable to the Secretary's flexibility to engage in modification under the section is the purpose provided for by the subsection itself: to "reduce the administrative costs and burdens on the applicant." *Id.*

The ordinary meaning of "methods" of verification of information *might* alone struggle to encompass the timeline for verification at issue here. However, the Court reads that word and the phrase it modifies in context, as it must. *See Johnson v. Zimmer*, 686 F.3d 224 (4th Cir. 2012)

("[I]t is a 'cardinal rule' of statutory interpretation that 'statutory language must be read in context [because] a phrase gathers meaning from the words around it.' (quoting *Gen. Dynamics Land Sys., Inc. v. Cline*, 540 U.S. 581, 596 (2004))). After subsection (c) provides the Secretary with such power to modify, subsection (e) discusses "[a]ctions relating to verification," including "[n]otice and opportunity to correct" information. 42 U.S.C. § 18081(e)(4)(A)(ii). There, the statute provides that the Exchange "shall . . . provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency . . . during the 90-day period beginning the date on which the notice required . . . is sent to the applicant," and it further provides that "[t]he Secretary may extend the 90-day period" for doing so "during 2014." *Id.*

That structure, along with the text of the subsection headings,[21] suggests to this Court that Congress intended to provide for the opportunity to correct information—including the time in which to correct it—as one such "method" which the Secretary has the flexibility to modify with respect to the verification of information. In providing that "[t]he Secretary may extend the 90-day period under subclause (II) for enrollments occurring *during 2014*," *id.* § 18081(e)(4)(A)(ii) (emphasis added), the Court further concludes that Congress intended to permit the agency to extend that period automatically for the first year of the program, *without* engaging in the process otherwise necessary to exercise its authority to modify under § 18081(c)(4)(B). At the same time, Congress wanted to establish an ordinary period (i.e., 90 days) for correction going forward, which

[21] Title 42 has not been enacted as positive law. *See Revock v. Cowpet Bay W. Condo. Ass'n*, 853 F.3d 96, 105 n.11 (3d Cir. 2017) ("Section 1988(a) is published at 42 U.S.C. § 1988(a), which is only "prima facie" evidence of the law, as Title 42 has not been enacted into positive law. 1 U.S.C. § 204(a)."); *U.S. Nat'l Bank of Oregon v. Indep. Ins. Agents of Am., Inc.*, 508 U.S. 439, 448 (1993). ("Though the appearance of a provision in the current edition of the United States Code is 'prima facie' evidence that the provision has the force of law, 1 U.S.C. § 204(a), it is the Statutes at Large that provides the 'legal evidence of laws,' § 112 . . . ."). However, the subsection headings in this section are included in the Statutes at Large that correspond with the section, so the Court may utilize them to aid in its interpretation. *See* Pub. L. No. 111-148, § 1411, 124 Stat. 119 (2010).

the Secretary could but did not necessarily have to modify pursuant to § 18081(c)(4)(B) where doing so "would reduce the administrative costs and burdens on the applicant." Thus, to enact both the standard period for opportunity to correct and to ensure extensions throughout 2014, Congress enacted the following text: "The Secretary may extend the 90-day period under subclause (II) for enrollments occurring during 2014." *Id.* § 18081(e)(4)(A)(ii). If Defendants' interpretation was correct, the Court would expect that provision to read as follows: "[t]he Secretary may extend the 90-day period . . . *only* during 2014." But Congress did not so say. Instead, it only affirmatively authorized the Secretary to grant extensions during 2014. In the context of this statute, the Court will not infer from the affirmative grant of authority an implicit limitation on the otherwise express authorization to the Secretary to modify such methods of information verification.

However, that Plaintiffs have the better reading of the statute means that it was *not* contrary to law for Defendants to modify or eliminate an extension to the ordinary period for correction, so long as (1) Defendants made the modification to "reduce the administrative costs and burdens on the applicant" and (2) their decision to do so was not otherwise arbitrary and capricious. Plaintiffs argue that CMS did not "engage[] with the evidence showing the need for a 150-day verification period" because it "wrongly believed that it was required by the statute to adopt this rule." ECF 65-1, at 49. Plaintiffs contend that "[i]f CMS had correctly understood its statutory authority, it could have engaged with the evidence showing the need for a 150-day verification period." *Id.* According to Plaintiffs, "[b]y the agency's own telling, this provision will cause 226,000 enrollees to lose eligibility for tax credits on the Exchanges." *Id.* (citing 90 Fed. Reg. at 27,199). "Apart from incorrectly asserting that its hands were tied," Plaintiffs contend that "CMS only briefly averted to 'program integrity' needs, without explaining how those needs would be advanced in any way." *Id.* at 50.

Defendants counter that "CMS very much engaged with relevant evidence suggesting that an automatic 150-day verification period provided no 'meaningful benefit to consumers' compared to a process in which extensions can be granted on a case-by-case basis as appropriate." ECF 68-1, at 45 (citing 90 Fed. Reg. at 27,119–20). Defendants further assert that "CMS also 'address[ed]' other 'relevant factors,' including the potential effects that rescinding the automatic 60-day extension might have on enrollment and the risk pool within Exchanges, as well as on federal expenditures for APTCs given to ineligible enrollees." *Id.* (citing 90 Fed. Reg. at 27,119).

A significant portion of Defendants' explanation for this provision of the Rule centers on a misreading of § 18081, as discussed above. *See* 90 Fed. Reg. at 27,119 ("However, as discussed previously, section 1411(c)(4)(B) of the ACA specifically limits modifications on how information is exchanged and verified between HHS and trusted data sources and does not extend to other aspects of the verification process. Therefore, section 1411(c)(4)(B) of the ACA does not provide a statutory basis to modify the length of the 90-day response period."). However, the agency also explained that "even if the statute allowed an automatic 60-day extension, our review of how applicants used the 60-day extension shows that the benefits we previously anticipated have not materialized." *Id.* Yet in attempting to explain that conclusion, in light of the 2024 automatic extension rule and its findings, the agency merely stated that it "must weigh" the "potential positive impact on the risk pool" identified by the prior rule "against the substantial increase in APTC expenditures that we identified from ineligible people who stay enrolled and receive APTC for an additional 60 days." *Id.* According to the agency, "the cost to taxpayers and decline in program integrity outweigh any possible benefit to the risk pool." *Id.*

But the statute permits the exercise of authority to modify methods for information verification "*if* the Secretary determines such modifications would reduce the administrative costs

and burdens on *the applicant*." 42 U.S.C. § 18081(c)(4)(B) (emphasis added). CMS's exercise of its authority centers on "program integrity" and "costs to taxpayers"—consideration of "the administrative costs and burdens on the applicant" are nowhere to be found, nor is any data which undermines the conclusions of the prior policy regarding the reduction in administrative costs and burdens to the applicant imposed by a 90-day timeline without extension. *See* 90 Fed. Reg. at 27,119 ("As we stated in the proposed rule (90 FR 12963), we previously determined 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 along with an explanation of seasonal employment or self-employment, including multiple jobs.").

In sum, the Court concludes that this provision of the Rule is contrary to law because it did not modify a "method[] used under the program established by" § 18081(a) based on a determination that the modification "would reduce the administrative costs and burdens on the applicant." 42 U.S.C. § 18081(c)(4)(B). And to the extent that the agency purported to do so, it did not provide "a reasoned explanation" necessary "for disregarding facts and circumstances that underlay or were engendered by the prior policy." *Fox Television Stations, Inc.*, 556 U.S. at 515–16. Accordingly, Plaintiffs are awarded summary judgment on their challenge to the provision of the Rule rescinding the automatic 60-day extension.

2. Income Verification When Data Shows Income Below 100 Percent of FPL

Under current regulations, if an applicant's attestation regarding their projected annual household income reflects a higher household income than that reflected in income data provided by the IRS or certain other sources, an Exchange generally "must accept the applicant's attestation . . . without further verification." 45 C.F.R. § 155.320(c)(3)(iii)(A). The Rule amends this provision by requiring an Exchange to instead further verify an applicant's household income if (1) an applicant attests to income that is between 100% and 400% of the FPL, (2) income data

from the IRS indicates household income below 100% of the FPL, and (3) the former income amount exceeds the latter amount by a "reasonable threshold." 90 Fed. Reg. at 27,123. The applicant would then be given an opportunity to resolve the inconsistency by providing additional documentation and taking other steps to verify their household income. *See* 45 C.F.R. § 155.315(f)(1)–(4).

Plaintiffs argue that "the mandatory audit policy is arbitrary for precisely the same reasons that this Court vacated the same policy five years ago." ECF 65-1, at 50 (citing *City of Columbus II*, 523 F. Supp. 3d at 731). According to Plaintiffs, "CMS improperly assumed that these enrollees must have been attempting to defraud the Exchanges," even though "[t]here are many reasons why an individual could, in good faith, project that he or she will have income next year higher than the federal poverty level even if current-year IRS data shows a lower income." *Id.* Plaintiffs further argue that the additional verification will cause significant obstacles to enrollment, as "[m]any such people are self-employed, or may have difficulty obtaining documentation to support their projections." *Id.*

Defendants acknowledge that the provision "parallels a provision from a 2018 rule that was vacated in *City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021)." ECF 68-1, at 46. However, Defendants maintain that the verification measures are necessary because an applicant may be "overestimating his or her projected household income to obtain APTCs for which the applicant is not otherwise eligible." *Id.* As noted, a similar challenge to a similar proposed change in the Rule was raised in 2018. *See City of Columbus II*, 523 F. Supp. 3d at 762 ("Plaintiffs contend that HHS's decision to impose income verification requirements is arbitrary and capricious because it failed to support its decision with anything more than unsubstantiated conclusions and failed to acknowledge the impracticability of low-income applicants being able to meet this

requirement."). There, Judge Chasanow held that "Defendant's stated rationale for imposing income verification requirements—to prevent fraud in states that did not expand Medicaid—[was] unfounded," because "Defendants failed to point to any actual or anecdotal evidence indicating fraud in the record." *Id.* Judge Chasanow reasoned that "HHS improperly elevated the objective of fraud prevention, for which it had no evidence, above the ACA's primary purpose of providing health insurance. *Id.* (citing *King*, 759 F.3d at 373–74).

This time around, Defendants posit that their justification "does not suffer from the same flaws that were fatal to the 2018 provision." ECF 68-1, at 46. Specifically, Defendants argue that "HHS now points to data that 'provide substantial evidence that applicants with household incomes below the APTC income eligibility threshold'—that is, 100 percent of the FPL—'are strategically inflating their household incomes,' or are 'getting assistance from' agents and brokers that have a 'financial incentive' to maximize Exchange enrollments, in order to obtain subsidized coverage in an Exchange despite their actual household incomes rendering them ineligible for such coverage." *Id.* at 46–47 (quoting 90 Fed. Reg. at 27,122). In its current effort to change the regulation, HHS cited to a study that "compared estimated potential enrollment in Exchanges based on income data reported in census surveys to actual enrollment by enrollees who reported household income above the FPL-based eligibility threshold and found that actual enrollment was 136 percent higher than the total population of potential enrollments." *Id.* at 47 (citing 90 Fed. Reg. at 27,122). Defendants also point out that the "same study also found that a far higher number of enrollees reported household income that was just above the Exchange-eligibility threshold in non-Medicaid expansion States compared to those in States that did expand Medicaid." *Id.* (citing 90 Fed. Reg. at 27,122). However, Plaintiffs respond that "one of the authors of that study submitted a comment to CMS (which the agency ignored) cautioning that the report did not support this conclusion,

given the difficulties that low-income people face in estimating their future incomes." ECF 65-1, at 51 (citing Urban Institute comment at 2 (Apr. 11, 2025), https://perma.cc/F5PH-WVN2, *also available at* ECF 65-2, at 150).

It appears that the agency did not directly address the comment by one of the study's authors in the final Rule. In their reply, Defendants note that "the other two authors of the [study] did not join their coauthor's comments," and point out that the "commenter admitted that her own research '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.'" ECF 71, at 23. Defendants further argue that "[t]hese 'flaws' are simply data limitations common to any study, which HHS identified." *Id.* (citing 90 Fed. Reg. at 27,210).

The Rule also cites to a report from the Paragon Health Institute (the "Paragon report") that purports to find a high rate of fraudulent enrollments, specifically citing it to show that "[a] more recent analysis of 2024 open enrollment data shows plan selections on HealthCare.gov among people ages 19–64 who reported household income between 100 percent and 150 percent of the FPL in non-Medicaid expansion States were 70 percent higher than potential enrollments estimated from Census data at that same income level." 90 Fed. Reg. at 27,122. The agency thus reasoned that "[b]ased on this mismatch between enrollment and the eligible population, this study estimates four to five million people improperly enrolled in QHP coverage with APTC in 2024 at a cost of $15 to $20 billion." *Id.* Plaintiffs point out that "the Paragon report compared apples to oranges by including children in its estimated number of applicants but not in its count of eligible persons; by mismatching 2023 data to estimate improper enrollments for 2024, when many more people gained eligibility for the Exchanges in light of changes in Medicaid enrollment standards; and by using fundamentally different measures of income for its two data sets." ECF 65-1, at 19–

20 (first citing Urban Institute comment at 2–3 (Apr. 11, 2025), https://perma.cc/7457-27KN, *also available at* ECF 65-2, at 150–51; then citing Jason Levitis et al. comment at 28–31 (Apr. 11, 2025), https://perma.cc/X3KY-KZLW, *also available at* ECF 65-2, at 220–23; then citing Ctr. for Budget & Policy Priorities comment at 4–5 (Apr. 11, 2025), https://perma.cc/KP9W-J63N, *also available at* ECF 65-2, at 155–56; and then citing Matthew Fiedler comment at 4–5 (Apr. 11, 2025), *available at* ECF 65-2, at 190–91)). Plaintiffs contend that "[t]hese flaws in the Paragon analysis were pointed out to CMS by commenters, but CMS did not explain why it chose to ignore them." *Id.* at 20.

Against this backdrop, the Court concludes that HHS failed to meaningfully address the comments pointing out potential flaws in the data contained in the Paragon report, despite continuing to rely on such data to justify the provision in the Rule. *See* 90 Fed. Reg. at 27,215 (explaining in response to commenters expressing concerns over unsound data in the Paragon Report that the agency "noted these limitations in the proposed rule and continue to reference them in this final rule. The Paragon report analysis informed our analysis, but we also incorporated Exchange data for a more fulsome analysis."). Defendants have essentially ignored the Paragon Report (and its flaws) during this litigation, except in their reply, *see* ECF 71, at 23. Defendants are not free to support a rule change with data of questionable validity and limited relevance, and then refuse to engage with commenters' reasonable concerns that the data fails to support the conclusion the agency drew from that data. This is particularly problematic where, as here, an *author* of one of the studies relied upon timely noted that the study she contributed to "did not support this conclusion, given the difficulties that low-income people face in estimating their future incomes," ECF 65-1, at 51 (citations omitted), which is the issue that purportedly motivated the rule change in the first place. The agency was thus required to meaningfully contend with this

comment because it affected a "fundamental premise" of the Rule, namely the very justification for the Rule itself. *See MCI WorldCom, Inc. v. FCC*, 209 F.3d 760, 765 (D.C. Cir. 2000) ("An agency is not obliged to respond to every comment, only those that can be thought to challenge a fundamental premise."). That the other two authors of that study did not join in their co-author's comment does not alter the Court's conclusion. The silence of those co-authors does nothing to rebut the legitimate reservations which the commenting author and other commenters brought to the agency's attention, and which the agency failed to adequately address.

In short, the agency refused to meaningfully engage with challenges to the data and reports used to justify the Rule, which began at the time of promulgating the final Rule and continues through this litigation. As Judge Chasanow previously (and eloquently) explained, the agency's "decision to prioritize a hypothetical risk of fraud over the substantiated risk that its decision result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic." *City of Columbus II*, 523 F. Supp. 3d at 763. Accordingly, this Court again concludes that CMS acted arbitrarily by instituting additional verification requirements without sufficient data justifying the need to do so. Summary judgment will be awarded to Plaintiffs with respect to this provision.

3. Income Verification When Tax Data is Unavailable

This provision of the Rule rescinds a regulation that requires an Exchange to accept an applicant's self-attestation of projected annual household income "without further verification" whenever (1) the Exchange requests tax return data from the IRS to verify the applicant's attested income, but (2) the IRS confirms that there is no such data available, 45 C.F.R. § 155.320(c)(5). *See* 90 Fed. Reg. at 27,130. The current regulation, which was adopted in 2023, creates an exception to the general requirement that an Exchange must verify an applicant's annual household income with certain trusted data sources, 45 C.F.R. § 155.320(c)(1)(ii), and otherwise follow an

alternative verification process if tax return data for an applicant is unavailable, *id.* § 155.320(c)(3)(vi). The Rule removes this exception and requires Exchanges to follow standard verification and data-matching procedures "when tax return data is unavailable to immediately verify a consumer's attestation of annual household income." 90 Fed. Reg. at 27,132.

Plaintiffs explain that "[i]t is a relatively common occurrence for tax data to be missing for an applicant, for entirely legitimate reasons," for example, "[a]n individual might have changed his or her name, had a change in family composition, had a change in filing status, or might not have been subject to a filing requirement for the year in question." ECF 65-1, at 52. According to Plaintiffs, "[f]or many of" the people with data discrepancies, "other documentation might not be readily available to substitute for tax data, which means that if these people are not permitted to attest to their income, they will be deprived of subsidized coverage." *Id.*

The question for the Court is not simply whether Defendants have presented sufficient evidence of fraudulent enrollment, but also whether there is sufficient evidence of a *nexus* between fraudulent enrollment and self-attestation to tax data such that it justifies requiring heightened income verification. Put differently, if the agency cannot point to data showing that self-attestation meaningfully contributes to increased fraud, then the agency adopted an incongruent solution to the problem. *See City of Columbus II*, 523 F. Supp. 3d at 762 ("HHS improperly elevated the objective of fraud prevention, for which it had no evidence, above the ACA's primary purpose of providing health insurance." (citing *King*, 759 F.3d at 373–374)).

After reviewing the agency's reasoning in the Rule, the Court finds that CMS concluded in a conclusory fashion that program integrity benefits would outweigh the administrative burden on applicants. The Court agrees with Plaintiffs that CMS "attempted to justify these burdens and these coverage losses simply by reciting that self-attestation 'may have played a role in weakening

the Exchange eligibility system,' but it provided no support for this assertion." ECF 65-1, at 52 (quoting 90 Fed. Reg. at 27,130). While Defendants argue that "[t]he agency made the reasonable observation that applicants without tax return data will likely have documentation verifying their household income (*e.g.*, pay stubs) 'readily available' to them and that the burden of submitting that documentation, by extension, would be relatively minimal," ECF 68-1, at 48 (quoting 90 Fed. Reg. at 27,131–32), the agency provides no basis for this conclusory statement.

In fact, this assertion is not even internally consistent, as CMS separately acknowledges in the Rule that "income verification can be more challenging for lower-income tax filers due to less consistent employment." 90 Fed. Reg. at 27,200. To address this concern, CMS merely stated "our experience with income verifications suggests the process does not impose a substantial burden." *Id.* The agency never explains what this history is or how it led to the conclusion it purportedly supports. The circular reasoning and conclusory statements offered to justify the policy change are not indicative of reasoned decision-making. This is particularly troubling because CMS, by its own estimation, acknowledges that 407,000 people will lose some, or all, of their APTCs as a result of this change. *See id.* Given the lack of sufficient data to justify this provision of the Rule, and the agency's lack of meaningful explanation for the provision, the Court finds that this provision was not "reasonable and reasonably explained."[22] *FCC v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021). Accordingly, Plaintiffs are entitled to summary judgment as to this provision as well.

[22] This holding is bolstered by the fact that the Rule relied on the Paragon report, which, as the Court described above, has serious flaws the agency did not address and which Defendants have sparsely and unpersuasively defended in their reply.

## V. CONCLUSION

For the foregoing reasons, Plaintiffs' motion for summary judgment is granted in part and denied in part, and Defendants' cross-motion for summary judgment is granted in part and denied in part. A separate implementing order will issue.

Dated: June 12, 2026

/s/
Brendan A. Hurson
United States District Judge

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

| | | |
|---|---|---|
| CITY OF COLUMBUS ET AL., | * | |
| Plaintiffs, | * | |
| v. | * | |
| ROBERT F. KENNEDY, JR. ET AL., | * | Civil No. 25-2114-BAH |
| Defendants. | * | |

* * * * * * * * * * * * *

**ORDER**

For the reasons stated in the accompanying memorandum opinion, and upon consideration of Plaintiffs' motion for summary judgment, ECF 65, and Defendants' cross-motion for summary judgment, ECF 68, it is this 12th day of June, 2026, by the United States District Court for the District of Maryland, hereby ORDERED that:

(1) Plaintiffs' motion for summary judgment, ECF 65, is GRANTED in part and DENIED in part;

(2) Defendants' motion for summary judgment, ECF 68, is GRANTED in part and DENIED in part;

(3) The following provisions of the final rule entitled "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," 90 Fed. Reg. 27074, are VACATED pursuant to 5 U.S.C. § 706:

a. The imposition of a $5 premium penalty on automatic re-enrollees, through the addition of 45 C.F.R. § 155.335(a)(3) and (n) and revisions to 45 C.F.R. § 155.330(j);

b. The revocation of guaranteed insurance coverage for individuals with past-due premiums, through revisions to 45 C.F.R. § 147.104(i);

c. The failure to reconcile policy in 45 C.F.R. § 155.305(f)(4), including the final rule's amendments to that policy through the addition of 45 C.F.R. § 155.305(f)(4)(iii);

d. The imposition of eligibility verification for the special enrollment period, through the revisions to 45 C.F.R. § 155.420(g);

e. The imposition of a shortened open enrollment period beginning in 2027, through revisions to 45 C.F.R. § 155.410(e) and (f);

f. The elimination of the 60-day extension of time to resolve inconsistencies in household income data, through the removal of 45 C.F.R. § 155.315(f)(7) and revisions to 45 C.F.R. § 155.320(c)(5);

g. The imposition of a requirement that Exchanges verify household income inconsistencies when a tax filer's attested projected annual household income differs from "trusted data sources," through revisions to 45 C.F.R. § 155.320(c)(3)(iii) and the addition of 45 C.F.R. § 155.320(c)(3)(vi)(C)(2);

h. The changes to the de minimis ranges for actuarial value calculations, through revisions to 45 C.F.R. §§ 156.140(c), 156.200(b)(3), and 156.400; and

(4) The following provision is not vacated by the Court's ruling and may take effect according to its terms:

a. The change to the measure for calculating the premium adjustment percentage set forth in 90 Fed. Reg. 27,166 through 27,178.

/s/
Brendan A. Hurson
United States District Judge

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

*

CITY OF COLUMBUS ET AL.,

*

Plaintiffs,

*

v.

* Civil No. 25-2114-BAH

ROBERT F. KENNEDY, JR. ET AL.,

*

Defendants.

*

* * * * * * * * * * * * *

**ORDER**

For the reasons stated in the Court's memorandum opinion, ECF 73, and upon consideration of Plaintiffs' motion for summary judgment, ECF 65, and Defendants' cross-motion for summary judgment, ECF 68, it is, by the United States District Court for the District of Maryland, hereby **ORDERED** that Plaintiffs' unopposed motion for clarification, ECF 75, is **GRANTED**, and this Court's order of June 12, 2026, ECF 74, is amended as clarified to provide as follows:

(1) Plaintiffs' motion for summary judgment, ECF 65, is GRANTED in part and DENIED in part;

(2) Defendants' motion for summary judgment, ECF 68, is GRANTED in part and DENIED in part;

(3) The following provisions of the final rule entitled "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," 90 Fed. Reg. 27074, are VACATED pursuant to 5 U.S.C. § 706:

a. The imposition of a $5 premium penalty on automatic re-enrollees, through the addition of 45 C.F.R. § 155.335(a)(3) and (n);

b. The revocation of guaranteed insurance coverage for individuals with past-due premiums, through revisions to 45 C.F.R. § 147.104(i);

c. The failure to reconcile policy in 45 C.F.R. § 155.305(f)(4), including the final rule's amendments to that policy through the addition of 45 C.F.R. § 155.305(f)(4)(iii);

d. The imposition of eligibility verification for the special enrollment period, through the revisions to 45 C.F.R. § 155.420(g);

e. The imposition of a shortened open enrollment period beginning in·2027, through revisions to 45 C.F.R.§ 155.410(e) and (f);

f. The elimination of the 60-day extension of time to resolve inconsistencies in household income data, through the removal of 45 C.F.R. § 155.315(f)(7);

g. The imposition of a requirement that Exchanges verify household income inconsistencies when a tax filer's attested projected annual household income differs from "trusted data sources," through revisions to 45 C.F.R. § 155.320(c)(3)(iii) and the addition of 45 C.F.R. § 155.320(c)(3)(vi)(C)(2);

h. The changes to the de minimis ranges for actuarial value calculations, through revisions to 45 C.F.R. §§ 156.140(c), 156.200(b)(3), and 156.400;

i. The changes to the policy regarding self-attestation of projected income, through revisions to 45 C.F.R. § 155.320(c)(5); and

(4) The following provision is not vacated by the Court's ruling and may take effect according to its terms:

a. The change to the measure for calculating the premium adjustment percentage set forth in 90 Fed. Reg. 27,166 through 27,178.

June 16, 2026
Date

/s/
Brendan A. Hurson
United States District Judge

**No. 26-1938**

**IN THE UNITED STATES COURT OF APPEALS**
**FOR THE FOURTH CIRCUIT**

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CITY OF COLUMBUS, *et al.*,
*Plaintiffs-Appellees*,

v.

ROBERT F. KENNEDY, JR., *in his official capacity as Secretary of the United States Department of Health and Human Services, et al*,
*Defendants-Appellants*.

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On Appeal from the United States District Court
for the District of Maryland

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# JOINT APPENDIX
# VOLUME II OF III

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APPEAL,CLOSED

# U.S. District Court
## District of Maryland (Baltimore)
## CIVIL DOCKET FOR CASE #: 1:25−cv−02114−BAH

City of Columbus et al v. Kennedy et al
Assigned to: Judge Brendan Abell Hurson
Related Cases: 1:18−cv−02364−DKC
1:26−cv−02215−BAH
Case in other court: USCA, 25−02012
Cause: 05:706 Judicial Review of Agency Action

Date Filed: 07/01/2025
Date Terminated: 06/23/2026
Jury Demand: None
Nature of Suit: 899 Other Statutes: Administrative Procedures Act/Review or Appeal of Agency Decision
Jurisdiction: U.S. Government Defendant

**Plaintiff**

**City of Columbus**

represented by **Christine L Coogle , Coogl**
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**Plaintiff**

**Mayor and City Council of Baltimore**

represented by **Christine L Coogle , Coogl**
(See above for address)
*ATTORNEY TO BE NOTICED*

**Cortney Robinson Henderson**
(See above for address)
*ATTORNEY TO BE NOTICED*

**Joel L McElvain**
(See above for address)
*ATTORNEY TO BE NOTICED*

**Plaintiff**

**City of Chicago**

represented by **Christine L Coogle , Coogl**
(See above for address)
*ATTORNEY TO BE NOTICED*

**Cortney Robinson Henderson**
(See above for address)
*ATTORNEY TO BE NOTICED*

**Joel L McElvain**
(See above for address)
*ATTORNEY TO BE NOTICED*

**Plaintiff**

**Doctors for America** represented by **Christine L Coogle , Coogl**
(See above for address)
*ATTORNEY TO BE NOTICED*

**Cortney Robinson Henderson**
(See above for address)
*ATTORNEY TO BE NOTICED*

**Joel L McElvain**
(See above for address)
*ATTORNEY TO BE NOTICED*

**Plaintiff**

**Main Street Alliance** represented by **Christine L Coogle , Coogl**
(See above for address)
*ATTORNEY TO BE NOTICED*

**Cortney Robinson Henderson**
(See above for address)
*ATTORNEY TO BE NOTICED*

**Joel L McElvain**
(See above for address)
*ATTORNEY TO BE NOTICED*

V.

**Defendant**

**Robert F. Kennedy, Jr.**
*in his official capacity as Secretary of the United States* represented by **Jordan Hulseberg**
DOJ−Civ
Federal Programs Branch
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Email: jordan.a.hulseberg2@usdoj.gov
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202−637−2200
Email: zach.sherwood@lw.com
*TERMINATED: 12/15/2025*

**Defendant**

**United States Department of Health and Human Services** represented by **Jordan Hulseberg**
(See above for address)
*LEAD ATTORNEY*
*ATTORNEY TO BE NOTICED*

**Zachary W. Sherwood**
(See above for address)
*TERMINATED: 12/15/2025*

**Defendant**

**Mehmet Oz**
*in his official capacity as Administrator of the Centers for Medicare and Medicaid Services*

represented by **Jordan Hulseberg**
(See above for address)
*LEAD ATTORNEY*
*ATTORNEY TO BE NOTICED*

**Zachary W. Sherwood**
(See above for address)
*TERMINATED: 12/15/2025*

**Defendant**

**Centers for Medicare & Medicaid Services**

represented by **Jordan Hulseberg**
(See above for address)
*LEAD ATTORNEY*
*ATTORNEY TO BE NOTICED*

**Zachary W. Sherwood**
(See above for address)
*TERMINATED: 12/15/2025*

| Date Filed | # | Docket Text |
|---|---|---|
| 07/01/2025 | 1 | COMPLAINT against CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ROBERT F. KENNEDY, JR, MEHMET OZ ( Filing fee $ 405 receipt number AMDDC−12075996.), filed by CITY OF CHICAGO, DOCTORS FOR AMERICA, MAYOR AND CITY COUNCIL OF BALTIMORE, CITY OF COLUMBUS, MAIN STREET ALLIANCE. (Attachments: # 1 Civil Cover Sheet, # 2 Summons, # 3 Summons, # 4 Summons, # 5 Summons, # 6 Summons, # 7 Summons, # 8 Attachment Corporate Disclosure Statement, # 9 Attachment Corporate Disclosure Statement, # 10 Attachment Corporate Disclosure Statement, # 11 Attachment Corporate Disclosure Statement, # 12 Attachment Corporate Disclosure Statement)(McElvain, Joel) (Entered: 07/01/2025) |
| 07/02/2025 | 2 | NOTICE of Appearance by Christine L Coogle, Coogl on behalf of All Plaintiffs (Coogle, Christine) (Additional attachment(s) added on 7/2/2025: # 1 FLATTENED Main Document) (bw5s). (Entered: 07/02/2025) |
| 07/02/2025 | 3 | Consent MOTION for Leave to File Excess Pages by CITY OF CHICAGO, CITY OF COLUMBUS, DOCTORS FOR AMERICA, MAIN STREET ALLIANCE, MAYOR AND CITY COUNCIL OF BALTIMORE (Attachments: # 1 Text of Proposed Order)(Coogle, Christine) (Entered: 07/02/2025) |
| 07/02/2025 | 4 | NOTICE of Appearance by Joel L McElvain on behalf of CITY OF CHICAGO, CITY OF COLUMBUS, DOCTORS FOR AMERICA, MAIN STREET ALLIANCE, MAYOR AND CITY COUNCIL OF BALTIMORE (McElvain, Joel) (Entered: 07/02/2025) |
| 07/02/2025 | 5 | MOTION to Appear Pro Hac Vice for Cortney Robinson (Filing fee $100, receipt number AMDDC−12078379.) by CITY OF CHICAGO, CITY OF COLUMBUS, DOCTORS FOR AMERICA, MAIN STREET ALLIANCE, MAYOR AND CITY COUNCIL OF BALTIMORE(Coogle, Christine) (Entered: 07/02/2025) |
| 07/02/2025 | 6 | QC NOTICE: 1 Complaint,, filed by Main Street Alliance, Mayor and City Council of Baltimore, Doctors for America, City of Chicago, City of Columbus was filed incorrectly.<br>***Your 103.3 Disclosure Statement must be filed as a separate entry using the event Local Rule 103.3 Disclosure Statement (Other Filings −> Other Documents −> Local Rule 103.3 Disclosure Statement). Your document has been accepted by court staff. No action is required on your part at this time.* (bw5s, Deputy Clerk) (Entered: 07/02/2025) |
| 07/02/2025 | 7 | QC NOTICE: 2 Notice of Appearance filed by Main Street Alliance, Mayor and City Council of Baltimore, Doctors for America, City of Chicago, City of Columbus was |

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| | | filed incorrectly.<br>***Not all pdf documents were flattened prior to filing. All pdfs uploaded to CM/ECF MUST BE FLATTENED for all future filings. Failure to comply may result in rejected filings and delays in case processing.*<br>***This filing has been corrected by court staff and no further corrective action is required.* (bw5s, Deputy Clerk) (Entered: 07/02/2025) |
| 07/02/2025 | 8 | Summons Issued 60 days as to Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, United States Department of Health and Human Services, U.S. Attorney and U.S. Attorney General(bw5s, Deputy Clerk) (Entered: 07/02/2025) |
| 07/02/2025 | 9 | PAPERLESS ORDER granting 5 Motion to Appear Pro Hac Vice on behalf of Cortney R Robinson. Directing attorney Cortney R Robinson to register for pro hac vice filing in the District of Maryland through PACER at https://pacer.uscourts.gov/ if attorney has not already done so. The *Pro Hac Vice* option must be selected when registering. Signed by Clerk on 7/2/2025. (mh4s, Deputy Clerk) (Entered: 07/02/2025) |
| 07/02/2025 | 10 | ORDER granting 3 Consent MOTION for Leave to File Excess Pages. Signed by Judge Brendan Abell Hurson on 7/2/2025. (bw5s, Deputy Clerk) (Entered: 07/02/2025) |
| 07/02/2025 | 11 | MOTION for Other Relief *for Stay under 5 U.S.C. 705 or, in the Alternative, for Preliminary Injunction* by City of Chicago, City of Columbus, Doctors for America, Main Street Alliance, Mayor and City Council of Baltimore (Attachments: # 1 Memorandum in Support, # 2 Affidavit Decl. of Christen Linke Young, # 3 Affidavit Decl. of Shawn Phetteplace, # 4 Affidavit Decl. of Brooke Legler, # 5 Affidavit Decl. of Dr. Janet Krommes, # 6 Affidavit Decl. of Dr. Beth Oller, # 7 Affidavit Decl. of Edward Johnson, # 8 Affidavit Decl. of Faith Leach, # 9 Affidavit Decl. of Dr. Olusimbo Ige, # 10 Text of Proposed Order)(McElvain, Joel) (Entered: 07/02/2025) |
| 07/08/2025 | 12 | PAPERLESS ORDER confirming the briefing schedule re 11 MOTION for Other Relief *for Stay under 5 U.S.C. 705 or, in the Alternative, for Preliminary Injunction* filed by Main Street Alliance, Mayor and City Council of Baltimore, Doctors for America, City of Chicago, City of Columbus. Per Local Rule 105.2(a), Defendants' response to the motion is due July 16, 2025. Plaintiffs' reply is due July 30, 2025. Signed by Judge Brendan Abell Hurson on 7/8/2025. (nd4s, Chambers) (Entered: 07/08/2025) |
| 07/14/2025 | 13 | [FILED IN ERROR] SUMMONS Returned Executed by City of Chicago, Doctors for America, Mayor and City Council of Baltimore, City of Columbus, Main Street Alliance. Centers for Medicare & Medicaid Services served on 7/9/2025, answer due 7/30/2025.(Coogle, Christine) Modified on 7/22/2025 (bw5s). (Entered: 07/14/2025) |
| 07/14/2025 | 14 | [FILED IN ERROR] SUMMONS Returned Executed by City of Chicago, Doctors for America, Mayor and City Council of Baltimore, City of Columbus, Main Street Alliance. United States Department of Health and Human Services served on 7/14/2025, answer due 8/4/2025.(Coogle, Christine) Modified on 7/22/2025 (bw5s). (Entered: 07/14/2025) |
| 07/14/2025 | 15 | [FILED IN ERROR] SUMMONS Returned Executed by City of Chicago, Doctors for America, Mayor and City Council of Baltimore, City of Columbus, Main Street Alliance. Mehmet Oz served on 7/10/2025, answer due 7/31/2025.(Coogle, Christine) Modified on 7/22/2025 (bw5s). (Entered: 07/14/2025) |
| 07/14/2025 | 16 | [FILED IN ERROR] SUMMONS Returned Executed by City of Chicago, Doctors for America, Mayor and City Council of Baltimore, City of Columbus, Main Street Alliance. Robert F. Kennedy, Jr served on 7/14/2025, answer due 8/4/2025.(Coogle, Christine) Modified on 7/22/2025 (bw5s). (Entered: 07/14/2025) |
| 07/14/2025 | 17 | AFFIDAVIT of Service for Summons served on Pam Bondi, in her official capacity as U.S. Attorney General, on 07/14/2025, filed by City of Chicago, City of Columbus, Doctors for America, Main Street Alliance, Mayor and City Council of Baltimore.(Coogle, Christine) (Entered: 07/14/2025) |
| 07/14/2025 | 18 | AFFIDAVIT of Service for Summons served on Kelly O. Hayes, in her official capacity as U.S. Attorney for the District of Maryland, on 07/09/2025, filed by City of Chicago, City of Columbus, Doctors for America, Main Street Alliance, Mayor and |

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| | | City Council of Baltimore.(Coogle, Christine) (Entered: 07/14/2025) |
| 07/15/2025 | 19 | NOTICE of Appearance by Zachary W. Sherwood on behalf of Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, United States Department of Health and Human Services (Sherwood, Zachary) (Entered: 07/15/2025) |
| 07/15/2025 | 20 | Consent MOTION for Extension of Time to File Response/Reply as to 11 MOTION for Other Relief *for Stay under 5 U.S.C. 705 or, in the Alternative, for Preliminary Injunction* by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, United States Department of Health and Human Services (Attachments: # 1 Text of Proposed Order)(Sherwood, Zachary) (Entered: 07/15/2025) |
| 07/15/2025 | 21 | ORDER Granting 20 Motion for Extension of Time to File Response/Reply. Signed by Judge Brendan Abell Hurson on 7/15/2025. (bas, Deputy Clerk) (Entered: 07/15/2025) |
| 07/15/2025 | 22 | PAPERLESS ORDER: A hearing on 11 MOTION for Other Relief *for Stay under 5 U.S.C. 705 or, in the Alternative, for Preliminary Injunction* filed by Main Street Alliance, Mayor and City Council of Baltimore, Doctors for America, City of Chicago, City of Columbus has been scheduled for Thursday, August 14, 2025, at 10:00 a.m. in Courtroom 3D (101 W. Lombard Street, Baltimore, MD 21201). Signed by Judge Brendan Abell Hurson on 7/15/2025. (nd4s, Chambers) (Entered: 07/15/2025) |
| 07/23/2025 | 23 | SUMMONS Returned Executed by City of Chicago, Doctors for America, Mayor and City Council of Baltimore, City of Columbus, Main Street Alliance. United States Department of Health and Human Services served on 7/14/2025, answer due 9/12/2025.(Coogle, Christine) (Entered: 07/23/2025) |
| 07/23/2025 | 24 | SUMMONS Returned Executed by City of Chicago, Doctors for America, Mayor and City Council of Baltimore, City of Columbus, Main Street Alliance. Robert F. Kennedy, Jr served on 7/14/2025, answer due 9/12/2025.(Coogle, Christine) (Entered: 07/23/2025) |
| 07/23/2025 | 25 | SUMMONS Returned Executed by City of Chicago, Doctors for America, Mayor and City Council of Baltimore, City of Columbus, Main Street Alliance. Centers for Medicare & Medicaid Services served on 7/9/2025, answer due 9/8/2025.(Coogle, Christine) (Entered: 07/23/2025) |
| 07/23/2025 | 26 | SUMMONS Returned Executed by City of Chicago, Doctors for America, Mayor and City Council of Baltimore, City of Columbus, Main Street Alliance. Mehmet Oz served on 7/10/2025, answer due 9/8/2025.(Coogle, Christine) (Entered: 07/23/2025) |
| 07/25/2025 | 27 | Consent MOTION for Leave to File Excess Pages by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, United States Department of Health and Human Services (Attachments: # 1 Text of Proposed Order)(Sherwood, Zachary) (Entered: 07/25/2025) |
| 07/25/2025 | 28 | RESPONSE in Opposition re 11 MOTION for Other Relief *for Stay under 5 U.S.C. 705 or, in the Alternative, for Preliminary Injunction* filed by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, United States Department of Health and Human Services. (Attachments: # 1 Text of Proposed Order)(Sherwood, Zachary) (Entered: 07/25/2025) |
| 07/28/2025 | 29 | PAPERLESS ORDER granting 27 Motion for Leave to File Excess Pages. It is hereby ORDERED that (1) Defendants may file an opposition of up to 55 pages, and (2) Plaintiffs may file a reply of up to 25 pages. Signed by Judge Brendan Abell Hurson on 7/28/2025. (nd4s, Chambers) (Entered: 07/28/2025) |
| 08/08/2025 | 30 | REPLY to Response to Motion re 11 MOTION for Other Relief *for Stay under 5 U.S.C. 705 or, in the Alternative, for Preliminary Injunction* filed by City of Chicago, City of Columbus, Doctors for America, Main Street Alliance, Mayor and City Council of Baltimore. (Attachments: # 1 Affidavit Declaration of Dr. Eric D. Fethke, # 2 Text of Proposed Order Amended Proposed Order)(McElvain, Joel) (Entered: 08/08/2025) |
| 08/14/2025 | 31 | Motion Hearing held on 8/14/2025 re 11 MOTION for Other Relief *for Stay under 5 U.S.C. 705 or, in the Alternative, for Preliminary Injunction* filed by Main Street Alliance, Mayor and City Council of Baltimore, Doctors for America, City of Chicago, City of Columbus before Judge Brendan Abell Hurson. (Russell Carrick − Courtroom |

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| | | 3D)(Court Reporter: Kassandra McPherson) (rc2s, Deputy Clerk) (Entered: 08/14/2025) |
| 08/15/2025 | 32 | PAPERLESS 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. Signed by Judge Brendan Abell Hurson on 8/15/2025. (cs10, Chambers) (Entered: 08/15/2025) |
| 08/17/2025 | 33 | RESPONSE re 32 Order *Plaintiffs' Submission in Response to Court's August 15, 2025 Minute Order* filed by City of Chicago, City of Columbus, Doctors for America, Main Street Alliance, Mayor and City Council of Baltimore. (Attachments: # 1 Exhibit Ex. A: Urban Institute Comment, # 2 Exhibit Ex. B: NAIC comment)(McElvain, Joel) (Entered: 08/17/2025) |
| 08/20/2025 | 34 | NOTICE OF FILING OF OFFICIAL TRANSCRIPT of Proceedings held on 08/14/2025, before Judge Brendan A. Hurson. Court Reporter Kassandra L. McPherson, Telephone number (410) 962−4544; Kassandra_McPherson@mdd.uscourts.gov. Total number of pages filed: 88. Transcript may be viewed at the court public terminal or purchased through the Court Reporter before the deadline for Release of Transcript Restriction. After that date it may be obtained from the Court Reporter or through PACER. Redaction Request due 9/10/2025. Redacted Transcript Deadline set for 9/22/2025. Release of Transcript Restriction set for 11/18/2025.(km10, Court Reporter) (Entered: 08/20/2025) |
| 08/22/2025 | 35 | MEMORANDUM OPINION. Signed by Judge Brendan Abell Hurson on 8/22/2025. (hmls, Deputy Clerk) (Entered: 08/22/2025) |
| 08/22/2025 | 36 | ORDER GRANTING IN PART and DENYING IN PART 11 Motion for a Stay under 5 U.S.C. § 705 or, in the alternative, for a Preliminary Injunction, construed as a Motion for a Stay. Signed by Judge Brendan Abell Hurson on 8/22/2025. (hmls, Deputy Clerk) (Entered: 08/22/2025) |
| 08/25/2025 | 37 | MOTION Unopposed Motion to Clarify Order of August 22, 2025 re 36 Order on Motion for Other Relief, by City of Chicago, City of Columbus, Doctors for America, Main Street Alliance, Mayor and City Council of Baltimore (Attachments: # 1 Text of Proposed Order)(McElvain, Joel) (Entered: 08/25/2025) |
| 08/25/2025 | 38 | ORDER granting 37 Motion for Clarification re: 36 Order. Signed by Judge Brendan Abell Hurson on 8/25/2025. (jf3s, Deputy Clerk) (Entered: 08/25/2025) |
| 08/28/2025 | 39 | NOTICE OF APPEAL by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, United States Department of Health and Human Services. (Sherwood, Zachary) (Entered: 08/28/2025) |
| 08/29/2025 | 40 | Transmission of Notice of Appeal and Docket Sheet to US Court of Appeals re 39 Notice of Appeal. IMPORTANT NOTICE: To access forms which you are required to file with the United States Court of Appeals for the Fourth Circuit please go to http://www.ca4.uscourts.gov and click on Forms & Notices. (av4s, Deputy Clerk) (Entered: 08/29/2025) |
| 08/29/2025 | 41 | USCA Case Number 25−2012 for 39 Notice of Appeal filed by Robert F. Kennedy, Jr., United States Department of Health and Human Services, Centers for Medicare & Medicaid Services, Mehmet Oz. Case Manager − Paige L. Ballard (jh6s, Deputy Clerk) (Entered: 08/29/2025) |
| 08/29/2025 | 42 | MOTION to Stay *Pending Appeal* by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, United States Department of Health and Human Services (Attachments: # 1 Memorandum in Support, # 2 Exhibit, # 3 Text of Proposed Order)(Sherwood, Zachary) (Entered: 08/29/2025) |
| 09/02/2025 | 43 | NOTICE by City of Chicago, City of Columbus, Doctors for America, Main Street Alliance, Mayor and City Council of Baltimore re 42 MOTION to Stay *Pending Appeal Notice of Intent to File Response* (McElvain, Joel) (Entered: 09/02/2025) |
| 09/02/2025 | 44 | RESPONSE in Opposition re 42 MOTION to Stay *Pending Appeal* filed by City of Chicago, City of Columbus, Doctors for America, Main Street Alliance, Mayor and City Council of Baltimore. (Attachments: # 1 Affidavit Second Declaration of Brooke Legler, # 2 Affidavit Second Declaration of Christen Linke Young)(McElvain, Joel) |

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| | | (Entered: 09/02/2025) |
| 09/04/2025 | 45 | Consent MOTION for Extension of Time to File Answer by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, United States Department of Health and Human Services (Attachments: # 1 Text of Proposed Order)(Sherwood, Zachary) (Entered: 09/04/2025) |
| 09/04/2025 | 46 | PAPERLESS ORDER granting 45 Motion for Extension of Time to Answer. Defendants' response to Plaintiffs' Complaint is due by September 25, 2025. Signed by Judge Brendan Abell Hurson on 9/4/2025. (nd4s, Chambers) (Entered: 09/04/2025) |
| 09/11/2025 | 47 | REPLY to Response to Motion re 42 MOTION to Stay *Pending Appeal* filed by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, United States Department of Health and Human Services.(Sherwood, Zachary) (Entered: 09/11/2025) |
| 09/18/2025 | 48 | NOTICE by City of Chicago, City of Columbus, Doctors for America, Main Street Alliance, Mayor and City Council of Baltimore re 42 MOTION to Stay *Pending Appeal Notice of Supplemental Authority* (McElvain, Joel) (Entered: 09/18/2025) |
| 09/18/2025 | 49 | ORDER of USCA Denying appellants' motion for stay pending appeal as to 39 Notice of Appeal filed by Robert F. Kennedy, Jr., United States Department of Health and Human Services and Centers for Medicare & Medicaid Services, Mehmet Oz. (slss, Deputy Clerk) (Entered: 09/19/2025) |
| 09/25/2025 | 50 | Consent MOTION for Extension of Time to File Answer by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, United States Department of Health and Human Services (Attachments: # 1 Text of Proposed Order)(Sherwood, Zachary) (Entered: 09/25/2025) |
| 09/25/2025 | 51 | PAPERLESS ORDER granting 50 Motion for Extension of Time to Answer. It is hereby ORDERED that Defendants' response to Plaintiffs' Complaint is due by October 16, 2025. Signed by Judge Brendan Abell Hurson on 9/25/2025. (nd4s, Chambers) (Entered: 09/25/2025) |
| 09/29/2025 | 52 | ORDER denying 42 MOTION to Stay Pending Appeal. Signed by Judge Brendan Abell Hurson on 9/29/2025. (bw5s, Deputy Clerk) (Entered: 09/30/2025) |
| 10/10/2025 | 53 | Consent MOTION for Extension of Time to File Answer *in Light of Lapse of Appropriations* by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, United States Department of Health and Human Services (Attachments: # 1 Text of Proposed Order)(Sherwood, Zachary) (Entered: 10/10/2025) |
| 10/14/2025 | 54 | ORDER granting 53 Consent MOTION for Extension of Time to File Answer in Light of Lapse of Appropriations. Signed by Judge Brendan Abell Hurson on 10/10/2025. (ybs, Deputy Clerk) (Entered: 10/14/2025) |
| 10/27/2025 | 55 | Consent MOTION for Extension of Time to File Answer *in Light of Lapse of Appropriations* by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, United States Department of Health and Human Services (Attachments: # 1 Text of Proposed Order)(Sherwood, Zachary) (Entered: 10/27/2025) |
| 10/28/2025 | 56 | PAPERLESS ORDER granting 55 Motion for Extension of Time to Answer All Defendants. It is hereby ORDERED that Defendants' response to Plaintiffs' Complaint is due by November 14, 2025. Signed by Judge Brendan Abell Hurson on 10/28/2025. (nd4s, Chambers) (Entered: 10/28/2025) |
| 11/13/2025 | 57 | Joint MOTION Enter Briefing Schedule by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, United States Department of Health and Human Services (Attachments: # 1 Text of Proposed Order)(Sherwood, Zachary) (Entered: 11/13/2025) |
| 11/14/2025 | 58 | ORDER granting 57 Joint MOTION Enter Briefing Schedule. Signed by Judge Brendan Abell Hurson on 11/13/2025. (bw5s, Deputy Clerk) (Entered: 11/14/2025) |
| 12/03/2025 | 59 | NOTICE of Appearance by Jordan Hulseberg on behalf of All Defendants (Hulseberg, Jordan) (Entered: 12/03/2025) |

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| 12/15/2025 | 60 | MOTION to Withdraw as Attorney by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, United States Department of Health and Human Services (Attachments: # 1 Text of Proposed Order)(Sherwood, Zachary) (Entered: 12/15/2025) |
| 12/15/2025 | 61 | PAPERLESS ORDER granting 60 Motion to Withdraw as Attorney. Attorney Zachary W. Sherwood terminated. Signed by Judge Brendan Abell Hurson on 12/15/2025. (bw5s, Deputy Clerk) (Entered: 12/16/2025) |
| 12/19/2025 | 62 | NOTICE of filing Administrative Record by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, United States Department of Health and Human Services (Attachments: # 1 Attachment Certification and Index)(Hulseberg, Jordan) (1 flashdrive rec'd by Balt intake 12/19/25, placed in chambers' mailbox) Modified on 12/19/2025 (av4s). (Entered: 12/19/2025) |
| 01/15/2026 | 63 | Consent MOTION for Leave to File Excess Pages by City of Chicago, City of Columbus, Doctors for America, Main Street Alliance, Mayor and City Council of Baltimore (Attachments: # 1 Proposed Order)(Robinson, Cortney) (Entered: 01/15/2026) |
| 01/16/2026 | 64 | ORDER granting 63 Consent MOTION for Leave to File Excess Pages. Signed by Judge Brendan Abell Hurson on 1/15/2026. (kb3s, Deputy Clerk) (Entered: 01/16/2026) |
| 01/20/2026 | 65 | MOTION for Summary Judgment by City of Chicago, City of Columbus, Doctors for America, Main Street Alliance, Mayor and City Council of Baltimore (Attachments: # 1 Memorandum in Support, # 2 Appendix Addendum volume 1, # 3 Appendix Addendum volume 2, # 4 Text of Proposed Order)(McElvain, Joel) (Entered: 01/20/2026) |
| 02/09/2026 | 66 | Consent MOTION for Leave to File Excess Pages by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, United States Department of Health and Human Services(Hulseberg, Jordan) (Entered: 02/09/2026) |
| 02/09/2026 | 67 | PAPERLESS ORDER granting 66 Motion for Leave to File Excess Pages. Signed by Judge Brendan Abell Hurson on 2/9/2026. (nd4s, Chambers) (Entered: 02/09/2026) |
| 02/17/2026 | 68 | Cross MOTION for Summary Judgment by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, United States Department of Health and Human Services (Attachments: # 1 Memorandum in Support)(Hulseberg, Jordan) (Entered: 02/17/2026) |
| 02/18/2026 | 69 | QC NOTICE: 68 Motion for Summary Judgment filed by Robert F. Kennedy, Jr., United States Department of Health and Human Services, Centers for Medicare & Medicaid Services, Mehmet Oz was filed incorrectly.<br>***The following attachments or exhibits are missing − Proposed Order. To correct this problem, file Proposed Order using the event Notice (Other) and link Proposed Order to 68 .* (ols, Deputy Clerk) (Entered: 02/18/2026) |
| 03/16/2026 | 70 | RESPONSE in Opposition re 68 Cross MOTION for Summary Judgment, REPLY to Response to Motion re 65 MOTION for Summary Judgment *Plaintiffs' Reply in Support of Their Motion for Summary Judgment and in Opposition to Defendants' Cross−Motion for Summary Judgment* filed by City of Chicago, City of Columbus, Doctors for America, Main Street Alliance, Mayor and City Council of Baltimore.(McElvain, Joel) Modified on 3/17/2026 (bw5s). (Entered: 03/16/2026) |
| 04/14/2026 | 71 | REPLY to Response to Motion re 68 Cross MOTION for Summary Judgment filed by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, United States Department of Health and Human Services.(Hulseberg, Jordan) (Entered: 04/14/2026) |
| 06/03/2026 | 72 | NOTICE by City of Chicago, City of Columbus, Main Street Alliance, Mayor and City Council of Baltimore *of Filing of Related Case* (McElvain, Joel) (Entered: 06/03/2026) |
| 06/12/2026 | 73 | MEMORANDUM OPINION. Signed by Judge Brendan Abell Hurson on 6/12/2026. (bw5s, Deputy Clerk) (Entered: 06/12/2026) |

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| 06/12/2026 | 74 | ORDER granting in part and denying in part 65 Motion for Summary Judgment; granting in part and denying in part 68 Cross MOTION for Summary Judgment; vacating provisions of the final rule entitled "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," 90 Fed. Reg. 27074 as specified herein. Signed by Judge Brendan Abell Hurson on 6/12/2026. (bw5s, Deputy Clerk) (Entered: 06/12/2026) |
| 06/15/2026 | 75 | Consent MOTION for Other Relief *to Clarify June 12m 2026 Order* by City of Chicago, City of Columbus, Doctors for America, Main Street Alliance, Mayor and City Council of Baltimore (Attachments: # 1 Text of Proposed Order)(Henderson, Cortney) (Entered: 06/15/2026) |
| 06/16/2026 | 76 | ORDER GRANTING 75 Consent Motion to Clarify 74 Order and AMENDING as clarified. Signed by Judge Brendan Abell Hurson on 6/16/2026. (hmls, Deputy Clerk) (Entered: 06/16/2026) |
| 06/23/2026 | 77 | ORDER of USCA Granting the motion to voluntarily dismiss this case pursuant to Rule 42(b) of the Federal Rules of Appellate Procedure as to 39 Notice of Appeal filed by Robert F. Kennedy, Jr., United States Department of Health and Human Services and Centers for Medicare & Medicaid Services, Mehmet Oz. (slss, Deputy Clerk) (Entered: 06/23/2026) |
| 06/23/2026 | 78 | RULE 42(b) MANDATE of USCA as to 39 Notice of Appeal filed by Robert F. Kennedy, Jr., United States Department of Health and Human Services, Centers for Medicare & Medicaid Services and Mehmet Oz. (slss, Deputy Clerk) (Entered: 06/23/2026) |
| 07/16/2026 | 79 | NOTICE OF APPEAL as to 73 Memorandum Opinion, 74 Order on Motion for Summary Judgment,,, by Centers for Medicare & Medicaid Services, Robert F. Kennedy, Jr, Mehmet Oz, United States Department of Health and Human Services. (Hulseberg, Jordan) (Entered: 07/16/2026) |
| 07/17/2026 | 80 | Transmission of Notice of Appeal and Docket Sheet to US Court of Appeals re 79 Notice of Appeal. IMPORTANT NOTICE: To access forms which you are required to file with the United States Court of Appeals for the Fourth Circuit please go to http://www.ca4.uscourts.gov and click on Forms & Notices.(slss, Deputy Clerk) (slss). (Entered: 07/17/2026) |

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

CITY OF COLUMBUS,
90 W. Broad St.
Columbus, OH 43215;

MAYOR AND CITY COUNCIL OF BALTIMORE,
100 N. Holiday St., Suite 101
Baltimore, MD 21202;

CITY OF CHICAGO,
121 N. Lasalle St., Room 600
Chicago, IL 60602;

DOCTORS FOR AMERICA,
2300 18th St NW
Washington, DC 20009; and

MAIN STREET ALLIANCE,
909 Rose Ave, Suite 400
North Bethesda, MD 20852,

*Plaintiffs*,

vs.

ROBERT F. KENNEDY, JR., in his official capacity as Secretary of the United States Department of Health and Human Services,
200 Independence Ave. SW
Washington, DC 20201;

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES,
200 Independence Ave. SW
Washington, DC 20201;

MEHMET OZ, in his official capacity as Administrator of the Centers for Medicare and Medicaid Services,
7500 Security Blvd.
Baltimore, MD 21244; and

Case No. 1:25-cv-2114

CENTERS FOR MEDICARE & MEDICAID SERVICES,
7500 Security Blvd.
Baltimore, MD 21244,

*Defendants*.

**COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF**

Plaintiffs the City of Columbus, Ohio; the Mayor and City Council of Baltimore; Maryland; the City of Chicago, Illinois; Doctors for America; and Main Street Alliance hereby sue Defendants Robert F. Kennedy, Jr., in his official capacity as Secretary of the U.S. Department of Health and Human Services; the U.S. Department of Health and Human Services; Mehmet Oz, in his official capacity as Administrator of the Centers for Medicare & Medicaid Services; and the Centers for Medicare & Medicaid Services, and allege the following:

## INTRODUCTION

1. When the Affordable Care Act (ACA) was enacted in 2010, millions of Americans gained access to affordable, comprehensive health care for the first time. Individuals could seek the medical care they needed, when they needed it, and medical providers across the country were better able to provide optimal treatment to their patients. One of the ways the ACA has achieved this result is through the establishment of health insurance Exchanges, where individuals can identify and enroll in affordable insurance policies that meet their health care needs. To ensure lower costs for more comprehensive coverage, the ACA subsidizes the costs of that coverage, which leads younger and healthier individuals to the insurance market, improving the risk pool and lowering premiums for everyone. And the ACA guarantees that individuals are not denied coverage because of a pre-existing health condition or discriminated against based on their history of insurance coverage.

2. The Centers for Medicare & Medicaid Services (CMS), on behalf of the Department of Health and Human Services (HHS), has now published a final rule, purportedly pursuant to the ACA, whose effects will be directly contrary to that landmark legislation. That rule—entitled "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability" (2025 Rule), 90 Fed. Reg. 27,074—purports to "strengthen[] the integrity of the

Patient Protection and Affordable Care Act (ACA) eligibility and enrollment systems to reduce waste, fraud and abuse" and "provide emergent relief from rising improper enrollment and health care costs." *Id.* at 27,074. But the rule accomplishes the opposite.

3. Rather than reducing the cost of insurance for consumers, or increasing their enrollment rates and benefits, Defendants' new policies will cause at least 1.8 million Americans to lose coverage on the ACA's health insurance Exchanges in 2026 alone and will ultimately result in higher premiums in the long term and higher out-of-pocket costs for the remaining enrollees.

4. The 2025 Rule does not spring from nowhere; rather, it is a clear continuation of the prior Trump Administration's yearslong effort to undermine the ACA. During the first Trump presidency, the Administration vowed to "watch Obamacare go down the tubes."[1] Previously, in a 2019 rule, 83 Fed. Reg. 16,930 (Apr. 17, 2018), CMS and HHS attempted to contravene the ACA with proposals that would have eliminated many of the ACA's guarantees, deterred consumers from enrolling in quality health insurance plans, and increased out-of-pocket costs, similar to the 2025 Rule. This Court responded to those efforts, vacating and remanding portions of the rule as arbitrary and capricious.

5. Now, the Trump-Vance Administration returns with another "death by a thousand paper cuts" approach to the ACA. Cloaked in the pretense of government efficiency and fraud prevention, the 2025 Rule creates numerous barriers to affordable insurance coverage, negating the ACA's goal of extending affordable health coverage to all Americans, and instead increasing the population of underinsured and uninsured Americans. Many of the 2025 Rule's provisions are in direct conflict with federal law. And many of its provisions are arbitrary, having been

[1] *Excerpts From The Times's Interview with Trump*, N.Y. Times (July 19, 2017), https://perma.cc/XT6Q-LSPA.

promulgated without observance of proper procedure, reasonable explanation, or meaningful response to public comments, and without consideration of the harm the Rule will impose on the millions of consumers whose health and wellbeing depend on access to affordable coverage and, ultimately, on the American public. In the absence of judicial intervention, the 2025 Rule will into effect on August 25, 2025.

## JURISDICTION AND VENUE

6. This Court has jurisdiction pursuant to 28 U.S.C. § 1331. Plaintiffs' challenge to the 2025 Rule is reviewable under the Administrative Procedure Act, 5 U.S.C. § 701 *et seq.*

7. Venue is proper in this judicial district under 28 U.S.C. § 1391(e)(1)(A) and (C). Defendants are agencies and officers of the United States and Defendant CMS is headquartered in Woodlawn, Maryland. Plaintiffs Main Street Alliance and the Mayor and City Council of Baltimore also reside in Maryland.

## PARTIES

8. Plaintiff the City of Columbus, Ohio, is a municipal corporation organized under Ohio law. *See* Ohio Const. art. XVIII. Columbus has all the powers of local self-government and home rule under the constitution and laws of the state of Ohio, which are exercised in the manner prescribed by the Charter of the City of Columbus.[2] Columbus, located in Franklin County, is the capital of Ohio. It is the largest city in the state and the fifteenth largest city in the United States, with a population of around 933,000, according to 2024 census estimates. Columbus provides a wide range of services on behalf of its residents, including health services for families and children, public health, public assistance, and emergency medical care.

[2] *See City Code and Charter*, City of Columbus (May 28, 2025), https://perma.cc/B9VK-D6JH; Ohio Rev. Code Ann. § 715.01 (West 1953).

9. Plaintiff the Mayor and City Council of Baltimore represent the largest city in Maryland and thirtieth largest city in the United States, with a population of over 568,000, according to 2024 census estimates. The Baltimore City Health Department is a city agency that has wide-ranging responsibilities for providing health services to residents of the city. [3]

10. Plaintiff the City of Chicago, Illinois, is a municipal corporation and home-rule unit organized and existing under the constitution and law of the state of Illinois.[4] Located in Cook County, Chicago is the largest city in Illinois and the third-largest city in the United States, with a population of over 2.7 million, according to 2024 census estimates. Chicago provides a wide range of services on behalf of its residents, including health services, public assistance, and emergency medical care.

11. Plaintiff Doctors for America (DFA) is a not-for-profit, § 501(c)(3) organization with over 27,000 member physicians and medical trainees (including medical residents and students) in all 50 states. DFA mobilizes doctors, medical trainees, and other health professionals to be leaders who put patients over politics to improve the health of patients, communities, and the nation. DFA also advocates for comprehensive health system reform, expansion of health insurance coverage, and improvements to health care delivery so that the health system better meets patients' needs.

12. Plaintiff Main Street Alliance (MSA) is 501(c)(3) organization and national network of small businesses, with approximately 30,000 small business members throughout the United States, many of whom rely on the ACA marketplace for health insurance.

13. Defendant Robert F. Kennedy, Jr., is sued in his official capacity as Secretary of the U.S. Department of Health and Human Services.

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[3] *See* Balt. City Charter, art. VII §§ 54-56, https://perma.cc/9WAJ-BUXZ (captured June 28, 2025).
[4] *See* Ill. Const. art. VII.

14. Defendant HHS is a federal agency headquartered at 200 Independence Ave. SW, Washington, D.C. 20201.

15. Defendant Mehmet Oz is sued in his official capacity as Administrator of CMS.

16. Defendant CMS is a component of Defendant HHS and is headquartered at 7500 Security Boulevard, Baltimore, MD 21244.

## BACKGROUND

### I. The ACA Aims to Provide Affordable Health Insurance for All Americans

17. In 2010, Congress enacted the Patient Protection and Affordable Care Act. Pub. L. No. 111-148, 124 Stat. 119 (2010) (as amended by Pub. L. No. 111-152, 124 Stat. 1029 (2010)). "The Act aims to increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012); *see also King v. Burwell*, 576 U.S. 473, 479 (2015).

18. Before the Act's market reforms went into effect in 2014, "individual health insurance markets were dysfunctional." *City of Columbus v. Cochran*, 523 F. Supp. 3d 731, 740 (D. Md. 2021). Insurers were free to deny coverage for people with pre-existing conditions, to refuse to renew such coverage, or even to revoke such coverage after it had been issued. Now, however, the Act's "guaranteed issue" requirement specifies that every "health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage," 42 U.S.C. § 300gg-1(a), subject to exceptions specified in the statute, such as the restriction of new enrollments to an annual open enrollment period or specified special enrollment periods, *id.* § 300gg-1(b); *see Me. Cmty. Health Options v. United States*, 590 U.S. 296, 301 (2020). "In other words, the Act 'ensure[s] that anyone can buy insurance.'" *Me. Cmty. Health Options*, 290 U.S. at 301 (quoting *King*, 576 U.S. at 493).

19. Separately, the Act's "guaranteed renewability" provision requires issuers to renew or continue in force such coverage, 42 U.S.C. § 300gg-2(a), again subject to statutory exceptions, including an exception for persons who have failed to pay premiums owed on their policies, *id.* § 300gg-2(b)(1); *see also id*. §§ 300gg-12, 300gg-42.

20. Health insurance plans must cover a set of "essential health benefits," such as preventive care. *Id.* § 300gg-6(a). And to protect patients from devastating costs when a medical condition exhausts their coverage, the Act limits so-called "cost-sharing"—for example, deductibles and copayments—for these essential health benefits. *See id*. § 18022(a)(2). The limitation on cost-sharing is adjusted each year by a "premium adjustment percentage," that compares average premiums for "health insurance coverage" in the current year with the same average for 2013, before the Act's marketplace reforms went into effect. *Id.* § 18022(c)(1), (4).

21. To help individuals to learn about and enroll in the health insurance options that are available to them, the Act "requires the creation of an 'Exchange' in each State where people can shop for insurance, usually online." *King,* 576 U.S. at 479 (quoting 42 U.S.C. § 18031(b)(1)); *see Me. Cmty. Health Options*, 590 U.S. at 301. These Exchanges, also known as health insurance Marketplaces, enable people not eligible for Medicare or Medicaid to obtain adequate, affordable insurance independent of their jobs. The Exchanges therefore serve as "marketplace[s] that allow[] people to compare and purchase" ACA-compliant plans. *King*, 576 U.S. at 479.

22. There are several different types of Exchanges. Some states have elected to create Exchanges themselves (state-based Exchanges or SBEs), as is the case in Maryland. Other states have created Exchanges that operate on the federal Healthcare.gov platform (state-based Exchanges on the federal platform, or SBE-FPs), such as the Exchange currently in use in

Illinois while it transitions to an SBE. Still other states, including Ohio, have an Exchange that is operated by CMS (federally facilitated Exchange, or the FFE). *See* CMS, Consumer Info. & Ins. Oversight, *State-based Exchanges*, https://perma.cc/JFT3-6EAK (captured June 28, 2025).

23. Plans that meet the requirements described above and that are offered on the Exchanges are known as "qualified health plans." Individuals primarily enroll in qualified health plans for a given benefit year during an annual open enrollment period, or under certain special enrollment periods. 42 U.S.C. § 18031(c)(6). To assist with enrollment, the Act requires Exchanges to award grants to healthcare "Navigators" that conduct public education and awareness campaigns, help consumers understand their choices, facilitate their enrollment, and ensure their access to consumer protections. *Id.* § 18031(i)(1), (3).

24. Plans on the Exchanges offer different levels of generosity. A "bronze" plan is designed to provide benefits that are actuarially equivalent to 60% of the full value of benefits to the plan (meaning that premiums are calculated in the expectation that 40% of the cost of coverage would be paid for through enrollee out-of-pocket spending). *Id.* § 18022(d)(1). "Silver," "gold," and "platinum" plans are designed to provide benefits that are actuarially equivalent to 70%, 80%, and 90%, respectively, of the full value of benefits under the plan. *Id.* Because actuarial predictions may be imprecise, the Act specifies that CMS may "provide for a de minimis variation . . . to account for differences in actuarial estimates." *Id.* § 18022(d)(3).

25. The Act also "seeks to make insurance more affordable by giving refundable tax credits to individuals." *King*, 576 U.S. at 482 (citing 26 U.S.C. § 36B). These "premium tax credits" (PTCs) vary depending on an individual's income—individuals who earn more must pay more toward the cost of their monthly premium—but are generally pegged to the cost of the so-called "benchmark silver plan," or the second-lowest cost silver plan offered within a market.

*See, e.g.*, 26 U.S.C. § 36B(b)(3)(B)–(C). The Act initially made these tax credits available to individuals with incomes between 100% and 400% of the federal poverty level. *Id.* There is no income cap on these tax credits under current law, *see id.* § 36B(b)(3)(A)(iii), but the 400% income cap will be reinstated for 2026 absent further congressional action.

26. Premium tax credits are claimed on an individual's tax return after the end of the year and are paid by the Internal Revenue Service (IRS). *Id.* § 36B(h). Rather than waiting to recover their costs the next year, enrollees may claim "advance premium tax credits" (APTCs) up front so that the value of the tax credits may be applied directly to the purchase of insurance. 42 U.S.C. §§ 18081, 18082; *City of Columbus*, 523 F. Supp. 3d at 741. CMS is responsible for determining whether individuals meet the statutory requirements of eligibility for APTCs, as well as for "redetermin[ing] eligibility on a periodic basis in appropriate circumstances." 42 U.S.C. § 18081(f)(1)(B).

27. In sum, the Act requires that insurers generally offer only quality health insurance and aims to lower the cost of coverage to encourage individuals to enroll. This coverage improves access to care and overall health, and it reduces financial burdens on consumers as well as institutions that pay for uncompensated care.

28. But increasing enrollment in quality health insurance coverage is not only the ACA's immediate goal; it is also key to the Act's long-term success. Insurance market stability requires robust enrollment, particularly by relatively healthy individuals. *Id.* § 18091(2)(I) (finding that "broaden[ing] the health insurance risk pool to include healthy individuals . . . will lower health insurance premiums"); *King*, 576 U.S. at 480. Limiting the cost of health insurance is, in turn, essential to promoting enrollment. *Id.* at 480–81. By driving costs down and insured rates up, the Act ensures that insurance markets function smoothly.

## II. CMS Publishes Its Marketplace Integrity and Affordability Rule, Flouting the Goals and Purpose of the ACA

29. When faithfully implemented, the Act's reforms successfully met Congress's goal of enabling more individuals to enroll in health insurance coverage. More than 24 million individuals are enrolled in Marketplace coverage in 2025. CMS, Press Release, *Over 24 Million Consumers Selected Affordable Health Coverage in ACA Marketplace for 2025* (Jan. 17, 2025), https://perma.cc/N8QF-NKHG.

30. The 2025 Rule, however, sets forth a wide range of changes that will render coverage on the Exchanges less affordable, less generous, and harder to obtain. Together, these policies undermine the ACA's purpose by reducing insurance affordability and benefits, creating administrative burdens that make it harder for individuals to enroll in and maintain insurance coverage, and narrowing eligibility for coverage across the board.

31. *Imposition of a Junk Charge on Certain Low-Income Enrollees*. Under regulations that have been in place since the Act was first implemented, 45 C.F.R. § 155.355(j), enrollees that remain eligible for a Marketplace plan from one year to the next are automatically re-enrolled in the same plan unless they terminate coverage or actively enroll in a different plan. Depending on an enrollee's income level and the level of coverage he or she is enrolled in, he or she may be eligible for a zero-premium plan, that is, a plan in which the entire cost of the premium is covered by the enrollee's APTCs. The 2025 Rule adds 45 C.F.R. § 155.335(n), only for the upcoming 2026 plan year, to require the federally facilitated Exchange to impose a monthly surcharge of $5 on each such enrollee until the enrollee confirms his or her intent and eligibility to remain on the zero-premium plan. 90 Fed. Reg. at 27,102. CMS invokes 42 U.S.C. § 18081(f)(1)(B) as statutory authority for this surcharge, 90 Fed. Reg. at 27,109, but that authority is limited to the establishment of procedures to determine an applicant's eligibility for

APTCs, not to reduce the amount of the APTC that is awarded under the statutory formula. CMS acknowledges that this provision will reduce enrollment among enrollees who used to have access to a zero-premium plan; independent estimates find enrollment among this population would be reduced by at least 14%, and possibly by as much as 33%. 90 Fed. Reg. at 27,195.

32. *Increased Costs through Revisions to the Premium Adjustment Methodology.* The Act protects consumers in both the individual and group markets by imposing a maximum annual limit on cost-sharing. This limit is adjusted annually by a "premium adjustment percentage," which measures the rate of premium growth. The IRS also uses the premium adjustment percentage to adjust the value of PTCs. CMS has historically used data from premiums for employer-sponsored insurance to calculate this percentage, because the individual insurance market premiums are more volatile. The 2025 Rule incorporates individual insurance market data into this measure, resulting in a 15% increase in the maximum annual out-of-pocket limit on cost sharing and a 4.5% increase in average premiums, which will lead to lost coverage, a worsened risk pool, and higher levels of uncompensated care.

33. *Eroding the Actuarial Value of Coverage*. The Act sets targets for the actuarial value of various types of plans on the Exchanges, subject to permissible range of "de minimis" variation to "account for differences in actuarial estimates." 42 U.S.C. § 18022(d)(3). The 2025 Rule expands the range of de minimis variation to permit bronze plans to range from 5 points above to 4 points below the statutory target (that is, bronze plans may offer coverage ranging from 56% to 65% of anticipated expenditures) and silver, gold, and premium plans to fall 4 points below the target (that is, silver plans may cover as little as 66% of anticipated expenditures). 90 Fed. Reg. at 27,207. By eroding the value of silver plan coverage, the final rule will also reduce PTCs, which are calculated on the basis of silver plan premiums. *Id.* at

27,208. Overall, net premiums on the Exchange would increase by up to $714 for a typical family per year as a result of this provision. *Id.* at 27,208.

34. *Revocation of the Act's Guarantee That Anyone Can Buy Insurance*. In some instances, enrollees in plans on the Exchanges may incur debts for premiums owed without realizing it. For instance, some enrollees may believe that they may terminate their coverage simply by stopping payment on premiums, without realizing (or being informed) that the coverage remains in effect and they continue to owe payments to their insurer. The 2025 Rule permits insurers to refuse to enroll these individuals and to apply any payments that these individuals make to the outstanding debt instead of to the premium for new coverage, without prior notice to the individuals. 90 Fed. Reg. at 27,084. In other words, an individual might complete all of the steps to enroll in coverage, including making the payment they understand to be needed to complete the transaction, only to learn at the end of the process that they have not been enrolled. This rule is contrary to the "guaranteed issue" requirement of 42 U.S.C. § 300gg-1. This provision is projected by independent experts to lead to the denial of coverage for 180,000 people who owe debts for old premiums as low as $10. 90 Fed. Reg. at 27,085.

35. *Changes to Enrollment Periods*. Under current policy, the open enrollment period for the Exchanges runs from November 1 to January 15. This two-and-a-half-month period has been beneficial for the health of the Exchanges, as younger and healthier people tend to enroll later in the process, and are particularly prone to enroll, if given the opportunity, after the end-of-the-year holiday period, when people face unusual financial distress. The 2025 Rule prohibits open enrollment in January by requiring all Exchanges to hold open enrollment periods that begin no later than November 1, that end no later than December 31, and that are no more than nine weeks in duration. This provision goes into effect for 2027.

36. Current policy also provides a special enrollment period (SEP) on a monthly basis for persons with incomes at or below 150% of the federal poverty level. 45 C.F.R. § 155.420(d)(16). This SEP was established as an additional safety net for consumers with variable income who may transition from Medicaid eligibility to Exchange eligibility over the course of the year. *See* 86 Fed. Reg. 53,412, 53,434 (Sept. 27, 2021). These enrollees tend to pose a lower risk of serious health conditions, so easing their ability to enroll in Exchange coverage has improved the financial viability of the Exchanges. *See* Mark A. Hall and Michael J. McCue, *Does Making Health Insurance Enrollment Easier Cause Adverse Selection?*, Commonwealth Fund (Apr. 4, 2022), https://perma.cc/9P86-ZFCR. The final rule, however, revokes this SEP, but only for 2025 and 2026. 90 Fed. Reg. at 27,079. This provision will lead to longer periods of time where people lack insurance, resulting in uncompensated care costs for hospitals, providers, community health centers, and municipalities. *Id.* at 27,145.

37. The final rule also requires the federally facilitated Exchange to conduct pre-enrollment verification for SEP eligibility for at least 75% of new enrollments through SEPs. Commenters on the proposed rule noted that the addition of this paperwork burden will depress coverage on the Exchanges. CMS acknowledged this concern and accordingly declined to make this policy permanent, but kept it in place for the upcoming 2026 plan year at an estimated $7 million cost to consumers. 90 Fed. Reg. at 27,204, 27,187.

38. *Failure to Reconcile (FTR) Penalty*. The amount of APTCs that an enrollee receives over the course of a year and the amount of PTCs that the enrollee receives on his or her tax return depends on the same statutory formula; APTCs are intended to be a substitute for the tax credit. 26 U.S.C. § 36B; 42 U.S.C. § 18082. But APTCs are calculated on the basis of enrollees' projected income, so if an enrollee, for example, works more shifts or hours than

expected and thus provides an incorrect estimate, he or she might owe a tax payment at the end of the year without realizing that any such debt is owed. Under current policy, any such enrollee must be given a notice of the tax debt in the first year that he or she enrolls in coverage after the debt is incurred, so that the debt can be repaid; if the enrollee does not do so, eligibility for APTCs may be revoked in the second year. 45 C.F.R. § 155.305(f)(4)(i), (ii). The 2025 Rule revokes that grace period, for 2026 only, and requires the Exchanges to determine the enrollee to be ineligible for APTCs in the first year, 45 C.F.R. § 155.305(f)(4)(iii), despite the fact that CMS lacks any authority to alter the statutory formula for eligibility for APTCs.

39. *Changes to Data Matching Policies*. When an Exchange attempts to verify an applicant's income for purposes of determining his eligibility for, and the amount of, APTCs, and it finds an inconsistency in that applicant's data, it notifies the applicant and provides him or her with an opportunity to respond. 42 U.S.C. § 18081(e)(4). The statute provides a default period of 90 days for that response, subject to CMS's authority to modify the procedures for this verification process. *Id.* § 18081(c)(4), (e)(1), (e)(4). In many cases, 90 days is not enough time for an applicant to track down the proof of his or her income needed to verify APTC eligibility. The current regulations accordingly modify the response deadline to provide for an additional 60 days where necessary. 45 C.F.R. § 155.315(f)(7). The final rule revokes that 60-day extension. 90 Fed. Reg. at 27,120.

40. In 2017, CMS adopted a policy requiring the Exchanges to audit all enrollees who project that their household income for the upcoming year will be greater than 100% of the federal poverty level, if the IRS reports data indicating that the enrollee's current income is below that threshold. Because this policy created "immense administrative burdens" for low-income enrollees, this Court held that it "defie[d] logic" and vacated it as arbitrary and capricious

under the Administrative Procedure Act. *City of Columbus*, 523 F. Supp. 3d at 763. CMS did not appeal that judgment, and it again acknowledges that this policy would cause tens of thousands of enrollees to lose their coverage. 90 Fed. Reg. at 27,200. The 2025 Rule nevertheless attempts to reinstate this policy for the 2026 plan year, forthrightly asserting its disagreement with this Court's prior decision. *Id.* at 27,121.

41. Following the *City of Columbus* decision, under current policy, an Exchange must accept an applicant's attestation of his or her projected annual income in cases where the IRS confirms that there is no tax return data available. 45 C.F.R. § 155.320(c)(5). The final rule revokes that policy, and for the 2026 plan year will require Exchanges to verify income with other trusted data sources and to require applicants to submit documentary evidence or otherwise resolve the income inconsistency; if no such evidence is available, the applicant will lose eligibility for APTCs. 90 Fed. Reg. at 27,131. These new data-matching policies, together, are projected to cause more than 400,000 people to lose coverage for the upcoming plan year. *Id.* at 27,199–200.

42. These provisions, each of which is prohibitive on its own, have a compounding effect in further restricting access to affordable health insurance coverage on the Marketplace.

43. Defendants justify the 2025 Rule's policies by citing a need to address "fraudulent and improper enrollment at scale by the enrollee's own doing or by a third party without the enrollee's knowledge." 90 Fed. Reg. at 27,074. But the provisions of the 2025 Rule that address these third parties—agents, brokers, and web-brokers—do not regulate them using penalties or other direct measures. Nor does the Rule adopt more common-sense approaches to prevent fraud that would not pose barriers to enrollment, like "requiring two-factor authentication, requiring verbal authorization from a consumer before certain changes can be made, better monitoring of

DE/EDE pathways, additional monitoring requirements for agents and brokers with fully-subsidized clients, new penalties for agents and brokers, and more resources for State Departments of Insurance to investigate fraud," as commenters suggested. *Id.* at 27,147.

44. Instead, the 2025 Rule's provisions create significant barriers to coverage for consumers and burdens on insurers and the Marketplace that will lead to coverage losses.[5] Indeed, CMS concedes that as many as 1.8 million individuals will lose coverage in 2026 alone as a result of the provisions in the 2025 Rule. 90 Fed. Reg. at 27,212.

## III. Defendants Failed to Adequately Consider Public Comments or Provide Adequate Reasoning for the Marketplace Integrity and Affordability Rule

45. CMS published a proposed version of the 2025 Rule on March 19, 2025. 90 Fed. Reg. 12,942. The agency received more than 26,000 comments[6] on the proposed rule, despite a shortened 23-day (rather than 30-day) formal comment period. Commenters raised serious concerns with many provisions of the 2025 Rule, highlighting flaws with the proposed changes to ACA policy.

46. But Defendants provided only surface-level responses to many of the public comments CMS received. And in most cases, rather than address the substance of public comments, Defendants excused themselves from taking account for the burdensome effect of the Rule's provisions by purporting to impose many policies on a temporary basis: almost half (eight out of seventeen) of the Rule's provisions that take effect this year or for the 2026 plan year are scheduled to sunset at the end of 2026. 90 Fed. Reg. at 27,178–79.

[5] *See* Katie Keith, *HHS Finalizes ACA Marketplace Rule, Part 1: Enrollment Restrictions, Premiums, Actuarial Value, and More*, Health Affs. (June 23, 2025), https://perma.cc/5WBT-JR9U.

[6] Regulations.gov, *Comments on CMS-2025-0020-0011*, https://perma.cc/GAC2-EFRB (captured June 28, 2025).

47. Defendants asserted that the "temporary policies in this rule and the expiration of fully subsidized plans" will cause "the level of improper enrollments to come down drastically in [plan year] 2026, diminishing the need for ongoing crisis-level program integrity policies." 90 Fed. Reg. at 27,144. But Defendants provided no explanation to justify that expectation, or to account for the incredible administrative burdens that compliance with the Rule will put on consumers, insurers, and the Marketplace this year. Nor do Defendants explain why they would be willing "to accept some risk of future improper enrollments after these policies sunset, in favor of limiting overall disruptions as the market adjusts and sheds holdover improper enrollments" in 2027, but yet remain willing to disrupt the same market next year, in 2026. *Id.* at 27,091. Defendants also failed to reasonably explain the rationale behind the Rule's most burdensome provisions.

48. For example, in promulgating the provision imposing a $5 premium penalty on automatic re-enrollees, CMS (i) failed to explain how implementation of the policy for only the 2026 plan year would combat fraudulent enrollments; (ii) failed to account for the substantial loss of coverage and increase in premiums that the provision will cause; and (iii) failed to address or consider consumer reliance interests or the existing procedures adequately safeguarding against eligibility errors.

49. CMS reversed the current policy prohibiting insurers from denying coverage to individuals with unpaid premiums without examining how the policy might impact unsubsidized consumers, including small businesses; supporting its assertion that the benefits of the policy outweigh "some negative impacts on low-income individuals," 90 Fed. Reg. at 27,087; and without considering suggested protective measures—like allowing installment or partial payments, appeals processes, or exemptions for fraud.

50. CMS revoked subsidized coverage for individuals that fail to file and reconcile tax credits by reinstating a one-year policy, only for 2026, without explaining CMS's analysis of "new evidence regarding unauthorized enrollments," *id.* at 27,133, adequately providing the data the agency relied on, or addressing concerns about coverage loss, impacts on risk pools, and long IRS processing times that may negatively impact FTR efforts.

51. CMS removed the automatic 60-day extension afforded to individuals verifying their household income under 45 C.F.R. § 155.315(f)(7), and in so doing asserted that the policy is a "statute-driven change," 90 Fed. Reg. at 27,120, to dismiss evidence that many eligible enrollees need the additional time to track down documentation for their applications for Exchange coverage.

52. CMS required Exchanges to generate household income inconsistencies when a tax filer's attested projected annual household income differs from "trusted data sources," by relying on reasoning from a 2019 Payment Notice, 83 Fed. Reg. at 16,985, that was rejected as insufficient by this Court in *City of Columbus*, 523 F. Supp. 3d at 763.

53. CMS shortened the open enrollment period despite comments that such changes to the open enrollment period would have adverse effects on coverage in the Exchanges, particularly for rural populations and non/limited-English speaking communities, and would strain enrollment assisters.

54. CMS eliminated a monthly special enrollment period for certain low-income people, but only from the effective date of the Rule through the end of the 2026 plan year, without explaining how the policy will address improper enrollments, adequately addressing comments raising concerns about potential coverage loss, or reviewing data suggesting that most

low-income SEP enrollees have fewer claims than non-SEP enrollees and remain enrolled for the full plan year. 90 Fed. Reg. at 27,145.

55. CMS imposed prohibitive verification requirements on SEP enrollees, but only for the 2026 plan year, without explaining why the additional burden and barriers the policy would create "is not significant enough to outweigh the merits of SEP verification," *id.* at 27,151, or why "the effect of deterring some young people from enrolling in coverage" does not "outweigh[] the benefits of preventing improper enrollments in Exchanges on the Federal platform," *id.*

56. CMS altered its methods for calculating premium adjustment percentages, permanently, rejecting suggestions that the provision be delayed to 2027 so that Exchanges' rates can adjust, and brushing aside comments asserting that the change will result in higher net premiums, out-of-pocket costs, coverage losses, increased medical debt and uncompensated care, and adverse selection in the Exchange. 90 Fed. Reg. at 27,172.

57. CMS expanded the permissible "de minimis" range for actuarial value calculations for plans on the Exchanges, resulting in plans that will offer less value to consumers, dismissing concerns that the changes will make it harder for consumers to compare plans and lead to greater out-of-pocket consumer costs. *Id.* at 27,208.

## IV. Plaintiffs Have Been, and Will Continue to Be, Harmed by the 2025 Rule

58. The 2025 Rule's challenged provisions, both individually and in combination, will raise premiums for plans on the Exchanges, limit coverage under those plans, and deter millions of individuals from enrolling in coverage, leading to higher uncompensated care costs for providers of last resort. Independent experts project that the rule will lead to at least 1.8 million fewer people enrolling on the Exchanges.

59. The rule accomplishes this result through the various measures discussed above. *First*, measures that will erode the value of coverage obtained through the Exchanges include the imposition of a junk charge on enrollees who are automatically reenrolled in the same plan; the revisions to the premium adjustment methodology that will increase average premiums and the maximum annual out-of-pocket limit on cost sharing; and the expansion of the permissible range of de minimis variation in coverage. *Second*, measures that impose barriers designed to depress enrollment in the Exchanges include the revocation of the ACA's guaranteed-issue requirement; the shrinking of the open enrollment period; and the revocation of the SEP for low-income individuals. *Third*, measures that impose further barriers limiting the availability of subsidized insurance, even for those enrollees that do successfully enroll, include the imposition of a penalty for failure to reconcile an enrollee's inaccurately projected income and changes to data-matching policies.

60. The resulting increase in premiums overtime, erosion of coverage, and decreased enrollment will increase the number of uninsured and underinsured individuals and will cause Plaintiffs irreparable harm.

61. Columbus, through its Department of Public Health, provides a wide range of services on behalf of its residents, including health services for families and children, public health, public assistance, and emergency medical care. The city also subsidizes a community health center, which serves residents regardless of insurance coverage; a number of specialty clinics that each focus a particular area, such as dental services and family planning; and a collection of eleven neighborhood health centers dedicated to the health care needs of vulnerable, uninsured, and underinsured residents. The increase in the number of uninsured and

underinsured individuals resulting from the 2025 Rule would lead to a greater burden on those city services and lower reimbursement, which will impose additional costs on the city.

62. In addition, Columbus maintains excellent emergency medical services (EMS) through its Columbus Division of Fire. That system dispatches ambulances to meet urgent health needs, regardless of whether the call comes from an individual who has health insurance or is otherwise able to pay for the call. Although reimbursement is sought from patients' Medicare, Medicaid, or commercial health insurance provider where applicable, Columbus serves uninsured residents equally and recoups only a small fraction of its costs for EMS transport services for uninsured residents. Uninsured residents are also more likely to delay care until conditions become serious and therefore more likely to require emergency transport services. An increase in the number of uninsured or underinsured individuals will thus result in more EMS transports for which Columbus does not receive reimbursement, and the city must make up for the shortfall in its budget.

63. Baltimore, through the Baltimore City Health Department, provides a wide range of health services to its residents and operates a number of specialty clinics. Baltimore also provides or subsidizes a number of other services for Baltimore's uninsured and underinsured residents, including a visiting-nurse program and various condition-specific programs. In addition, Baltimore subsidizes several other entities that provide health services to its residents. An increase in the number of uninsured and underinsured individuals will lead to a greater burden on each of those services and programs and create a strain on the city's budget.

64. The Baltimore City Fire Department (BCFD) also maintains an ambulance system. BCFD's EMS seeks reimbursement for its costs from patients' health insurance, but the EMS answers calls regardless of the individuals' health insurance coverage or ability to pay.

Although EMS has in the past been able to recoup approximately 90% of its costs from patients who have insurance, it has been able to recover less than 4% of costs from uninsured patients. An increase in the number of uninsured and underinsured individuals therefore leads to more ambulance calls for which Baltimore does not receive reimbursement, and the city must make up for the shortfall in its budget. An increase in uninsured and underinsured individuals also increases the avoidable use of acute health services, increasing the strain on Baltimore's EMS and other health programs.

65. Chicago's Department of Public Health operates seven mental health centers, four immunization clinics, and three clinics that provide free testing and treatment for sexually transmitted infections. It also provides at-home and in-field programs and funds and staffs a network of Women, Infants, and Children (WIC) clinics. These clinics and programs serve thousands of uninsured and underinsured city residents, and an increase in those types of patients increases the burden on those city services. By increasing health care costs, barriers to coverage, and the number of uninsured residents, the 2025 Rule would add to the burden on Chicago's health care safety net and the city's budget.

66. The Chicago Fire Department provides ambulance transportation services to Chicago residents, including its uninsured and underinsured residents, without regard to income and insurance status. Chicago generally does not receive full reimbursement for ambulance services from uninsured and underinsured residents. Those same residents are more likely to wait until their conditions become more severe and require emergency care, and they disproportionately rely on ambulance services for transport. A higher number of uninsured and underinsured individuals will therefore result in greater emergency services needs and more

ambulance transports for which Chicago does not receive reimbursement and thus must make up for the shortfall in its budget.

67. Further, all city Plaintiffs would be irreparably harmed by the increase in uninsured and underinsured individuals caused by the 2025 Rule for the additional reason that when individuals do not get the medical care that they need, they are necessarily less healthy, less productive, and less able to participate in city life. This has cascading negative effects on city programs and communities.

68. Many of Main Street Alliance's members rely on the Marketplace for health insurance, and those members would be significantly harmed by the 2025 Rule. The erosion of coverage under the rule will create additional costs for MSA members and negatively affect the health of those who rely on care or medication that they cannot afford without insurance coverage. The increase in costs would even threaten the continued operation of some MSA members. Small businesses often operate on small profit margins, so if health insurance through the marketplace becomes unaffordable or inadequate, then owners and their employees may be forced to seek alternative employment to have access to employer-sponsored health insurance.

69. For example, one MSA member operates a small business in Wisconsin and needs affordable health insurance that covers expensive medications that she takes to prevent the degradation of her bones due to rheumatoid arthritis. She operates her business, which has about 10 employees, on narrow margins. The 2025 Rule would increase her health insurance costs to levels that she cannot afford. This would force her to close her business, to either find different employment with employer-sponsored insurance or explore other coverage options through a state health care system.

70. DFA's members, including physicians and medical trainees, will likewise be irreparably harmed by the 2025 Rule's disastrous effects on the costs, administrative burdens, and coverage of health insurance under the ACA. With the increased number of uninsured and underinsured patients, DFA's members would be more likely to see patients who delay care until their needs are acute; they would receive less than full reimbursement for those patients who lose insurance or whose coverage becomes more limited; and they would lose contact with many patients altogether, particularly in low-income communities. The Rule will thus force medical providers to direct more time to providing uncompensated care, more administrative time to determining whether insurance coverage is possible, and more time locating patients who are no longer seeking care for serious conditions.

71. Even when DFA's members provide uncompensated patient care—which will occur increasingly if the final rule is implemented—their work does not end with the patient visit. Lack of insurance coverage when a patient needs treatment requires finding a specialist willing to provide care, trying to find an alternative medicine that a patient may be able to afford but is not the optimal treatment, and intervening on behalf of a patient in an attempt to get testing or procedures performed. This will take up greater amounts of clinicians' time as patients lose coverage. The end result is additional time for which DFA members do not get paid that detracts from patient care. Medical providers will expend more time and effort, receive less compensation—threatening the continuation of medical practices, particularly in rural areas—and be unable to provide optimal care to their patients.

72. Some patients will be forced to forgo standard medical care altogether, despite the efforts of their physician to solve these problems, and some will be forced to go to an emergency

room. Not only will this strain community resources, but the care will be limited to what an emergency room can provide. The outcomes will be worse, and the cost will be greater.

## CAUSES OF ACTION

73. Plaintiffs reallege and incorporate by reference all prior and subsequent paragraphs.

### COUNT I
### Violation of the Administrative Procedure Act – Contrary to Law
### (Against All Defendants)

74. The APA provides that courts "shall . . . hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law."

75. The 2025 Rule is a "final agency action for which there is no other adequate remedy in a court" and is "subject to judicial review." 5 U.S.C. § 704.

76. Several of the 2025 Rule's provisions violate the ACA and other federal statutes and regulations and are therefore "not in accordance with the law," including:

a. the $5 premium penalty on automatic re-enrollees in the 2025 Rule's addition of 45 C.F.R. § 155.335(a)(3) and (n) and revisions to 45 C.F.R. § 155.330(j) is contrary to 42 U.S.C. §§ 18081 and 18082, as the statutes provide no authority for the Secretary to set APTC amounts, withhold APTCs, or require consumers to pay an arbitrary amount in pre-APTC premiums;

b. the revocation of guaranteed insurance coverage for individuals with past-due premiums in the 2025 Rule's amendment to 45 C.F.R. § 147.104(i) is contrary to the requirement in 42 U.S.C. § 300gg-1 that "each health

insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the state that applies for such coverage," subject to exceptions not applicable here, 42 U.S.C. § 300gg-1(a), and the guaranteed renewability requirement in 42 U.S.C. § 300gg-2(a); and

c. the failure to reconcile (FTR) policy provision in the 2025 Rule's amendments to 45 C.F.R. § 155.305(f)(4) is contrary to the requirement in 26 U.S.C. § 36B(a) and (c) that access to premium tax credits is guaranteed so long as an individual qualifies as an "applicable taxpayer."

77. Accordingly, this Court must hold unlawful and set aside the aforementioned provisions of the 2025 Rule.

**COUNT II**
**Violations of the Administrative Procedure Act – Arbitrary and Capricious and Without Observance of Procedure Required by Law**
**(Against All Defendants)**

78. The APA provides that courts "shall . . . hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" or that is "without observance of procedure required by law." 5 U.S.C. § 706.

79. The 2025 Rule is a "final agency action for which there is no other adequate remedy in a court" and is subject to judicial review. *Id.* § 704.

80. As detailed above, Defendants failed to provide adequate reasons for, and failed to adequately respond to comments about, the following provisions, such that they are arbitrary and capricious under the APA, and Defendants failed to observe required procedure in adopting these provisions, *id.* § 706(2)(A), (D):

a. the $5 premium penalty on automatic re-enrollees in the 2025 Rule's addition of 45 C.F.R. § 155.330(a)(3) and (n) and revisions to 45 C.F.R. § 155.330(j);

b. the premium nonpayment penalty reversing the guaranteed-issue requirement in the 2025 Rule's amendment of 45 C.F.R. § 147.104(i);

c. the failure to reconcile (FTR) policy in 45 C.F.R. § 155.305(f), including the 2025 Rule's amendments to 45 C.F.R. § 155.305(f)(4);

d. the shortening of the open enrollment period in the 2025 Rule's amendments to 45 C.F.R. § 155.410(e) and (f);

e. the elimination of the low-income special enrollment period in the 2025 Rule's removal of 45 C.F.R. §§ 147.104(b)(2)(i)(G) and § 155.420(d)(16);

f. the imposition of special enrollment period verification in the 2025 Rule's amendments to 45 C.F.R. § 155.420(g);

g. the prohibitive data-matching requirements in the 2025 Rule's removal of 45 C.F.R. § 155.315(f)(7) and amendment to 45 C.F.R. § 155.320(c)(5);

h. the requirement in the 2025 Rule's amendments to 45 C.F.R. § 155.320(c)(3)(iii) that Exchanges find general household income inconsistencies when a tax filer's attested projected annual household income differs from "trusted data sources";

i. the amendment to the premium adjustment percentages set forth in 90 Fed. Reg. 27,166 through 27,178; and

j. the revisions to the de minimis ranges for actuarial value calculations in the 2025 Rule's amendments to 45 C.F.R. §§ 156.140(c), 156.200(b)(3), and 156.400.

81. These provisions, individually and collectively, also violate section 1554 of the ACA, which bars CMS from issuing any rule that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care." 42 U.S.C. § 18114.

82. Accordingly, this Court must hold unlawful and set aside the aforementioned provisions of the 2025 Rule.

**PRAYER FOR RELIEF**

WHEREFORE, Plaintiffs pray that this Court:

83. declare that the provisions of the 2025 Rule identified in Counts I and II are arbitrary, capricious, without observance of proper procedure, or otherwise not in accordance with law under the Administrative Procedure Act;

84. vacate and set aside the provisions of the 2025 Rule identified in Counts I and II under the Administrative Procedure Act;

85. stay the effective date of the provisions of the 2025 Rule identified in Counts I and II under 5 U.S.C. § 705;

86. preliminarily and permanently enjoin Defendants from implementing the provisions identified in Counts I and II;

87. award Plaintiffs their costs, attorneys' fees, and other disbursements for this action; and

88. grant such other and further relief as the Court may deem just and proper.

Dated: July 1, 2025

Respectfully submitted,

*/s/ Joel McElvain*
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**Pro hac vice* motion pending

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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

**DECLARATION OF CHRISTEN LINKE YOUNG**

I, Christen Linke Young, declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. The facts contained in this declaration are known personally to me and, if called as a witness, I could and would testify competently thereto under oath. I submit this sworn declaration in support of Plaintiffs' challenge to the Marketplace Program Integrity Final Rule (Final Rule).

2. I am a visiting fellow with the Brookings Center on Health Policy, a research center within the Economic Studies program at the Brookings Institution. My research concerns a variety of topics in health policy, including issues related to health insurance: how Americans get health care coverage, how that coverage is financed, and how the health care system can be improved to make coverage more affordable and accessible. I have published many pieces of scholarly analysis on these topics. I have testified before Congress and before state legislatures, my work is frequently cited in national media, and I have served in multiple leadership roles in state and federal government. My full curriculum vitae, including a list of publications, appears as an Appendix to this declaration.

**Summary of Observations**

3. The American health insurance system is complicated. Most Americans who do not get health insurance from their own or a family member's employer are eligible for a form of subsidized coverage, but many face barriers accessing that coverage. For people seeking coverage through the Health Insurance Marketplaces, these barriers include (1) the fact that coverage may be too expensive, and (2) that the system of applying for and obtaining coverage may create administrative obstacles that consumers do not successfully navigate. As a result, people who are eligible for coverage often remain uninsured.

4. Several provisions of the Marketplace Program Integrity Final Rule (Final Rule) are expected to worsen the barriers to Marketplace coverage by making coverage more expensive or by heightening the administrative obstacles consumers face. These changes are expected to directly *decrease* the number of people with coverage and *increase* the number of uninsured. For example, the Congressional Budget Office has concluded that the rule as a whole will decrease enrollment in Marketplace coverage by 2.2 million and increase the number of uninsured by 1.8 million.[1]

5. People who are relatively younger and healthier are more likely to be deterred from enrolling by higher costs or additional administrative obstacles. Therefore, the policies in the final rule that raise costs and increase administrative obstacles will generally be expected to worsen the Marketplace risk pool. A worse risk pool will generally lead to higher health insurance premiums, further exacerbating the problem of high costs, which in turn can cause additional people to become uninsured.

[1] *See* Email from Cong. Budget Office, Estimated Effects of Proposed Marketplace Rule (Apr. 9, 2025), https://democrats-waysandmeans.house.gov/sites/evo-subsites/democrats-waysandmeans.house.gov/files/evo-media-document/cbo-aca-coverage-loss-estimates.pdf.

6. The decrease in Marketplace enrollment and increase in the uninsured will result in increased burden of uncompensated care, especially for safety net providers.

**The Structure of the Affordable Care Act and the Health Insurance Marketplaces**

7. A primary goal of the Affordable Care Act (ACA) was to create pathways to quality, affordable health insurance for Americans who do not get coverage from their jobs. The law did this through two primary mechanisms: expanding Medicaid and creating the Health Insurance Marketplaces where individuals could buy regulated and often subsidized coverage. Promoting access to health coverage was designed to ensure that Americans had access to the health care system and the health benefits that flow from reliable health care, had financial protection in the event of illness or injury, and benefited from improved overall health and well-being. Analyses since passage of the law consistently demonstrate that the law has helped to achieve those goals.[2]

8. The Health Insurance Marketplaces are the mechanism the ACA created to provide coverage to people with incomes generally over the poverty level. A critical feature of the Marketplaces is that all available plans meet standards for health plan quality by covering a robust set of benefits and protecting consumers from exposure to very high-cost care. This

[2] *See, e.g.*, Jacob Goldin, Ithai Z. Lurie & Janet McCubbin, *Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach*, 136 Q.J. Econ. 1 (2021), https://academic.oup.com/qje/article-abstract/136/1/1/5911132 (experimental evidence that health insurance reduces mortality through a randomized study of taxpayers who received informational letters about ACA penalty requirements); American Hospital Association, Report: The Importance of Health Coverage, https://www.aha.org/guidesreports/report-importance-health-coverage (health insurance coverage improves access to care, health outcomes, and financial well-being, while highlighting the continuing challenges faced by the uninsured population); Kaiser Family Foundation, The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020, https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/ (analyzing 404 studies published from January 2014 through January 2020 on Medicaid expansion impacts, finding positive effects on coverage gains, access to care, financial security, health outcomes, and economic benefits for states and providers); Kosali Simon, Aparna Soni & John Cawley, The Impact of Health Insurance on Preventive Care and Health Behaviors: Evidence from the First Two Years of the ACA Medicaid Expansions, 36 J. Pol'y Analysis & Mgmt. 390 (2017), https://onlinelibrary.wiley.com/doi/abs/10.1002/pam.21972 (the Affordable Care Act affected preventive healthcare utilization and health behaviors during the first two years of implementation).

allows consumers to shop and insurers to compete on a level playing field.[3]

9. Marketplaces serve to pool risk between healthy and sick individuals. Health insurance premiums in the Marketplace are set by insurance plans based on the total costs of providing coverage to the entire covered population in the state, not on the expected costs of any one individual. If only the very sickest individuals enroll, then coverage will be extremely expensive; if a robust mix of healthy and sick individuals enroll, then premiums will be lower because they reflect the average cost of a much healthier pool.[4]

10. Critically, the premiums that individuals have to pay influence their decisions about whether or not to enroll. Economic theory and empirical evidence show that when coverage is expensive, only people with high expected health care costs choose to enroll, because they are the only individuals for whom the expected value of the coverage exceeds its costs. However, if coverage is less expensive, individuals in better health will find it attractive to enroll.[5] For this reason, affordable premiums that draw in healthy individuals are an important predicate for a stable and well-functioning Marketplace.

**A Wide-Ranging Literature Establishes that High Costs and Increased Administrative Obstacles Decrease Enrollment and Worsen Risk Pools**

11. Twenty-eight million Americans are currently uninsured.[6] Studies have established that most people who are uninsured are eligible for subsidized coverage through Medicaid or the Health Insurance Marketplaces established by the ACA. For instance, a recent

[3] *See* Christen Linke Young, Taking a Broader View of "Junk Insurance," Brookings Institution (July 2020), https://www.brookings.edu/articles/taking-a-broader-view-of-junk-insurance/.

[4] *See, e.g.,* American Academy of Actuaries, Risk Pooling: How Health Insurance in the Individual Market Works (June 2023), https://actuary.org/wp-content/uploads/2017/11/RiskPoolingFAQ071417.pdf.

[5] For a discussion of this literature, *see, e.g.*, Linda J. Blumberg & John Holahan, Early Experience with the ACA: Coverage Gains, Pooling of Risk, and Medicaid Expansion, 44 J Law Med Ethics 538 (2016), https://pubmed.ncbi.nlm.nih.gov/28661254/.

[6] Elizabeth M. Briones & Robin A. Cohen, Health Insurance Coverage: Early Release of Quarterly Estimates from the National Health Interview Survey, 2023–December 2024, Nat'l Ctr. for Health Statistics (June 2025), https://www.cdc.gov/nchs/nhis/early-release/health-insurance-coverage.html.

analysis using data from 2023 to study the nonelderly uninsured finds that 57 percent are eligible for subsidized coverage, 25 percent through Medicaid and 32 percent through the Marketplaces.[7] These results are generally consistent across age and race and for most income categories, but do vary by geography and for certain income groups.[8]

12. Eligible people remain uninsured for a variety of reasons. In one survey, about one quarter of the uninsured say that they do not need or want coverage, while most report that the reason they are uninsured is because they are experiencing some sort of barrier to obtaining health insurance.[9]

*Costs*

13. Cost is a common reason that uninsured people do not enroll in coverage for which they are eligible; in the survey described above, 62 percent of the uninsured indicated that they did not have coverage because it was too expensive.[10]

14. For consumers shopping for coverage through the Health Insurance Marketplaces, a number of factors affect the costs faced by different groups. Some potential enrollees—including those who are relatively higher income—pay the gross or "sticker" premium charged by insurance companies. Therefore, policies that increase gross premiums will directly increase the cost of coverage for this group.

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[7] Jennifer Tolbert et al., Key Facts About the Uninsured Population, KFF (Dec. 18, 2024), http://kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population.

[8] *See, e.g.*, Patrick Drake et al., A Closer Look at the Remaining Uninsured Population Eligible for Medicaid and CHIP, KFF (Mar. 15, 2024), https://www.kff.org/uninsured/issue-brief/a-closer-look-at-the-remaining-uninsured-population-eligible-for-medicaid-and-chip/, Jameson Carter et al., Uninsurance and Medicaid Eligibility Among Young Adults in 2025, Urban Inst. (Mar. 18, 2025), https://www.urban.org/research/publication/uninsurance-and-medicaid-eligibility-among-young-adults-2025; Linda J. Blumberg, et al., Characteristics of the Remaining Uninsured: An Update,
Urban Inst. 2 (July 2018), https://www.urban.org/sites/default/files/publication/98764/2001914-characteristics-of-the-remaining-uninsured-an-update_2.pdf.

[9] *See* Tolbert et al., *supra* note 7.

[10] *Id.*; *see also*, Reaching the Remaining Uninsured: An Evidence Review on Outreach & Enrollment, Ass't Sec'y for Planning & Evaluation (Oct. 2021), https://aspe.hhs.gov/sites/default/files/documents/666bcb121e373ec517def3b1fcd4af23/aspe-remaining-uninsured-outreach-enrollment.pdf.

15. Most consumers who buy coverage through the Marketplace qualify to receive financial assistance.[11] These consumers pay a "net premium" that is the gross premium for coverage less the amount of financial assistance they receive. The structure of this assistance means that gross premiums are not usually the most important factor influencing the net cost the household will pay for coverage. For this group, household net premiums are primarily affected by policies that change the terms on which they receive financial assistance.

16. For any product, higher costs are associated with reduced demand. A body of literature has specifically examined how increased premiums affect enrollment in health coverage through Health Insurance Marketplaces. This literature demonstrates that even small increases or decreases in premiums have significant impacts on enrollment. For example:

- Decreases in financial assistance, and the associated increase in net premiums, has a large enrollment effect: each $40 increase in net monthly premiums decreases enrollment by 25 percent.[12]
- For enrollees without financial assistance, increases in gross premiums are associated with large reductions in Marketplace enrollment, including a decline of more than 5 percent in one year.[13]
- A premium increase of less than $10 per month was associated with a 14% reduction in enrollment.[14]

[11] For 2025, 92% of Marketplace enrollees receive financial assistance. 2025 Marketplace Open Enrollment Period Public Use Files, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files.

[12] Amy Finkelstein et al., Subsidizing Health Insurance for Low-Income Adults: Evidence from Massachusetts, 109 Am. Econ. Rev. 1530 (2019), https://pubs.aeaweb.org/doi/pdfplus/10.1257/aer.20171455.

[13] Michael Cohen & Michelle Anderson, Premium Effects on ACA Enrollment, Wakely (Apr. 2019), https://www.wakely.com/wp-content/uploads/2024/04/premium-effects-aca-enrollment-final.pdf.

[14] Adrianna McIntyre, Mark Shepard & Timothy J. Layton, Small Marketplace Premiums Pose Financial and Administrative Burdens: Evidence from Massachusetts, 2016–17, 43 Health Aff. 80 (2024), https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00649.

- The availability of $0 premium plans increases days of enrollment in the Marketplace.[15]
- Overall, studies find a high price elasticity of demand for coverage in the Marketplaces: a 1 percent premium increase for a plan decreases enrollment by 1.7 percent[16] (though note that this is not a direct measure of coverage loss).

17. Therefore, there is significant evidence that policies that increase gross and net premiums by even small amounts are expected to lead to reduced enrollment and an increased number of uninsured.

18. Policy changes can affect gross premiums in different ways. For example, policies that decrease the benefits covered by plans in the Marketplace will decrease gross premiums, while policies that decrease the share of relatively healthy people covered by Marketplace plans will increase gross premiums.[17]

19. Similarly, policies can change net premiums for people receiving financial assistance through a variety of mechanisms. At the most extreme end, policies that eliminate (or newly provide) eligibility for financial assistance will dramatically increase (or decrease)

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[15] Coleman Drake et al., Financial Transaction Costs Reduce Benefit Take-up Evidence from Zero-Premium Health Insurance Plans in Colorado, 89 J. Health Econ. 102752 (2023), https://www.sciencedirect.com/science/article/abs/pii/S0167629623000292.

[16] Jean Abraham et al., Demand for Health Insurance Marketplace Plans Was Highly Elastic in 2014–2015, 159 Econ. Letters 69 (2017), https://www.sciencedirect.com/science/article/abs/pii/S0165176517302823; *see also* Benjamin Hopkins, Jessica Banthin & Alexandra Minicozzi, How Did Take-up of Marketplace Plans Vary with Price, Income, and Gender?, 11 Am. J. Health Econ. (2025), https://www.journals.uchicago.edu/doi/10.1086/727785.

[17] Policies that decrease the share of low-income people covered by Marketplaces can also decrease gross premiums for certain types of Marketplace plans (specifically "silver" plans). This is because of a practice referred to as "silver-loading," under which premiums for silver plans in Marketplaces are raised to cover the cost of providing cost-sharing reductions. Independent of any risk pool effects, policies that decrease the share of low-income people in Marketplaces will decrease silver plan gross premiums. However, such policies may worsen the risk pool overall and therefore increase premiums for other types of plans. Further, lower silver plan premiums mean higher net premiums for many people with financial assistance, and do not affect the lowest-cost options available for people who pay gross premiums. Therefore, lower silver plan premiums do not mean consumers face lower costs; instead, it will often mean the opposite. *See, e.g.,* Christen Linke Young, Understanding Marketplace "Silver Loading," Brookings Inst. (May 9, 2025), https://www.brookings.edu/articles/understanding-marketplace-silver-loading/.

premiums. Policies can also change the formula used for calculating financial assistance, which will have smaller impacts.

*Administrative Obstacles*

20. Beyond costs, administrative obstacles—like paperwork submission requirements—are also a significant factor that results in eligible people remaining uninsured. Twenty-four percent of the uninsured say the primary reason they do not have coverage is that "signing up was too difficult or confusing." An additional 18 percent report difficulty finding a plan, which may also reflect administrative barriers.[18]

21. The Marketplace application process contains a number of steps. At a minimum, consumers (on their own, or in partnership with a broker or assister) must (1) submit an application that contains responses to questions, (2) receive and understand fairly detailed information about their eligibility, (3) select a health plan from among the dozens of options available, and (4) establish a relationship with the insurance company offering their coverage, including providing payment information in most cases. Some consumers are also required to submit additional documentation by mail or upload to an online portal, or to resolve issues that may be affecting their coverage with other entities, like the Internal Revenue Service (IRS), their state Medicaid agency, or an insurance plan.[19]

22. Literature within and outside health care has established that administrative obstacles generally reduce enrollment of eligible people. Analyses looking specifically at Marketplace health insurance have found:

- Adding an additional step to the reenrollment process for Marketplace health

[18] Tolbert et al., *supra* note 7.

[19] *See. e.g.,* Rachel Schwab et al., Policy Innovations in the Affordable Care Act Marketplaces, Commonwealth Fund (Nov. 21, 2023), https://www.commonwealthfund.org/publications/issue-briefs/2023/nov/policy-innovations-affordable-care-act-marketplaces.

insurance decreases enrollment by 33 percent.[20]

- A randomized experiment examining a checkbox to reduce a step in the enrollment process increased enrollment by 11 percent.[21]
- Scholars argue that the literature on the ways in which *costs* deter Marketplace enrollment can also be understood as administrative burdens deterring enrollment, because the costs are often small and it is likely that the time and paperwork burden of establishing payment contributes to the enrollment effects.[22]

23. Outside of the Marketplaces, researchers have documented similar impacts. For example:

- Making an administrative component of the food assistance application process more flexible increases enrollment by 6 percentage points.[23]
- Offering assistance resolving administrative obstacles to enroll in food assistance increases enrollment by 12 percentage points.[24]
- Many researchers have shown that simplifying enrollment in retirement savings plans increases take-up significantly.[25]

24. Thus, there is significant evidence that policies that an increase in administrative

[20] Mark Shepard & Myles Wagner, Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment, 115 Am. Econ. Rev. 772 (2025), https://doi.org/10.1257/aer.20231133.

[21] Keith Marzilli Ericson et al., Reducing Administrative Barriers Increases Take-Up of Subsidized Health Insurance Coverage: Evidence from a Field Experiment, Rev. Econ. & Stat., Mar. 5, 2025, at 1, https://doi.org/10.1162/rest_a_01573.

[22] *See, e.g.,* Adrianna McIntyre, Mark Shepard & Myles Wagner, Can Automatic Retention Improve Health Insurance Market Outcomes?, 111 AEA Papers & Proc. 560 (2021), https://doi.org/10.1257/pandp.20211083; Letter from Matthew Fiedler to Ctrs. for Medicare & Medicaid Servs., Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability [CMS-9884-P] (Apr. 11, 2025), https://www.brookings.edu/wp-content/uploads/2025/04/Fiedler-Comment-on-Program-Integrity-Rule-FINAL.pdf.

[23] Eric Giannella et al., Administrative Burden and Procedural Denials: Experimental Evidence from SNAP, 16 Am. Econ. J.: Econ. Pol'y 316 (2024), https://doi.org/10.1257/pol.20220701

[24] Amy Finkelstein & Matthew J. Notowidigdo, Take-Up and Targeting: Experimental Evidence from SNAP, 134 Q.J. Econ. 1505 (2019), https://economics.mit.edu/sites/default/files/2022-08/aaFinkelstein_Noto_QJE_August_2019%20%281%29.pdf.

[25] *See, e.g.*, Brigitte C. Madrian & Dennis F. Shea, The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior, 116 Q.J. Econ. 1149 (2001), https://doi.org/10.1162/003355301753265543.

obstacles leads to reduced enrollment and an increased number of uninsured.

25. Policy changes can add additional administrative obstacles or complexify administrative burdens that already exist. For example, more consumers can be required to submit additional documentation, the document process can be made more challenging, or consumers can be required to interact with third parties in more or different circumstances. Such changes can affect all Marketplace enrollees or certain subsets. The evidence indicates that these policy changes would be expected to decrease enrollment.

*Risk Pool Impacts*

26. The economic literature has also established that the individuals deterred from enrollment by higher costs and administrative obstacles tend to be healthier. For example:

- Enrollees who would potentially lose coverage if an additional administrative step was required at reenrollment have health costs 44% lower than those who are not likely to be affected.[26]
- The group of enrollees retained through a change to reduce administrative burden have spending 2.5% lower than other enrollees.[27]

27. When healthy people exit health insurance markets, the risk pool worsens and gross premiums for the market as a whole tend to go up. That is, the insurance market becomes less effective at pooling risk and has higher overall costs.

28. As noted above, higher gross premiums resulting from worsened risk pools can further deter enrollment and increase the number of uninsured.

[26] Shepard & Wagner, *supra* note 20.
[27] McIntyre, Shepard & Wagner, *supra* note 22.

**The Challenged Provisions of the Final Rule Are Expected to Increase Costs and Administrative Obstacles, and Therefore Reduce Enrollment**

29. The Final Rule includes a variety of policies that are expected to increase net premiums for people receiving financial assistance, increase gross premiums for at least some plans, and impose additional administrative obstacles, which are in turn expected to cause decreases in enrollment.

*$5 Premium at Reenrollment*

30. The Final Rule makes changes for enrollees who are being automatically enrolled into plans that would otherwise have a $0 net premium. Specifically, the rule requires a $5 premium charge be added unless the individual actively reenrolls.

31. This is transparently an increase in net premiums. Consistent with all of the evidence described above, it would be expected to decrease enrollment.

32. Moreover, there are several analyses that look *specifically* at the impacts of added premium charges at reenrollment—examining how a change from a $0 net premium to a small charge (generally under $10) decreases enrollment. This literature consistently finds large decreases in enrollment associated with the exact policy change advanced in the Final Rule.[28]

33. The individuals deterred from enrollment under this policy are likely to be healthier than average, worsening risk pools.

*Premium Adjustment Percentage*

34. The Final Rule alters the formula that is the basis for calculating the value of

[28] *See, e.g.*, McIntyre, Shepard & Layton, *supra* note 14 (increasing premiums at reenrollment from $0 to less than $10 decreases enrollment 14 percent); Drake et al., *supra* note 15 ($0 premium at reenrollment meaningfully increases enrollment); Laura Dague, The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach, 37 J. Health Econ. 1 (2014), https://doi.org/10.1016/j.jhealeco.2014.05.001 (adding premiums at reenrollment in Medicaid decreases enrollment).

financial assistance.[29] The changes mean that financial assistance will be lower for nearly all enrollees who receive it, and net premiums will be higher. CMS notes that net premiums will be about 2 percent higher on average.

35. This increase in net premiums will decrease enrollment. Indeed, CMS reaches the same conclusion and estimates 80,000 people will lose coverage as a result of this change.[30]

36. Consistent with the literature described above, these enrollees are likely to be healthier than average, and their loss will likely worsen the risk pool.

*Actuarial Value*

37. Marketplace plans are generally required to cover a specified percentage (60, 70, 80, or 90 percent) of total health care costs, and rules have long allowed some de minimis variation from the target amount. The Final Rule asymmetrically widens the allowable de minimis range, including allowing plans to be as much as 4 percentage points below the target and still be considered in compliance. Prior policy had allowed variation only 2 percentage points below the target, and 0 for silver plans.

38. This change will generally decrease the value of the health insurance purchased through the Marketplace and lower gross premiums for this reason. It will also affect net premiums. Because the policy's impact on silver plans is larger compared to prior law than on other types of plans, the gross premium impact for silver plans will be larger as well. This will reduce the value of financial assistance and *increase* net premiums for people seeking to buy

[29] The CMS Final Rule changes regulatory text that establishes a formula used to calculate cost-sharing in private health insurance. IRS, through separate guidance, applies the formula to calculations for Marketplace financial assistance. In the regulatory impact analysis for the final rule, CMS unambiguously treats its policy change as affecting financial assistance and net premiums. Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 27,074, 27,206-27,207 (June 25, 2025), https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability ("Net premium increases of approximately $530 million per year for PY 2026 through PY 2030"). Accordingly, it is appropriate to attribute these premium increases to the Final Rule.

[30] *Id.*

non-silver plans with financial assistance.[31]

39. As with other policies increasing net premiums, this change may reduce Marketplace enrollment.

*Denial of Coverage for Past Non-payment of Premiums*

40. The Final Rule includes a policy that allows insurers to deny coverage to enrollees for past non-payment of premiums. An individual will not be able to begin enrollment into a new health plan unless she has paid any past-due premium debts associated with prior enrollment with the insurer.

41. This functions as an increase in net and/or gross premiums for the first month of coverage. Specifically, in order to start her first month of coverage, she must pay an amount larger than her "true" monthly premium. If her prior enrollment was associated with an amount of financial assistance similar to the new enrollment, then she would have to pay roughly double her actual premium to begin coverage. These are the sorts of premium increases that the literature discussed above demonstrates lead to reduced enrollment.

42. This policy can also function as a particularly confusing sort of administrative obstacle for some consumers, even if they are willing to pay the additional amount. A consumer in this situation may have selected a plan at the website of the Health Insurance Marketplace (i.e., HealthCare.gov) and then visited the insurer's website to make a payment that she believes is the payment for her first month of coverage. The insurance company may *accept* the payment she has provided, but treat some or all of it as payment of the past-due premium debt; therefore, the consumer will have to make an additional, separate payment to the insurer even though she believes she is fully paid. While no literature speaks directly to this precise form of unusual

[31] For an explanation of the mechanics of this impact, *see* Young, *supra* note 17.

consumer burden, it is consistent with the broader literature on administrative complexity of a long, multi-step enrollment process to conclude the consumer confusion associated with this policy change is also likely to lead to reduced enrollment.

*Open Enrollment Period*

43. The Final Rule shortens the annual Open Enrollment Period (OEP) by one month in states that use the federal Marketplace, and by varying amounts in other states.

44. This is mechanically an increased administrative burden that will decrease enrollment. Consumers will have fewer available weeks, and fewer are expected to enroll as a result.

45. The risk pool and premium impacts are more complicated, but available data tend to suggest this policy change will worsen risk pools and increase gross premiums. In the Final Rule preamble, the Centers for Medicare & Medicaid Services (CMS) expressed concern about individuals who identified a health concern in late December or early January (e.g., an injury or new symptoms of illness) and decided to enroll in coverage only after the issue emerged. It is likely that some number of people enroll on that basis. These individuals would be expected to have higher health care costs, and so blocking their enrollment with a shorter OEP will improve risk pools. On the other hand, because healthy individuals are less motivated to enroll in coverage, longer enrollment windows provide more time to recruit these marginal consumers. A shorter OEP will also block this group from enrolling, which will worsen risk pools. Data from state-based Marketplaces tend to suggest that there is a much larger set of people in the latter category. Data from California show that in past years, OEP enrollees in January are about 5 percent healthier (as measured by prospective risk scores) than enrollees prior to December 15.[32]

[32] Data Snapshot: Covered California Open and Special Enrollment Periods, Covered Cal. (Apr. 3, 2025), https://hbex.coveredca.com/data-research/library/CoveredCA_OE_SEP_Data_Snapshot_20250403.pdf.

New York also finds January enrollees to be younger on average than enrollees earlier in OEP.[33] Based on these state findings, it is reasonable to expect this change to worsen risk pools and increase gross premiums.

*Special Enrollment Periods*

46. The Final Rule also eliminates an existing Special Enrollment Period (SEP) for consumers with incomes below 150 percent of the Federal Poverty Level, and requires most people applying for coverage through an SEP to submit documentation establishing that they meet the criteria for an SEP.

47. As with a shorter OEP, eliminating the low-income SEP will mechanically reduce the number of people enrolled because there are fewer available opportunities. There is limited nationwide data available about use of the low-income SEP, but available information suggests it has been a major source of enrollment. For example, CMS reported that in an 11-month period ending in mid-2023, 1.3 million enrollees selected a plan through the low-income SEP.[34] While some of these individuals may have otherwise obtained coverage through another SEP or during the OEP for a past or subsequent year, these results are suggestive that eliminating the low-income SEP will result in a large reduction in enrollment and increase in the uninsured.

48. The administrative obstacles associated with documenting eligibility for an SEP are also expected to reduce enrollment. Affected individuals must obtain some specific document (like a letter from their former employer about the loss of employer-based coverage or a

[33] Letter from N.Y. State of Health to Ctrs. for Medicare & Medicaid Servs., Comments on the Patient Protection and Affordable Care Act; Market Stabilization [CMS-9929-P] (Mar. 7, 2017), https://info.nystateofhealth.ny.gov/sites/default/files/Comments%20on%20Proposed%20Market%20Stabilization%20Regulations%203.7.17.pdf

[34] 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, 88 Fed. Reg. 82,510 (Nov. 24, 2023), https://www.federalregister.gov/documents/2023/11/24/2023-25576/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2025#p-655

marriage certificate) and upload or mail that information. These documents are not the sort of information that consumers tend to keep readily available; this is substantially more complicated than simply removing one's driver's license from a purse or wallet. Consumers will need to set aside time and attention to complete the process and some will fail to do so. Consistent with the literature above, this will decrease enrollment.

49. Some economic theory suggests these changes to SEP policies could improve the risk pool, while other theory suggests the opposite. Empirical data provided by states, however, indicates that it is more likely that these policies would worsen the risk pool.

50. With respect to the low-income SEP, in the preamble to the Final Rule, CMS discusses their concern that individuals with low incomes could opt not to enroll during the usual OEP, and wait until they had some reason to be concerned about their health to enroll through the SEP. Alternatively, individuals may only begin seeking information about health insurance, which ultimately leads to an enrollment through the SEP, when they have some sort of health concern. It is likely that these factors explain some enrollment through the low-income SEP, and eliminating the associated enrollment would improve risk pools. On the other hand, overall uptake of coverage is fairly low, especially for people who become eligible mid-year. For example, in the early years of the Marketplaces, one group of researchers estimated that less than 15 percent of people who were eligible to enroll through an SEP did in fact do so, and the people who did enroll were likely to be less healthy than the 85 percent that did not.[35] Low-income people may be especially likely to forego the opportunity to enroll. Therefore, policies that increase take-up among eligible people would likely bring healthier people into the

[35] Matthew Buettgens, Stan Dorn & Hannah Recht, More than 10 Million Uninsured Could Obtain Marketplace Coverage Through Special Enrollment Periods, Urban Inst. (Nov. 2015), https://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf

Marketplaces, and blocking these enrollments would worsen risk pools.

51. The same basic dynamic applies to additional document submission requirements for SEP enrollments. To the extent individuals are improperly claiming eligibility for an SEP because they need health care services, blocking these enrollments will improve risk pools; to the extent that healthy people are deterred by additional submission requirements, the deterred enrollments will tend to be among healthier people and will worsen risk pools.

52. Across both policies, data from California tend to suggest that the risk pool worsening effects of these policy changes may be more pronounced. Specifically, California has shared information about the relative health, as measured by prospective risk scores, of SEP and OEP enrollees. They find that the overall health profile of SEP enrollees is consistently slightly better than those enrolling during the OEP.[36] Similarly, other state Marketplaces have indicated they do not find their SEP enrollee population to be sicker than OEP enrollees.[37] Note that these data generally look at all SEP enrollees together, not just those enrolling through the low-income SEP, and they do not specifically identify who would be deterred from enrollment by administrative barriers, so they are not a perfect predictor. Nonetheless, they suggest that eliminating the low-income SEP and creating additional verification burden would worsen risk pools.[38]

[36] Data Snapshot: Covered California Open and Special Enrollment Periods, Covered Cal. (Apr. 3, 2025), https://hbex.coveredca.com/data-research/library/CoveredCA_OE_SEP_Data_Snapshot_20250403.pdf.

[37] *See, e.g.,* Letter from Audrey Morse Gasteier, Chief of Policy & Strategy, Mass. Health Connector, to Ctrs. for Medicare & Medicaid Servs., Notice of Proposed Rulemaking, "Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond" (July 28, 2021), https://www.regulations.gov/comment/CMS-2021-0113-0240; Letter from Jason Levitis, Sabrina Corlette & Christen Linke Young to Ctrs. for Medicare & Medicaid Servs., Re: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability (Apr. 11, 2025).

[38] Because this policy is likely to reduce the share of enrollment attributable to low-income people, gross silver plan premiums will likely fall, separate from any risk pool effects, but this will not translate to consumers facing lower costs as described above.

*Failure to Reconcile*

53. The Final Rule makes changes to a Marketplace administrative process known as Failure to Reconcile. Marketplace consumers cannot receive financial assistance if data from the IRS show that they received financial assistance in a prior year and have not "reconciled" on their tax return. Consumers are blocked from financial assistance until they correct the issue with the IRS. The prior policy required two years of IRS demonstrating a failure to reconcile before financial assistance was denied; the Final Rule changes that to one year.

54. This process operates as a complicated administrative obstacle for some consumers. Because whether or not an individual has reconciled their tax credit is considered Federal Tax Information (FTI), that information must be protected from disclosure and handled consistently with federal tax privacy laws. Specifically, rules around the handling of FTI limit the ways in which Marketplaces are able to display in their computer systems (for enrollees and for customer service representatives) the notation that an individual is affected by a failure to reconcile blocking their financial assistance. A consumer may find himself blocked from financial assistance, but the explanation for this block and information on how to correct it may not be accessible outside of specialized channels that he does not know he needs to access.

55. The literature described above generally shows that even simple administrative obstacles like the submission of a single form deter enrollment, especially by healthier people. The Kafka-esque circumstances of the failure to reconcile block are likely to have even greater effects. The existence of the process and the expansion of the number of affected enrollees is expected to decrease enrollment and worsen risk pools.

*Data Matching Issues*

56. The ACA and Marketplace rules require that consumers submit documentation to prove their eligibility for enrollment and financial assistance if their eligibility cannot be

established through trusted data sources. The document submission requirement is known as a "data-matching issue." The Final Rule changes Marketplace policies so that income information that was treated as adequately verified under prior rules will no longer be designated as such, thus triggering a data-matching issue and requiring affected consumers to submit documentation. If consumers fail to submit adequate documentation, they will generally lose their financial assistance, and generally drop from Marketplace coverage as a result.[39]

57. Consumers generally will need to submit information like paystubs, invoices, or a narrative explaining their income situation. Similar to the information required for SEP verification, obtaining and submitting the needed documents requires time and attention from consumers, and these are the sorts of burdens that the literature above demonstrates lead to reduced enrollment in coverage.

58. CMS estimates in the Final Rule that 488,000 people will fail to successfully resolve a data-matching issue triggered under the rule[40] and will have their financial assistance reduced—generally to $0. Most of this group can be reasonably expected to lose coverage.

59. As with other policies, this coverage loss is likely to affect disproportionately healthy consumers, worsening risk pools.

**Conclusion**

60. The challenged provisions of the Final Rule each operate to increase gross premiums, increase net premiums, impose administrative burdens, worsen Marketplace risk

[39] Marketplace rules specify that if a data-matching issue cannot be successfully resolved, financial assistance is to be recalculated based on available information; the circumstances of these new data-matching issues mean that in most cases the Marketplace will not have information or the information it has will result in no financial assistance being available. Loss of financial assistance will mean that, on average, premiums increase from $113 to $619. *See* Health Insurance Exchanges 2025 Open Enrollment Report, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/files/document/health-insurance-exchanges-2025-open-enrollment-report.pdf. These very large cost increases mean that people will generally drop coverage if they cannot restart their financial assistance.

[40] Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 27,074 (June 25, 2025), https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability.

pools, or some combination of those effects. They are expected to decrease Marketplace enrollment and increase the number of uninsured.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Dated: June 28, 2025

Washington, D.C.



CHRISTEN LINKE YOUNG

# APPENDIX

# CHRISTEN LINKE YOUNG

## Career

Brookings Institution, 2025-Present
Visiting Fellow, Center on Health Policy

White House Domestic Policy Council, 2021-2025
Deputy Director and Deputy Assistant to the President for Health and Veterans

Biden-Harris Transition Team, 2020
Director of Health Policy

Brookings Institution, 2018-2021
Fellow, Schaeffer Initiative for Health Policy

NC Department of Health and Human Services, 2017-2018
Deputy Secretary

Centers for Medicare & Medicaid Services, 2015-2017
Principal Deputy Director of the Center for Consumer Information and Insurance Oversight

White House Domestic Policy Council, 2013-2015
Senior Policy Advisor for Health Reform

U.S. Department of Health and Human Services, 2013
Director of Coverage Policy, Office of Health Reform

## Education

Yale Law School
Juris Doctor, 2009
Editor-in-Chief, Yale Journal of Health Policy, Law, and Ethics
Senior Editor & Admissions Committee, Yale Law Journal

Stanford University
Bachelor of Science with Honors and with Distinction, Biological Sciences, 2004
Phi Beta Kappa

## Publications

Jason Levitis, Christen Linke Young, Sabrina Corlette, Ellen Montz, and Claire O'Brien, "The Reconciliation Bill Eliminates Long-Standing State Flexibility to Operate Marketplaces and Regulate Private Health Insurance" *Georgetown Center for Health Insurance Reforms* (June 13, 2025).

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Christen Linke Young and Kathleen Hannick, "GAO Report Sheds Additional Light on Misleading and Deceptive Marketing Practices," *Brookings Institution* (September 25, 2020).

Christen Linke Young, James C. Capretta, Stan Dorn, David Kendall, and Joseph R. Antos, "How To Boost Enrollment: Three Practical Steps That Merit Bipartisan Support," *Health Affairs* (August 17, 2020).

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Loren Adler and Christen Linke Young, "The Laws Governing COVID Test Payment and How To Improve Them," *Brookings Institution* (July 13, 2020).

Christen Linke Young, "Taking a Broader View of Junk Insurance," *Brookings Institution* (July 6, 2020).

Christen Linke Young and Sobin Lee, "Making ACA Enrollment More Automatic for the Newly Unemployed," *Brookings Institution* (May 28, 2020).

Christen Linke Young and Sobin Lee, "How Well Could Tax-Based Auto-Enrollment Work," *Brookings Institution* (April 14, 2020).

Christen Linke Young, Stan Dorn, Loren Adler, Cheryl Fish-Parcham, Tara Straw, "Responding To COVID-19: Using The CARES Act's Hospital Fund To Help The Uninsured, Achieve Other Goals," *Health Affairs* (April 10, 2020).

Christen Linke Young and Kathleen Hannick, "Misleading Marketing of Short-Term Plans Amid COVID-19," *Brookings Institution* (March 24, 2020).

Erica Turret, Abbe R. Gluck, Adam L. Beckman, Suhas Gondi, Sara Rosenbaum, Ruth J. Katz, Kavita K. Patel, Brendan G. Carr. Christen Linke Young, Elizabeth Fowler, Megan L. Ranney, Timothy Jost, and Howard P. Forman, "The Families First Coronavirus Response Act Is Necessary But Not Sufficient – Here's What Congress Should Do Next," *Health Affairs* (March 18, 2020).

Christen Linke Young, "What Do I Do If I Lose My Job Based Health Insurance?," *Brookings Institution* (March 17, 2020).

Matthew Fiedler, Christen Linke Young, and Loren Adler, "What Are the Health Coverage Provisions in the House Coronavirus Bill?," *Brookings Institution* (March 13, 2020).

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Christen Linke Young, "Federal Surprise Billing Legislation Does Not Violate the Constitution," *Brookings Institution* (July 1, 2019).

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Loren Adler, Matthew Fiedler, Paul B. Ginsburg, and Christen Linke Young, "Comments On The No Surprises Act," *Brookings Institution* (May 29, 2019).

Christen Linke Young, Loren Adler, Paul B. Ginsburg, and Mark Hall, "The Relationship Between Network Adequacy and Surprise Billing," *Brookings Institution* (May 10, 2019).

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**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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

**DECLARATION OF SHAWN PHETTEPLACE**

I, Shawn Phetteplace, declare as follows:

1. I am the National Campaigns Director at Main Street Alliance ("MSA"). I have held that position since 2023, and have been on staff with MSA since 2020. In my role as national campaigns director, I work closely with MSA's small business members. I make this statement based on personal knowledge and if called as a witness could and would testify competently thereto.

2. MSA is a § 501(c)(3) organization and national network of small businesses, with approximately 30,000 members throughout the United States. MSA helps small business owners realize their full potential as leaders for a just future that prioritizes good jobs, equity, and community through organizing, research, and policy advocacy. MSA also seeks to amplify the voices of its small business membership by sharing their experiences with the aim of creating an economy where all small business owners have an equal opportunity to succeed.

3. Many of MSA's members rely on the ACA marketplace for health insurance. According to a recent survey, over 45% of MSA members access health insurance either through the marketplace or Medicaid.

4. Those members will be negatively impacted by the new Centers for Medicare & Medicaid Services (CMS) rule, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," which will increase the cost of health insurance and limit insurance coverage. The financial and health impact of the rule will cause direct harm to MSA members, their families, and their businesses.

5. The erosion of coverage under the new rule will create additional costs for MSA members and negatively impact the health of those who rely on care or medication that they cannot afford without insurance coverage. The increase in costs will even threaten the continued operation of some MSA members. Small businesses often operate on small profit margins, so if health insurance through the marketplace becomes unaffordable or inadequate, then owners and their employees may be forced to seek alternative employment to have access to employer-sponsored health insurance.

6. MSA's founding was directly focused on the passage of the Affordable Care Act, and the organization has remained focused on the subsequent strengthening of the law over the past 15 years. The new CMS rule undermines the hard-fought legislative victories that MSA helped to secure.

I declare under penalty of perjury under the laws of the United States of America, pursuant to 28 U.S.C. § 1746, that the foregoing is true and correct to the

best of my knowledge. Executed this 30th day of June 2025 in Madison, Wisconsin.



SHAWN PHETTEPLACE

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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

**DECLARATION OF BROOKE LEGLER**

I, Brooke Legler, declare as follows:

1. I am over 18 years old and competent to make this declaration. I have personal knowledge of the facts and information in this declaration. I respectfully provide this declaration to explain why the cost increases that would be caused by the new Centers for Medicare and Medicaid Services rule, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," would threaten my ability to access medication that I require for my health and risk the loss of my small business.

2. I am a member of the Main Street Alliance, which is a national association of approximately 30,000 small businesses.

3. I am a resident of New Glarus, Wisconsin.

4. I am a small business owner. My business is an early childhood education program with about 10 employees.

5. When I was 10 years old, I was diagnosed with rheumatoid arthritis. Rheumatoid arthritis is an autoimmune condition that causes inflammation in the joints and damage to various parts of the body, leading to bone degradation. My condition has never been in remission. Since

my diagnosis, I have dependent on substantial medication to treat the condition, including medications that address secondary issues caused by the primary medications.

6. Among other medications, I take a biologic to protect my health by suppressing my immune system, which costs about $10,000 per month. My insurance covers a portion of that medication, and I also qualify for payment assistance through the drug company. I would not be able to afford this medication without health insurance, or with a less comprehensive insurance plan.

7. I know from past experience that the consequences to my health are severe if I am off the biologic for any period of time. Several years ago, when I had my children, I had to stop taking the biologic for a period of time, and my bones quickly began to cripple. I experienced such severe bone damage that I had to have surgery on my left foot, which is now supported by screws and rods. The medication I take is crucial to prevent further such damage.

8. Because of my condition and dependence on unaffordable medication, health insurance has always been crucial to me. Before the Affordable Care Act (ACA), I had to make major life decisions—including my career and personal relationships—based on what would help me keep my health insurance coverage. Among other things, the ACA gave me the freedom to operate my own small business and keep about 10 employees.

9. Because of the ACA, I have been able to enroll in a plan on the individual insurance market through Healthcare.gov. I currently pay about $200 per month, after ACA subsidies, for an insurance plan that provides me access to my critical medications.

10. For my employees who are not on their spouses' insurance plans, I am able to offer up to $150 per month for them to likewise enroll in an insurance plan through the ACA Marketplace.

11. I operate my business on narrow margins. The new Centers for Medicare and Medicaid Services rule will cause my health insurance coverage costs to increase to a level that I cannot afford. These increased costs will likely make it impossible for me to continue by business, as I would be forced either to find different employment with employer-sponsored insurance, or to terminate my business and explore other coverage options through Wisconsin's BadgerCare system.

12. Continuing my business would not be an option in this circumstance, because I need to have access to affordable insurance that will cover the medications I need. My employees may also lose their jobs, and they may also lose access to affordable coverage through the Exchange.

I declare under penalty of perjury under the laws of the United States of America, pursuant to 28 U.S.C. § 1746, that the foregoing is true and correct to the best of my knowledge. *(Signature on the following page.)*

Executed this 30th day of June 2025 in New Glarus, Wisconsin.

BROOKE LEGLER

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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

**DECLARATION OF DR. JANET KROMMES**

I, Janet Krommes, declare as follows:

1. I am over 18 years old and competent to make this declaration. I have personal knowledge of the facts and information in this declaration. I respectfully provide this declaration to explain why the barriers to insurance and cost increases that would be caused by the new Centers for Medicare and Medicaid Services rule, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," would significantly harm DFA members. The rule would create significant hurdles to the provision of standard medical care to patients such that chronic diseases cannot be treated consistently, screening procedures cannot be done, and patients with critical conditions will be lost to follow-up. To address these failings, medical providers will direct more time to providing uncompensated care, more administrative time to determining whether insurance coverage is possible, and more time locating patients who are no longer seeking care for serious conditions.

2. I am a retired rheumatologist and member of DFA. I serve as an impact area leader at DFA. In that role, I use my 35 years of experience in clinical medicine to educate our members on healthcare policy.

3. DFA is a nonpartisan, not-for-profit, 501(c)(3) organization of over 27,000 physicians and medical trainees, including medical residents and students in all 50 states, representing all medical specialties. DFA mobilizes doctors, other health professionals, and medical trainees to be leaders who put patients over politics to improve the health of patients, communities, and the nation. DFA equips physicians and medical trainees with skills and resources to advocate for health care issues at the local, state, and federal level. DFA members include clinicians who provide direct care to patients, those who provide education to other clinicians and trainees, and those who conduct clinical and public health research.

4. DFA's work focuses on access to affordable care, community health and prevention, and health justice and equity. We advocate at the national and state levels for comprehensive health system reform, expansion of health insurance coverage, and improvements to health care delivery so that it better meets our patients' needs.

5. DFA understands that the new Centers for Medicare & Medicaid Services (CMS) rule, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," will increase the cost of health insurance and limit insurance coverage, creating harmful effects for our members and their patients.

6. When health care costs increase and insurance coverage becomes more limited, patients are less likely to seek the medical care they need and more likely to delay care until conditions become serious. The CMS rule would have this effect in communities throughout the country by increasing the number of uninsured and underinsured individuals. Our members would therefore see patients who delay care until their needs are acute; they would receive less than full reimbursement for those patients who lose insurance or whose coverage becomes more limited; and they would lose contact with many patients altogether, particularly in low-income communities.

7. Appropriate medical care includes referral to a specialist when needed, the prescription of medicine as warranted, and recommendation for procedures when necessary. Even when a clinician provides patient care that will go uncompensated—which will occur increasingly if the final rule is implemented—the clinician's work does not end with the visit. Lack of insurance coverage when a patient needs treatment will require finding a specialist willing to provide care, trying to find an alternative medicine that a patient may be able to afford but is not the optimal treatment, and intervening on behalf of a patient in an attempt to get testing or procedures performed. This will take up greater amounts of time as patients lose coverage. The end result is uncompensated time that detracts from patient care.

8. Some patients will be forced to forgo standard medical care despite the efforts of their physician to solve these problems. Some patients will be forced to go to an emergency room. Not only will this strain community resources, but the care will be limited to what an emergency room can provide. The outcomes will be worse, and the cost will be greater.

9. If the CMS rule were to go into effect, therefore, it would cause significant and irreparable injury to DFA members, their patients, and their communities.

I declare under penalty of perjury under the laws of the United States of America, pursuant to 28 U.S.C. § 1746, that the foregoing is true and correct to the best of my knowledge.

Executed this 1st day of July 2025 in Washington, D.C.



JANET KROMMES

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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

**DECLARATION OF DR. BETH OLLER**

I, Beth Oller, declare as follows:

1. I am over 18 years old and competent to make this declaration. I have personal knowledge of the facts and information in this declaration. I respectfully provide this declaration to explain the devastating effects that the new Centers for Medicare & Medicaid Services (CMS) rule, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," would have on my medical practice, my patients, and my community.

2. I have a Bachelor of Science in Nursing from the University of Kansas and received my medical degree from the University of Kansas School of Medicine. I did my residency at the Wesley Family Medicine Residency Program in Wichita, Kansas. Since completing my residency more than fifteen years ago, I have practiced medicine in Rooks County, Kansas—a rural part of the state with approximately 5,000 residents. I have been a member of DFA since 2022.

3. As a family medicine physician, I care for patients of all ages. My daily practice involves everything from conducting yearly check-ups to treating common illnesses, such as colds and the flu, to screening and treating for conditions such as high blood pressure or diabetes,

to providing comprehensive reproductive healthcare.

4. For more than a decade, I ran a small private practice in Rooks County. Practicing as a family medicine physician in a rural community like mine means seeing many patients who are on Medicare, Medicaid, or uninsured—and many of whom have no other options in our rural community for getting the care that they need. Operating an independent practice became impossible in light of the insurance coverage and payment difficulties that are compounded in my rural community. For the last couple of years, I have practiced as a primary care provider at the Rooks County Health Center. I have a patient panel of more than 800 patients.

5. After the Affordable Care Act (ACA) was enacted in 2010, many patients gained access to health insurance that they could afford for the first time. The ACA had an especially positive effect in states like Kansas, which has not expanded Medicaid coverage, and in rural areas like Rooks County, where many residents are employed by small companies or self-employed, for example, as farmers or ranchers. As a result of getting affordable insurance through the ACA, many of my patients sought preventative care for the first time, which allows patients to identify potential health problems early and get the care they need before conditions become serious and require more acute or emergency care.

6. The new CMS rule would put many of those patients back in the position they were in before: unable to access affordable, comprehensive health insurance and therefore unable to get the preventative care that they need. Because of the administrative red tape that the rule would create and the ways it would limit coverage and ultimately increase costs for individuals, many of my patients would lose their insurance or have their coverage limited as a result of the rule.

7. This rule would have a devastating effect on my practice and my community. Because many of my patients would become uninsured or underinsured, they would be more

likely to opt out of critical preventative care services that my practice provides, hindering my ability to provide optimal care to my patients and jeopardizing their long-term health. For those services that we do provide, we would receive less compensation, as coverage becomes limited (meaning less reimbursement for medical services) and patients cannot pay (meaning no reimbursement for those who lose insurance). And all the red tape means our patients may not even be aware of the changes to their coverage until my practice seeks that reimbursement and it is too late.

8. Patients who are uninsured or underinsured are also more likely to see family medicine physicians for conditions that may normally be provided by a specialist. I regularly perform minor procedures for which I cannot be reimbursed even if the patient is insured because of the barriers and limitations to coverage that the insurance-driven fee schedules create. For example, a patient's coverage may require a mole removal to be performed at a separate appointment from their wellness check, but that patient may not have the means or flexibility to travel to the clinic again for a follow-up appointment. Seeing a specialist is financially out of the question for many of my patients.

9. Uninsured or underinsured patients who forgo or delay the preventive care for which they would normally see a family medicine physician end up with severe or chronic conditions that are not diagnosed or treated until they are forced to seek delayed, emergency care in the hospital. Because those patients are unable to pay, their time in the hospital is uncompensated care. The increase in uncompensated care ultimately increases the cost of healthcare. The increase in uncompensated and undercompensated care that the new rule would cause will force more hospitals and clinics to close, as providers will be unable to make a living, especially in rural areas like mine.

I declare under penalty of perjury under the laws of the United States of America, pursuant to 28 U.S.C. § 1746, that the foregoing is true and correct to the best of my knowledge.

Executed this 1st day of July 2025 in Stockton, Kansas.



BETH OLLER

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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

**DECLARATION OF EDWARD JOHNSON**

I, Edward Johnson, declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. The facts contained in this declaration are known personally to me and, if called as a witness, I could and would testify competently thereto under oath. I submit this sworn declaration in support of Plaintiffs' challenge to the Centers for Medicare & Medicaid Services rule, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability."

2. I am currently the Assistant Public Health Commissioner for External Affairs for the Columbus Department of Public Health ("Columbus Public Health"). I have served as an Assistant Public Health Commissioner for close to three years. Prior to my role as Assistant Public Health Commissioner, I served Columbus Public Health as the Director of Public Health Policy for over four years.

3. As Columbus Public Health's Assistant Public Health Commissioner for External Affairs, I assist the Health Commissioner with representing the needs and concerns of Columbus's residents to protect their health and improve their lives.

4. Plaintiff the City of Columbus is a municipal corporation organized under Ohio law. *See* Ohio Const. art. XVIII. Columbus has all the powers of local self-government and home rule

under the constitution and laws of the state of Ohio, which are exercised in the manner prescribed by the Charter of the City of Columbus.[1]

5. Columbus, located in Franklin County, is the capital of Ohio. It is the largest city in the state and the fifteenth largest city in the United States, with a population of nearly 905,748, according to the 2020 Census.[2]

6. According to 2022 Census estimates, 10.8% of Columbus's population under the age of 65 lacks health insurance.[3]

7. Columbus provides a wide range of services on behalf of its residents, including health services for families and children, public health, public assistance, and emergency medical care.

8. Columbus Public Health employs close to 600 employees who operate more than 90 different public health programs and provide critical services to residents. These programs and services include disease investigation, immunizations, and testing, treatment, and prevention of sexually transmitted infections, among others.[4]

9. Columbus Public Health subsidizes a community health center, which faces greater demand from uninsured or underinsured individuals who cannot obtain health care elsewhere as the uninsured and uninsured rate rises.

10. Columbus Public Health also financially supports PrimaryOne Health, which is a collection of eleven Columbus neighborhood health centers in medically underserved areas. PrimaryOne

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[1] *See City Code and Charter*, City of Columbus, https://library.municode.com/oh/columbus/codes/code_of_ordinances; O.R.C. § 715.01.

[2] *QuickFacts,* U.S. Census Bureau, https://www.census.gov/quickfacts/fact/table/columbuscityohio/PST045224.

[3] *Id.*

[4] *More About Columbus Public Health,* City of Columbus, https://www.columbus.gov/Services/Public-Health/About-Public-Health/About-Columbus-Public-Health.

is designed to be a "system of health center sites throughout Columbus and Franklin County to serve the health care needs of vulnerable, un/under and insured residents within the community."[5] If the rate of uninsured or underinsured individuals increases, then the PrimaryOne Health centers will necessarily see even more patients, and either Columbus will have to provide them with additional funding or they will have to decrease the range of services or patients they are able to cover.

11. Columbus Public Health also operates a number of specialty clinics for alcohol and drug abuse prevention, dental services, family planning, immunizations, sexual health, tuberculosis control, women, infants, and children nutrition, and women's health and wellness.[6] Each of these clinics operates on a free or reduced-fee scale and principally serves the uninsured and underinsured populations.[7] As with PrimaryOne Health, growth in the uninsured and underinsured population will translate to additional costs for Columbus.

12. Columbus also maintains "one of the best Emergency Medical Services (EMS) in the United States," operated by the Columbus Division of Fire.[8] That system dispatches ambulances to meet urgent health needs, regardless of whether the call comes from an individual who has health insurance or is otherwise able to pay for the call.

13. If possible, "[r]eimbursement for the expense of emergency ambulance transport is sought from a patient's Medicare, Medicaid, or commercial health insurance provider."[9] If an individual "live[s] in the City of Columbus and do[es] not have health insurance coverage, [they] will

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[5] *The History of PrimaryOne Health,* PrimaryOne, http://www.primaryonehealth.org/about/.

[6] *See About Columbus Public Health,* City of Columbus, https://www.columbus.gov/Services/Public-Health/About-Public-Health.

[7] *See, e.g., Dental Clinic,* City of Columbus, https://www.columbus.gov/Services/Public-Health/Find-Health-Care-Resources/Dental-Services.

[8] *Division of Fire,* City of Columbus, https://www.columbus.gov/Services/Public-Safety/Fire/About-Us/Reports/EMS-Report.

[9] *Id.*

not receive a bill for transport"; thus, "no Columbus resident will pay anything 'out of pocket' as the result of being transported to a hospital by The Columbus Division of Fire."[10] They will still receive a bill, but it does not get sent to collections. Thus, while Columbus recoups the majority of its costs for transportation for individuals with private insurance, Columbus only recoups a small fraction of its costs for uninsured individuals. For that reason, reimbursements "in no way cover all the costs incurred for treatment and transport."[11]

14. An increase in the number of uninsured or underinsured individuals will result in more transports for which Columbus does not receive reimbursement and thus must make up for the shortfall in its budget.

15. Aside from these budgetary impacts, Columbus—a city of over 900,000 people, with an economy of approximately $182 billion—is harmed by the need to care for a population that is increasingly uninsured. When individuals cannot seek medical treatment, they are necessarily less healthy, less productive, and less able to participate in city life. That has ripple effects throughout the City's programs and the community.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: July 1, 2025

Columbus, Ohio

J. Edward Johnson

EDWARD JOHNSON

[10] *Id.*

[11] *Id.*

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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

**DECLARATION OF FAITH LEACH**

I, Faith Leach, declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. The facts contained in this declaration are known personally to me and, if called as a witness, I could and would testify competently thereto under oath. I submit this sworn declaration in support of Plaintiffs' Motion for a Preliminary Injunction.

2. I am the Chief Administrative Officer of the City of Baltimore. I have served in this role since March 2023. In my role, I manage the day-to-day government operations across the entire City enterprise, ensuring the effective, eficient, and equitable delivery of City services.

3. Baltimore is the largest city in Maryland and the thirtieth largest city in the United States, with a population of around 568,000 according to 2024 Census estimates.[1]

4. According to 2024 Census estimates, 6.7% of Baltimore's population under the age of 65 lacks health insurance.[2]

[1] *QuickFacts*, U.S. Census Bureau, https://www.census.gov/quickfacts/fact/table/baltimorecitymaryland/PST045224.
[2] *Id*.

5. The City of Baltimore is a municipal corporation organized pursuant to Articles XI and XI-A of the Maryland Constitution, entrusted with all the powers of local self-government and home rule afforded by those articles.

6. The Baltimore City Health Department (BCHD) is a City agency and the oldest continuously operating health department in the United States. BCHD has wide-ranging responsibilities for providing health services to residents of the City, including those related to acute communicable diseases, chronic disease prevention, HIV/STD, maternal-child health, school health, and senior services. My duties as Chief Administrative Officer include oversight of BCHD, which is staffed by approximately 900 employees and has an annual budget of approximately $200 million.

7. In particular, BCHD operates a number of specialty clinics out of two principal facilities. These include clinics for reproductive health, sexually transmitted diseases, dental and oral health care, and immunizations.[3]

8. The Baltimore City Health Department also provides or subsidizes a number of other services for Baltimore's uninsured and underinsured residents. In particular, the Department funds a visiting-nurse program that makes house calls for older adults, including those with chronic health conditions like diabetes, hypertension, asthma, and mental health disorders. The Department also funds a number of other programs focused on specific health conditions, including a Community Asthma Program, a Tuberculosis Control Program, a Childhood Lead Poisoning Prevention Program, and programs for substance abuse.[4] And the

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[3] *Health Clinics & Services*, Baltimore City Health Department, https://health.baltimorecity.gov/programs/health-clinics-services.

[4] *See*, *e.g.*, *Asthma*, Baltimore City Health Department, https://health.baltimorecity.gov/node/454; *Health Clinics & Services*, Baltimore City Health Department, https://health.baltimorecity.gov/programs/health-clinics-services; *Lead Poisoning*, Baltimore City Health Department,

Department subsidizes a number of other entities that provide services to Baltimore residents, including the Baltimore Family League and Health Care Access Maryland.

9. An increase in the uninsured rate will impose additional burdens on each of these programs and therefore require more funding from the City.

10. The Baltimore City Fire Department (BCFD) also maintains an ambulance system that responds to calls covering 92 square miles with a daytime population exceeding 1,000,000. BCFD's emergency medical service seeks reimbursement for its costs from patients' Medicare, Medicaid, or commercial health insurance, but BCFD answers calls regardless of the individuals' health insurance coverage or ability to pay. In 2023, with a budget of more than $62 million for emergency medical services, BCFD answered over 145,000 emergency medic calls, including 15,398 from uninsured residents. In 2024, BCFD answered roughly the same number of total calls, including 17,259 from uninsured residents.

11. If a patient lacks insurance, BCFD will seek reimbursement from the patient personally, making several attempts to collect on the debt. However, these attempts are rarely successful. While EMS was able to recoup about 90.5% of costs from patients with insurance coverage, it only recovered 3.8% of costs from uninsured patients.

12. Thus, an increase in the number of uninsured and underinsured individuals results in more ambulance calls for which Baltimore does not receive reimbursement and thus must make up for the shortfall in its budget.

13. In addition, as one of the busiest emergency medical services departments in the nation, BCFD's emergency medical service is often taxed beyond its capabilities. Wait times

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https://health.baltimorecity.gov/lead/lead-poisoning; *Substance Use and Misuse*, Baltimore City Health Department, https://health.baltimorecity.gov/programs/substance-abuse; *Tuberculosis*, Baltimore City Health Department, https://health.baltimorecity.gov/node/164.

exceed national rates, and transport units often wait up to an hour to offload patients. To help reduce strain on our overburdened emergency systems, BCFD developed the population health program. BCFD's Population Health Units are a community-focused arm of its EMS Division, designed to improve public health outcomes by delivering care outside the traditional 911-response model. These units are central to Baltimore's shift toward proactive, community-based healthcare. By integrating EMS with public health strategies including harm reduction, in-home care, and transitional support, the unit works to reduce unnecessary 911 calls, emergency department strain, and hospital readmissions, while improving access, equity, and outcomes across vulnerable communities. An increase in the uninsured rate will only increase the avoidable use of acute health services that these programs are designed to address, causing further strain on a system that is already overstretched.

14. Finally, Baltimore—a city of over 560,000 people, at the center of a $259.7 billion regional economy—is harmed by the need to care for a population that is increasingly uninsured. When individuals cannot seek medical treatment, they are necessarily less healthy, less productive, and less able to participate in city life. That has ripple effects throughout the City's programs and the community.

* * *

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: June 30, 2025.

Baltimore, MD

Faith P. L

Faith Leach

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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

**DECLARATION OF DR. OLUSIMBO IGE**

I, Dr. Olusimbo Ige, declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. I am a resident of the City of Chicago ("City" or "Chicago") in the State of Illinois. I am over the age of 18 and have personal knowledge of all the facts stated herein, except to those matters stated upon information and belief; as to those matters, I believe them to be true. If called as a witness, I could and would testify competently to the matters set forth below.

2. I currently serve as Commissioner of Chicago's Department of Public Health ("CDPH"). I have held this position since December 2023. Before my appointment as CDPH Commissioner, I served as the Managing Director of Programs at the Robert Wood Johnson Foundation. There, I oversaw partnerships with health organizations nationwide working towards making public health and health care systems accountable and equitable. Previously, I served as the Assistant Commissioner for the New York City Department of Health and Mental Hygiene, where I provided oversight to a wide range of programs, including New York City's pandemic response, food security programs, housing and health initiatives, mental health programs, violence prevention, and the Public Health Corps initiative.

3. I have a Bachelor of Medicine and Surgery and a Master of Science degree in Epidemiology and Biostatistics from the University of Ibadan in Nigeria. I received a Public Health Master's degree from the University of Manchester in the United Kingdom.

4. As Commissioner of CDPH, I make strategic decisions, in collaboration with the Mayor's Office and stakeholders across the City, to manage public health threats; design and deliver disease control services; and protect the food, air, and environment for 2.7 million Chicago residents.[1] I serve as a liaison and subject matter expert on all related policy matters, and use of authorities and resources to promote and protect public health. I have built and currently manage an executive team of ten professionals, a budget of $750M, and approximately 760 employees, with a dedication to sustaining a strong public health workforce and capacity.

5. CDPH's overarching mission is to work with communities and partners to create an equitable, safe, resilient, and healthy Chicago. While Chicago does not operate a fully integrated health and hospital system, the Department operates seven mental health centers that provide low-barrier services to uninsured and underinsured Chicago residents, four immunization clinics, and three clinics that provide free testing and treatment for sexually transmitted infections. The City also provides certain at-home and in-field health programs, such as nursing home support for pregnant people and newborn babies and directly observed therapy for tuberculosis. Additionally, the City funds and staffs a network of Women, Infants, and Children (WIC) clinics providing nutrition counseling and supplemental food to pregnant, post-partum and breastfeeding women, their infants and children. Collectively, these clinics and services serve thousands of uninsured and underinsured City residents and support the City's safety net for health-related services. Each of these clinics faces greater demand when there is an increase in either the health needs of Chicago

[1] U.S. Census Bureau QuickFacts (V2024). https://www.census.gov/quickfacts/fact/table/chicagocityillinois/HSG010224.

residents or in the number of uninsured or underinsured individuals who cannot obtain those services or other forms of health care elsewhere.

6. I am deeply concerned with CMS's "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Final Rule" and its potentially harmful impacts on our residents. In Chicago, nearly one in ten residents is uninsured.[2] The Rule would significantly increase barriers to coverage and the number of uninsured residents, increase health care costs for residents, and further burden the City's health care safety net. Under the guise of increased "integrity" and "affordability," the Rule would implement exactly the opposite. For example, eliminating monthly Special Enrollment Periods for individuals with low incomes to enroll in coverage outside of standard enrollment cycles will make affordable insurance harder to obtain for many Chicago residents. The monthly Special Enrollment Periods are a safeguard for people and families who experience unexpected life events. A single parent in our City working part-time with fluctuating work hours and income too high for Medicaid would lose the ability to enroll in affordable coverage outside of the regular enrollment period.

7. Per our Department's analysis of CMS data, 113,038 Chicagoans are enrolled in Marketplace coverage, and the overwhelming majority (approximately 98,908 residents) receive premium tax credits, or subsidies from the federal government, to make their coverage more affordable.[3] The Inflation Reduction Act of 2022 enhanced these subsidies through the end of 2025 and the average tax credit among Chicagoans enrolled in Marketplace coverage is $431.[4] With the anticipated end of these subsidy enhancements after 2025 leading to higher monthly premiums, the Rule will compound the effect on Marketplace enrollees by allowing insurers to deny new

[2] Chicago Health Atlas. Uninsured rate. https://chicagohealthatlas.org/indicators/UNS?tab=map.
[3] Centers for Medicare and Medicaid Services. 2025 Marketplace Open Enrollment Period Public Use Files. CMS.gov. https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files.
[4] *Id.*

coverage for individuals with past-due premiums. This alarming rise in premium costs would lead to potentially thousands of Chicago residents losing health insurance, and thus losing access to preventative services to keep them out of the hospital, primary care, mental health services, and medications, in addition to causing unnecessary and unsafe disruption to residents undergoing active treatment.

8. Residents who lose health coverage would likely delay essential visits – including preventative screenings, primary care appointments, and recommended treatments – until conditions worsen and emergency care and hospital services are needed. This would lead to later-stage disease detection, higher risks of complications exacerbated by untreated chronic diseases, and increased utilization of Chicago's emergency departments and hospitals – increasing uncompensated care and further straining safety net providers in our City beyond repair.

9. The higher the uninsured and underinsured rate, the more that the clinics operated by CDPH and its community-based partners will necessarily have to provide forms of low-barrier and reduced-cost care to patients. In that event, Chicago either must provide the Department and its partners with more funding, or the Department and its partners must decrease the services that they provide. Furthermore, the Department works collaboratively with the State of Illinois, Cook County, and service providers across the City to strengthen resource navigation for Chicago residents who are uninsured and underinsured. The Rule's effects will increase the burden on the City to coordinate essential resources and services across agencies and sectors to ensure that the hardest-to-reach communities receive care.

10. The Department also partners with all hospitals and healthcare organizations in the City through the Healthcare System Preparedness Program, which supports the Chicago Health System Coalition for Preparedness and Response. This program includes coordination of all thirty-five acute care and specialty hospitals, 110 long term care facilities, 50 dialysis centers, all

Federally Qualified Health Centers, and other organizations that provide health care services within the City.

11. This program includes safety net hospitals which, as part of their participation, demonstrate their ability to react to patient surges and complete accreditation requirements. Safety net hospitals provide healthcare for individuals regardless of their insurance status or ability to pay, and typically serve a higher proportion of uninsured, low-income, and other vulnerable individuals than do other hospitals.

12. Chicago's partnership with these hospitals includes financial support such as situational awareness communication, support for data collection and reporting, disaster exercises, clinical trainings, and providing supplies, such as personal protective equipment, mechanical ventilators, and radios. In particular, this program benefits patients during surge events, like the COVID-19 pandemic and other public health emergencies.

13. The Chicago Fire Department provides ambulance transportation services to its residents, including its uninsured and underinsured residents, and regardless of income and insurance status. Chicago generally seeks reimbursement for ambulance services from the patient or, if applicable, the patient's insurer. However, Chicago usually does not receive full reimbursement for ambulance services from its uninsured and underinsured residents. For example, based on our review of Chicago Fire Department ambulance records, in 2024, the City provided 56,556 ambulance transports to Chicago residents for whom no insurance was identified. The City's net charges for these patients were $173,672,181, but the City collected just $5,647,941 – a loss of over $168 million. The Rule would only exacerbate this loss further, and other big cities and jurisdictions will also likely experience similar shortfalls.

14. In Chicago's experience, the uninsured and underinsured disproportionately rely on ambulance services for transport to the emergency department. Such individuals, for instance, are

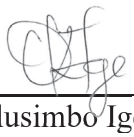
more likely to wait until their conditions become more severe and then use ambulance services to receive necessary care. A higher number of uninsured and underinsured individuals will therefore result in more ambulance transports for which Chicago does not receive reimbursement and thus must make up for the shortfall in its budget. Aside from these budgetary impacts, Chicago is harmed by the need to care for a population that is increasingly uninsured. When individuals cannot seek medical treatment, they are necessarily less healthy, less productive, and less able to participate in city life – all of which has cascading impacts throughout the City's programs and the community.

15. We are alarmed by the potential harms of this Rule on our City's residents, including our most vulnerable communities for which other forms of health coverage are out of reach. The Rule would significantly degrade access, affordability, and the integrity of Marketplace coverage for our residents.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: July 1, 2025

Chicago, Illinois



Dr. Olusimbo Ige

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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

**DECLARATION OF DR. ERIC D. FETHKE**

I, Eric Fethke, declare as follows:

1. I am over 18 years old and competent to make this declaration. I have personal knowledge of the facts and information in this declaration. I respectfully provide this declaration to explain the ways the Centers for Medicare & Medicaid Services (CMS)'s "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability" rule will harm my medical practice and endanger the children who rely on my services. My statements in this declaration are my own, based on my own professional experience, and do not reflect the views, opinions, policies, or position of Boston Children's Health Physicians; I do not speak on the behalf of the Boston Children's Health Physicians or any other entities associated with my medical practice.

2. I have a Bachelor of Arts from Princeton University and received my medical degree from Columbia University. I completed my pediatric residency and pediatric cardiology fellowship at the Children's Hospital of New York Presbyterian in New York, New York. For the last 30 years, I have been an active physician in New York, while also teaching medical, nursing and physician assistant students, residents and fellows at Columbia, Albert Einstein and Touro universities. I have been a member of Doctors for America since 2023.

3. I am a pediatric cardiologist known for successfully treating the most difficult heart conditions in babies, children and adults. I specialize in noninvasive pediatric cardiology, including pediatric exercise testing, pediatric and fetal echocardiography, fetal and congenital heart disease, noninvasive cardiac diagnostic testing and community-based care. My practice is highly specialized and not readily available to most patients. The children I care for often live several counties, states and hours away from any alternative pediatric cardiology care. Children with the complex heart conditions I care for who cannot access the kind of specialty care I provide are at a higher risk of preventable sudden death or serious morbidity than their peers who have access to my clinical services.

4. In 1998, I founded the Pediatric Cardiology Associates of Greater Hudson Valley, which provides specialty, regional community-based services for patients across a large expanse of the Hudson Valley, New York community—in some cases as far north as Albany, New York; west into Pennsylvania; and south into northern New Jersey. My group has spent nearly three decades building out the practice's health care provider network through various alliances and partnerships, to create a complex web of localized, highly skilled children health specialists to serve patients in the Hudson Valley. As a result, my patients include children and adults from all backgrounds: rural, suburban, metropolitan, low-income, and immigrant. Roughly a quarter of my patients are on Medicaid; another quarter have private, non-exchange insurance; and over half of my patients have health care insurance via ACA Exchanges.

5. CMS' new rule would make it more complicated and expensive for many of my patients to obtain or keep their health coverage. In my experience, the more complicated and expensive it is for people to access care and insurance, the more my patients— predominantly vulnerable and dependent babies, children and youth with complex conditions I have spent years creating access to care for—will go uninsured.

6. An increase in the uninsured population creates devastating problems for my

practice. There are administrative burdens associated with taking care of patients when they are uninsured. My staff and I spend hours, uncompensated and often after our office has closed, trying to find alternative sources of payment for services provided to the uninsured. These efforts are often unsuccessful, and my practice and I are left to incur these costs of treating patients who lack insurance.

7. Further, my practice does not turn away patients who come seeking emergency healthcare simply because they do not have insurance; when, for example, a parent shows up with a baby or newborn who is turning blue and needs help, I have an ethical responsibility to provide care.

8. As an additional example, I have had young patients with heart rhythm abnormalities who are uninsured or whose insurance will not cover specialty care beyond their local community's general cardiologist, even if that generalist does not perform the life-saving procedures my patient needs. As a result, I spend hours writing letters to insurance companies fighting to have specialty care such as catheterizations, electrophysiology studies and surgery at my trusted and accessible pediatric tertiary centers covered under their insurance. If I am unsuccessful, those patients' parents are often forced to rely on other providers who are extremely far from their homes. And when their child has an emergency, and they come back to my office in crisis, I am often forced to provide care without compensation. Or, those parents try to travel long distances to make it to a covered, healthcare provider, risking that they might not get there in time to save their child. These emergencies will only be more frequent and overwhelming if more of my patients are under or uninsured as a result of the proposed rule.

9. Even operating within a larger group of healthcare providers, my practice cannot survive increased uncompensated care costs. The 25 percent of my patients with private insurance cannot make up for financial loss from increased uncompensated costs that will arise when even a fraction of my patients who formerly had ACA coverage lose or drop that coverage

(especially considering the government's recent cuts to Medicaid). The network of care I have built over the last 30 years will collapse. And the burden of providing care will fall on tertiary health centers, city hospitals and clinics—even if patients can make it there in time during life-threatening emergencies.

I declare under penalty of perjury under the laws of the United States of America, pursuant to 28 U.S.C. § 1746, that the foregoing is true and correct to the best of my knowledge.

*Signature on following page.*

Executed this 6th day of August, 2025 in Middletown, New York.

ERIC D. FETHKE, M.D.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND
NORTHERN DIVISION

CITY OF COLUMBUS, ET AL.,)
Plaintiffs, )
)
vs. ) CIVIL CASE NO. BAH-25-cv-2114
)
KENNEDY, ET AL, )
Defendants. )
_____)

THURSDAY, AUGUST 14, 2025
Courtroom 3D
Baltimore, Maryland

MOTIONS HEARING

BEFORE: THE HONORABLE BRENDAN A. HURSON, Judge

On Behalf of the Plaintiffs:

JOEL L. MCELVAIN, ESQUIRE
COURTNEY R. ROBINSON, ESQUIRE
Democracy Forward
P.O. Box 34553
Washington, D.C. 20043

On Behalf of the Defendants:

ZACHARY W. SHERWOOD, ESQUIRE
Department of Justice - Civil
Federal Programs Branch
Washington, D.C. 20005

(Computer-aided Transcript of Stenotype Notes.)

Reported by: Kassandra L. McPherson, RPR
Federal Official Court Reporter
101 W. Lombard Street, 4th Floor
Baltimore, MD 21201
(410) 962-4544

P R O C E E D I N G
10:01 a.m.

THE CLERK: Your Honor, calling the case of City of Columbus, et al., versus Kennedy, et al, case number BAH-25-cv-2114. Case is called for a motion for a preliminary injunction.

And if the Plaintiff counsel could put their appearance on the record, please.

MR. MCELVAIN: Good morning, Your Honor. Joel McElvain from Democracy Forward Foundation for the Plaintiffs. With me is my co-counsel, Courtney Robinson.

THE COURT: All right. Nice to see both of you.

MR. SHERWOOD: Your Honor, Zachary Sherwood, United States Department of Justice, representing the Defendants in this matter.

THE COURT: All right. Nice to see you too.

Give me one second to log in here. All right.

A couple preliminary -- well, really more preliminary confessions. There's a lot in this rule, a lot in the pleadings. You both did a very good job trying to simplify it. But, obviously, the Court is not as familiar with the ins and outs of all of this as you are.

I've done my best to get up to speed, but to the extent that you are going into detail on a specific provision, just make sure you let me know exactly which one you're talking about

because there is a little bit of overlap on here on some of these things. And I guess it's more a cry for help to simplify it more than it is anything else, but I'll do my best to hang with you guys.

The other issue that I have is just -- I was trying to, you know, figure out how to structure this. I didn't know how many lawyers I would be met with. This is actually -- not that I don't like lawyers; obviously, I rely on them. But it's nice it's a little smaller group, so it makes it a little easier to control.

But I didn't know if you -- and I'll start with the Plaintiff. I was going to tell you how I was going to proceed, but, you know what, I'll let you tell me how you want to move forward this morning.

My initial thought was I'll give you -- each side 30 minutes, and I'll give you 15 minutes for rebuttal. I don't know if you had any other structure, if you had any thoughts on how you wanted to go forward.

MR. MCELVAIN: Your Honor, if left to my own devices, I suppose I would sort of walk through each of our merits arguments. But really, I'm happy to follow your lead and answer any questions you have.

THE COURT: No, that's fine. That seems to be where a lot of the action is.

The standing issue I have some questions on, but not too

many, so that's fine.

Government, I mean, do you have any thoughts on how to roll ahead?

MR. SHERWOOD: I would defer to what's most helpful to the Court, recognizing the complexity and the multifaceted nature of what's being argued.

THE COURT: Yeah, I have a lot of questions that I've written. It got to the point where I had so many questions that I kind of lost track of my own amount of questions. So I don't know who that's good or bad for, but I'm going to maybe cut you off and ask about things specifically.

But if I'm looking down, it's not that I'm not paying attention; I'm matching up your arguments with the questions that I came up with.

So why don't we do that. Why don't we start. And I say, you know, about half hour is what I'm trying to get at. But I'll keep an eye on the clock, and if you go longer, I'll tell you where you are, and I'll try not to cut you off too bad.

So without further ado, it's your motion. You can go to the podium, talk at the table, whatever you want to do.

MR. MCELVAIN: I'm used to speaking from a podium, so we'll try this.

Is this microphone on? Can you hear me?

THE COURT: Yes, I can hear you great. And I think you're getting picked up by the court reporter. Perfect.

MR. MCELVAIN: So, may it please the Court, Joel McElvain on behalf of the Plaintiffs.

The Affordable Care Act extends a promise. All Americans are guaranteed access to comprehensive and affordable health coverage, whether through exchanges or the individual insurance, or through other reforms to other pieces of the health market.

And with respect to the exchanges specifically, the Act aims to keep the cost of these policies down by subsidizing the cost of coverage, which attracts younger and healthier people into the market and, in turn, improves the risk pool and lowers premiums for everyone. When the Act is implemented as Congress intended it to be, it succeeds at this goal. At the end of 2024, over 24 million people, a record, had enrolled in an ACA plan.

New policymakers this year, at the Centers for Medicare and Medicaid Services, however, have a different vision for the healthcare market that departs from the statutory vision. They prefer policies that would lower federal subsidy payments and drive people off the exchange. And they are seeking to fulfill this vision for a new rule issued at the end of June. The rule aims to accomplish three things.

First, it will enact policies that will aim to drive up the cost of coverage on the exchanges.

Second, the rule will make it harder for people to enroll in policies through the exchange.

And third, even for those people who do enroll, the rule will impose barriers on obtaining subsidized coverage, even for those people who do successfully enroll.

Our Plaintiffs, who are providers of last resort and enrollees in the exchange plans, urgently need relief from these provisions of the rule. And that is why we're here today. We're asking this Court to enter a Section 705 stay.

And I'll be happy to turn directly to just walk through each of our merits arguments. Again, I will follow the Court's lead if there is anything in particular you may like to focus on.

THE COURT: I wanted to ask you about standing for the Doctors for America. The theory of standing in the other -- for the other plaintiffs seems to rest on economic injury in the form of increased premiums for the main street folks, and then increased costs that are going to end up being shouldered by cities. I'm trying to figure out what's the direct economic injury to physicians who, admittedly, treat patients regardless of their ability to pay.

MR. MCELVAIN: The physicians' claim to injury is very similar to the cities' claim of injury. They will incur more uncompensated care. They will be left eating the cost, to the extent that their patient mix becomes -- a greater mix of uninsured patients are within the mix of patients that they see each year.

THE COURT: Is that the physicians' problem or the people they work for?

MR. MCELVAIN: It's the physicians' problem. I think both Dr. Oller's declaration, Dr. Fethke, F-e-t-h-k-e, both of their declarations demonstrated they, themselves, would suffer a monetary harm. And partly monetary harm, but partly it's a paperwork harm because you are left with more of a rigamarole of possibly hunting down other possible -- other sources of payment for the uninsured. And even that hassle of going through more paperwork itself is an Article III injury. But primarily, it's a financial harm because they will lose reimbursement.

THE COURT: Okay. I mean, that was sort of -- I was -- that was my issue, was whether that gets imputed to the doctors. I guess I need to look closer at the declarations, but some of it, admittedly, is my own experience. There are obviously solo doctors, but the overwhelming majority now are working for practice groups or even hospitals.

And just playing this string out a little bit further, the theory, in my eyes, is that when people get off coverage, they're going to go to emergency care places. They are probably less likely to walk into a solo practice doctor and seek emergency care. So it seems to me that the economic harms, which I'm not questioning with respect to the other two, but with respect to the doctors, it just seems like a bit of a leap to say that they're going to have economic injury.

Now, this paperwork injury, if you will, I think I suffer that a lot. We probably all do in some other areas, perhaps. I was reading it more as the theory was the doctors -- their patients were going to suffer the lack of care. It was going to exacerbate their conditions; it was going to make the doctors' jobs harder. That's what I thought the injury was. I didn't see it directly as economic.

MR. MCELVAIN: That's part of it, in that they will see the same patient mix, but the patients will come in less frequently with more serious conditions. And again, these will be patients for whom it is harder to obtain reimbursement, so they will be unpaid, or they will go through the paperwork rigamarole of having to search for an alternative source of payment --

THE COURT: I'll look --

MR. MCELVAIN: -- which often will be unsuccessful.

THE COURT: I'll look closer at the declarations as well. Please proceed on the merits.

MR. MCELVAIN: May I depart from the podium so I can grab my water bottle?

THE COURT: Please. Please.

MR. MCELVAIN: So, turning to the merits, and turning to the first bucket of provisions in the rule that we flagged, which are provisions that will drive up the cost of coverage.

And the first such revision is what we've called the Junk

Fee Rule. And this has to do with imposing a $5 charge to enrollees who auto-re-enroll in the same plan.

And maybe I should back up and explain what that is.

THE COURT: I think I understand it. The part I'm maybe a little fuzzier on is at what point does the $5 kick in? When do they have to pay that, and how? And what is it credited toward, if anything?

MR. MCELVAIN: As I understand the rule, when you auto-re-enroll in your plan, and if you are an enrollee who would otherwise qualify for a zero dollar plan, meaning the advanced premium tax cut would otherwise cover the cost of the coverage that you were choosing to enroll in or have chosen to enroll in, CMS will reduce the amount of advance premium cash out by $5. Meaning, that you owe a payment of $5 up front in the first month that you are enrolling in coverage. So by January 1st, if you're enrolling in a calendar year plan, you would owe that $5 for that month, and then you'd owe another $5 for February, another $5 for March.

THE COURT: Until you --

MR. MCELVAIN: Until such time as you complete new paperwork re-enrolling in the plan.

And to take a step back, the current leadership at CMS does not like this notion of automatic re-enrollment. They considered in this rule itself just banning automatic re-enrollment entirely, but decided to not take that more

drastic step, but instead imposed this, what we would consider be an arbitrary and illegal penalty in auto re-enrollment to attempt to --

THE COURT: How do you avoid the $5 under the new rule?

MR. MCELVAIN: You would fill out new paperwork demonstrating that you do, in fact, intend to enroll in the plan that you are automatically re-enrolled in.

THE COURT: Why have automatic enrollment then? I don't understand. I'm asking the wrong person, I think. I'm confused. That's not automatic enrollment. I mean, okay.

MR. MCELVAIN: I agree, Your Honor. I think that, perhaps, is a question better addressed to the Government because we don't understand it either.

Once you accepted a principle then you can be automatically re-enrolled.

And I will say, personally, I'm on my spouse's employer-sponsored coverage, and we just auto-re-enroll in the employer-sponsored plan. I think that's a fairly common practice.

THE COURT: Oh, yeah. If it wasn't for auto-re-enrollment, my family wouldn't -- probably wouldn't be covered for the last 15 years. It's one of those things you sometimes forget about. I suppose that's their point. Is that in the case of a fraudulent enrollment, that auto enrollment

just sort of perpetuates the fraudulent enrollment, but it's -- is this provision sunsetted? I can't remember. Is this only a one year?

MR. MCELVAIN: You know, I'll just --

THE COURT: I think it might be. It might just be for 2026. So it's sort of --

MR. MCELVAIN: I think that's correct. I do think that's correct, yes.

THE COURT: All right. Well, all right. I don't really have any more questions on that particular provision.

MR. MCELVAIN: So, very quickly on that provision, I would just like to reiterate that we consider that to be both unlawful and to be arbitrary.

And the unlawfulness point, the statute is quite clear. There is a formula for what your subsidy is under the ACA. Your premium tax credit and, in turn, your advanced premium tax credit is set by factors like your income, the particular plan you're enrolling in, what the various cost is of benchmark plans is on the exchange that you're enrolling in. And it's just a formula. It's formulated. A number gets spit out, and that is the number that you are entitled to.

CMS is arbitrarily taking that number and just deciding they're going to take that number and reduce it by $5 without any statutory authority to do so. Now, they're citing statutory authority to set procedures to determine eligibility, but that

can't override the rest of the statute. You can't rely on general rulemaking authority or general procedural authority to override other specific provisions of the statute here.

THE COURT: And the five. Where does the number five come from?

MR. MCELVAIN: I believe out of thin air. I mean, they did ask for comments as to what the amount should be. And to -- and the events to whether that should be a larger number, but decided to keep the $5 that they proposed.

THE COURT: And I guess I do have one more question. Do you know where -- let's say it takes a couple months for the insured to get the proper documentation, or to just express their intent to re-enroll. What happens to that money? When they do re-enroll, do they get it back?

MR. MCELVAIN: They don't get it immediately back, but when they claim their premium tax credit at the end of the year, that would be trued up.

THE COURT: Okay. They can get it back at the end of the year.

MR. MCELVAIN: So the insured would get the money back. Actually, the insurer is left holding the bag. But it's -- the concern is not so much, at our end, as to whether the enrollees would eventually, 12 months later, be trued up or 18 months later, however long it takes to get your tax refund. It's just that all of the sludge in the system will make it

harder to enroll, will make more people drop out. And the people who are more likely to drop out are the younger, healthier people who are on the fence of I don't know if I need health insurance coverage or not.

THE COURT: And the theory is they would drop out because they would see the $5 and just walk?

MR. MCELVAIN: Yep. Yeah. Yes. And there's a huge difference between zero dollars and any positive number. And again, we're just not inventing this concern; there's actual empirical evidence on this.

I would commend to the Court the Adriana McIntyre comment, who cited her own study on the Massachusetts experience. When Massachusetts attempted virtually the same policy, what they saw was one in seven affected enrollees dropped out of coverage. So it was a huge hit to the market. And out of those one in seven, again, they tended to be the younger and healthier people. And so it affected the overall risk pool; it affected overall premiums for everybody else.

THE COURT: Sure. Okay.

MR. MCELVAIN: Now, as to arbitrariness, CMS did have these concerns that younger, healthier people would drop out, given the sludge factor of imposing this added paperwork burden on enrollees. But they characterized the $5 a month as a nominal amount that would not impose undue hardship. But again, that ignored the specific empirical evidence that I just

discussed from Massachusetts. There's no response to the rule-making itself, and there really should have been for the Agency to have engaged in any reasoned decision-making.

CMS's primary point here on this particular provision, and with various provisions throughout the rule, is that even if there were going to be some coverage losses, it's justified to respond to this problem of improper enrollment that has arisen. And they've relied on the reasoning of this Paragon Health Report called the Great Obama Care Fraud.

That report itself was fundamentally mistaken, for multiple reasons, as we explained in our briefs. And as commenters explained at the Jason Livitis comment and the Centers for Budget and Policy Comments were particularly helpful in this regard.

In that, Paragon was simply looking into the wrong data sets. It was comparing datasets that did not provide apples-to-apples correlation. So it inflated the numerator but deflated the denominator to suppose that there was a much greater problem of improper enrollments than there actually has been, and failed to take in account that this problem, while, in fact, has been a real problem in the past, is a problem that has been isolated to a few federal exchange states; namely, Florida was the worst offender.

So that leads to a few conclusions. First, the Agency really should have considered measures that took on broker

behavior directly rather than attempted to punish enrollees. The Agency also should have considered measures that might be targeted to where the problem actually had occurred, such as the practice in federal exchange states of permitting what are known as Enhanced Direct Enrollment Entities to submit enrollment paperwork on behalf of applicants, rather than punishing the applicants even in cases where the applicants are submitting their own paperwork.

So there's a fundamental mismatch between what the Agency was doing, the rationale they were asserting for what they were doing, and the supposed problem that they were addressing, which could have much more easily been addressed through more targeted means.

And, in fact, CMS had been adopting measures, again, that were targeted broker behavior from the second half of 2024 through the spring that have been very, very successful. They've been dropping. The rate of the problem that had been arising previously had dropped around 70 percent or 90 percent, given these newer measures that came after the Paragon Report.

THE COURT: And those were brought to the attention of CMS?

MR. MCELVAIN: Absolutely. Absolutely. And it's from CMS's own data. I mean, we cited CMS's own data back to it.

THE COURT: I guess I struggle with, and I think all the arbitrary and capricious cases that are similarly situated,

there's always a better way, and the law speaks, it's not always necessarily a better way. But at some point, if the solution is so incongruous with the alleged problem, there is -- and that's pointed out, I think that's where I struggle here.

Because I, too, see the situation, hey, the problem is you think people are being enrolled who don't even know they're being enrolled, which I actually take some issue with it. Because the footnote they were citing to in the rule talked about people switching -- being switched from one plan to another, not necessarily people being enrolled who were not enrolled previously. So slightly different problem is the data is citing to that than what was actually stated in the text of the rule. But putting that aside, why can't you just reach out directly to the individuals and say, Did you intend to switch? If not, then, okay, we're going to launch an investigative procedure.

But it seemed, again, I'm stuck with, well, that's a good idea. Maybe I should have gone into health exchange work. But am I allowed to say there's a better way, and maybe that's a better question for you, is what's that line between a better way and the way that they have chosen? Why don't we just have a policy debate?

MR. MCELVAIN: I guess the way that I would put it is if all we were here arguing about was we think the Agency should have struck the balance differently, and CMS thinks it's more

important to come at this problem than to protect coverage and exchanges, and we think it's more important to protect coverages and exchanges and that's the only thing we were talking about, we wouldn't have an APA claim. I mean, the Agency is entitled to make policy calls.

But what we are entitled to is to see reasoned decision-making from the Agency. Responses to comments where we pointed out defects in the Agency's analysis, the Agency was obligated to engage with that analysis. And when we explain that the Paragon Report just simply wasn't worth the paper it was written on, we should have at least gotten a response to that and some sort of reasoned response rebutting why the Agency believed the report was worthwhile. And the Agency didn't do that at all. Either in the rule-making or briefing in this Court.

And that really affects not every single provision because not every provision depends on the Paragon Report, but every single provision to the extent that the Agency is asserting this or banning improper enrollment rationale, that defect really affects all of those provisions of the rule.

THE COURT: Okay.

MR. MCELVAIN: I would turn next to the second of the three provisions that we've placed into the bucket of driving up the cost of coverage. And this has to do with the premium adjustment percentage methodology. I have struggled with a way

to make this sound less wanting, and I'm not sure I've succeeded.

But essentially what we're talking about, the premium adjustment percentages, is something like a cost-of-living adjustment that occurs each year for out-of-pocket maximums, for the amount of tax credits, so on and so forth. It's not exactly a cost of living percentage; it's actually a judgment that depends on to what extent health insurance coverage has grown more rapidly than overall GDP.

And there are two possible ways to look at that. One -- and it's a comparison of 2013, the year before ACA reform went into effect, and the current year. There are two possible ways to look at it.

Historically, CMS has looked to a comparison of employer-sponsored coverage in 2013 and the current year because that provides a more stable measure. What the Agency intends to do now is incorporate individual market insurance, which, in a vacuum, perhaps sounds reasonable because, of course, this is setting rates for the individual market. But it's actually not a helpful measure at all because it's common ground that the individual market is more volatile. There's more of a tendency for insurers to put risk premium pricing into the rates that they bid, and it fluctuates more wildly. So it's actually not a helpful measure of the overall growth of health insurance coverage to serve the purposes of the statute.

THE COURT: The statute I thought said, and I had written this question out, so forgive me if it covered some ground you maybe already had. But the statute directs the Agency to determine an annual premium adjustment percentage based on the average per capita premium for health insurance coverage in the United States for the preceding calendar year.

And so the Agency says, you know, a more accurate estimate of this includes this additional data, not just employer-sponsored plans but individual insurance markets as well. They seem to respond meaningfully to the argument that that's not accurate. Why is that now not adequately addressed under at least the APA framework?

You said, Hey, these are too high. They said, Well, we're supposed to accurately reflect the cost for the preceding calendar year, so we're going to incorporate this. That's why we're doing it, because it is the cost. Regardless of whether it fluctuates too much or it's, you know, different than an employer-sponsored plan average, or whatever they're doing, I don't know if I want to say the word average, but why is that not a reasoned response under the statute?

MR. MCELVAIN: So two points. Actually, three points, Your Honor.

First, as to the language of the statute, the cost of health insurance coverage in 2013.

THE COURT: Okay. So it's not -- when they say

preceding calendar year, they're talking about 2013?

MR. MCELVAIN: It's comparing 2013 to the current year.

THE COURT: Okay.

MR. MCELVAIN: So it's actually a fresh calculation. Last year was 2013-2024. This year it's a 2013 and 2025. So the delta is, however much that may have changed between '24 and '25, but it's always a comparison back to 2013, if that makes sense.

THE COURT: I mean, this may be helpful, but wouldn't you be stuck with the rationale in 2013, because you can't compare -- or are they able to collect the data from 2013 that they're now adding? Probably not because there was no -- the exchanges weren't even available.

Again, thinking out loud, but I'm trying to figure out how you can change the methodology if you were comparing back to an earlier year, and you don't have the same data from that earlier year.

MR. MCELVAIN: I'm actually not sure how they would go back to 2013 data, if that's your question.

THE COURT: Okay. Well, I think you're saying they're supposed to compare it to that year; is that right?

MR. MCELVAIN: Yes. Yes.

THE COURT: So, when you say compare it to 2013, what are they looking at in 2013?

MR. MCELVAIN: They're looking -- what they are proposing to do now is look at the cost of health insurance coverage on a nationwide basis for both employer-sponsored coverage and individual coverage.

THE COURT: In 2013 as well.

MR. MCELVAIN: In 2013, and then compare that same bucket.

THE COURT: Is there any challenge to how they come up with that number?

MR. MCELVAIN: I don't know, Your Honor.

THE COURT: There, the problem would be we're just not there yet because we don't necessarily know how they're going to do it.

MR. MCELVAIN: I can't speak to that.

THE COURT: All right.

MR. MCELVAIN: But the point that we would like to emphasize for the Court, is that health insurance coverage in 2013, within the meaning of how that phrase is used in the ACA itself, would not have included health insurance coverage in 2013 because the phrase "health insurance coverage" is a term of art that means coverage that meets ACA standards. That's guaranteed issue, guarantee renewability, all those sorts of things.

In 2013, none of those provisions applied so it simply didn't meet the definition of what the ACA considers to be

health insurance.

In 2014, and in contrast, that standard was met because the reforms had taken place. From 2013 to 2014, that would have driven up the cost of plans, but again, it wouldn't have been apples-to-apples comparison because you're talking about two fundamentally different things. Insurance that actually is comprehensive, it actually does provide meaningful health benefits to people, which was not a feature that was present in the initial health insurance market before 2014.

THE COURT: Sure. Well, the whole reason for the --

MR. MCELVAIN: The entire reason for the ACA in the first place, yes.

THE COURT: Yeah. Okay.

MR. MCELVAIN: So to the extent that the Agency believed that it was bound by the language of the statute to adopt a broader measure, they are simply mistaken because they failed to take into account that distinction between 2013 individual market and the 2014 individual market.

I'm not entirely sure the Agency thinks it was statutorily bound. It's not entirely clear to me, given the way they phrased their reasoning in the rule, but if that was, in fact, the Agency's reasoning, they were mistaken.

To the extent that the Agency believed it had discretion, then it acted arbitrarily because it failed to consider, failed to take into account the point from commenters that I believe

I've already touched on, which is that it was arbitrary in that individual health insurance data was actually not a more accurate measure because it's more volatile; it doesn't measure anything real it just measures risk premium pricing.

And again, we are entitled to at least a response to that reason and engagement on our point, even if the Agency were ultimately to disagree with us on that point.

The third thing I'd like to point out is that on top of all that, the Agency displayed an unalterably closed mind on this particular issue. And I will acknowledge that is a hard standard for us to meet. It is rare for a plaintiff to win on such a claim, but that standard is met here for a few reasons.

First, in the proposed rule itself, the Agency forthrightly declared it was going to disregard comments from adverse commenters on this point.

What's more, the Agency went ahead and published an actuarial evaluator calculator, which is data that they threw up on their website, which insurers were required to use this past spring, even though the rule had not been finalized until June. So the Agency itself essentially treated the rule as final well in advance of finalizing the rule, well in advance of even receiving any comments from commenters.

So for those two primary reasons, even though it's hard for Plaintiffs to win on an unalterably closed-mind type challenge, here we have, in fact, met that.

Turning to our third claim, which has to do with the actuarial value methodology. And again, this is wonky, and I've tried to avoid the wonkiness, and I'm not entirely sure I've succeeded. But the essential point of the deal that is offered to an enrollee in an exchange is you have a choice of different levels of coverage. You can enroll in bronze, silver, gold, or platinum, which would cover 60, 70, 80, or 90 percent of your expected costs. So, how much of it you want to pay in your premium versus how much you want to incur, what's leftover for your cost-of-living obligations. Different people may have different preferences for that, and so the Agency -- I'm sorry, the statute gives essentially four different choices there.

And it's hard to get that target exactly. If you're an insurer attempting to put a silver plan on the market, there's no way to know you've hit the 70 percent target exactly because you're making predictions as to future healthcare expenditure trends for the coming year. So the statute allowed CMS to adopt procedures to adopt a methodology for de minimis variations to account for variances in actuarial estimates.

Here, the Agency asserted that authority but went well beyond anything that would be de minimis to allow insurers to degrade the value of their plans to, for example, to permit a cheaper plan be marketed as silver even though it would only cover 66 percent of benefits as opposed to 70 percent. So that's a bit of a bait and switch. I mean, if I'm an enrollee

thinking I'm enrolling in a silver plan, I think I know what the deal is. But then you find out that you're actually not getting the full benefit of the coverage that you think that you're enrolled in. This fear exceeds what is de minimis.

Now the term de minimis may be a matter of art and there will be some room to discuss it, but margins, what's de minimis or what's not, but it has to be de minimis within the standards in the statute itself, which again has to do with variations and actuarial estimates not to promote innovation which was the goal of the Agency. They made up an entirely separate goal that doesn't appear in the statute itself.

THE COURT: And is this not cured by notice to the consumer that this is a possibility? That though it says it's 70, it might be 66?

MR. MCELVAIN: I don't imagine that would be successful, because I think you're assuming the absolutely perfectly economically rational person, who fully reads, you know, every possible term in every possible plan. Whereas I think it's more realistic to assume people log onto the exchanges, they see they have a choice between bronze, silver, gold, and platinum, they think they know what the deal is for silver and they find out after the fact that there's a bait and switch, that not all of their costs are covered.

THE COURT: So what does it say now? Understanding that there already is some wiggle room, what does it say now?

Just, I assume, an asterisk that leads you to a morass of fine print.

MR. MCELVAIN: I'm not a hundred percent sure, so don't hold me to this. I believe under the current rule, you could go as low as 68.

THE COURT: So somewhere in the fine print right now. So I guess that goes back to the original question. Now it says 66. Their point, I think, there's a lot of reasons people pick plans; they may have lower co-pays or, you know, there may be other reasons. But -- yeah, go ahead, because there's a lot of provision here, so I don't want to get stuck on this one.

MR. MCELVAIN: No, I mean, I think that is their point, but I think that underscores the error. Is that they do have a vision for the healthcare market where there are fewer regulations, there are cheaper plans, insurer are allowed to do more. And that is a policy view that they're entitled to advance in the halls of Congress or advance in public opinion, but they still have an obligation to faithfully administer the statute. And the vision of the enacting Congress was that the ACA was intended to provide for comprehensive coverage, provide a fair deal to enrollees, and not allow this sort of a bait and switch.

So I'll turn next to the Secretary's bucket of claims, and these are provisions that impose barriers on enrollment.

And the first such provision under this bucket of

provisions is the provision that would revoke the promise of guaranteed issue. And this is one of the core provisions of the Affordable Care Act itself. I think this, perhaps more than anything, goes to the direct motivation of the enacting Congress why insurance reform was needed when the ACA was enacted in 2010.

Whereas, under the prior rule, insurers could deny coverage to anybody for any reason, the ACA adopted a rule that anybody who seeks to enroll in individual health insurance and the individual health insurance market is entitled to enroll as the guaranteed issue provision. There's a narrow set of exceptions but it's only for exceptions like open enrollment periods or procedural mechanisms such as that. There is no such exception under the guaranteed issue provision for failure to pay prior debts. There is such an exception under the separate provision of guaranteed renewability, and also, there's a separate provision on top of that for when you may rescind current coverage.

Under these provisions, if you failed to pay the premium, then, of course, after a proper period of notice, the insurer can, in fact, revoke coverage because paying for insurance is part of the deal, of course.

But there's a fundamental difference between guaranteed issue and guaranteed renewability. And the Agency's statutory theory here is that they can mix and match. If there is an

exception in guaranteed renewability, we think it makes sense that we can rewrite the statute to import that exception over to the guaranteed issue provision. And that just simply violates fundamental principles of statutory construction.

First, under the guaranteed issue provision itself, the fact that Congress enacted certain exceptions but didn't see fit to include this exception demonstrates that Congress didn't intend for this exception to apply. It's not free for the Agency to write new exceptions on top of what Congress wrote.

And then second, the fact that there's a meaningful difference in language between the guaranteed issue provision and the guaranteed renewability provision demonstrates that Congress had different concepts in mind; that Congress intended those differences to be meaningful. So that's the statutory claim.

And as to arbitrariness, again, in a vacuum, it may seem reasonable to say, well, if somebody hasn't paid for their prior coverage, why should they be allowed to re-enrolled. But the background here is there are many, many people out there who don't even know that they owe a prior debt. There are many people who believe, incorrectly, all you have to do to drop your old insurance coverage is just stop paying, and then you're not insured anymore. In fact, you do remain insured, but you incur the debt of the unpaid premium. But you wouldn't have any reason to know that. First time you would find that out is when

you attempt to re-enroll. So this -- again, that's a fundamental bait and switch, which is unfair to the proposed, to impose on the enrollees.

THE COURT: Okay.

MR. MCELVAIN: Turning to the next provision in the bucket is the special enrollment period verification issues.

I think you may have seen in our initial papers we had also challenged a 150 percent special -- what had been a special enrollment period for people with incomes below 150 percent of the poverty level. There's been intervening congressional actions so we're no longer challenging that provision.

But as to the verification procedures for special enrollment periods, CMS is doing two things. First, it's requiring each exchange -- I'm sorry, it's requiring the federal exchange for 2026 to conduct pre-enrollment verification for any special enrollment periods that are offered on that exchange. And then also must verify at least 75 percent of the new enrollees through SEPs. Whereas previously, you could rely on the enrollee's own self-attestation.

So this will generate about 293,000 verification issues. That's a pretty substantial paperwork hit on exchanges, insurers, and enrollees. And many people will drop out as a result of this paperwork sludge that's now being imposed on them.

And again, to reiterate a common theme, the people who will

be dropping out will be the younger and healthier people who are less motivated to jump through every possible hoop to maintain their health insurance coverage. So this will affect the risk pool, that will raise premiums on everybody else.

And again, and I know I'm repeating myself, but the Agency rationale here depended on the Paragon Report, and I've already explained why we believe that was deficient and why we were entitled to at least a response from the Agency as to why that report was deficient.

THE COURT: So this is back, I've been showing a little ignorance on. The SEP currently, if you toggle off Medicaid and you become eligible for a plan and you are within that range, you can, at any point, sign up for a plan; is that correct?

MR. MCELVAIN: So there are a few different special enrollment periods, and I'll confess, I'm not sure I'll be able to recite all of them. But one of them would be if you toggled off of Medicaid coverage, or you've lost other coverage. Another would be if your family size has changed.

THE COURT: Sure. I think there's --

MR. MCELVAIN: Those are the two primary ones.

THE COURT: A move. I mean, what you would think of as like a qualified life event or something like that. That currently entitles you to enroll at any time --

MR. MCELVAIN: Correct.

THE COURT: -- if you experience one of those. The change that just had congressional action does what?

MR. MCELVAIN: So what -- one of the special enrollment periods that had been adopted within the last few years was that anybody within 150 percent of the federal poverty level could enroll at any time. So it was, in a sense, a prophylactic measure to more broadly get at the issue of people switching back and forth between Medicaid eligibility and ACA eligibility. It was just more of a no-questions-asked. So if you are within this income range, you can enroll. You don't have to go through all the extra paperwork to show you had Medicaid and were now off Medicaid.

THE COURT: Sure.

MR. MCELVAIN: You know, our personal policy preference would have been to maintain that period. CMS adopted a rule that would -- that terminated the availability of that period. What Congress just did was something slightly different, which was not to terminate the availability of that period but to declare that enrollees through that special enrollment period would not be entitled to Affordable Care Subsidies, which essentially is a fatal blow to the applicant in the special enrollment period.

THE COURT: But the others remain. So a change in coverage would allow you still to -- that would be considered a special enrollment period? I keep calling it a special

enrollment period event. But you could still -- a loss of coverage, you could still then enroll at any time?

MR. MCELVAIN: Yes. I mean, there may be time limits; I would have to double-check that, but that's the concept if you have a qualifying life event.

THE COURT: I guess what I'm getting at is, a number of these SEP-related changes are ostensibly to address the problem of fraud or the problem of people getting sick and then immediately enrolling. Would you agree that's what they're saying is the rationale?

MR. MCELVAIN: Let me unpack that a little bit.

THE COURT: Okay.

MR. MCELVAIN: Taking the issue of people becoming sick. I think that is part of the motivation of the Agency, but it's undermined by the actual evidence. Because to the extent that you're doing what the Agency does now, and make it harder to enroll in a special enrollment period, you're not getting at the problem of people waiting to be sick. What you're doing is imposing a burden that is more likely to have an impact on the people who are healthy, young, sort of on the fence. Maybe I need insurance coverage, maybe I don't, I'm not sure, I have to go through all of this rigamarole, I don't want to do it.

THE COURT: That was really -- my question was there just seems to be some incongruity between the problem and the solution.

MR. MCELVAIN: Yes.

THE COURT: Okay.

MR. MCELVAIN: Yes, that's precisely our point. And as to the question of addressing the problematic behavior of fraudulent brokers, again, there's a fundamental disconnect between this measure and that asserted problem. And that goes back to our critiques of the Paragon Report, which again, I think, affect many of these provisions that we're discussing today.

THE COURT: For example, with the brokers, again, maybe I'll wait and ask Mr. Sherwood, but is there a problem with people faking eligibility for SEP by claiming that they have experienced one of these events? Are the brokers doing that in their -- because part of me was saying, I don't see that -- it seems to me that the fraud that the brokers were engaging in may have been cured by the congressional action that eliminates enrollment automatically for folks whose income changes. Why put these other barriers where you have to prove various life events, so to speak. Is that a problem?

MR. MCELVAIN: To our understanding, it's not a problem, and I would commend the Centers for Budget and Policy Priorities comment to the court on this point, which sort of walked through, like empirically, this just hasn't been an issue. The Agency's intuiting a problem among enrollees, as opposed to brokers, among enrollees that simply doesn't exist.

So what the Agency should have done is fairly assess the concerns of fraud, and fairly assess the downside risks that they were driving legitimate people off of coverage and engage in a balance of fair evidence on both sides, and the Agency simply didn't do that.

THE COURT: Okay.

MR. MCELVAIN: Turning to the last bucket of merits challenge, and these are provisions that impose on new barriers on obtaining subsidies for coverage.

The first has to do with a failure to reconcile policy. And here, our argument is very similar to the point that I previously made with respect to the $5 honorary enrollment Junk Fee Rule. Which is that the Agency is asserting its determination authority, or its procedural authority over rulemaking generally over ACA, to tinker with what is the statutory formula for eligibility and for enrollment.

The ACA is quite clear: If you are eligible to enroll in exchange, you're eligible to obtain subsidies. If you tick certain boxes, if you are a resident in the county in which you're enrolling, if you're below certain income levels so on and so forth. Nowhere in the ACS is there any provision that says you are only eligible if you have reconciled the tax credits from a prior year's return.

And that's telling, because frequently under the Internal Revenue Code, and under other tax coded programs, Congress does

impose such a condition. Each time Congress considers whether to extend a tax credit, Congress is faced with a decision: Okay, are we going to condition eligibility on this tax credit, on trueing up what your taxes were from the prior year, or not. Pardon me.

And here, with respect to the premium tax credits, Congress chose not to do that, and that's a very meaningful distinction in our view. That doesn't mean that the IRS is powerless. Of course, there's all sorts of means available in power lien authorities and levy authorities, and so on and so forth, to tax cuts. Just the one thing it can't do is freeze people out of the health insurance market entirely.

THE COURT: Talk to me about the time issue here. Wasn't this rule from 2012?

MR. MCELVAIN: So there are two different rules.

THE COURT: Okay.

MR. MCELVAIN: From 2012 going forward, there was a provision that adopted what's known as the two-year failure-to-reconcile policy, which essentially, if you failed to reconcile two years in a row, and you received adequate notice in the meantime, and you still hadn't reconciled, then you would be thrown off of coverage. What the Agency is doing now is changing that to a one-year policy; you can be thrown off immediately without any notice.

THE COURT: It's really -- sorry to cut you off. But

I guess it's an irreparable harm issue, as I was thinking about it more. One, it's a one-year provision, but also it's been in place in some form, admittedly with a little bit more room, since 2012. So it's a little harder to make out irreparable harm.

MR. MCELVAIN: Well, as to the new policy, the delta between the old policy and the new policy will throw people off of coverage and will raise premiums. So we are harmed by this change in policy for reasons we explained.

THE COURT: Like immediately? Or is it one year from -- I mean, no one is on the -- people's insurance aren't necessarily pegged to the issuance of the rule time, but are you saying that people who have been -- on the date the rule comes into effect, if it's not stayed there are people who will immediately, who have not within the previous year reconciled, so they're going to be cut off?

MR. MCELVAIN: Yes, immediately. For 2026 coverage, anybody who hadn't -- who hadn't reconciled for the previous year would be cut off. Whereas they would not have -- some of these people would not have been cut off under the currently existing policy. So there is a change in policy that has a real on-world effect that we will be seeing here.

THE COURT: Do you have any idea about the numbers of people who will be at risk of being terminated soon after the rule change?

MR. MCELVAIN: I'm afraid I don't have those numbers in front of me. I believe it's in our pleadings, but I would be happy to follow-up.

THE COURT: Okay.

MR. SHERWOOD: So as to the legality, for the points I've already said, it's illegal for many of the same reasons that we've previously discussed with regard to the auto-re-enrollment rule, which is that the Agency may have broad procedural authorities, but it doesn't have the authority to actually change other provisions in the statute itself. And here the statutory formula is for eligibility for tax credits for the amount of the tax credits.

THE COURT: And as for the arbitrary and capricious aspect of it, what's the evidence of fraud that would be necessary to justify this type of provision?

MR. MCELVAIN: I'm not sure I can quantify that.

THE COURT: Yeah.

MR. MCELVAIN: I think what I would say is that the Agency would, at a minimum, need to engage in reasoned decision-making, engage with our comments, address how it actually found a real recurring problem of fraud, not just among brokers but among enrollees, and that's why we chose this measure to respond.

And then also consider the coverage losses that it was incurring and explain how it balanced the two. And again, the

Agency just simply didn't do that here.

And one point in particular is the fact that they chose not to impose a notice requirement. And then, in other words, people are going to be thrown off coverage immediately. And our declarant, Christen Linke Young, called this, I think accurately, a Kafkaesque scenario. Because people are going to be thrown off of coverage, but they won't know why, because the Exchange is forbidden from sharing tax data with the enrollee. So all they will know is there is some reason they can't be enrolled, but they won't be told what the reason is or what they need to do to fix it.

THE COURT: And is that currently the situation with respect to the two years? That's the current state of affairs when one is terminated after two years for failure to reconcile.

MR. MCELVAIN: My understanding is under the current policy, with two years, there is a notice requirement. And more importantly, because there are two years, there is time to investigate, there's time to learn. And then I think the thinking of the original rule, which, to be clear, we also think is unlawful, but that aside. The thinking of the original rule was allowing that two-year period allows sufficient time for the enrollee to engage in inquiries and solve the problem before the second year comes up.

THE COURT: Okay.

MR. MCELVAIN: And then there's a set of data matching

policies which we also contend to be arbitrary. The first is shortening what is now the 150-day period for an enrollee to resolve any data issues that may come to 90 days.

The Agency asserted that it was statutorily required to shorten this period. It believes it could not extend what is described in the statute as a 90-day period. Under its modification authority, we think that the Agency fundamentally misconstrued its statutory powers here. And when the Agency failed to understand the scope of its statutory discretion, that's, per se, error that requires vacatur of this particular provision of the rule.

THE COURT: So this would be a Loper-Bright statutory interpretation situation.

MR. MCELVAIN: I think that's right. Yes. Yes. Yes.

THE COURT: Okay.

MR. MCELVAIN: Because here the Agency had modification authority, and that modification authority extends to any procedure not in a particular subsection in which that particular authority relies, but in the entire section. So the entire section encompasses the period of 90 days, that's the default under the statute. So the Agency does, in fact, have the authority to modify that provision.

The second in the set of data matches issues that we brought to the Court's attention has to do with a requirement to impose mandatory audits on anybody who asserts income above the

federal poverty level, where there's current tax data showing that they're below the federal poverty level. And this is going to trap many people in a paperwork barrier. Because when you enroll for coverage, you are projecting your income for the coming year. And you may be below the poverty level for the current year, but there may be entirely legitimate reasons why you reasonably think that you're going to end up with higher than the poverty level for the coming year.

There is wide, wide, wide fluctuation in income levels, particularly among lower-income people. I think I've seen something like it could be as much as an 85 percent meeting variation. Meaning, somebody who is at 100 percent FPL in one year could be anywhere from 15 percent to 185 percent the coming year, could expect that.

So there are many, many reasons that somebody in good faith can legitimately project that they will be within the income range for ACA coverage, which is all they need to do to be statutorily entitled to coverage, even if current year tax data shows that they're below that level.

And so this issue came up in this Court in a prior City of Columbus case, and it's essentially the same policy, and it's arbitrary for essentially the same reasons that this Court ruled in the prior City of Columbus case.

THE COURT: There was -- just before I forget, there was a link, a permalink to an Urban Institute comment that

didn't work?

MR. MCELVAIN: Yes. If you look at our reply brief, we corrected that.

THE COURT: Oh, it's corrected in the reply? That's helpful.

MR. MCELVAIN: I apologize for that.

THE COURT: That's okay.

MR. MCELVAIN: There was that, and I believe there was one other permalink in our first brief that was inoperative, but we corrected both of them in our reply brief.

THE COURT: Okay.

MR. MCELVAIN: And then the third of the three data matching issues has to do with revoking self-attestation. There's some instances where there just simply isn't other documentation available for an individual's income. They may be a GIG employee, they may be self-employed, there may be any number of issues. And historically, an enrollee has been able to self-attest to, you know, certify that they're income project is, in fact, an accurate income projection.

The Agency will no longer allow that. And in instances where tax data may be missing for that applicant, and this is no small problem. This is actually going to wrap up 2.7 million applicants, and that's just because that's how poor the IRS tax data is. There are substantial lags in the IRS tax data. So many, many, many people are going to get caught up on this

paperwork burden. And even under CMS's own estimate, this will throw over 400,000 people off of coverage. So it's no small thing.

CMS's only point on this was to assert that self-attestation may have played a role in linking the exchange of eligibility system, but they didn't explain what that means.

THE COURT: There's a lot of times in the rule, and I apologize for interrupting, where it says they may have. This may have, this may have been a problem.

I mean, is -- that seems to be problematic in and of itself because it's not based on much but -- or anything. It could just be -- I mean, it could be accurate, and it might be accurate, and sometimes when you read it, you say, yeah, that makes sense.

But with respect to the pay stub thing, there's a comment -- or they say it's reasonable to -- or the Agency made the reasonable observation, they're saying that people will have their pay stubs. Is there any additional support for that reasonable observation?

MR. MCELVAIN: To my knowledge, if the Agency had any more support, they didn't show it in the rule itself, which they're required to show their work.

I mean, I would say in general, in a vacuum, in a plain vanilla case, the Agency could rely on suppositions like that as a general matter. But here, when you know you're going to throw

400,000 people off of coverage, it is incumbent upon the Agency to explain why it's taking that drastic measure, why it considered the problem not to be just a hypothetical problem but a serious enough problem to incur that real harm to the market.

THE COURT: I guess what I'm getting at is, it just strikes me as an unreasonable observation, and to the extent the Court can do that. I mean, one, if you're paid by check, particularly if you're on the margins of the -- at the poverty level, what we're talking about, typically, you cash your check and you toss aside the rest of it, or it's crumpled up on the floor of your car, or if you even got a pay stub to begin with.

Add to that the number of electronic transfers that are happening, where the pay stubs -- you have to take affirmative steps to even access it. I mean, most people don't even access the pay stub.

So I don't understand where the reasonable observation that people will have this available even comes from. Quite frankly, this is where I run into problems. Maybe it's just me. I don't think it's particularly reasonable to think people have access to this at all, putting aside what happens when you submit it, but I'll ask the Government about it.

MR. MCELVAIN: And I think that's an entirely fair point. When you consider the range of potential ways that people are employed in the country itself, and self-employed or you know, they're a worker, it becomes that much harder.

THE COURT: This just seems -- and I guess all of this is -- the reality is that if I'm correct in this, and I think I am, and this is probably why you're even here. The ten non-expansion states or whatever, this is the difference between no coverage and coverage.

And some of these rules, they just seem pretty disassociated from the fraud problem and just more likely to make it impossible for people who are barely making it to enroll. And that the logical conclusion is they're just not going to enroll. And that's, you know, I mean, I'm just stating the obvious.

I guess I'm just thinking out loud again, but that seems, to me, to be the problem here is with a lot of these, particularly against that legislative backdrop, you're trying to enroll more people.

I'm sure that's music to your ears, that musing. But this one, and I'm kind of giving the Government a heads up. This particular one, I don't understand how that's reasonable, but anyway, they'll tell me. They'll tell me.

MR. MCELVAIN: I fully agree, Your Honor. I know you're not supposed to hear that.

Believe it or not, I've managed to make it through the arguments. I'm happy to turn to irreparable harm or anything else that you have questions on.

THE COURT: No, I think I got that covered well. The

briefing was very helpful, so I appreciate your points. I'll give you some time at the end.

Kassandra, are you okay to keep plugging?

Government.

MR. MCELVAIN: Thank you, Your Honor.

THE COURT: And if you want to collect your thoughts for a second. Go for it.

MR. SHERWOOD: Yeah, if that's all right. I'll assemble up here and --

THE COURT: Sure.

MR. SHERWOOD: Is the Court prepared to proceed?

THE COURT: Anywhere you want to go.

MR. SHERWOOD: Perfect.

I know Plaintiffs covered a lot of ground, and will do my best to address the questions that prompted and also the questions that the Court came prepared with.

I just want to start with some high-level themes here, and I think the Court was asking Plaintiffs what is the inquiry here, when assessing under the APA, the reasonableness of certain rule provisions.

I think a lot of the objections that Plaintiffs leverage against certain rule provisions, some rule provisions, could be boiled down to this is not a bad -- or this is a bad idea, there's a better approach to doing this, we disagree with how the Agency is prioritizing one thing over another.

And I just want to underscore that under the APA it's a deferential standard. And what matters is, is the regulatory action lawful in the sense that it is consistent with statutory authority, and is it rational and reasonably explained.

Defendant submits all the provisions at issue here satisfy that deferential standard. But I do think once we're getting into the debate about well, maybe that wasn't the most narrowly tailored way the Agency could have approached the problem; maybe the Agency thinks a certain problem is a bigger deal than what Plaintiffs do, that is precisely the leeway that the APA affords to agencies. And especially when it comes to the Affordable Care Act, where the HHS Secretary is given broad authority to set the requirements, and importantly ensure compliance with eligibility compliance that are statutorily mandated. I also don't want to get that lost.

Recognize the economics of the healthcare system, where any time there is a barrier to -- any time that something is made slightly harder, there is a risk that people won't go through with it and results in a decrease in coverage.

That said, to qualify for exchange coverage and to qualify for premium tax credits, enrollees have to have their income verified. And a lot of these provisions ensure that HHS is able to do that.

And I think, too, the Affordable Care Act, of course, is about coverage on exchanges. But on the scale of priorities

that the HHS Secretary very much can consider is the public FISK, too. Every single dollar of an advanced premium tax credit that is paid out comes from federal taxpayers. So that is also an important consideration that has to be weighed in the calculus.

A lot of the arguments are sometimes it can come across from Plaintiffs as sort of a one-way ratchet where -- because there's a change in policy that might reduce enrollment potentially, irrespective of concerns about the public FISK, then the regulatory move is somehow almost like presumptively unlawful or worth taking a double look at, or a second -- worth second guessing. I don't think that's the proper inquiry here, under the APA at least. When, in balancing multiple competing priorities, HHS Secretary has a lot of broad authority to advance policy goals, and that is what is taking place here.

So with some of that clearing of the high-level themes from the outset, I do want to start with standing. To the extent -- and irreparable harm to the extent the Court will permit.

As I discussed in our briefing, Plaintiffs here, particularly the Doctors and the Cities, rely on downstream economic harms tied to a decrease in enrollment and exchange coverage, which would then have -- so multiple steps would have to occur before the financial harms they're alleging would materialize.

The rule provision would have to cause certain people to

either elect not to continue with their coverage or lose their coverage. Those people would then go uninsured. They would then seek care in the Plaintiffs' jurisdictions at publicly funded hospitals or receive emergency care from publicly funded emergency services. And only then, once that care is provided and not compensated because that particular person is uninsured, do the Plaintiffs suffer their financial injuries.

THE COURT: But the rule itself says that, as we explained earlier in this final rule, the Department has strong reason to believe many of the individuals who would lose coverage as a result of the policies in this rule may represent improper enrollments.

So that seems to acknowledge many of them might not. So we've already established in the rule itself that there are going to be people who lose coverage. That seems to be the first hurdle. We're not talking about services that are -- let me, I suppose, and sadly, this does happen, people go without. We're talking about healthcare, so it seems fairly reasonable to assume they're going to seek healthcare, and now they have no coverage. Why is it not just logical that they would go to a city-provided clinic or service to get that?

MR. SHERWOOD: Well, importantly, Your Honor, one limit on any injury, in fact, requirement, not only does the chain of events have to be actual or at least likely to occur, but in Alliance for Hippocratic Medicine, the Supreme Court made

clear that continuation is also a concern too. And I think that case is a little bit more on point than what Plaintiffs would probably be comfortable admitting. That case directly addressed financial harms claimed by doctors who were basing their financial harm on the increase in care they're going to have to provide.

THE COURT: And the doctor one I understand. I've already expressed some skepticism there, and I'll look closer at the docket. But I'm thinking more in terms of cities.

And, quite frankly, talk about precedent. There's a prior case with the same title, in the same court, with a different judge that found standing. Why would I not just say I agree. What's changed?

MR. SHERWOOD: Well, that case preceded Alliance for Hippocratic Medicine. I mean, there could be rigorous debate about the doctors' standing, and the court identified in the Alliance for Hippocratic Medicine, and how that's conceptually or fundamentally different than downstream economic harms that the cities are alleging here. Because in -- what the court in Alliance was troubled with, is that idea that, you know, any policy change of consequence is going to have some sort of downstream effect on people in a way that could literally happen if you extend the chain out far enough.

And in that case, a policy change involving the provision of Mifepristone, there was an allegation that that would result

in some people coming in and getting more treatment. More or less what the cities are alleging here, which is that because of policy changes and a loss of coverage there are going to be more people seeking care at state-funded hospitals.

And the Supreme Court said that it had never recognized -- it used the doctor standing, so I recognize it's a little bit more specific than municipalities, but I do think there's some overlap, undoubtedly, between the attenuated nature of the harm being alleged here, as to also the first City of Columbus case as well. Those standing --

I do want to underscore that the standing analysis was at the motion to dismiss stage. Obviously, the Court was just taking the allegations in the complaint as true. And then at the summary judgment stage the court even acknowledged that defendants didn't contest standing, and so the court solely and independently assessed it.

I think what is also different from -- now, as well, you have the injury fact component. I do think the Alliance for Hippocratic Medicine requires courts to think about the continuing nature of alleged downstream financial harms. Especially since, particularly, anybody could argue that some federal, nationwide change is going to impact their wallet to some extent in a lot of ways.

THE COURT: Isn't it different if it's health care? Again, we're not talking about a rule that changes a food

product that you could choose to not purchase or something like that; we're talking about healthcare. So it would seem to be a predictable result, which is the standard.

MR. SHERWOOD: Understood.

I think it is definitely harder to distinguish between the example that you just gave and what healthcare is. But the court did highlight the continuing nature of the injury in fact.

THE COURT: Sure.

MR. SHERWOOD: Also, too, I think besides the injury fact requirement, there's also causation and redressability concern here as well.

A major theme addressed throughout the rule's preamble, and throughout the briefing, is that the enhanced subsidy regime that was enacted during the COVID-19 pandemic will expire at the end of this calendar year. Meaning that fully subsidized exchange coverage will no longer be available, and individuals who have an annual household incomes above 400 percent of the poverty level will no longer qualify for premium subsidies.

So that, in and of itself, and the rule acknowledges that, will cause a substantial change to the makeup of the exchange and the accessibility and affordability of exchange coverage.

THE COURT: So is that the argument -- I mean, there are some insurers who are already raising rates, presumably in anticipation of this rule. Is your view that is actually perhaps just in anticipation of the change in the COVID-era

premium tax credits?

MR. SHERWOOD: Well, I think that --

THE COURT: Because that would seem to represent immediate injury already. You're already raising rates and saying you're doing it because of this rule.

MR. SHERWOOD: Well, the one example that Plaintiff's point to, I think, was Maryland insured. It was noted about the effectiveness of the rule, but that insurer also acknowledged the expiration of premium subsidies.

And I think in terms of causation, and under an essential component, or essential premise of Plaintiff's area of standing here, is that there is going to be a loss of exchange enrollment query that when somebody shows up in a hospital nine, 12 months from now having lost insurance, can it really be traced back to, you know, the income verification requirements on the exchange versus the fact that their coverage just became much more expensive because of the expiration of enhanced subsidies, such that they opted to not continue with their coverage.

And so a lot of these enrollment losses that will cause the cities to allegedly incur increased cost from uncompensated care will be traceable to that statutory change, and a significant one at that. The plaintiffs, of course, are not challenging that in this case.

And that leads to redressability issue as well. If the Court -- if the concern is for plaintiffs' loss of coverage

results in more uncompensated care, ergo the court enjoins the rule, they've not demonstrated the likelihood that people would then go back onto exchange coverage and therefore avert the financial harms that plaintiffs are identifying here.

If coverage is expensive on the exchange, or more expensive on the exchange because fully subsidized coverage is no longer available as a statutory matter, that is what is causing plaintiffs harm, not the rule provisions here. Many of which, I'm happy to turn to the merits.

THE COURT: Yeah. You can probably do that.

MR. SHERWOOD: And one other important point, too, I think, for at least for the preliminary injunction analysis, is that the harms that Plaintiffs are identifying here can only be described as distant at the end of a multi-link chain. They're asking that the rule be stayed at the outset immediately now, and they have failed to demonstrate that come August 25th, when this rule takes effect, that their likelihood of suffering imminent irreparable harm is going to be any different than it is today.

THE COURT: What about the example, the one year -- two years to one year, and the representation that that will mean there's a number of people who lose coverage on August 26th, because now the one year is the reconciliation period versus two years. What about in that instance?

MR. SHERWOOD: Well, I think the Court has a point

where I do think it's essential to do a provision-by-provision analysis because the changes will result in the alleged harms that plaintiffs assert here very differently.

For the reconciliation, I think it's also important to note that if there are losses in coverage, and I would submit that the loss in coverage because of a lawful -- a lawful -- a provision that is meant to lawfully implement eligibility requirements, and here in this case, the failure to reconcile policy, one year versus two year. Even then, I think, individuals would be subject to that provision. Open enrollment period doesn't begin to November 1st, so there is still time to decide this case on the merits without having to necessarily enjoin the provisions prior to the effective date.

And it is Plaintiff's burden to show, too, that their hospitals and their emergency care services are going to start immediately having financial losses because of an increase in uncompensated care, as a logical matter, is unlikely, given how many steps have to take place before that would materialize.

And I think that's important to the irreparable harm analysis, given that it's -- an emergency stay is an extraordinary form of relief. And if injury won't materialize until after the merits can be resolved in the ordinary course of litigation, that is reason enough to deny a request for preliminary relief.

Pivoting to the merits, Your Honor, happy to proceed

somewhat provision by provision to the extent it would be helpful, but would also defer to the Court if the Court had specific concerns that it wanted to address.

THE COURT: Sure. I mean, you heard some of the issues. Why don't we start where I ended with the Plaintiffs, which was on the question of the requiring verification when the IRS has no data on income. There's that statement the Agency made, the reasonable observation that applicants without tax return data will have documentation verifying their household income, and gave the one example of pay stubs, quote, "Readily available to them." What is that based on?

MR. SHERWOOD: Well, Your Honor, the rule's preamble also acknowledges that in order to apply for government benefits, it is understood that verifying someone's income is a necessary step to qualify. And so I think -- one, its people get paid and they're -- they have to be able to verify their income for a variety of reasons, and to apply to a variety of programs, and this one is no different.

And I think crucially, too, what these income verification provisions are doing is ensuring that the statutory requirement an individual make or meets certain income thresholds are accurate. And the statute also lays out the verification processes that HHS must follow in order to verify that information.

The income verification provisions we're talking about

here, I guess, the missing tax data one, so to speak. Under current regulation, the -- HHS is required to just accept an attestation of income without further verification.

THE COURT: Right.

MR. SHERWOOD: Now we can debate the merits of whether that's a good idea or not. But here the Agency made a reasonable decision that income should be verified in order to ensure eligibility for premium tax credits that come out of the public FISK. And so the change is that no longer is the Agency hand-tied when it comes to some self-attestation of income, the Agency just has to take additional steps to verify someone's income.

Now, I think, as a literal matter, that could potentially be more difficult than just relying exclusively to a self-attestation of income. I don't think people dispute that. The question is, though, whether it comes back kind of a one-way ratchet idea. If you loosen up eligibility requirements so much, any change back toward verifying statutorily mandated eligibility requirements may result in a loss of coverage, that cannot be a reason alone to render something arbitrary and capricious.

THE COURT: Back to my question. When you're coming up with the new way of verifying, who -- what is it based on to say it's a reasonable observation that people will have pay stubs? Where is that coming from?

MR. SHERWOOD: I can't speak to what the Agency was speaking to in the moment. I do note under the APA, agencies are allowed to make predictive judgments based upon both logic and experience. And I think the court --

THE COURT: No, I agree with all that. And again, I'm not quibbling with your idea necessarily that they have the authority to verify income, but I'm asking a slightly different question, which is okay, the manner in which they've chosen to do that, what's the reason behind that?

And what -- so they say it's a reasonable observation. I just said Hey, I don't think that's actually reasonable. But look, it can't always come down to that. But in this instance, the Agency doesn't seem to have explained why that is their view. And it could be just something some folks thought up; they're sitting around a table and said, you know what, people probably have pay stubs. I have pay stubs. Is that enough?

MR. SHERWOOD: I think what's important here, the pay stub situation is just an explanation for why the burden imposed by this income verification requirement is not as burdensome as the Plaintiff's suggested, or at least that was the Agency's reason behind it. The Agency was explaining and addressing concerns raised by the barriers, so to speak, that this sort of income verification would create.

And if the question is, you know, did HHS conduct an empirical study on the availability of pay stubs for

individuals --

THE COURT: Yeah, something like that. That's exactly what I'm getting at. I know you're being slightly facetious, and that's okay.

MR. SHERWOOD: That was not my intention, Your Honor.

THE COURT: It's mine. I'm putting that on me. I mean, you can't do a study on everything.

MR. SHERWOOD: Yeah.

THE COURT: But that's what I'm getting at, is this question of hey, we should really be doing more to verify income. Hey, you're right. That's -- because there's possibilities that people could just say yes, I make this much, and they could be lying. Or a broker could be doing it for them and they don't even know they're not being accurate.

MR. SHERWOOD: Sure.

THE COURT: But it's that next step that then the Agency comes up with some ideas on how to do that, and those commenters say are bad ideas, and what is the Agency's obligation at that point to say, no, these aren't actually bad ideas for income verification, they're reasonable.

MR. SHERWOOD: Sure.

THE COURT: What is the support that's necessary for the assertion that something is reasonable?

MR. SHERWOOD: Your Honor, I think it will depend on the context, but here I think it's the sort of predictive

judgment based on experience the agencies are familiar with. And any -- the APA does not require empirical evidence to support every inference or supposition that an agency makes.

Now, whether you personally or I personally think the availability of pay stubs is a reasonable one or not, I do think the Agency, at least rationally, explained that individuals when applying for government programs there is an expectation that they would have to verify their income. And that may be more difficult for some people than others, but that is not such an out-of-the-blue expectation that this requirement that -- the Agency is asking here is just giving individuals, or requiring the Agency to just follow-up and require additional documentation to verify an individual's income. Again, that can be more difficult for some people than others, but that is not necessarily arbitrary and capricious just because it proves to be slightly more difficult than the status quo.

THE COURT: That's where you're not necessarily combatting fraud; it's an outgrowth of the requirement that is statutory to provide --

MR. SHERWOOD: I think it's both. The overarching -- it's an important consideration because the overarching driver of the rule was addressing improper enrollment. And improper enrollment can include the fraud of overinflating income, but also just ensuring compliance with eligibility requirements, and a lot of these provisions do that. Again, motivated by holdover

improper enrollment stemming from -- the Agency found anyway, that the holdover improper enrollments from the enhanced subsidy regime from the COVID era.

But also, when explaining why it was acting, the Agency was also making clear that there are statutory eligibility requirements that it is obligated, or at least has the authority to enforce all to ensure the stability of the exchange marketplace and also to protect public FISK. And I think that's what's crucial to the income verification requirements.

In addition to addressing fraud, the 150 percent of the federal poverty, line one speaks directly to what was addressed in the Paragon Report and other studies cited by the Agency in the rule's preamble, where the threshold of a hundred percent of the federal poverty line is critical in determining eligibility for subsidies.

And so those income verification requirement are just ensuring that people have an opportunity -- people will be given an opportunity, subject to the regulatory verification process that is already in place, to submit additional documentation to verify their income over the course of 90 days. An extension to that period is available if good cause is shown. And then once income is sufficiently verified, pursuant to regulatory standards, then that person is insured their premium, or advanced premium tax credits.

THE COURT: So this covers a lot, I think, but you

made reference to the reports. So what's an Agency supposed to do when it says I'm doing X because this report says we should do X, and then the actual author of the report says Whoa, no, no, no. Do not use my report to justify that action. And then the Agency says we're still going to do it.

How can that not be considered to be unlawful under the Arbitrary and Capricious Act? I can't think of any -- if the author says don't use it for this, how can you continue to rely on it?

And I think that's Hawkins, right? I don't have it in front of me. It's not the Paragon Report.

MR. SHERWOOD: Right. There is another specific one. That is something difficult to address. I think I'm not familiar with the precise facts of what the Agency was using, the proposition for which the Agency was using the study compared to what the author was disagreeing with. But I also think in a lot of cases the Agency was relying on additional sources of data and studies, one of many, to support or at least demonstrate or at least establish the reasonableness of its concern about improper enrollment.

So I do think it would be important to consider that if the Agency approached a subset of studies in a way that somebody arguably could say was arbitrary. The Agency reasonably explained itself in another way that is much more reasonable, that should be enough to uphold a rule provision.

Going to the Paragon Report, I think the -- HHS did address and acknowledge the shortcomings of the report that were identified by certain commenters. That was addressed in the rule's preamble. and so I think to the extent that Plaintiffs are suggesting that the Agency just completely ignored those concerns is not right.

And the APA requires consideration of relevant factors. And the Agency acknowledged there were shortcomings to this particular report. But similar to Prometheus, you know, agencies aren't required to operate in a world of perfect information and can advance policy priorities based on the information that they have available to them.

THE COURT: Yeah, it just seems like a fine line. Because they're using this report as justification for significant changes. People come back with valid critiques of the report and some significant conclusions that the report has, and the Agency says Well, yeah, thanks for that, but we're going to stick with it anyway because we have another report, the author of which said Please don't rely on this.

At some point, the legs collapse. And, I guess, the question is, when is that?

MR. SHERWOOD: I don't -- I think that would be a fact-dependent inquiry. I don't think that's here, Your Honor. Throughout the rule, HHS points to provision by provision. And I think it is important for you to consider provision by

provision as well. But if, to the extent that Plaintiffs are disputing the existence of improper enrollment, the Agency points to not only the Paragon Report but also internal Agency analyses comparing actual enrollment and fully subsidized coverage, comparing that to what's reported on censuses --

THE COURT: Yeah, which I understand. That establishes the problem.

I think one of my major issues I was talking about in the SEP stuff is, I understand there is an identification of a potential problem, being fraud. It seems to me that the problem will be addressed almost completely when the subsidies are rolled back, so we're talking about a more finite period. What do we do between now and then?

And it seems -- like my question about the verification for various events, how does that address the fraud problem that you've identified?

There seems to be a disconnect between the problem and the solution that, for example, was there a finding that there was a significant number of enrollees who were fabricating particular SEP events?

MR. SHERWOOD: So I --

THE COURT: Because you say -- I mean, just to finish the thought so you know where I'm coming from. You say Hey, the census says they're showing me this many people who qualify, yet we have twice as many people, okay. But then, isn't there some

sort of obligation to say, all right, how are -- what are the areas in which people are taking advantage of CMS to qualify when they shouldn't?

Seems here, a lot of these rules they just say, well, it could be this. Might be this, might be this, so let's change all of them. At what point do they have to be a little more precise in their solutions?

MR. SHERWOOD: If it's a question of fit, we have a problem, and how do you go about addressing it.

I do want to emphasize, as a more atmospheric point, that while improper enrollments in the exchange is a primary motivator for the rule, other provisions are being implemented for other reasons, too. Including to, again, ensure compliance with eligibility requirements, getting rid of holdover improper enrollments. And I think for the SEP eligibility, that one is a little trickier, because I think those were -- that provision was also -- there was the other -- the pause in the income-based SEP. The pause in the SEP -- the income-based special enrollment period. That is no longer being challenged by Plaintiff's because of the statutory change.

For these special enrollment periods, I think it's important to kind of get what is the rule actually doing. Under current regulation, federal exchanges are actually prohibited from verifying eligibility for special enrollment periods other than the income-based one. States actually have the leeway to

determine their -- to the extent they wish, whether to conduct pre-enrollment eligibility verification. So the rule will put the federal exchange on the same playing field as states. So I don't think it's as radical of a change as, you know, the suggestion that just by -- that Plaintiff's sometimes campaign some of these provisions. It's a change to ensure that pre-enrollment eligibility verification is permissible.

And then the second step is that the rule then requires 75 percent -- at least 75 percent of enrollment to be verified. To enroll again in the exchange you have to have verification because that's -- of the triggering event in this case for special enrollment periods, and that's what this rule is doing, is it's just ensuring that the triggering events that qualify somebody for enrollment are just being verified.

Now, what that looks like in practice, I can't speak to, but just as a legal matter, it allows for --

THE COURT: The problem that I'm having, it seems to be coming at the expense of other aspects of the statute that encourage robust enrollment. And these are all ideas. In no way am I disputing that these ideas may result in some of the desired outcomes, but they just seem to be unmoored from the identified issues and likely to result in significant numbers of people not being enrolled, some who should be enrolled. And, therefore, it seems to run against what other aspects of the statute ask for, if not require. That's my problem.

Because you're giving good ideas, and these -- or ideas, whether they're good or bad, I don't know that it matters, but they're ideas.

MR. SHERWOOD: Sure.

THE COURT: And there are other ways to fulfill income verification. But when one tinkers with the regulations and then is met with responses that say if you do this, you're going to cause significant, perhaps even unintended harm. There has to be a response to that is rational and reasoned, and that's what, I think, is missing. It seems to be going to back to, but it's a good idea. And is that enough.

MR. SHERWOOD: Certainly, I mean, I don't think that the idea that the Agency wasn't adequately considering the potential concerns that were raised. I mean, throughout the rule, they highlight yes, this rule has -- I mean, even estimated that this might have the potential to reduce enrollment by X amount. Crucially, the Agency is of the view that a substantial amount of that enrollment will be from improper enrollments, i.e., enrollments that shouldn't have taken place.

THE COURT: And what's that based on?

MR. SHERWOOD: Again, it -- I think, too, we can go back and forth as well with Plaintiffs about what might be the best approach here to tackling what is improper enrollment. But if you were to concede that the Agency has provided, at least

under the deferential APA standard, that there's a reasonable concern to have about improper enrollments and exchanges, how does the Agency decide to go about that? It implements a number of policy changes here that, I think, to use the special enrollment period verification requirement as an example, the Agency posits that by verifying that somebody has actually experienced the triggering event that renders somebody eligible for that sort of enrollment, that just ensures that people who are eligible for that enrollment get enrolled rather than rely on self-attestations.

THE COURT: You're answering the question.

So my question is, is there a problem with people alleging that they're having qualified life events, in the terms that maybe I understand better, when they actually aren't. And you're saying that's not the point. It doesn't matter. We don't have to show you that that's actually a problem; is that correct?

MR. SHERWOOD: I don't know if I'd paint the position as strongly there. What I'm trying to highlight that the Agency's decision-making here was at least reasoned, and considered the fact that by just requiring eligibility verification, it was advancing a lawful policy goal that is related to ensuring that, who is deemed eligible for advance premium subsidies are, in fact, eligible for that.

I think -- and a lot of the other rule revisions do the

same by ensuring that somebody actually has income within over a hundred percent of the federal poverty limit, because if they don't, then under statute, they are ineligible.

I think the Agency is considering all of these different approaches. It doesn't have to be a perfect fit. And to the extent that the Court might be concerned well, does the Agency have to consider the drawbacks of the potential policy? Of course, that's what reasoned decision-making requires.

I think here, though, that the standard that the Plaintiffs are asking for is much higher than what the deferential, arbitrary, and capricious standard requires. Is that standard requires a rational connection between the problem identified and the regulatory action taken. And it's a rational one at best, not a superior one.

THE COURT: But what's the problem? That's what I'm saying when I'm talking about the -- again, I'm back to the SEP event verification. What's the problem that's been identified that is then fixed?

MR. SHERWOOD: My understanding, Your Honor, is the -- as we explained in our briefing, that there was a concern about just relying solely on attestations of eligibility for -- just relying solely on self-attestations of whether a triggering event has occurred or not. Because if nobody double-checks, or at least verifies that is what is taking place, and somebody can claim enrollment during a special enrollment period for an event

for which they otherwise would not qualify, start receiving coverage, and, importantly, start receiving premium subsidies that, again, they otherwise wouldn't qualify for.

Again, you can debate whether that's a good idea or whether that problem is as salient as -- or less salient than what Plaintiffs would like it to be, but it is still an identifiable problem. The Agency explained what it was trying to tackle in that -- by just requiring basic verification, that would discourage any incentive to try to improperly enroll in special enrollment periods.

That also has effects for adverse selection. If people are only electing to enroll outside the open enrollment period because they need care, that can have effects on, like I said, the risk pool. And the Agency explained all of that. Again, Plaintiffs might disagree with that approach.

THE COURT: Yeah. I don't know -- I understand that. And I guess what I'm struggling with is that the -- against the understanding that the result of these rules, at least according to commentators, is going to be a loss of coverage for a number of eligible individuals. Is the Agency under any additional obligation -- which would go against the very purpose of the Affordable Care Act. Isn't the Agency then under some obligation to explain not only how its solution meets the problem, but that it's actually a problem at all?

MR. SHERWOOD: I mean, the Agency would be under an

obligation, yes, to address legitimate concerns about the costs and benefits of any rule change. I think that took place here. Throughout the rule, the Agency would say, you know, the commenters have identified legitimate costs of this rule. Question is, do the benefits outweigh those costs? Whether it comes from -- enrollment is an important part of the Affordable Care Act, but so is the idea of ensuring that the public FISK is able to fund a stable marketplace in which people are actually eligible for the benefits of Affordable Care Act coverage are actually receiving it. And that's the sort of policy balance that the APA allows for.

Subject, of course, you know, the Agency has to consider relevant considerations; it can't completely ignore them. The decision-making has to be rational. It can't be completely pretextual or not based on reality or predictive judgment, but I don't think that can be said about a lot of the rule provisions here. I only bring this up because the Court was focused on the special enrollment period provision in particular.

THE COURT: Yeah. I sort of was maybe a little too focused on it because there were obviously other provisions. But let me take you to one of those.

They call it Junk Fee, I guess you call it the Annual Eligibility Brief Termination Provision. I like the different naming, that was helpful actually. But either way, the fee, if we call it that.

The APTCs are set by statutory formula. So how is this -- how do you respond to the argument that they make? You can't flout -- even if it's towards a goal, as you're talking about, determining eligibility; you can't flout the express rule. And here that would be the formula for APTCs. How do you get around that?

MR. SHERWOOD: We cited to the authority conferred by the ACA to HHS to determine and re-determine annually eligibility for enrollment in -- enrollment in the exchanges, but also eligibility for premium tax credits.

THE COURT: No, I understand that, but then there's a separate statute. It's in the statute. This is how you calculate APTCs. It makes no mention of an extra $5 or $10 or $100 whatever number you want to come up with.

I understand where you're finding the authority, but that would seem to expressly conflict with other authority.

MR. SHERWOOD: I think, Your Honor, the -- what HHS is doing here is adopting a procedure that prompts individuals to reconfirm their eligibility. Now, maybe it comes down to like you were highlighting the language determination, changing the APTC amount. Critically, individuals who still qualify for the same premium tax credit amount it just addresses what happens up front, all in service of meeting other statutory and regulatory requirements for re-determining eligibility. And the Secretary does have the authority to adopt certain procedures that enables

it to do so. And the procedure here is the reduction -- $5 reduction in the APTC amount. Whether that -- I think could be read, I think the statutory authority, as to where the -- since HHS has the authority to set an APTC amount, and also has to balance that with re-determining eligibility every year --

THE COURT: They have authority to set it, but pursuant to a formula that is statutorily set as well.

MR. SHERWOOD: That's understood. Yep.

And I think, Your Honor, if I were to concede of the three contrary to law claims here, this one, I think, is a little bit less clear-cut for us in that it does amount to, is this Agency's authority to re-determine eligibility, does that encapsulate its ability to -- or its obligation, also, to determine eligibility for a set amount of an advanced premium tax credit?

I think it does. I think there -- we argue that it can interpret the statute as such to ensure that -- it's just meant to be a prompt to facilitate that re-determination process, which, again, the Agency has to engage in.

But I do want to highlight, because the Court was focusing also on that special enrollment period a lot. To the extent that the Court finds one particular provision more problematic than the other, for purposes of preliminary relief, I do want to underscore the severability of these rules.

THE COURT: No, I understand that.

MR. SHERWOOD: Moving to the other two, if -- just quickly. I think the other two contrary to law claims, though, pretty clear-cut in terms of legality, at least, for example, on the passing premium policy. That -- the fundamental premise of enrollment in exchange coverage is being -- is paying your premium. Like the Affordable Care Act provides coverage to individuals who pay their premiums, and that applies with equal force to the initial premium.

And that is what the passion premium policy is addressing is whether that first initial premium amount is being paid. Now it comes down to the allocation policy between when past, like, money is paid for past due premiums, does that then eventually get credited to the initial premium amount. The regulation just allows insurers to do -- to adopt that sort of lawful allocation policy. Critically subject to state law; states don't have to adopt the policy at all if they don't want to, if they disagree with the wisdom of it, or they can set their additional parameters.

But to the idea that by requiring individuals to just pay their initial premium amount is no way in conflict with guaranteed availability requirement, which, I mean, the Supreme Court kind of described in Keen v. Burwell, a critical part of that provision is ensuring that people aren't denied coverage for health conditions. Or so long as they meet the requirements, like pay your premium, you're not going to get

denied coverage. Rather than the regime that existed before the ACA, where people could get denied coverage because they had a pre-existing condition that an insurer didn't want to cover, because it would have been too expensive.

Here, the passion premium policy just addresses, you know, you can't be discriminated against on the basis health status for being able to enroll in a plan, but you have to the first month's premium. And if you don't, then that plan never comes into effect.

And then for the failure to reconcile provision, too, I do think it is -- I mean, that's a policy that has been in existence. Another atmospheric point I wanted to make, too, is a lot of these policies were previously adopted by HHS. That resulted in a change in the past administration. This new administration is re-adopting a lot of those policies, and that's just inherent to the nature of policymaking under the Affordable Care Act.

But the failure to reconcile a policy uniquely, I mean, the requirement that APTC eligibility be conditioned on compliance with the statutory reconciliation requirement has been in existence since 2012. Here, the difference is just whether it's a one-year window or two-year window.

THE COURT: But that is not without significance. Because one, the Plaintiffs are arguing because of privacy law, you're not going to get notice, and you're just going to

essentially be told you're getting cut, but we can't tell you why.

And then, as a second point, that they didn't raise here but I think they raised in the briefing, is the reduction in force at the IRS, which I think is well-established; at least it's in the news. And those two events put together make it such that perhaps changing the rule from two years to one isn't indicative of reasoned decision-making.

What is your response to that?

MR. SHERWOOD: I'll start with the notice, Your Honor.

My -- the change in the rule implements here is about the window for -- I mean, it reverts back to when your policy, which existed until, I believe, the year 2021, or it was expanded to two years. Currently, people are provided with notice after one year of failing to reconcile and then after two years of failing to reconcile as well.

THE COURT: Then they have one year to fix it.

MR. SHERWOOD: That might be a decision about whether that's enough time. But the idea that they're not getting any notice, I mean, the rules preamble lays out that the Agency intends to adopt a notice regime that was in existence during the one-year window.

THE COURT: Okay.

MR. SHERWOOD: Where people would -- individuals -- there's an entire chart in the rules preamble talking about the

types of notice that would be provided. Whether you're a tax filer, you'd be given notice that you haven't reconciled or been identified as not reconciling. There's also a more general notice reminding individuals of their duty or obligation to reconcile and how that can affect their eligibility for APTC.

So I think the notice thing is -- the notice concern, I'm not sure where that is coming from, it's the failure to reconcile policy has been in effect for several years.

THE COURT: Well, it's not so much of lack of notice, just that the notice doesn't provide sufficient detail because they are not allowed to share tax information. So you're aware there's a problem, you're just not told precisely what it is and how to fix it.

MR. SHERWOOD: I'm -- to confess ignorance, Your Honor, I don't know what those precise notice is that people receive now look like, to the specificity of it. But I would encourage the Court, I can at least look at it immediately here and point to the pages in the rules preamble where the Agency explains the notice regime.

THE COURT: I suspect it's fairly similar, but given that you have more time to address it, perhaps it --

MR. SHERWOOD: And that can come down to a policy concern. But I think the Agency addressed that concern by just identifying that the policy was in effect for several years, and that it made the reasoned determination that one year will

ensure that there's compliance with that statutory reconciliation requirement and also prevent improper enrollments from lasting for two years rather than one. Again, Plaintiffs may think it's a bad idea, but that APA requirements --

THE COURT: I actually don't know. I hope just "we used to do it this way" can't possibly be a reasoned justification --

MR. SHERWOOD: Of course not.

THE COURT: -- because --

MR. SHERWOOD: Of course not.

THE COURT: I don't even need to finish the sentence, and you don't seem to need me to. But that can't possibly be a reasoned justification.

What about the loss in reduction of force at the IRS?

MR. SHERWOOD: The Agency addressed that and concluded, reasonably so, that, you know, the concerns about processing at the IRS can't just be a stand-alone reason for not re-implementing a one-year failure to reconcile provision. But I also, to address that concern, the Agency also highlighted how, notwithstanding potential concerns, about delays in IRS processing. There are procedures in place to ensure that if somebody does comply with the reconciliation requirement, I think it's the FTR, Failure To Reconcile recheck process, where, so long as they attest to having reconciled by the late filing date for tax returns in October, then they will be deemed

eligible for their APTCs.

The Agency will then check into whether that reconciliation obligation was actually met. I think the -- if I recall from the rules preamble, that there have to be four checks on compliance with the reconciliation requirement before APTC eligibility becomes an issue.

So there are -- the Agency did explain that there are procedures in place to ensure that people who do follow the reconciliation process, as they are statutorily required to, are not just needlessly kicked off of coverage. There are protections in place, including an FTR re-check policy.

Recognizing my time, Your Honor, if the Court has any other specific questions about provisions --

THE COURT: Yeah. Let me just see what I have. I had -- I had one that I had written out earlier on the actuarial value issue.

The rule says HHS made the reasonable observation that consumers considering different plan options typically care less about marginal differences in the actuarial values of plans than they do about more meaningful differences that they can understand and appreciate. Such as whether a high deductible plan with no co-insurance is a better value than a plan with a lower deductible but more co-payments.

What is that observation based on? It didn't appear to be backed up by any data or evidence, which is a bit of a theme.

Again, not necessarily a crazy thought, but what's it based on?

MR. SHERWOOD: Your Honor, if -- I would have to look at the specific part of the rule to see if it was cited to anything. But I do know, at least with respect to the actuarial value policy, the Agency identified that it was -- has received feedback from providers -- or insurers, or issuers themselves. And so I think a reasonable inference could be drawn that how -- what customers are looking for in the market can be spoken to by providers of that sort of coverage.

I think what the Agency is also -- reasonable determinations, again, the APA doesn't require empirical studies to back up every reasonable assumption, presumption, prediction made. And I think here, especially with the actuarial value, I mean, I had to spend time figuring out what that actually means in practice. So I think this idea that when consumers are scouring their options, like a 68 percent versus a 67 percent actuarial value, I think Agency's point was that is not necessarily the most meaningful metric of the quality of coverage, because actuarial values are also measured at the aggregate average level.

In my experience, for example, if I don't hit my high deductible, the actuarial value of my plan is effectively zero because every single dollar I spend on my healthcare comes out of pocket. So it's the 70 percent versus 68 percent is the plan across, like, on average, for a consumer.

I think what the Agency was just recognizing is that this concern that this is somehow an arbitrary policy decision because expanding the range from 60, 60 percent to 69 percent is somehow going to confuse consumers in a way that is detrimental to their understanding of the marketplace.

I think the Agency was just identifying that I don't think its actuarial value is strictly the driver of coverage options, it's what do I pay. I have to pay a premium, but also do I have a high out-of-pocket maximum? Do I get co-insurance? Once I hit my out-of-pocket, am I able to get full coverage for the rest of the year? People make health decisions based on the timing all the time. You have to fit in all your coverage for the whole year to take advantage of having hit your out-of-pocket maximum.

And so it's those sorts of considerations that are more meaningful. And the actuarial value policy allows for different types of cost-sharing structures that might, as a literal matter, make some plans slightly less -- have a slightly lower actuarial value than others. But what matters, from the consumer's perspective, is what am I gonna -- the comprehensiveness of the coverage and the amount that I have to pay for that.

THE COURT: Okay.

MR. SHERWOOD: And --

THE COURT: All right.

MR. SHERWOOD: -- respectfully, Your Honor, yeah, I appreciate your patience going through --

THE COURT: No, no.

MR. SHERWOOD: -- provision by provision.

THE COURT: The only thing I didn't ask, and I'll do it before Plaintiff's get the last word.

The case in Boston had a hearing yesterday. And by the case, were you involved in that?

MR. SHERWOOD: I was, Your Honor.

THE COURT: Okay. You were up there?

MR. SHERWOOD: Uh-huh.

THE COURT: Okay. So there was no ruling there; is that right?

MR. SHERWOOD: The court took the matter under advisement.

THE COURT: Okay. All right. I mean, the interplay between these two obviously have, nothing to do with that. We wear a similar outfit, but he's a lot better looking than me; I got nothing there. But I was curious, the overlap here. Like if you got different decisions from the two cases, is it the same provisions being challenged?

MR. SHERWOOD: There is substantial overlap. There is a provision at issue in the District of Massachusetts case that is not at issue here.

THE COURT: Okay.

MR. SHERWOOD: But I think -- I think the only difference -- and then the only provision at issue here that's not an issue there is the 60-day automatic extension provision.

THE COURT: Okay.

MR. SHERWOOD: But yeah, the merits of, for example, the failure to reconcile passion premium policy, the annual eligibility re-determination, those are all at issue. Maybe a slight difference between whether there's a contrary to law claim in addition to an arbitrary capricious claim, but all those provisions are being challenged as arbitrary and capricious as well.

THE COURT: All right. Thanks.

MR. SHERWOOD: Thank you, Your Honor.

THE COURT: I said 15, I might make it just 10 minutes so that we can finish up around noon. Is that okay?

MR. MCELVAIN: That is more than okay, Your Honor. I will aim to be even briefer than that.

THE COURT: Great.

MR. MCELVAIN: I always promise to be brief in reply, I very rarely follow through, but I really will try.

THE COURT: That's okay. Everyone always says -- I wish somebody just got up and said this is going to be a while. I would actually say that's great, go ahead. Everyone always says briefly, it's not. But go ahead.

MR. MCELVAIN: That would be more honest, I

acknowledge that, Your Honor. But I really do aim to just have a few points, although, of course, I will go over any questions you have.

THE COURT: Sure.

MR. MCELVAIN: To touch on standing, just a couple points on that.

First, to reiterate what the standard is when there is a claim of standing that depends on the conduct of third parties. It's well-established; this is discussed in the prior City of Columbus cases itself, it's discussed in subsequent Supreme Court case law. That it's perfectly permissible to have an area of standing that turns on the conduct of third parties when you're able to make reasonable predictions based on common sense economic predictions or what have you, as to how third parties will respond to a rule.

There's a lengthy discussion of this in the City of Columbus versus Trump, as well as City of Columbus versus Corcoran. The Hippocratic Medicine Case, which the Government relies on itself, acknowledges that principle.

And the Supreme Court in Diamond Alternative Energy, which just issued just this past month, again reiterated the point that it's perfectly permissible to have plaintiffs who are indirectly affected by a rule to have Article III standing to pursue a challenge, as long as they're able to demonstrate that there is a predictable, reasonable chain of events that leads to

the harm that they are seeking redress for. And here we meet that standard.

First of all, the rule will result in coverage losses on a widespread basis. This is common ground. We've presented the Young declaration, which walks through, in detail, why, in fact, many people will be thrown off of insurance coverage, potentially as many as 2.2 million people. And in context, we're talking about a marketplace that, as of the end of 2024, was 24 million people. So we're talking about ten percent of the total coverage. It's a pretty substantial hit to the overall marketplace.

And this is common ground. Even CMS itself, in its own analysis, acknowledged that at least 800,000 people will be thrown off of coverage. This is from 90 Federal Register at 27213. 800,000, ranging up to 1.8 million under the Agency's own estimate.

And to underscore the point, these are estimates that are based on top of other factors at play. This is even after taking into account that enhanced premium tax credits will expire, absent further Congressional action and other factors in play. It's the counterfactual between adopting this rule and not adopting this rule. So it's absolutely a matter of common ground that there will be widespread coverage losses under this rule.

And then when you turn from that to the proof we presented

as to our individual plaintiffs, the factual accuracy of which has not been challenged by the Government at all, they've simply challenged the legal adequacy of these declarations. We've demonstrated why widespread coverage losses will harm each of the Plaintiffs.

The Johnson Declaration, having to do with the City of Columbus, paragraphs 8 through 14, explain all of the ways in which Columbus provides care, and that Columbus will incur more costs when more Columbus residents are uninsured or underinsured.

Again, in Baltimore, the City of Baltimore, the Leach Declaration, paragraph 7 through 13, again walks through that same analysis.

The Chicago declaration that -- I'm sorry, I don't know the pronunciation of my own declarant's name, I-g-e. Ige declaration. I apologize if I'm mispronouncing that. Paragraphs 5 through 12 walk through the names analysis for the City of Chicago.

As for the Doctors, Dr. Oller directly explains that she relies on a mix of patients that includes ACA coverage, and that she knows that as more of her patients drop out of ACA coverage she will, herself, incur more costs. That is paragraphs 6 and 7 of her declaration.

Dr. Fethke's Declaration, paragraphs 4 through 6, walks through the same analysis. He, himself, will incur more costs

once his mix of patients goes from ACA coverage to more of an uninsured population. And, in fact, he fears that his practice could not survive in the face of the increased costs. That's paragraph 9 of his declaration.

You know, again, just the fact that he experiences the cost is enough for standing. The fact that he -- even his entire business is threatened is, you know, a further demonstration of that.

And as to the Main Street Alliance as well, the Brooke Legler Declaration, paragraphs 11 and 12 demonstrate that she is an enrollee that is heavily dependent on affordable coverage. And if she faces increased costs, she will, of course, pay more costs. And that is enough, in and of itself, to demonstrate standing, but also, there is the very real possibility that she would have to shutter her business in the face of those increased costs.

Turning to the merits. There's really just one point I want to make in the merits because we already discussed them at length, and that is just a sort of general, overarching point. I understand the overall thematic point that my colleague presses on behalf of the Government, that CMS has an obligation to ensure the statutory standards of eligibility here. And, of course, that is true. But the Agency must exercise that authority reasonably.

If I could offer the Court a reductio ad absurdum, and, of

course, this is a ridiculous hypothetical, but I think it demonstrates the point.

If CMS were to assert that to rely on its authority to determine if eligibility is met, and to assert the standard, and under which no enrollee could be enrolled in exchanges or obtain subsidies in the exchanges unless they sat for a deposition and proved, under oath, that they met every single standard. That would be an invocation of that statutory authority, but it would be an absurd invocation of that statutory authority.

Of course, the Agency has to act reasonably in asserting that authority, and it has to balance countervailing considerations. And one of the things it has to take into account is the purposes of the ACA itself, which is to expand coverage and to keep coverage affordable.

And even -- that's even reiterated in the text of the statute itself, 42 U.S.C. 18114, cited in our opening brief. One thing that the Agency is prohibited from doing is exercising its discretion to impose unreasonable barriers on the availability of healthcare and healthcare coverage.

Having demonstrated each of these points, our Plaintiffs need relief now. The Government questions why we brought this as a motion for a Section 705 stay. We filed our complaint and we filed our motion within two weeks of the rule becoming finalized, precisely because timing is of the essence.

These provisions go into effect January 1st for the 2026

year, open enrollment begins November 1st. But insurers' plans and the preparations that the exchanges need to engage in, and all of the underlying machinery, don't spring into effect on October 31st to allow open enrollment to happen then November 1st.

Insurers right now are in the process of finalizing the plan offerings and setting their plan rates in reliance on what the current rule offers, and what they anticipate the market will look like on the basis of this rule.

So we do need relief now to allow time for the market to adjust in advance of the opening of open enrollment on November 1st.

THE COURT: All right. Well, thank you all for a very, I don't want to say a surprisingly interesting, but whenever administrative law is involved, I'm afraid one doesn't anticipate a good time.

But thanks for the briefing, and I will try to get through this as quickly as I possibly can because, obviously, time for both sides is important.

Thanks again. Safe travels if you came from far or even close. Take care.

(The proceedings concluded at 12:03 p.m.)

CERTIFICATE OF OFFICIAL REPORTER

I, Kassandra L. McPherson, Registered Professional Reporter, in and for the United States District Court for the District of Maryland, do hereby certify, pursuant to 28 U.S.C. § 753, that the foregoing is a true and correct transcript of the stenographically-reported proceedings held in the above-entitled matter and that the transcript page format is in conformance with the regulations of the Judicial Conference of the United States.

Dated this 19th day of August 2025.

-S-

KASSANDRA L. MCPHERSON, RPR
FEDERAL OFFICIAL COURT REPORTER

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**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

| | | |
|---|---|---|
| CITY OF COLUMBUS ET AL., | * | |
| Plaintiffs, | * | |
| v. | * | |
| ROBERT F. KENNEDY, JR. ET AL., | * | Civil No. 25-2114-BAH |
| Defendants. | * | |

* * * * * * * * * * * * *

**MEMORANDUM OPINION**

Plaintiffs filed suit under the Administrative Procedure Act ("APA") seeking to prevent Defendants from implementing changes to federal regulations enforcing the Patient Protection and Affordable Care Act (the "ACA," or the "Act"). ECF 1 (complaint). These changes, embodied in the Marketplace Integrity and Affordability Rule (the "Rule"), are set to take effect on August 25, 2025. *See* Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 27,074 (June 25, 2025). Plaintiffs—three cities, a coalition of doctors, and an interest group representing small business owners—allege they will shoulder increased costs or see their members lose health insurance coverage if these changes are implemented. *See generally* ECF 1; ECF 11 (motion for preliminary relief). Defendants, the Secretary of the Department of Health and Human Services ("HHS") and many in his employ charged with crafting and implementing the Rule, counter that changes to ACA-related regulations are needed to prevent fraud and to readjust the cost of health insurance. *See* ECF 28 (opposition to preliminary relief motion).

This matter is currently before the Court on Plaintiffs' motion for a stay under 5 U.S.C. § 705 or, in the alternative, for a preliminary injunction (the "Motion"). ECF 11. Upon consideration of the parties' filings and after a robust oral argument on the Motion, the Court **GRANTS** in part and **DENIES** in part Plaintiffs' Motion and enters a **STAY** enjoining certain provisions of the Rule from taking effect on August 25, 2025.

The Court finds that Plaintiffs have met their burden of showing that there is a strong likelihood that they will succeed on the merits of their challenges to seven provisions of the Rule. Plaintiffs have failed to show likelihood of success on the merits sufficient to warrant preliminary relief on the remaining challenges to two other provisions of the Rule. As to the seven provisions in which Plaintiffs have shown a likelihood of success on the merits, Plaintiffs have also shown they will face irreparable harm if the challenged portions of the Rule are not enjoined. Finally, the balance of equities and the public interest weigh in favor of a stay. This memorandum opinion is offered to explain the Court's reasoning.

## I. BACKGROUND

### A. The Affordable Care Act

In 2010, Congress enacted the ACA "to increase the number of Americans covered by health insurance and decrease the cost of health care." *NFIB v. Sebelius*, 567 U.S. 519, 538 (2012). "Prior to the enactment of the ACA, individual health insurance markets were dysfunctional." *City of Columbus v. Trump*, 453 F. Supp. 3d 770, 778 (D. Md. 2020).[1] The ACA "adopts a series of interlocking reforms designed to expand coverage in the individual

[1] The Court frequently cites two prior opinions by Judge Chasanow, which included the same City Plaintiffs involved in this case. One opinion is from 2020 and addresses a motion to dismiss. *See City of Columbus*, 453 F. Supp. 3d at 770. The other opinion, from the same case, addresses the parties' cross-motions for summary judgment. *See City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021).

health insurance market."[2] *King v. Burwell*, 576 U.S. 473, 478–79 (2015). Individual market health plans are referred to as qualified health plans ("QHPs"). Individuals primarily enroll in QHPs for a given benefit year during an annual open enrollment period, or under specified special enrollment periods. 42 U.S.C. § 18031(c)(6). Ultimately, the ACA "aims to achieve systemic improvements in the individual health insurance market by means of certain key reforms[.]" *City of Columbus*, 453 F. Supp. 3d at 778.

First, the Act's "guaranteed issue" requirement specifies that every "health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage," 42 U.S.C. § 300gg-1(a), subject to exceptions specified in the statute, such as limiting sign-ups to the aforementioned enrollment periods, *id.* § 300gg-1(b); *see Me. Cmty. Health Options v. United States*, 590 U.S. 296, 301 (2020). "In other words, the Act 'ensure[s] that anyone can buy insurance.'" *Me. Cmty. Health Options*, 590 U.S. at 301 (quoting *King*, 576 U.S. at 493).

Second, the Act's "guaranteed renewability" provision requires issuers to renew or continue in force such coverage. 42 U.S.C. § 300gg-2(a). This provision, too, is subject to statutory exceptions, including an exception for persons who have failed to pay premiums owed on their policy. *Id.* § 300gg-2(b)(1); *see also id.* §§ 300gg-12, 300gg-42.

Third, the Act requires all QHPs to cover "essential health benefits" and limits cost-sharing (in the form of deductibles and co-pays) by enrollees for these essential health benefits. 42 U.S.C. § 300gg-6(a); *id.* § 18022(a)(2). The limitation on cost-sharing is adjusted each year by a "premium adjustment percentage," which is "the percentage (if any) by which the average

[2] "Individual health insurance is insurance that individuals purchase themselves, in contrast to, for example, joining employer-sponsored group health plans." *City of Columbus*, 453 F. Supp. 3d at 778 (citation omitted).

per capita premium for health insurance coverage in the United States for the preceding calendar year [] exceeds such average per capita premium for 2013," the year before the Act's reforms to the individual health insurance market went into effect *Id.* § 18022(c)(1),(4).

Fourth, the Act "requires the creation of an 'Exchange' in each State where people can shop for insurance, usually online." *King*, 576 U.S. at 479 (quoting 42 U.S.C. § 18031(b)(1)); *see also Me. Cmty. Health Options*, 590 U.S. at 301. The Act "gives each State the opportunity to establish its own Exchange, but provides that the Federal Government will establish the Exchange if the State does not." *King*, 576 U.S. at 479; *see also* 42 U.S.C. §§ 18031, 18041. The purpose of the Exchange is to serve as a "marketplace that allows people to compare and purchase" ACA-compliant plans.[3] *Id.*

Fifth, exchange plans are categorized into different "metal tiers"—bronze, silver, gold, and platinum—based on their "level of coverage." 42 U.S.C. § 18022(d) (setting the "level of coverage" for each of the plan types). For example, "silver plans," must have an actuarial value of 70%, meaning the plan is designed such that the issuer will pay around 70% of covered medical expenses, and the enrollee will pay the remaining 30% of expenses through out-of-pocket spending.[4] *Id.* Because actuarial predictions may be imprecise, the Act specifies that the

[3] As Plaintiffs describe, "[s]ome states have elected to create Exchanges themselves (state-based Exchanges or SBEs), as is the case in Maryland, while others have created Exchanges that operate on the federal Healthcare.gov platform (state-based Exchanges on the federal platform, or SBE-FPs), such as the Exchange currently in use in Illinois while it transitions to an SBE. The Exchange in other states, including Ohio, is operated by the Centers for Medicare & Medicaid Services ("CMS") (federally facilitated Exchange, or the FFE)." ECF 11-1, at 6 (citing CMS, Consumer Info. & Ins. Oversight, *State-Based Exchanges*, https://perma.cc/JFT3-6EAK).

[4] Bronze, gold, and platinum plans are designed to provide benefits that are actuarially equivalent to 60%, 80%, and 90%, respectively, of the full value of benefits under the plan. 42 U.S.C. § 18022(d)(1).

Centers for Medicare & Medicaid Services ("CMS"), an agency within HHS, may "provide for a de minimis variation . . . to account for differences in actuarial estimates." *Id.* § 18022(d)(3).

Sixth, the Act "seeks to make insurance more affordable by giving refundable tax credits to individuals[.]" *King*, 576 U.S. at 482 (citing 26 U.S.C. § 36B). These "premium tax credits" ("PTCs") vary depending on an individual's income—individuals who earn more must pay more toward the cost of their monthly premium—but are generally pegged to the cost of the so-called "benchmark silver plan," or the second-lowest-cost silver plan offered within a market. *See, e.g.*, 26 U.S.C. § 36B(b)(3)(B)–(C). The Act initially made these tax credits available to individuals with incomes between 100% and 400% of the federal poverty level ("FPL"). 26 U.S.C. § 36B(c)(1)(A). During the COVID-19 pandemic, Congress—via the American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4 ("ARPA")—temporarily increased the generosity of the ACA's premium subsidies and expanded subsidy eligibility to enrollees with household incomes above 400% of the FPL. The 2022 Inflation Reduction Act, Pub. L. No. 117-169, 136 Stat. 1818 ("IRA"), extended these enhanced subsides through 2025. The enhanced subsidies are set to expire at the end of 2025.

PTCs are claimed on an individual's tax return after the end of the year, and are paid by the Internal Revenue Service ("IRS"). 26 U.S.C. § 36B(h). Rather than an enrollee paying the entire insurance premium up front and then later claiming a credit toward that amount on the taxpayer's tax return, the Department of Health and Human Services ("HHS"), the federal agency that largely administers the ACA, may also make an advance payment of the premium tax credit amount directly to the enrollee's insurance provider. 42 U.S.C. §§ 18081, 18082. Such credits are known as advance premium tax credits ("APTCs"). "APTCs act as a subsidy for low-income individuals who could not afford to purchase insurance outright." *City of Columbus*, 523

F. Supp. 3d at 741. CMS is responsible for determining whether individuals meet the statutory eligibility requirements for APTCs, as well as for "redetermin[ing] eligibility on a periodic basis in appropriate circumstances." 42 U.S.C. § 18081(f)(1)(B). The amount of the APTC owed ultimately depends on the individual's income at the end of the year. Thus, individuals must file a federal tax return each year to "reconcile" the APTCs they received with the PTC amount they ultimately qualify for based on their actual income during the applicable tax year. *See* 26 U.S.C. § 36B(f)(1).

"Each year, HHS promulgates rules pursuant to its rulemaking authority under the ACA and the Public Health Service Act ("PHS Act"). Such rules are the mechanisms by which HHS makes ongoing adjustments to the regulations and processes surrounding ACA insurance markets." *City of Columbus*, 523 F. Supp. 3d at 741.

**B. The Marketplace Integrity and Affordability Rule**

On March 19, 2025, CMS issued a Notice of Proposed Rulemaking for a proposed rule that would implement "several regulatory actions aimed at strengthening the integrity of the [ACA] eligibility and enrollment systems to reduce waste, fraud, and abuse." 90 Fed. Reg. 12,942 (Mar. 19, 2025) ("NPRM"). CMS further explained that it "expect[ed] these actions would provide premium relief to families who do not qualify for [ACA] subsidies and reduce the burden of . . . [ACA] subsidy expenditures on the Federal taxpayer." *Id.* CMS received more than 26,000 comments on the proposed rule. After reviewing those comments and revising certain provisions of the proposed rule, HHS issued (and publicly released) the Rule on June 20, 2025, and it was published in the Federal Register on June 25. 90 Fed. Reg. 27,074.

As relevant here, the Rule implements policies concerning the effectuation of new Exchange coverage when a customer owes past-due premiums to an issuer, *id.* at 27,084–91; the

requirement that recipients of APTCs file a federal tax return and reconcile those APTCs with the recipient's PTC amount, *id.* at 27,113–17; and the procedures HHS uses to annually redetermine Exchange enrollees' eligibility to receive APTCs, *id.* at 27,102–10. The Rule additionally makes changes to the procedures that HHS uses to verify enrollees' eligibility for APTCs, *id.* at 27,118–32; pauses an income-based special enrollment period ("SEP"), *id.* at 27,140–48; and amends certain verification procedures that apply to SEPs, *id.* at 27,148–52. The Rule also updates the methodology used to calculate the "premium adjustment percentage," *id.* at 27,166–74, and makes adjustments to the allowable ranges of actuarial values applicable to the different plan types sold on Exchanges, *id.* at 27,174–78.

HHS explained in the Rule's preamble that, "[b]ased on [its] review of enrollment data and [its] experience fielding consumer complaints," it believes that the "temporary expansion of ACA premium subsidies" via the ARPA and IRA "resulted in conditions that were exploited to improperly gain access to fully-subsidized coverage" on Exchanges. *Id.* at 27,074. More specifically, "the widespread availability" of fully subsidized plans—*i.e.*, plans with post-subsidy net premiums of $0—"created the incentive and opportunity for fraudulent and improper enrollments at scale," either by individual enrollees wanting no-cost Exchange coverage or by third-party brokers that collected commissions on improper enrollments that were made without customers' knowledge. *Id.* The Rule purports to "take[] a carefully curated set of temporary actions to immediately reduce the crisis-levels of improper enrollments over the short-term as the market readjusts to the new subsidy environment in which enhanced subsidies are no longer available." *Id.* The Rule also implements a number of "permanent reforms to help the markets reset to the changing subsidy environment to improve affordability and stability over the long-term" *Id.*

Plaintiffs contend that the Rule "contains a number of provisions that, in their individual and collective effect, will raise consumers' premiums for plans on the Exchanges, limit coverage under those plans, and deter millions of individuals from enrolling in coverage, leading to higher uncompensated care costs for providers of last resort." ECF 11-1, at 8. According to Plaintiffs, "the [R]ule will lead to at least 1.8 million fewer people enrolling on the Exchanges." *Id.* (citing ECF 11-2, at 2 ¶ 4). Plaintiffs argue that "[t]he [R]ule accomplishes this result through measures that erode the value of coverage obtained through the Exchanges, impose barriers designed to depress enrollment in the Exchanges, and impose further barriers limiting the availability of subsidized insurance even for those enrollees that do successfully enroll." *Id.*

The Rule is set to take effect next week, on August 25, 2025, 90 Fed. Reg. 27,074, but many of its provisions will apply to Exchange plans that will first be available in 2026, *see id.* at 27,178–79.

### C. Procedural History

Plaintiffs are three city governments—the City of Columbus, Ohio; the Mayor and City Council of Baltimore, Maryland; and the City of Chicago, Illinois (collectively the "City Plaintiffs")—and two nonprofit organizations, Main Street Alliance ("MSA"), a "national network of small businesses," and Doctors for America ("DFA"), an advocacy organization consisting of "member physicians and medical trainees . . . in all 50 states." ECF 1, at 5–6 ¶¶ 8–12. Plaintiffs seek review of agency action under the APA, claiming that three of the Rule's provisions are contrary to law (Count I), and that those same three provisions plus seven others are arbitrary and capricious (Count II).[5] *Id.* at 26 ¶¶ 74–82. On July 2, 2025, Plaintiffs filed a

[5] While the Complaint and the initial Motion sought relief on the revocation of the low-income SEP, Plaintiffs clarified in their Reply brief that they are no longer seeking a stay of that provision given the enactment of Pub. L. No. 119-21 §§ 71301–71305. ECF 30, at 15 n.7.

motion for preliminary relief, in which they seek a stay of the August 25, 2025 effective date of the challenged Rule provisions under 5 U.S.C. § 705 or, in the alternative, a preliminary injunction. *See* ECF 11. Defendants filed an opposition arguing that Plaintiffs lack standing to bring suit and the provisions at issue are lawful. *See* ECF 28. Plaintiffs filed a reply brief. *See* ECF 30. The Court held a hearing on the Motion on August 14, 2025. *See* ECF 34 (Tr. of Hearing). The Motion is now ripe for decision.

## II. LEGAL STANDARDS

### A. Preliminary Injunction / Section 705 Stay

A preliminary injunction is warranted when the movant demonstrates four factors: (1) that the movant is likely to succeed on the merits, (2) that the movant will likely suffer irreparable harm in the absence of preliminary relief, (3) that the balance of equities favors preliminary relief, and (4) that injunctive relief is in the public interest. *League of Women Voters of N.C. v. North Carolina*, 769 F.3d 224, 236 (4th Cir. 2014) (quoting *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008)); *Frazier v. Prince George's Cnty.*, 86 F.4th 537, 543 (4th Cir. 2023). Where the government is a party the balance of equities and public interest factors merge. *Nken v. Holder*, 556 U.S. 418, 435 (2009). The movant must establish all four elements to prevail. *Pashby v. Delia*, 709 F.3d 307, 320–21 (4th Cir. 2013). A preliminary injunction is an "extraordinary remed[y] involving the exercise of very far-reaching power [that is] to be granted only sparingly and in limited circumstances." *MicroStrategy, Inc. v. Motorola, Inc.*, 245 F.3d 335, 339 (4th Cir. 2001).

Section 705 of the APA permits a court to "issue all necessary and appropriate process to postpone the effective date of an agency action or to preserve status or rights pending conclusion of review proceedings" where "required and to the extent necessary to prevent irreparable injury." 5 U.S.C. § 705. "The factors governing issuance of a preliminary injunction

also govern issuance of a § 705 stay." *Casa de Maryland, Inc. v. Wolf*, 486 F. Supp. 3d 928, 950 (D. Md. 2020) (quoting *District of Columbia v. Dep't of Agric.*, 444 F. Supp. 3d 1, 16 (D.D.C. 2020)).

**B. Review Under the APA**

The APA requires courts to "hold unlawful and set aside agency action, findings, and conclusions" that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). Previously, "[w]hen a challenger assert[ed] that an agency action conflicts with the language of a statute, [the reviewing court] generally appl[ied] the two-step analytical framework set forth in *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842–43 (1984)." *City of Columbus*, 523 F. Supp. 3d at 744. However, *Loper Bright* overturned *Chevron* and changed this Court's role in reviewing an administrative agency's interpretation of a statute. *See Loper Bright Enters. v. Raimondo*, 603 U.S. 369, 412 (2024). Section 706 of the APA requires courts to decide "'all relevant questions of law' arising on review of agency action." *Id.* at 392 (quoting 5 U.S.C. § 706). "A court may give weight to an agency's authoritative interpretation but ultimately must rule on matters of law." *Molina-Diaz v. Bondi*, 128 F.4th 568, 574–75 (4th Cir. 2025) (first citing *Loper Bright*, 603 U.S. at 2262; and then citing *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944)); *see also Loper Bright*, 603 U.S. at 400–01 ("[A]gencies have no special competence in resolving statutory ambiguities. Courts do.").

"The scope of review under the 'arbitrary and capricious' standard is narrow and a court is not to substitute its judgment for that of the agency." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). However, the agency must "articulate a satisfactory explanation for its action including a 'rational connection between the facts found

and the choice made.'" *Id.* (quoting *Burlington Truck Lines v. United States*, 371 U.S. 156, 168 (1962)). Agency action is generally considered arbitrary or capricious if the agency "has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *Id.*

## III. ANALYSIS

### A. Standing

Standing is an "irreducible constitutional minimum" of federal jurisdiction. *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560 (1992). "The party invoking federal jurisdiction bears the burden of establishing" that it has standing. *Id.* Where a plaintiff lacks standing, "there is no case or controversy for the federal court to resolve." *TransUnion LLC v. Ramirez*, 594 U.S. 413, 423 (2021) (citation omitted). Standing "tends to assure that the legal questions presented to the court will be resolved, not in the rarified atmosphere of a debating society, but in a concrete factual context conducive to a realistic appreciation of the consequences of judicial action." *Valley Forge Christian Coll. v. Ams. United for Separation of Church & State*, 454 U.S. 464, 472 (1982). Thus, "[f]or a plaintiff to get in the federal courthouse door and obtain a judicial determination of what the governing law is, the plaintiff cannot be a mere bystander, but instead must have a 'personal stake' in the dispute." *Food & Drug Admin. v. All. for Hippocratic Med.*, 602 U.S. 367, 379 (2024) (quoting *TransUnion*, 594 U.S. at 423).

A plaintiff seeking relief in federal court must establish standing by showing: (1) that it suffered an injury in fact, which is a concrete and particularized harm that is actual or imminent, rather than hypothetical, (2) a causal connection between the injury and the challenged conduct that is fairly traceable to the defendant's actions, and (3) a non-speculative likelihood that the

injury will be redressed by a decision in the plaintiff's favor. *See Lujan*, 504 U.S. at 560–61. Only one Plaintiff must have standing for the case to proceed. *See Outdoor Amusement Bus. Ass'n, Inc. v. Dep't of Homeland Sec.*, 983 F.3d 671, 681 (4th Cir. 2020); *Bowsher v. Synar*, 478 U.S. 714, 721 (1986).

Defendants argue that each of Plaintiffs' "alleged injuries rests on speculative predictions about the Rule's potential effects on a complex health insurance market and a multistep chain of possibilities that is unlikely to materialize any time soon." ECF 28, at 12. Plaintiffs maintain that they "may challenge the rule to protect themselves from [uncompensated care costs and higher premiums], just as other providers of last resort were able to challenge other actions by CMS that predictably increased the cost of health care." ECF 30, at 7 (citing *Massachusetts v. U.S. Dep't of Health & Hum. Servs.*, 923 F.3d 209, 225 (1st Cir. 2019); *California v. Azar*, 911 F.3d 558, 571 (9th Cir. 2018); *Pennsylvania v. Trump*, 351 F. Supp. 3d 791, 807 (E.D. Pa. 2019), *aff'd*, 930 F.3d 543 (3d Cir. 2019), *rev'd on other grounds*, 591 U.S. 657 (2020); *U.S. House of Representatives v. Price*, Civ. No. 16-5202, 2017 WL 3271445, at *1 (D.C. Cir. 2017) (per curiam)). For the reasons stated below, the Court finds that Plaintiffs have established standing as to MSA and the City Plaintiffs based on the increased premiums and uncompensated care costs that are "predictable results" of the challenged provisions of the Rule. *City of Columbus*, 453 F. Supp. 3d at 791. As noted at the hearing, the Court has some doubt as to the extent of the injury to DFA, *see* ECF 34, at 7:12–17, but the Court need not reach the question of standing for DFA because only one Plaintiff must have standing for the case to proceed. *See Outdoor Amusement Bus. Ass'n,* 983 F.3d at 681. Because the Court has found that the other Plaintiffs have standing to sue, the Court defers judgment on the question of DFA's standing.

*i. Main Street Alliance*

Main Street Alliance is a "national association of approximately 30,000 small businesses." ECF 11-4 (Legler Decl.), at 1 ¶ 2. "[A]n association may have standing solely as the representative of its members." *Warth v. Seldin*, 422 U.S. 490, 511 (1975); *see also Hunt v. Wash. St. Apple Advert. Comm'n*, 432 U.S. 333, 343 (1977) ("[A]n association has standing to bring suit on behalf of its members."). This is often called "associational" standing, which is a type of representational standing. *White Tail Park, Inc. v. Stroube*, 413 F.3d 451, 459 n.3 (4th Cir. 2005). Here, as to MSA, Plaintiffs claim associational standing. For associational standing to exist, an organization must demonstrate that (a) "'its members would otherwise have standing to sue in their own right; (b) the interests it seeks to protect are germane to the organization's purpose; and (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit.'" *Students for Fair Admissions, Inc. v. President & Fellows of Harvard Coll.*, 600 U.S. 181, 199 (2023) (quoting *Hunt*, 432 U.S. at 343).

**1. Member Standing to Sue**

As noted, the first element of associational standing requires that at least one member of each plaintiff organization has standing to sue in his or her own right. *Id.* Defendants argue that because Brooke Legler, the MSA member-declarant, ECF 11-4, fails to establish standing in her own right, MSA does not have associational standing to challenge the Rule. ECF 28, at 14. Defendants aver that "MSA attempts to base its associational standing on a single declaration from a member who owns a small business in Wisconsin and is enrolled in a health plan through the ACA's individual marketplace. ECF 28, at 12 (citing ECF 11-4, at 1 ¶¶ 1–4). According to Defendants, Legler "does not claim that any of the challenged Rule provisions would impact her directly or otherwise interfere with her eligibility to remain enrolled in her current Exchange plan." *Id.* at 13 (citation omitted). Further, Defendants maintain that Legler's "assertion that the Rule's impact on insurance markets more broadly will necessarily cause *her* particular insurance

premium to increase is likewise wholly speculative." *Id.* (emphasis in original) (citation omitted). Accordingly, Defendants conclude that Legler has "failed to establish that the future economic injury she claims she will suffer as a result of the Rule is sufficiently likely to materialize, let alone imminently so." *Id.* (cleaned up).

Plaintiffs respond that the Rule will "increase the cost of coverage," and "leav[e] members of [MSA] with the Hobson's choice of retaining less generous but costlier coverage or dropping out of coverage altogether." ECF 30, at 4. Plaintiffs point to the declaration of Christen Linke Young, a visiting fellow with the Brookings Center on Health Policy, ECF 11-2, at 1 ¶ 2, to show that "each of the challenged provisions will increase coverage costs by disproportionately driving younger and healthier people out of the Exchanges, worsening the risk pool for those who remain, increasing costs, and adding to existing headwinds for the individual insurance market." ECF 30, at 5 (citations omitted). According to Plaintiffs, MSA's "small business members [] can't opt out of the higher costs that will result from CMS's rule." *Id.* at 7.

Defendants' objection to Legler's standing on the basis that she "does not claim that any of the challenged Rule provisions would impact her directly or otherwise interfere with her eligibility to remain enrolled in her current Exchange plan," ECF 28, at 13, appears to be based on an incomplete reading of her declaration. Legler explains in detail her significant underlying condition, the cost of essential medication to treat that condition, and the freedom the ACA gave her to operate her small business while still maintaining affordable health insurance despite her condition. ECF 11-4, at 2 ¶¶ 6, 8. She goes on to explain that she "operate[s] [her] business on narrow margins" and the new Rule will "cause [her] health insurance coverage costs to increase to a level that [she] cannot afford." *Id.* at 3 ¶ 11. Legler explicitly affirms that "continuing [her]

business would not be an option" because the Rule will "cause [her] health insurance coverage costs to increase to a level that [she] cannot afford." *Id.* at 3 ¶¶ 11, 12. Legler attests that she would be "forced either to find different employment with employer-sponsored insurance, or to terminate [her] business and explore other coverage options through Wisconsin's BadgerCare system." *Id.* ¶ 11. Thus, Legler states with precision how the regulation change will directly impact her.

Defendants further argue that Legler "provides no factual basis for assuming that, even if there were some increase in her premium (whether caused by the Rule or not), she would ineluctably decide to drop her Exchange coverage, close down her business, and seek insurance elsewhere, notwithstanding her satisfaction with her current Exchange plan and the uncertainty of finding alternative coverage that is both adequate and affordable." ECF 28, at 13. This reading of Legler's declaration is inaccurate. Legler affirms that she "take[s] a biologic" which costs about $10,000 per month, ECF 11-4, at 2 ¶ 6, and she "would not be able to afford this medication without health insurance, or with a less comprehensive insurance plan," *id.* She emphasizes that the new Rule will "cause [her] health insurance coverage costs to increase to a level that [she] cannot afford." *Id.* at 3 ¶ 11. According to Legler, "[c]ontinuing [her] business would not be an option in this circumstance, because [she] need[s] to have access to affordable insurance that will cover the medications [she] need[s]." *Id.* ¶ 12. An "increase in premiums constitutes economic harm and is [] 'a classic and paradigmatic form of injury in fact[.]'" *City of Columbus*, 453 F. Supp. 3d at 787 (quoting *Air Evac EMS, Inc. v. Cheatham*, 910 F.3d 751, 760 (4th Cir. 2018)). Legler's attestations are thus sufficient to establish injury-in-fact for Article III standing purposes.

Further, the Court is satisfied that this injury is sufficiently likely to materialize, given the conclusions reached by independent experts on the effects of the Rule and the fact that at least one QHP insurer has already raised rates for 2026. *See* ECF 11-2, at 11 ¶ 29 (explaining that the Rule is expected "to increase net premiums for people receiving financial assistance, increase gross premiums for at least some plans, and impose additional administrative obstacles"); *see also* United Healthcare, *Optimum Choice, Inc., Part III: Actuarial Memorandum: PUBLIC; Maryland 2026 Individual Exchange Rates* 7 (May 22, 2025), https://perma.cc/35L2-M49D (increasing premiums to account for impact of Rule). Legler is not required to prove that she has suffered *actual* injury before filing suit. *See Adams v. Watson*, 10 F.3d 915, 921 (1st Cir. 1993) ("[I]t could hardly be thought that administrative action likely to cause harm cannot be challenged until it is too late." (quoting *Rental Hous. Ass'n of Greater Lynn v. Hills*, 548 F.2d 388, 389 (1st Cir. 1977))). Rather, Legler has shown enough to establish that there is a "'substantial risk' that the harm will occur." *Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 158 (2014) (quoting *Clapper v. Amnesty Int'l, USA*, 568 U.S. 398, 409, 414 n.5 (2013)). Accordingly, Legler has suffered a concrete injury sufficient for Article III standing.

Separately, Defendants argue that the claimed harm is not traceable to the Rule provisions. ECF 28, at 13. "For an injury to be traceable, 'there must be a causal connection between the injury and the conduct complained of' by the plaintiff." *Air Evac EMS, Inc.*, 910 F.3d at 760 (quoting *Lujan*, 504 U.S. at 560). "The causation requirement precludes speculative links—that is, where it is not sufficiently predictable how third parties would react to government action or cause downstream injury to plaintiffs." *All. for Hippocratic Med.*, 602 U.S. at 383 (citing *Allen v. Wright*, 468 U.S. 737, 757–59 (1984)). Although a plaintiff's theory of standing may "not rest on mere speculation about the decisions of third parties[,]" it may "rel[y] instead

on the predictable effect of Government action on the decisions of third parties." *Dep't of Com. v. New York*, 588 U.S. 752, 768 (2019). In short, to establish causation, a plaintiff must show "a predictable chain of events leading from the government action to the asserted injury—in other words, that the government action has caused or likely will cause injury in fact to the plaintiff." *All. for Hippocratic Med.*, 602 U.S. at 385. Here, Plaintiffs have clearly articulated this "predictable chain of events." *Id.*

According to Defendants, "CMS attributes the estimated increase in 2026 premiums" not to the changes embodied in the Rule, but "to the expiration of the enhanced subsidies that were enacted during the COVID-19 pandemic—a statutory change that Plaintiffs do not challenge." ECF 28, at 14 (citing 90 Fed. Reg. at 27,212). Defendants posit that "the Rule will actually cause premiums to be *lower than* they would be otherwise in that post-expiration environment." *Id.* (emphasis in original) (citations omitted). In response, Plaintiffs argue that "CMS cites to the rule's regulatory impact analysis, which projects that it will lead to lowered premiums . . . [b]ut this was based entirely on a projected decrease from the termination of the low-income special enrollment period."[6] ECF 30, at 5 n.1. Plaintiffs point out that "CMS acknowledges that the remaining challenged provisions will increase premiums and net costs for consumers, and indeed the agency repeatedly points to these acknowledgements to defend the rationality of its rulemaking." *Id.* (citations omitted).

The Court is unpersuaded by Defendants' attempt to blame the increased cost of premiums on the expiration of subsidies alone. First, CMS itself has acknowledged in various sections of the challenged provisions that there will be increased premiums and costs for

[6] Plaintiffs clarify that the "projection was never credible, but any dispute on this score is now immaterial, as Plaintiffs no longer challenge" the Rule's provision addressing termination of the low-income special enrollment period. ECF 30, at 5 n.1.

consumers as a result of the implementation of the Rule. *See* 90 Fed. Reg. at 27,212; *see also id.* at 27,107 (reconfirming eligibility rule); *id.* at 27,171 (premium adjustment percentage); *id.* at 27,176–77 (actuarial value calculations); *id.* at 27,192 (guaranteed issue); *id.* at 27,116 (failure-to-reconcile policy); *id.* at 27,119, 27,131 (data matching policies). And as Plaintiffs point out, the Court "[need not] guess how the market will respond to the rule; insurers have already begun to increase their rates in response to the rule." ECF 30, at 6. In issuing 2026 Individual Exchange Rates in Maryland, UnitedHealthcare issued the following statement: "An adjustment of 1.009 was applied to account for the impact of the CMS 2025 Marketplace Integrity and Affordability Proposed Rule. We believe that the changes in the proposed rule, including shortening of the open enrollment period and stricter verification requirements, will lead to healthier enrollees leaving the market and an overall worsening of the risk pool." United Healthcare, *Optimum Choice, Inc., Part III: Actuarial Memorandum: PUBLIC; Maryland 2026 Individual Exchange Rates* 7 (May 22, 2025), https://perma.cc/35L2-M49D. Thus, the Court finds that Plaintiffs have offered "independent analyses and issuers' explanations [to] confirm . . . that Defendants' actions [will] cause[] price increases." *City of Columbus*, 453 F. Supp. 3d at 789. Finally, while the expiration of subsidies will plausibly cause an increase in premiums, that fact does not defeat causation, as Defendants' actions need not be "the sole or even immediate cause of the injury." *Sierra Club v. U.S. Dep't of the Interior*, 899 F.3d 260, 284 (4th Cir. 2018). Accordingly, the injury is fairly traceable to Defendants' conduct because Plaintiffs have established that "insureds and issuers reacted in predictable ways to Defendants' actions." *City of Columbus*, 453 F. Supp. 3d at 789.

Defendants do not appear to directly challenge redressability. *See* ECF 28. The Court is satisfied that the relief sought here—a stay enjoining the agency from enforcing the challenged

provisions—would redress Plaintiffs' injuries by "ameliorating the predictable results of Defendants' challenged actions." *City of Columbus*, 453 F. Supp. 3d at 792. As such, Legler has established standing to sue in her own right, and therefore MSA also has associational standing to sue, so long as the organization can satisfy the second and third prongs of associational standing.

**2. Interests Germane to Organization's Purpose**

As discussed, the second element of associational standing requires that the interests the organization "seeks to protect are germane to the organization's purpose." *Students for Fair Admissions, Inc.*, 600 U.S. at 199 (quotation marks and citation omitted). Shawn Phetteplace, the National Campaigns Director at MSA, indicates that "MSA [] seeks to amplify the voices of its small business membership by sharing their experiences with the aim of creating an economy where all small business owners have an equal opportunity to succeed." ECF 11-3, at 1 ¶ 2. According to Phetteplace, "MSA's founding was directly focused on the passage of the [ACA], and the organization has remained focused on the subsequent strengthening of the law over the past 15 years." *Id.* at 2 ¶ 6. "According to a recent survey, over 45% of MSA members access health insurance either through the marketplace or Medicaid." *Id.* ¶ 3. Defendants do not contend that the interests of Plaintiffs in protecting their members' ability to operate their businesses with affordable health insurance are not germane to MSA's purpose. The Court is therefore satisfied that the interests MSA seeks to protect are "germane" to MSA's organizational purposes.

**3. Individual Member Participation**

The third element of associational standing requires that "neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit." *Students for Fair Admissions, Inc.*, 600 U.S. at 199 (quotation marks and citation omitted). "'[I]ndividual

participation' is not normally necessary when an association seeks prospective or injunctive relief for its members . . . ." *United Food & Com. Workers Union Loc. 751 v. Brown Grp., Inc.*, 517 U.S. 544, 546 (1996) (quoting *Hunt*, 432 U.S. at 343).

Plaintiffs seek a stay under § 705 of the APA, not monetary damages. If MSA's members were to each bring suit on their own behalf, the challenged conduct would generally implicate the same facts, the same defendants, and the same arguments regarding rulemaking procedure.[7] The Court is thus satisfied that the participation of individual members is not necessary. In sum, MSA has established associational standing to sue.

*ii. City Plaintiffs*

The Court now turns to standing for the City Plaintiffs. As noted, to establish injury in fact, "a plaintiff must show that he or she suffered 'an invasion of a legally protected interest' that is 'concrete and particularized' and 'actual or imminent, not conjectural or hypothetical.'" *Spokeo, Inc. v. Robins*, 578 U.S. 330, 339 (2016) (quoting *Lujan*, 504 U.S. at 560). A future injury must be "certainly impending." *Clapper*, 568 U.S. at 409. "If a defendant's action causes an injury, enjoining the action or awarding damages for the action will typically redress that injury." *All. for Hippocratic Med.*, 602 U.S. at 381.

Plaintiffs argue that "[b]y driving up the rate of uninsured or underinsured individuals within the city Plaintiffs' jurisdictions, the rule would force these cities to devote additional funding, personnel, and other resources to subsidizing and providing uncompensated care for their residents." ECF 11-1, at 44. The City Plaintiffs will "have no choice but to take on increased costs as a direct result of the rule's impact on the healthcare marketplace." ECF 30, at

[7] Additionally, Defendants have not asserted that individual member participation is required for the relief requested.

7. According to Plaintiffs, the cities "must provide care whether or not [residents] are compensated by insurance," thus as "providers of last resort," they are able to challenge the actions by CMS that "predictably increase[] the cost of health care." *Id.* The Court finds that this is sufficient to show injury-in-fact, as the City Plaintiffs will bear additional economic costs that come with treating people left uninsured by the implementation of the Rule. *See City of Columbus*, 453 F. Supp. 3d at 787–88 (finding plaintiffs had standing to sue where policies shifted costs onto city governments to provide uncompensated healthcare); *see also Massachusetts*, 923 F.3d at 223 (finding injury-in-fact where "the Commonwealth has demonstrated that there is a substantial risk of fiscal injury to itself").

Defendants maintain that the injury claimed by City Plaintiffs "lies at the end of a highly attenuated chain of possibilities." ECF 28, at 16 (citation omitted). Defendants argue that "the budgetary harms they fear could materialize only if (1) the Rule provisions Plaintiffs challenge cause a certain number of individuals currently enrolled in Exchange plans to disenroll or otherwise lose coverage, and (2) a portion of that recently uninsured group—which, Plaintiffs note, is likely to be 'relatively young[] and health[y],'—seeks medical care (3) in the city Plaintiffs' jurisdictions (4) specifically at city-run health care facilities (rather than privately operated ones) or through a city-funded emergency medical service and (5) receives services at such a rate that the cities (6) are required to increase the budgets for their respective public health departments to cover that increase in potentially uncompensated care." ECF 28, at 16 (citing ECF 11-2, at 2 ¶ 5). Defendants aver that standing cannot derive from such a "lengthy chain of assumptions." ECF 28, at 17 (citing *Chambliss v. Carefirst, Inc.*, 189 F. Supp. 3d 564, 569 (D. Md. 2016)).

Importantly, however, "[a] causal chain does not fail simply because it has several 'links,' provided those links are not hypothetical or tenuous." *Maya v. Centex Corp.*, 658 F.3d 1060, 1070 (9th Cir. 2011) (internal quotation marks and citation omitted); *see also California*, 911 F.3d at 571 (finding standing where the interim final rules "first le[]d to women losing employer-sponsored contraceptive coverage, which [] then result[ed] in economic harm to the states"). In *City of Columbus v. Trump*, Judge Chasanow, in evaluating a nearly identical fact pattern involving the same plaintiffs, held that the plaintiffs had standing to challenge the provisions at issue in that case. 453 F. Supp. 3d at 788. There, defendants lodged a similar argument to the one advanced here, namely that the alleged injury to the plaintiffs was founded on a "number of uncertain links in the causal chain, which are either premised on invalid assumptions or are attributable to the City Plaintiffs themselves." *Id.* Judge Chasanow noted that "this challenge does not dispute that budgetary outlays constitute injury in fact but rather focuses on traceability." *Id.* Ultimately, Judge Chasanow held that Plaintiffs "tie[d] . . . the challenged provisions of the 2019 Rule to increased costs, inaccessibility of quality coverage, and rises in the uninsured and underinsured rates." *Id.* at 790–91. The holding was based on numerous "allegations outlin[ing] the predictable results of the 2019 Rule." *Id.* at 791.

Here, the City Plaintiffs have adequately "outline[d] the predictable results" of the challenged provisions of the Rule. *Id.* First, Plaintiffs have pointed to sufficient record evidence to establish that the rate of uninsured people will go up as a direct result of the implementation of the Rule, a fact confirmed in the Rule itself. *See* ECF 11-2, at 2 ¶ 4 (estimating 1.8 million more people will be insured as a result of the Rule); *see also* 90 Fed. Reg. at 27,074, 27,213 (acknowledging that the Rule will cause at least 800,000 Americans to lose coverage). As Young explains, "[t]he decrease in Marketplace enrollment and increase in the uninsured will result in

[an] increased burden of uncompensated care, especially for safety net providers." ECF 11-2, at 3 ¶ 6. Dr. Olusimbo Ige, the Commissioner of Chicago's Department of Public Health, explains that "[i]n Chicago's experience, the uninsured and underinsured disproportionately rely on ambulance services for transport to the emergency department." ECF 11-9, at 5–6 ¶ 14. Because such individuals are "more likely to wait until their conditions become more severe and then use ambulance services to receive necessary care . . . [a] higher number of uninsured and underinsured individuals will therefore result in more ambulance transports for which Chicago does not receive reimbursement and thus must make up for the shortfall in its budget." *Id.* Additionally, Ige affirmed that "[t]he Rule would significantly increase barriers to coverage and the number of uninsured residents, increase health care costs for residents, and further burden the City's health care safety net." *Id.* at 3 ¶ 6.

Similarly, Edward Johnson, the Assistant Public Health Commissioner for External Affairs for the Columbus Department of Public Health, and Faith Leach, the Chief Administrative Officer of the City of Baltimore, outlined the same effects on the cities of Columbus and Baltimore. *See* ECF 11-7 (Johnson Decl.), at 2–3 ¶¶ 9–11 (noting that if the rate of uninsured individuals increases, the health care system designed to serve the uninsured residents within the community "will necessarily see even more patients, and either Columbus will have to provide them with additional funding or they will have to decrease the range of services or patients they are able to cover"); ECF 11-8 (Leach Decl.), at 3–4 ¶¶ 12, 13 (explaining that an increased uninsured rate will cause "further strain on a system that is already overstretched," and more ambulance calls for which Baltimore does not receive reimbursement and must make up for in its budget). What is more, the Rule itself acknowledged that if enrollees become uninsured as a result of the Rule, they "may face higher costs for care and medical debt

if care is needed," and that "[t]hese costs may, in turn, be incurred by hospitals and municipalities in the form of uncompensated care." 90 Fed Reg. at 27,192; *see also* 90 Fed. Reg. at 27,213 (acknowledging that an "increase in the rate of uninsurance may impose greater burdens on the health care system through strain on emergency departments").

Accordingly, the Court finds that the City Plaintiffs have sufficiently shown that they are likely to suffer financial injury because the Rule will directly lead to increased costs incurred by the City Plaintiffs in the form of shouldering the expense of uncompensated care. Further, the asserted imminent fiscal injury is clearly "fairly traceable" to the Defendants' actions. *Lujan*, 504 U.S. at 560–61. As to redressability, a stay preventing the challenged provisions from going into effect would unquestionably stop the alleged fiscal injury from occurring. Therefore, the City Plaintiffs have established standing.[8]

**B. Motion to Stay**

As noted above, Plaintiffs challenge nine provisions as either contrary to law, arbitrary and capricious, or both. Plaintiffs initially challenged the revocation of the low-income SEP in their opening brief but abandoned that claim on Reply. *See* ECF 30, at 15 n.7 ("Given the enactment of Pub. L. No. 119-21 §§ 71301–71305, Plaintiffs no longer seek a Section 705 stay with respect to the revocation of the low-income special enrollment period."). Plaintiffs separate their challenges into three categories: challenges to provisions that erode the value of coverage, challenges to provisions that impose barriers on enrollment, and challenges to provisions that limit the availability of subsidized coverage. ECF 11-1, at 2.

Plaintiffs' first three challenges under the "erosion of the value coverage" section seek relief from a provision imposing a monthly surcharge of $5 on enrollees to reconfirm eligibility,

[8] As previously described, the Court need not reach the question of standing for DFA at this time.

a provision revising the premium adjustment methodology, and a provision revising the actuarial value policy. *See generally* ECF 11-1. Plaintiffs' next two challenges under the "barriers to enrollment" section seek relief from a provision requiring enrollees to pay past-due premiums before receiving new coverage and a provision adding verification requirements for SEP enrollments. *Id.* Plaintiffs' final three challenges under the "limiting the availability of subsidized coverage" section seek relief from a provision re-instituting a policy regarding failure-to-reconcile tax data and two provisions requiring heightened income verification when a person's projected annual income does not match IRS data or when tax data is unavailable. *Id.* The Court will address each challenge in turn.

1. Likelihood of Success on the Merits

*i. Eligibility Redetermination / Imposition of a "Junk Fee"*

As noted, a taxpayer is eligible for tax credits to cover the cost of premiums if he or she enrolls in coverage through the Exchange, falls within the specified income thresholds, and lacks an offer for other affordable health insurance. 26 U.S.C. § 36B(c)(1), (2). As Plaintiffs describe, "[t]he amount of the tax credit is determined by the taxpayer's income and the cost of a benchmark plan offered through the Exchange." ECF 11-1, at 20 (citing 26 U.S.C. § 36B(b)). Additionally, "[e]ligibility for, and the amount of, APTCs turn on the same statutory criteria." *Id.* (first citing 42 U.S.C. § 18081(a)(2), and then citing *id.* § 18082(a)(1)). The Rule provides that (1) if an enrollee does not submit an application for an updated APTC eligibility determination for plan year 2026 on or before the deadline to select Exchange coverage and (2) that enrollee's post-APTC premium will be zero dollars (*i.e.*, the enrollee's coverage will be fully subsidized), then (3) the Exchange "must decrease the amount of" the APTC "applied to the [enrollee's] policy such that the remaining monthly premium owed for the policy equals $5."

90 Fed. Reg. at 13,031. Plaintiffs colorfully describe this requirement to reduce the value of the APTC by at least $5.00 a month as a "junk fee." ECF 11-1, at 20.

To justify the fee, Defendants argue that "many consumers are unknowingly enrolled in [subsidized Exchange] plans or in multiple forms of coverage" because brokers allegedly improperly enroll consumers in fully subsidized plans to earn commission payments. ECF 28, at 32. According to Defendants, these "improper enrollments can persist due to enrollees being continuously reenrolled in fully subsidized Exchange plans from year to year without having to take any action." *Id.* Defendants maintain that "[t]he Rule [] addresses this enrollment issue by 'prompt[ing]' individuals enrolled in fully subsidized Exchange plans 'to update or confirm' their eligibility for such plans 'or else pay a $5 monthly premium' until they do so." *Id.* at 33 (first quoting 90 Fed. Reg. at 27,103; and then citing *id.* at 27,102).[9]

As the basis for the agency's authority, Defendants argue that the "ACA grants the HHS Secretary the authority to 'establish a program' for making [APTC] eligibility determinations and to 'establish procedures' for 'redetermin[ing] eligibility on a periodic basis in appropriate circumstances.'" ECF 28, at 34 (first quoting 42 U.S.C. § 18081(a)(1); and then quoting *id.* § 18081(f)(1)(B)). Plaintiffs acknowledge the agency's obligation to redetermine eligibility on a periodic basis in appropriate circumstances. ECF 11-1, at 20 (citations omitted). However, they argue that "CMS's authority under the statute is to determine *whether* the statutory criteria for APTC eligibility are met, not to *alter* those criteria." *Id.* (emphasis added) (citing *Neumann v. Prudential Ins. Co. of Am.*, 367 F. Supp. 2d 969, 975 (E.D. Va. 2005)). Plaintiffs contend that "[n]othing in section 18081 or the remainder of the Act grants CMS the power to change the

[9] The Rule states that "the full amount of" an enrollee's APTC will be "reinstate[d]" once the enrollee submits an application "confirm[ing] [their] eligibility for APTC that covers the entire monthly premium." 90 Fed. Reg. at 27,102.

statutory calculation" to reduce APTCs by $5 per month for applicants who automatically re-enroll in a plan that would otherwise be fully subsidized. *Id.*

Relying on 42 U.S.C. § 18081(a)(2), Defendants counter that the "ACA tasks HHS with 'determining' whether individuals enrolled in Exchange plans 'meet[] the income and coverage requirements' for claiming PTCs, and with determining 'the amount' of those tax credits." ECF 28, at 34 (quoting 42 U.S.C. § 18081(a)(2)).[10] Defendants further argue that it is "likewise HHS's responsibility to determine an Exchange enrollee's eligibility for APTCs and to calculate the amount of those APTCs (which mirror the applicable PTC amount)." *Id.* (first citing 42 U.S.C. § 18082(a)(1), (3); and then citing 45 C.F.R. § 155.305(f)(5)). Importantly, however, 26 U.S.C. § 36B provides a formula for calculation of tax credits, which is determined by income and the cost of a benchmark plan offered through the Exchange. That statutory provision states:

> 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 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.

[10] Under 42 U.S.C. § 18081(a)(2), the Secretary "shall establish a program meeting the requirements of this section for determining . . . in the case of an individual claiming a premium tax credit or reduced cost-sharing under section 36B of title 26 or section 18071 of this title—(A) whether the individual meets the income and coverage requirements of such sections; and (B) the amount of the tax credit or reduced cost-sharing."

26 U.S.C. § 36B. The agency cannot utilize its general rulemaking authority to override explicit statutory provisions. *See Air All. Hous. v. EPA*, 906 F.3d 1049, 1061 (D.C. Cir. 2018) ("[I]t is well established that an agency may not circumvent specific statutory limits on its actions by relying on separate, general rulemaking authority."). As such, CMS lacks authority to tinker with the premium cost structure outlined in 26 U.S.C. § 36B.

Relatedly, CMS does not have the authority to change the statutory formula for APTCs under 42 U.S.C. § 18081(f)(1)(B). That section provides that the Secretary of HHS "shall establish procedures by which the Secretary or one of such other Federal officers—redetermines eligibility on a periodic basis in appropriate circumstances." 42 U.S.C. § 18081(f)(1)(B). The Court finds that the relatively limited grant of authority to "redetermine[] eligibility" for APTCs under "appropriate circumstances" does not encompass broad power to adjust the amount of APTCs, which are set according to a statutory formula. *Id.* According to Defendants, "the provision's very purpose is to facilitate HHS's ability to *redetermine* enrollees' *eligibility* to remain enrolled in fully subsidized Exchange plans, and the 'procedure[]' HHS opted for in the Rule is the assessment of a nominal premium that is designed to prompt certain enrollees to affirmatively reconfirm their eligibility." ECF 28, at 34 (emphasis in original) (quoting 42 U.S.C. § 18081(f)(1)(B)). But "an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate." *Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 328 (2014). Merely stating that the purpose of the provision comports with the agency's general rulemaking authority to "redetermine eligibility" does nothing to address Plaintiffs' argument that Defendants were not free to choose a procedure that "change[d] the statutory calculation in this way." ECF 11-1, at 20. Defendants' interpretation of its authority stretches the "redetermine eligibility" language beyond its plausible meaning and scope. *See Util. Air Regul. Grp.*, 573

U.S. at 328 ("Agencies are not free to "adopt . . . unreasonable interpretations of statutory provisions and then edit other statutory provisions to mitigate the unreasonableness." (quotation marks and citation omitted)). In short, the authority to verify eligibility does not infuse the agency with authority to re-write Congress's unambiguous statutory formulas. Indeed, even Defendants, in a separate section of their brief, explicitly acknowledge that tax credits are based on a statutory formula:

> Eligibility to claim such a premium tax credit [] is governed by the Internal Revenue Code [], which provides that an 'applicable taxpayer' whose annual household income is below a certain level can claim on his federal return a PTC amount that turns on (1) the percentage of annual household income that the individual is required to contribute to monthly health insurance premiums (as prescribed by statute) and (2) the monthly premium cost of a "benchmark" silver plan on the relevant Exchange.[11]

ECF 28, at 24 (citing 26 U.S.C. § 36B(b)(2)–(3)).[12]

The Court finds that HHS lacks the authority to impose a fee on plans that would otherwise be fully subsidized through APTCs via the formula prescribed by Congress. There are explicit formulas in the statutes for calculating APTCs, and Defendants do not have authority to re-write those formulas by reading broad authority into the limited statutory directive allowing HHS to "redetermine[] eligibility" for enrollment under "appropriate circumstances." 42 U.S.C. § 18081(f)(1)(B). Additionally, the Court agrees that the "Treasury's obligation is to pay the

[11] Defendants further acknowledge that "[a]n individual's eligibility for these APTCs is tied to his or her eligibility for PTCs[.]" ECF 28, at 25 (citing 42 U.S.C. § 18082(c)).

[12] Though certainly not conceding the point, Defendants at least acknowledged at the hearing that there exists an incongruity between the imposition of the $5.00 charge and the statutory framework for setting APTCs. *See* ECF 34, at 72:9–15 ("And I think, Your Honor, if I were to concede of the three contrary to law claims here, this one [the "junk fee"], I think, is a little bit less clear-cut for us in that [the question] does amount to, is this Agency's authority to re-determine eligibility, does that encapsulate its ability to -- or its obligation, also, to determine eligibility for a set amount of an advanced premium tax credit?").

amount that would be owed under the section 36B formula, not a different amount arbitrarily selected by CMS." ECF 11-1, at 21.

In short, Plaintiffs are likely to succeed in showing that the "junk fee" provision is contrary to law because applicants cannot be compelled to pay a fee that is untethered to the statutory formula.[13]

*ii. Revised Premium Adjustment Percentage Methodology*

The ACA directs the HHS Secretary to determine an annual "premium adjustment percentage" based on "the average per capita premium for health insurance coverage in the United States for the preceding calendar year." 42 U.S.C. § 18022(c)(4). This measure of premium growth is then used to set the rate of increase for a number of parameters defined in the ACA, such as the maximum annual limitation on cost sharing under Exchange plans, *see* 45 C.F.R. 156.130(a). Because the IRS traditionally adopts the same premium growth indexing methodology as HHS, the methodology used to calculate the premium adjustment percentage also affects how PTC and APTC amounts are calculated and, by extension, the cost of health care coverage on Exchanges.[14] *See* 90 Fed. Reg. at 27,171. HHS presently only considers premiums for *employer*-sponsored coverage in the premium adjustment percentage calculation, not insurance purchased by *individuals* on the marketplace. The Rule, however, incorporates

[13] Because the Court finds that Plaintiffs are likely to succeed on their argument that this provision of the Rule is contrary to law, the Court need not reach Plaintiffs' alternative argument that adopting the provision was arbitrary and capricious.

[14] In the reply brief, Plaintiffs confirmed: "[a]s expected, after we filed our opening brief, the IRS followed its ordinary practice of deferring to CMS's calculation, thereby confirming that tax credits will be lower for Exchange enrollees across the board." ECF 30, at 12 (first citing Rev. Proc. 2025-25, https://perma.cc/SZ5A-LDBG; and then citing Gideon Lukens and Elizabeth Zhang, Centers for Budget & Policy Priorities, *Administration's ACA Marketplace Rule Will Raise Health Care Costs for Millions of Families* (Aug. 1, 2025), https://perma.cc/VZ43-SNJY).

individual insurance market data into this measure. *Id.* at 27,169. Section 1302(c)(4) of the ACA and § 156.130(e) provide that the premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013. *Id.* at 27,166. In response to the proposed rule, commenters expressed concern that "individual market premiums should not be used to measure premium growth since 2013 because premiums in the early years of ACA were volatile[.]" *Id.* at 27,173.

Plaintiffs contend that "[a]s a result" of the Rule's incorporation of individual plan prices into the premium growth indexing methodology, "the maximum out-of-pocket limit in 2026 will be about $450 higher for an individual and $900 higher for a family than it otherwise would have been." ECF 11-1, at 24 (citing 90 Fed. Reg. at 27,206). According to Plaintiffs, "[t]his will lead to increased premiums across the board and 80,000 fewer enrollments in the Exchanges under CMS's own estimates, running the risk of a spiral of a worsening risk pool and increased premiums, as well as higher volumes of uninsured patients being seen by health centers." *Id.* (internal quotation marks and citations omitted). Plaintiffs argue that "CMS acknowledged that its choice ran contrary to the Act's goals, but it brushed this concern aside, reasoning that it didn't need to take these issues into account when it exercised its discretion under section 18022(c)(4) to adopt an 'appropriate' methodology." ECF 11-1, at 25 (first citing 90 Fed. Reg. at 27,172, then citing 90 Fed. Reg. 12,942, 12,990 (Mar. 19, 2025)). Plaintiffs conclude that "CMS was not free to disregard the costs it was imposing on Exchange enrollees." *Id.*

Defendants do not dispute that the new Rule will affect the cost of Exchange plans. *See* ECF 28, at 50 ("HHS acknowledges that the new methodology will increase the maximum annual limitation on cost sharing and net premiums for enrollees with incomes under 400 percent

of the FPL, which could in turn negatively impact the cost of Exchange coverage and enrollment." (citing 90 Fed. Reg. at 27,171, 27,206–07)). However, Defendants maintain that "any such impact would be a consequence of *Congress's* decision to tie the value of certain forms of financial assistance under the ACA to the premium adjustment percentage." ECF 28, at 50 (emphasis in original). Defendants also argue that "HHS [] concluded—and reasonably so—that a premium adjustment percentage methodology that considers 'all private health insurance premiums' is 'more consistent with' that congressional intent and the ACA's text." ECF 28, at 50 (quoting 90 Fed. Reg. at 27,172). In the Rule, CMS explained that "[b]ecause the role of the premium adjustment percentage is to appropriately index various parameters defined in the ACA, the primary consideration for setting the value of the premium adjustment percentage should be whether it accurately and comprehensively captures the rate of premium growth in the United States rather than the impact of the indexing methodology on net premiums, enrollment, access to health care, health outcomes, or out-of-pocket costs for those who receive non-covered or out-of-network care." 90 Fed. Reg. at 27,172. According to the agency, "[c]onsidering these other impacts when setting the premium adjustment percentage may result in a measure of premium growth that does not accurately reflect actual premium growth in the United States, artificially inflating the generosity of provisions of the ACA beyond the intent of Congress." *Id.*

That the agency changed its view on how to set the premium adjustment percentage does not mean its position was not substantially justified. "Agencies are free to change their existing policies as long as they provide a reasoned explanation for the change." *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 221 (2016). "In such cases it is not that further justification is demanded by the mere fact of policy change; but that a reasoned explanation is needed for

disregarding facts and circumstances that underlay or were engendered by the prior policy." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515–16 (2009). "We defer to the agency's new position no less than the old, so long as we are satisfied that the agency's change in position was intentional and considered." *Philip Morris USA, Inc. v. Vilsack*, 736 F.3d 284, 290 (4th Cir. 2013).

Here, the agency's change in position was not arbitrary and capricious because it provided the necessary reasoned explanation for the change. In the Rule, HHS clarified that premiums from the individual market were previously excluded because they were "most affected by the significant changes in benefit design and market composition in the early years of implementation of the ACA market rules and were most likely to be subject to risk premium pricing," and later, in 2022, the agency "anticipated that these premiums would be more volatile in response to the COVID-19 PHE than employer-sponsored premiums." 90 Fed. Reg. at 27,173. However, the agency reasoned that "the ACA is now past the initial years of implementation and issuers have had the opportunity to collect data on the risk composition of the individual market and adjust pricing accordingly . . . [a]dditionally . . . premiums in the employer-sponsored market increased more rapidly than premiums in the individual market during the COVID-19 PHE, the impact of which has led to a decreasing gap in premium growth between the individual market and employer-sponsored market." *Id.* In light of those findings, the agency determined that "a comprehensive measure incorporating both individual market and employer-sponsored premiums will more accurately reflect true premium growth going forward." *Id.*

While Plaintiffs argue that the agency "entirely failed to engage with the point raised by commenters that the new methodology was *less* accurate, since it incorporated data from individual insurance premiums in 2013 that wouldn't provide an apples-to-apples measure of

growth in health care costs, but that would inevitably inflate the premium adjustment percentage," ECF 30, at 13, the Rule reflects that the agency explicitly responded to this concern by commenters:

> We acknowledge that the premium adjustment percentage is a cumulative measure and, as such, the market fluctuations in the early years of ACA implementation are included in the calculation when using private health insurance premiums (excluding Medigap and property and casualty insurance) as the data source for indexing. However, because it is a cumulative measure, the impact of these early years decreases as more time elapses between the applicable plan year and the benchmark year (2013). For example, for PY 2018, PY 2014 was 1 of 4 years of growth included in the premium adjustment percentage measure and therefore the weight of PY 2014 premium growth was approximately one quarter of the overall measure. For PY 2026, PY 2014 is 1 of 12 years of growth included in the measure. Therefore, for PY 2026, the weight of PY 2014 is only one twelfth of the overall measure. As such, the greater time between the benchmark year and the applicable plan year reduces the impacts of any individual year, even if the premium growth in that year is unusual.

90 Fed. Reg. at 27,173. HHS both explained the reasoning behind the policy change and addressed commenters' concerns that the new methodology would lead to less accurate measures of premium growth. While this policy change will undoubtedly have effects on the broader insurance market, including, as HHS concedes, an increase in premiums and a worsening risk pool, the Court is constrained to conclude that HHS did not act without explanation or rationale in making this decision. In fact, the agency took these negative effects into account when responding to comments in the final Rule, but ultimately concluded that the new methodology was more closely aligned with Congressional intent and the text of the ACA, and therefore should nonetheless be adopted. *See id.* at 27,172 (acknowledging commenters' concern that healthy enrollees "may be less likely to enroll due to the higher net premiums that result from the change in the premium adjustment methodology" but ultimately finding "consideration of the impact of this proposal on the risk pool to be outside the scope of the indexing provisions of

the ACA because the purpose of the premium adjustment percentage is to accurately index program parameters against the growth in premiums, not to control the growth of those premiums"). Accordingly, the Court is satisfied that "such a change in course was made as a genuine exercise of the agency's judgment." *Philip Morris*, 736 F.3d at 290; *see also City of Columbus*, 523 F. Supp. 3d at 758 ("The court may not supplant the agency's view that the new policy is better than the old one simply because Plaintiffs prefer the old policy.").[15] Consequently, Plaintiffs have not shown likelihood of success on the merits on their claim that the provision was arbitrary and capricious.

*iii. Actuarial Value Policy*

Under the ACA, health insurance plans offered on Exchanges must cover certain "essential health benefits" and adhere to certain "level[s] of coverage" specified in the statute. 42 U.S.C. § 18022(a). A plan's "level of coverage," or actuarial value, reflects the estimated average percentage of covered health care expenses that will be paid by the insurance plan. For example, under a plan with an actuarial value of 80%, the insurer will pay, on average, 80% of covered medical expenses, and the enrollee will pay the remaining 20% of expenses through a combination of deductibles, coinsurance, co-payments, and maximum out-of-pocket limits. Consequently, the higher a plan's actuarial value, the lower an enrollee's out-of-pocket costs, on average. Plans that have a higher actuarial value also have higher premiums.

[15] In light of the Court's finding on this point, the Court is unconvinced that Plaintiffs' argument that the agency had an "unalterably closed mind" during rulemaking could provide an independent basis for relief on this claim. ECF 11-1, at 25. The examples put forth by Plaintiffs, *see id.*, are insufficient to show that Defendants were "unwilling or unable to rationally consider arguments." *Mississippi Comm'n on Env't Quality v. EPA*, 790 F.3d 138, 183 (D.C. Cir. 2015) (quotation marks and citations omitted).

The statute instructs the Secretary to "develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates." 42 U.S.C. § 18022(d)(3). As relevant here, current regulations provide that the "allowable variation" in the actuarial value of silver, gold, and platinum plans is two percentage points above and below their respective benchmark actuarial values (*i.e.*, +2/-2 percentage points). 45 C.F.R. § 156.140(c)(2). The Rule will change this range to +2/-4 percentage points. *See* 90 Fed. Reg. at 27,174. And for bronze plans, current regulations allow for a +5/-2 percentage point range, which the Rule will change to +5/-4 percentage points. *Id.*

Plaintiffs explain that "[t]he formula for PTCs turns on the cost of the second-lowest-cost silver plans available on the Exchange." ECF 11-1, at 26 (citing 26 U.S.C. § 36B(b)(2)(B)). Thus, "[b]y permitting insurers to sell cheaper, but less comprehensive, silver plans, CMS will therefore decrease the value of the tax credits for all enrollees, leading to a reduction in PTCs by $1.22 billion overall for 2026 alone, by CMS's own calculation." *Id.* (citing 90 Fed. Reg. at 27,208). Plaintiffs argue that "[t]he rule does not even attempt to justify the new policy as an effort to account for differences in actuarial estimates." *Id.* at 27 (citation omitted). Defendants counter that "CMS [] made the reasoned judgment that such 'short-term' concerns about how wider ranges would affect subsidized enrollees should not necessarily take priority over the longer-term prospect of plans with lower premiums and competitive cost-sharing structures drawing unsubsidized consumers to Exchanges, 'potentially improv[ing] the risk pool as coverage becomes more affordable for generally healthy people who currently may opt to forgo coverage altogether.'" ECF 28, at 54 (quoting 90 Fed. Reg. at 27,175).

Generally, "an agency decision is arbitrary and capricious if 'the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.'" *Sierra Club*, 899 F.3d at 293 (quoting *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 43). Defendants posit that "HHS [] made the reasonable observation that consumers considering different plan options typically care less about marginal differences in the actuarial values of plans than they do about more 'meaningful differences' that they can 'understand and appreciate,' such as whether a high-deductible plan with no coinsurance is a better value than a plan with a lower deductible but more co-payments." ECF 28, at 53 (quoting 90 Fed. Reg. at 27,177). That may well be true, but the agency is nonetheless constrained to rely only "on factors which Congress has [] intended it to consider" when exercising its authority under the statute. *Sierra Club*, 899 F.3d at 293. Here, as Plaintiffs point out, "[t]he purpose of the standard is set forth in section 18022(d)(3) itself [and] the only permissible 'de minimis' variations are those that account for uncertainties in 'differences in actuarial estimates,' not variations to reflect a new Administration's policy preference for less generous subsidies." ECF 11-1, at 27.

Moreover, the agency was obligated to establish a "rational connection between the facts found and the choice made." *Motor Vehicle Mfrs. Ass'n*, 463 U.S. at 43. The agency stated that it believes that "lower AVs would lead to lower premiums, and in turn potentially improve the risk pool as coverage becomes more affordable for generally healthy people who currently may opt to forgo coverage altogether." 90 Fed. Reg. at 27,175. The agency then acknowledged that "although this may mean that those eligible for APTCs receive less money in tax credits, we believe that in the long term there would be a sufficient choice of affordable plans." *Id.*

Similarly, in response to commenters' concerns that the provision would "lead to increased out-of-pocket consumer costs as plan cost-sharing generosity decreases and higher overall premiums for some consumers given a potential impact on the generosity of the SLCSP, the benchmark plan used to determine an individual's PTC," *id.* at 27,176, the agency merely stated that the "change is essential to restoring greater balance between access and affordability in the long term," and "the overall benefits to the risk pool as a result of this change will better incentivize unsubsidized enrollees to enroll in coverage, which we expect to lower overall costs and further drive down premiums as the risk pool improves," *id.* at 27,176–77.

This reasoning is conclusory and unsupported by evidence. Defendants cannot merely label something a "short-term" trade-off to avoid engaging with data and justifying the change during the rulemaking process. There is no data to back up the claim and reasoning that coverage would become "more affordable" over time when *even CMS itself* estimates that the policy widening the de minims range will reduce aggregate PTCs by $1.2 billion in 2026. *See* 90 Fed. Reg. at 27,208. And, as Plaintiffs note, data shows that "[a] typical family of four would see their subsidies decrease, and their cost of coverage rise, by up to $714 for the year." ECF 11-1, at 26 (citing Ctr. for Budget & Policy Priorities comment at 34–35 (Apr. 11, 2025), https://perma.cc/KP9W-J63N). Plaintiffs argue, and the Court agrees, that the "relationship between subsidies and the strength of the risk pool is well established by empirical research, but CMS simply stated that it 'expect[ed]' its rule to have the opposite effect, without citing any evidence to support this subjective belief or engaging with the record." *Id.* (quoting 90 Fed. Reg. at 27,107). Such "[n]odding to concerns raised by commenters only to dismiss them in a conclusory manner is not a hallmark of reasoned decisionmaking." *Gresham v. Azar*, 950 F.3d 93, 103 (D.C. Cir. 2020). Thus, the Court finds that Defendants provided an insufficient and

conclusory rationale for altering the de minimis variation, and Plaintiffs are likely to succeed on their claim that the agency acted in an arbitrary and capricious manner.

*iv. Revocation of Guaranteed-Issue / Past Due Premium*

The next challenged provision will allow issuers to require a customer to pay (1) any past-due premiums the customer owes the issuer (or related issuers) for prior coverage *and* (2) the initial premium amount (also known as a "binder payment") required for new coverage before the latter coverage is effectuated. *See* 90 Fed. Reg. at 27,084, 27,220. If the customer fails to pay that combined amount in full, the issuer can decline to effectuate the new coverage. *Id.* at 27,084.

Defendants argue that "an issuer's provision of coverage is of course contingent on the enrollee's payment of premiums." ECF 28, at 22 (citing 42 U.S.C. § 300gg-2(b)(1) (providing that an issuer may "nonrenew or discontinue health insurance coverage" if an enrollee "has failed to pay premiums")). Defendants also cite 45 C.F.R. § 155.400(e) in support of their argument, which provides that federally facilitated Exchanges and State-based Exchanges on the federal platform "will[] require payment of a binder payment" equivalent to "the first month's premium" to "effectuate an enrollment" in an Exchange plan. *Id.* According to Defendants, "[t]he Rule simply allows an issuer who is owed past-due premiums from a particular customer to lawfully credit any payments made by that customer for new coverage to the past-due balance before crediting any payments to the initial premium amount for the new coverage." *Id.* In doing so, "if, as a result of such a lawful allocation policy, the consumer still has an outstanding balance on the initial premium amount, then the issuer can decline to effectuate the new policy for failure to pay the requisite initial premium." *Id.* (citations omitted). Plaintiffs maintain that "[t]he

agency was not free to rewrite the text to carve out a new exception to the statute's categorical [guaranteed-issue] rule." ECF 11-1, at 28 (citation omitted).

The ACA's guaranteed-issue requirement provides that "each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept *every* employer and individual in the State that applies for such coverage," subject only to specified exceptions. 42 U.S.C. § 300gg-1(a) (emphasis added). Defendants invoke separate statutory provisions that relate to renewability and termination of coverage, rather than issuance, to justify the new past-due premium policy. *See* 42 U.S.C. § 300gg-2(b)(1).

The Court finds no authority in the text of the statute for the agency's decision to "credit any payments made by that customer for new coverage to the past-due balance before crediting any payments to the initial premium amount for the new coverage." ECF 28, at 22. As Plaintiffs point out, "[a]n exception for past-due premiums is not one of the Act's enumerated exceptions to the guaranteed-issue requirement, as CMS itself has long understood." ECF 11-1, at 28 (citing 77 Fed. Reg. 70,584, 70,599 (Nov. 26, 2012)). Plaintiffs clarify that "[t]here is such an exception for past-due premiums in the Act's parallel provision that guarantees the *renewability* of policies. But, [] that exception is absent from the guaranteed-issue provision." ECF 11-1, at 28 (emphasis added) (citing 42 U.S.C. § 300gg-2(b)(1)). This demonstrates "Congress's understanding that an outstanding debt could prevent an enrollee from maintaining the policy he or she currently has, but that the debt wouldn't lock the enrollee out of the market altogether." *Id.* at 29 (citation omitted). Had Congress wanted to condition issuance of a new policy on payment of past premiums, it clearly knew how to do so expressly. *See* 42 U.S.C. § 300gg-2(b)(1) (providing that an issuer may "nonrenew or discontinue health insurance coverage" if an enrollee "has failed to pay premiums"). In the absence of an enumerated exception to the guaranteed-issue

requirement, the agency "has no power to tailor legislation to bureaucratic policy goals by rewriting unambiguous statutory terms." *Util. Air Regul. Grp.*, 573 U.S. at 325 (internal quotation marks omitted); *see also TRW, Inc. v. Andrews*, 534 U.S. 19, 28 (2001) ("Where Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied, in the absence of evidence of a contrary legislative intent" (cleaned up)); *Polselli v. IRS*, 598 U.S. 432, 439 (2023) ("We assume that Congress acts intentionally and purposely when it includes particular language in one section of a statute but omits it in another section of the same Act." (internal quotation marks and citations omitted)).

Defendants put forth various concerns and objections to the current regulation, including the alleged "perverse incentives" it creates. ECF 28, at 21. According to Defendants, the Rule's past-due premium policy will "help to promote continuous coverage, reduce gaming and adverse selection, ensure that ACA subsidies are targeted to those who are eligible, and allow issuers to more accurately predict costs and prices." *Id.* (citing 90 Fed. Reg. at 27,084). Regardless of the merits of those arguments, they are best directed to Congress, as it is only Congress who can add enumerated exceptions to the guaranteed-issue requirement. *See Brown & Williamson Tobacco Corp. v. Food & Drug Admin.*, 153 F.3d 155, 161 (4th Cir. 1998), *aff'd*, 529 U.S. 120 (2000) ("[N]either federal agencies nor the courts can substitute their policy judgments for those of Congress."). The Court is bound by the plain text of the statute in its current form, which contains a guaranteed-issue requirement, subject only to specific, enumerated exceptions. The exceptions do not include a provision permitting insurers to deny issuance of coverage based on

failure to pay a past-due premium. Accordingly, Plaintiffs are likely to succeed in challenging the provision as contrary to law.[16]

*v. SEP Eligibility Verification Requirements*

The ACA requires Exchanges to provide for SEPs during which qualifying individuals may enroll for coverage in between the annual open enrollment periods. 42 U.S.C. § 18031(c)(6)(C). Under current regulations, federally facilitated Exchanges are required to conduct pre-enrollment eligibility verification only for applicants seeking to enroll in an Exchange plan under the loss-of-minimum-essential-coverage SEP; they are not permitted to conduct such pre-enrollment eligibility verification in conjunction with any other category of SEP. *See* 45 C.F.R. § 155.420(g). Under the Rule, federally facilitated Exchanges will instead be required to conduct pre-enrollment eligibility verification for other categories of SEPs as well (*e.g.*, permanent move, marriage, etc.), which is consistent with the eligibility verification policy that was in place between 2017 and 2022. *See* 90 Fed. Reg. at 27,148–49. The Rule further requires those federal Exchanges to conduct pre-enrollment eligibility verification "for at least 75 percent of new enrollments through SEPs." *Id.* at 27,148, 27,223. The Rule is time-limited and will sunset at the end of 2026, and the eligibility verification requirements do not apply to State Exchanges.[17] *Id.* at 27,151.

[16] Because the Court finds that Plaintiffs are likely to succeed on their argument that this provision of the Rule is contrary to law, the Court need not reach Plaintiffs' alternative argument that the agency's adoption of this provision was arbitrary and capricious.

[17] States are given the "option" to conduct pre-enrollment eligibility verification for SEP enrollment, but they are not required to do so, a policy unchanged by the Rule. *See* 90 Fed. Reg. at 27,151 ("[T]he program integrity issues are largely concentrated in Exchanges utilizing the Federal platform.").

Plaintiffs maintain that "[t]his rule will generate 293,000 verification issues to resolve in the coming year, resulting in a further barrier to coverage, through additional paperwork and administrative burdens, and costing consumers more than $7 million in 2026." ECF 11-1, at 33 (citing 90 Fed. Reg. at 27,186). According to Plaintiffs, "[y]ounger and healthier people are more likely to drop coverage as a result, leading to a worsening of the risk pool, as CMS itself realized the last time it considered (and rejected) a similar policy." *Id.* (citations omitted). Plaintiffs argue that Defendants failed to provide "an adequate explanation for why the agency acted at all," and there was a "fundamental mismatch between the agency's policy and the problem it claimed it was trying to solve." *Id.* at 34. Specifically, "CMS attempted to justify this policy as a response to the problem of improper enrollments by brokers," but according to Plaintiffs, "the agency fundamentally misconceived the scope of that problem and ignored the success of recent efforts to address broker misconduct." *Id.* (citing 90 Fed. Reg. at 27,150).

Defendants respond that "because of their limited scope, the regulations 'do not provide enough protection against misuse and abuse' of SEPs, which enables otherwise ineligible individuals to enroll in Exchange plans 'only after they become sick or . . . need expensive health care services,' which in turn 'negatively impacts both the risk pool and program integrity around determining eligibility for' APTCs and other subsidies." ECF 28, at 47 (quoting 90 Fed. Reg. at 27,148). According to the Rule, requiring pre-enrollment eligibility verification for all SEP categories "improves the risk pool by restricting people from gaming SEPs to wait to enroll until they need health care services."[18] 90 Fed. Reg. at 27,150. Additionally, CMS reasons that "pre-

[18] The agency suggested that pre-enrollment verification requirements that previously applied to SEPs did not create substantial barriers to Exchange enrollment, and that such requirements had the effect of "encourag[ing] continuous enrollment by making it more difficult to engage in strategic enrollment and disenrollment" based on customers' changing health status. 90 Fed. Reg. at 27,149.

enrollment verification for SEPs strengthens program integrity by denying ineligible enrollments and discouraging ineligible enrollees who know they cannot meet verification standards from attempting to enroll which, in turn, reduces Federal subsidies to ineligible consumers who would otherwise enroll and receive APTC and CSR subsidies." *Id.*

While an agency "is not required to choose the best solution, only a reasonable one," *Petal Gas Storage, LLC v. FERC*, 496 F.3d 695, 703 (D.C. Cir. 2007), it is required to "provide[] an explanation of its decision that includes a rational connection between the facts found and the choice made," *Nat'l Audubon Soc'y v. U.S. Army Corps of Eng'rs*, 991 F.3d 577, 583 (4th Cir. 2021). Importantly, courts are not free to "ignore the disconnect between the decision made and the explanation given." *Dep't of Com.*, 588 U.S. at 785. "The reasoned explanation requirement of administrative law, after all, is meant to ensure that agencies offer genuine justifications for important decisions, reasons that can be scrutinized by courts and the interested public." *Id.*

Here, the Court finds that the agency's chosen solution is unmoored from the problem it seeks to address. The provision purports to address "urgent program integrity concerns," 90 Fed. Reg. at 27,151, and alleged "gaming" of SEPs through enrollees waiting until they are sick to enroll in coverage, *id.* at 27,150, in an effort to "discourag[e] ineligible enrollees who know they cannot meet verification standards from attempting to enroll," *id.* But the agency offers no current data, reports, or evidence establishing that the "misuse and abuse" of SEPs, 90 Fed Reg. at 27,148, stems from SEP enrollment *in particular*. In the Rule, the agency cites to a "GAO undercover testing study of SEPs" from 2016, which found that "9 of 12 of GAO's fictitious applicants were approved for coverage on the Federal and selected State Exchanges." *Id.* But as noted, that study was from 2016, and the parties have not identified, nor can the Court locate, any evidence in the Rule to corroborate Defendants' conclusory assertion that abuse of SEPs is

*currently* contributing to the "program integrity concerns" the agency seeks to address through this provision. Accordingly, it remains merely a theory that the "temporary policy will help stabilize the marketplace in [Plan Year] 2026 as the subsidy environment normalizes and the high levels of improper enrollments are reduced before reverting back in PY 2027." 90 Fed. Reg. at 27,152. Further, the agency's conclusion that "the additional burden [on enrollees] is not significant enough to outweigh the merits of SEP verification and the increases in program integrity that it provides," *id.* at 27,151, is insufficient to address the very real concern raised by numerous commenters that the Rule change will improperly hinder the enrollment of eligible individuals.[19] Defendants similarly fail to articulate how an audit of 75% of new enrollments will curb the alleged problem.

After reviewing the record, the Court finds that Plaintiffs' disagreement with CMS is more than a mere policy debate on the merits of the provision, as Plaintiffs have established that Defendants' rationale was not indicative of reasoned decision-making. In short, the hypothesis that such "gaming" and "abuse" of subsidized coverage stems from enrollees and brokers fabricating events triggering SEPs is without support. *See Dep't of Com.*, 588 U.S. at 783 (remanding rule to agency where the record "reveal[ed] a significant mismatch between the decision the Secretary made and the rationale he provided"). The Court agrees with Plaintiffs' principal argument that "CMS offered no good reason to impose this burden on enrollees." ECF 30, at 18. As such, the Court finds that Plaintiffs have shown a likelihood of success on the

[19] Indeed, one commenter noted that "a study published by the American Economic Association found that adding one single additional step to the enrollment process prompted a 33 percent decline in enrollment, predominantly among young, healthy, and economically disadvantaged people." *See* Ctr. for Budget & Policy Priorities comment at 29 (Apr. 11, 2025), https://perma.cc/KP9W-J63N (citing Mark Shepard & Myles Wagner, *Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment*, 115 Am. Econ. Rev. 772 (2025), doi: 10.1257/aer.20231133).

merits on their claim that instituting SEP pre-enrollment verification procedures was arbitrary and capricious.

*vi. Failure-to-Reconcile Provision*

This provision reinstates a prior Failure to File and Reconcile ("FTR") policy that requires an Exchange to determine that a "tax filer" is ineligible for APTCs under the ACA if the applicant (1) received APTCs the prior year and (2) failed to comply with the statutory requirement to file a tax return and "reconcile APTC" for that year. *See* 90 Fed. Reg. at 27,113, at 27,221. This provision, which will apply only through the end of 2026, *see id.* at 27,115, amends the current requirement that such a determination be made only after a tax filer fails to reconcile for two consecutive tax years. *See* 45 C.F.R. § 155.305(f)(4).

The IRS requires taxpayers who receive APTCs—which are typically scaled to the recipient's projected annual household income—to reconcile those advanced payments with the PTC amount they otherwise qualify for in the applicable tax year, as determined by their actual annual household income in that year. *See* 26 U.S.C. § 36B(f). If the APTCs the taxpayer received exceed that allowable PTC amount, then the taxpayer may incur a tax liability, subject to certain income-based caps. *Id.* § 36B(f)(2). Since 2012, HHS has prohibited an Exchange from "determin[ing] a tax filer eligible for" APTCs if the filer (1) received APTCs the prior year and (2) failed to comply with the requirement to file a federal income tax return and reconcile those APTCs for that year. 45 C.F.R. § 155.305(f)(4). Taxpayers who are determined ineligible for APTCs due to their failure to reconcile can still claim on their tax returns the full amount of the PTC they are otherwise eligible for; such taxpayers just would not be able to receive that PTC amount in advance. *Id.*

In 2023, CMS amended the failure-to-reconcile regulations such that a taxpayer becomes ineligible for APTCs only after failing to file a federal income tax return and reconcile their APTCs for *two* consecutive tax years. *See* 90 Fed. Reg. at 27,113. The current Rule provision reverts back to the requirement that a taxpayer be deemed ineligible for APTCs after one year of failing to reconcile, and that change applies only through plan year 2026. *Id.*

In their contrary to law claim, Plaintiffs challenge the agency's authority to "condition eligibility for a tax credit on the reconciliation of old tax debts." ECF 11-1, at 35. Plaintiffs posit that "while CMS may establish procedures to determine whether the statutory standards for APTC eligibility are met, it may not use that procedural authority to change the substantive standards for eligibility." ECF 30, at 20 (first citing 42 U.S.C. § 18081(a), (f); and then citing *N.Y. Stock Exch. LLC v. SEC*, 962 F.3d 541, 546 (D.C. Cir. 2020)). According to Plaintiffs, "[n]othing in the statute conditions eligibility for tax credits or APTC on reconciliation of debts shown on a prior year's tax return." *Id.*

Defendants rightly point out that "the regulation precluding a taxpayer from being eligible for APTCs because of a failure to reconcile, 45 C.F.R. § 155.305(f)(4), was promulgated back in 2012, and the Rule will not change that aspect of the regulation." ECF 28, at 27. According to Defendants, "because Plaintiffs' contrary-to-law claim against the Rule's failure-to-reconcile provision is effectively a challenge to a regulation that has been in force for over a decade, that claim is barred by the six-year statute of limitations applicable to suits against the United States." ECF 28, at 27 (citing 28 U.S.C. § 2401(a)). Plaintiffs respond that "commenters on this year's rule asked the agency to 'fully repeal' the failure-to-reconcile rule on the ground that even the older version of the rule was unlawful," and "CMS understood that these comments were within the scope of the rulemaking and engaged with them on the merits, invoking

(incorrectly) its Section 18041 rulemaking authority." ECF 30, at 20 (quoting 90 Fed. Reg. at 27,117). Plaintiffs continue that, even if the rule were time-barred, they "may nonetheless challenge the new rule, because an agency 'cannot take by adverse possession the authority to impose [a rule] in a way that shields the devaluation of statutory language from judicial review.'" *Id.* at 21 (quoting *City of Providence v. Barr*, 954 F.3d 23, 45 (1st Cir. 2020)).

Plaintiffs' first argument appears to invoke the "reopening doctrine," which "allows an otherwise stale challenge to proceed because the agency opened the issue up anew, and then reexamined and reaffirmed its prior decision." *Wash. All. of Tech. Workers v. U.S. Dep't of Homeland Sec.*, 892 F.3d 332, 346 (D.C. Cir. 2018) (internal quotation marks and citation omitted). Specifically, the "doctrine arises where an agency conducts a rulemaking or adopts a policy on an issue at one time, and then in a later rulemaking restates the policy or otherwise addresses the issue again without altering the original decision." *CTIA–Wireless Ass'n v. FCC*, 466 F.3d 105, 110 (D.C. Cir. 2006) (internal quotation and alterations omitted). "The doctrine only applies, however, where the entire context demonstrates that the agency has undertaken a serious, substantive reconsideration of the existing rule." *All. for Safe, Efficient & Competitive Truck Transp. v. Fed. Motor Carrier Safety Admin.*, 755 F.3d 946, 954 (D.C. Cir. 2014) (internal quotation marks and citation omitted). In 2017, another trial court in this Circuit noted that it "[could not] find [any] Supreme Court or Fourth Circuit precedent recognizing the reopening doctrine." *Indep. Cmty. Bankers of Am. v. Nat'l Credit Union Admin.*, No. 16-cv-1141, 2017 WL 346136, at *4 (E.D. Va. Jan. 24, 2017). This Court has similarly not been able to find, and the parties have not provided, any in-circuit case law addressing this doctrine. However, the reopening doctrine is well-established in the D.C. Circuit, which regularly hears APA claims. *See, e.g.*, *Growth Energy v. EPA*, 5 F.4th 1, 21 (D.C. Cir. 2021) ("When a later proceeding

explicitly or implicitly shows that the agency actually reconsidered the rule, the matter has been reopened and the time period for seeking judicial review begins anew." (internal quotation marks and citations omitted)). As such, despite the lack of in-circuit precedent, the Court cannot identify a reason the reopening doctrine would not apply.

Assuming the doctrine does apply, Plaintiffs have shown it likely cures the statute of limitations issue Defendants identify here. By explicitly re-evaluating and subsequently affirming its statutory authority to issue the failure-to-reconcile provision during the notice and comment rulemaking process, CMS reopened the issue of Congressional authorization for the provision. According to the Rule, "commenters stated that HHS should fully repeal [the failure-to-reconcile] processes because there is no statutory authority for it." 90 Fed. Reg. at 27,117. The agency responded to the comment by evaluating, and then confirming, the purported statutory authority for its action:

> We disagree with commenters that there is no statutory authority for Exchanges to conduct FTR. Consumers who receive APTC are required to file income taxes pursuant to section 6011(a) of the Code and regulations prescribed by the Secretary of Treasury. Section 36B(f) of the Code requires taxpayers to reconcile their APTC under section 1412 of the ACA with their PTC allowed under section 36B of the Code. FTR regulations, implemented pursuant to the Secretary of HHS' general rulemaking authority under section 1321(a) of the ACA, facilitate compliance with those requirements and were implemented as part of the original Exchange Establishment Rule.

*Id.* In the Court's view, this constitutes a "serious, substantive reconsideration of the existing rule." *All. for Safe, Efficient & Competitive Truck Transp.*, 755 F.3d at 954. Even though conditioning APTC eligibility on tax return reconciliation existed in the prior provision, and the Rule re-affirms it, "the [agency] opened its (previous) decisions up to legal challenge when [it] promulgated the Rule through notice and comment rulemaking." *Doe v. U.S. Dep't of Just.*, 650 F. Supp. 3d 957, 984 (C.D. Cal. 2023). The agency explicitly engaged with the statutory

authority for its action in response to targeted comments claiming the full provision must be repealed. Thus, the Court finds that Plaintiffs are likely to succeed in showing that CMS's re-evaluation and subsequent affirmance of its statutory authority to issue the provision during rulemaking falls within the reopening doctrine, thereby curing the statute of limitations issue.

As to the merits, the Court agrees with Plaintiffs that, "[t]he statute does not contemplate that the existence of a prior tax debt affects an applicant's eligibility for APTCs in any way. And if Congress intended to condition eligibility for a tax credit on the reconciliation of old tax debts, it knew how to do so." ECF 11-1, at 35 (first citing 26 U.S.C. §§ 24(*l*), 32(k); and then citing *Nat'l Elec. Mfrs. Ass'n v. Dep't of Energy*, 654 F.3d 496, 507 (4th Cir. 2011)). Once again, Defendants' invocation of its general rulemaking authority under 42 U.S.C. § 18041(a)(1) does not authorize it to flout separate, express provisions of the statute. ECF 28, at 28; *see NRDC v. Reilly*, 976 F.2d 36, 40 (D.C. Cir. 1992) (explaining that a "general grant of rulemaking power . . . [cannot] trump the specific provisions of the act"); *see also Air All. Hous.*, 906 F.3d at 1061 ("[I]t is well established that an agency may not circumvent specific statutory limits on its actions by relying on separate, general rulemaking authority."). CMS is not free to re-write the statutory formula to accomplish its policy goals, irrespective of the efficacy of such a policy. As the Court previously described in evaluating the provision addressing the $5 fee, even Defendants acknowledge that PTCs (and thus, by extension, APTCs) are prescribed by statutory formula. *See* ECF 28, at 24 (citing 26 U.S.C. § 36B(b)(2)-(3)). Thus, the agency's decision to condition APTC eligibility on reconciling tax information reads an exception into the statutory formula that is simply not there. Because the plain text of the statute contradicts the agency's

provision, Plaintiffs have shown they are likely to succeed on their claim that the failure-to-reconcile provision is contrary to law.[20]

*vii. Data-Matching Policies / Income Eligibility Verification*

(1) Recission of Automatic 60-Day Extension

When an Exchange attempts to verify an applicant's income for purposes of determining an applicant's eligibility for APTCs, and it finds an inconsistency in that applicant's data, it notifies the applicant and provides the applicant with an opportunity to respond. 42 U.S.C. § 18081(e)(4). The statute provides a default period of 90 days for that response. *Id.* §§ 18081(c)(4), (e)(1), (e)(4). The current regulations provide for an additional 60 days where necessary. 45 C.F.R. § 155.315(f)(7). The final Rule revokes that 60-day extension. 90 Fed. Reg. at 27,120. Plaintiffs argue that "CMS wrongly reasoned that it was compelled by the statute to impose a 90-day policy." ECF 11-1, at 37. Defendants respond that "[i]t is Plaintiffs' flawed reading of the ACA's plain text that is arbitrary, not the Rule." ECF 28, at 38.

The Supreme Court recently held that "[c]ourts must exercise their independent judgment in deciding whether an agency has acted within its statutory authority, as the APA requires." *Loper Bright*, 603 U.S. at 412. The Court explained that "[c]areful attention to the judgment of the Executive Branch may help inform that inquiry," however, "courts need not and under the APA may not defer to an agency interpretation of the law simply because a statute is ambiguous." *Id.* at 412–13. "If a statute is ambiguous, courts exercise their independent judgment to determine the single, best meaning, but do so with the agency's body of experience

[20] Because the Court finds that Plaintiffs are likely to succeed on their argument that this provision of the Rule is contrary to law, the Court need not reach Plaintiffs' alternative argument that the agency's adoption of this provision of the Rule was arbitrary and capricious.

and informed judgment . . . at [their] disposal." *Valladares v. Ray*, 130 F.4th 74, 83–84 (4th Cir. 2025) (alterations in original) (internal quotation marks and citations omitted).

According to Plaintiffs, 42 U.S.C. § 18081(e)(4)(A)(ii) and 42 U.S.C. § 18081(c)(4)(B) grant the agency power to modify the timeline described in paragraph (e)(4)(A). *Id.* at 37–38. However, according to Defendants, "one of those provisions expressly states that the HHS Secretary 'may extend the 90-day period' for resolving income-related inconsistencies 'for enrollments *occurring during 2014*,' and makes no mention of extensions being available during any other year." ECF 28, at 37 (emphasis in original) (citing 42 U.S.C. § 18081(e)(4)(A)(ii)). Further, Defendants argue that while the other provision "provides that the HHS Secretary 'may modify' the 'methods' for verifying information prescribed by the ACA, that provision plainly limits such modifications to the methods by which HHS verifies information with trusted data sources and other federal agencies, not the methods by which Exchanges must try to resolve income-related inconsistencies *with applicants*." *Id.* at 37–38 (emphasis in original) (citing 42 U.S.C. § 18081(c)(4)(B)). Defendants further point out that "§ 18081(c)(4)(B) falls under a subsection titled 'Verification of information contained in records of specific Federal officials,' and the example of a permissible modification that the provision provides concerns the transfer of tax return information from a federal official (*i.e.*, the Treasury Secretary) directly to another trusted data source (*i.e.*, an Exchange or the HHS Secretary)." *Id.* at 38. Plaintiffs respond that "section headings cannot limit the plain meaning of a statutory text." ECF 30, at 22 (citing *Merit Mgmt. Grp., LP v. FTI Consulting, Inc.*, 583 U.S. 366, 380 (2018)). Additionally, Plaintiffs argue "[t]he subsection heading is further beside the point here, given that the relevant statute gives the authority to modify procedures anywhere in the 'section' (not just the subsection)." *Id.* at 22–23 (citation omitted).

The Court begins, as it must, with the statutory text. 42 U.S.C. § 18081(c)(4)(B) provides that "[t]he Secretary may modify the methods used under the program established by this section for the Exchange and verification of information if the Secretary determines such modifications would reduce the administrative costs and burdens on the applicant." 42 U.S.C. § 18081(e)(4)(A)(ii) provides that the Exchange, in the case of an inconsistency or inability to verify, shall "provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with the person verifying the information under subsection (c) or (d) during the 90-day period beginning the date on which the notice required under subclause (I) is sent to the applicant." The section also states that "[t]he Secretary may extend the 90-day period under subclause (II) for enrollments occurring *during 2014*." 42 U.S.C. § 18081(e)(4)(A)(ii) (emphasis added).

It is not clear to the Court that Plaintiffs are likely succeed on their argument that "the agency misunderstood the scope of its authority on this score." ECF 30, at 23. In short, Plaintiffs assert that the 2014 limiting provision in 42 U.S.C. § 18081(e)(4)(A)(ii) is merely a redundancy, ECF 11-1, at 38, and the heading of Section 18081(c) should be ignored because the plain meaning of the text prevails, and the authority to modify is granted anywhere in the "section," not just the subsection, ECF 30, at 22–23. As to 42 U.S.C. § 18081(c)(4)(B), the Court agrees with Plaintiffs that the mere title of the subsection cannot alter the otherwise unambiguous meaning of the language in its text. And the Court further agrees that CMS's reading of 42 U.S.C. § 18081(c)(4)(B) is unreasonable given that the Section "authorizes modification of methods in order to reduce administrative burdens on the applicant, and this language would make little sense if the statute permitted the agency only to modify the procedures it used with other federal agencies without the applicant's involvement." ECF 30, at 23.

However, the 2014 limiting provision gives the Court pause. In 42 U.S.C. § 18081(e)(4)(A)(ii), Congress expressly indicated that the agency could extend the 90-day deadline for enrollments occurring *in 2014*. Thus, the Court is inclined to find that this time-limited extension provision prevents the Court from interpreting the statute as allowing blanket modifications for enrollments *at any time*. "When Congress provides exceptions in a statute, it does not follow that courts have authority to create others. The proper inference . . . is that Congress considered the issue of exceptions and, in the end, limited the statute to the ones set forth." *United States v. Johnson*, 529 U.S. 53, 58 (2000).

The Court notes, however, that the matter is further complicated by the agency's internal inconsistency in applying its own modification authority. Curiously, the agency claims that its modification power is limited, but simultaneously uses that modification authority to allow extensions on a case-by-case basis to individual applicants in years other than 2014. In an attempt to reconcile this inconsistency, Defendants argue that "any authority the HHS Secretary might have to '*modify*' a statutorily prescribed timeline in order to 'reduce the administrative costs and burdens' faced by a particular '*applicant*' cannot be reasonably understood to include the authority to promulgate a regulation that categorically *replaces* a statutorily prescribed timeline (90 days) with a different one (90 days plus an automatic 60-day extension) for *all applicants*." ECF 28, at 38 (emphasis in original) (first quoting 42 U.S.C. § 18081(c)(4)(B); then citing 45 C.F.R. § 155.315(f)(7); and then citing *Util. Air Regul. Grp.*, 573 U.S. at 328). Plaintiffs insist "[t]his is a distinction without a difference under the statutory text, which permits the agency to modify its methods if doing so 'would reduce the administrative costs and burdens on the applicant.'" ECF 30, at 23 (citing 42 U.S.C. § 18081(c)(4)). According to Plaintiffs, "CMS could permissibly (and at one point did) find that it would be less burdensome on

applicants to permit a blanket extension rather than requiring each applicant to jump through a paperwork hoop to request one." *Id.* (citing 88 Fed. Reg. 25,740, 25,819 (Apr. 27, 2023)). And as Plaintiffs point out, even CMS must understand its authority with respect to modification to operate in this way, as the agency has "used this authority to modify the 90-day time limit in other contexts." *Id.* (citing 45 C.F.R. § 155.315(f)(3)).

While this is a close call, the Court finds, at least at this preliminary stage, that Plaintiffs have not shown a likelihood of success on the merits on their argument that CMS misunderstood the scope of its authority in revoking the 60-day extension. Nonetheless, the Court invites further briefing on this claim at subsequent stages of the litigation, as this determination in the preliminary relief context is not dispositive on the merits.

Further, Plaintiffs' complaints about the agency's failure to engage with the evidence fails to provide an independent basis for relief. Plaintiffs claim that CMS did not "engage[] with the evidence showing the need for a 150-day verification period." ECF 11-1, at 38. However, CMS explained that a 150-day stay provided no "meaningful benefit to consumers" compared to a process in which extensions can be granted on a case-by-case basis as appropriate. 90 Fed. Reg. at 27,119; *see also id.* at 27,120 (explaining that a review of "income inconsistency resolution data" indicates that "under most conditions[,] consumers across all income data matching issue scenarios . . . can verify their data matching issues in the provided timeframe").[21] Additionally, in response to commenters' concerns that the reported metrics did not "sufficiently demonstrate[] evidence of widespread fraudulent behavior," the agency clarified that "this change [was] determined to be necessary on the grounds of statutory alignment and thus is

[21] Additionally, CMS "estimated this increased APTC expenditures by $170 million in 2024," and therefore, "the automatic 60-day extension did not provide a meaningful benefit to consumers and weakened program integrity." 90 Fed. Reg. at 27,119.

independent of the identified data concerns." 90 Fed. Reg. at 27,120. In sum, on this record, Plaintiffs have failed to show likelihood of success on their arbitrary and capricious claim because Plaintiffs have not sufficiently shown that the agency misinterpreted its modification authority.

(1) Income Verification When Data Shows Income Below 100 Percent of FPL

Under current regulations, if an applicant's attestation regarding their projected annual household income reflects a higher household income than that reflected in income data provided by the IRS or certain other sources, an Exchange generally "must accept the applicant's attestation . . . without further verification." 45 C.F.R. § 155.320(c)(3)(iii)(A). The Rule amends this provision by requiring an Exchange to instead further verify an applicant's household income if (1) an applicant attests to income that is between 100% and 400% of the FPL, (2) income data from the IRS indicates household income below 100% of the FPL, and (3) the former income amount exceeds the latter amount by a "reasonable threshold." 90 Fed. Reg. at 27,123. The applicant would then be given an opportunity to resolve the inconsistency by providing additional documentation and taking other steps to verify their household income. *See* 45 C.F.R. § 155.315(f)(1)-(4).

Plaintiffs argue that "the mandatory audit policy is arbitrary for precisely the same reasons that this Court vacated the same policy four years ago." ECF 11-1, at 39 (citing *City of Columbus*, 523 F. Supp. 3d at 731). According to Plaintiffs, "CMS improperly assumed that these enrollees must have been attempting to defraud the Exchanges," even though "[t]here are many reasons why an individual could, in good faith, project that he or she will have income next year higher than the federal poverty level even if current-year IRS data shows a lower income." *Id.* Plaintiffs further argue that the additional verification will cause significant

obstacles to enrollment, as "[m]any such people are self-employed, or may have difficulty obtaining documentation to support their projections." *Id.*

Defendants acknowledge that the Rule "parallels a provision from a 2018 rule that was vacated in *City of Columbus v. Cochran* []." ECF 28, at 40. Defendants maintain that the verification measures are necessary because an applicant may be "overestimating his or her projected household income in order to obtain APTCs for which the applicant is not otherwise eligible—an incentive that is especially strong in states that did not expand their Medicaid programs under the ACA." *Id.* According to Defendants, "it is reasonable [] to request additional documentation verifying an applicant's actual income in such circumstances, so as to protect against overpayment of APTCs." *Id.*; *see also* 90 Fed. Reg. at 27,123 ("[W]e believe it would be reasonable, prudent, and even necessary in light of the program integrity weaknesses just outlined to request additional documentation, since the consumer's attested household income could make the consumer eligible for APTC that would not be available using income data from electronic data sources.").

As noted, a similar challenge to a similar proposed change in the Rule was raised in 2018. *See City of Columbus*, 523 F. Supp. 3d at 762 ("Plaintiffs contend that HHS's decision to impose income verification requirements is arbitrary and capricious because it failed to support its decision with anything more than unsubstantiated conclusions and failed to acknowledge the impracticability of low-income applicants being able to meet this requirement."). There, Judge Chasanow held that "Defendant's stated rationale for imposing income verification requirements—to prevent fraud in states that did not expand Medicaid—[was] unfounded," because "Defendants failed to point to any actual or anecdotal evidence indicating fraud in the record." *Id.* Judge Chasanow reasoned that "HHS improperly elevated the objective of fraud

prevention, for which it had no evidence, above the ACA's primary purpose of providing health insurance. *Id.* (citing *King*, 759 F.3d at 373–74). This time around, Defendants posit that their justification "does not suffer from the same flaws that were fatal to the 2018 provision." ECF 28, at 41.

In its current effort to change the regulation, HHS cited to a study that "compared estimated potential enrollment in Exchanges based on income data reported in census surveys to actual enrollment by enrollees who reported household income above the FPL-based eligibility threshold and found that actual enrollment was 136 percent higher than the total population of potential enrollments." *Id.* (citing 90 Fed. Reg. at 27,122). Defendants also point out that the "same study also found that a far higher number of enrollees reported household income that was just above the Exchange eligibility threshold in non-Medicaid expansion States compared to those in States that did expand Medicaid." *Id.* (citing 90 Fed. Reg. at 27,122). However, Plaintiffs respond that "one of the authors of that study submitted a comment to CMS (which the agency ignored) cautioning that the report did not support the agency's conclusions, given the difficulties that low-income people face in estimating their future incomes." ECF 11-1, at 40 (citing Urban Institute comment at 2 (Apr. 11, 2025), https://perma.cc/F5PH-WVN2). It appears that the agency did not directly address the comment by one of the study's authors in the final Rule, and Defendants did not respond directly to Plaintiffs' argument in the response brief.[22] Despite a compelling challenge to HHS's use of the study by one of the study's own authors,

[22] At the hearing, the Court asked counsel for Defendants how it could not be considered arbitrary and capricious for the agency to continue to rely on a report to justify its action after the author of that report indicated that the conclusions in the report do not support the agency's action. ECF 34, at 61:1–9. In response, counsel conceded, "[t]hat is something difficult to address," and noted that "[he] [was] not familiar with the precise facts of what the Agency was using, the proposition for which the Agency was using the study compared to what the author was disagreeing with." *Id.* at 61:13–16.

HHS continued to rely on the data in that study to justify the Rule's income verification provision.

The Rule also cites the Paragon Health Report to show that "[a] more recent analysis of 2024 open enrollment data shows plan selections on HealthCare.gov among people ages 19–64 who reported household income between 100 percent and 150 percent of the FPL in non-Medicaid expansion States were 70 percent higher than potential enrollments estimated from Census data at that same income level." 90 Fed. Reg. at 27,122. The agency thus reasoned that "[b]ased on this mismatch between enrollment and the eligible population, this study estimates four to five million people improperly enrolled in QHP coverage with APTC in 2024 at a cost of $15 to $20 billion." *Id.* Plaintiffs point out that "the Paragon report compared apples to oranges by including children in its estimated number of applicants but not in its count of eligible persons; by mismatching 2023 data to estimate improper enrollments for 2024, when many more people gained eligibility for the Exchanges in light of changes in Medicaid enrollment standards; and by using fundamentally different measures of income for its two data sets." ECF 11-1, at 15 (first citing Urban Institute comment at 2-3 (Apr. 11, 2025), https://perma.cc/7457-27KN; then citing Jason Levitis et al. comment at 28–31 (Apr. 11, 2025), https://perma.cc/X3KY-KZLW; and then citing Ctr. for Budget & Policy Priorities comment at 4–5 (Apr. 11, 2025), https://perma.cc/KP9W-J63N). Plaintiffs contend that "[t]hese flaws in the Paragon analysis were pointed out to CMS by commenters, but CMS did not explain why it chose to ignore them." ECF 11-1, at 15.

Against this backdrop, the Court concludes that HHS failed to meaningfully address the comments pointing out potential flaws in the data contained in the Paragon report, despite continuing to rely on such data to justify the provision in the Rule. *See* 90 Fed. Reg. at 27,215

(explaining in response to commenters expressing concerns over unsound data in the Paragon Report that the agency "noted these limitations in the proposed rule and continue to reference them in this final rule. The Paragon report analysis informed our analysis, but we also incorporated Exchange data for a more fulsome analysis."). Defendants have essentially ignored the Paragon Report (and its flaws) during this litigation, as it is not mentioned a single time in their response brief in opposition to Plaintiffs' Motion. Defendants are not free to support a rule change with data of questionable validity and limited relevance, and then refuse to engage with commenters' reasonable concerns that the data fails to support the conclusion the agency drew from that data. This is particularly problematic where, as here, an *author* of one of the studies relied upon timely noted that the study she contributed to "did not support the agency's conclusions, given the difficulties that low-income people face in estimating their future incomes," ECF 11-1, at 40 (citations omitted), which is the issue that purportedly motivated the rule change in the first place. The agency was thus required to meaningfully contend with this comment because it affected a "fundamental premise" of the Rule, namely the very justification for the Rule. *See MCI WorldCom, Inc. v. FCC*, 209 F.3d 760, 765 (D.C. Cir. 2000) ("An agency is not obliged to respond to every comment, only those that can be thought to challenge a fundamental premise."). In short, the agency refused to meaningfully engage with challenges to the data and reports used to justify the Rule, which began at the time of promulgating the final Rule and continues through this litigation. As Judge Chasanow previously (and eloquently) explained, the agency's "decision to prioritize a hypothetical risk of fraud over the substantiated risk that its decision result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic." *City of Columbus*, 523 F. Supp. 3d at 763. Accordingly, Plaintiffs are likely to succeed on the merits of their claim that CMS acted

arbitrarily by instituting additional verification requirements without sufficient data justifying the need to do so.

(2) Income Verification When Tax Data is Unavailable

This provision of the Rule rescinds a regulation that requires an Exchange to accept an applicant's self-attestation of projected annual household income "without further verification" whenever (1) the Exchange requests tax return data from the IRS to verify the applicant's attested income, but (2) the IRS confirms that there is no such data available, 45 C.F.R. § 155.320(c)(5). *See* 90 Fed. Reg. at 27,130. The current regulation, which was adopted in 2023, creates an exception to the general requirement that an Exchange must verify an applicant's annual household income with certain trusted data sources, 45 C.F.R. § 155.320(c)(1)(ii), and otherwise follow an alternative verification process if tax return data for an applicant is unavailable, *id.* § 155.320(c)(3)(vi). The Rule removes this exception and requires Exchanges to follow standard verification and data-matching procedures "when tax return data is unavailable to immediately verify a consumer's attestation of annual household income." 90 Fed. Reg. at 27,132.

Plaintiffs explain that "[i]t is a relatively common occurrence for tax data to be missing for an applicant, for entirely legitimate reasons," for example, "[a]n individual might have changed his or her name, had a change in family composition, had a change in filing status, or might not have been subject to a filing requirement for the year in question." ECF 11-1, at 40. According to Plaintiffs, "[m]any people, such as self-employed individuals, lack the ability to document their income, so they will necessarily lose access to subsidized coverage under this rule." ECF 30, at 24. Defendants argue that "the agency ultimately concluded that the 'administrative burden' of requiring applicants with no tax return data 'to provide documentation to verify [their] income' would be 'more than offset by the program integrity benefits' related to

addressing improper enrollments in subsidized Exchange coverage." ECF 28, at 43 (first quoting 90 Fed. Reg. at 27,130; and then citing *id.* at 27,131). Plaintiffs argue "the premise of each of the agency's program integrity measures is undermined by its reliance on the flawed Paragon methodology, which CMS hasn't even tried to defend here." ECF 30, at 24. Additionally, Plaintiffs point out that "[t]here would be no way for a broker to know one way or the other if tax data is unavailable for a particular individual before targeting him or her for an unauthorized enrollment." *Id.* at 24–25.

The question for the Court is not simply whether Defendants have presented sufficient evidence of fraudulent enrollment, but also whether there is sufficient evidence of a *nexus* between fraudulent enrollment and self-attestation to tax data such that it justifies requiring heightened income verification. Put differently, if the agency cannot point to data showing that self-attestation meaningfully contributes to increased fraud, then the agency adopted an incongruent solution to the problem. *See City of Columbus*, 523 F. Supp. 3d at 762 ("HHS improperly elevated the objective of fraud prevention, for which it had no evidence, above the ACA's primary purpose of providing health insurance. (citing *King*, 759 F.3d at 373–374)).

After reviewing the agency's reasoning in the Rule, the Court finds that CMS concluded in a conclusory fashion that program integrity benefits would outweigh the administrative burden on applicants. The Court agrees with Plaintiffs that CMS "attempted to justify these burdens and these coverage losses simply by reciting that self-attestation '*may* have played a role in weakening the Exchange eligibility system,' but it provided no support for this assertion." ECF 11-1, at 40 (emphasis added) (citing 90 Fed. Reg. at 27,130). Additionally, while Defendants argue "[t]he agency made the reasonable observation that applicants without tax return data will likely have documentation verifying their household income (*e.g.*, pay stubs) 'readily available'

to them and that the burden of submitting that documentation, by extension, would be relatively minimal," ECF 28, at 43 (quoting 90 Fed. Reg. at 27,131–32), the agency provides no basis for this conclusory statement. In fact, this assertion is not even internally consistent, as CMS separately acknowledges in the Rule that "income verification can be more challenging for lower-income tax filers due to less consistent employment." 90 Fed. Reg. at 27,200. To address this concern, CMS merely stated "our experience with income verifications suggests the process does not impose a substantial burden." *Id.* The agency never explains what this history is or how it led to the conclusion it purportedly supports. The circular reasoning and conclusory statements offered to justify the policy change are not indicative of reasoned decision-making. This is particularly troubling because CMS, by its own estimation, acknowledges that 407,000 people will lose some, or all, of their APTCs as a result of this change. *See id.* Given the lack of sufficient data to justify the rule, and the agency's lack of meaningful explanation for the provision, the Court finds that this provision was not "reasonable and reasonably explained."[23] *FCC v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021).

2. Irreparable Harm

Having addressed the likelihood of success on the merits of each of the challenged provisions of the Rule, the Court turns to the question of whether Plaintiffs have "demonstrate[d] that irreparable injury is *likely* in the absence of an injunction." *Winter*, 555 U.S. at 22 (emphasis in original) (citing cases). "To establish irreparable harm, the movant must make a 'clear showing' that it will suffer harm that is 'neither remote nor speculative, but actual and imminent.'" *Mountain Valley Pipeline, LLC v. 6.56 Acres of Land, Owned by Sandra Townes*

[23] This holding is bolstered by the fact that the Rule relied on the Paragon report, which as the Court described above, Defendants do not even attempt to address, let alone defend.

*Powell*, 915 F.3d 197, 216 (4th Cir. 2019) (quoting *Direx Israel, Ltd. v. Breakthrough Med. Corp.*, 952 F.2d 802, 812 (4th Cir. 1991)). Irreparable harm is harm that "cannot be fully rectified by the final judgment after trial." *Id.* (quoting *Stuller, Inc. v. Steak N Shake Enters.*, 695 F.3d 676, 680 (7th Cir. 2012)).

While "[m]ere injuries, however substantial, in terms of money, time and energy necessarily expended in the absence of [an injunction] are not enough," *see Roe v. Dep't of Def.*, 947 F.3d 207, 228 (4th Cir. 2020), *as amended* (Jan. 14, 2020) (quoting *Di Biase v. SPX Corp.*, 872 F.3d 224, 230 (4th Cir. 2017)), "irreparable harm may still occur in extraordinary circumstances, such as when monetary damages are unavailable or unquantifiable." *Handsome Brook Farm, LLC v. Humane Farm Animal Care, Inc.*, 700 F. App'x 251, 263 (4th Cir. 2017). For instance, "economic damages may constitute irreparable harm where no remedy is available at the conclusion of litigation." *Mountain Valley Pipeline, LLC v. W. Pocahontas Props. Ltd. P'ship*, 918 F.3d 353, 366 (4th Cir. 2019). Similarly, harm that "threaten[s] a party's very existence" can qualify as irreparable. *Mountain Valley Pipeline v. 6.56 Acres of Land*, 915 F.3d at 218. The Fourth Circuit has indicated that where an organizational plaintiff's standing is based on a representation theory (as is the case with respect to MSA), district courts should look at the irreparable harm to its members. *N.C. State Conf. of the NAACP v. Raymond*, 981 F.3d 295, 311 n.9 (4th Cir. 2020).

Plaintiffs argue that their injuries would be irreparable without a § 705 stay of the Rule's effective date. While Plaintiffs acknowledge that "economic losses generally do not constitute irreparable harm," they clarify that "[g]iven sovereign immunity, Plaintiffs have no vehicle to recover their losses, in the form of uncompensated care costs and higher premiums, from CMS after the fact." ECF 30, at 7. According to Plaintiffs, "open enrollment for 2026 is fast

approaching," and "[a]bsent a stay, the coverage losses and higher costs caused by the rule will be locked in for the coming year, ensuring that Plaintiffs will suffer harm 'before a decision on the merits can be rendered.'" ECF 30, at 7–8 (quoting *M.A.B. v. Bd. of Educ. of Talbot Cnty.*, 286 F. Supp. 3d 704, 726 (D. Md. 2018)).

Defendants insist that neither MSA nor the City Plaintiffs have made out irreparable harm sufficient to justify preliminary relief. As for MSA, Defendants argue that "the challenged Rule provisions will apply to Exchange plans that will not take effect until 2026 at the earliest, meaning that the Rule will have no immediate impact on the member's current coverage." ECF 28, at 13. As such, according to Defendants, MSA has "failed to establish that any such injury would occur before Plaintiffs' claims could be resolved in the regular course of litigation—an essential feature of irreparable harm." *Id.* (citations omitted). As for the City Plaintiffs, Defendants maintain that any "remote harm" suffered is "certainly not imminent enough to qualify as the sort of irreparable injury that warrants extraordinary preliminary relief." *Id.* at 17.

The Court finds that Plaintiffs will suffer significant and irreparable harm if the challenged provisions of the Rule go into effect next week. As discussed in the standing analysis, it is reasonably probable that the Plaintiffs will suffer economic injury from the challenged provisions. Of course, economic harm is not normally considered irreparable. *See Mountain Valley Pipeline v. 6.56 Acres of Land*, 915 F.3d at 218. However, "economic damages may constitute irreparable harm where no remedy is available at the conclusion of litigation." *Mountain Valley Pipeline v. W. Pocahontas Properties*, 918 F.3d at 366 (citation omitted). Moreover, where "a temporary delay in recovery somehow translates to permanent injury—threatening a party's very existence by, for instance, driving it out of business before litigation

concludes—could [] qualify as irreparable." *Mountain Valley Pipeline v. 6.56 Acres of Land*, 915 F.3d at 218 (citation omitted).

Here, Legler affirmed that she "operate[s] [her] business on narrow margins," the Rule will "cause [her] health insurance coverage costs to increase to a level that [she] cannot afford," and as a result, "[t]hese increased costs will likely make it impossible for [her] to continue [her] business, as [she] would be forced either to find different employment with employer-sponsored insurance, or to terminate [her] business and explore other coverage options through Wisconsin's BadgerCare system." ECF 11-4, at 3 ¶ 11. Legler further explains that "[c]ontinuing [her] business would not be an option in this circumstance because [she] need[s] to have access to affordable insurance that will cover the medications [she] need[s]." *Id.* ¶ 12; *see also* United Healthcare, *Optimum Choice, Inc., Part III: Actuarial Memorandum: PUBLIC; Maryland 2026 Individual Exchange Rates* 7 (May 22, 2025), https://perma.cc/35L2-M49D (increasing insurance premiums to account for impact of Rule). Because the final Rule going into effect "threatens a party's very existence," the type of harm Legler, and thus MSA, attests to constitutes irreparable harm sufficient to warrant a stay. *Mountain Valley Pipeline v. 6.56 Acres of Land*, 915 F.3d at 218 (citation omitted).

Additionally, the harm to the City Plaintiffs is irreparable because money damages are likely not available. *See City of New York v. U.S. Dep't of Def.*, 913 F.3d 423, 430 (4th Cir. 2019) ("The APA waives the federal government's sovereign immunity for a limited set of suits, brought by 'a person suffering legal wrong because of agency action' to obtain relief '*other than money damages*.'" (emphasis added) (quoting 5 U.S.C. § 702)). As Plaintiffs explain, "[t]hese cities fund and operate a range of community health centers, general and specialty clinics, and other health care services, as well as emergency medical transport." ECF 11-1, at 18–19 (citing

ECF 11-9 (Ige Decl.), at 2 ¶ 5; ECF 11-7 (Johnson Decl.), at 3 ¶ 11; ECF 11-8 (Leach Decl.), at 2–3 ¶¶ 7–8). City Plaintiffs "provide these services to patients regardless of their insurance coverage or ability to pay." *Id.* at 19. An increase in the number of uninsured and underinsured residents resulting from the final Rule would create a strain on those services and, ultimately, the cities' budgets, which must make up the shortfall from decreased compensation and increased demand for emergency services. *See* ECF 11-9, at 3 ¶ 6, at 5–6 ¶ 14; ECF 11-7, at 2–3 ¶¶ 9–11; ECF 11-8, at 3–4 ¶¶ 12, 13. Once the Rule goes into effect, it will be difficult, if not impossible, to unwind the harm Plaintiffs complain of. Young explained that the Congressional Budget Office has concluded that the rule as a whole will "increase the number of uninsured by 1.8 million." ECF 11-2, at 2 ¶ 4. Additionally, "[p]eople who are relatively younger and healthier are more likely to be deterred from enrolling by higher costs or additional administrative obstacles," and therefore the policies in the Rule are "generally [] expected to worsen the Marketplace risk pool." *Id.* ¶ 5. Plus, "[a] worse risk pool will generally lead to higher health insurance premiums, further exacerbating the problem of high costs, which in turn can cause additional people to become insured." *Id.* As Plaintiffs point out, the City Plaintiffs "would necessarily be servicing more individuals with no or inadequate coverage, and the cities would not be able to recoup the costs of those services." ECF 11-1, at 44; *see also Chef Time 1520 LLC v. Small Bus. Admin.*, 646 F. Supp. 3d 101, 115–16 (D.D.C. 2022) (explaining that the unavailability of money damages for APA claims counsels in favor of a finding of irreparable harm).

Separately, Defendants argue that "the challenged Rule provisions will apply to Exchange plans that will not take effect until 2026 at the earliest, meaning that the Rule will have no immediate impact on the member's current coverage." ECF 28, at 13. Defendants thus urge

that "there is still time to decide this case on the merits without having to necessarily enjoin the provisions prior to the effective date." ECF 34, at 54:11–13; *see also* ECF 28, at 13. Plaintiffs counter that they "need relief now to allow time for the market to adjust in advance of the opening of open enrollment on November 1st." ECF 34, at 88:10–12.

It is true that the provisions go into effect on January 1, 2026 for the 2026 year and open enrollment begins on November 1 of this year. Thus, there is some surface appeal to Defendants' argument that the Plaintiffs have failed to meet their burden to establish irreparable harm because increased costs, decreased coverage, and uncompensated care costs will not suddenly materialize on August 26, 2025, the day after the Rule goes into effect. But as Plaintiffs explained at the hearing, "insurers' plans and the preparation that the exchanges need to engage in, and all of the underlying machinery, don't spring into effect on October 31st to allow open enrollment to happen [on] November 1st." *Id.* at 88:1–5. Rather, "[i]nsurers *right now* are in the process of finalizing the plan offerings and setting their plan rates in reliance on what the current rule offers, and what they anticipate the market will look like on the basis of this rule." *Id.* at 88:6–9; *see also* United Healthcare, *Optimum Choice, Inc., Part III: Actuarial Memorandum: PUBLIC; Maryland 2026 Individual Exchange Rates* 7 (May 22, 2025), https://perma.cc/35L2-M49D (increasing insurance rates to account for impact of Rule). Moreover, the record evidence shows that at least one insurer has already increased rates as a result of the Rule's anticipated effect on the insurance market, and Plaintiffs have pointed out that "open enrollment for 2026 is fast approaching," and "[a]bsent a stay, the coverage losses and higher costs caused by the rule will be locked in for the coming year, ensuring that Plaintiffs will suffer harm 'before a decision on

the merits can be rendered.'"[24] ECF 30, at 7–8 (first citing Am. Acad. of Actuaries, *Issue Brief: Drivers of 2026 Premium Changes* 3, 8 (July 21, 2025), https://perma.cc/YP3X-WS74; and then quoting *M.A.B.*, 286 F. Supp. 3d at 726). So, while it may be true that the harms to Plaintiffs may not be felt until later in time, it is also true that the first domino in the "predictable chain of events leading from the government action to the asserted injury," *All. for Hippocratic Med.*, 602 U.S. at 385, will fall when the regulation goes into effect next week.

Further, despite arguing that preliminary relief is not warranted because the Court has time to decide the case on the merits before open enrollment begins, ECF 28, at 13, Defendants have not addressed whether (or even how) the readjustment of insurance rates can be righted by a later finding that the Rule was promulgated in violation of the APA.[25] Thus, Plaintiffs have shown irreparable harm, both in terms lack of remedy at the conclusion of litigation and imminence. *See Habeas Corpus Res. Ctr.*, 2009 WL 185423, at *9 (finding irreparable harm where plaintiff faced a myriad of immediate decisions about how to handle clients' post-conviction claims "even though it would take some amount of time" for the rule to apply to the state because if the rule were to go into effect, it would "thrust [p]laintiff into uncertainty over the legal framework"); *California*, 911 F.3d at 581 (finding irreparable harm where it was "reasonably probable that the states [would] suffer economic harm" from the rule and "the states [would] not be able to recover monetary damages connected to the [rule]"). While Defendants

[24] The Court notes that "[a]llowing the rule to go into effect for a time, only later to determine it invalid, would serve no purpose." *Habeas Corpus Res. Ctr. v. U.S. Dep't of Justice*, Civ. No. 08-2649, 2009 WL 185423, at *10 (N.D. Cal. Jan. 20, 2009). It would waste the resources of the litigants and the Court and cause significant chaos in the insurance market. This too tips the scales in favor of Plaintiffs in the irreparable harm analysis.

[25] There is no evidence in the record to suggest that insurers can continue to adjust rates up until the eve of the open enrollment period on November 1, 2025.

insist that the harms are too speculative, the Court finds, as it did with respect to standing, that the harm is sufficiently concrete, imminent, and supported by the record. Accordingly, MSA and the City Plaintiffs have demonstrated they will suffer irreparable harm in the absence of a stay.

3. Prejudice and Public Interest

The final two factors—balance of the equities and weighing the public interest—"merge when the Government is the opposing party." *Nken*, 556 U.S. at 435. The court "must balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief," with "particular regard for the public consequences in employing the extraordinary remedy of injunction." *Winter*, 555 U.S. at 24 (quoting *Amoco Prod. Co. v. Vill. of Gambell*, 480 U.S. 531, 542 (1987)). Logically, "[t]here is generally no public interest in the perpetuation of unlawful agency action." *League of Women Voters of U.S. v. Newby*, 838 F.3d 1, 12 (D.C. Cir. 2016). On the other hand, there is a substantial public interest "in having governmental agencies abide by the federal laws that govern their existence and operations." *Washington v. Reno*, 35 F.3d 1093, 1103 (6th Cir. 1994); *see also HIAS, Inc. v. Trump*, 415 F. Supp. 3d 669, 686 (D. Md. 2020) (same), *aff'd*, 985 F.3d 309 (4th Cir. 2021). The Court is mindful that the Fourth Circuit recently cautioned against collapsing "the first *Winter* factor—likelihood of success on the merits—with the merged balance of equities and public interest factor." *USA Farm Lab. Inc. v. Micone*, No. 23-2108, 2025 WL 586339, at *4 (4th Cir. Feb. 24, 2025). As such, "[l]ikelihood of success on the merits alone does not suffice." *Am. Fed. of State, Cnty. & Mun. Emps., ALF-CIO et al., v. Soc. Sec. Admin. et al.*, 778 F. Supp. 3d 685, 779 (D. Md. 2025).

Plaintiffs argue that "[t]he rule's harms will not be limited to Plaintiffs and their members, but will extend to the millions of Americans who will lose coverage on the Exchanges

and who will suffer from higher health care costs as a result." ECF 30, at 25. According to Plaintiffs, "[i]ncreases in uninsured people lead to increases in uncompensated care, putting a strain on providers of last resort and emergency services and limiting the quality of care that medical professionals can deliver, with particularly harmful results for lower-income people." *Id.* Defendants respond that "staying the effective date of the Rule would hamstring Defendants' efforts to address legitimate concerns about improper enrollments in Exchange plans that are subsidized by taxpayers, as well as interfere with Defendants' lawful implementation of their policy priorities." ECF 28, at 55. Additionally, Defendants aver that "when a law is stayed, 'the inability to enforce its duly enacted plans clearly inflicts irreparable harm on' the government that enacted it." *Id.* (quoting *Abbott v. Perez*, 585 U.S. 579, 602 n.17 (2018)).

There is a strong public interest in Americans maintaining affordable healthcare coverage. Indeed, that was the primary purpose of enacting the ACA. *See NFIB*, 567 U.S. at 538 (explaining that the purpose of the ACA is "to increase the number of Americans covered by health insurance and decrease the cost of health care"). Moreover, eliminating coverage for an estimated 1.8 million people will drive up costs for the insured and lead to a significant decrease in the quality of care for the newly uninsured, which is unquestionably not in the public interest. Defendants concede as much in admitting that the Rule will likely lead to decreased coverage and increased costs, 90 Fed. Reg. at 27,074, 27,213, but nonetheless maintain that intervention is warranted based on program integrity concerns, *see, e.g.*, 90 Fed. Reg. at 27,116. It is of course the case that reducing fraud by both brokers and Exchange applicants, thereby reducing the burden of subsidy expenditures on taxpayers, is also in the public interest. But the Court is not convinced that this concern outweighs the damage that will flow from enactment of the Rule. Further, though the agency no doubt posits a laudable goal it wishes to achieve through

the enactment of the Rule, "that does not mean that the government can flout the law to do so." *Am. Fed. of State, Cnty. & Mun. Emps., AFL-CIO*, 778 F. Supp. 3d at 779.

Defendants' claim that they will suffer irreparable harm is similarly unpersuasive. Beyond its argument that a stay would "hamstring" its efforts to address improper enrollments, ECF 28, at 55, Defendants fail to explain how the stay would cause it irreparable harm. Indeed, as the Court has noted above, many of the provisions purportedly targeting fraud are unsupported by data showing that if enacted, they will, in fact, reduce any such fraud. Plus, simply preventing the government from "enforc[ing] its duly enacted plans," ECF 28, at 55, does not tip the scales in favor of Defendants on the third and fourth factors, particularly given the significant harms suffered by Plaintiffs in the absence of a stay. Accordingly, the Court is satisfied that the balance of equities and the public interest favor the issuance of a stay.

4. Scope of Injunction

CMS asks this Court to limit relief to the Plaintiffs here. *See* ECF 28, at 56 (arguing that any relief should be "no broader than necessary to afford relief to those Plaintiffs who have established standing and irreparable harm"). Plaintiffs respond that "[t]his request can't be squared with the text of Section 705, which instructs that 'the effective date,' in the singular, of the rule should be postponed if the standards for relief are met." ECF 30, at 26. As such, "[e]ach challenged provision of the rule has only one effective date, not different effective dates that apply for plaintiffs and non-plaintiffs." *Id.* (citing *David v. King*, 109 F.4th 653, 661–62 (4th Cir. 2024) (the definite article "the" "normally indicates that the statute refers to only one such object")).

This Court finds that the appropriate course of action here is to temporarily stay the challenged provisions—that is, to postpone its effective date—under 5 U.S.C. § 705 pending a

final resolution in this matter. Under § 705, when "justice so requires" and "to the extent necessary to prevent irreparable injury," a reviewing court may "issue all necessary and appropriate process to postpone the effective date of an agency action or to preserve status or rights pending conclusion of the review proceedings." "APA suits ultimately target the rule, and not necessarily the application of it to a particular person." *Am. Fed'n of Tchrs. v. Dep't of Educ.*, --- F. Supp. 3d ---, Civ. No. SAG-25-628, 2025 WL 2374697, at *33 (D. Md. Aug. 14, 2025); *see also Corner Post, Inc. v. Bd. of Governors*, 603 U.S. 799, 831 (2024) (Kavanaugh, J., concurring) ("When a reviewing court determines that agency regulations are unlawful, the ordinary result is that the rules are vacated—not that their application to the individual petitioners is proscribed.").

Here, Plaintiffs' requested relief, to postpone the enforceability of certain provisions in the Rule, is properly within the scope of the APA. *See* 5 U.S.C. § 705 (allowing courts to "postpone the effective date of an agency action"); *see also Loper Bright*, 603 U.S. at 391 (explaining that courts must serve "'as a check upon administrators whose zeal might otherwise have carried them to excesses not contemplated in legislation creating their offices.'" (quoting *United States v. Morton Salt*, 338 U.S. 632, 644 (1950)). Additionally, setting aside an agency action is the standard remedy for APA cases. *See* 5 U.S.C. § 706(2)(A) ("The reviewing court shall . . . set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law[.]").

The recent Supreme Court case, *Trump v. CASA*, does not change the outcome. In *CASA*, the Supreme Court held that injunctive relief must be limited to "administer[ing] complete relief between the parties." *Trump v. CASA, Inc.*, 606 U.S. ---, 145 S. Ct. 2540, 2557 (June 27, 2025). However, the Supreme Court explicitly left open "whether the [APA] authorizes federal courts

to vacate federal agency action." *Id.* at 2554 n.10 (citing 5 U.S.C. § 706(2) (authorizing courts to "hold unlawful and set aside agency action")). Justice Kavanaugh's concurrence highlighted that, even after *CASA*, "plaintiffs may ask a court to preliminarily 'set aside' a new agency rule" "in cases under the Administrative Procedure Act." *Id.* at 2567 (Kavanaugh, J., concurring).

Accordingly, the Court finds, in line with other recent cases addressing the issue, that the limiting principle on universal or national injunctions announced in *CASA* does not apply to APA cases like the one at bar. *See, e.g., Drs. for Am. v. Off. of Pers. Mgmt.*, No. 25-cv-322 , 2025 WL 1836009, at *22 (D.D.C. July 3, 2025) ("[A]s this is a case involving APA vacatur, not a universal or national injunction, . . . [*CASA*] does not apply."); *Walker v. Kennedy*, --- F. Supp. 3d. ---, No. 20-CV-2834, 2025 WL 1871070, at *7 (E.D.N.Y. July 8, 2025) ("*CASA* does not require the Court to reconsider its stay."); *Ass'n of Am. Univs. v. Dep't of Defense*, --- F. Supp. 3d. ---, No. 25-cv-11740, 2025 WL 2022628, at *27 (D. Mass. July 18, 2025) (finding that "a stay under the APA" is not "subject to the same limitations espoused in *CASA*"); *Refugee & Immigrant Ctr. for Educ. & Legal Servs. v. Noem*, --- F. Supp. 3d. ---, Civ. No. 25-306, 2025 WL 1825431, at *51 (D.D.C. July 2, 2025) (noting that binding precedent and the text of the APA plainly authorize vacatur).[26]

Additionally, limiting postponement to Plaintiffs would be impractical. The complicated interplay between the ACA and numerous market actors would make it exceedingly difficult if

[26] The Court is unpersuaded by Defendants' citation to *Casa de Maryland*, 486 F. Supp. 3d at 971–72, a case in which Judge Xinis of this Court limited preliminary relief in the APA context to the plaintiffs. In making that decision, Judge Xinis explicitly noted that the limited stay was compelled by an earlier decision of the Fourth Circuit on facts that she could not "meaningfully distinguish." *Id.* at 972 (citing *CASA de Maryland, Inc. v. Trump*, 971 F.3d 220, 236 (4th Cir. 2020)). Given that just over two months ago the Supreme Court considered the propriety of national injunctions and explicitly left open "whether the [APA] authorizes federal courts to vacate federal agency action," *CASA,* 145 S. Ct. at 2554 n.10, the Court is satisfied that the relief need not be limited to Plaintiffs.

the challenged provisions went into effect for some of the population served by the Exchange but were stayed as to others. Defendants have "failed to identify any plausible manner in which the Court could set the guidance aside as to the individual plaintiffs and the organizational plaintiffs, while leaving it in place as to all others." *Refugee & Immigrant Ctr. for Educ. & Legal Servs.*, 2025 WL 1825431, at *51.

Accordingly, the Court finds the scope of Plaintiffs' relief, requesting a stay of the challenged provisions under the Rule, proper.

**C. Security**

The government has requested that, if the Court were to issue a preliminary injunction, it order Plaintiffs to provide an injunction security under Fed. R. Civ. P. 65(c).[27] ECF 28, at 57. This Court is not granting a preliminary injunction. The Supreme Court has explained that "[a]n injunction and a stay have typically been understood to serve different purposes." *Nken*, 556 U.S. at 428. "The APA only authorizes courts to 'set aside' and 'postpone' agency actions—a far narrower authority than the court's equitable power to issue preliminary injunctive relief." *Am. Fed'n of Tchrs. v. Dep't of Educ.*, 779 F. Supp. 3d 584, 623 n.14 (D. Md. 2025).

The APA has no bond requirement. *See* 5 U.S.C. § 705; *see also Seafreeze Shoreside, Inc. v. U.S. Dep't of Interior*, No. 22-cv-11091, 2023 WL 3660689, at *3 (D. Mass. May 25, 2023) ("Unlike a preliminary injunction, a stay under 5 U.S.C. § 705 does not expressly require the movant post a bond."); *Coal. for Humane Immigrant Rights v. Noem*, No. 25-cv-872, 2025 WL 2192986, at *38 (D.D.C. Aug. 1, 2025) (declining to require a bond because "Plaintiffs here seek a stay under APA section 705, which is neither a preliminary injunction nor a temporary

[27] Fed. R. Civ. P. 65(c) states, in relevant part: "The court may issue a preliminary injunction . . . only if the movant gives security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongfully enjoined . . . ."

restraining order"). Because the Court is issuing a stay under § 705, not a preliminary injunction, the Court declines to require a bond.

## IV. CONCLUSION

For the foregoing reasons, Plaintiffs' motion for a stay under 5 U.S.C. § 705 or, in the alternative, for a preliminary injunction, ECF 11, construed as a motion for a stay under 5 U.S.C. § 705, is **GRANTED** in part and **DENIED** in part. A separate implementing Order will issue.

Dated: August 22, 2025

/s/
Brendan A. Hurson
United States District Judge

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

*

CITY OF COLUMBUS ET AL.,

*

Plaintiffs,

*

v.

* Civil No. 25-2114-BAH

ROBERT F. KENNEDY, JR. ET AL.,

*

Defendants.

*

* * * * * * * * * * * * *

**ORDER**

For the reasons stated in the accompanying memorandum opinion, it is, by the United States District Court for the District of Maryland, hereby **ORDERED** that:

1. Plaintiffs' motion for a stay under 5 U.S.C. § 705 or, in the alternative, for a preliminary injunction, ECF 11, construed as a motion for a stay under 5 U.S.C. § 705, is **GRANTED** in part and **DENIED** in part;

2. The effective dates of the following provisions of the final rule entitled "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," 90 Fed. Reg. 27074, are **STAYED** pursuant to 5 U.S.C. § 705 pending a final ruling on the merits of this case:

    a. The imposition of a $5 premium penalty on automatic re-enrollees, through the addition of 45 C.F.R. § 155.335(a)(3) and (n) and revisions to 45 C.F.R. § 155.330(j);

    b. The revocation of guaranteed insurance coverage for individuals with past-due premiums, through revisions to 45 C.F.R. § 147.104(i);

    c. The failure to reconcile policy in 45 C.F.R. § 155.305(f)(4), including the final rule's amendments to that policy through the addition of 45 C.F.R. § 155.305(f)(4)(iii);

    d. The imposition of eligibility verification for the special enrollment period, through the revisions to 45 C.F.R. § 155.420(g);

e. The imposition of a requirement that Exchanges verify household income inconsistencies when a tax filer's attested projected annual household income differs from "trusted data sources," through revisions to 45 C.F.R. § 155.320(c)(3)(iii);

f. The changes to the de minimis ranges for actuarial value calculations, through revisions to 45 C.F.R. §§ 156.140(c), 156.200(b)(3), and 156.400.

3. The Court **DECLINES** to stay the effective dates of the following provisions:

a. The change to the measure for calculating the premium adjustment percentage set forth in 90 Fed. Reg. 27,166 through 27,178;

b. The elimination of the 60-day extension of time to resolve inconsistencies in household income data, through the removal of 45 C.F.R. § 155.315(f)(7) and revisions to 45 C.F.R. § 155.320(c)(5).

**SO ORDERED.**

Dated: August 22, 2025

/s/
Brendan A. Hurson
United States District Judge

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

| | |
|---|---|
| CITY OF COLUMBUS *et al.*,<br>*Plaintiffs*,<br>v.<br>ROERT F. KENNEDY, JR. *et al.*,<br>*Defendants*. | Civil No. 25-2114-BAH |

**ORDER**

For the reasons stated in the Court's memorandum opinion, ECF 35, it is, by the United States District Court for the District of Maryland, hereby **ORDERED** that Plaintiffs' unopposed motion for clarification is **GRANTED**, and this Court's order of August 22, 2025 is amended as clarified to provide as follows:

1. Plaintiffs' motion for a stay under 5 U.S.C. § 705 or, in the alternative, for a preliminary injunction, ECF 11, construed as a motion for a stay under 5 U.S.C. § 705, is **GRANTED** in part and **DENIED** in part;
2. The effective dates of the following provisions of the final rule entitled "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," 90 Fed. Reg. 27074, are **STAYED** pursuant to 5 U.S.C. § 705 pending a final ruling on the merits of this case:
    a. The imposition of a $5 premium penalty on automatic re-enrollees, through the addition of 45 C.F.R. § 155.335(a)(3) and (n) and revisions to 45 C.F.R. § 155.330(j);

b. The revocation of guaranteed insurance coverage for individuals with past-due premiums, through revisions to 45 C.F.R. § 147.104(i);

c. The failure to reconcile policy in 45 C.F.R. § 155.305(f)(4), including the final rule's amendments to that policy through the addition of 45 C.F.R. § 155.305(f)(4)(iii);

d. The imposition of eligibility verification for the special enrollment period, through the revisions to 45 C.F.R. § 155.420(g);

e. The imposition of a requirement that Exchanges verify household income inconsistencies when a tax filer's attested projected annual household income differs from "trusted data sources," through revisions to 45 C.F.R. § 155.320(c)(3)(iii) and the addition of 45 C.F.R. § 155.320(c)(3)(vi)(C)(2);

f. The changes to the de minimis ranges for actuarial value calculations, through revisions to 45 C.F.R. §§ 156.140(c), 156.200(b)(3), and 156.400;

g. The changes to the policy regarding self-attestation of projected income, through revisions to 45 C.F.R. § 155.320(c)(5).

3. The Court **DECLINES** to stay the effective dates of the following provisions:

a. The change to the measure for calculating the premium adjustment percentage set forth in 90 Fed. Reg. 27,166 through 27,178;

b. The elimination of the 60-day extension of time to resolve inconsistencies in household income data, through the removal of 45 C.F.R. § 155.315(f)(7) and revisions to 45 C.F.R. § 155.320(c)(5).

**SO ORDERED**.

August 25, 2025

/s/
Brendan A. Hurson
U.S. DISTRICT JUDGE

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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

**SECOND DECLARATION OF BROOKE LEGLER**

I, Brooke Legler, declare as follows:

1. I am over 18 years old and competent to make this declaration. I have personal knowledge of the facts and information in this declaration. I have previously submitted a declaration in this action. I respectfully provide this supplemental declaration to further explain why the cost increases that would be caused by the new Centers for Medicare and Medicaid Services rule, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," would threaten my ability to access medication that I require for my health and risk the loss of my small business.

2. I am a member of the Main Street Alliance, which is a national association of approximately 30,000 small businesses.

3. I am a resident of New Glarus, Wisconsin.

4. I am a small business owner. My business is an early childhood education program with about 10 employees.

5. I have rheumatoid arthritis and I am dependent on substantial medication to treat the condition, including medications that address secondary issues caused by the primary

medications. I also take a biologic to protect my health by suppressing my immune system, which costs about $10,000 per month.

6. I purchase individual insurance on the Exchange and receive subsidized coverage under a silver "Quartz One Achieve" plan. I currently pay a net premium of about $200 per month, after application of the Affordable Care Act's subsidies for my coverage.

7. My personal income will be about $30,000 for 2025. I project that my personal income in 2026 will be about the same amount. I understand that, at this income level, I will remain eligible for Affordable Care Act premium tax credits next year, even if legislation is not adopted to extend subsidies that are currently available for other people with higher income levels.

8. My insurance covers my rheumatoid arthritis medications, and a portion of my biologic. I also qualify for payment assistance through the biologic drug company. I would not be able to afford the biologic, or my other medications, without health insurance, or with a less comprehensive insurance plan.

9. As explained in my prior declaration, without access to an insurance plan with the benefits and affordability of my current coverage, I would not be able to afford the medications I need or continue my small business' operations.

10. Accordingly, even if insurers are permitted to sell cheaper plans next year that offer less generous benefits, I would not wish to purchase such a plan. In shopping for a plan next year, I will seek to retain the comprehensive benefits that I have under my current plan, which I need to be able to afford my medications. If lower tax credits are available to subsidize my coverage, I will be required to pay more in net premiums to maintain the same level of coverage.

I declare under penalty of perjury under the laws of the United States of America, pursuant to 28 U.S.C. § 1746, that the foregoing is true and correct to the best of my knowledge.

Executed this 2nd of September, 2025 in New Glarus, Wisconsin.

BROOKE LEGLER

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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

**SECOND DECLARATION OF CHRISTEN LINKE YOUNG**

I, Christen Linke Young, declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. The facts contained in this declaration are known personally to me and, if called as a witness, I could and would testify competently thereto under oath. I submit this sworn declaration in support of Plaintiffs' opposition to the motion for stay pending appeal. I have previously submitted a declaration in support of Plaintiffs' motion for interim relief.

**2.** I am a visiting fellow with the Brookings Center on Health Policy, a research center within the Economic Studies program at the Brookings Institution. My research concerns a variety of topics in health policy, including issues related to health insurance: how Americans get health care coverage, how that coverage is financed, and how the health care system can be improved to make coverage more affordable and accessible. I have published many pieces of scholarly analysis on these topics. I have testified before Congress and before state legislatures, my work is frequently cited in national media, and I have served in multiple leadership roles in state and federal government. My full curriculum vitae, including a list of publications, was submitted as an Appendix to my first declaration.

**Summary of Observations**

3. Implementing more narrow *de minimis* ranges will require action by federal and state regulators and by issuers over the next two months, in order to provide consumers the benefits to which they are entitled.

4. It is feasible for regulators and issuers to take these actions. Marketplace actors have made changes on far more aggressive timelines in the past, most notably in October 2017 in response to federal policy changes that resulted in the loss of $7 billion in federal payments just three weeks before the start of Open Enrollment.

5. Consumers will be harmed with higher out-of-pocket spending – some with higher deductibles and cost-sharing and others with higher premiums – if these changes are not made.

**Although Changes Related to Cost-Sharing Reductions in October 2017 Were a Major Disruption, Issuers Could and Did Quickly Adapt to Those Changes**

6. On October 12, 2017, the federal government announced that it would no longer make Cost-Sharing Reduction (CSR) payments to issuers.[1] This was a major disruption to Marketplace operations that cut payments to Marketplace health plans by $7 billion.[2] The change was made *after* that year's September 27 deadline for issuers to finalize premiums and sign contracts for Marketplace participation for the following year.[3]

7. At the time, this change was understood to be a very significant disruption to Marketplace operations and issuers on a timeline that posed threats to the market. Observers said

[1] U.S. Dep't of Health & Hum. Servs., Memorandum on Discontinuance of Cost-Sharing Reduction Payments (Oct. 12, 2017), https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.
[2] Alison Kodjak, Halt in Subsidies for Health Insurers Expected to Drive Up Costs for Middle Class, NPR (Oct. 13, 2017), https://www.npr.org/sections/health-shots/2017/10/13/557541856/halt-in-subsidies-for-health-insurers-expected-to-drive-up-costs-for-middle-clas.
[3] Rabah Kamal, Ashley Semanskee, Michelle Long, Gary Claxton & Larry Levitt, How the Loss of Cost-Sharing Subsidy Payments Is Affecting 2018 Premiums, KFF (Oct. 27, 2017), https://www.kff.org/private-insurance/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/

it was a "a dramatic move"[4] or an "Obamacare bombshell"[5] that would "roil individual markets."[6] President Trump wrote the next day that "Obamacare is imploding" in association with the change.[7]

8. However, in the days immediately after the October announcement, issuers, the Centers for Medicare & Medicaid Services (CMS), and states worked together to quickly update issuers' individual market filings to react to the change. Issuers generally needed to adopt revised premiums for their plan offerings using novel pricing strategies that differed in important ways from any they had used in the past. CMS and states provided flexibility to allow changes that otherwise were not contemplated under the Marketplace timeline, and by the end of October issuers had made the necessary changes.[8] Open Enrollment began on time on November 1, 2017, nineteen days after the federal government's announcement.

9. Prior to the October 12 announcement, there were widespread rumors that the federal government could take this step, and so most insurance companies likely engaged in some degree of contingency planning to prepare.

10. Facilitating Marketplace premium updates in the days after October 12, 2017 was undoubtedly a complex undertaking that required careful work by dedicated staff at CMS, state-based Marketplaces, state insurance regulators, and issuers. The staff undertook those efforts to

[4] Kevin Liptak, Tami Luhby & Phil Mattingly, CNN, Trump Will End Health Care Cost-Sharing Subsidies (Oct. 12, 2017), https://www.cnn.com/2017/10/12/politics/obamacare-subsidies
[5] Dan Mangan, Obamacare Bombshell: Trump Kills Key Payments to Health Insurers, CNBC (Oct. 12, 2017), https://www.cnbc.com/2017/10/12/obamacare-bombshell-trump-kills-key-payments-to-health-insurers.html
[6] Timothy Jost, Administration's Ending of Cost-Sharing Reduction Payments Likely to Roil Individual Markets, Health Affairs Forefront (Oct. 13, 2017), https://www.healthaffairs.org/do/10.1377/forefront.20171022.459832/
[7] Kevin Liptak, Tami Luhby and Phil Mattingly, CNN, Trump Will End Health Care Cost-Sharing Subsidies (Oct. 12, 2017), https://www.cnn.com/2017/10/12/politics/obamacare-subsidies
[8] Rabah Kamal, Ashley Semanskee, Michelle Long, Gary Claxton & Larry Levitt, How the Loss of Cost-Sharing Subsidy Payments Is Affecting 2018 Premiums, KFF (Oct. 27, 2017), https://www.kff.org/private-insurance/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/

support the successful functioning of the Marketplaces in the wake of a last-minute policy change made by the federal government.

11. I am not aware of any issuers that dropped out of the Marketplace as a result of the events in October 2017. Every county was served by at least one Marketplace issuer in 2018, as has been the case every year of Marketplace operations.

12. This experience that CMS, states, and issuers had in implementing novel pricing strategies shortly before the open enrollment period at the end of 2017 demonstrates that it will be feasible for these actors to implement the District Court's order before open enrollment begins this year. The task that these actors were faced with in 2017 was undertaken over a much shorter time period than the task that these actors now face in conforming plan offerings to the version of the CMS rule governing permissible actuarial value ranges that was in place before June 2025.

**It Is Feasible For Plans To Adapt to Changes to the *De Minimis* Range**

13. To respond to the District Court's ruling, some issuers will be required to change the deductibles and cost-sharing for some of the plans that they will offer on the Exchanges, and to update the premiums for these plans in association with the change.

14. The result of these changes by issuers will be to make health care more affordable for consumers.

- Consumers receiving advance premium tax credits (APTC) and purchasing benchmark silver plan coverage will pay the same premium for more generous coverage.
- Consumers receiving APTC and purchasing coverage other than the benchmark silver plan will generally pay lower premiums for the same coverage or the same premium for more generous coverage, or some combination.

- The small share of consumers not receiving APTC will generally pay slightly higher premiums for more generous coverage.

These impacts are described in more detail in the following section.

15. Changing deductibles, cost-sharing, and premiums to be consistent with more narrow *de minimis* ranges requires issuers to use straightforward plan design tools. While the timeline will be different and more compressed than usual, issuers will not need to develop any novel designs or work with any new types of tools to achieve the changes.

16. It is critical to note that not all plans will require changes: issuers will only be required to change plans with actuarial values outside the *de minimis* ranges that are permissible under the District Court's ruling. CMS possesses data from issuers on the share of plans filed for 2026 that fall outside the permissible ranges but those data are not publicly available. However, one can use data from 2022 to understand the likely scope. Specifically, CMS rules applicable to the 2022 plan year allowed *de minimis* ranges as wide as those the agency attempted to allow for 2026. In 2022, only about one quarter of plans had actuarial values that were outside the ranges that are allowed under the District Court's ruling.[9] While issuers may have behaved somewhat differently for 2026 than they did in 2022, these data support the reasonable inference that the share of filed plans for 2026 that will require changes is likely to be around one quarter.

17. There is reason to think that the share of plans that will require changes for 2026 could be considerably smaller than the share that fell outside the more narrow *de minimis* ranges in 2022. That is because, unlike in 2022, issuers in the federally-facilitated Marketplace are now required to offer standardized plans (i.e. plans with cost-sharing designs specified by CMS, and

[9] Email from Jason Levitis & Claire O'Brien to Christen Linke Young (Sep. 11, 2025) (on file with author) (citing Marketplace Public Use Files for 2022, Ctrs. for Medicare & Medicaid Servs., https://www.cms.gov/marketplace/resources/data/public-use-files).

those designs were finalized in 2024 and not changed by the 2025 rulemaking) and are limited in the number of non-standardized plans that they can offer. Only non-standardized plans can fall outside the more narrow *de minimis* ranges. Thus, the plans even potentially affected by the District Court's ruling constitute a limited slice of Marketplace offerings.

18. CMS first published a final Marketplace rule for 2026 coverage in January 2025, which made no changes to the then-existing rules governing *de minimis* ranges for actuarial value calculations.[10] The publication of that rule kicked off the plan design period for most issuers, and issuers likely began designing plans based on more narrow *de minimis* ranges that had been in effect since the 2023 plan year. In March 2025, CMS proposed wider ranges in its Notice of Proposed Rulemaking,[11] and the rule was finalized at the end of June.[12] Issuers in many states were required to begin filing proposed individual market fillings with their state insurance regulators prior to the publication of the final rule. Thus, issuers would have gone through the early plan design period with the expectation that the pre-existing rules governing *de minimis* ranges would govern their plan offerings, and would have continued through the plan design period in recognition that there was significant uncertainty about what *de minimis* ranges would apply. The proposed and then final rules were immediately controversial and litigation commenced quickly after finalization, thus reinforcing for issuers that there was continuing uncertainty about the rules that would govern Marketplaces in 2026. Given this significant and extended period of uncertainty, I expect issuers will have engaged in some degree of contingency

[10] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program, 90 Fed. Reg. 4424 (Jan. 15, 2025).
[11] Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 12,942 (Mar. 19, 2025) (proposed rule).
[12] Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 27,074 (June 25, 2025) (final rule).

planning, which will likely facilitate the changes necessary to return to more narrow *de minimis* ranges.

19. Indeed, in the spring of 2025, CMS was encouraging issuers to engage in contingency planning for possible changes that Congress could -- or could not -- make that would affect Marketplace plans. In early May, CMS told plans "to be prepared to react to Congressional action that could affect PY 2026 individual market premiums."[13] Notably, legislation that passed the House (but not the Senate) a few weeks after this memorandum included changes to permissible actuarial value *de minimis* ranges consistent with the CMS proposed (and then final) rule.[14] That is, CMS has since May advised plans to be prepared for possible changes in these areas.

20. In my view, CMS, states, and issuers will be able to work together over the next two months to achieve these changes. There is at most a minimal risk that issuers would be unable to conform their plan offerings to the actuarial value rule that was in place prior to June of this year, or that issuers would drop out of the Marketplace. I am not aware of any issuer that has indicated it would leave the Marketplace in association with these changes; issuers generally publicize these actions as far in advance as possible to avoid surprising customers and regulators, so one would expect issuers to have made any such plans public by now.

**Allowing Wider *De Minimis* Ranges To Continue Would Harm Consumers**

21. As noted above, to respond to the District Court's ruling, some issuers will be required to change the deductibles and cost-sharing for some of the plans that they will offer on the Exchanges, and to update the premiums for these plans in association with the changes.

[13] Ctrs. for Medicare & Medicaid Servs., Plan Year 2026 Individual Market Rate Filing Instructions (May 2, 2025), https://www.cms.gov/files/document/py-26-individual-market-rate-filing-instructions.pdf
[14] H.R. 1, 119th Cong. § 44201(c) (as passed by House, May 22, 2025).

22. The result of these changes will be to make health care more affordable for consumers in a wide range of common scenarios.

23. Consumers receiving APTC and purchasing benchmark silver plan coverage will pay the same premium for more generous coverage. That's because the APTC amount changes dollar-for-dollar with changes to the benchmark silver premium. If the benchmark plan is changed to have a higher actuarial value (and thus typically to have a higher premium), APTC recipients enrolled in it will get more generous coverage for the same price.

24. Consumers receiving APTC and purchasing coverage other than the benchmark silver plan will generally pay lower premiums for the same coverage or the same premium for more generous coverage, or some combination.

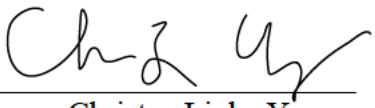
25. Specifically, consumers receiving APTC and intending to purchase coverage that is not affected by the District Court's order will generally pay a lower premium for that coverage. That's because, as explained above, the APTC amount changes dollar for dollar with the benchmark silver premium. So, if the benchmark premium increases while the consumer's plan's premium remains unchanged, the consumer's *net premium* will fall. Moreover, because the benchmark premium is the second-lowest-cost silver plan available, it typically has an actuarial value at the low end of the permissible range.

26. Consumers receiving APTC who would have otherwise purchased coverage that is affected by the District Court's order will generally have a choice between paying about the same net premium for more generous coverage that they would have otherwise received, or using their greater purchasing power on a different plan. Whatever they decide, the larger APTC means a better deal on their coverage.

27. The small share of consumers not receiving APTC may or may not be affected by the ruling. Those intending to purchase coverage not affected by the District Court's ruling will not generally be affected. Those who would have otherwise purchased coverage that is changed due to the District Court's ruling will generally pay slightly higher premiums for more generous coverage. Since all plans must have actuarially justified rates, the consumer would not generally receive a worse deal under this scenario.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: September 1, 2025



Christen Linke Young
Washington, D.C.

**No. 26-1938**

**IN THE UNITED STATES COURT OF APPEALS**
**FOR THE FOURTH CIRCUIT**

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CITY OF COLUMBUS, *et al.*,
*Plaintiffs-Appellees*,

v.

ROBERT F. KENNEDY, JR., *in his official capacity as Secretary of the United States Department of Health and Human Services, et al*,
*Defendants-Appellants*.

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On Appeal from the United States District Court
for the District of Maryland

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# JOINT APPENDIX
# VOLUME III OF III

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**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

| | |
|---|---|
| CITY OF COLUMBUS, *et al.*,<br><br>Plaintiffs,<br><br>v.<br><br>ROBERT F. KENNEDY, JR., in his official capacity as Secretary of the United States Department of Health and Human Services, *et al.*,<br><br>Defendants. | Civil Action No. 1:25-cv-2114-BAH |

**CERTIFICATION AND INDEX FOR THE ADMINISTRATIVE RECORD**

I, Jeff Wu, Deputy Director for Policy, Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services ("CMS"), United States Department of Health and Human Services, certify that, to the best of my knowledge, the materials listed in the accompanying index constitute a true and complete copy of the administrative rulemaking record for the final rule entitled *Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability*, CMS 9884-F, published in the Federal Register at 90 Fed. Reg. 27,074 (June 20, 2025), portions of which have been challenged in the above-captioned case.

Dated: December 12, 2025

Jeff Wu
Deputy Director for Policy
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

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**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

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|---|---|
| CITY OF COLUMBUS, *et al.*,<br><br>*Plaintiffs*,<br><br>v.<br><br>ROBERT F. KENNEDY, JR., *et al.*,<br><br>*Defendants*. | Case No. 1:25-cv-2114 |

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Mark Shepard & Myles Wagner, *Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment*, 115 Am. Econ. Review 772 (2025) AR38965

Paragon Health Inst., *The Great Obamacare Enrollment Fraud* (June 2024) AR39294

April 8, 2025

Dear Secretary Kennedy,

We write in response to the proposed program integrity rule, CMS-9884-P. Dr. Drake is an associate professor in the Department of Health Policy Management at the University of Pittsburgh, and Dr. Anderson is an assistant professor in the Department of Health Services, Policy and Management at the University of South Carolina. Drs. Drake and Anderson are leading academic experts on the Health Insurance Marketplaces, having published over two dozen peer-reviewed articles on this topic in leading journals such as *Journal of Public Economics, Journal of Health Economics, Health Affairs, JAMA Internal Medicine* and *JAMA Health Forum*.

We wish to highlight some recent and important work from the academic, peer-reviewed literature that should inform the trade-offs and assumptions that are being made in this proposed rule. We will discuss several topics listed below, including:

- Enrollment trade-offs as affordability changes
- Ordeals and selection markets
- The incidence of administrative burden in selection markets
- The role of automatic re-enrollment to maintain continuity of coverage
- Open Enrollment Periods
- Automatic re-enrollment hierarchy

In the proposed rule, the Centers for Medicare and Medicaid Services (CMS) has prioritized improving affordability and competition in the non-subsidized segment of the ACA-compliant individual health insurance market. We believe that CMS should fully engage with the strong evidence that increasing administrative burdens for Marketplace enrollees will result in a smaller, sicker pool of enrollees that will necessitate insurers increase premiums, both on and off the Marketplaces. The proposed rule will increase administrative burdens by increasing data verification requirements, reducing the length of the Open Enrollment Period, and making it harder for current enrollees to automatically renew their coverage.

We believe that CMS is not fully considering the disenrollment effects of changes in the minimum cost of coverage for both subsidized and non-subsidized individuals, as the changes in enrollment (750,000-2,000,000) are attributed to improper enrollments.

> We believe the majority of improper enrollments would disenroll from coverage as a result of the enhanced subsidies, therefore, we assume a range of approximately 750,000 to 2,000,000 fewer individuals would enroll in QHP coverage in 2026 as a

result of the proposals in this rule, if finalized jointly and as proposed. We seek comment on this estimate and assumptions.

Increasing the minimum cost of coverage while also increasing administrative burden will lead to substantially higher disenrollments.

***Enrollment trade-offs as affordability changes***

The ACA individual health insurance market is a bifurcated market where some individuals are eligible for and receive income-based premium tax credits to reduce the cost of their monthly premiums, and other individuals do not receive these credits. The price-linked nature of Marketplace subsidies produces counter-intuitive dynamics that must be considered. [1]

Prior research has shown the minimum cost of coverage is, by far, the single most important determinant of whether people enroll in Marketplace coverage.[2,3] Potential enrollees are not sensitive to benefit design in choosing whether to enroll.[4] Larger subsidies lead to lower premiums for subsidized individuals, in turn increasing enrollment and reducing the average costs of covering enrollees (i.e., marginal enrollees tend to be healthier than other enrollees).[5] Treasure et al[6] identified that CSR-94 Silver plan enrollees who faced a $22 monthly premium for the benchmark plan and may have been exposed to zero premium plans during the 2018 plan year had similar per member per month spending to Bronze enrollees who likely selected low premium and high cost sharing plans as a matter of their risk profile. Healthy potential enrollees are only purchasing coverage when the minimum cost of coverage is low.

Federal and state policies can and do change the minimum cost of coverage and thus enrollment levels in the marketplaces. Anderson, Golberstein and Drake provide new evidence that Section 1332 reinsurance waivers have a substantial enrollment trade-off.[7] They analyzed both enrollment and the cost of the least expensive plans available to enrollees in Georgia at various income and subsidy eligibility levels both before and after the implementation of the Section 1332 reinsurance waiver relative to bordering states. The reinsurance waiver was successful in reducing the minimal cost of coverage for individuals who were unlikely to receive a premium subsidy as intended. However, the minimum cost of coverage increased for enrollees with incomes between 200-400% FPL leading to disenrollments among this group eight times as large as the state projected non-subsidized enrollee growth would be. **Small changes in the minimum cost of coverage for unsubsidized enrollees likely will have large changes in enrollment for subsidized buyers who are most likely to be healthier and lower in costs than the average enrollee.**

Actions which increase the minimum cost of coverage for subsidized enrollees, such as increasing the allowable de minimas variation for the benchmark silver plan, will likely affect disproportionately large enrollment losses among subsidized enrollees relative to any plausible enrollment gains among non-subsidized enrollees. Insurers will likely compete on price and lower the actuarial value to the new proposed boundaries:

> We propose to change the de minimis ranges at § 156.140(c) beginning in PY 2026 to +2/-4 percentage points for all individual and small group market plans subject to the AV requirements under the EHB package, other than for expanded bronze plans…
>
> We also propose to revise §156.200(b)(3) to remove from the conditions of QHP certification the de minimis range of +2/0 percentage points for individual market silver QHPs. We also propose to amend the definition of "de minimis variation for a silver plan variation" in § 156.400 to specify a de minimis range of +1/-1 percentage points for income-based silver CSR plan variations.

Decreasing the actuarial value of silver plans of the -00, -01, -04, -05, and -06 plan variants will lead to lower benchmark premiums and higher minimum cost of coverage as the premium spreads will be compressed.[5] Furthermore, as discussed below, enrollees that drop coverage are likely to have lower than average risks and costs relative to the remaining enrollees, leading to higher premiums and higher per enrollee premium tax credit expenditures.

CMS projects that changing the de minimas variation rule will lead to a 1% decrease in premiums. Assuming this 1% change in premium applies evenly to all metal levels, we anticipate that the minimum cost of coverage for a subsidized enrollee will increase by $6.00 to $7.00 per member per month for individuals who do not have the option to purchase zero-premium Bronze plans. This will lead to a substantial decrease in enrollment that is not being considered by CMS in the proposed rule.

***Administrative Burden, Ordeals and Selection Markets***

We would like to bring new work by Shepherd and Wagner recently published in the American Economics Journal to the attention of CMS.[8] Classic public economics thinking has focused on using ordeals to impose non-cash prices on potential enrollees in order to more effectively target public assistance to individuals who have the highest valuation of that assistance.[9] In health insurance markets, however, individuals who likely have lower value on assistance are also likely to have far lower costs than individuals who highly value the assistance. In such a market that is vulnerable to adverse selection, ordeals in the form

of increased administrative burdens and compliance costs could plausibly lead to increased average morbidity and higher average claims expenses as the lowest acuity, lowest risk enrollees would be the most likely to drop coverage in response to increases in price and/or administrative burdens.

Shepherd and Wagner examine automatic re-enrollment. They note that there is substantial variation in expected monthly costs as a function of risk:

> In our health insurance data, the highest-risk (sickest) 10 percent of enrollees incur 15 times higher medical costs than the healthiest 10 percent (about $1,400 versus $90 per month). Moreover, the healthy are likely to value insurance less, precisely because they have fewer medical needs and use less care. This example illustrates the key correlation in settings with adverse selection: low-value types also tend to be low-cost.

The key point is that increasing burden in a health insurance selection market likely drives out the lowest risk and lowest cost enrollees, leading to higher premiums for the remaining enrollees. As they elaborate

> We use a natural experiment to study descriptively how much ordeals matter for take-up and which types of people they screen out. We find that even minor hassles lead to major reductions in take-up among an otherwise uninsured low-income population. Consistent with adverse selection, the excluded group is differentially younger, healthier, and poorer, suggesting ordeals screen out people with low private value (demand) but also low cost of insurance.1 Using an empirical model estimated with our data, we find that ordeals worsen targeting efficiency, despite successfully screening out low-value types. More generally, we show that adverse selection works alongside behavioral frictions to weaken the (revealed preference) link between demand and efficiency that is key to self-targeting. This makes ordeals relatively poorly suited tools for adverse selection markets.

This insight, which reinforces other recent research by Domurat, Menashe and Yin,[10] informs the rest of our comments.

***Automatic re-enrollment and zero premium plans***

The agency has proposed a substantial change in automatic re-enrollment policy for individuals passively re-enrolling in zero-premium plans.

> We propose that, when an enrollee does not contact an Exchange to obtain an updated eligibility determination and select a plan on or before the last day to do so for January 1 coverage, in accordance with the effective dates specified in §§155.410(f) and 155.420(b), as applicable, and the enrollee's portion of the

> premium for the entire policy would be zero dollars after application of APTC through the Exchange's annual redetermination process, all Exchanges must decrease the amount of the APTC applied to the policy such that the remaining monthly premium owed by the enrollee for the entire policy equals $5 for the first month and for every following month.

Automatic re-enrollment is critical for maintaining continuity of coverage. Drake and Anderson showed that individuals who were enrolled in December and who were not passively re-enrolled into plans—that is, they had to actively reenroll in coverage in a manner consistent with what CMS proposes here—were 30 percentage points less likely to reenroll in coverage than individuals who could passively re-enroll.[11] Mcintyre and colleagues have shown that small premiums, like the proposed $5 premium penalty, act as substantial barriers to re-enrollment. They found that individuals who previously had zero dollar premiums but were defaulted to small premiums of less than $10 per month had a 14% reduction in re-enrollment.[12] In other work, McIntyre and colleagues found that the individuals who were most likely to be negatively impacted by administrative burden on re-enrollment are:[13]

> Switchers are younger (by 4.1 years), less likely to have a chronic illness (by 3.4% points, or 6%), and have lower medical risk scores (by 0.025, or 2.5% lower predicted spending). Their average medical spending per month enrolled is 8.6% lower. Notably, the larger percentage gap in spending than risk score indicates that switchers are differentially profitable even after risk adjustment. Spending for auto-switchers is particularly low in the six months following the auto-switch, consistent with research showing that enrollees lapse at times when they use less health care (Diamond et al., 2020)."

Increasing the administrative burdens of individuals who are enrolled in zero dollar premium plans likely leads to a more morbid and higher cost risk pool because these burdens create strong adverse selection incentives. Increasing adverse selection runs counter to the stated goals of the agency in this proposed rule.

**Open Enrollment Period Changes to December 15th**

The proposed rule indicates a desire to change the open enrollment period:

> We propose to amend § 155.410(e), which provides the dates for the annual individual market Exchange OEP in which qualified individuals and enrollees may apply for or change coverage in a QHP. Specifically, we propose to add § 155.410(e)(5) and (f)(4) to change the OEP for benefit years starting January 1, 2026, and beyond so that it begins on November 1 and runs through December 15 of the

> calendar year preceding the benefit year and to set an effective date of January 1 for QHP selections received by the Exchange on or before this December 15 OEP end date. The Exchange OEP is extended by cross-reference to non-grandfathered individual health insurance coverage, both inside and outside of an Exchange, under the guaranteed availability regulations at § 147.104(b)(1)(ii). We also are making conforming revisions to § 155.410(e)(4) and (f)(3).

Drake and Anderson identified that counties which used Healthcare.gov from 2015-2018 where low income enrollees (175% FPL) were exposed to zero premium plans had 14% higher enrollment.[14] In follow-on work using individual level data from Colorado's state based marketplace and a rigorous regression discontinuity design (RDD), Drake and colleagues found that administrative burdens of small premiums were a substantial barrier to enrollment.[15] Individuals that enrolled in zero premium plans were more likely to effectuate coverage by the January 1st deadline. Individuals who faced even small premiums frequently needed a second chance to correct mistakes and good faith errors that they made during the enrollment process. The availability of an Open Enrollment Period after the auto-re-enrollment process was completed likely allowed for individuals to pay their token premiums and start coverage for February 1st.

Eliminating an opportunity for individuals who desire to enroll in health insurance for January 1st but were tripped up by good faith errors and complexity likely will lead to increased adverse selection. Furthermore, the Notice for Benefit Payment Parameters for Plan Year 2026 (NBPP 2026) on p. 82336 of the Federal Register Volume 89, No 197 published on October 10, 2024, indicates that adverse selection due to partial year enrollment declines substantially for adults as evidenced by the Enrollment Duration Factors that only apply to individuals with between 1 and 6 months of enrollment and at least one HCC. NBPP 2023 removed monthly enrollment duration factors while adding the limited HCC contingent enrollment duration. Under the risk adjustment model that CMS has published, received notice and comment on, and has finalized a rule as of January 2025, 11-month enrollment, especially 11 month enrollment for the February-December span, has no additional predictable cost than 12 month enrollment.

Furthermore, we believe that the analysis offered on the impact of post-January 1st OEP is not a relevant analysis. We excerpt the analysis below:

> From 2017 (the year before the end date changed to December 15) to 2021 (the last year of the December 15 end date), we found that Exchanges on the Federal Platform experienced a larger (47 percent) growth in enrollment among people who enrolled in coverage with only APTC compared to 28 percent growth among people enrolled with only APTC through State Exchanges. This suggests the change to the

December 15 OEP end date did not compromise access to coverage for people selecting plans through the Exchanges on the Federal platform.

States that had always operated a state based marketplace are markedly different than states that have always used Healthcare.gov as either the FFM or FFM-SP.[16] A simplistic comparison of the growth rates between states that have different trajectories is neither meaningful nor informative. SBM states had enrolled a higher proportion of eligible enrollees into either Medicaid or an ACA QHP prior to 2017.[17] More simply, it is easier to have high enrollment growth in a state with high uninsurance rates in 2017 like Texas than in states like Massachusetts with low uninsurance rates.

One key difference is that for plan year 2018-2021 Silverloading, or the increasing of premiums of Silver plans to compensate insurers for the cost of providing mandatory Cost-Sharing Reduction (CSR) took effect. The incremental change in silver premiums due to Silverloading likely varies as a function of two critical state policies. First, states that have adapted a Section 1331 Basic Health Plan (Minnesota and New York during this time period) or have exceptionally high general eligibility for Medicaid for 19-64 year old adults (Washington DC) would have removed the overwhelming majority of the potential value of Silverloading from the ACA individual market.[18,19] CMS recognized this dynamic in the August 24, 2018 Final Administrative Order.

**Changes to Special Enrollment Periods**

CMS proposes to eliminate a Special Enrollment Period for individuals with incomes between 100-150% FPL in § 155.420. We would like to highlight recently published work by Chatrath et al that found almost no change in adverse selection after a substantial change in the validation and verification of SEPs.[20] We would encourage CMS to reconsider as the selection incentives are weak and this low income population is likely to have highly variant income and access to benefits.

If the goal of CMS is to increase the attractiveness and competitiveness of the non-subsidized individual health insurance markets, steps that increase administrative burden and morbidity in the subsidized portion of the market will work against that goal.

Sincerely,

Dr. David M Anderson PhD, Dr. Coleman D. Drake PhD

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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

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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,

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**Submitted online via Regulations.gov**

April 10, 2025

Secretary Robert F. Kennedy, Jr.
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

**Re: RIN 0938-AV61; CMS-9894-P**
**Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability**

Dear Secretary Kennedy:

The National Health Law Program (NHeLP) is a public interest law firm that works to advance equitable access to health care and protect the health rights of people with low incomes and underserved populations. For over fifty-five years, we have litigated, advocated, and educated at the federal and state levels to advance health and civil rights in the United States.

Consistent with our mission, we strongly believe that health care is a human right. Every individual should have access to high quality, affordable, and comprehensive health care and be able to achieve their own highest attainable standard of health. Accordingly, we generally appreciate the opportunity to comment on the Department of Health and Human Services' (HHS) proposed rule, *Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability* (hereinafter "Proposed Rule").[1]

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**§ 147.104(i) Coverage Denials for Failure To Pay Premiums for Prior Coverage**

HHS proposes removing § 147.104(i), which would allow qualified health plans (QHPs) to prohibit individuals who owe past due premiums from enrolling in coverage until they satisfy all prior arrearages.[2] HHS proposes a more stringent provision than what was in the Market Stabilization Rule, which limited the policy to unpaid premiums in the last 12 months.[3] We oppose HHS's proposal as it is an unlawful interpretation of the guaranteed availability provision. The statute is clear; an issuer "must accept every employer and individual in the State that applies for such coverage."[4] HHS's misinterpretation violates the right to guaranteed availability of coverage under the ACA and § 147.104(a). Further, in addition to being unlawful, removing § 147.104(i) will create significant hardship for consumers as guaranteed access to affordable health care improves individuals' health outcomes.[5]

HHS introduced § 147.104(i) after it concluded that the guaranteed availability requirement prohibited issuers from denying coverage to individuals for their failure to pay past due premiums. As stated above, our position is that it is improper and illegal to hold new or renewed enrollment contingent on past premiums. The bar to access care is evident under a plain reading of the statute.

The requirement to pay past due premiums to enroll creates barriers to health coverage that disproportionately affects low-income individuals who are more likely to owe past due premiums.[6] Some of these individuals may be punished by the policy through no fault of their own because unpaid premiums may arise through issuer accounting errors or other marketplace recordkeeping mistakes. We have observed numerous case examples where individuals regularly paid their premiums but issuers failed to match the payment to a particular individual's account, issued bills that did not match the amount individuals were supposed to pay, or caused other accounting irregularities that were of no fault to the

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[1] U.S. Dep't. Health & Human Srvs., *Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, Notice of Proposed Rulemaking*, 90 Fed. Reg. 12944 (proposed Mar. 19, 2025), https://www.federalregister.gov/documents/2025/03/19/2025-04083/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability (hereinafter "Proposed Rule").
[2] 90 Fed. Reg. 12942, 12944 (Mar. 19, 2025).
[3] 82 Fed. Reg. 18349.
[4] 42 U.S.C. § 300gg–1(a).
[5] *See, e.g.*, Renuka Tipirneni et al, *Health Insurance Affordability Concerns And Health Care Avoidance Among U.S. Adults Approaching Retirement*, 3 Jama Network Open 6, 8 (2020).
[6] *See* 87 Fed. Reg. 27208 (HHS stating that the requirement for individuals to pay past due premiums in order to enroll "has the unintended consequence of creating barriers to health coverage that disproportionately affect low-income individuals."). *See also* Lunna Lopes et al., Kaiser Family Found., *Americans' Challenges with Health Care Costs* (2024), available at https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/.

individuals.[7] Throughout the proposed rule, however, HHS brands all unpaid premiums as evidence of individuals "gaming" the guaranteed availability requirement. This portrayal neglects the stories of individuals who accumulate these debts due to system or other barriers beyond their control. And it is problematic to attribute misconduct in these scenarios and leverage individuals' health and well-being to compel the resolution of administrative problems.

To address HHS's stated concern that individuals only enroll in, and pay for, coverage when they need medical care, we support measures that allow issuers to recoup unpaid premiums while still maintaining enrollment. Research shows that there are other effective methods of recovering medical debt that do not restrict individuals' access to health care.[8] Thus, HHS can achieve its objective and ensure marketplace payment integrity without blocking enrollment and jeopardizing individuals' health.

If HHS proceeds with implementing this provision, then a number of protections are needed to ensure compliance and understanding from individuals and families. Notably, issuers should be required to notify enrollees and applicants that coverage may be denied due to unpaid past premiums. And in order to protect individuals against the potential adverse health consequences of blocking enrollment due to past due premiums, HHS should also consider: extending existing grace periods, offering alternatives to lump sum repayments, allowing enrollment after partial repayment, and exempting individuals who earn below certain incomes or exempting those who can demonstrate they had (or have) a genuine inability to pay for (or repay) past premiums.

The guaranteed availability requirement recognizes that access to health care is crucial to achieve a healthy population. Severe health consequences may arise when policy-makers impose barriers to affordable care. HHS's proposal will hold individuals' health hostage in an attempt to resolve administrative problems. Instead, issuers can recover unpaid premiums through the lawful and effective means that already exist. Accordingly, we oppose HHS's proposal to remove §147.104(i) as it would violate the guaranteed availability requirement.

**§ 155.20 Definitions**

NHeLP opposes the proposed modification of the definition of "lawfully present" used to determine eligibility for the Centers for Medicare & Medicaid Services (CMS)' health insurance affordability programs. The modification would exclude "Deferred Action for Childhood Arrivals" (DACA) recipients from enrolling in a Qualified Health Program (QHP)

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[7] *See, e.g.*, Kaiser Health News, *Covered California: Error means thousands surprised by higher premiums* (2017), available at https://www.mercurynews.com/2017/01/19/covered-california-error-means-thousands-surprised-by-higher-premiums/.

[8] Consumer Financial Protection Bureau, *Consumer credit reports: A study of medical and non-medical collections* 7 (2014), available at https://files.consumerfinance.gov/f/201412_cfpb_reports_consumer-credit-medical-and-non-medical-collections.pdf.

through an exchange, receiving advance payments of the premium tax credits (APTC) and cost-sharing reductions (CSRs), and enrolling in a Basic Health Program (BHP) in States that elect to operate a BHP.

People granted deferred action under the DACA program are lawfully present and should be treated as such for health insurance purposes. HHS has maintained eligibility for insurance affordability programs for all others granted "deferred action" over the years.

On May 3, 2024, the U.S. Department of Health and Human Services (HHS) issued a final rule modifying the definition of "lawfully present" to include individuals who receive Deferred Action for Childhood Arrivals (DACA). This would allow DACA recipients meeting all other eligibility requirements to enroll in a Qualified Health Plan through the Marketplace, or a Basic Health Plan.[9] The policy went into effect on November 1, 2024, and was expected to enable 100,000 DACA recipients to enroll in health insurance.[10]

To be eligible for health coverage under the Affordable Care Act (ACA), an individual must either be a U.S. citizen, national, or "lawfully present" in the United States. When the DACA program was first established, existing HHS policies would have classified DACA recipients as "lawfully present," making them eligible to enroll in various insurance affordability programs, such as Qualified Health Plans (QHPs) through the Health Insurance Marketplace, Basic Health Programs (BHPs), and Medicaid or the Children's Health Insurance Program (CHIP) in states that have opted to cover "lawfully residing" pregnant people and children through the CHIPRA 214 option.[11]

However, shortly after the DACA program began, HHS issued regulations and guidance that excluded DACA recipients from the definition of "lawfully present."[12] This exclusion denied DACA recipients access to affordable health coverage, negatively impacting their health outcomes and financial well-being, increasing overall healthcare system costs, and exacerbating health inequities.[13] The Proposed rule would once again exclude DACA recipients from the marketplace and all other health insurance affordability programs.[14]

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[9] 45 C.F.R § 152.2.
[10] Ctrs. for Medicare & Medicaid Srvs., Fact Sheet: *HHS Final Rule Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens* (May 3, 2024) https://www.cms.gov/newsroom/fact-sheets/hhs-final-rule-clarifying-eligibility-deferred-action-childhood-arrivals-daca-recipients-and-certain.
[11] Ctrs. for Medicare & Medicaid Srvs., Dear State Health Official, *SHO #10-006: Medicaid and CHIP Coverage of "Lawfully Residing" Children and Pregnant Women* (Jul. 1, 2010), https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/sho10006.pdf.
[12] Ctrs. for Medicare & Medicaid Srvs., Dear State Health Official, *SHO #12-002: Individuals with Deferred Action for Childhood Arrivals* (Aug. 28, 2012), https://www.medicaid.gov/federal-policy-guidance/downloads/sho-12-002.pdf.
[13] Nat'l Immigr. Law Ctr., *DACA Recipients' Access to Health Care: 2023 Report* (May 2023), https://www.nilc.org/news/special-reports/daca-recipients-access-to-health-care-2023-report/.
[14] Proposed Rule, *supra* note 1

A 2023 survey found that DACA recipients were nearly three times as likely to be uninsured than the general population in the United States.[15] About 20% of survey respondents indicated that they were not covered by any kind of health insurance or health care plan. Excluding DACA recipients from health insurance exchanges and APTCs does not eliminate their needs for health care. While some uninsured DACA recipients can access treatment for emergency medical conditions, they cannot access the comprehensive services necessary to cultivate positive long-term health outcomes.[16] Delaying or forgoing care because of high out-of-pocket costs is not cost-effective, and burdens the health care system with increased emergency department use and avoidable hospitalizations.[17]

Extending ACA coverage to DACA recipients likely had a beneficial effect on Exchange risk pools because they are healthy young adults. DACA recipients generally are between the ages of 21 and 40 with an average of 29.[18] Among individuals likely eligible for DACA, estimates find that 64% report their health as excellent or very good, while an additional 28% report their health as good.[19]

When proposed, the current rule indicates that HHS initially estimated that 100,000 people with DACA were likely to benefit from eligibility for marketplace coverage. However, in the current proposed rule HHS, estimates a reduction to 10,000 people in the QHPs and 1,000 more in the BHP. This is not a fair estimate of the potential harm of excluding DACA recipients from marketplace and BHP eligibility because pending court challenges in 19 states prevented DACA recipients from enrolling in coverage after the first month of open enrollment.[20]

**§§ 155.305, 155.315, and 155.320 Verification Process Related to Income Eligibility for Insurance Affordability Programs**

**A. § 155.305(f)(4) - Failure to File Taxes and Reconcile APTC Process**

The failure to reconcile (FTR) process that ensures individuals receive the appropriate APTCs based on their tax filings has been an evolving process since 2017 as the relevant departments dealt with the intricacies of delayed tax data, privacy requirements of tax filers

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[15] KFF, *Key Facts on Deferred Action for Childhood Arrivals (DACA)* – February 11, 2025 (Mar. 28, 2025), https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/.
[16] 8 U.S.C. § 1611(b)(1)(A).
[17] Jennifer Tolbert et al., Kaiser Fam. Found., *Key Facts about the Uninsured Population* (Dec. 19, 2022), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.
[18] U.S. Citizenship & Immigr. Srvs., *Active DACA Recipients – December 16, 2024* (Mar. 28, 2025), https://www.uscis.gov/sites/default/files/document/data/Active_DACA_Recipients_Dec_FY23_qtr1.pdf.
[19] KFF, *supra note 17.*
[20] KFF, *How Pending Health-Related Lawsuits Could be Impacted by the Incoming Trump Administration*, November 25, 2024 (Mar. 28, 2025) https://www.kff.org/medicare/issue-brief/how-pending-health-related-lawsuits-could-be-impacted-by-the-incoming-trump-administration/.

and providing notice to APTC recipients; notice requirements that comply with due process; and consumer confusion.[21] In the current proposal, HHS seeks to return to a previous policy without a rationale that differs from those already considered in the current FTR policy or specific data to support the claims that individuals are purposefully misstating income or improperly enrolled.[22] In fact, despite the current two consecutive years of FTR status policy, HHS relies on a belief that the "current process could incentivize tax filers to not file and reconcile."[23] When in fact, HHS has access to data that would indicate a basis for this change in policy. The data that is cited indicates that many will be harmed under the proposed one year FTR status rule given that the 2025 OEP data cited shows approximately 1,500,000 potential reenrollments with either a one-year tax FTR status, a tax filing extension, or filed taxes without the APTC reconciliation form.[24] That same 2025 OEP data shows only 356,000 potential reenrollments with a two-tax year FTR status.[25] HHS's proposal to change the FTR policy from a two year to one year FTR leading to ineligibility for APTCs will eliminate coverage for over 1 million people without sufficient reason for the reversal to a previous policy that had well-considered changes.[26]

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[21] NHeLP has consistently commented on this process to ensure that people are not denied the APTCs for which they are eligible and that HHS follows all due process requirements in any action that denies or terminates this benefit and we incorporate those previous comments by reference. *See, e.g.,* Nat'l Health Law Prog., *2025 NBPP Proposed Rule Comments,* 9-13 (Jan. 8, 2024), https://healthlaw.org/resource/comments-on-the-notice-of-benefit-and-payment-parameters-for-2025/; Nat'l Health Law Prog., *2024 NBPP Proposed Rule Comments,* 6-8 (Jan. 30, 2023), https://healthlaw.org/resource/nhelp-comments-on-patient-protection-and-affordable-care-act/ . HHS must meet due process requirements in any changes that create denials or terminations of APTCs. U.S. Const. Amend. XIV; *Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1, 14 (1978); *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 314-15 (1950) (requiring "notice reasonably calculated, under all circumstances, to apprise intended parties of the pendency of the action and afford them an opportunity to present their objections" and that "[t]he means [of notice] employed must be such as one desirous of actually informing the absentee might reasonably adopt to accomplish it."); *Goldberg*, 397 at 267-68 (requiring "timely" notice "detailing the reasons for a proposed action"); *Mathews v. Eldridge*, 424 U.S. 319, 348 1976) (risk of erroneous deprivation through procedures being used); *Carey v. Quern*, 588 F.2d 230, 232 (7th Cir. 1978) (due process requires the assistance program be administered to insure fairness and avoid risk of arbitrary decision making).; *see also Goldberg v. Kelly*, 397 U.S. 254, 267-68 (1970) (requiring detailed reasons in notice, including "the legal and factual bases"); *Gray Panthers v. Schweiker*, 652 F.2d 146, 168 (D.C. Cir. 1981) (without adequate notice of reasons for denial "hearing serves no purpose."); *Barry v. Lyon*, 834 F.3d 706, 720 (6th Cir. 2016) (agency must provide "specific, individualized reasons for the agency action"); *Rodriguez v. Chen*, 985 F. Supp. 1189, 1195 (D. Ariz. 1996) (public interest in assuring health benefits will not be erroneously terminated or denied outweighs inconvenience to the state and the notice must include specific financial information where applicable so that errors may be corrected); *Ortiz v. Eichler*, 616 F. Supp. 1046, 1062 (D. Del. 1985), aff'd 794 F.2d 880 (3d Cir. 1986) (requiring notice include what financial information was considered and include what financial information was considered and relevant calculations of income are involved in the eligibility decision).

[22] Proposed Rule, supra note 1, at 12958-62.

[23] *Id.* at 12959. (emphasis added)

[24] *Id.*

[25] *Id.*

[26] *Id.*; *see also id.* at 12960 (estimating that the number of people who would remain covered under the two-tax year FTR policy would be greater than the 81,600 they previously estimated).

In 2023, HHS proposed that an individual would be ineligible for APTC only if the person has a FTR status for two consecutive years.[27] This decision was based on HHS's experience with the FTR process in which people became ineligible for APTCs after one year of FTR status. Under that policy, there was often significant delays in tax return processing, consumer and tax-preparer confusion, and significant costs associated with FTR-related appeals that could have been avoided with the two-year FTR status process.[28] The tax return processing delays continue and will likely continue to impact the accuracy of FTR status, particularly under a one-year FTR policy.[29] The requirement that an individual have FTR-status for two consecutive years was finalized on the rationale that it was the right balance of protecting the interests of APTC recipients and the government. In addition, the process and notices of the existing FTR procedure would help protect against arbitrary actions by the government that affected benefits provided to individuals, as required by the Constitution.[30]

In adopting the current two-year FTR process, HHS weighed the risks of individuals facing higher tax liabilities due to the two-year process, against the risks of wrongful denials of APTCs due to data issues and delays and found that there was a greater likelihood of harm from the wrongful denials. HHS also weighed the risk to the government in unnecessary appeals, additional processing, and the possibility of fraud.[31] On the fraud concern, HHS cited that individuals were still required to reconcile each year and it would monitor yearly FTR consumer data and that people who abused the system could be subject to enforcement action, including additional tax liability, interest, and penalties.[32]

HHS's proposed change to the FTR process focuses on curbing government spending on APTCs for individuals that may not be eligible, but offers very little proof that this is occurring and little recognition or balancing of the harm from denying APTCs wrongfully. HHS cites the problem of "lead generating companies" that induce improper broker actions, but does not address those issues nor did they address the effectiveness of enforcement actions already taken. Instead, HHS proposes to policy around the individuals harmed by

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[27] 88 Fed. Reg. 25740, 25814-18 (Apr. 27, 2023).
[28] *Id.*
[29] *See generally* TREASURY INSPECTOR GEN. FOR TAX ADMIN., 2024-406-020, THE IRS CONTINUES TO REDUCE BACKLOG INVENTORIES IN THE TAX PROCESSING CENTERS REPORT (2024), https://www.tigta.gov/sites/default/files/reports/2024-03/2024406020fr.pdf (describing significant delays in tax processing).
[30] U.S. Const. Amend. XIV; *Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1, 14 (1978); *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 314-15 (1950) (requiring "notice reasonably calculated, under all circumstances, to apprise intended parties of the pendency of the action and afford them an opportunity to present their objections" and that "[t]he means [of notice] employed must be such as one desirous of actually informing the absentee might reasonably adopt to accomplish it."); *Goldberg*, 397 at 267-68 (requiring "timely" notice "detailing the reasons for a proposed action"); *Mathews v. Eldridge*, 424 U.S. 319, 348 1976) (risk of erroneous deprivation through procedures being used); *Carey v. Quern*, 588 F.2d 230, 232 (7th Cir. 1978) (due process requires the assistance program be administered to insure fairness and avoid risk of arbitrary decision making).
[31] *Id.*
[32] *Id.* at 25818

those improper broker actions and limit individual access to APTCs. The change from the two-year FTR policy to one-year harms the individuals who rely on APTCs to access health care. This policy change also creates significant confusion among all stakeholders.[33]

Because NHeLP opposes the change from the two-year FTR policy to a one-year FTR policy, we also oppose the removal of the associated notice requirements. Proper FTR notices help individuals understand the potential APTC repercussions of FTR. In addition, as explained in previous comments, the indirect notice sent to the APTC recipient is insufficient to meet due process requirements as the timing of the notices is too spread out to be considered proper notice. Further, the indirect notice will not explain in sufficient detail why the individual is losing their APTCs and what they can do to remediate the issue and be successful in an appeal.[34] The current process of requiring two-consecutive FTR status years and all current notices should remain in place to help ensure that individuals are not denied APTCs for which they are eligible and are not denied merely because of data, delays, and other administrative issues.

### B. § 155.320(c)(3)(iii) - Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL & § 155.320(c)(5) - Income Verification When Tax Data Is Unavailable

We have a number of concerns with HHS's proposal to address income inconsistencies in circumstances when an individual's attested projected annual household income is less than 100% of the FPL (removal of § 155.320(c)(5)), or equal to or greater than 100% of the FPL and no more than 400% of the FPL (revisions to § 155.320 (c)(3)(iii)). In short, we oppose the additional verification requirements proposed in these sections.

We oppose HHS's proposal to remove § 155.320(c)(5), which requires marketplaces to accept an applicant or enrollee's self-attestation of projected household income when the marketplace requests tax return data from the IRS but the IRS confirms there is no such tax return data available. First, HHS itself notes that many individuals are unable to complete their tax filing requirements due to administrative burdens. Instead of easing this burden, HHS plans to add to it. HHS states that the additional proposed income verifications will yield a minimal, one-hour administrative burden on individuals. However, HHS's time estimate an average, conceals the fact that many administrative barriers are bimodal and averages do not accurately reflect an individual's experience. People with disabilities, for

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[33] Proposed Rule, *supra* note 1, at 12960. Although HHS cites program integrity concerns but gives little weight or consideration to the impact on individuals who do not receive the APTCs for which they are eligible but are prohibited from receiving the benefit due to tax data delays or other administrative issues that have been the reason for the two-year FTR status policy.

[34] Proposed Rule, *supra* note 1 (note with previous comments and due process case law); *see also Goldberg, 397 U.S. at 267-68; Goss v. Lopez, 419 U.S. 565, 579 (1975)* (due process has little reality or worth unless a person understands the issue is pending); *see also Waldrop v. New Mexico Dept. Hum. Servs. Dep't,* No. CV 14-047 JH/KBM, 2015 WL 13665460, at *24 (D.N.M. Mar. 10, 2015) (beneficiary must be provided notice about the process).

example, may encounter unique barriers and citing an average will misrepresent individuals' actual experiences.[35] In reality, the administrative burden to verify, and often re-verify, income is high. Additionally, other intangible costs—like stress, psychological harms, and distrusts of the system—may arise when individuals are repeatedly asked to respond to administrative requests.

Administrative burdens will also increase under HHS's revisions to § 155.320(c)(3)(iii). For example, marketplaces would now need to verify information with other trusted data sources instead of accepting the attestation. To that end, the proposal estimates an increase of approximately $32 million in annual costs to the federal government and state marketplaces due to additional DMIs projected under § 155.320(c)(3)(iii) alone.[36] These resources would be better used for educational materials for individuals to help improve income reporting accuracy. HHS's sweeping proposal underestimates the potential harms. As such, we urge HHS to continue to allow attestations of income for these populations, and instead increase its front-end consumer education to address potential APTC overpayments or fraud.

We are also concerned that the proposed language in § 155.320 (c)(3)(iii) and the removal of § 155.320(c)(5) could allow a state to perform periodic data matching more than two times per year. We believe twice a year, as currently enforced by HHS, is the correct balance between program integrity and consumer protection. Allowing states to perform data matching more than twice per year, especially with the problems we have sometimes seen when data matching is done (especially in states without integrated eligibility systems), could result in consumers erroneously losing their coverage without a legitimate increase in program integrity.

In the proposed rule, HHS disproportionately attributes weakening program integrity to lower income individuals. For example, HHS draws attention to recent increases in excess APTCs among households below 100% FPL, but does not acknowledge that higher income households have even greater rates of excess APTCs.[37] It is unclear whether these increases in APTCs is evidence of weakening program integrity, or whether consumers of all incomes struggle to accurately project and verify their income.

We are concerned that HHS's proposals will increase administrative burdens on consumers while not achieving the presumed benefits. Namely, it is unclear that additional verifications will reduce APTC overpayments among lower income households and strengthen program integrity considering low-income households' rate of excess APTCs is less than other

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[35] *See* Pamela Heard et al., *Health care administrative burdens: Centering patient experiences* (2021), available at https://pmc.ncbi.nlm.nih.gov/articles/PMC8522557/. *See also* Marla McDaniel et al., Urban Inst., *Customer Service Experiences and Enrollment Difficulties Vary Widely across Safety Net Programs* 12 (2023) (finding that fulfilling documentation requests for public benefits was more challenging for individuals with diagnosed mental health conditions than those without).
[36] *See* 90 Fed. Reg. 12942, 13013 (Mar. 19, 2025).
[37] *See Id* at 12965 (Table 2 shows the percent of APTC tax returns with excess APTCs increase as income increases).

populations.[38] Verifying income can be more challenging for individuals with lower incomes because they may lack formal documentation or may have inconsistent income streams.[39] These proposed changes appear to only impose additional barriers to affordable health care, increase instability for low-income families, and strain administrative systems.

### C. § 155.315 60-Day Extension To Resolve Income Inconsistency

Similarly, we oppose HHS's proposal to remove § 155.315(f)(7) which requires marketplaces to provide a 60-day extension in addition to the 90 days currently provided to allow applicants sufficient time to provide documentation to verify household income. HHS acknowledges the value of the extended window as a significant percentage of individuals who successfully reconcile their matching errors make use of the 60-day extension.

The proposed rule states that in 2024, over half of consumers who successfully reconciled their data matching issues (DMIs) availed themselves of the 60-day extension.[40] And prior years showed that around one third of consumers required more than 90 days to reconcile DMIs. Meaning that the majority of those needing to verify their income benefit from the 60-day extension. Also, the error rate of the extension is low as these statistics measure successful reconciliations. HHS diminishes the value of these statistics by concluding that the remaining individuals who did not reconcile DMIs were inappropriately receiving APTCs despite the fact that other conclusions remaining equally likely (*e.g.* some consumers who failed to reconcile DMIs within these timeframes were still income-eligible for APTCs). Conversely, we believe the statistics alert us to the fact that the 90-day window does not reflect the reality and needs of consumers who wish to resolve DMIs. Sections 1411(c)(4)(B) and (e)(4)(A) of the ACA grant HHS authority to address the potential arbitrariness of the 90-day deadline and expressly allow deadline modifications to reduce the administrative costs and burdens on individuals. Accordingly, HHS acted within its authority when it added a 60-day extension.

We disagree with HHS's current characterization that the additional 60 days "only" serves to maintain the coverage of people who were able to provide documentation within the extended deadline. HHS previously argued that maintaining APTCs through the 60-day window ensured continuous coverage.[41] We align with these previous findings, and add that reducing coverage losses for income-eligible individuals are important legal and moral obligations. Observing these duties maintains program integrity. Contrary to HHS's assessment, the integrity of marketplaces are not preserved when it encourages the loss of coverage of those who remain income-eligible for its programs.

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[38] *Id.*
[39] *See generally* Marla McDaniel et al., Urban Inst., *Customer Service Experiences and Enrollment Difficulties Vary Widely across Safety Net Programs* 7–12 (2023) (listing a variety of barriers low-income individuals face when applying for public health benefits).
[40] 90 Fed. Reg. 12942, 12963 (Mar. 19, 2025).
[41] 88 Fed. Reg. 25819.

We oppose the removal § 155.315(f)(7) due in large part to the statistics cited by HHS. The data reveals that the majority of consumers need more than 90 days to resolve income verification issues. HHS acted within its ACA authority to address these concerns by extending the 90-day deadline. Removing the extension would have harmful impacts on individuals' ability to access affordable care. Many income-eligible individuals would lose coverage if HHS removes the provision. Thus, any financial gains credited to this policy change would not be a true savings but rather a harmful cut at the expense of people's ability to access affordable health care.

**§ 155.335 Annual Eligibility Redetermination**

We have serious concerns about HHS's proposal to impose a $5 premium penalty on individuals who are currently automatically re-enrolled into $0 premium Marketplace plans in states with FFEs and SBEs. Specifically, HHS proposes to amend the annual eligibility redetermination procedure by adding § 155.335(a)(3) and (n) to prevent enrollees from being automatically re-enrolled in coverage with APTC that fully covers their premium if they do not actively confirm their eligibility. If HHS does enact a premium penalty on such individuals, we oppose making it more than $5.

Automatic re-enrollment benefits everyone. It reduces the administrative burden on enrollees and marketplace service centers, and it promotes continuous enrollment. HHS's proposal would create confusion for enrollees, increase premium costs for enrollees, and ultimately result in coverage loss throughout the country, risking chaos in the marketplaces.

The ACA significantly modernized and streamlined the process of enrolling in a health plan, and its procedures—including automatic re-enrollment—have become the standard to which people living in the United States who obtain their health care through the marketplaces are accustomed. And since 2021, households with income below 150% FPL have been able to avail themselves of both $0 premium plans *and* automatic re-enrollment in those plans.

HHS's proposal, which would decrease the APTC amount by $5 for individuals who are currently automatically re-enrolled into a $0 premium plan, and then send them bills for that amount every month until eligibility is confirmed, will create mass confusion for these enrollees. Enrollees who understood themselves to be enrolled in a $0 premium plan (and who, in actuality, still are) will be surprised and perplexed to receive a notice from the marketplace, and a bill from their qualified health plan (QHP), for a premium that they should not owe.

This confusion will place a considerable administrative burden on enrollees as they attempt to determine the origin of the bill, reconcile the existence of the bill with their understanding of their plan eligibility, pay the bill so they do not have their coverage terminated, and then confirm the eligibility information HHS proposes must be confirmed so they do not continue to receive the $5 premium penalty. It is important to note that these enrollees do not presently have payment information on file, which is yet another administrative step they

will be required to take. Forcing enrollees to undertake these extra steps erodes enrollee trust and satisfaction, and doing so in the name of program integrity is unnecessary given the availability of other interventions that do not place such a burden on enrollees. Moreover, such confusion and administrative burden has been linked to coverage loss; even "minor hassles" impact people's ability to "secur[e] and maintain health coverage."[42]

HHS's proposal also puts enrollees who are typically automatically re-enrolled, but who are enrolled into new plans because their old plans have been discontinued, at risk of coverage loss. If they are enrolled into a new $0 premium plan but they do not verify their information in accordance with the proposed requirements, then the $5 premium penalty becomes, in effect, a binder payment. If the affected enrollee does not make the binder payment, then their coverage does not effectuate. That enrollee is then without coverage until the next OEP (assuming they do not become eligible for an SEP). Moreover, they likely will not realize they are not covered until they attempt to use their coverage, leaving them in need of yet unable to obtain care.

The proposed rule also stands to place an additional financial burden on the country's most economically vulnerable households, making their coverage costlier in the short term and ultimately placing them at greater risk of uninsurance, should they be unable to pay the $5 premium penalty. It is unclear from the proposed rule how the premium penalty will be credited back to enrollees once they verify their information, and we have serious concerns about enrollees losing that money. The proposed rule could also be particularly catastrophic for an enrollee who misses the marketplace notice informing them of the $5 premium penalty for several months in a row. It could also have a ripple effect for affected enrollees: for example, an enrollee whose coverage is terminated for failure to pay the premium penalty over several months may, with the proposed elimination of 45 C.F.R. § 147.104(i), be required to pay those past-due premium amounts before they can effectuate new coverage in another year. HHS's proposal also comes at a time of uncertainty for the federal enhanced premium tax credits, which are in danger of expiring at the end of 2025—meaning even fewer enrollees may have access to $0 premium plans. Those who retain marketplace coverage also stand to be harmed: the potential coverage losses that HHS's proposal risks setting in motion will destabilize the risk pool, resulting in higher costs for everyone.[43]

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[42] Adrianna McIntyre & Mark Shepard, *Automatic Insurance Policies—Important Tools for Preventing Coverage Loss*, 386 New Eng. J. Med. 408, 408 (2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC9597888/; *see also* Keith Marzilli Ericson, et al., *Reducing Administrative Barriers Increases Take-Up of Subsidized Health Insurance Coverage: Evidence from a Field Experiment* (Nat'l Bureau of Econ. Research, Working Paper No. 30885, 2023), https://sacamy.com/wp-content/uploads/2024/06/ELMS-Admin-Barriers-2024-05.pdf (the act of having to pay the premium is an additional hassle that impacts getting and keeping coverage).

[43] A 2019 analysis estimated that eliminating automatic re-enrollment as proposed in the 2020 NBPP would have increased premiums by 5.7% by 2025, in part because of the projected coverage losses that would have resulted. *See* Avalere, *HHS Proposed Changes Could Reduce ACA Coverage and Increase Premiums* (Feb. 18, 2019), https://avalere.com/press-releases/hhs-proposed-changes-could-reduce-aca-coverage-and-increase-premiums.

HHS contends that this proposed policy will benefit enrollees by reducing surprise tax liabilities, increasing their awareness and engagement in their health coverage decisions, and ensuring that their coverage aligns with their current needs and eligibility. But the enrollees who are and remain eligible for $0 premium plans (as evidenced by their re-enrollment into such a plan) are unlikely to accrue any tax liability. If their needs change, they have the choice to enroll in a new plan that meets those changing needs—or not. If they are being automatically re-enrolled into the same plan, then their eligibility has not changed, and their coverage is already aligned with their eligibility. In all of these situations, a financial penalty is unnecessary at best and punitive at worst.

There are already ample safeguards in place that protect against erroneous eligibility determinations and the "increased federal spending" about which HHS states it is concerned. For example, excess APTC is paid back in part or entirely, depending on the tax filer's income, at reconciliation. And eligibility for health plans is still redetermined annually, including for those who are automatically re-enrolled. If HHS wishes to redouble its efforts to increase enrollee engagement with the enrollment process, there are less potentially harmful ways to do so, such as increasing education and outreach efforts (the success of which HHS acknowledges).[44]

HHS also seeks comment on its renewed proposal to automatically re-enroll eligible individuals who do not confirm their information into a policy *without any* APTCs at all. We strongly oppose this proposal. As HHS itself acknowledges, this approach is likely to place enrollees in significant debt to issuers, which will financially harm enrollees and create "significant barrier[s] to accessing health coverage."[45] No degree of concern regarding program integrity—especially when such concern is addressed so readily by other, less draconian interventions, as described above—justifies upending the health care access and finances of enrollees in the way that HHS's proposal would do.

We also have concerns about HHS's proposal to eliminate the automatic enrollment hierarchy at § 155.335(j)(4) that allows marketplaces to move enrollees from bronze to silver QHPs if a silver QHP is available in the same product, with the same provider network and with a lower or equivalent net premium at the bronze plan. The enrollment hierarchy vastly improves enrollee experience by providing more comprehensive coverage for the same or lesser cost. Further, as HHS notes, eliminating it would result in only a small reduction in APTC expenditures.[46] As such, any potential cost savings to HHS is clearly outweighed by the benefit to enrollees, and does not justify the proposal.

Finally, if this provision is finalized, state-based exchanges (SBEs) should not be required to modify their re-enrollment procedures to implement a $5 premium penalty. SBEs should retain the flexibility to determine their own enrollment procedures, factoring in state-specific considerations.

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[44] 90 Fed. Reg. 12942, 12970 (Mar. 19, 2025).
[45] *Id.*
[46] 90 Fed. Reg. 12942, 13015 (Mar. 19, 2025).

**§§ 147.104(b)(2), 155.410 Limited Open Enrollment Periods, Annual Open Enrollment Period**

We are concerned about HHS's proposal to shorten the annual open enrollment period (OEP). A longer OEP benefits enrollees, issuers, and enrollment assisters. Shortening the OEP will increase the burden on enrollees and hurt overall enrollment numbers.

HHS contends that shortening the OEP will reduce enrollee confusion and prevent people from missing a month of coverage because they enrolled in January instead of December. But HHS does not explain how shortening the OEP will, in itself, ensure that people sign up by the December 15 deadline. We are concerned that the same people will continue to wait until January 15 to sign up for coverage, but now risk being without coverage for an entire year—not just a month—if they are not otherwise eligible for a SEP. HHS further asserts that most people have become accustomed to enrolling in coverage by December 15, so the January 15 deadline is unnecessary. Even if most people sign up for coverage by an earlier date, that does not support eliminating the later deadline if it is still capturing people who would otherwise be uninsured.[47]

Closing open enrollment on December 15 is also problematic because it puts enrollees in the position of having to pick a plan during the holiday season, which is generally a time of increased financial and psychological burden; one analysis called this period "the worst time of the year to require complex health insurance enrollment decisions."[48] A January 15 deadline gives people additional time to make competent, informed decisions about their coverage without being distracted by the demands of one of the most stressful periods of the year.

As HHS notes, retaining a longer OEP also allows time for people who are automatically re-enrolled into plans with cost increases—which often do not become apparent until enrollees receive their first bill in early January—to change to a more affordable plan.[49] Without that opportunity, people in this situation may end up stuck in a plan that they cannot afford. And, if they are unable to pay the costlier premiums, they risk having their health insurance terminated and being without coverage until the next OEP.

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[47] For example, in the final five days of California's 2025 OEP, more than 46,000 people newly enrolled in coverage through California's SBE. *See* Covered California, *Covered California Reaches Record-Breaking 1.9M Enrollees Before Open Enrollment's Jan. 31 Deadline* (Jan. 29, 2025), https://www.coveredca.com/newsroom/news-releases/2025/01/29/covered-california-reaches-record-breaking-1-9m-enrollees-before-open-enrollment-s-jan-31-deadline/ (299,060 new enrollees as of January 26, 2025); *see also* Covered California, *Covered California Reaches Landmark Achievement with Nearly 2 Million Enrolled as Open Enrollment Concludes* (Feb. 20, 2025), https://www.coveredca.com/newsroom/news-releases/2025/02/20/covered-california-reaches-landmark-achievement-with-nearly-2-million-enrolled-as-open-enrollment-concludes/ (345,711 new enrollees at the end of the OEP).

[48] Katherine Swartz & John A. Graves, *Shifting the Open Enrollment Period for ACA Marketplaces Could Increase Enrollment and Improve Plan Choices*, 30 Health Affairs 1286 (2014).

[49] 90 Fed. Reg. 12942, 12978 (Mar. 19, 2025).

Shortening the OEP will also impact enrollment assisters' work. Navigators, insurance agents and brokers, Certified Application Counselors, and other enrollment assisters already work long hours to reach prospective and active enrollees during the OEP; shortening that period will leave them with less time to reach all who need assistance.[50] This is especially concerning following the recent massive cuts to the federal Navigator program. With less funding *and* a shorter OEP, there will be fewer helpers to meet the needs of enrollees, and less time for them to try. Inevitably, people will be left behind, and coverage loss will result.

HHS also asserts, without explaining how, that shortening the OEP will reduce the risk of adverse selection. But research has found that making health insurance enrollment easier in general—including through expanded enrollment periods—does not increase the risk of adverse selection.[51] Additionally, previous comments from states running SBEs noted that extending the OEP until January in their states did not introduce adverse selection into their markets.[52] In fact, a longer OEP allowed these states to ensure additional eligible individuals could enroll in coverage.[53]

If HHS does shorten the OEP, we recommend that the shorter OEP should not take effect until plan year 2027. This will provide the marketplaces additional time to strategize how to perform outreach, education, and marketing for a shorter OEP. This will also ensure that, if enhanced subsidies are allowed to expire at the end of 2025, people will have the chance to make informed decisions regarding their coverage once they see the new, higher cost for coverage starting January 2026.

Additionally, should HHS implement this proposal, we urge HHS to engage in extensive outreach to inform enrollees as widely as possible about the changes. Broad public information campaigns, as HHS suggests it may undertake, are a good start and an approach we support. We also urge HHS to develop outreach materials in multiple languages and to employ additional, targeted outreach strategies such as personalized mailers and phone calls; such approaches have been associated with increased enrollment and fewer plan choice errors.[54]

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[50] Families USA, *Navigators Help Open the Door to Health Coverage During Open Enrollment* (Jan. 3, 2023), https://familiesusa.org/resources/navigators-help-open-the-door-to-health-coverage-during-open-enrollment/ (commenting on the particular importance of Navigators during the OEP).
[51] *See, e.g.*, Sarah Lueck, *Proposed Change to ACA Enrollment Policies Would Boost Insured Rate, Improve Continuity of Coverage*, Ctr. on Budget and Pol'y Priorities (Jun. 5, 2019), https://www.cbpp.org/research/health/proposed-change-to-aca-enrollment-policies-would-boost-insured-rate-improve.
[52] 90 Fed. Reg. 12942, 12979 (Mar. 19, 2025).
[53] *Id.* (commenting on "the benefits of increased consumer enrollments.")
[54] HHS, *Reaching the Remaining Uninsured: An Evidence Review on Outreach & Enrollment* at 7 (2021), https://aspe.hhs.gov/sites/default/files/documents/666bcb121e373ec517def3b1fcd4af23/aspe-remaining-uninsured-outreach-enrollment.pdf.

Finally, we oppose the proposed requirement that SBEs shorten their OEPs to 45 days. We also oppose any restrictions on SBEs using blanket SEPs to extend their OEPs. SBEs are in the best position to decide their own enrollment periods, factoring in state-specific considerations.

**§ 155.400 Premium Payment Threshold**

At § 155.400(g), HHS proposes to revoke the provision in the recently finalized 2026 Final Regulations that gives qualified health plans (QHPs) additional ways to avoid terminating coverage for individuals who underpay premiums by a de minimus amount. Specifically, the rule proposes to remove paragraphs (2) and (3), which allow QHPs to implement a fixed dollar and gross percentage-based premium payment threshold policy. If implemented, the rule would limit QHPs to the net percentage-based premium payment threshold at § 155.400(g)(1), which restricts QHPs to setting a premium payment threshold policy at 95% of the net premium or higher.

This proposed change will negatively impact enrollment in the marketplaces. QHPs need additional flexibilities to maintain coverage for enrollees who only owe a de minimus amount of their premiums. Individuals may be unaware of the small premium amounts that are outstanding, and the additional flexibilities laid out in the 2026 Final Regulations prevent unnecessary disruptions in health insurance coverage and medical care. Also, in many instances, triggering grace period notices or cancelling the plan of an individual for non-payment of a de minimus amount of the premium is too severe of a consequence. This provision, coupled with the proposal to impose a $5 premium penalty for individuals who currently are automatically re-enrolled in a plan, will result in marked declines in marketplace enrollment.

**§ 155.420 Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Projected Household Income at or Below 150 Percent of the Federal Poverty Level**

HHS proposes to eliminate the low-income special enrollment period (SEP) currently available at § 155.420(d)(16) for enrollees and their dependents who are eligible for APTC and whose projected household income is at or below 150% of the federal poverty level (FPL). HHS also proposes a conforming amendment to remove § 147.104(b)(2)(i)(G), which excludes § 155.420(d)(16) as a triggering event for a limited open enrollment period for coverage outside of the marketplace. Additional conforming changes are proposed to remove § 155.420(a)(4)(ii)(D) and § 155.420(b)(2)(vii) and to amend the introductory text of § 155.420(a)(4)(iii) to remove reference to paragraph (d)(16).

Individuals have limited opportunities to enroll in marketplace coverage, and if they miss the annual open enrollment period (OEP), they may not be able to enroll later unless they experience a qualifying life event (QLE). The 2025 Final Regulations made the 150% FPL SEP permanent, recognizing the continued need to provide additional opportunities for low-income individuals and families to enroll in free or low-cost coverage that was previously

available on a temporary basis during the COVID public health emergency.[55] In finalizing this SEP, HHS expressly stated that there would be no fiscal impact to implementing the 150% FPL SEP if the federal enhanced subsidies under the Inflation Reduction Act are continued beyond 2025.[56]

The 150% FPL SEP is critical to providing low-income individuals and families a monthly opportunity to enroll in affordable marketplace coverage. The SEP also allows individuals to switch plans, so that they can take advantage of Silver plans with $0 cost-sharing. Many individuals who use the 150% FPL SEP, and did not enroll during the OEP, may not have been aware of their option to enroll in a plan with no monthly premium through the marketplace. For example, low-income individuals who are juggling multiple jobs may miss the annual OEP entirely because they are focused on meeting their basic needs, and may be unaware of the option for zero-cost or low-cost plans. The 150% FPL SPE is particularly important for individuals who churn off Medicaid, young people, and people of color.[57]

The 150% FPL SEP helps ensure that low-income individuals and families have multiple opportunities to access coverage so that they do not go uninsured for long periods of time. This SEP helps enroll chronically uninsured individuals who would not otherwise enroll, despite outreach and marketing efforts. This SEP also helps low-income individuals stay on top of their preventive care, so that health conditions do not go unchecked and end up costing the health care system more money.

HHS argues that eliminating the 150% FPL SEP would improve the risk pool by reducing adverse selection by people who wait to enroll until they need health care services. We do not find this argument persuasive. Individuals and families eligible for the 150% FPL SEP are likely young and healthy, and with zero dollar or low-cost premiums, there is no cost-related reason that individuals in this population would delay enrollment. Also, health services are not immediately available through the 150% FPL SEP, so it is a flawed argument to suggest that individuals and families enroll to receive medical care right away. State experiences with low-income SEPs also demonstrates that they do not lead to adverse selection. For example, Massachusetts has had a low-income SEP for individuals and families in place since 2014 that is touted as key to "boosting the health and stability" of the marketplace.[58]

The 150% FPL SEP has been widely used by marketplaces across the country. A recent survey found that 21 states, in addition to the FFM, have a low-income SEP.[59] Of these

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[55] 89 Fed. Reg. 26218, 26405 (Apr. 15, 2024).
[56] *Id.*
[57] Keith, Katie, *New Special Enrollment Period for Low-Income People Could Boost Coverage,* The Commonwealth Fund (Sept. 7, 2021), https://www.commonwealthfund.org/blog/2021/new-special-enrollment-period-low-income-people-could-boost-coverage.
[58] *Id.*
[59] Rachel Swindle et al., *ACA Marketplace Models and Key Policy Decisions,* The Commonwealth Fund (last visited March 27, 2025), https://www.commonwealthfund.org/publications/maps-and-interactives/aca-state-marketplace-models-and-key-policy-decisions.

states, 8 states offer a SEP for populations above 150% FPL.[60] This illustrates the broad support for, and awareness of, low-income SEPs across the country. It will certainly take a substantial amount of time and resources to dismantle the 150% FPL SEP functionality in each state's marketplace, and there may be costly functionality changes associated with this process.

HHS states that after analyzing use of this SEP over time, there is an immediate need to halt this SEP. HHS proposes to stop this SEP across *all* marketplaces by the effective date of the rule, not in December 2025, due to the "growth of improper enrollments."[61] HHS states that the 150% FPL SEP has been used by insurance agents, brokers and web-brokers to improperly enroll individuals in marketplace plans. To the extent these improper enrollments exists, HHS should establish more guardrails on agents, brokers and web-brokers, not punitive policy changes against low-income individuals and families that will restrict their ability to enroll in marketplace coverage. Also, the speed at which HHS wants to dismantle the 150% FPL SEP is unrealistic. Marketplaces need time to reprogram systems, update notices, and change call center talking points. If HHS proceeds with implementing this provision, we urge HHS to eliminate the 150% FPL SEP on a less aggressive timeline.

**§ 155.420(g) Pre-enrollment Verification for Special Enrollment Period**

HHS proposes to amend § 155.420(g) to reinstate pre-enrollment verification requirements for individuals and families to enroll in special enrollment periods (SEPs). Specifically, HHS proposes to require individuals and families to verify eligibility for several SEPs (marriage, adoption, moving to a new coverage area, loss of MEC, and Medicaid/CHIP denials) in the federal marketplace. The proposed rule also requires state-based marketplaces to newly conduct SEP eligibility verification for at least 75% of new enrollments through SEPs for individuals not already enrolled in coverage. Individuals would have their eligibility verified electronically, or would be asked to submit documentation to confirm eligibility for the SEP, and this process would need to be complete before coverage takes effect.

The burden of imposing pre-enrollment verification requirements on individuals and families seeking marketplace coverage outweighs HHS's concern about fraudulent enrollment and program integrity. SEP proofs, like paperwork confirming an adoption or marriage, are often difficult to track down from government agencies. Paperwork requests from government agencies and county offices also take time to process and mail to the consumer. Once the individual submits their proofs to their marketplace, incorrect information and errors in processing documents can cause delays in proving eligibility for the SEP. All of these administrative barriers could delay enrollment, or deter enrollment altogether.

It is well documented that the use of SEPs is grossly underutilized, so the additional administrative burden of pre-enrollment verifications will only further hinder marketplace

[60] *Id.*
[61] 90 Fed. Reg. 12942, 12980 (Mar. 19, 2025).

enrollment. One study which relied on CMS data found that fewer than 15% of uninsured SEP eligible individuals enroll in coverage.[62] Consumers may not be enrolling due to factors like lack of awareness, affordability concerns, or because of the difficulty of the enrollment and SEP verification process.[63] Regardless, the underutilization of SEPs contributes to annual enrollment declines, which ultimately results in a higher uninsured rate. Individuals and families will only be more deterred from enrolling in marketplace coverage through SEPs if pre-enrollment verifications are mandated.

Requiring SEP pre-enrollment verifications will likely deter healthy individuals and families from enrolling when they are eligible for a SEP. Data indicates that younger, healthier consumers submit SEP verification requirements at much lower rates than older consumers.[64] This is in part why the 2023 Final Regulations removed SEP verification requirements for all SEPs except loss of minimum essential coverage (MEC) for new consumers.[65] HHS also acknowledges in the preamble to this proposed rule that verifications can undermine the risk pool by "imposing a barrier to eligible enrollees, which may deter healthier, less motivated individuals from enrolling."[66] Overall, imposing pre-verification requirements for more SEPs will negatively impact the risk pool and adversely impact premium rates.

This proposed change will also be cumbersome for the federal marketplace and state marketplaces to implement. Requiring marketplaces to newly conduct SEP eligibility verification for at least 75% of new enrollments requires complex programmatic changes to the marketplace's system, as well as the development of consumer notices, training for marketplace service center staff, and protocols for verifying proofs of income (both manually and electronically). Each SEP also requires different paperwork, and even if a SBE is only requiring pre-enrollment for 2 to 3 SEPs, this will require extensive training to ensure marketplace service center staff understand the requirements for each SEP.

The cost associated with implementing this provision is also prohibitive. HHS states that these changes will cost a state using the federal exchange approximately $12 million in one-time expenses, whereas the 5 states that did not previously conduct SEP verifications for at least 75% of enrollments would spend $60 million in one-time expenses.[67] Since marketplaces will have to perform additional pre-enrollment verifications, they are projected to incur ongoing costs of $46.7 million for fiscal years 2026 to 2029.[68] Additionally,

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[62] Matthew Buettgens et al., *More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods,* Urban Inst. (Nov. 20, 2015), https://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf.
[63] *Id.*
[64] 87 Fed. Reg. 27208, 27278 (May 6, 2022).
[65] *Id.*
[66] 90 Fed. Reg. 12942, 12984 (Mar. 19, 2025).
[67] 90 Fed. Reg. 12942, 13017 (Mar. 19, 2025).
[68] *Id.*

marketplaces using the federal platform will incur annual labor costs of $2.8 million, whereas state marketplaces will incur annual labor costs of $1.7 million.[69]

For the reasons stated above, we opposed these proposed changes. If HHS proceeds with requiring more extensive pre-enrollment verifications across marketplaces, we urge HHS to track and make publicly available data on how many individuals and families have incomplete enrollment applications because of a problem with their SEP verification. Prior CMS data indicates that implementing a pre-enrollment verification process decreases the already low enrollment numbers through SEPs, and we anticipate that this proposed provision will negatively impacting enrollment numbers.[70]

**§ 156.115(d) – Provision of EHB**

HHS proposes to prohibit issuers of non-grandfathered individual and small-group market plans from covering "sex-trait modifications" as an essential health benefit (EHB), which would also allow insurers to impose annual or lifetime caps on such benefits. In essence, this proposal would prohibit states from updating their EHB base-benchmark plan in order to incorporate key gender-affirming care services for individuals experiencing gender dysphoria, regardless of whether such update complies with other regulatory EHB benchmarking and actuarial requirements, or otherwise required by law. For the reasons outlined below, NHeLP strongly opposes this proposal.

Gender dysphoria is a serious medical condition characterized by clinically significant distress or impairment in social, occupational, or other important areas of functioning due to a marked incongruence between the patient's gender identity (*i.e.*, the innate sense of one's own gender) and sex assigned at birth.[71] People diagnosed with gender dysphoria can greatly benefit from treatment. The standard of care for treatment of gender dysphoria is outlined in evidence-based clinical guidelines from medical professional associations such as the Endocrine Society and the World Professional Association for Transgender Health (WPATH).[72]

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[69] *Supra* note 53.
[70] U.S. Dept. of Health & Human Servs., *FAQs Regarding Verifications of SEPs* (Sept. 6, 2016), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/FAQ-Regarding-Verification-of-SEPs.pdf.
[71] *See* American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5-TR); *Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders: DSM-5-TR* at 512–13 (2022); see also World Health Org., *International Classification of Diseases*, Eleventh Revision (ICD-11) (2019/2021).
[72] Wylie C. Hembree, et al., *Endocrine Treatment of Gender Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLIN. ENDOCRINOL. & METAB. 3869 (2017), https://perma.cc/3L9J-428B; Eli Coleman, et al., *Standards of Care for the Health of Transgender and Gender Diverse People*, 23 INT'L J. TRANSGENDER HEALTH S1 (8th ed. 2022), https://perma.cc/7SU3-RPK9.

Barring medical care for individuals with gender dysphoria — while expressly proposing to create exceptions to cover these same services for other indications — is discriminatory.[73] In fact, the use of the term "sex-trait modifications" specifically targets individuals experiencing gender dysphoria and the transgender population to be denied care, since the Proposed Rule purports to allow states to require coverage of the same services, as EHB, when medically necessary to treat cisgender individuals.[74]

As support for the Proposed Rule, HHS references Executive Order 14168, which as HHS acknowledges is currently subject to two preliminary injunctions. That Executive Order is riddled with misinformation and misconceptions that are solely based on stigma towards transgender individuals and not on real science or medicine. Neither the Executive Order or the Proposed Rule explain why banning coverage of treatment for gender dysphoria represents a policy solution for a real and actual problem. Moreover, the Executive Order is limited to gender-affirming care for minors, while the Proposed Rule applies to treatment for gender dysphoria for both minors and adults.

In addition, by finalizing the proposed § 156.115(d), HHS would unnecessarily disrupt the carefully crafted balance that has been established between the need to ensure access to a minimum set of benefits for enrollees across the country and the idea that, as HHS expressed when it adopted the current EHB benchmarking framework in 2018, "states should have additional choices with respect to benefits, which may foster innovation in plan design and greater access to coverage…"[75] A wide range of states, from Illinois to South Dakota, have used the current benchmarking standard to update their benchmark plans in

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[73] For analysis of anti-trans animus underlying recent state bans on gender-affirming care and its parallels with anti-Black discrimination, both of which violate the Equal Protection Clause of the U.S. Constitution, see *Skrmetti v. U.S.*, Brief of Amicus Curiae NAACP Legal Defense & Educational Fund, Inc., In Support of Petitioner and Respondents in Support of Petitioner, (Sept. 2024), https://www.supremecourt.gov/DocketPDF/23/23-477/323943/20240903152518831_US%20v.%20Skrmetti%20-%20LDF%20Amicus%20Brief.pdf.

[74] While we believe it is clear that the Proposed Rule discriminatorily targets transgender people and individuals diagnosed with gender dysphoria, we caution that inadvertently, the Proposed Rule may also impact other medically necessary services. Cisgender people, or those who identify with their assigned sex at birth, frequently use the same medical care that is being questioned by HHS in the Proposed Rule. "Sex trait modification" is undefined in the Proposed Rule and indistinguishable from a host of medical interventions provided to cisgender persons, such as hormone replacement therapy for treatment of menopause, hormone blockers in the treatment of precocious puberty, mammoplasty, testicular implants, and circumcision. *See* Theodore E. Schall and Jacob D. Moses. *Gender-Affirming Care for Cisgender People*, 3 HASTINGS CTR. REP. 15–24 (2023), https://pubmed.ncbi.nlm.nih.gov/37285414/. HHS provides no indication on how it might differentiate how these services are provided, or the administrative burden and cost to issuers and regulators. For example, reconstructive mammoplasty is a normalized part of breast-cancer surgical care. In 1976, one psychoanalyst stated that mammoplasty "represented the restitution of loss, the restoration of an ideal or former self which [patients] could experience as their 'real' self, not as something artificial or added on, not a new identity but as 'really me.'" Similarly, the use of testicular implants has been found to be medically necessary in the treatment of cisgender men. Experts agree that that is not uncommon for cisgender men to be depressed following the loss of a testicle and that the procedure "frequently induced considerable psychic trauma," pointing to the need for testicular implants beyond the context of gender-affirming care for transgender individuals.

[75] 83 Fed. Reg. 17010 (April 17, 2018).

order to address specific gaps in coverage affecting their populations. This shows that the current approach, whereby HHS sets some minimum coverage standards and states decide when and to what extent to go beyond those standards, is working in the absence of national standards across EHB. It would also be contrary to the current administration's policies in many areas to return power to the states to prohibit them from covering certain services.[76]

### A. HHS has no legal authority to categorically exclude gender dysphoria treatment as EHB

Congress gave the Secretary of HHS broad authority to define EHB.[77] However, that authority is not unlimited. For instance, the ACA requires the Secretary to ensure that EHB coverage and benefit design does not "discriminate against individuals because of their age, disability or expected length of life."[78] The Secretary also must "take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups."[79] Because gender dysphoria is recognized by experts as a disability, HHS's proposal to prohibit treatment for gender dysphoria as EHB is directly contrary to the plain language and intent of the law to provide patient protections and access to care.

The proposed ban on gender dysphoria treatment is unprecedented. When HHS originally promulgated § 156.115(d), it noted that "[i]n contrast with the benefits covered by a typical employer health plan, [routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, and non-medically necessary orthodontia] often qualify as excepted benefits."[80] However, HHS provides no evidence (and we are unaware of any evidence) that treatment for gender dysphoria has ever been offered by insurers as an excepted benefit plan.[81]

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[76] We have received reports that HHS has cancelled the EHB-Benchmark Plan Modernization Grant for States with a Federally-Facilitated Exchange, https://www.grants.gov/search-results-detail/356740. We are concerned that, if true, the cancellation of these grant funds will further impede state flexibility and efforts to upgrade their EHB benchmark plans.

[77] 42 U.S.C. § 18022(b)(1).

[78] *Id.* § 18022(b)(2)(A); (4)(B).

[79] 42 U.S.C. § 18022(b)(4)(C).

[80] *See* Dep't of Health and Hum. Srvs., Patient Protection and Affordable Care Act, *Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Proposed Rule*, 77 Fed. Reg. 70644, 70651 (Nov. 26, 2012); 78 Fed. Reg. 12845.

[81] As we have noted previously, the statutory language of the ACA does not mandate any express exclusion of benefits traditionally provided in excepted benefits plans from EHB. *See* Nat'l Health Law Prog., Letter to Dr. Ellen Montz Re: Potential Changes to Essential Health Benefits Regulations in the Notice of Benefit and Payment Parameters for 2025 (Sept. 13, 2023), https://healthlaw.org/wp-content/uploads/2023/09/NHeLP-Letter-to-CCIIO-on-EHB-authorities-9.2023.pdf; Nat'l Health Law Prog., RIN 0938-AV22; CMS-9895-P 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 (COOP) Program; and Basic Health Program* (Jan 8, 2024), https://healthlaw.org/resource/comments-on-the-notice-of-benefit-and-payment-parameters-for-2025/. Moreover, in 2024, HHS recognized that "oral health has a significant impact on overall health and quality of life" when it lifted the regulatory prohibition

Unlike § 156.115(d)'s general designation of eye exam services, home care benefits, and non-medically necessary orthodontia as non-EHB, HHS here seeks to prohibit specific medical services used by a specific population — transgender people diagnosed with gender dysphoria — even when they are medically necessary. This not only harms transgender people; it creates a dangerous precedent whereby HHS can ban medical treatments for other populations subject to stigma and discrimination. What is next? Banning treatment for HIV, substance use disorder, or sickle cell simply because a particular administration opposes it? The ACA's EHB provision, as well civil rights laws including Section 1557 of the ACA, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act, prohibit discrimination, including discrimination against people with gender dysphoria.[82]

In the past, HHS has used its authority to define, within the benchmarking framework, minimum standards for states to follow or to expand the flexibilities afforded to states.[83] The agency has never sought to ban states from including non-excepted benefits that comply with the actuarial limitations, much less when those bans involve potential violations of nondiscrimination protections that would contravene the EHB standards. Subjecting services for gender dysphoria to this unprecedented standard would be a radical departure and would exceed HHS' legal and regulatory authority.

### B. HHS falsely claims that employer-sponsored plans exclude coverage of gender-affirming care

HHS bases the Proposed Rule on the ACA's provision requiring that EHB be equal in scope to coverage in typical employer plans. There are various problems with HHS' rationale. First, HHS claims that the fact that treatment for gender dysphoria does not squarely fit within any of the ten listed EHB categories, supports the exclusion of these services from coverage as EHB. This analysis is factually and legally incorrect. All gender-affirming care services can be classified under some of the ten listed categories, such as hospitalization, ambulatory care, and prescription drugs.[84] Even if the services were outside

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on non-pediatric, non-routine oral health services as EHB, proving that even for benefits considered excepted benefits, the agency has been willing to expand state flexibility when the evidence points towards significant need and benefit of covering a specific service. Dep't of Health & Human Srvs., *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 Final Rule*, 89 Fed. Reg. 26218, 26342 (Apr, 15, 2024), https://www.govinfo.gov/content/pkg/FR-2024-04-15/pdf/2024-07274.pdf.

[82] *See, e.g.*, *Prescott v. Rady Children's Hosp.* (S.D.C.A. 2016), *Flack v. Wisconsin Dept. of Health Srvs.* (W.D. Wis. 2018), Boyden v. Conlin (W.D. Wis. 2018), *Tovar v. Essentia Health* (D. Minn. 2018), *Williams v. Kincaid*, 45 F.4th 759, 766 (4th Cir. 2022).

[83] *See*, for example, 45 C.F.R. § 156.115(a)(3) (requiring that plans comply with mental health and substance use disorder parity laws); *Id.* § 156.115(a)(5) (requiring plans to cover habilitative services on the same level as rehabilitative services); and *Id.* § 156.122 (establishing minimum coverage requirements for prescription drugs).

[84] Katie K. & Jason L., *HHS Proposes to Restrict Marketplace Eligibility, Enrollment, and Affordability in First Major Rule Under Trump Admin (Part 1)*, HEALTH AFF. FOREFRONT (2025),

the scope of the ten listed categories, however, a plain reading of the statute shows that Congress' intent was for HHS to ensure that, *at a minimum*, EHB were defined as including services in the ten categories listed in the statute. It is clear that HHS, and states through benchmarking, have authority to require coverage of services outside of the scope of the ten categories as EHB. Any other conclusion would make the words "at least" meaningless.

Second, the way HHS references typical employer plans is not in line with the way the agency has defined typicality in recent rules. Current EHB rules define a "typical employer plan" as "one of the selecting State's ten base-benchmark plan options established at § 156.100, and available for the selecting State's selection for the 2017 plan year; or the largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the State."[85] Using that definition, a state should be allowed to require coverage of services for gender dysphoria as EHB if *any one* of those options provides coverage for the services in question. Instead, HHS vaguely and generally discusses the supposed lack of coverage in some of those plans, a standard that is contrary to the current rule on typicality.

Third, HHS claims, without evidence, that treatment for gender dysphoria is not typically covered in employer plans.[86] This is false. The Proposed Rule only cites one report from the Movement Advancement Project (MAP) to support HHS' claim that employer-sponsored plans do not typically cover treatment for gender dysphoria, despite numerous studies that show otherwise and are discussed below.[87] In addition, MAP's report does not show what the proposed rule claims. The report suggests that 55% of transgender people live in states with bans on gender-affirming care. However, that's not the same thing as an analysis of how many employers categorically exclude treatment for gender dysphoria from coverage (especially since many large group employers self-insure and will not be subject to those state laws). Further, HHS cherry-picked their statistics from MAP's report, which also states that twenty-four states and DC explicitly *include* gender-affirming care in their health benefits for state employees.[88]

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https://www.healthaffairs.org/content/forefront/hhs-proposes-restrict-marketplace-eligibility-enrollment-and-affordability-first-major.

[85] 45 C.F.R. § 156.111(b)(2)(i)(A)

[86] As we discuss in our comments, we strongly object to HHS' position that services for gender dysphoria are not covered by typical employer plans. However, even if that were the case, we believe it would make little sense for the typicality requirement to exclude services that are not typically covered from coverage because Congress' intent, in passing the ACA, was to improve upon pre-ACA coverage. Before the ACA, it was common for plans to exclude services we now consider typically covered, such as services within the maternity and newborn services and mental health and substance use disorders categories. Therefore, we believe the typicality requirement should be read as a floor or minimum level of coverage and should not be read to allow a ban on coverage of services that have traditionally not been covered by employer plans, but are now considered essential. This reading aligns with HHS' authority to periodically review and update EHB coverage to keep up with medical evidence or scientific advancement. *See* 42 U.S.C. § 18022(4)(G).

[87] Movement Advancement Project, *Equality Maps: Healthcare Laws and Policies* (Mar. 28 2025), https://www.mapresearch.org/equality-maps/healthcare_laws_and_policies.

[88] *Id.*

HHS attempts to justify the Proposed Rule by saying that twelve states do not mention or have no clear policy regarding gender-affirming care. However, this lack of clarity is likely because gender-affirming care encompasses a wide array of services that are also used to treat other health conditions, in addition to treatment for gender dysphoria, so coverage may not explicitly be stated in some health plans. Apparent silence or omission in state employee health plans does not justify entirely excluding these services from EHB.

HHS also ignores various other studies and reports documenting how employers are providing and expanding coverage of treatment for gender dysphoria and gender-affirming care. In fact, employers increasingly work to ensure their health insurance plans cover treatments for gender dysphoria for their employees. In its annual assessment of corporate benefits, policies, and practices, the Human Rights Campaign found that 72% of Fortune 500 businesses offer coverage of gender-affirming care, as well as 91% of businesses listed on the Corporate Equality Index.[89] This means that over 1,300 of the largest corporations in the United States cover treatment for gender dysphoria, twenty-eight times as many employers as in 2009, showing the increasing coverage of these services.[90]

An October 2024 peer-reviewed study found that in 2023, over 72% of all people seeking gender-affirming care had their care covered by commercial health insurance.[91] In practice, this means that a vast majority of people seeking gender-affirming care are primarily covered by commercial insurance.[92] A 2025 study found that over 92% of ACA marketplace silver plans from all fifty states plus DC did not exclude gender-affirming care and over 54% of all plans specifically included language indicating that at least some medically necessary care would be covered.[93] Further, a 2022 peer-reviewed study found that people receiving and accessing gender-affirming care through private insurance increased rapidly from 2011 to 2019.[94] Even if states are not explicitly mandating coverage of treatment for gender dysphoria, which at least twenty-four states and DC do, employers are continuing to provide and even expand coverage of these services.

### C. Banning gender-affirming care as EHB will harm persons diagnosed with gender dysphoria

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[89] Human Rights Campaign, *Corporate Equality Index 2025: Rating Workplaces on Lesbian, Gay, Bisexual, Transgender, and Queer Equality* (Jan. 2025), https://www.hrc.org/resources/corporate-equality-index.
[90] *Id.*
[91] Jason Brian Gibbons, et al., *Insurance Type and Social Determinants of Health for Individuals Seeking Gender-Affirming Care in the United States*. J Gen. Intern. Med. (Oct. 2024). https://doi.org/10.1007/s11606-024-09040-x.
[92] *Id.*
[93] Out2Enroll, *Summary of Findings: 2025 Marketplace Plan Compliance with Section 1557 of the Affordable Care Act* (2024), *available at* https://drive.google.com/file/d/1FpSNyaZVfC25o3zXnYBWUVaYRWokwbwg/view?usp=sharing.
[94] Kellan Baker & Arjee Restar, *Utilization and Costs of Gender-Affirming Care in a Commercially Insured Transgender Population*, 50(3) J. LAW MED. ETHICS 456 (2022), https://doi.org/10.1017/jme.2022.87.

The definitions HHS uses in this Proposed Rule are unscientific and lack an understanding of human biology. The preamble defines "sex" as a "person's immutable biological classification as either male or female," with the term "female" described as a person "of the sex characterized by a reproductive system with the biological function of producing eggs," and "male" as a person "of the sex characterized by a reproductive system with the biological function of producing sperm." This definition is simplified to the point of fatuousness as it excludes individuals who identify with their sex assigned at birth but who have medical conditions that make them unable to reproduce.

Moreover, as the Williams Institute notes, while there is no universal definition of the word "sex," medical professionals and social scientists have long understood that sex and gender are complex and intertwined concepts.[95] Researchers also note there is evidence to suggest there are biological bases for a gender identity that is incongruent with a person's sex assigned at birth.[96] In addition, there can be considerable variation in sex characteristics, like reproductive systems, that this definition does not consider.[97] This uninformed and unscientific proposed rule will have far-reaching consequences beyond the intended target of transgender people.

1. *Gender-affirming care is scientifically and medically well-established*

The proposed rule states that "[w]e are also concerned about the scientific integrity of claims made to support [the] use [of gender-affirming care services] in health settings."[98] It is unclear what concerns HHS has regarding the scientific integrity of gender-affirming care in health care settings. Gender dysphoria is clearly defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as a serious health condition. It is defined as "the marked incongruence between a person's experienced or expressed gender and the one they were assigned at birth" and associated clinically significant distress or impairment in social, occupational, or other important areas of functioning.[99] Gender dysphoria is recognized by national medical associations like the American Academy of Pediatrics (AAP), the American Medical Society (AMA), and the American Psychological Associations (APA).[100] Treatment of gender dysphoria is established by evidence-based medical standards of care that are maintained by medical experts such as the Endocrine Society

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[95] Elana R., Williams Inst., *Impact of the Executive Order Redefining Sex on Transgender, Nonbinary, and Intersex People* (Jan 2025). https://williamsinstitute.law.ucla.edu/publications/impact-eo-redefine-sex-tbi/.
[96] E. C., et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*. 23(sup1) INT'L J. OF TRANSGENDER HEALTH S1 (2022) https://www.tandfonline.com/doi/10.1080/26895269.2022.2100644.
[97] *Id.*
[98] 90 Fed. Reg. 12987.
[99] Garima G., et al., *Gender Dysphoria* (2023). StatPearls https://www.ncbi.nlm.nih.gov/books/NBK532313/; American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders at 452 (5th ed., 2013).
[100] *Skrmetti v. U.S.*, Brief of Amicus Curiae NAACP Legal Defense & Educational Fund, Inc., *supra* note 73.

and are endorsed by every major U.S. medical association such as the AMA and the APA.[101]

International organizations also recognize that gender-affirming care is medically necessary, effective, and safe as a treatment of gender dysphoria.[102] The WPATH is an international, multidisciplinary professional association that promotes evidence-based care, education, research, and public policy in regards to transgender health care. WPATH promotes a high standard of care for transgender and gender diverse people. WPATH first established a Standard of Care (SOC) in 1979 and has since released an updated version in 2022 (SOC-8). This resource is based on the best available science and professional consensus and provides health care professionals with clinical guidance on providing safe and effective care to transgender individuals through physical and mental health care.[103]

The Endocrine Society is a global community of physicians and scientists dedicated to accelerating scientific breakthroughs and improving patient care. The Endocrine Society takes the position that their Clinical Practice Guidelines on gender dysphoria establishes a "methodical, conservative framework for gender-affirming care, including pubertal suppression, hormones, surgery, and standardized terminology for health care professionals." These recommendations include evidence that treatment for gender dysphoria is medically necessary and should be covered by insurance.[104]

2. *Gender-affirming care saves lives and limiting gender-affirming care causes harm*

Cornell University researchers conducted a systematic literature review of all peer-reviewed articles published between 1991 and 2017 that assessed the effect of gender transition and transgender individuals' well-being. Ninety-three of the analyzed studies found that gender transition improves the well-being of transgender people, while no studies concluded that gender transition causes overall harm.[105] The researchers also found that gender transition is effective for treating gender dysphoria. Gender-affirming care can significantly improve mental health conditions like anxiety, depression, suicidality, and substance use while those who cannot access treatment are more likely to experience those harms.[106]

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[101] Katie K. & Jason L., *supra* note 84; *See* Advocates for Trans Equality, *Medical Organizations Statements*. https://transhealthproject.org/resources/medical-organization-statements/. Theodore E. Schall & Jacob D. Moses. *Gender-Affirming Care for Cisgender People*, 3 HASTINGS CENTR. REP. 15 (2023), https://pubmed.ncbi.nlm.nih.gov/37285414/.
[102] Advocates for Trans Equality, Medical Organization Statements, https://transhealthproject.org/resources/medical-organization-statements/.
[103] Katie K. & Jason L., *supra* note 84.
[104] Endocrine Soc'y, Transgender Health An Endocrine Society Position Statement (2020), https://www.endocrine.org/advocacy/position-statements/transgender-health.
[105] What We Know Project, Cornell University, *"What Does the Scholarly Research Say about the Effect of Gender Transition on Transgender Well-Being?"* (online literature review), 2018.
[106] *Id. See also* van der Miesen, et al., *Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers*, 66(6) J. OF ADOLESCENT HEALTH 699 (2020) (finding that pubertal suppression in youth with GD has a positive effect on psychological functioning including a decrease in behavioral and emotional problems, a decrease in depressive symptoms, and improvement in general functioning); L.E.

Gender-affirming care improves life satisfaction as well. The 2022 U.S. Transgender Survey asked participants about their life satisfaction when living in a gender different from the one they were assigned at birth. Ninety-four percent of participants reported that they were either a lot more satisfied or a little more satisfied with their life. Further, 98% of those who were receiving hormone treatment reported that receiving hormones made them feel a lot more satisfied or a little more satisfied. Of those who had at least one form of gender-affirming surgery 97% felt that they were a lot more satisfied or a little more satisfied with their lives.[107]

The AMA urged state governors to oppose legislation that would prohibit medically necessary gender transition-related care for minors. They aptly called this effort to restrict care "a dangerous intrusion into the practice of medicine."[108] The AMA recognizes that transgender identity and other gender expansive identities are normal variations of human identity and expression. There is evidence that transgender people are more likely to be diagnosed with mental health disorders.

The Trevor Project's 2022 National Survey on LGBTQ Youth Mental Health found alarming rates of depression and anxiety among transgender youth. Overall, 58% of LGBTQ youth reported experiencing symptoms of depression including nearly two-thirds of transgender and non-binary youth. Seventy-three percent of LGBTQ youth reported experiencing symptoms of anxiety, including more than three-quarters of transgender and non-binary youth.[109] This increased prevalence of mental health conditions is likely to be a consequence of the chronic stress from experiencing societal stigma and discrimination based on a person's gender identity and expression.[110]

Similarly, the Williams Institute found that access to gender-affirming care is associated with a lower prevalence of suicidal ideation and attempts among adults. The researchers

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Kuper, et al., *Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy*, 145(4) PEDIATRICS e20193006 (2020) (finding that transgender and non-binary youth starting either pubertal blockade or gender-affirming hormone treatment demonstrated improvement at follow up (around a year) in depression, anxiety and body esteem); A.N. Almazan & A.S. Keuroghlian, *Association Between Gender-Affirming Surgeries and Mental Health Outcomes* 156 JAMA SURGERY 611 (2021) (finding that gender-affirming surgeries are effective in treating gender dysphoria); K.E. Baker, et al., *Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review*, 5(4) J. OF THE ENDOCRINE SOC'Y 1 (2021) (A systematic review of 20 studies showing improved quality of life, decreased depression, and decreased anxiety with hormonal treatment in transgender people).

[107] Sandy E. James, et al., *Early Insights: A Report of the 2022 U.S. Transgender Survey. Nat'l Cent. for Transgender Equality* (2024), https://transequality.org/sites/default/files/2024-02/2022%20USTS%20Early%20Insights%20Report_FINAL.pdf.

[108] James L. Madara, AMA to States: Stop Interfering in Healthcare of Transgender Children, Am. Med. Ass'n (Apr. 26, 2021), https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children.

[109] The Trevor Project, 2022 National Survey on LGBTQ Youth Mental Health (2022), https://www.thetrevorproject.org/survey-2022/assets/static/trevor01_2022survey_final.pdf.

[110] *Id.*

also found that those who have been living in their gender identity for longer were less likely to experience suicidal ideation and attempts than those who had more recently transitioned.[111] This study found that of those who wanted and received gender-affirming care like hormone therapy or surgical care had significantly lower prevalence of suicidal thoughts and attempts than those who wanted gender-affirming care and did not receive it.[112] Other studies have found similar results. For example, one study found that transgender people who were ready but were unable to medically transition were more likely to have symptoms of depression than those who were able to medically transition.[113]

Gender-affirming care may also have an impact on substance use disorder. A study of transwomen found that access to gender-affirming care resulted in significantly lower odds of binge drinking and non-injection substance use than those who did not access gender-affirming care.[114] Substance use can be a coping mechanism for the chronic stress of discrimination and gender-affirming care may help mitigate this stress.[115]

In addition to the well-researched data on the harms of untreated gender dysphoria and the positive outcomes associated with gender-affirming care, efforts to change a person's gender identity to match with their gender assigned at birth are established to be ineffective and harmful.[116] The Williams Institute found that "de-transitioning," which is characterized by a transgender person returning to living as their assigned sex at birth, may be harmful. The researchers found that those who de-transitioned were significantly more likely to report suicidal ideation and attempts than those who did not de-transition. Of those who reported de-transitioning, almost 12% attempted suicide compared to nearly seven percent of those who did not de-transition.[117] Those that reported de-transitioning noted they did so because of social pressure and experiencing harassment and discrimination.

Mental health conditions like depression, anxiety, and substance use disorders are associated with premature mortality.[118] Studies have shown that people with mental health

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[111] Jody L. Herman, et al., *Suicidal Thoughts and Attempts Among Transgender Adults Findings from the 2015 U.S. Transgender Survey*. Williams Inst. (2019), https://williamsinstitute.law.ucla.edu/publications/suicidality-transgender-adults/.
[112] *Id.*
[113] Nooshin Khobzi Rotondi, et al., *Nonprescribed Hormone Use and Self-Performed Surgeries: "Do-It-Yourself" Transition in Transgender Communities in Ontario, Canada*, 103(10) AM. J. PUBLIC HEALTH 1830 (2013), https://pmc.ncbi.nlm.nih.gov/articles/PMC3780733/.
[114] Erin C. Wilson, et al., *Connecting the Dots: Examining Transgender Women's Utilization of Transition-Related Medical Care and Associations with Mental Health, Substance Use, and HIV*, 91(1) J. URBAN HEALTH 182 (2015), https://pmc.ncbi.nlm.nih.gov/articles/PMC4338120/.
[115] *Id.*
[116] Christy Mallory, et al., *Conversion Therapy and LGBT Youth*, Williams Inst. (2019), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-Update-Jun-2019.pdf.
[117] Jody Herman, et al., *supra* note 111.
[118] Joe Kwun Nam Chan, et al., *Life Expectancy and Years of Potential Life Lost in People with Mental Disorders: A Systematic Review and Meta-Analysis*, 65 ECLINICALMEDICINE (2023). https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(23)00471-6/fulltext.

conditions have substantially reduced life expectancy relative to the general population.[119] With the well-established research on the negative effects of mental health conditions and on the importance of gender-affirming care for reducing the prevalence of mental health conditions for transgender people, it is cruel and unjust to apply unscientific barriers to life-saving care.

3. *Treatment Services for gender dysphoria are cost-effective*

Not only are the services that HHS seeks to ban effective in treating gender dysphoria and improving the mental health of transgender individuals, but studies have shown that the cost of providing the services is minimal. In fact, some states have used the current benchmarking flexibilities to add gender-affirming care services to their benchmarks and have done so precisely because an actuarial report showed that, because of the expected low utilization rates, the addition of the services would not exceed the actuarial limitations imposed by HHS. Colorado, for example, added gender-affirming care as well as other services because the State still had actuarial room to expand coverage even after adding gender-affirming care services.[120] These findings highlight that the services that HHS seeks to ban from coverage as EHBs can have an invaluable, often life-saving, impact on the lives of transgender individuals across the country, while having a negligible effect on premiums enrollees.

4. *The Proposed Rule affects individuals receiving treatment for gender dysphoria in states with benchmarks that already cover these services*

It is unclear to us whether gender-affirming care services would continue to be covered as EHB in states that currently include these services as part of their benchmark plans. The Proposed Rule states that "If a State mandates coverage of a benefit that is in its EHB-benchmark plan, the benefit will continue to be considered EHB…"[121] Later, however, the Proposed Rule states that "If this proposal is finalized as proposed, health insurance issuers will be prohibited from providing coverage for sex-trait modification as an EHB beginning in PY 2026."[122] Those sentences appear to contradict each other and HHS should clarify the agency's intentions. If, as we believe, HHS' intent is to allow issuers to stop covering treatment for gender dysphoria unless a state defrays the cost of coverage, then this policy will lead to massive disruption in those states that have relied on HHS' previous rules and guidance to update their benchmarks to add services without running afoul of defrayal requirements. The practical effect of this policy would be that enrollees that are currently receiving necessary services will have to face the reality that their

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[119] *Id.*; Sandra M. Meier, et al., *Increased Mortality Among People with Anxiety Disorders: Total Population Study*, 209(3) BRIT. J. PSYCHIATRY 216 (2016), https://pmc.ncbi.nlm.nih.gov/articles/PMC5082973/.
[120] *See* CMS, Information on Essential Health Benefit (EHB) Benchmark Plans, Colorado 2023–2026 EHB Benchmark Plan Information, https://www.cms.gov/files/zip/co-ehb-benchmark.zip.
[121] 90 Fed. Reg. 12987 (Mar. 19, 2025).
[122] *Id.*

insurance will likely stop paying for the services, and will have to either pay for them out-of-pocket or end their treatment altogether.

Transgender individuals whose insurance stops paying for their gender dysphoria treatment are thus likely to be forced to detransition. The vast majority of individuals who detransition attribute their detransition to external factors, including lack of coverage of services.[123] When individuals detransition for factors outside of their control, it can lead to harmful health consequences, including anxiety, depression, and increased risk of suicidal tendencies.[124]

**Conclusion**

We have included numerous citations to supporting research, including direct links to the research. We direct HHS to each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If HHS is not planning to consider these materials part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies and articles into the record.

Thank you for your attention to our comments. If you have any questions or need further information, please reach out to Mara Youdelman, Managing Director of Federal Advocacy, at youdelman@healthlaw.org.

Sincerely,

Elizabeth G. Taylor
Executive Director

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[123] Jack L. Turban, et al., *Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis*, 8 LGBT HEALTH 273 (2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC8213007/pdf/lgbt.2020.0437.pdf.

[124] *See* N. Eugene Walls, et al., *Interrupted Gender Transitions: Underlying Motivations as Correlates of Psychosocial Risks*, 26 INT. J. TRANSGENDER HEALTH 119 (2024), https://www.tandfonline.com/doi/full/10.1080/26895269.2023.2299020?scroll=top&needAccess=true; Landon D. Hughes, et al., *"These Laws Will be Devastating": Provider Perspective on Legislation Banning Gender-Affirming Care for Transgender Adolescents*, 69 J. ADOLESCENT HEALTH 976 (2021), https://www.jahonline.org/article/S1054-139X(21)00435-3/pdf.

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April 10, 2025

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

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

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

Dear Administrator Oz:

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

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

While CMS frames the proposed rule as advancing program integrity and lowering premiums, numerous provisions therein would instead restrict eligibility, limit enrollment opportunities and increase enrollee costs. Such changes would also conflict with the intent of the Affordable Care Act to "make affordable health insurance available to more people," the Department of Health and Human Services (HHS)'s mission to "enhance the health and well-being of all Americans," and CMS's mission to provide health

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

coverage to millions through the ACA marketplaces.[4] This is particularly concerning given the popularity of the ACA and the number of Americans who rely on it for coverage, including more than 24 million people who selected a marketplace plan for 2025.[5]

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

## I. Premium Adjustment Percentage

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

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

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

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

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

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

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

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

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

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

## II. Levels of Coverage (Actuarial Value)

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

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

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

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

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[9] Ibid.
[10] Proposed Rule; Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability
[11] Jared Ortaliza and others, "Inflation Reduction Act Health Insurance Subsidies: What is Their Impact and What Would Happen if They Expire?," KFF, July 26, 2024, available at https://www.kff.org/affordable-care-act/issue-brief/inflation-reduction-act-health-insurance-subsidies-what-is-their-impact-and-what-would-happen-if-they-expire/.

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

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

## III. Provision of Essential Health Benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## IV. Eligibility Definitions

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

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

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

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

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

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

[29] Ibid.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## VI. Income Verification When Tax Data is Unavailable

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

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

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

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

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

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

[39] Ibid.

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

[41] Ibid.

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

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

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

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

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

## VIII. Annual Open Enrollment Period

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

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

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

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[43] 26 U.S. Code § 36B; 42 U.S. Code § 18081
[44] Sara Collins and others, "First Look at Health Insurance Coverage in 2018 Finds ACA Gains Beginning to Reverse," The Commonwealth Fund, May 1, 2018, available at https://www.commonwealthfund.org/blog/2018/first-look-health-insurance-coverage-2018-finds-aca-gains-beginning-reverse.
[45] Centers for Medicare and Medicaid Services, "CMS Announcement on Federal Navigator Program Funding," February 14, 2025, available at https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding.
[46] Karen Pollitz and others, "Consumer Assistance in Health Insurance: Evidence of Impact and Unmet Need," Kaiser Family Foundation, August 7, 2020, available at https://www.kff.org/report-section/consumer-assistance-in-health-insurance-evidence-of-impact-and-unmet-need-issue-brief/.

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

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

## IX. Special Enrollment Periods for Low-Income individuals

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

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

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

**Conclusion**

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

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

Sincerely,

Center for American Progress

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

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

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

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

April 11, 2025

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

**Re: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability [CMS-9884-P]** — *Submitted via https://www.regulations.gov/*

Dear Secretary Kennedy,

I appreciate the opportunity to offer comments on the marketplace integrity rule proposed by the Centers for Medicare and Medicaid Services.[1]

As a researcher who studies Marketplace coverage, I appreciated CMS's statement that, "Here and throughout this proposed rule we encourage commenters to include supporting facts, research, and evidence in their comments." However, the very short window for accepting comments (23 days after publication in the Federal Register) and deficiencies in publicly available data reflecting federally-facilitated Marketplace (FFM) enrollment[2] complicated efforts to observe the agency's request.

This administration has averred a commitment to "Making America Healthy Again." I worry that many of the proposals in this notice of proposed rulemaking (NPRM) will have the opposite effect: imposing new and cumbersome administrative burdens — which target enrollees, rather than the brokers acting in poor faith that the NPRM identifies as driving the waste, fraud, and abuse that the provisions are intended to curb — will instead compromise health insurance coverage and access to medical care for low- and middle-income Americans.

In this comment letter, I first offer feedback in five high-level areas that cut across the various specific proposals included in the NPRM ("general policy considerations"). I follow with discussion of specific regulatory provisions where my expertise and prior research are particularly relevant. I note that omission of comments on specific aspects of this proposed rule should not be construed as support for those measures.

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[1] Views represented in this comment letter are my own and do not reflect the views of the Harvard T.H. Chan School of Public Health, Harvard University, or any other institution with which I am affiliated. Analyses and interpretations presented are my own and do not reflect the views of the Massachusetts Health Connector; any errors are my own.
[2] Unlike with Medicare and Medicaid data, CMS does not make de-identified, individual-level data for FFM enrollees available to researchers. The public use files available only reflect enrollment trends during open enrollment (OE) — meaning they cannot be informative for many of the provisions in this proposed rule that will affect enrollment outside OE. Even analyses of trends during open enrollment are severely hamstrung by the agency's decision to only publish data after it has been aggregated to a county or demographic category (or county x demographic category). If CMS is truly interested in non-industry commenters having the capacity to respond to proposed Marketplace rules with "facts, research, and evidence," an important first step would be to drastically improve the data publicly available for evaluation of FFM enrollment and performance.

To summarize the comments that follow, I offer the following general policy considerations:

A. Agency efforts to estimate "erroneous and improper" enrollment in fully or highly subsidized coverage should be more attentive to acknowledged limitations and should do more to evaluate the role of broker intervention.

B. The proposed rule anticipates coverage disruptions among those lawfully and appropriately enrolled but fails to contemplate possible safeguards against disruptions to health insurance coverage and health care access.

C. Estimates of risk pools effects likely do not comprehensively account for relevant dynamics and, as a result, likely misunderstand resulting changes to gross premiums.

D. Program integrity efforts might be more effective if targeted toward inappropriate behavior by insurance brokers, rather than broadly imposing administrative burdens on individual low-income enrollees.

E. CMS appears to have overlooked several opportunities to substantiate proposed policies with data the agency should have available for analysis.

I offer more granular feedback on the following specific policy proposals:

A. Requiring people to pay $5 if auto-renewed into coverage that would otherwise be fully subsidized would lead to coverage loss; evidence suggests this would also worsen the risk pool (§155.335). *I urge the agency to not finalize this proposal.*

B. Removing the option for Exchanges to auto-reenroll individuals who qualify for fully or partially subsidized plans would dramatically decrease enrollment and increase average risk and gross premiums (§155.335). *I urge the agency to not finalize this proposal.*

C. Shortening the annual open enrollment period would decrease enrollment and increase adverse selection, particularly in the context of expiring enhanced premium tax credits and other policies contemplated in the proposed rule (§155.410). *I urge the agency to not finalize this proposal.*

D. Removing the special enrollment period (SEP) for households with incomes below 150% FPL would exacerbate negative enrollment consequences likely to arise from other provisions included in the proposed rule (§155.420). *I urge the agency to not finalize this proposal.*

E. Removing the "bronze to silver crosswalk policy" option for Exchanges will increase financial burdens for enrollees, potentially leading to attrition among healthier enrollees, worsening the risk pool (§155.335).

## I. GENERAL POLICY CONSIDERATIONS

### A. Agency efforts to estimate "erroneous and improper" enrollment in fully or highly subsidized coverage should be more attentive to acknowledged limitations and should do more to evaluate the role of broker intervention.

CMS seeks comment on its approach to estimating "the possible reduction in erroneous and improper enrollments under the proposed changes." CMS attempted to estimate "erroneous and improper" enrollments by summing the total number of enrollments in 2024 that exceed 100 percent of potential enrollees with incomes of 100-150% of the federal poverty line (FPL). To carry out these calculations, CMS estimates "potential enrollees" (the denominator) using income reported in the American Community Survey. "Exchange sign-ups" reflect plan selections during open enrollment.

I first want to underscore one of the agency's own statements, specifically that, "this estimate fully attributes excess enrollments to error and improper enrollments and does not adjust for the presence of general uncertainty around expected income among enrollees, which is not expected to change as a result of the proposed provisions, nor does it take into account the imprecision inherent in the use of survey data to identify and measure the population eligible for Exchange coverage."

Given the agency's methodological approach, it is not appropriate to "fully attribute" excess enrollments to error and improper enrollment — implicitly suggesting that enrollees, or their brokers, are intentionally misrepresenting projected annual income. **This assumption is inconsistent with what is known empirically about the volatility of income for families with lower incomes and the difficulty Marketplace enrollees have historically had in projecting their own income.**

As the agency knows, to receive advance premium tax credits (APTCs) to improve the affordability of Marketplace coverage, individuals must estimate, to the best of their abilities, their anticipated income for the calendar year. The difference between the APTCs received and the premium tax credits to which an individual/household was ultimately entitled based on actual, realized income for the year is "reconciled" when individuals file their taxes.

It is possible for an enrollee to have an income in a given month that disqualifies them for Medicaid — because Medicaid eligibility is determined on a real-time monthly basis — and if the individual made the reasonable assumption that that might prove to be their average monthly income, they would qualify for Marketplace coverage. Ultimately, this may not prove to be true because of income volatility that is typical for low-income households. The best-intentioned and most comprehensively designed rules intended to root out waste, fraud, and abuse cannot entirely account for the simple fact that many people cannot reliably estimate their income for a given month or year.

According the Federal Reserve Board's 2023 Survey of Household Economics and Decisionmaking (author analysis of publicly-available data[3]), over half (54.9%) of

[3] Data – Survey of Household Economics and Decisionmaking. Federal Reserve Board of Governors. Accessed April 10, 2025.

respondents aged 19-64 with household incomes between $10,000 and $24,999 said that their (and their spouses', if applicable) income varied at least "occasionally" month-to-month, with **more than one in six (17.8%) saying their incomes "varie[d] quite often from month to month."**

Research has documented how this income volatility manifests itself in the Medicaid program. In a recent paper using survey and administrative data on Medicaid enrollment, the authors found that a large share of enrollees had *annual* income above the Medicaid typical eligibility threshold in that state, but that this disconnect could be entirely or almost entirely explained by people entering Medicaid through a pathway with a higher eligibility threshold (e.g., pregnancy) or by having partial-year income below the Medicaid threshold and partial-year eligibility above the threshold.[4]

We can also look to reporting on reconciliation of advance premium tax credits from the Internal Revenue Service (IRS). The IRS's annual Statistics of Income (SOI) bulletins offer some insights into how challenging it is for individuals to actually estimate their income, and that this dynamic predated the enhanced premium tax credits made available starting in 2021. For example, in 2018, 6.1 million returns reporting advance premium tax credits were filed. At reconciliation, 2.6 million returns resulted in the individual/household recouping net tax credit (an average of about $700) to which they were entitled (because they had ostensibly over-estimated their income) and 3.4 million returns resulted in the individual/household repaying excess tax credit (an average of about $875, because they had ostensibly under-estimated their income). The average amount of tax credit received was about $4,000, meaning that these misestimates of income were quite significant, in a relative sense and on average, even before fully-subsidized plans were available.[5]

Lastly, in attempts to replicate Table 15 in the proposed rule, it seemed that the agency had used general household income to construct the "potential enrollee" estimate, rather than the more appropriate measure of income tailored to the health insurance unit.[6] This would generally have the effect of artificially deflating the estimate of the potential enrollee population.

**B. Program integrity efforts would be more effective if targeted toward inappropriate behavior by insurance brokers, rather than broadly imposing administrative burdens on individual low-income enrollees.** Evidence presented in the proposed rule suggests that unauthorized enrollments and plan switches are not a concern in state-based Marketplaces, making it unclear why most policies are generally being proposed as mandatory in these settings, rather than as state options.

The proposed rule largely motivates its provisions by outlining inappropriate behavior by agents, brokers, and web-brokers, enrolling people into coverage or switching their

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[4] Kim G, Minicozzi A, White C. Why Some Nonelderly Adult Medicaid Enrollees Appear Ineligible Based on Their Annual Income. *Journal of Health Politics, Policy and Law*. 2024;49(6):1051-1074.
[5] Parisi M. *Individual Income Tax Returns, Preliminary Data, 2016.* Internal Revenue Service; 2018.
The relevant figures can be found on pages 7 ("Excess advance premium tax credit repayment") and 9 ("Total net premium tax credit," Advance payment of premium tax credit").
[6] Alarcon G, Fried B, Hest R. *2020 Update of SHADAC's Health Insurance Unit.*; 2020.

health insurance plans without the individual's consent, a phenomenon that has been reported in popular press.[7] The proposed rule relies on various statistics related to unauthorized enrollments and plan switching. It also stipulates, for example, that "We believe [...] the 150 percent FPL SEP was one of the primary mechanisms that certain agents, brokers, and web-brokers used to conduct unauthorized enrollments to improperly enroll consumers in fully subsidized Exchange plans" and "The existence of fully subsidized plans by itself creates an opportunity for some agents, brokers, and web-brokers to conduct improper enrollments of consumers in Exchange coverage without them knowing."

However, **the bulk of the proposed policy changes intervene on and create new administrative burdens for *enrollees* rather than the agents, brokers, and web-brokers who are generally understood to be the driving force behind erroneous and improper enrollments.** This mismatch between problem and policy target has the potential to exacerbate incomplete take-up and avoidable disenrollments among people genuinely eligible for subsidized Marketplace coverage, with disenrollment/incomplete take-up more likely among healthier, lower-cost potential enrollees (as discussed at greater length below, in subsection D.).

The recently finalized Notice of Benefit and Payment Parameters (NBPP) for 2026 made regulatory changes intended to respond to misconduct and noncompliance among agents and brokers, but the present proposed rule does not outline why the additional steps (which primarily operate by requiring additional effort and documentation from enrollees) is necessary addition to the NBPP changes.

A related point on targeting draws on the distinctive roles of brokers and agents in state-based marketplaces (SBMs) versus the federally-facilitated marketplace (FFM). As has been noted elsewhere, "One key difference between Healthcare.gov and SBM states is the level of technology available to brokers. No SBM currently offers a program like EDE that integrates third-party enrollment platforms."[8] The proposed rule itself refers to evidence that "people with household incomes too low to qualify for APTC in States that did not expand Medicaid have a strong incentive to attest to income just above the eligibility threshold to obtain APTC," but SBM states are generally also states that have opted to expand Medicaid under the Affordable Care Act (with the exception of Georgia). Given this context, it's not clear why CMS considers it necessary to make most of the proposed program integrity policies obligatory for SBMs (particularly those in states that have expanded Medicaid), rather than advising that states can optionally adopt such policies.

**C. The proposed rule anticipates (and almost certainly understates) potential coverage disruptions among eligible individuals but fails to contemplate possible safeguards to minimize inappropriate coverage loss or facilitate re-entry into coverage of eligible individuals.**

The regulatory impact analysis in the proposed rule stipulates that estimates of coverage losses "may underestimate the actual number of individuals impacted, as

[7] Appleby J. ACA health insurance plans are being switched without enrollees' OK. *NPR*. April 1, 2024.
[8] Gürel A. The impact of brokers on ACA marketplace growth. *Risk Manage Insurance Review*. 2024;27(2):227-236.

eligible enrollees may lose coverage as a result of the administrative burdens imposed by the provisions of this rule." As noted in section I.A., the agency's decision to "fully attribute" excess enrollments to error and improper enrollment is inconsistent with empirical evidence on income volatility and available **evidence discussed elsewhere in this comment letter suggests that significant disenrollment among eligible individuals is likely to occur.**

Taking these considerations alongside empirical evidence that bears directly on specific provisions that might disrupt continuous coverage, such as the $5 premium for people automatically renewing into fully-subsidized coverage (discussed in more detail in section II below), it seems very likely that the proposed rule, if finalized, would certainly result in disenrollment of eligible individuals; however the proposed rule fails to contemplate potential safeguards to protect those enrollees.

**Unexpected disenrollment from Marketplace coverage is arguably substantially more consequential than disenrollment from, for example, Medicaid**. Whereas Medicaid-eligible enrollees can enroll year-round, Marketplace-eligible enrollees need to enroll during the open enrollment period (which this proposed rule anticipates shortening). Outside open enrollment, people need a qualifying life event (for example, moving to a new rating area, losing employment-based coverage, or having a baby) to be eligible for a special enrollment period. New verification requirements proposed in this rule will make these special enrollment periods (SEPs) more difficult to use and decrease mid-year take-up among eligible enrollees. In effect, people inadvertently being screened out of coverage by program integrity measures, despite remaining eligible for their subsidies, could be locked out of coverage until the following January.

Given the way the proposed rule is written, and the manner in which payment delinquency leads to coverage termination, someone who experiences a transition from fully-subsidized coverage to owing a $5 premium (because they do not actively renew and re-confirm their income information) would have their coverage terminated at the end of March, in accordance with the three-month grace period, with termination backdated to January 31. At this time, they would be well outside the open enrollment window and would only be permitted to re-enter Marketplace coverage if they could demonstrate a qualifying life event (which they may not have) to trigger a special enrollment period (SEP).

**As suggested elsewhere in this comment letter, one step the agency could take to ameliorate this concern is to keep the recurring special enrollment period for enrollees with incomes below 150% FPL intact,** rather than rescinding it as proposed. Enrollees who qualify for fully-subsidized plans are disproportionately in this lowest-income group, which will be particularly the case if the enhanced APTCs lapse; these lower-income individuals and families are also less likely to be able to manage unexpected medical expenses that might arise if locked out of insurance.

**Barring maintenance of this SEP, the agency should consider giving enrollees who have coverage terminated because of new program integrity policies a 90-day SEP** that starts on last day of their grace period (e.g., March 31 in cases where the enrollee fails to pay a new $5 premium starting in January). The 90-day recommendation reflects increasing prevalence of 90-day prescription drug fills; nearly

one-quarter (23%) of prescription drug fills in 2020 were 90-day fills and 90-day fills comprised three-quarters (74%) of mail-order prescriptions.[9] In a recent study of Medicaid enrollee experiences with "unwinding," about one in four enrollees who reported losing coverage learned about their coverage change at point of care, rather than from official communications, with attempts to refill prescriptions being the most common health care setting.[10]

**D. Estimates of risk pools effects do not comprehensively account for relevant dynamics and, as a result, may misunderstand resulting changes to gross premiums borne in their entirety by unsubsidized enrollees.**

In general, the policies proposed in this NPRM can be understood to increase the administrative burdens, or learning and hassle costs, that must be overcome in order to enroll or stay enrolled in Marketplace health insurance coverage. Policies that directly increase administrative burdens on enrollees include:

- Shortening the open enrollment period
- Imposing nominal monthly premiums where people would otherwise be auto re-enrolled into fully subsidized coverage
- Removing the special enrollment period for people with incomes < 150% FPL
- Requiring states to verify qualifying life events for 75% of special enrollment period enrollments
- Creating additional opportunities for potential enrollees to experience a data matching issue (DMI) and requiring manual requests for additional time to resolve any DMIs that occur

The agency proposes to impose these administrative burdens are proposed in service of program integrity goals, but the intent behind the burdens does not change their ultimate impact: In general, administrative burdens in health insurance coverage are understood to screen out those who are least likely to need use their insurance — people who, all else equal, have better risk profiles, improving the risk pool and lowering gross premiums.

The NPRM itself recognizes this, in the discussion of DMIs for income: "we stated in the 2024 Payment Notice (88 FR 25820) that consumers in the 25–35 age group were most likely to lose their APTC eligibility due to an income DMI, resulting in a loss of a population that, on average, has a lower health risk, thereby negatively impacting the risk pool."

The inference above should be understood to extend to other policies that have the effect of increasing administrative burdens. As discussed in greater detail elsewhere in

[9] Barnett BS, Carlo AD, Phatak A. Intentional Overdose Prevention in the Era of the 90-Day Prescription. *PS*. 2022;73(4):460-462.
[10] McIntyre A, Sommers B, Aboulafia G, Orav EJ, Epstein AM, Figueroa JF. "Experiences with Medicaid Unwinding Among Low-Income Adults in Four Southern States." Forthcoming in *Health Affairs Scholar*; manuscript available upon request.

this comment letter, research has consistently shown that reducing administrative burdens improves take-up among healthier, lower-cost enrollees.[11]

Finally, the agency stipulates at several points throughout the rule that it believes people are being enrolled into coverage without their consent or knowledge. To the extent that this is true — and to the extent that proposed policies prevent such unauthorized enrollments — provisions within the NPRM will have the practical effect of removing "never-utilizers" from the risk pool (assuming that people do not use insurance they do not know they have). The NPRM does not seem to contemplate what the elimination of never-utilizers would mean for the risk pool and gross premiums.

The NPRM stipulates that, "Lower premiums may also increase enrollment among unsubsidized consumers and help lower the uninsured rate." I agree with this sentiment, but strongly disagree that the proposed policies are likely to lead to an improved risk pool and lower gross premiums, on net. I suspect that, instead, the proposals contained within the NPRM will worsen the risk pool, increase gross premiums, and will undermine the agency's goal of making Marketplace coverage more affordable for potential unsubsidized enrollees.

**E. CMS appears to have overlooked several opportunities to substantiate their proposed policies with data the agency should have available for analysis.** As noted in the preamble to this comment letter, FFM data that the agency makes publicly available is generally insufficient for evaluating the potential outcomes of provisions proposed within this rule. It is therefore troubling that the CMS did not undertake more thorough analyses using data that is available to the agency, but not the public.

1. **CMS should use risk score data to more comprehensively evaluate the risk pool effects of proposed policies, including shortening open enrollment, eliminating the under 150% FPL SEP, and imposing $5 premiums on people who would otherwise be renewed into fully-subsidized coverage.**

   In various places throughout the proposed rule, CMS speculates about potential risk pool implications where the agency should have the ability to conduct analyses using risk score data from prior years of enrollment.

   For example, the agency should be able to use risk profile data on individuals enrolling through open enrollment with application dates that would be prohibited under the new open enrollment window to evaluate whether shortening open enrollment would improve or worsen the risk pool. Data presented below and shared elsewhere by state-based marketplaces suggest it would worsen the risk pool.

   The agency should similarly be able to broadly evaluate the effect of eliminating the under 150% FPL SEP by evaluating the risk profiles of people entering "CSR-94" plans (silver plans available only to those with incomes below 150% FPL) outside of open enrollment.

[11] Kwon C. Overcoming administrative burdens: Strategies to increase access to health insurance in the United States. The Abdul Latif Jameel Poverty Action Lab (J-PAL). April 27, 2023.

CMS should also be able to more completely evaluate the enrollment and risk pool effects of imposing $5 premiums where people would otherwise be automatically re-enrolled into fully subsidized coverage by evaluating the effect of natural churn in fully subsidized silver CSR-94 plans.[12] To what extent was attrition observed in these plans after they transitioned from being fully subsidized to having small after-subsidy premiums? How did the risk pools of those exiting the plan compare to the risk profiles of those who sustained premium payments and stayed enrolled or actively switched to other plans?

2. **CMS should do more to specifically evaluate the role of brokers to inform whether brokers are a more suitable target for intervention than enrollees.** CMS maintains data, not publicly available to researchers or other key stakeholders, on which enrollees are enrolled through direct enrollment or enhanced direct enrollment (DE/EDE) pathways and which brokers/agents.

   To the extent that CMS is concerned by analyses suggesting that there is implausible "bunching" of enrollees just above the poverty line, it may be prudent for the agency to investigate the extent to which these enrollees may be disproportionately entering via broker-assisted means or if particular brokers are disproportionately represented within the bunching. If there are particular "problematic" brokers, there may be strategies available to rectify fraudulent and abusive behavior that has less potential to inadvertently screen out people who are attempting to enroll in coverage in good faith. I discuss this more in the next section.

3. **The proposed rule stipulates that "recent enrollment data suggest people are manipulating guaranteed availability and grace periods to time coverage to when they need health care services;" however, presentation and discussion of these data appears to be omitted from the regulatory text.** Given that (1) FFM enrollment data are not linked to medical claims data in the FFM context, except distally through risk scores, and, (2) the proposed rule implies that many people with incomes < 150% FPL are being enrolled without their knowledge (and if this is true, we would generally expect them to be non-utilizers), it would be helpful to understand how the agency is arriving at this inference.

## II. SPECIFIC REGULATORY PROVISIONS

Below I comment on four specific provisions contemplated by the proposed rule that would each have the likely effect of decreasing enrollment — with enrollees having little recourse to obtain affordable coverage absent a new qualifying life event — and would generally worsen the risk pool, increasing premiums for unsubsidized enrollees.

[12] Kong E, Shepard M, McIntyre A. Turnover in Zero-Premium Status Among Health Insurance Marketplace Plans Available to Low-Income Enrollees. *JAMA Health Forum.* 2022;3(4):e220674; Ludwinski D, Anderson DM. Dynamic Price Competition for Low-Cost Silver Plans on Healthcare.gov 2014–2021. *Med Care Res Rev.* 2023;80(5):540-547.

**A. §155.335: Empirical evidence suggests that requiring people to pay $5 if auto-renewed into coverage that would otherwise be fully subsidized would lead to coverage loss and patterns of coverage loss would worsen the risk pool.** (§155.335)

CMS is proposing to "prevent fully subsidized enrollees from being automatically re-enrolled without taking an action to confirm their eligibility information" by requiring insurers, when an enrollee who would otherwise be auto-renewed into a fully subsidized plan, apply a premium of "$5 for the first month and for every following month that the enrollee does not confirm their eligibility for APTC." The agency stipulates that coverage loss resulting from such a policy change "would be low given the nominal expense associated with the proposed APTC adjustments."

This policy is likely to affect a meaningful share of low-income enrollees. As CMS noted in prior rulemaking, "in 2020, 77 percent of the consumer population at or below 150 percent FPL had access to a zero-dollar bronze plan with 16 percent of the same population having access to a zero-dollar silver plan in addition to the zero-dollar bronze plan."

**Available evidence suggests that introducing new $5 premiums to plans that would otherwise have net-$0 premiums would meaningfully decrease coverage and do so in ways that worsen the risk pool.** We have direct evidence on this phenomenon from the Massachusetts Health Connector, which had fully subsidized coverage for households < 150% FPL prior to enhanced federal subsidies (through supplemental state subsidies). In 2016 and 2017, enrollees with incomes of 100-150% FPL had access to exactly one fully subsidized plan, the lowest-priced of the available plans. Which plan was fully subsidized could change as a result of market competition; from December 2016 to January 2017, the fully-subsidized plan changed in approximately half of the state's rating areas. Where it changed, enrollees faced a new, nominal (< $10/month) premium.[13]

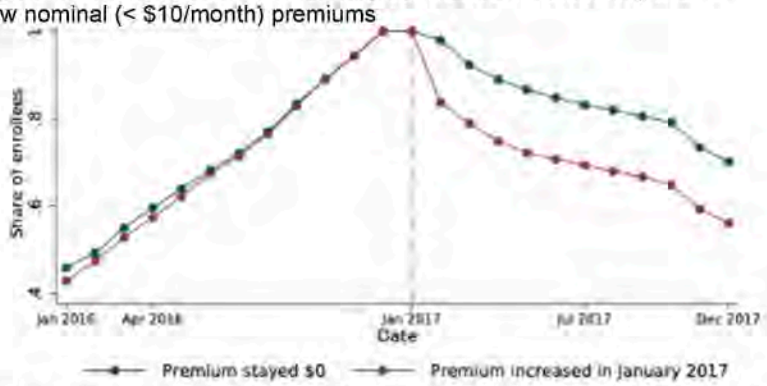
Among enrollees subject to the $0-to-positive premium transition, there was an excess 14% attrition, largely occurring immediately, with terminations backdated to January 31, consistent with terminations for nonpayment (**Figure 1**, next page). Put another way, 1 in 7 enrollees lost coverage as a result of new monthly premiums. Enrollees who lost coverage following the premium transition were, on average, younger (and thus likely lower risk) than those who stayed enrolled.

These findings are consistent with research on a pre-ACA Massachusetts policy targeting people who qualified for fully subsidized plans but fell behind on premiums.[14] This "auto-retention" policy moved eligible individuals into fully-subsidized coverage, rather than terminating them for nonpayment. Under the policy, 14% of the targeted income group was auto-retained, largely driven by plans changing from $0 to positive-premium. **Monthly medical spending for auto-retained enrollees was, on average,**

[13] McIntyre A, Shepard M, Layton TJ. Small Marketplace Premiums Pose Financial and Administrative Burdens: Evidence from Massachusetts, 2016–17. *Health Affairs*. Published online January 8, 2024.
[14] McIntyre A, Shepard M, Wagner M. Can Automatic Retention Improve Health Insurance Market Outcomes? *AEA Papers and Proceedings*. 2021; 111:560-566.

**14% lower than peer enrollees.** Analysis of the state all-payer claims database did not substantiate concerns that the policy was leading to widespread duplicative coverage.

**Figure 1.** Enrollment trends when fully subsidized enrollees experience new nominal (< $10/month) premiums




*Notes:* Author's analysis of 2016-2017 Massachusetts Health Connector data. Figure plots raw enrollment trends (was someone enrolled in a given month) among people continuously enrolled Dec. 2016-Jan. 2017, separated by whether their plan stayed $0 or required a new, nominal premium starting in January. included in the supplemental appendix for *McIntyre A, Shepard M, Layton TJ. Small Marketplace Premiums Pose Financial and Administrative Burdens: Evidence From Massachusetts, 2016–17.* Health Affairs. *Published online January 8, 2024. doi:10.1377/hlthaff.2023.00649*

The agency also solicits comment on the size of the monthly premium if they move forward with introducing premiums in cases where enrollees would otherwise be auto re-enrolled into fully subsidized coverage. While I believe the entire policy is misguided and will worsen the risk pool by differentially screening out healthy, eligible enrollees, **if the agency moves forward with finalizing the policy, the required premium should be $1, not $5 or more.**

**A single-dollar premium effectively screens (younger, healthier) people out of coverage, as we observed in the Massachusetts study referenced above** (see **Figure 2**, next page). People in rating areas that experienced a transition from $0 to $1 experienced almost as much plan exit as people living in $2 or $4 rating areas. Attrition was somewhat higher in rating areas that transitioned to plans requiring $9 monthly premiums, which we attribute to affordability issues compounding the effects of administrative burdens imposed by new nominal premiums.

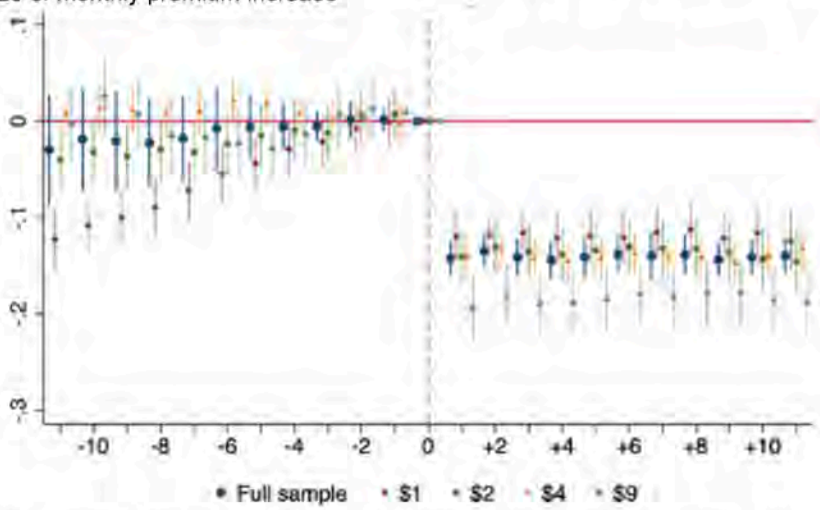
**There are reasons beyond affordability that small premiums can be more difficult for lower-income households to pay** compared to middle- and higher-income households. Generally speaking, people often set up automatic, recurring payment options, using direct ACH (bank) transfers or using a credit card. However, low-income households are less likely to have a bank or credit card to facilitate automatic payments. In 2023, about one in ten (9.0%) households with annual incomes of $15,000-$30,000 were "unbanked," meaning they do not have a bank account from which they can make ACH deposits.[15] Almost half of households at this income level did not have a credit card. In both cases, the likelihood of having access to these resources are inversely

[15] *2023 FDIC National Survey of Unbanked and Underbanked Households*. Federal Deposit Insurance Corporation (FDIC); 2024.

related to age — that is, young people are more likely to be unbanked and less likely to have a credit card than older people — which has risk pool implications.

*For these reasons, I urge the agency to not finalize this or any proposal that introduces new premiums for enrollees auto-reenrolled into fully subsidized coverage. If the agency moves forward with the proposal, I suggest a $1 premium instead of a $5 premium.*

**Figure 2.** Differential attrition after introduction of new premium, stratified by size of monthly premium increase




*Notes: Author's analysis of 2016-2017 Massachusetts Health Connector data. Figure Reports results from a difference-in-differences event-study model comparing enrollment among people continuously enrolled Dec. 2016-Jan. 2017 with fully subsidized coverage against those whose plans required a new, nominal premium starting in January, stratified by the size of the new premium. Included in supplemental appendix for McIntyre A, Shepard M, Layton TJ. Small Marketplace Premiums Pose Financial and Administrative Burdens: Evidence From Massachusetts, 2016–17. Health Affairs. Published online January 8, 2024. doi:10.1377/hlthaff.2023.00649*

**B. §155.335: Removing the option for Exchanges to auto-reenroll individuals who qualify for fully or partially subsidized plans would dramatically decrease enrollment and likely increase average risk and gross premiums. Requiring that they be re-enrolled without APTC would result in disenrollment among a majority of affected enrollees.**

The agency seeks comment on "removing the option for Exchanges to auto-reenroll individuals who qualify for fully or partially subsidized plans." **Evidence suggests that this proposal would needlessly cause widespread coverage loss.** Losing Marketplace coverage due to nonpayment is not, itself, a qualifying life event, so many individuals losing terminated as a result of this policy would be locked out of coverage until the next open enrollment period.

Prior research using data from Covered California has found that losing the ability to be automatically reenrolled (because of plan exit) was associated with a 30-percentage point decline in continued enrollment.[16]

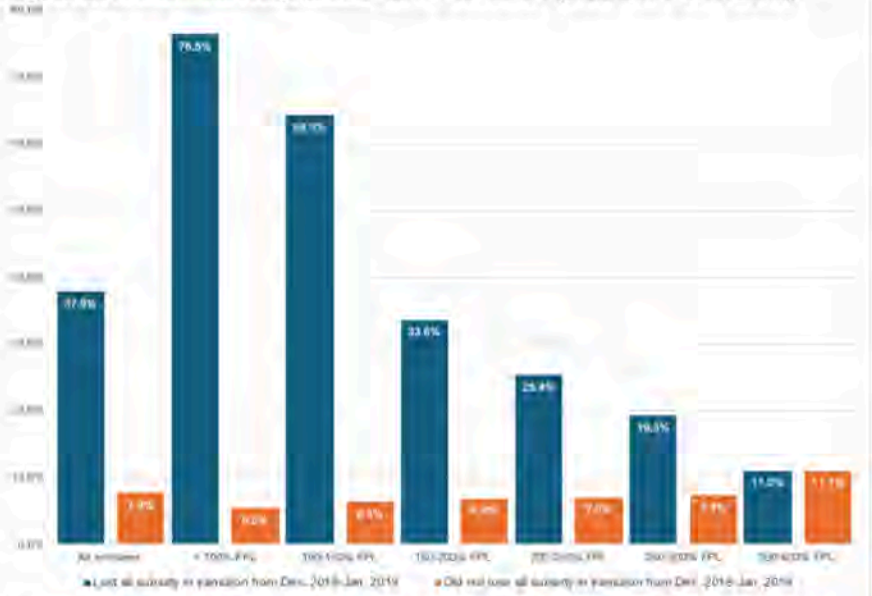
[16] Drake C, Anderson DM. Association Between Having an Automatic Reenrollment Option and Reenrollment in the Health Insurance Marketplaces. *JAMA Intern Med.* 2019;179(12):1725.

The proposed rule also seeks comment on a proposal from the 2021 Notice of Benefit and Payment Parameters that would instead require that any enrollee who would otherwise be re-enrolled into a fully subsidized plan "be automatically re-enrolled without APTC." **Such actions would drastically reduce enrollment among those automatically being re-enrolled and would likely worsen the risk pool.**

I examine this empirically using enrollment data from the Massachusetts Health Connector (Health Connector). Approximately 6% of enrollees transitioned from having some amount of subsidy (in December 2018) to having no subsidy at all (in January 2019). This was due to a combination of genuine income fluctuations and the Health Connector's inability to resolve a household's income during the eligibility redetermination process.

Among people who transitioned to an unsubsidized state, nearly four in ten (37.9%) had their coverage terminated for nonpayment, with an effective data of December 31. However, the effect was very pronounced for people with incomes under 150% FPL, where more than two-thirds of enrollees lost coverage (**Figure 3**).

**Figure 3.** Attrition following termination of subsidies (Dec. 2018-Jan. 2019)




*Notes:* Author's analysis of Massachusetts Health Connector data. Individuals renewed without subsidy may have had genuine income increases or could not have their income automatically confirmed during the annual redetermination process and did not respond to the Health Connector's notice requesting updated information

Though I do not have access to risk scores, which would most precisely inform effects on the risk pool, we can develop a coarse sense for how this attrition affected the risk pool by examining how ages vary across (1) people who did not lose all of their subsidy (but may have experienced other subsidy fluctuations); (2) all enrollees who lost their subsidies entirely going into January 2019; (3) the subset of enrollees who lost their subsidies (2) who did not re-enroll, perhaps because they did not have a qualifying life event or did not know how to navigate the special enrollment process; and (4) the

subset of enrollees losing their subsidies who managed to navigate the special enrollment period process to re-enroll in coverage at some point in 2019.

**Table 1.** Mean ages of enrollees who did and did not lose all subsidy in Jan. 2019, by income group

| Income | Did not lose all subsidy, stayed enrolled into January | Lost all subsidy in Jan. 2019 | | |
|---|---|---|---|---|
| | | All enrollees losing subsidy | Did not re-enroll in 2019 | Did re-enroll in 2019 |
| All enrollees | 41.4 | 39.8 | 39.4 | 41.3 |
| < 150% FPL | 41.2 | 40.2 | 39.7 | 41.2 |
| 150-200% FPL | 41.9 | 40.1 | 39.5 | 41.9 |
| 200-250% FPL | 42.3 | 38.9 | 38.3 | 41.2 |
| 250-300% FPL | 43.2 | 38.8 | 38.4 | 41.7 |
| 300-400% FPL | 42.9 | 40.9 | 41.1 | 38.9 |

*Notes:* Author's analysis of Massachusetts Health Connector data. Individuals renewed without subsidy may have had genuine income increase or could not have their income automatically confirmed during the annual redetermination process and did not respond to the Health Connector's notice requesting updated information

**Table 1** presents these mean ages, stratified by income. Across the subpopulations, people who exited coverage immediately after subsidy loss were younger than the enrollees who remained enrolled in good standing into January. With only one exception (the 300-400% FPL group) people who lost coverage but re-entered were older than people who lost coverage and did not re-enroll within the calendar year, consistent with the theory that people with greater health needs (here proxied by age) will be more willing and able to overcome administrative burdens to obtain health insurance coverage.

**Table 2.** Age distribution of enrollees with incomes < 150% FPL who did and did not lose all subsidy in Jan. 2019

| Age Band | Did not lose all subsidy, stayed enrolled into at least January | Lost all subsidy in Jan. 2019 | | |
|---|---|---|---|---|
| | | All enrollees losing subsidy | Did not re-enroll in 2019 | Did re-enroll in 2019 |
| Under 18 | 0.5% | 0.5% | 0.6% | 0.2% |
| 18-25 | 11.1% | 13.3% | 13.9% | 11.8% |
| 26-34 | 24.0% | 26.6% | 28.9% | 21.0% |
| 35-44 | 24.1% | 22.7% | 21.4% | 25.8% |
| 45-44 | 20.3% | 19.9% | 18.3% | 23.4% |
| 44-64 | 19.9% | 17.1% | 16.8% | 17.9% |

*Notes: Author's analysis of Massachusetts Health Connector data. Individuals renewed without subsidy may have had genuine income increase or could not have their income automatically confirmed during the annual redetermination process and did not respond to the Health Connector's notice requesting updated information.*

Because we would expect this policy to disproportionately affect the lowest-income enrollees, those with incomes below 150% FPL who are more likely than not to qualify for full-subsidized bronze plans, it may be instructive to examine the age distribution for this income group, specifically (**Table 2**, prior page). Again, for this income group, younger enrollees are more likely to be screened out and less likely to reenter coverage.

A final note on the proposal to remove all APTC if the enrollee does not actively re-confirm their eligibility: **To do so would shorten the enrollee's grace period — the time during which they could confirm their subsidy eligibility and pay owed premium by two-thirds — from three months to one months**, compounding issues of coverage loss and adverse selection outlined throughout this comment letter.

*For these reasons, I urge the agency to not finalize this proposal.*

**C. §155.410: Shortening the annual open enrollment period would decrease enrollment and increase adverse selection, particularly in the context of expiring enhanced premium tax credits and other policies contemplated in the proposed rule.**

CMS proposes to shorten the open enrollment period (OEP) for both the federally-facilitated exchange and state-based marketplaces (SBMs).

As noted in the "general policy considerations" section of this comment letter, the agency could do more to substantiate its assertion using data available to the agency but not to the public. Available data from state-based marketplaces offers evidence of the opposite: that longer open enrollment period attract healthier enrollees who ultimately improve the risk pool and reduce premiums.[17]

**Table 3.** Age distribution of Massachusetts Health Connector enrollees entering coverage in January versus February 2024, accounting for prior Medicaid enrollment status

| | Month initiating enrollment, plan year 2024 | | | | | |
|---|---|---|---|---|---|---|
| | *All enrollees* | | | *Excluding those exiting Medicaid in prior 90 days* | | |
| **Age Band** | January 2024 | February 2024 | **Feb-Jan Difference** | January 2024 | February 2024 | **Feb-Jan Difference** |
| Under 18 | 8.7% | 7.1% | **-1.6%** | 4.9% | 4.4% | **-0.6%** |
| 18-25 | 14.3% | 16.4% | **2.1%** | 11.5% | 13.7% | **2.2%** |
| 26-34 | 21.5% | 24.9% | **3.3%** | 24.9% | 28.5% | **3.6%** |
| 35-44 | 19.6% | 20.3% | **0.7%** | 20.8% | 21.4% | **0.6%** |
| 45-54 | 17.2% | 16.2% | **-1.0%** | 17.6% | 16.5% | **-1.2%** |
| 55-64 | 18.6% | 15.2% | **-3.5%** | 20.4% | 15.7% | **-4.7%** |

*Notes: Author's analysis of Massachusetts Health Connector data. Individuals with exiting Medicaid in prior 90 days would qualify for a special enrollment period and thus would be able to enroll in February even if the open enrollment period did not extend into January.*

[17] New CMS Proposed Rule: Marketplace Integrity. State Health Value Strategies; April 1, 2025.

I analyzed 2024 data from the Massachusetts Health Connector to evaluate whether average ages differed among people entering coverage that takes effect January 1 versus people entering coverage that takes effect February 1 to proxy for the difference in enrollment timing (**Table 3**, prior page). I first conduct the analysis for all enrollees entering coverage in these months. I then impose a restriction that excludes people who exited Medicaid in the prior 90 days and would thus qualify for a special enrollment period.

In both analyses, people entering coverage in February are younger than those entering coverage in January; the differences are more pronounced when excluding those who would be able to enter through a SEP related to exiting Medicaid.

This is consistent with an expectation that people with health needs and so-called "pent-up demand" would be more likely to proactively enroll early, and those who are healthiest and least attached to health insurance would be more likely to lag in their enrollment actions. **If the agency moves forward with finalizing the OEP restrictions as proposed, it will likely worsen the risk pool and increase gross premiums** (which are borne in their entirety by unsubsidized enrollees).

*For these reasons, I urge the agency to not finalize this proposal.*

**D. §155.420: Removing the special enrollment period (SEP) for households with incomes below 150% FPL would exacerbate negative enrollment consequences likely to arise from other provisions included in the proposed rule**

As noted above, the cumulative effect of imposing additional administrative burdens on Marketplace enrollees will be to reduce enrollment among those eligible for subsidized coverage. The proposed policies will diminish both take-up and retention of coverage and will likely do so disproportionately among people who are healthier and more likely to improve insurance risk pools, decreasing gross premiums and costs for unsubsidized enrollees.

One step the administration could take to reduce these adverse effects is to maintain the SEP for individuals and households with incomes under 150% FPL. These households are more likely to be screened out of coverage by the policy, proposed elsewhere in the NPRM, to impose new premiums on people who would otherwise be auto re-enrolled into fully subsidized coverage. These households will also be the least able, among Marketplace-eligible households, to absorb unexpected medical costs.

*For these reasons, I urge the agency to not finalize this proposal.*

**E. Removing the "bronze to silver crosswalk policy" option for Exchanges will increase financial burdens for enrollees, potentially leading to attrition among healthier enrollees, worsening the risk pool (§155.335).**

In the NPRM, the agency proposes to eliminate that "bronze to silver crosswalk policy" that permits Exchanges to "direct re- enrollment for enrollees who are eligible for CSRs from a bronze QHP to a silver QHP if a silver QHP is available within the same product, with the same provider network, and with a lower or equivalent" net premium.

This policy ensures enrollees receive greater financial protection with reduced out-of-pocket expenses and lower monthly premiums. By removing the crosswalk, enrollees might inadvertently remain on less beneficial bronze plans, facing higher deductibles and cost-sharing, which could impede access to necessary healthcare services.[18]

Recent research highlights a critical finding: automatic reenrollment into silver plans is much more effective than outreach at correcting choice errors caused by consumer inattention or inertia.[19] Many enrollees remain unaware of the advantageous shift unless prompted or assisted by policy interventions and it is possible that not all brokers are adequately counseling their enrollees on benefits of silver plans (such as cost-sharing reductions). As noted in the analysis by Anderson (2021), lower-income individuals are often burdened by the psychological and time costs of plan selection. Without the crosswalk, these individuals might default to plans that offer inadequate coverage relative to their needs, potentially worsening underinsurance issues for vulnerable populations.

If the agency finalizes this proposal, I urge that state-based marketplaces be encouraged, and the federally-facilitated exchange be required, to send explicit and targeted notices, prior to and during open enrollment, to individuals who would have previously benefited from the bronze-to-silver crosswalk. These notices should alert enrollees to the fact that a plan with a lower premium, less cost-sharing, and the same insurer and provider network is available to them. The agency should also make switching into the more affordable plan as seamless an experience as possible.

*For these reasons, I urge the agency to not finalize this proposal; if finalized, the agency should implement additional targeted outreach strategies in lieu of the crosswalk.*

Thank you again for the opportunity to comment on this proposed rule. The facts, research, evidence and analysis above are intended to help improve the agency's understanding of enrollment and risk pool implications of the proposed policies and offer additional considerations as the agency decides whether and how to finalize specific proposals.

I would be happy to provide additional information and feedback as useful.

Sincerely,

**Adrianna McIntyre, PhD, MPH, MPP**
Assistant Professor of Health Policy and Politics
Department of Health Policy and Management
Harvard TH Chan School of Public Health

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[18] Anderson DM, Rasmussen PW, Drake C. Estimated Plan Enrollment Outcomes After Changes to US Health Insurance Marketplace Automatic Renewal Rules. *JAMA Health Forum.* 2021;2(7):e211642.
[19] Wolf E, Feher A, Ravel K, Menashe I. Comparing The Effects Of Nudges And Automatic Plan Switching On Choice Errors Among Low-Income Marketplace Enrollees: Study examines interventions to help eligible households avoid choice errors in the ACA Marketplace. *Health Affairs.* 2023;42(7):1002-1010.

NATIONAL ASSOCIATION OF Community Health Centers

April 11, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services (HHS)
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

**Re: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Proposed Rule (ATTN: CMS-9884-P)**

Dear Administrator Oz,

The National Association of Community Health Centers (NACHC) is the leading national membership organization dedicated to promoting Community Health Centers (CHCs) (also known as Federally Qualified Health Centers or health centers) as the Employer, Provider, and Partner of choice in all communities, as well as the foundation of the primary health care system in America.

Community Health Centers are the best, most innovative, and resilient part of our nation's health system. For nearly sixty years, health centers have provided high-quality, comprehensive, affordable primary and preventive care. In addition to medical services, CHCs provide dental, behavioral health, pharmacy, vision, and other essential health services to America's most vulnerable, medically underserved communities in urban, rural, suburban, frontier, and island communities. Today, health centers serve more than 32.5 million people at over 16,000 locations, ensuring patients receive the care they need and pay what they can based on a sliding fee scale.

NACHC maintains its role as the national voice for health centers and believes that high-quality primary health care is essential in creating healthy communities and preventing chronic conditions. The collective mission and mandate of NACHC and the 1,496 health centers nationwide is to close the primary care gap and provide access to high-quality, cost-effective primary and preventative medical care.

Health centers serve a critical role in the success of the Marketplaces in every state. They serve as the medical home for millions of Americans eligible for reduced cost-sharing through Federal and State marketplaces. Twenty percent of health center patients have private insurance, and 50% have Medicaid coverage, some of whom receive coverage through Medicaid expansion.[1]

These individuals are frequently eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost-sharing reductions. Additionally, health centers are a vital source of outreach and enrollment (O&E) assistance nationally. With support from the Health Resources and Services Administration (HRSA), and often from CMS programs, health centers have assisted over 4.5 million individuals seeking coverage in 2023.[2] This assistance includes helping individuals with re-enrollments, renewals, or redeterminations, as well as understanding and utilizing their newly acquired insurance.

[1] 2023 UDS HRSA Health Center Program Data
[2] Ibid.

NACHC welcomes the opportunity to comment on the 2026 Marketplace Integrity and Affordability Proposed Rule. Our comments are broken into three sections: I. Affordability; II. Access and Eligibility; and III. Enrollments.

## *I. Affordability*

**Premium Adjustment Percentage**

**NACHC urges CMS to reevaluate the methodology used at § 156.130(e) to calculate the premium growth measure.** NACHC appreciates CMS's intentional focus on comprehensiveness, availability, transparency, and accuracy as a guide for setting PY 2026 premiums. However, we are concerned that the proposed adjustment and updated requirement contribution percentages are too high for many of the patients health centers serve. The resulting annual out-of-pocket costs have increased significantly from PY 2025 and could result in many low-income individuals and households being unable to afford coverage, even with tax credits and cost-sharing reductions.

Health center patients are four times more likely to have an income at or below the Federal Poverty Level (FPL) and twice as likely to have income under 200% of FPL as compared to the U.S. population.[3] More specifically, two out of three health center patients are at or below 100% of the FPL and 90% of health center patients live at or below 200% of the FPL.[4] Premium increases are most impactful for those with the lowest incomes, particularly among enrollees with incomes below the FPL. This policy would quickly impact the majority of patients health centers serve. Additionally, a large body of research shows that premiums can serve as a barrier to obtaining and maintaining healthcare coverage among low-income individuals[5], meaning many patients at health centers may struggle to afford the increasing costs of their insurance or may be unable to sign up for new coverage.

Increasing premiums historically correlates with pressure on safety net providers like CHCs. [6] Several studies show that coverage losses following premium increases lead to higher volumes of uninsured patients being seen by health centers.[7] This is especially burdensome on CHCs, as they are legally mandated to serve every patient that walks through their doors, regardless of their ability to pay. Higher premiums serve as a barrier to obtaining and maintaining coverage for low-income individuals, particularly those with the most limited incomes, and even relatively small levels of cost-sharing reduce the utilization of services. Seeing more insured patients helps health centers pay for those patients in dire need of care who cannot afford coverage. Community health centers are already facing intense financial pressure while operating on razor-thin margins. Already in 2025, several health centers in Virginia were forced to close their doors or suspend vital services over delayed federal funding, highlighting the financial stress CHCs are currently experiencing.[8] A decrease in insured patients would likely force many more CHCs to close doors and could exacerbate health care access in many rural areas. **NACHC urges CMS to reconsider the implementation**

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[3] https://www.nachc.org/wp-content/uploads/2024/07/2024-2022-UDS-DATA-Community-Health-Center-Chartbook.pdf
[4] Ibid.
[5] https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/#:~:text=As%20such%2C%20increases%20in%20premiums,increased%20financial%20burdens%20for%20families.
[6] https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/#:~:text=As%20such%2C%20increases%20in%20premiums,increased%20financial%20burdens%20for%20families.
[7] Stephen Zuckerman, Dawn M Miller, and Emily Shelton Page, "Missouri's 2005 Medicaid Cuts: How Did they Affect Enrollees and Providers?," Health Affairs 28, 2, (2009):w335-w345; Mark Gardner and Janet Varon, Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations, (Washington, DC: Kaiser Family Foundation, May 2004); Pamela Hines, et. al., Assessing the Early Impacts of OHP2: A Pilot Study of Federally Qualified Health Centers Impact in Multnomah and Washington Counties, Prepared for Office for Oregon Health Policy & Research, (Salem, OR: Office for Oregon Health Policy & Research, December 2003).
[8] https://www.vpm.org/news/2025-02-04/virginia-community-health-centers-close-federal-funding-grant-access

**of the revised methodology and weigh the possibility that fewer low-income consumers would be able to afford their out-of-pocket costs, even with tax credit and cost-sharing reductions, as a result.**

**Failure to File Taxes and Reconcile the APTC Process**

**NACHC asks CMS to reconsider amending § 155.305(f)(4) to deny APTCs to tax filers who have failed to file and reconcile their APTCs for a single year.** The current policy gives the enrollees a chance to properly document their APTCs on their taxes, so they remain eligible for APTCs the following year if applicable. Furthermore, recent laws have extended APTCs (2021-2022 and 2023-2025)[9] to new populations who may be unfamiliar with the reconciliation process on their taxes at the end of the year. In 2022, many people waited until the last minute to file their taxes, with 21% of respondents stating "general confusion" around all the different tax credits.[10] Additionally, a 2024 survey of over 2,000 people aged 18 or above found that more than half of respondents lack basic tax knowledge, with only 2% possessing "proficient" tax knowledge.[11] With the median household income reported at $80,610 for 2023, having access to APTCs can be crucial to affording comprehensive coverage.[12]

We also know that failing to file APTCs properly is not always the consumer's fault. The proposed rule acknowledges that delays and errors in the Internal Revenue Service (IRS) processing tax returns and issues with sharing tax return information with the Exchanges can cause the IRS to incorrectly note an enrollee with a Failure to File and Reconcile (FTR) status. We understand and appreciate the Administration's intention to maintain program integrity but ask that the Administration craft policies to leverage Marketplace communications to help prevent enrollees from losing financial assistance due to misunderstandings or miscommunications and allow the current policy of only denying APTC after a tax filer failed to file and reconcile their APTC for two consecutive years.

**NACHC understands the conforming change to notice requirements at § 155.305(f)(4)(i) and the removal of notice requirement at § 155.305(f)(4)(ii) and urges the agency to leverage data from CHCs when sending direct notices about FTR status.** We are concerned about our transient and lower-technological literate patients receiving these direct and indirect notices about their FTR status. Health centers have established relationships with their more transient patients, and we encourage HHS and the Exchanges to use CHCs as a resource. We understand there are privacy concerns related to notification of FTR status. Still, NACHC recommends that HHS utilize health centers if a person's address is not up to date after doing their due diligence in attempting to contact them. We want to ensure these direct notices, sent via the U.S. Postal Service (USPS) to the address of record for tax filers, will arrive at the health center patient, especially if they do not realize their FTR status with an indirect notice. We also recommend States partner with homeless services providers (including the assigned health care providers) to help to ensure addresses are up to date.

NACHC is also concerned about the quick anticipated timeline of the FTR proposal § 155.305(f)(4) and recommends delaying the effective date to Open Enrollment Year 2027 if finalized as proposed.

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

**NACHC recommends CMS reconsider their proposal at § 155.320(c)(3)(iii) to require all Exchanges to generate annual household income inconsistencies in certain circumstances when applicants report a household income that is *greater than* the income amount represented by income data from trusted sources.** We anticipate that this proposal will have negative ramifications for some of the lowest-income

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[9] https://www.cms.gov/marketplace/technical-assistance-resources/aptc-csr-basics.pdf
[10] https://www.cbsnews.com/newyork/news/expert-confusion-reigns-supreme-as-americans-wait-until-the-last-minute-to-file-their-tax-returns/
[11] https://taxfoundation.org/research/all/federal/us-tax-literacy-poll-knowledge-perceptions/
[12] https://www.census.gov/library/publications/2024/demo/p60-282.html

enrollees, many of whom are served by health centers, and believe this will impact Exchange operations as well. The law directs using both the applicant's projection of their income for the coming year and recent tax return data provided by the IRS to see if they qualify for APTCs. If projected income is inconsistent with what's shown in tax data, the Exchange generates a "data matching issue," or DMI. The consumer must then provide additional information to substantiate their projection; if they do not, APTC eligibility is determined based on tax data.

This proposal will impact very low-income consumers; over 45% of health center patients are 100% below the FPL – meaning they make a little over $15,000 per year as a single person.[13] It will create a substantial administrative burden on these enrollees who would be required to respond to the DMIs through submitting pay stubs or additional information, which could be difficult to gather to prove their income projection, or risk losing tax credits. The proposed rule estimates 81,000 people annually would be denied tax credits, reducing APTC payments by $189 million, and will create 550,000 DMIs a year.[14] We also are concerned that this will divert time and money at the Exchanges away from other pertinent enrollment and eligibility issues; the proposed rule states the increased DMIs will cost $32 million per year to Exchanges.[15]

**Income Verification When Tax Data is Unavailable**

**NACHC recommends CMS revisit modifying § 155.320(c)(5) and continue accepting enrollee self-attestation of income due to the anticipated negative impact a change could have on health center patients.** We understand and sympathize with the Administration's desire to maintain program integrity within the Exchanges. This proposal appears to treat Exchanges having incomplete information as a DMI, where the onus falls on the enrollee to help alleviate the burden. This proposal also does not consider that there are reasons why a person's tax data is unavailable, not due to a DMI. For instance, low-income taxpayers do not have to pay taxes or file a tax return if their income falls below the standard deduction amount for their filing status. For tax year 2025, for a single tax filer it is $15,000, and for a married couple, $30,000.[16]

We appreciate the clarification that people who have legitimate reasons for not having tax data available, like marriage, the birth of a child, name changes, and other demographic updates, would have the opportunity to be verified through other trusted data sources. However, we believe this verification through other trusted data sources should be applied to all enrollees, not just people with cases that fall under the reasons above. Lastly, we believe it could take an enrollee longer than 1 hour to submit documentation related to this income verification requirement. In the instance the enrollee is experiencing homelessness or has been under the income threshold, it would be difficult to gather adequate documentation showcasing their situation. They may need to work with case workers, their healthcare team, and others to gather enough evidence to demonstrate their potential income.

## *II. Access & Eligibility*

**Premium Payment Threshold**

**NACHC encourages CMS to reconsider modifying the premium payment options allowed at § 155.400, which were established under the 2026 Payment Notice, that have proven crucial for low-income enrollees who struggle to pay the full premium amount.** Health center patients are disproportionately financially strained compared to other patients; as mentioned previously, 61% are low-income (below 200% of the FPL). This proposal will negatively impact health centers' low-income patient

[13] 2023 UDS HRSA Data
[14] https://www.federalregister.gov/d/2025-04083/p-674
[15] https://www.healthaffairs.org/content/forefront/hhs-proposes-restrict-marketplace-eligibility-enrollment-affordability-part-two
[16] https://www.irs.gov/newsroom/irs-releases-tax-inflation-adjustments-for-tax-year-2025

population. We believe the payment options that are proposed to be eliminated enhance coverage continuity for our patients and allow issuers flexibility to receive payments from enrollees. As such, we request CMS to allow insurers to continue utilizing these provisions. Most recent data show that nearly a quarter of Americans live paycheck to paycheck.[17] Insurance issuers should be granted the flexibility to meet enrollees where they are, regardless of the payment the enrollee is attempting to pay for their health insurance. The additional thresholds allow issuers to focus on collecting most of the premium rather than pursuing small outstanding amounts that might lead to coverage loss. We encourage CMS to explore other options to improve program integrity that do not increase the risk of terminating enrollees from coverage they have made payments on.

**Coverage Denials for Failure to Pay Premiums for Prior Coverage**

**NACHC is concerned about decreased access to coverage if the interpretation of guaranteed availability at § 147.104(i) does not include coverage denials for failure to pay past premiums as a violation.** As mentioned, health centers primarily serve low-income populations who may face financial barriers to paying premiums on time. According to a KFF survey, nearly half of insured adults surveyed in 2024 worried about being able to afford their monthly premium.[18] This worry is particularly felt by low-income health center patients. While NACHC appreciates CMS's concerns about creating perverse incentives for individuals not to pay past debt and only enroll in coverage when sick, the guardrails in place, such as short grace periods and requirements to retroactively pay medical expenses, limit the perverse incentives to consumers and impact to issuers. We encourage CMS to look at other guardrails that could be put in place that would not act as a barrier to enrollment. With these guardrails, NACHC concurs with CMS's previous position that the benefits of having someone insured outweigh the potential risks of abuse.

Additionally, health centers serve every patient who walks through the door, regardless of whether they have public, private, or no insurance. Health center patients often experience insurance churn with job loss or access to new coverage. This churn can confuse what plans, coverage, and support are available to them.[19] Patients may not realize they need to terminate coverage, especially if they are not using the insurance. Even if the debt for past due premiums is small, the patients would face barriers to seeking insurance coverage if this proposal were enacted. When patients face barriers to obtaining insurance, health centers, already on razor-thin financial margins, still serve the patient regardless of insurance status. While we appreciate that CMS notes that the impact would be minimal, we believe that CHC patients would face added barriers to access due to this policy.

**Annual Eligibility Redeterminations**

**NACHC supports regulatory efforts to prevent agents, brokers, and web brokers from abusing the system and causing confusion for enrollees. However, we are concerned that the proposal at § 155.335 will negatively impact consumers.** We are also concerned that adding an amendment at § 155.335(a)(3) and (n) to prevent enrollees from being automatically re-enrolled in coverage with an APTC that fully covers their premium without taking action to confirm their eligibility information could deter low-income, but eligible consumers from enrolling, as the process can already be confusing and burdensome for patients. We agree that agents and brokers should not abuse the system for commission and should be held accountable for enrolling consumers in inappropriate plans. However, this policy would only impact the consumer, who, as established in this proposal's preamble, may not be aware they are enrolled in the fully subsidized plan. NACHC is especially concerned that this policy would negatively impact self-employed consumers who typically file taxes later in the year. The shortened timeline and the proposed policy to remove self-attestation could prevent many eligible consumers from enrolling in essential coverage.

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[17] https://www.cbsnews.com/news/paycheck-to-paycheck-definition/
[18] https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/
[19] Churning, Confusion And Disruption — The Dark Side Of Marketplace Coverage - KFF Health News

NACHC is worried about the lack of additional communication with enrollees about this policy. Health centers serve some of the poorest, low-income communities. While $5 may not seem substantial for many Americans, it can quickly add up. Without additional communication requirements from insurers regarding this eligibility check, we are concerned rural, unhoused, and/or special populations could incur large fees that they are unaware of until they can no longer afford to pay their premiums. We encourage the agency to revisit the proposed requirement, given its potential to penalize low-income enrollees.

We would also note that this policy would lead to higher rates of uninsured individuals. While the underlying statute envisioned active consumer engagement, many factors, such as time limitations, indifference about their plan, insufficient information about open enrollment, or the complexity of shopping, can prevent consumers from actively shopping. Consumers may also be satisfied with their current plan despite changes that may have been made to the availability of new alternatives. Additionally, communities who have had trouble accessing health care in the past may face higher barriers to active re-enrollment, such as complex enrollment processes, transportation and geographical barriers, financial constraints, language barriers, and distrust of the health care system.[20] Health centers are the key providers for these communities, and we anticipate this policy would negatively affect many of the patients that CHCs serve.

**NACHC suggests that CMS reevaluate the policy to focus the penalties on bad actors, such as the agents and brokers performing these improper enrollments, rather than the enrollee to mitigate unnecessary financial penalties and higher rates of uninsured patients in vulnerable communities.** We support increased oversight to hold agents of insurance agencies accountable for non-compliance or misconduct when enrolling individuals on Federal and State Exchanges. NACHC recommends that the agency consider requiring insurance agents and brokers to undergo similar training that Navigators must complete[21] before assisting enrollees to reduce the number of improper enrollments and better track malpractice. We also urge CMS to investigate marketing ploys by broker agencies and prohibit certain marketing tactics used to bolster deceptive enrollments. We welcome the opportunity to work with CMS on appropriate and effective policies aimed at reducing and eliminating improper enrollments without penalizing the consumer. NACHC has heard from multiple health centers and Primary Care Associations (PCAs) that there is continued interest to have open discussions with the Administration on sharing best practices to reduce improper enrollments, such as a notification system for the original broker if there is a change in broker that does not allow change in plans or brokers if not acknowledged.

**Additionally, NACHC supports reducing consumer confusion but requests the agency reconsider removing 155.335(j)(4).** The automatic re-enrollment hierarchy standards policy, finalized in the 2026 Payment Notice, was created to improve an enrollee's quality of care without increasing costs. When seeking health insurance coverage, it can be confusing and overwhelming for individuals to understand and choose from all the different plan options presented on the Exchange. For instance, from 2019 to 2023, the number of plans shown to the average marketplace consumer has grown from 25.9 to 113.6.[22] Some studies have shown that too many plan choices—such as over 30—can lead to poor enrollment decisions because they confuse and overwhelm the enrollee.[23] Still, elements such as benefits, provider networks, and/or formularies can help enrollees better discern key differences between plans, helping them better compare and understand their options. Health centers continue to support patients eligible for cost-sharing reduction subsidies, and we anticipate this policy will improve health coverage for our patients even after APTCs

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[20] https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01466

[21] https://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf: Conflict-of-Interest Standards for Navigators (§155.215(a)(1)) and for Non- Navigator Assistance Personnel Carrying Out Consumer Assistance Functions Under §155.205(d) and (e) (§155.215(a)(2)); List of required training module content standards is set forth in §155.215(b)(2).

[22] https://www.shvs.org/the-proposed-2024-notice-of-benefit-payment-parameters-implications-for-states/

[23] Rose Chu et.al., "Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces, ASPE Office of Health Policy Issue Brief, December 28, 2021.

have expired. Instead of removing the policy altogether, we support added notices and communications regarding the crosswalking of policies to better inform enrollees of the availability of a similar quality plan for the same price. **We urge CMS to continue streamlining and simplifying the selection process for enrollees.**

### *III. Enrollment*

**Annual Open Enrollment Period**

**NACHC supports efforts at § 155.410(e) to decrease consumer confusion but urges CMS to delay implementation of the 45-day open enrollment period and consider keeping the 76-day enrollment period.** The proposed rule asserts this shortened open-enrollment timeline would alleviate the administrative and financial burdens on enrollment staff. However, a shorter enrollment period will likely have significant impacts on CHCs. Under federal law, health centers are mandated to provide care to every patient who comes to them regardless of their ability to pay. In 2023, health centers cared for 5.6 million uninsured individuals, with the total cost of the care gap exceeding $3.16 billion.[24] In comparison, health centers cared for one million fewer uninsured patients in 2019, but the cost of that care gap has increased by $1 billion. In 2023, Federal Section 330 grant funding, which supports health centers' role as safety net providers, only made up 11% of health center revenue.[25] Health centers relied heavily on reimbursements from their insured populations to ensure they could pay for the care they provide to their uninsured patients. This rise in costs for health centers will only be exacerbated by a decrease in health insurance enrollments.

Health center enrollment teams are sometimes booked out weeks in advance of an open enrollment period and continue to see consumers coming in at the last minute to enroll. Several outreach and enrollment staff also note they typically experience a large wave of enrollment and re-enrollments right before the January 15 deadline. One health center in Pennsylvania highlighted that they see a greater number of enrollments between December 15 – January 15 for consumers who are self-employed or independent contractors because they file their taxes later in the year. Health centers assist these individuals in ensuring they have the coverage needed to stay healthy, and a shortened timeline will impact their ability to find quality, affordable healthcare coverage.

We are also concerned about the compound impact on enrollments given the recent decrease in funding available for the Navigator program.[26] Past reductions to Navigator funding have been associated with decreases in unsubsidized enrollment. This decrease will ultimately add to the burden on the safety net and generally lead to poorer public health, as being uninsured is associated with decreased access to health services and poorer health monitoring.[27, 28, 29]

Health centers continue playing a crucial role in helping uninsured patients receive critical care, but inadequate funding for enrollment efforts will lead to less revenue for health centers to operate, ultimately leading to physician burnout and a reduction in services health centers are able to provide. **We urge the agency to consider delaying the implementation of the proposed 45-day timeline to PY 2027 to ensure**

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[24] HRSA UDS Data, 2023.
[25] https://www.kff.org/medicaid/issue-brief/community-health-center-patients-financing-and-services/
[26] https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding
[27] McWilliams, J. M., Zaslavsky, A. M., Meara, E., & Ayanian, J. Z. (2003). Impact of Medicare coverage on basic clinical services for previously uninsured adults. JAMA, 290(6), 757–764.
[28] Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., ... & Finkelstein, A. N. (2013). The Oregon experiment — effects of Medicaid on clinical outcomes. New England Journal of Medicine, 368(18), 1713–1722.
[29] Buchmueller, T. C., Grumbach, K., Kronick, R., & Kahn, J. G. (2005). Book review: The effect of health insurance on medical care utilization and implications for insurance expansion: A review of the literature. Medical Care Research and Review, 62(1), 3–30.

**health center staff and navigators have sufficient time to plan and perform significant outreach to their communities to ensure their patients are insured.**

**Monthly Special Enrollment Period for Low-Consumers**

**NACHC is concerned about the proposal at § 155.420 to eliminate the monthly special enrollment period (SEP) for APTC-eligible individuals with incomes at or below 150% of the FPL due to a potential decrease in enrollment.** The goal of this SEP was to ensure that uninsured people who qualify but are not enrolled in coverage can access free or nearly-free platinum-equivalent Marketplace coverage,[30] but additional provisions were included to elevate the SEP as an additional safety net, especially for consumers transitioning from Medicaid or CHIP into other coverage, and a lower-than-anticipated risk of adverse selection. The 150% FPL SEP was also used to mitigate the impact of individuals disenrolled from Medicaid. According to states with available data, the majority (69%) of those who were disenrolled lost their health insurance coverage.[31] For health centers, nearly one in four patients lost coverage during the unwinding, with only about 25% of disenrolled patients able to successfully re-enroll in Medicaid coverage.[32] The implementation of the 150% SEP was a critical safety net for low-income families and those affected by the unwinding to maintain access to coverage and continuous health care.

The policy was made permanent in the 2026 Payment Notice to create flexibility for eligible consumers whose annual income is no more than 150% of the FPL ($22,590 for a single person, $38,730 for a family of 3).[33] Many of the consumers using this opportunity were eligible for silver plans with small or no premiums, sometimes with cost-sharing subsidies that dramatically reduced their deductibles and copays. Reflecting the mission of health centers to serve anyone regardless of ability to pay, nine in ten patients served at health centers had incomes that were at or below 200% of the FPL, and two-thirds of patients (67%) had incomes at or below the poverty level in 2023.[34] Additionally, the share of low-income patients served at health centers is three times that of the U.S. population. The removal of this enrollment period could impact a substantial number of health center patients, many of whom are eligible for the 150% SEP, thus reducing the time consumers have to apply for insurance and drastically reducing enrollments.

Additionally, NACHC appreciates CMS's focus and commitment to maintaining program integrity, particularly as group and individual health insurance markets are interlocked with Exchanges. While CHCs serve all patients regardless of insurance status, at least one in five CHC patients had private insurance in 2022.[35] Much of the strength and sustainability of community health centers can be attributed to the mixed payor pool. **While we agree with the spirit of reducing premiums and improving adverse selection, NACHC is concerned about the negative impact on enrollment if the SEPs for those at or below 150% of the FPL were eliminated for the group and individual Health Insurance Marketplaces in addition to the elimination for the Exchange, as proposed in § 147.104(b)(2).**

In response to CMS's concerns that Navigators and Certified Application Counselors (CACs) could be encouraging low-income enrollees to underreport their income to qualify for the special enrollment period, we want to assure the agency that CHCs and Navigators do not engage in this way. Navigators provide enrollees with unbiased information about the Exchanges and available health plans.[36] They also help

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[30] https://www.commonwealthfund.org/blog/2021/new-special-enrollment-period-low-income-people-could-boost-coverage
[31] https://www.benefitspro.com/2024/07/04/new-special-enrollment-period-offers-lifeline-to-affordable-health-insurance/?slreturn=20250402112458
[32] https://publichealth.gwu.edu/community-health-centers-report-impact-medicaid-unwinding-year-later
[33] https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/i-hear-there-is-a-new-special-enrollment-opportunity-in-2022-for-people-with-very-low-income-how-does-that-work/
[34] 2023 HRSA UDS Data
[35] https://www.nachc.org/wp-content/uploads/2024/07/2024-2022-UDS-DATA-Community-Health-Center-Chartbook.pdf
[36] https://www.healthinsurance.org/glossary/navigator/#:~:text=In%20the%20guidelines%20for%202020,FFEs%20to%20help%20more%20consumers.%22

enrollees determine whether they qualify for subsidies or Medicaid and assist with enrollment. Most Navigators assist with Medicaid enrollments, while most brokers do not, as there is no commission for Medicaid enrollments.[37] As of 2018, Navigators also provided targeted assistance for underserved and uninsured populations[38], which as we have stated throughout this letter, are a major patient population for health centers. There are strict integrity guardrails for Navigators, including training and certification, conflict of interest attestations, and meaningful access standards.[39] These are not required for insurance brokers. Navigators are also assigned ID numbers that must be recorded on the enrollments they assist with, meaning any malpractice can easily be tracked. Experienced health center enrollment staff and Navigators assist consumers in ensuring they meet all the requirements to qualify for the SEP. We have heard from many health center O&E staff that, if anything, they encourage consumers to overestimate their income and receive a lower APTC to avoid having to pay back their tax credits. Consumers are not trying to game the system to qualify for greater subsidies but simply trying to enroll in a health plan they can afford.

Removing the 150% SEP would mostly affect low-income consumers and inadvertently impact health centers, which will no longer be able to enroll their uninsured patients who would be eligible for the 150% FPL SEP. As previously noted, NACHC is also concerned about how this new policy would compound with the reduction in Navigator funding.

**NACHC echoes our concerns with the proposal at § 155.420(g) to include pre-enrollment verification of eligibility for applicants in all categories of individual market SEPs. We are concerned about the amendment requiring all Exchanges to conduct pre-enrollment verification of eligibility for at least 75% of new SEP enrollments.** The proposed rule highlights that pre-enrollment verification and the process of locating and submitting documents or other proof pose a barrier to enrollment and would deter consumers. As previously mentioned, we echo these concerns, especially for individuals who do not make enough annually to report their income to the IRS.

We are also concerned about the administrative burden being placed on state-based exchanges (SBEs) to perform. For pre-enrollment verification, applicants must submit additional documentation to verify the SEP. Consumers can pick a plan before submitting proof, but their enrollment is "pended" until SEP eligibility is verified. Once verified, the person must pay the first month's premium, and coverage will be effective based on when the person selects their plan. Although SBEs could ask to use alternative SEP verification methods, this change could also be costly for SBEs: most SBEs would incur one-time costs of about $12 million, while five SBEs would incur one-time costs of about $60 million.[40] This is in addition to ongoing annual costs to implement and operationalize SEP verification requirements. **We are concerned that the implementation timeline for this proposal and the cost could delay approvals, thus delaying the start of the enrollee's coverage. As we have highlighted throughout our response, this could lead to decreased patient access and increased costs for health centers and states. As such, we urge the agency to reconsider this proposal.**

**Standards for Termination of an Agent's, Broker's, or Web-broker's Exchange Agreements for Cause NACHC supports CMS' proposal at § 155.220(g)(2) for HHS to apply a "preponderance of evidence" standard of proof to assess potential non-compliance with agents, web brokers, and brokers.** We appreciate the Administration's focus on rooting out unscrupulous enrollment practices by brokers, given the high number of enrollment issues health centers have helped their patients overcome. We appreciate

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[37] "A 90% Cut to the ACA Navigator Program" KFF.org. Feb. 14, 2025.
[38] 45 CFR 155.210(e)(9)
[39] https://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf; Conflict-of-Interest Standards for Navigators (§155.215(a)(1)) and for Non- Navigator Assistance Personnel Carrying Out Consumer Assistance Functions Under §155.205(d) and (e) (§155.215(a)(2)) ; List of required training module content standards is set forth in §155.215(b)(2).
[40] https://www.healthaffairs.org/content/forefront/hhs-proposes-restrict-marketplace-eligibility-enrollment-and-affordability-first-major

CMS's system changes last year to prevent unauthorized activity on enrollees' Marketplace accounts[41] and believe this proposal further builds upon that. These proposals will help ensure the entire entity is held accountable in the case of patterns of non-compliant behavior and support enrollees' ability to work with honest agencies.

Many health center patients possess characteristics that correlate to lower health literacy; for instance, patients with lower incomes, chronic conditions, and those who are non-native English speakers are associated with lower health literacy.[42] Even when the patient is already enrolled in one plan, they oftentimes get a call from another broker urging them to enroll in another plan. If a patient with an existing Marketplace plan gets swayed to move to another plan constantly, this could negatively impact their care continuity because their regular doctors are suddenly outside their network. Health center patients can be unfairly taken advantage of by these commission-based agents. A pattern of unethical business practices can wreak havoc on patients' access to quality, affordable health coverage, and these businesses need to be held accountable. The "preponderance of guilt" standard will help create more uniform standards when trying to consider what violates an Exchange agreement.

NACHC appreciates the intense oversight and enforcement actions CMS will have to hold brokers and lead agencies to the highest standards. We seek to ensure that all eligible patients receive non-biased, comprehensive enrollment assistance, and it's essential that CMS holds all brokers and lead agencies accountable. Here are two key instances that illustrate the importance of tackling this issue:

1) A Community Health Center and certified Primary Care Medical Home in Ohio has noticed an alarming number of fraudulent enrollment cases among its patients for the past year. This health center served more than 14,400 patients with 73,330 visits in 2022, and since Marketplace Open Enrollment in 2023, it has identified more than 200 patients who have been impacted by being enrolled in unauthorized plans despite already having Medicaid coverage.

   The health center, trying to cancel these fraudulent plans for their patients, has navigated a slow and cumbersome process. To date, they have only successfully canceled approximately 50 to 60 plans. The health center impresses upon the patient the importance of this issue and has the patient file the fraud claim with the Marketplace, the state's insurance commission, and any other agencies tracking fraud and abuse claims. Many of these fraudulent plans have been in place for months, and therefore, when the fraud claim is submitted, it must be reviewed back to when the plan started, often 45 to 60 days. In the meantime, the health center cannot bill Medicaid for any of the patient's visits until the patient's Medicaid coverage is backdated.

   Additionally, if the patient had any healthcare encounters when they had both Medicaid and Marketplace coverage, the health center is not able to bill Medicaid until the Marketplace plan is fully wiped out of the system. This lengthy process is delaying providers, especially safety net providers, from billing timely. Sometimes, when the plans have been canceled, another agent steps in and re-enrolls that patient, and the process begins again.

   Being enrolled in an unauthorized plan places immense stress on patients as well. Not only does it bring unease and stress that they were enrolled in a plan without their knowledge, but canceling their plan is also time-consuming. The patients themselves must be the ones to call the Marketplace

[41] https://www.cms.gov/newsroom/press-releases/cms-statement-system-changes-stop-unauthorized-agent-and-broker-marketplace-activity
[42] https://pmc.ncbi.nlm.nih.gov/articles/PMC6391993/#:~:text=Low%20health%20literacy%20is%20associated,are%20non%2Dnative%20English%20speakers.&text=Approximately%2080%20million%20adults%20in,limited%20or%20low%20health%20literacy.

to cancel their plan.[43] Health center patients are lower-income and may be working multiple jobs to make ends meet, proving difficult to carve out the time to be on hold with the Marketplace call center to cancel their plan.

2) A Community Health Center in Indiana, which serves more than 8,500 patients and provided over 25,000 visits in its service area in 2023, has encountered many instances of brokers potentially taking advantage of patients and providing inaccurate or misleading information to their benefit. They have noticed consumers with a Marketplace plan, but it remains unclear how those patients were enrolled, as they qualified for Indiana's Medicaid program. Many of their patients shared that they received phone calls, and the suspicious agent/broker knew about the patient's insurance situation. In other instances, some CHC patients are unaware that their coverage switched from Medicaid to a Marketplace plan until they arrive at the health center for an appointment. The health center then must allocate additional time and resources to help the patient understand the fraud that has occurred and then help ensure the patient gets enrolled in the appropriate coverage.

   Enrollment in multiple plans puts significant financial stress on the patient and the health center. When a patient comes in for an appointment, it becomes a battle of which insurance will pay for the visit. Often, health centers find it difficult to reconcile, and neither insurance believes they should pay; the Marketplace says the patient has Medicaid coverage, and then Medicaid says the patient has Marketplace coverage. Health centers operate on slim financial margins; more than half of community health centers operate with margins below 5%.[44] Health centers serve anyone regardless of their ability to pay and depend on getting paid on time. Having patients enrolled in multiple insurances, through no fault of their own, puts an unfair financial strain on health centers and needs to be acknowledged.

**As mentioned, NACHC also urges HHS to continue looking into marketing ploys broker agencies post on social media.** We have heard anecdotally from state PCAs that many patients are finding out about these Marketplace plans via social media such as Facebook or YouTube ads. These Facebook ads or YouTube videos entice consumers by stating they will get money back on their taxes if they enroll in Marketplace plans. We appreciate CMS publishing best practices for Marketplace Advertising and Marketing Guidelines to clearly outline what is and what is not allowed.[45] If CMS could take a stronger stance by prohibiting certain marketing tactics, as it has in a prior Medicare Advantage rule,[46] enrollees and health centers would benefit. CMS could include this in its plan as it continues to investigate agencies engaged in murky enrollment practices; if not, we urge CMS to include marketing within the scope of its investigation.

We greatly appreciate the opportunity to comment on this proposed rule and work with the Administration to balance program integrity with consumer administrative burden. Should you have any questions about our comments, please feel free to contact Elizabeth Linderbaum, Deputy Director of Regulatory Affairs, at elinderbaum@nachc.org.

Sincerely,

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[43] https://www.healthcare.gov/how-to-cancel-a-marketplace-plan/
[44] 2023 National Report (hrsa.gov)
[45] https://www.cms.gov/files/document/agent-and-broker-advertising-and-marketing-tip-sheet.pdf
[46] https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

Joe Dunn
Chief Policy Officer



AR 030505

**STATE OF CALIFORNIA OFFICE OF THE ATTORNEY GENERAL ROB BONTA**

**COMMONWEALTH OF MASSACHUSETTS OFFICE OF THE ATTORNEY GENERAL ANDREA JOY CAMPBELL**

**STATE OF NEW JERSEY OFFICE OF THE ATTORNEY GENERAL MATTHEW J. PLATKIN**

April 11, 2025

**Via Federal eRulemaking Portal at www.regulations.gov**
Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Comments on Proposed Rule: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability
Docket No. CMS-2025-0020-0011 (formerly CMS-9884-P), RIN 0938–AV61
90 Fed. Reg. 12,942 (Mar. 19, 2025)

Dear Ms. Carlton:

We, the undersigned Attorneys General of California, Massachusetts, New Jersey, Arizona, Colorado, Connecticut, the District of Columbia, Delaware, Hawai'i, Illinois, Maine, Maryland, Michigan, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Vermont, Washington, and Wisconsin write[1] in response to the proposed rulemaking by the U.S. Department of Health and Human Services and Centers for Medicare & Medicaid Services (collectively, "Department") entitled "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability."[2] The Proposed Rule creates new hurdles that will significantly restrict eligibility, diminish enrollment, and increase consumers' health insurance premiums and out-of-pocket costs. This outcome will undermine the purpose of the Patient Protection and Affordable Care Act (the

[1] The Department should deem all materials cited to in this comment letter as submitted into the administrative record.
[2] 90 Fed. Reg. 12,942 (March 19, 2025) (hereafter the "Proposed Rule").

ACA), which is to increase access to high quality and affordable healthcare. As discussed below, most of the Proposed Rule's changes should be withdrawn.[3]

Congress enacted the ACA to "*increase* the number of Americans covered by health insurance and *decrease* the cost of health care."[4] The goal of covering as many Americans as possible is at the heart of the ACA; Congress elected to model the ACA on the then-existing system in Massachusetts, which combined tax credits, market regulations, and a coverage mandate, resulting in an uninsured rate of "2.6 percent, by far the lowest in the nation."[5]

The Department is tasked with furthering the ACA's twin goals—cover as many people as possible, as affordably as possible—when implementing its provisions, while protecting the financial integrity of the marketplace. The Proposed Rule, however, will have the opposite effect, and will not accomplish its purported goals. Millions of Americans will go uninsured under the Proposed Rule. The Proposed Rule projects that between 750,000 and two *million* individuals will lose their health coverage because of the proposed changes.[6] And when these newly uninsured individuals need healthcare—as everyone eventually will—the States will bear the cost.

The Proposed Rule claims to target fraud but does little to address the actual sources of fraud—most of which occurs at the federal, not state level. Instead, the Proposed Rule introduces measures that will not meaningfully decrease fraud, and instead will throw millions of people out of the healthcare marketplaces. This, in turn, will result in: (1) "potential costs to State governments and private hospitals in the form of charity care for individuals who become uninsured as a result of the proposals in this rule"; (2) increased state Medicaid expenditures from "enrolling more people in Medicaid who would have otherwise enrolled in" subsidized marketplace coverage; and (3) potential increased costs to the States from covering emergency medical treatment for DACA recipients "who would become uninsured if the proposal pertaining to DACA recipients in this Rule is finalized."[7] The Department should not finalize a Proposed

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[3] The undersigned States also object to the truncated review period for the Proposed Rule. The Proposed Rule was published in the Federal Register on March 19, 2025, and comments are accepted through April 11, 2025. HHS therefore provided only 23 days to review a complicated, multifaceted rule spanning 90 pages in the Federal Register. At a minimum, rulemaking requires at least thirty full days, and ideally longer, for public comment. *See, e.g., Nat'l Lifeline Ass'n v. Fed. Commc'ns Comm'n*, 921 F.3d 1102, 1117-18 (D.C. Cir. 2019) ("When substantial rule changes are proposed, a 30-day comment period is generally the shortest time period sufficient for interested persons to meaningfully review a proposed rule and provide informed comment.") Nevertheless, a Proposed Rule of this complexity and magnitude warrants a comment period of 60 days, which is standard. That would have allowed for proper analysis of the dozens of significant changes being proposed. The California Attorney General submitted a letter to HHS and the Office of Management and Budget on April 2, 2025, making this objection and asking for at least 30, and ideally 60, days for public comment.

[4] *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012) (emphases added); *see King v. Burwell*, 576 U.S. 473, 491(2015) ("Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them.")

[5] *King*, 576 U.S. at 481.

[6] 90 Fed. Reg. at 13,007.

[7] 90 Fed. Reg. at 13,008.

Rule that—by its own admission—will spike the uninsured rate and unfairly shift significant healthcare costs to state and local governments.

Nor is the damage limited to those who will lose their health coverage entirely. Consumers who remain in the marketplaces will face higher premiums and out-of-pocket costs because of the Proposed Rule's changes to the premium adjustment methodology[8] and actuarial value targets.[9] This will also lower the amount of advance premium tax credits (APTCs).

Additionally, the elimination of eligibility for DACA recipients does nothing to further the goals of the ACA, weakens the risk pool, and unfairly targets a vulnerable group of individuals who have lived in this country for at least 17 years (and often more). Because DACA recipients are frequently among the younger and healthier members of the health insurance risk pool, ending their eligibility for coverage is not just cruel and capricious, it squarely contradicts sound healthcare policy. Excluding DACA recipients from the marketplaces does nothing to advance public health.

Similarly, there is no reason to remove medically necessary treatments for transgender individuals from the definition of an Essential Health Benefit (EHB). The Proposed Rule is simply wrong when it asserts that employer-sponsored plans do not cover such care; many, in fact, do, at very little cost. This proposal, too, smacks of discriminatory targeting of a vulnerable group of individuals purely because they are politically disfavored.

Finally, the Proposed Rule infringes on our states' independence and sovereignty by mandating several changes that reduce flexibility in our own marketplaces. Congress established the Federally Facilitated Exchange (FFE) alongside the State-Based Exchanges (SBEs) precisely so that States could experiment with their own approaches to healthcare marketplace provisions if they wished to do so. States, not the federal government, are best positioned to respond to their citizens' unique needs, and allowing SBEs to operate with broad discretion promotes innovation in the marketplace. Tellingly, the Proposed Rule does not suggest that any of the integrity concerns it raises are present in the SBEs. The federal government should encourage, not suppress, the flexibility and experimentation represented in the SBEs.[10]

We appreciate the opportunity to provide these comments and stand ready to collaborate with the Department to ensure a robust, affordable, comprehensive, and secure healthcare marketplace.

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[8] 90 Fed. Reg. at 12,987-95.
[9] 90 Fed. Reg. at 12,995-97.
[10] Randy Pate, former Director of the CMS Center for Consumer Information and Insurance Oversight during the previous Trump Administration, has argued that States should eschew the federal exchange platform and run their own SBEs and utilize the ACA's Section 1332 waivers to "reduce costs, increase state autonomy and oversight, and promote state flexibility," pointing out that the Constitution leaves health and welfare decisions largely to the States. Randy Pate, Statement to the Managed Care (B) Committee, Annual Conf. of the Nat'l Ass'n of Ins. Comm'rs (Summer 2022), https://tinyurl.com/4nc9pnh5.

## I. THE MARKETPLACE INTEGRITY CHANGES ARE NOT SUPPORTED BY EVIDENCE, ARE NOT REASONABLY EXPLAINED, AND IGNORE SUBSTANTIAL RELIANCE INTERESTS

### A. Several Proposals Will Make Coverage Unnecessarily Difficult to Obtain

Federal agencies may not justify their decisions using explanations that are "incongruent with what the record reveals about the agency's priorities and decisionmaking process."[11] The Department of Health and Human Services exists to promote public health. And while many of the Proposed Rule's changes are justified on the basis that they combat fraud, increase efficiency, or promote marketplace integrity and consumer protection, several of the proposed changes will make it more difficult for enrollees to secure coverage. These proposals contradict HHS's priorities and should be withdrawn.

#### 1. Requiring all exchanges to end open enrollment on December 15 will likely cause hundreds of thousands of people to miss the enrollment window.

To help encourage consumers to maintain coverage year-round, health insurance exchanges generally only accept enrollees for the upcoming calendar year during the open enrollment period (OEP). The length of the OEP should be calibrated to balance the risk of adverse selection—enrollees only seeking coverage when sick—against the need to make coverage accessible to as many people as possible. Sometimes, special circumstances might necessitate allowing enrollees to access coverage outside of the OEP, as discussed in the following section. Here, this Proposed Rule would limit open enrollment to 45 days (November 1 through December 15) on both the FFE and the SBEs.[12] SBEs have always had the flexibility to establish a longer open enrollment period, and most do so. There is no reason to eliminate states' flexibility to have a longer open enrollment period. Data shows that permitting open enrollment through mid-January allows hundreds of thousands of additional consumers to enroll and gives them sufficient time to choose the plan that is right for them.

The Proposed Rule claims that a longer open enrollment period contributes to adverse selection.[13] But the Proposed Rule does not provide any data showing that the risk of adverse selection is worsened by a longer OEP, or that shortening the OEP is likely to have a material impact on adverse selection risk for insurers. On the contrary, in previous rulemaking, the Department acknowledged that a "shortened enrollment period could lead to a reduction in enrollees, primarily younger and healthier enrollees who usually enroll late in the enrollment period."[14] The Proposed Rule also acknowledges that extending the OEP through January 15 allows consumers who had been automatically re-enrolled in a plan they may not want "the opportunity to change plans after receiving updated plan cost information from their issuer and to

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[11] *Dep't of Com. v. New York*, 588 U.S. 752, 785 (2019).
[12] 90 Fed. Reg. at 12,976.
[13] *Id.*
[14] *Patient Protection and Affordable Care Act; Market Stabilization*, 82 Fed. Reg. 18,346, 18,377 (Apr. 18, 2017) (final rule).

select a new plan that is more affordable to them."[15] Further, the Proposed Rule acknowledges that several marketplace experts, including "Navigators, certified application counselors (CACs), agents, and brokers" conveyed during prior rulemaking that they were concerned about "a lack of time to fully assist all interested Exchange applicants with comparing their different plan choices," suggesting that the longer OEP is both necessary and justified.[16] The Department's sudden disregard for those concerns, which remain just as valid today, is not "reasonable and reasonably explained."[17]

As the Department admits, nearly half a million individuals—or approximately three percent of enrollees—for the 2025 plan year elected to end coverage or switch plans between December 15 and January 15.[18] Many of those consumers will likely fail to sign up in time if open enrollment ends on December 15. The shortening of the annual OEP to 45 days disregards the need for consumers to have sufficient time to understand their options and make informed decisions. At a bare minimum, if the Department finalizes the shorter OEP for the FFE, the Department should not take away the flexibility SBMs have had to set OEPs that work in their markets and should delay shortening the open enrollment period until 2027, given the uncertainty over whether the enhanced premium tax credits will expire at the end of 2025.

Our States know firsthand that longer OEPs benefit our residents. New Jersey, for instance, utilizes an OEP that runs from November 1 through January 31. In the most recent OEP, 513,217 New Jerseyans signed up for coverage through Get Covered NJ—a 30% increase year-over-year, and a 108% increase since New Jersey launched its Get Covered NJ initiative.[19] At the same time, New Jersey has no significant problem with fraudulent enrollments on its exchange. And in Massachusetts, over half of enrollees who manually shopped for a plan during the most recent OEP completed their plan selections after December 15, 2024. Those later enrollees also tended to have lower average medical expenses than the earlier enrollees. The story is similar in the District of Columbia, where an average of 46% of new enrollments in the two most recent OEPs occurred after December 15. In Colorado, too, those who enrolled after December 15 tended to be younger and healthier, raising concerns that a shorter OEP would harm the risk pool and cause premiums to increase. In Washington State, 46% of new customers selected a plan after December 15, and 4 in 10 of those new customers are under the age of 35, compared to 3 in 10 under age 35 for those who enrolled before December 15. Finally, in Connecticut, consumers who enrolled before December 15 tended to be older than those who enrolled on December 15 or later, and a higher percentage of the post-December 15 enrollment pool were "new" enrollees rather than returning enrollees. These data demonstrate that the longer enrollment period is key to maintaining robust enrollment and a balanced and healthy risk pool.

The proposal to not only shorten the OEP, but to mandate that independent state exchanges shorten theirs, too, is not in the best interests of consumers and should be withdrawn.

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[15] 90 Fed. Reg. at 12,978.
[16] 90 Fed. Reg. at 12,978.
[17] *Fed. Commc'ns Comm'n v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021).
[18] 90 Fed. Reg. at 12,978.
[19] N.J. Dep't. of Banking and Ins., *Governor Murphy and Commissioner Zimmerman Announce Historic 2025 Get Covered New Jersey Sign-Ups* (Feb. 20, 2025), https://tinyurl.com/379j9f9u.

**2. Eliminating the low-income special enrollment period (SEP) for individuals whose projected annual household income is at or below 150 percent of the federal poverty level (FPL) needlessly restricts access to coverage for low-income Americans.**

In addition to the standard OEP, there are several different special enrollment periods (SEPs) for individuals facing particular circumstances. One such SEP allows individuals or families whose projected annual household income is at or below 150 percent of the federal poverty level to sign up for coverage at any time of the year. This mirrors Medicaid and the Children's Health Insurance Program (CHIP), both of which allow enrollment for low-income Americans at any time of year. One rationale for creating this SEP was to ensure that those who were transitioning off Medicaid or CHIP would not be stranded without coverage until the next OEP. Such flexibility is especially vital now, with over 25 million people having been disenrolled from Medicaid since the unwinding of the Covid-era continuous enrollment condition.[20] The Proposed Rule eliminates the low-income SEP entirely.[21] This would harm hundreds of thousands of our residents. In Illinois alone, over 146,000 current enrollees have incomes that fall within 100 to 150 percent of the FPL.

The Department has cited no evidence supporting its contention that this SEP is a unique driver of fraudulent enrollment, or that eliminating it is likely to have a material effect on any such abuse. The monthly SEP for those with household incomes at or below 150 percent of the federal poverty level is a critical protection for the lowest-income Americans. Last year, the Department acknowledged that the continued availability of this SEP "may continue to help consumers who lose other [minimum essential] coverage, especially those disenrolling from Medicaid or CHIP coverage to regain health care coverage."[22] The Department additionally found that the risk of adverse selection associated with this SEP was lower than anticipated.[23]

Unable to point to any data showing that its prior evaluation was wrong, the Department now asserts—without citing evidence—that "more experience with this SEP suggests it has substantially increased the level of improper enrollments, as well as increased the risk for adverse selection, as [this] SEP incentivizes consumers to wait until they are sick to enroll in Exchange coverage."[24] Neither assertion is well taken.

With respect to improper enrollments, while it is true that "some agents, brokers, and web-brokers have exploited" certain weaknesses in the Healthcare.gov technology to allow

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[20] *Medicaid Enrollment and Unwinding Tracker*, Kaiser Family Foundation (Mar. 31. 2025), https://tinyurl.com/5eb2rsbj.

[21] 90 Fed. Reg. at 12,979-82.

[22] 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 Fed. Reg. 26,218, 26,320 (April 15, 2024) (final rule).

[23] *See* 89 Fed. Reg. at 26,321 ("[A]n analysis of the plans available to consumers in 2020, just before implementation of the enhanced subsidies, suggests that the risk of adverse selection we acknowledged may be lower than expected, and therefore, downstream impacts of that risk may be mitigated.")

[24] 90 Fed. Reg. at 12,979.

enrollment—and thus earn commissions—without a consumer's consent,[25] there are other, less burdensome changes—such as requiring two-factor authentication and verbal authorization from the consumer—that would adequately address the problem of fraudulent enrollment without imposing a heavy burden on the poorest Americans. The Department also acknowledges that the number of consumer complaints for unauthorized enrollments dropped from a high of 39,985 in February 2024 to just 7,134 in December 2024—even though the SEP remained available during that entire period.[26] In light of that massive decrease in complaints while the SEP remained in place, eliminating the SEP is not necessary to substantially reduce the problem of fraudulent enrollment by unscrupulous brokers.

The Department also points to a supposed discrepancy between the number of Floridians who claimed estimated annual household income between 100 and 150 percent of the FPL and the number of Floridians who have income within that level according to the U.S. Census American Community Survey.[27] But commentators have called this an "an apples-to-oranges" comparison,[28] and it is not clear why the Department expect households' estimates of income to match Census Bureau data, especially when the respondent populations do not perfectly overlap with one another and when other factors such as immigration status, household size, and geographic location may drive distinctions between the two groups.

Eliminating this SEP would harm the most vulnerable residents of our States and leave the lowest-income participants unable to obtain health coverage when they need it. This proposal should be withdrawn.

**3. Requiring that all exchanges verify enrollment eligibility for those who claim SEP eligibility due to a "triggering event" risks barring consumers from coverage due to paperwork errors and imposes tremendous costs on State exchanges.**

Another kind of SEP allows for enrollment in a health plan after some triggering event such as the loss of a job, a move to a new geographical area, or the birth of a child. The Proposed Rule reintroduces an earlier rule that exchanges on the federal platform verify all such claims of eligibility, and newly requires that all exchanges—including SBEs—verify eligibility for at least 75% of new enrollees under this SEP prior to commencing coverage.

These changes would impose difficult—and sometimes insurmountable—verification barriers. The paperwork to verify qualifying life events is not always readily available. A small employer that suddenly goes bankrupt may not be able to provide its former employees with the paperwork that would allow access to the healthcare marketplace, or a local government might need over a month to mail a birth certificate to a new parent. In these situations, the enrollee faces

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[25] 90 Fed. Reg. at 12,980.
[26] *Id.*
[27] 90 Fed. Reg. at 12,980-81; *see also id.* at n.121 (citing U.S. Census Bureau, U.S. Dep't. of Commerce, *American Community Survey* (2022), https://tinyurl.com/4bw2aajf).
[28] Katie Keith & Jason Levitis, *HHS Proposes to Restrict Marketplace Eligibility, Enrollment, and Affordability In First Major Rule Under Trump Administration (Part I)*, Health Affairs (March 12, 2025), https://tinyurl.com/bd3289tp (hereafter "Keith & Levitis Part 1").

the prospect of going without coverage due to these paperwork requirements that they are unable to satisfy.

The Department acknowledges that only 73 percent of consumers were able to submit documents within 14 days after an SEP verification issue (SVI) was generated—meaning 27 percent, or more than one in four, enrollees attempting to utilize an SEP may be blocked from doing so for technical reasons unrelated to their eligibility.[29] Therefore, the Department's claim that pre-enrollment verification poses no "substantial enrollment barrier"[30] is simply untrue according to its own data. And any barrier to enrollment is likely to discourage younger, healthier enrollees from completing the sign-up process. Requiring consumers to navigate complex documentation processes, often during times of significant and sudden changes in their personal circumstances, will undoubtedly deter eligible individuals, including younger and healthier people, from obtaining coverage.

By turning away eligible individuals because of inadequate paperwork, this proposed change is also likely to negatively impact the risk pool. In DC, for instance, enrollees utilizing "triggering event" SEPs tend to be younger than enrollees utilizing the Open Enrollment Period. As the Department acknowledges, "younger people submit acceptable documentation to verify their SEP eligibility at lower rates than older consumers, which can negatively impact the risk pool as younger consumers use less health care on average,"[31] meaning that the added verification requirements are likely to result in fewer young enrollees entering the risk pool. Imposing this additional requirement is almost certain to weaken the risk pool, not strengthen it. *See infra* p. 31.

In addition to imposing an unnecessary burden on consumers and weakening the risk pool, this change also imposes substantial burdens on the State-Based Exchanges, which will have to fund extensive document verification operations in the absence of any demonstrated benefit to the States for doing so. With at least sixty days to evaluate this change, *see supra* n.2, California and other undersigned States could have conducted a robust analysis of the fiscal and administrative impact of the 75% verification requirement on their state Exchanges.

Finally, there is no evidence showing that this change is necessary to reduce fraudulent enrollment or adverse selection.

The Department should withdraw the proposal to require exchanges to verify enrollment eligibility for at least 75% of those who claim SEP eligibility due to a "triggering event," or, at a minimum, should allow SBEs to opt out of implementing this change.

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[29] 90 Fed. Reg. at 12,983.
[30] 90 Fed. Reg. at 12,984.
[31] *Id.*

**4. Eliminating APTC eligibility for individuals who fail to file and reconcile (FTR) their income data against their APTC award for one year rather than two years increases the chance of wrongful terminations due to administrative error, limits consumer choice, and threatens to allow government ineptitude to harm consumers.**

The ACA provides tax credits—APTCs—to individuals whose projected household income qualifies them for assistance with paying their healthcare premiums. Because those APTC awards are based on projections, the recipient must later reconcile their APTC award against their actual income, as shown in their tax filings with the Internal Revenue Service (IRS). If the enrollee earned more than projected, the enrollee then owes the difference as a tax liability when they next file taxes. This requirement ensures that patients cannot claim and retain credits to which they are not entitled. When an individual fails to file taxes and reconcile their income data with the APTC award, they lose eligibility for future credits and owe the prior period's credits as a tax liability. This is known as failure to file and reconcile, or FTR. This proposal would eliminate APTC credit eligibility and impose a corresponding tax liability after one FTR year, rather than after two consecutive FTR years.

Reverting to a one-year FTR rule increases the risk of eligible individuals losing access to APTCs due to administrative complexities or processing delays. Many more people receive one-year FTR codes than two-year FTR codes; in Massachusetts, for instance, one percent of enrollees for January 2025 coverage received a one-year FTR code, while just 0.1% received a two-year code. This implies that most people with one-year FTR codes can resolve their FTR status before receiving a two-year code. If this proposed change were to be implemented, all those people would lose coverage. But there are sometimes anodyne explanations for FTR status: the Department acknowledged that FTR needed to be paused during the Covid-19 public health emergency "due to concerns that consumers who had filed and reconciled would lose APTC due to IRS processing delays resulting from IRS processing facility closures and a corresponding processing backlog of paper filings."[32] The Department should formalize this practice via rulemaking, so that future IRS processing delays do not cause an enrollee to lose coverage through the FTR process. APTC beneficiaries are especially vulnerable to IRS processing delays in the future because the IRS is reportedly seeking to cut as much as half of its 90,000-person workforce.[33] The Department has not considered the potential impact of this change on otherwise eligible enrollees who may lose tax credits erroneously. The Department should evaluate the risk of IRS processing delays before implementing this change.

The Department claims this change will help reduce tax liability for consumers, because the maximum accumulated wrongful benefit will be just one year of APTC rather than two.[34] To the extent any consumers do face increased tax liability, the Department should consider whether such a trade-off was a rational choice for the consumer at the time, *i.e.*, the maintenance of health coverage was worth more to the consumer than the increased tax liability at the end of the two-year FTR period. The Department should evaluate whether, for such consumers, the tax liability

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[32] 90 Fed. Reg. at 12,958.
[33] Fatima Hussein, *The IRS is drafting plans to cut as much as half of its 90,000-person workforce, AP sources say*, Associated Press (March 4, 2025), https://tinyurl.com/m58czdjb.
[34] 90 Fed. Reg. at 12,959.

is not as burdensome as the loss of coverage would have been. Because the Department claims that respecting consumer choice is a motivating factor behind its proposal to eliminate the crosswalk policy, as discussed *infra*, the Department should also consider the role that consumer choice and rational economic decisionmaking plays in the FTR context.

The Department estimates this change could remove up to $1.86 billion of federal tax credits from the health insurance market.[35] Reducing tax credits, not protecting consumers, appears to be the reason behind this proposed change.

The proposal to move to a one-year FTR period should be withdrawn.

**5. Allowing plans to deny coverage for those with prior past-due premiums will block access to healthcare for those whose prior nonpayment may have been unintentional.**

Currently, insurance plans may pursue collection for past-due premiums but may not condition the provision of new coverage upon the payment of past-due premiums from prior coverage. Insurers, like any business, have legal options for pursuing collection of amounts owed to them. This proposal, for the first time, would allow insurers to deny coverage to an enrollee who owes past-due premiums from *any* prior period, not just the last twelve months, as an earlier rule provided. This proposed change does not require insurers to notify enrollees if they implement this policy—raising concerns that consumers could be denied coverage without being aware that the denial is due to owing a past-due premium.

This rule change is likely to harm consumers whose earlier nonpayment may not have been intentional. The Department acknowledges that this change would cause those individuals to lose coverage but expects that such losses would be minimal; no evidence is provided for that assertion.[36]

In previous rulemaking, the Department acknowledged that nonpayment could be due to a variety of factors and found that existing balance-collection methods are sufficient to protect insurers.[37] At a minimum, the Department should not mandate this change across the board. States should be free to enact their own policies regarding premium payments.

The proposal to allow insurance plans to deny coverage to consumers who owe a past-due premium from any prior period should be withdrawn.

**B. Several Proposals Will Result in Increased Costs and Decreased Coverage for Remaining Enrollees**

The previous set of proposals, along with the wholesale deletion of DACA recipients from the risk pool, seem designed to eliminate coverage for as many people as possible. The following

[35] 90 Fed. Reg. at 13,011-12.
[36] 90 Fed. Reg. at 13,009-10.
[37] *Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review*, 78 Fed. Reg. 13,406, 13,416-17 (Feb. 27, 2013).

set of proposals, if adopted, will ensure that those who remain enrolled in an Exchange plan pay higher premiums for lower-quality coverage. The Department has wholly failed to consider the costs that these changes will impose on consumers, and has not explained why, in its view, the purported benefits of these changes outweigh the very significant harms.[38] Because it has not done so, the Department should withdraw these proposals.

**1. Changing the premium adjustment calculation methodology and the acceptable actuarial value ranges will increase health insurance plans' costs and lower their quality.**

Exchange plans set a maximum annual limit on cost-sharing, such as copays, coinsurance, and out-of-pocket maxima due from the enrollee over the plan year. Those annual limits are adjusted in reference to a measure of premium inflation called the annual premium adjustment percentage, set by the HHS Secretary each year. In addition, the IRS uses the premium adjustment percentage when determining individuals' expected contributions and thus the amount of APTC the enrollee will receive. Accordingly, subtle changes in the way the premium adjustment percentage is calculated can have large effects on both out-of-pocket costs and the amount of APTC an enrollee is entitled to receive.

Present policy recognizes that the premium adjustment methodology needs to be price-stable to reduce volatility and keep premiums from spiking. Presently, the adjustment methodology looks to a biannual measure of premium inflation that is based on the employer-sponsored insurance (ESI) market, rather than the individual market, which is much more price-volatile. Including the more price-volatile market in the measure of inflation is certain to increase out-of-pocket costs to consumers.[39] The Department has not shown that this change will increase efficiency or improve resource allocation.

Because the point of the ACA is to make healthcare more accessible and affordable,[40] it is concerning that HHS now believes that "making coverage more accessible and affordable" is an improper "policy objective" that "can only serve to distort the alignment the ACA requires HHS to maintain between premium growth and the parameters subject to the premium adjustment percentage."[41] This exceedingly narrow reading of HHS' statutory authority is wrong and disregards Supreme Court precedent regarding the law's purpose.[42]

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[38] *See Dep't. of Commerce v. New York*, 588 U.S. at 785 (agencies must provide "reasons that can be scrutinized by courts and the interested public.")

[39] *See* Keith & Levitis Part 1, *supra* note 28 (finding that the 2020 update to premium adjustment methodology, which accounted for individual market premiums, "resulted in a higher premium adjustment percentage *and thus a higher annual limit on out-of-pocket costs* and a higher required contribution from subsidy-eligible consumers") (emphasis added).

[40] *Nat'l. Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. at 539.

[41] 90 Fed. Reg. at 12,990.

[42] *See Nat'l. Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. at 539 (the purpose of the ACA is to "*increase* the number of Americans covered by health insurance and *decrease* the cost of health care") (emphasis added).

The change to premium adjustment methodology will cause out-of-pocket maxima, copays, and annual limits to increase, without justification. This proposal, if adopted, will cause "consumer premiums [to] rise as well to about 4.5 percent higher for a benchmark plan compared to current rules."[43] In 2023, for example, an average on-exchange plan in the individual market cost $590.08 per member per month (PMPM), for an annual premium of $7,080.96 per member.[44] A 4.5 percent increase in that premium is an additional $318.64 annually. For an average annual premium of $25,572 for family coverage, a 4.5% increase is an extra $1,150.74 per year.[45] Any increase in premiums causes enrollment to suffer. [46] States will be fiscally impacted as well. Massachusetts estimates that, because of this change, state subsidy costs will increase by approximately $10 million in 2026.

Aside from the increase to premiums, a change in the premium adjustment percentage would also affect other out-of-pocket costs such as copays and deductibles. "Even relatively small levels of cost sharing in the range of $1 to $5 are associated with reduced use of care, including necessary services."[47] Any increase in out-of-pocket cost for the consumer is statistically certain to result in a decreased utilization rate, meaning more Americans choosing to go without coverage (and then skipping needed medical treatment as a result).

The Department should withdraw this proposed change.

**2. Expanding the acceptable actuarial value ranges for health plans will also increase health insurance plans' costs and lower their value.**

Plans sold on the exchanges fall into Bronze, Silver, Gold, and Platinum tiers based on how much of an average consumer's expected medical cost will be paid by the plan. Bronze plans must cover 60 percent of the expected cost; Silver plans, 70 percent; Gold plans, 80 percent; and Platinum plans, 90 percent. Higher-tier plans typically have higher premiums and lower out-of-pocket costs. Lower-tier plans have the opposite: lower premiums and higher out-of-pocket costs. Insurers on the exchanges must offer plans that meet these targets within some range of accepted de minimis variation. These ranges are presently small—most plans must fall within +2/-2, or +2/-0, percentage points. The reason for this narrow range is to encourage transparency and diminish consumer confusion in the marketplace, because a plan that claims to be Silver but undershoots its target by five percentage might only offer Bronze-level value and should be priced accordingly. Keeping the bands narrow promotes that policy goal.

The Proposed Rule widens the accepted ranges. For expanded bronze plans, the proposed range is +5/-4 percentage points. For all other plans, the proposed range is +2/-4 percentage points.

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[43] Keith & Levitis Part 1, *supra* note 28.

[44] Cal. Dep't of Managed Health Care, *Individual and Small Group Aggregate Premium Rate Report: Measurement Year 2023* 1, https://tinyurl.com/mwjumsd5.

[45] *2024 Employer Health Benefits Survey*, Kaiser Family Foundation (Oct. 9, 2024), https://tinyurl.com/pd5umckm.

[46] *See* Samantha Artiga et al., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings*, Kaiser Family Foundation (June 1, 2017), https://tinyurl.com/2hmm9pf7 (finding that "[p]remiums serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals.").

[47] *Id.*

By allowing all plans to undershoot their claimed targets by four percentage points, this proposal is certain to decrease the level of coverage provided to consumers, while charging those consumers the same price for their premiums.

The certain result of this change will be that a plan in 2027 will provide up to four percentage points less coverage than the same plan did in 2024. And although this change does not directly affect the premium, other rule changes affecting the premium adjustment methodology and shrinking the risk pool mean that consumers will be paying more for worse coverage. The Department claims that the benefit of this change is that plans need wider AV variability ranges for better plan cost sharing, but the Department did not provide any evidence to support this claim, nor did the Department acknowledge—let alone quantify—the harms to consumers of enrollment in lower-value plans.[48]

The proposed change to actuarial value *de minimis* variation will ultimately reduce affordability by increasing premiums and out-of-pocket costs for consumers. This change appears designed to prioritize insurer flexibility over ensuring affordable and comprehensive coverage for the public. This proposal should be withdrawn.

**3. Eliminating the "crosswalk" policy will decrease marketplace efficiency and reduce the value of the ACA's subsidies to consumers.**

Under current policy, an enrollee who selects a Bronze-tier plan, where there is a Silver-tier plan available at the same or lesser cost in the same provider network, will be automatically re-enrolled in the better plan. This policy ensures rational economic decisionmaking in the marketplace by automating the objectively superior plan choice when it is available. By automating the selection of the best available deal, this policy also minimizes the need for a consumer to rely on brokers and other third parties. The Proposed Rule eliminates this policy.

This proposed change is not supported by evidence and is counterproductive. The Department asserts that the crosswalk is no longer necessary because consumers are now aware of their options, and automatically enrolling a consumer in a better plan at the same or less cost overrides consumer choice. The Department does not explain how the deliberate selection of a lower-tier plan could ever be a rational choice. The crosswalk policy offers free upgrades to qualifying consumers. No reasonable consumer would decline the option to pay less for identical or better healthcare coverage.

Moreover, the Proposed Rule's reasoning disregards the reality that many enrollees, particularly those with limited resources, may not actively shop for or fully understand the nuances of different health plans.[49]

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[48] *See* 90 Fed. Reg. at 12,996-97 (stating "we believe" seven times but providing no data).

[49] *See* Kaye Pestaina et al., *Signing Up for Marketplace Coverage Remains a Challenge for Many Consumers*, Kaiser Family Foundation (Oct. 30, 2023), https://tinyurl.com/7r8un3ac (finding that 35% of marketplace enrollees "found it somewhat or very difficult to find a plan that meets their needs," and that "[a] large share (41%) of people with Marketplace coverage said

This change prioritizes a narrow interpretation of consumer autonomy over the tangible benefits of automatically connecting eligible individuals with more comprehensive and affordable coverage. It should be withdrawn.

**4. Ending acceptance of self-attestation of projected annual household income at or above 100% of FPL will needlessly harm the lowest-income enrollees, who tend to be young and healthy, thus harming the risk pool and increasing premiums for everyone.**

Exchange plans currently accept the self-attestation of an enrollee who claims eligibility by projecting annual household income at or above 100% of the federal poverty level. This policy is distinct from the FTR rules, discussed above, which still ensure that an enrollee who over-claims APTC eligibility must repay the overpayment via tax liability or else lose APTC eligibility. This self-attestation policy is designed to ensure that the lowest-income enrollees, who are often younger and healthier, are not discouraged from entering the risk pool due to paperwork burdens.

Aside from a fleeting reference to "internal analysis of historical enrollment and DMI [data-matching issue] data," the Department provides no information on the number of enrollees actually submitting inflated income data to qualify for APTC, and thus offers no actual evidence that impoverished consumers are misusing the self-attestation feature when representing their income.[50] Nor does the Department acknowledge that many consumers might legitimately expect their incomes to be greater than 100% of FPL when they apply for coverage, but later finish the year with incomes below 100% of FPL; individuals in that position have committed no wrongdoing. As discussed *supra*, the existing FTR policy helps to ensure that overpayment of APTC is discouraged and recovered through tax liability imposed on those who over-claim.

With this questionable justification, the Proposed Rule ends this policy, requiring income verification for all such enrollees.

This policy is likely to cause younger, lower-income enrollees to drop out of the risk pool. Additionally, this policy is more likely to impact healthy enrollees than sick ones, because, as commentators have observed, "sicker individuals are typically more motivated to overcome administrative burdens to enroll in coverage."[51] The Department acknowledges this, too, writing

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it was very or somewhat difficult to compare the doctors, hospitals, and other health care providers you could see for each option compared to fewer adults with Employer-sponsored coverage (32%), Medicaid (27%), and Medicare (19%) who said the same").

[50] 90 Fed. Reg. at 13,012. Indeed, in states that have accepted the ACA's Medicaid expansion, there is little to no incentive to inflate incomes for APTC purposes because adults with modified gross incomes up to 138% of the FPL are generally eligible for Medicaid. Many such states have mechanisms to ensure that Medicaid-eligible clients do not receive APTC. For example, Washington State has an integrated eligibility portal, so that those who opt out of Medicaid are barred from APTC eligibility until they provide updated documentation showing they once again qualify for APTC due to a change in income.

[51] Jason Levitis & Katie Keith, *HHS Proposes to Restrict Marketplace Eligibility, Enrollment, and Affordability in First Major Rule Under Trump Administration (Part 2)*, Health

that "verification [of SEP eligibility] can also undermine the risk pool by imposing a barrier to eligible enrollees, which may deter healthier, less motivated individuals from enrolling."[52]

In addition, terminating enrollment eligibility for those without available tax data is especially concerning given the likelihood of staffing cuts at the IRS, which increase the likelihood that tax data for many filers will be delayed or unavailable.[53] This policy change could lead to eligible individuals being wrongly denied crucial financial assistance. The Department estimates that this requirement would deny APTC to 81,000 people annually, reducing these tax credits by $189 million.[54] The Department further estimates that this change would create 550,000 data-matching issues (DMIs) per year, and that it would cost the Exchanges $32 million per year to verify enrollees' income and resolve those DMIs.[55] This policy should be withdrawn.

### C. The Proposed Rule Should Implement Broker-Focused Anti-Fraud Provisions

All government programs should strive to obtain the most benefit per taxpayer dollar and minimize waste, fraud, and abuse; the ACA is no exception. However, the changes contemplated by this Proposed Rule discussed above are not necessary "to reduce waste, fraud, and abuse."[56] There are several other, far less burdensome changes that the Department should implement to reduce the problem of fraudulent enrollment or unauthorized plan-switching without placing the burden on Exchange enrollees. The Department considered none of them; here, there is no "rational connection between the facts found and the choice made."[57]

#### 1. Removing brokers for cause by a preponderance of the evidence will help protect consumers from unscrupulous business practices, but the Department should adopt other changes to combat broker fraud.

The Proposed Rule will allow HHS to utilize a preponderance-of-the-evidence standard when terminating brokers for cause, instead of a more stringent standard such as clear and convincing evidence. This change is aimed at penalizing brokers who change enrollees' plans without consent to collect a commission, or other such dishonest practices. The undersigned States share the Department's concern about the increased prevalence of unauthorized plan switching and enrollments. We support the proposed revision to Section 155.220(g)(1) regarding evidentiary standards that the Department will utilize when removing brokers for cause.[58] It is imperative that the Department take robust steps to curb this abusive and fraudulent practice, and to protect consumers from predatory brokers who engage in such tactics. Unauthorized plan changes can

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Affairs (March 13, 2025), https://tinyurl.com/4xkjf7jy.

[52] 90 Fed. Reg. at 12,983.

[53] *See* Hussein, *supra* note 33 and accompanying text.

[54] 90 Fed. Reg. at 13,013.

[55] *90* Fed. Reg. at 13,013.

[56] 90 Fed. Reg. at 12,942.

[57] *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

[58] 90 Fed. Reg. at 12,955.

cause enrollees to lose access to medical care, face higher out-of-pocket costs, and be surprised with unexpected tax bills.

However, as explained above, the Proposed Rule does little to strike at the root of the problem. Broker-driven fraud is the main cause of unauthorized plan switching and enrollments. And this fraud has occurred primarily on the federal government's own healthcare platform, healthcare.gov—not on the exchanges operated by the States.[59] There is no indication that SBEs have experienced similar broker misconduct.[60] In light of that, the Proposed Rule should not limit the ability of SBEs to combat fraud that has not occurred on those platforms.

California, for instance, simply does not have a large-scale issue with fraudulent enrollments, despite having one of the largest state-based exchanges. California sends users a one-time code to share with an agent, while Pennsylvania similarly allows only agents designated by the consumer to access the user's account.[61] Other SBMs use multiple tools to prevent, mitigate, and shut down fraudulent enrollments including logging information recording changes, multi-factor authentication to access accounts, broker certification and all carrier appointments requirements, and rescissions in cases of fraud.

The Proposed Rule also fails to take meaningful steps to combat broker fraud on the federal platform (beyond lowering the evidentiary standard for broker misconduct). The Proposed Rule does not introduce new guidelines or limits on brokers' behavior, make it technically harder to engage in such behavior, or address the financial incentives underlying fraudulent enrollment. Curbing abusive broker practices will require the Department to address these issues. As other commentators have suggested,[62] the Department should consider introducing the following reforms:

- Impose a standard of conduct that obligates brokers to act in the best interest of the consumer and holds liable those who do not.

- Require two-factor authentication (such as a one-time password) or verbal or written consent from an enrollee before any plan change can occur, and require that a broker document, submit, and verify that consent before receiving a commission.

- Require enrollees to create an account on the exchange website and affirmatively select which brokers can access their account, and bar access to all other agents.

- Require third-party marketing entities—significant contributors to fraudulent plan-switching—to register with the marketplace and meet marketing standards.

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[59] Justin Giovannelli & Stacey Pogue, *Policymakers Can Protect Against Fraud in the ACA Marketplaces Without Hiking Premiums*, The Commonwealth Fund (March 5, 2025), https://tinyurl.com/rw5wxjze.

[60] *Id.*

[61] Julie Appleby, *How the Government is Trying to Stop Rogue Brokers from Plaguing ACA Enrollees*, NPR: Health Shots (May 7, 2024), https://tinyurl.com/3bkbcu5d.

[62] Giovannelli & Pogue, *supra* note 59.

The cumulative result of the Proposed Rule's changes is a smaller risk pool and a sicker population that must pay more for lower-quality health coverage, all in the name of preventing fraud that is not occurring at scale in the SBEs.

## II. THE PROPOSAL TO BAR DACA RECIPIENTS FROM ACCESS TO STATE AND FEDERAL ACA EXCHANGES IS CONTRARY TO LAW, IS ARBITRARY AND CAPRICIOUS, AND WOULD HARM STATES AND THEIR RESIDENTS.

Less than a year ago, the U.S. Department of Health and Human Services and Centers for Medicare & Medicaid Services completed a thorough rulemaking aimed at increasing patient access to state and federal exchanges under the ACA.[63] The Department's current proposal reverses course, changing the definition of "lawfully present" so it excludes individuals receiving deferred action pursuant to the Deferred Action for Childhood Arrivals policy from the ACA exchanges.[64] That proposal is unlawful and harmful. First, the Proposed Rule will cause significant harm to the States' economies, public health, and welfare by ripping away ACA insurance eligibility from an entire population, thereby increasing the number of uninsured residents in our States. Second, the Proposed Rule is contrary to the text of the ACA, and undermines Congress's aim of increasing access to insurance. Third, the Proposed Rule is arbitrary and capricious for multiple reasons: it fails to consider the myriad of benefits associated with expanding ACA exchange eligibility to DACA recipients, its analysis runs contrary to the text of the ACA, it insufficiently considers the reliance interests of DACA recipients and the States, and it fails to consider reasonable alternatives to complete reversal of DACA recipients' eligibility to participate in ACA exchanges. Fourth, its Regulatory Impact Analysis ("RIA") is flawed and inaccurate, ignoring costs to persons who purchased insurance under the 2024 Rule and costs to States of reversing DACA recipients' ACA exchange eligibility. As state Attorneys General, we urge you to withdraw this proposal.

### A. Background

The 2024 Rule authorized DACA recipients to purchase their health insurance on the ACA exchanges, ensuring reliable access to insurance and benefiting DACA recipients, their families, and the States alike. During the rulemaking process for the 2024 Rule, the Department considered the views of businesses, industry groups, workers' organizations, unions, nonprofits, academics, states, state agencies, and private citizens as expressed in 583 comment letters. The Department discussed in detail the ways increasing health insurance access for DACA recipients provides

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[63] *See Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients & Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, & a Basic Health Prog.*, 89 Fed. Reg. 39,392 (May 8, 2024) ("2024 Rule").

[64] *See* 90 Fed. Reg. 12,942.

substantial health and financial benefits to recipients and their communities,[65] while assessing the harms associated with a lack of access to such affordable and adequate health insurance.[66]

Prior to the 2024 Rule, many DACA recipients were unable to obtain affordable health insurance through any means other than an employer-sponsored health plan. The federal government has a long history of deferred action, including seventeen different deferred action policies that existed prior to DACA, and none of the recipients of those other programs have been categorically denied access to government health insurance affordability programs. By comparison, prior to the 2024 Rule, the Department had an exception that carved out DACA recipients alone from eligibility, effectively locking recipients out of health insurance programs their tax dollars help fund. In other words, in many cases, unless a DACA recipient's employer provided health insurance benefits for employees, prior to the 2024 Rule, the DACA recipient would have been unable to secure insurance coverage for themselves or, in some instances, their children via ACA exchanges. This barrier to coverage translated to high uninsured rates among the DACA population[67] and resulted in an economic and health precarity felt by recipients' families, communities, and the States. The 2024 Rule extended to DACA recipients the ability to purchase adequate and affordable health insurance.

The 2024 Rule went into effect on November 1, 2024,[68] and thousands of DACA recipients have already enrolled in health plans purchased via ACA exchanges.[69] Given this newfound access to health insurance, DACA recipients have likely started seeking medical care that they previously put off because of insurance concerns.[70] And the States have come to rely on the expectation that

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[65] *See, e.g.*, 89 Fed. Reg. at 39,405 (noting benefits of the 2024 Rule may be especially important "for those DACA recipients who may be victims of child abuse, domestic violence, sexual assault, and human trafficking"); *id.* at 39406 (Rule "could help decrease the amount of uncompensated care that [emergency departments] provide which could lead to better financial sustainability for emergency care safety net providers," and thus "promote a lower cost and more efficient health care system by reducing high-cost emergency care, increasing lower-cost preventive care, and ultimately decreasing the number of DACA recipients and other impacted noncitizens who qualify only for the treatment of an emergency medical condition under Medicaid").

[66] *See, e.g.*, 89 Fed. Reg. at 39,396 ("[i]ndividuals without health insurance are less likely to receive preventive or routine health screenings and may delay necessary medical care, incurring high costs and debts"); *id.* at 39,406 (explaining "that uninsured individuals might delay seeking vital care, which can result in [emergency department] use").

[67] *See* 89 Fed. Reg. at 39,392 (noting effective date); 89 Fed. Reg. at 39,395 (noting "that DACA recipients are still more than three times more likely to be uninsured than the general U.S. population, which had a national uninsured rate of 7.7 percent); Isobel Mohyeddin et al., *DACA Recipients' Access to Health Care: 2023 Report*, National Immigration Law Center (May 2023), https://tinyurl.com/5t2ra26w.

[68] *See* 89 Fed. Reg. at 39,392 (noting effective date).

[69] *Kansas et al. v. United States of America*, No. 1:24-cv-150 (D. N.D. Aug. 8, 2024), ECF 156-7 at ¶ 17 (As of January 2025, California estimates that over 1,868 DACA recipients have enrolled in a plan). Data on record with the New Jersey Department of Banking and Insurance (DOBI) indicates that, in New Jersey, 519 DACA recipients have enrolled in a plan for the 2024-2025 open enrollment period.

[70] *Cf.* 89 Fed. Reg. at 39,396 (noting "[i]ndividuals without health insurance are less likely to receive preventive or routine health screenings and may delay necessary medical care, incurring high costs and debts").

more residents will seek preventive care, less residents will need to seek emergency care, and the States will need to expend less on uncompensated care costs for uninsured individuals. *See infra* at 21-23. Significantly, the States are also now counting on increased taxes stemming from DACA recipients' enrollment in health plans via the ACA exchanges. But the Proposed Rule disregards all these benefits and threatens to throw these reliance interests into disarray.

### B. Removal of DACA Recipients from ACA Exchanges Is Harmful and Unlawful

The Department should withdraw the Proposed Rule. The proposal would harm the States and their residents. It would violate the plain language and purpose of the ACA. It is arbitrary and capricious. And it rests on multiple analytical errors.

#### 1. The Proposed Rule would harm the States and their residents.

Eliminating DACA recipients' access to health insurance from the ACA exchanges would leave them, in many cases, without access to affordable quality health insurance. That would harm not only DACA recipients, but would impose significant harms on the States' economies and on public health and welfare within their borders. This Proposed Rule is ill-advised and harmful.

##### a. The Proposed Rule, if adopted, would impose significant economic harm on the States.

The Proposed Rule, by its own terms, would deprive all DACA recipients of access to affordable health insurance options on ACA exchanges. In many cases, that would leave DACA recipients without access to health insurance entirely; as the Department recently acknowledged in its 2024 Rule, DACA recipients were over three times more likely than the general U.S. population to be uninsured.[71] But DACA recipients, like any other population, will still have health needs, whether or not they have insurance. Indeed, as the Department is well aware, States incur significant costs for the care of their uninsured residents, including millions in annual unreimbursed costs for the care of uninsured residents at public hospitals,[72] and hundreds of millions in annual subsidies to defray the cost of health care services provided to uninsured residents.[73] It is thereby undeniable that removing DACA recipients' access to ACA exchanges will generate significant expenses for preventive and emergency care that States would now have to assume.

New Jersey's health care programs illustrate ways in which States incur costs for health care services provided to uninsured residents, including uninsured DACA recipients. For example, an uninsured resident can visit Federally Qualified Healthcare Centers ("FQHC") to obtain free or

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[71] 89 Fed. Reg. at 39,395.

[72] *Kansas*, No. 1:24-cv-00150, ECF 156-4 (New Jersey University Hospital's uninsured costs), ECF 156-5 (New Jersey Charity Care and Uncompensated Care Fund (UCF) costs).

[73] *Id.* at ECF 156-4 (same), ECF 156-5 (same), ECF 156-8 (NJ FamilyCare and related healthcare program costs), ECF 156-9 (Arizona uninsured DACA recipient emergency medical care costs).

low-cost preventive health services. New Jersey's UCF subsidizes these services by paying a flat rate from State funds per visit for an uninsured resident: $114 per visit for primary and dental care and $74 per visit for mental health services.[74] New Jersey funds the UCF, so the greater the number of uninsured residents in New Jersey, the more the State spends on preventive care for those who obtain such services.[75] Similar logic applies to New Jersey's Charity Care program (which offers annual subsidies to support free or low-cost emergency care services for uninsured residents), and its Supplemental Prenatal and Contraceptive Program (which provides prenatal and family-planning services to residents who do not qualify for Medicaid due to immigration status).[76] For each of these programs, the greater the number of uninsured residents, the more the State spends on health care for uninsured individuals.[77]

Other States' programs offer further illustrations of this reality. In FY 2024, Arizona paid $501,411 in state funds through the Federal Emergency Services Program (FESP) to provide emergency medical or behavioral health care services to 519 DACA recipients.[78]

The States would incur these costs for each of the thousands of DACA recipients who are no longer able to purchase insurance plans through an ACA exchange for the 2024-2025 open enrollment period.[79] Because the Department's Proposed Rule does not grandfather[80] in the DACA recipients that have purchased insurance through the exchanges,[81] it would leave most of these individuals without health insurance (even if they are eligible to procure health insurance via an employer in the middle of the year) and concomitantly require the States to incur significant expenses when they seek preventive or emergency health care.

Nor are those the only costs the Proposed Rule would impose on the States. The Proposed Rule would also result in lost revenue streams from the assessments levied on the payment of insurance premiums by many States for each DACA recipient who is no longer able to purchase insurance through the exchanges. States like New Jersey and California have assessed hundreds of thousands of dollars in fees tied directly to insurance premiums paid by DACA recipients who, under the 2024 Rule, can purchase insurance via ACA exchanges.[82] Moreover, the Proposed Rule would also impose direct and entirely unnecessary compliance costs on the States that operate their own state exchanges. If this Proposed Rule reverses DACA eligibility for their exchanges, such

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[74] *Id.* at ECF 156-5 at ¶ 24.
[75] *Id.* at ECF 156-5 at ¶¶ 20-24.
[76] *Id.* at ECF 156-5 at ¶¶ 16-20; ECF 156-8 at ¶¶ 10-19.
[77] *Id.*
[78] *Id.* at ECF 156-9 at ¶ 9.
[79] *Id.* at ECF 156-7 at ¶ 17 (California estimates that over 1,868 DACA recipients have enrolled in a plan). Data on record with the New Jersey Department of Banking and Insurance (DOBI) indicates that, in New Jersey, 519 DACA recipients have enrolled in a plan for the 2024-2025 open enrollment period.
[80] *Infra* pp.34-35.
[81] On the contrary, the Proposed Rule estimates that its changes would result in 10,000 fewer QHP and 1,000 fewer BHP enrollments by DACA recipients. 90 Fed. Reg. at 13,010.
[82] *See, e.g.*, *Kansas*, No. 1:24-cv-150 at ECF 156-6 at ¶¶ 19-20 (New Jersey's projected loss of revenue would be $68,584 if the Proposed Rule is effectuated); ECF 156-7 at ¶¶ 29-30 (California's projected loss of revenue would be $409,151 if the Proposed Rule is effectuated).

States would incur compliance costs, including to implement changes to technology platforms, retrain their staff, update websites and publications, conduct advertising and outreach, and send notices to participating DACA recipients.[83]

The Proposed Rule thus imposes significant economic costs on the States—by (1) requiring them to incur costs for unreimbursed preventive and emergency care by newly-uninsured DACA recipients; (2) depriving them of lost revenue streams from insurance premium assessments; and (3) imposing compliance costs directly imposed by its reversal of a policy that required numerous technological and personnel-related changes to implement just last year.

**b. In addition to economic harms, the Proposed Rule would impose significant harms to the public health of the States.**

Depriving DACA recipients of access to affordable health insurance on the exchanges will undermine short-term and long-term health outcomes across the board.

The Proposed Rule recognizes that the loss of affordable insurance for a large swath of DACA recipients would result in many recipients becoming uninsured.[84] But while the Proposed Rule acknowledges "[t]his may result in costs to the Federal Government and [] States,"[85] it does not analyze the dangers that this poses to health outcomes for DACA recipients. The absence of such consideration is particularly striking given that the Proposed Rule does consider the potential for adverse health outcomes in connection with other provisions unrelated to DACA recipients.[86] And there would no doubt be adverse health outcomes for DACA recipients and other residents in our states. The Department is well aware that "[i]ndividuals without health insurance are less likely to receive preventive or routine health screenings and may delay necessary medical care, incurring high costs and debts."[87] This includes foregoing preventive services for chronic conditions such as cardiovascular disease, cancer, and diabetes.[88] Such "[d]elays in care can lead to negative health outcomes including longer hospital stays and increased mortality."[89]

These negative health outcomes are not just limited to DACA recipients who lose their affordable and adequate health insurance. To take one obvious example, reversing the 2024 Rule will also immediately impact the children of uninsured DACA recipients—who number at least

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[83] *See, e.g.*, *Kansas*, No. 1:24-cv-150 at ECF 156-7 at ¶¶ 21-27 (detailing over $600,000 in compliance costs incurred by California and describing additional costs that would be incurred if the 2024 Rule were invalidated); ECF 156-6 at ¶¶ 23-27 (describing New Jersey's compliance costs).

[84] 90 Fed. Reg. at 13,010 ("However, we anticipate the majority who lose Exchange or BHP coverage would become uninsured.").

[85] *Id.*

[86] *See* 90 Fed Reg. at 13,014 (potential impact of proposed change to annual eligibility redetermination "could lead to adverse health outcomes"), 13,019 (potential impact of premium adjustment percentage index changes "may contribute to negative public health outcomes").

[87] 89 Fed. Reg. at 39,396.

[88] U.S. Dep't of Health and Human Servs., *Access to Health Services*, Healthy People 2030, https://tinyurl.com/5n7s2cu7 (last visited Apr. 7, 2025).

[89] 89 Fed. Reg. at 39,396.

250,000, as the Department of Homeland Security has found—who are likely to be uninsured, since children are generally less likely to be uninsured when their parents have health insurance.[90] Medicaid and CHIP do not serve to patch up these insurance holes as DACA recipients are often hesitant to enroll their U.S.-born children in these programs due to fear and uncertainty in their own status and a concern over threats of deportation and family separation.[91]

The Proposed Rule's harms to public health would also redound beyond the households of DACA recipients to the broader communities of DACA recipients' home states by increasing the risk and magnitude of disease outbreaks and placing a greater strain on hospitals. One study found that "wider insurance gaps exacerbated local COVID-19 outbreaks and resulted in more cases, hospitalization, and death than experienced by jurisdictions with better coverage," meaning that "[r]educing the number of [individuals] without health insurance is a crucial and underappreciated component of pandemic preparedness."[92]

Additionally, by decreasing access to health insurance, the Proposed Rule would decrease access to regular outpatient care, leading to greater rates of hospitalization for longer periods of time.[93] This can cause particularly acute problems in smaller communities with fewer resources to address these higher hospitalization rates, where "[h]igh uninsured rates contribute to rural hospital closures and greater financial challenges for rural hospitals, leaving individuals living in rural areas at an even greater disadvantage to accessing care."[94] Simply put, the Proposed Rule increases gaps in insurance coverage[95] and so threatens the public health of the greater community.[96]

In short, the Proposed Rule would undermine public health within our States: of our DACA recipient residents, their families, and the broader communities at large.

**c. Beyond threatening public health, the Proposed Rule also endangers public welfare.**

As the Department has previously recognized, real-world evidence confirms that a lack of insurance can result in uncompensated care costs, increased medical debt, reduced spending power, lost work productivity, absenteeism, and increased premature mortality—among other

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[90] 89 Fed. Reg. at 39,402.

[91] Samantha Artiga & Anthony Damico, *Nearly 20 Million Children Live in Immigrant Families that Could Be Affected by Evolving Immigration Policies*, Kaiser Family Foundation (Apr. 18, 2018), https://tinyurl.com/37dwfce9. *See also* Samantha Artiga & Petry Ubri, *Living in an Immigrant Family in America: How Fear and Toxic Stress are Affecting Daily Life, Well-Being, & Health*, Kaiser Family Foundation (Dec. 13, 2017), https://tinyurl.com/46m24hur.

[92] Travis Campbell et al., *Exacerbation of COVID-19 mortality by the fragmented United States healthcare system: A retrospective observational study*, The Lancet Regional Health (May 12, 2022), https://tinyurl.com/mr26zt3r.

[93] *See* 89 Fed. Reg. at 39,396.

[94] Jennifer Tolbert et al., *Key Facts about the Uninsured Population*, Kaiser Family Foundation (Dec. 18, 2024), https://tinyurl.com/2s3jmmbm.

[95] 90 Fed. Reg. at 13,010.

[96] *See* Tolbert et al., *supra* note 94.

harms.[97] And, as the Department recognizes, DACA recipients are generally younger and healthier than the overall population who participates in the exchanges.[98] By eliminating them from the ACA insurance pools, the Proposed Rule will likely weaken those pools and increase costs across the board.[99]

Overall, the Proposed Rule threatens significant harms to the States' economies and their public health and welfare. The Department should withdraw this proposal.

**2. The Proposed Rule contravenes the text and purpose of the ACA.**

**a. The Proposed Rule is contrary to the text, history, and structure of the ACA.**

Under the ACA, noncitizens may be eligible to purchase insurance through ACA exchanges and to receive certain federal subsidies, provided that they are "lawfully present in the United States." For almost three decades, the Executive Branch has understood this term of art to encompass recipients of deferred action for purposes of certain federal benefits statutes. The 2024 Rule removes the Department's previous exception to this well-established understanding of lawful presence as it relates to DACA recipients, and allows DACA recipients to access affordable and adequate health insurance under the ACA.

The ACA uses a term of art—"lawfully present"—as an eligibility criterion in numerous provisions.[100] In doing so, Congress conveyed a clear policy directive: individuals who are lawfully present, rather than only those who have citizenship or another lawful status, would receive access to the ACA's benefits.[101] Although the ACA does not define "lawfully present," the phrase is also used in 8 U.S.C. § 1611(b)(2), which predates the ACA, as an eligibility criterion for Social Security. That statutory provision grants authority to the Attorney General (now the Secretary of Homeland Security) to define who is lawfully present.[102] Lawful presence has long been understood to encompass an individual "who is (under the law as enacted by Congress) subject to removal, and whose immigration status affords no protection from removal, but whose temporary presence in the United States the Government has chosen to tolerate, including for reasons of resource allocation, administrability, humanitarian concern, agency convenience, and

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[97] *See* 89 Fed. Reg. at 39,396 (lack of insurance "can have downstream impacts that further disrupt individuals' health and financial stability, and therefore their ability to work or study. Delays in care can lead to negative health outcomes …whereas being unable to pay medical bill puts individuals at higher risk of food and housing insecurity.").

[98] 90 Fed. Reg. at 13,010.

[99] *See* 89 Fed. Reg. at 39,398; *Kansas*, No. 1:24-cv-150 at ECF 156-7 at ¶¶ 32-33, ECF 156-10 at ¶¶ 24-26, ECF 156-8 at ¶¶ 7, 33.

[100] *See* 42 U.S.C. § 18032(f)(3) (eligibility to enroll in a health plan on the exchange); 26 U.S.C. § 36B(e) (eligibility for refundable premium tax credits); 42 U.S.C. § 18071(e) (eligibility for cost sharing); 42 U.S.C. 18081(c) (process by which lawful presence will be verified); 42 U.S.C. § 18082(d) (advanced payment of credits or cost sharing).

[101] *See id.*

[102] *See* 8 U.S.C. § 1103(a)(1).

other factors."[103] That background understanding was in place before the adoption of the ACA, and thus Congress's use of that term brought with it that old soil.[104]

The Department's contrary statutory analysis—an about-face from its view as recently as a few months ago—is unavailing. The reason the Department provides for reversing course from its 2024 Rule is that it believes its proposal "realign[s] [HHS's] policy with the text of the ACA."[105] Citing only to two recent Executive Orders, the Department explains it is "reconsidering the[] arguments" that it laid out in the 2024 Rule.[106] The Department maintains simply that, even though it previously believed it "should 'align' its position to that of DHS," it now believes that "the separate statutory and policy considerations" that govern HHS and DHS do "not compel HHS to 'align' its position on DACA recipients with the position that DHS took with regard to DACA recipients' eligibility for certain Social Security benefits."[107] But the Department says nothing of how "the broad aims of the ACA"—namely "to increase access to health coverage"— informed its analysis just a year prior.[108] And it does not sufficiently grapple with the reality that the ACA is using a specialized term that already carried with it a specialized meaning. The Department gives no reason why Congress would have wanted to use that term but to abrogate its meaning.

By comparison, as part of the rulemaking for its 2024 Rule, the Department reviewed comments noting its prior exclusion of DACA recipients from the definition of "lawfully present" was "inconsistent with other rules pertaining to public benefits for individuals with deferred action," including DHS regulations for Social Security benefits.[109] The Department also addressed comments opposing the changes the then-proposed 2024 Rule would make, ultimately noting that its inclusion of DACA recipients in the definition of "lawfully present" for purposes of the ACA exchanges is "consistent with the relevant statutory authorities," and consistent with DHS's ability to "recognize[] that even individuals who did not enter the United States legally could become 'lawfully present' under the statutes governing particular benefit programs."[110] In response to comments, the Department explained that the 2024 Rule "aim[ed] to establish criteria only for [the ACA exchanges]" and "d[id] not address or revise immigration policy, including DHS's DACA policy," reiterating "that other recipients of deferred action have long been considered lawfully present under [HHS] regulations and policies" and the Department was simply "removing the exception for DACA Recipients for the purposes of eligibility for [the ACA exchanges]."[111] The Department underscored that it "d[id] not believe that [the 2024 Rule] w[ould] encourage irregular

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[103] 87 Fed. Reg. at 53,209.

[104] *Cf., e.g.*, *Lamar, Archer & Cofrin, LLP v. Appling*, 584 U.S. 709, 721-22 (2018) (noting use of term of art with preexisting meaning indicates Congress intended for the statutory term to carry with it that same meaning).

[105] 90 Fed. Reg. at 12,954.

[106] 90 Fed. Reg. at 12,954.

[107] 90 Fed. Reg. at 12,954.

[108] 89 Fed. Reg. at 39,395 (explaining rationale for 2024 Rule); *see also* 90 Fed. Reg. at 12953-55 (briefly acknowledging the benefits that underpinned the 2024 Rule, but otherwise failing to engage with the Department's own analysis of the ACA in 2024).

[109] *See* 89 Fed. Reg. at 39,398.

[110] 89 Fed. Reg. at 39,399 (explaining how the term "lawfully presence" has been applied historically).

[111] 89 Fed. Reg. at 39,399.

migration, fraud or abuse of government systems, or encourage dependency on Federal programs."[112] In its new proposal, the Department fails to engage with any of its previous reasons for including DACA recipients in the definition of "lawfully present," other than saying excluding DACA recipients "reflect[s] the better view of the appropriate intersection of DACA and the ACA."[113] That is not statutory analysis.

The Department's current reasoning also completely disregards how DHS treats DACA recipients for the purposes of immigration law. Although DACA (and deferred action generally) is not a form of "lawful status," DHS does not consider those subject to a grant of deferred action to be *un*lawfully present in the U.S. as long as the deferred action is in effect.[114] Unlawful presence has serious ramifications: a person who accrues unlawful presence in the U.S. and leaves the country and tries to reenter may be barred and deemed inadmissible for 3 or 10 years, depending on the length of unlawful stay.[115] DACA recipients do not accrue that unlawful presence time so long as the individualized grant of their DACA requests and renewals remains valid.[116] Moreover, DACA recipients and other recipients of deferred action are, due to decades-old DHS regulations, eligible for work authorization.[117] Taken as a whole, for the past decade, current DACA recipients had been eligible to live and work in the U.S. and have been eligible to receive benefits like Social Security, but they still *could not* access crucial aspects of the healthcare system. This is despite the fact that according to one estimate, as of 2021, DACA recipients and their households pay $6.2 billion in annual federal taxes and about $3.3 billion in annual State and local taxes—meaning that DACA recipients were previously paying into the very same benefits from which they are barred.[118] By denying DACA recipients access to the ACA's benefits, the Proposed Rule once again treats these individuals as a *sui generis* subset of deferred action recipients when, in fact, DACA is just one in a historically long line of deferred action programs in the nation's history.[119]

Setting aside the Department's slipshod statutory analysis and its disregard for DHS's treatment of deferred action historically, the Proposed Rule simply misunderstands immigration law. The Department raises a purported concern about "inadvertently expand[ing] the scope of the DACA process"[120] as a basis for its proposal. The Proposed Rule maintains that DACA's "purpose did not include extending ACA access to health insurance Exchanges."[121] But nothing in the

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[112] 89 Fed. Reg. at 39,399.
[113] 90 Fed. Reg. at 12,954.
[114] *See What is Deferred Action for Childhood Arrivals*, U.S. Citizenship and Immigr. Servs., https://tinyurl.com/mr4yn5pe (last updated May 30, 2023).
[115] Immigration and Nationality Act (INA), 8 U.S.C. § 1182(a)(9)(B)(i)(1). *See also Unlawful Presence and Inadmissibility*, U.S. Citizenship and Immigr. Servs., https://tinyurl.com/2eazvc4v (last updated June 24, 2022).
[116] *See What is Deferred Action for Childhood Arrivals?*, *supra* note 114.
[117] 8 C.F.R. §§ 274a.12, 274a.13.
[118] Nicole Prchal Svajlenka & Trinh Q. Truong, *The Demographic and Economic Impacts of DACA Recipients: Fall 2021 Edition*, Center For American Progress (Nov. 24, 2021), https://tinyurl.com/mryjxdkd.
[119] *See* Ben Harrington, Congressional Research Service, *An Overview of Discretionary Reprieves from Removal: Deferred Action, DACA, TPS, and Others* (April 10, 2018), https://tinyurl.com/2f3z4mt9.
[120] 90 Fed. Reg. at 12,955 (cleaned up).
[121] 90 Fed. Reg. at 12,954 (explaining that DACA rests on three principles: the

DACA regulations indicates that *denying* DACA recipients access to health insurance fits deferred action either. In fact, DACA recipients can access health insurance through employer-sponsored health plans. Allowing them to access the ACA exchanges only gives them the ability to *purchase* health insurance on the marketplace when an employer-sponsored plan is unaffordable or inadequate—it does not fold DACA recipients into government-funded benefits programs like Medicaid. Just a year ago, the Department discussed DHS's DACA regulations, noting DHS itself acknowledged that the term "lawfully present" "does not confer lawful status or authorization to remain in the United States, but instead describes noncitizens who are eligible for certain benefits."[122] In that vein, the Department's prior rulemaking aptly understood DHS's goal in promulgating the DACA regulations, noting "it is clear that the DACA policy is intended to provide recipients with a degree of stability and assurance that would allow them to obtain education and lawful employment, including because recipients remain lower priorities for removal," and "[e]xtending eligibility to these individuals is consistent with those [DHS] goals."[123] The Department's current concern that allowing DACA recipients to buy health insurance on the marketplace would disrupt DHS's immigration policy is not supported by law—as giving DACA recipients access to the marketplace does not change anything about their legal immigration status.[124]

Despite its misplaced concerns over immigration law, the Department also asserts that it does not need to operate in lock-step with DHS.[125] As noted, the Proposed Rule avers "there is no requirement that HHS align[] its definition of 'lawfully present' with DHS's" definition, and there is "no requirement that HHS align its treatment of DACA recipients with other recipients of deferred action, particularly given the fundamental differences between DHS's DACA policy and other policies under which DHS may grant deferred action."[126] But the Proposed Rule also points to nothing requiring the Department maintain a separate definition of "lawfully present" that excludes DACA recipients.[127] Simply because the Department is not *required* to harmonize its definition of "lawfully present" with DHS's definition, does not mean it is *prohibited* from doing so. And where the Department previously sought to adopt a definition to effectuate "the broad aims of the ACA to increase access to health coverage,"[128] and cited evidence in support of its regulatory change, this Proposed Rule does precisely the opposite.

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identification of a group of individuals deemed low enforcement priorities, forbearance from removal for these individuals, and work authorization during this period of deferred action).

[122] 89 Fed. Reg. at 39,394 (referencing DHS's discussion of "lawfully present" in its DACA regulations).

[123] 89 Fed. Reg. at 39,395.

[124] *See* 89 Fed. Reg. at 39,400 (making clear the 2024 Rule "in [no] way change[s] existing immigration policy, nor does it confer lawful immigration status").

[125] 90 Fed. Reg. at 12,955.

[126] *Id.*

[127] *Cf.* 89 Fed. Reg. at 39,395 (noting in 2024 Rule that there is "no statutory mandate to distinguish between recipients of deferred action under the DACA policy and other deferred action recipients").

[128] *Id.*

Put simply, the Proposed Rule rests on circular logic.[129] The Department's explanation for changing course amounts to: because DACA recipients were previously excluded from the definition of "lawfully present" they should remain excluded now. This reasoning does nothing to engage with the Department's rationale for changing the definition of "lawfully present" last year, or to justify its change in position now. As discussed, the rulemaking for the 2024 Rule indicates that the inclusion of DACA recipients in the definition of "lawful presence" is supported by the fact that "other recipients of deferred action have long been considered lawfully present under [HHS] regulations and policies."[130] Likewise, nothing in the DACA regulations indicate that DHS intended to deny DACA recipients the ability to purchase affordable and adequate health insurance on the ACA exchanges as part of the agency's deferred action policy.[131] Importantly, the 2024 Rule did not "change existing immigration policy," nor did it "confer lawful immigration status."[132]

The Department has disregarded the statutory arguments that underlaid its prior position, failing to engage with its own reasons for including DACA recipients in the definition of "lawfully present" just a year ago. The Department's Proposed Rule is contrary to law and, in its current formulation, violates the APA.[133]

**b. The Proposed Rule is also inconsistent with Congress's purposes in adopting the ACA.**

Insufficient insurance coverage is a barrier to improving health outcomes and addressing health disparities across the United States. Inequitable access to healthcare and resulting adverse health outcomes, in turn, impose significant costs on society at large, diminish national and local economic potential, and increase national vulnerability to future disease outbreaks and pandemics. Recognizing these systemic issues, Congress enacted the ACA to increase access to health insurance and improve health and well-being by tackling barriers to accessing affordable, quality insurance coverage. Tens of millions of individuals have since gained insurance coverage through ACA policies focused primarily on helping individuals who do not receive coverage through an employer or government program to purchase affordable insurance directly. ACA coverage can improve health, quality of life, and economic productivity for all State residents, including low-income and vulnerable individuals. In passing the ACA, Congress intended to reduce the number of uninsured individuals in the country and to make health insurance more available. The 2024 Rule sought to align the eligibility for all lawfully present recipients of deferred action with the aims of the ACA, with data demonstrating that the 2024 Rule would address a significant health insurance coverage gap and provide substantial economic and public health benefits for many states.[134] The Proposed Rule does the opposite, while lacking any evidence-based justification.

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[129] *See* 90 Fed. Reg. at 12,954 (maintaining that "the use of the term 'lawfully present' in the ACA is best implemented by excluding DACA recipients for purposes of" ACA exchange eligibility).
[130] 89 Fed. Reg. at 39,399.
[131] See 89 Fed. Reg. at 39,400-01.
[132] 89 Fed. Reg. at 39,400.
[133] *Ball, Ball & Brosamer, Inc. v. Reich*, 24 F.3d 1447, 1450 (2d Cir. 1994).
[134] *See, e.g.*, 89 Fed. Reg. at 39,395-96, 39,403-04.

Further, the ACA may expressly prohibit the type of action the Proposed Rule seeks in removing eligibility for participation in ACA exchanges to DACA recipients. The ACA prohibits HHS from promulgating "any regulation that creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care . . . [or] limits the availability of health care treatment for the full duration of a patient's medical needs."[135] When a Rule, like the Proposed Rule, places a "substantive barrier" on individuals' ability to obtain appropriate care, it runs afoul of the statutory intent of the ACA.[136] This is not an instance where Congress has decided whether or not to fund programs under the ACA, but rather an explicit rulemaking proposal that prevents DACA recipients who accessed ACA marketplaces—and who may have begun care—from continuing to receive appropriate medical care.

High rates of uninsured can result in uncompensated care costs, increased medical debt, reduced spending power, lost work productivity, absenteeism, increased premature mortality, and social and systemic costs-of-illness. *See supra* pp. 22-23. Without recognizing the economic burden associated with coverage gaps, the Proposed Rule overlooks significant social, systemic, and economic benefits that result from the expanded, rather than restricted, access to health insurance.

The Proposed Rule undermines the ACA's aims to increase access and availability to health insurance and will result in significant costs on States' medical and insurance industries. Without access to affordable health insurance, DACA recipients are "less likely to receive preventive or routine health screenings and may delay necessary medical care, incurring high costs and debts."[137] The Proposed Rule acknowledges that prohibiting DACA recipients from purchasing insurance on the ACA exchanges would reduce enrollments by up to 10,000 otherwise eligible individuals.[138] The Proposed Rule discounts the effect of the 2024 Rule, asserting that actual enrollment of DACA recipients in insurance was much lower than anticipated.[139] States who have expanded insurance and Medicaid access to DACA recipients provide ample evidence that increasing access to health insurance yields positive outcomes for residents and public health at large. For example, a May 2024 report by the Kaiser Family Foundation indicated that immigrant adults in States with more expansive health care coverage policies are half as likely to be uninsured or to report delaying or going without medical care due to cost compared to those in less expansive States.[140] Another study found that after New York and California extended eligibility for their States' Medicaid programs to DACA recipients, DACA-eligible immigrants were 4% more likely to report insurance coverage than in other States that did not extend coverage to low-income DACA recipients.[141] In New York alone, more than 13,000 DACA recipients have enrolled in Medicaid,

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[135] 42 U.S.C. § 18114.

[136] *California v. Azar*, 950 F.3d 1067, 1095 (9th Cir. 2020) (articulating a standard for invalidating a regulation under 42 U.S.C. § 18114.

[137] 89 Fed. Reg. at 39,396.

[138] 90 Fed. Reg. at 13,010.

[139] 90 Fed. Reg. at 13,010.

[140] Akash Pillai et al., *State Health Coverage for Immigrants and Implications for Health Coverage and Care*, Kaiser Family Foundation (May 1, 2024), https://tinyurl.com/5cd2jjx6.

[141] *See State Spotlight: California's Landmark Coverage Expansion for Immigrant Populations*, Manatt Health (Nov. 2022), https://tinyurl.com/3b4jcu5f; Osea Giuntella & Jakub Lonsky, *The Effects of DACA on Health Insurance, Access to Care, and Health Outcomes*, IZA

aided by specially trained enrollment assistors in a number of languages,[142] while in Minnesota, 281 DACA recipients have received state-funded Medicaid through MinnesotaCare.[143] And in 2023, New Jersey expanded Medicaid and CHIP to children under 19 whose families meet income and eligibility requirements regardless of immigration status.[144] During the initial six-month period, 17,896 children who satisfied income and other eligibility criteria and who had previously been ineligible due to their immigration status were enrolled. As of the end of August 2024, the total number of enrolled children had reached 41,532.[145]

While the Proposed Rule asserts that the actual number of DACA recipients is lower than the 2024 Rule anticipated, it ignores the consequence of a preliminary injunction issued in the midst of many States' open enrollment periods that halted eligibility for individuals living in States covered by the injunction.[146] Indeed, several States represented in this letter filed an amicus brief in support of the 2024 Rule[147] and, as articulated *supra*, several of these States demonstrate the effectiveness and benefits of extending eligibility for insurance programs to DACA recipients.

### 3. The Proposed Rule is arbitrary and capricious

Under the APA, agencies must engage in "reasoned decisionmaking."[148] When an agency changes longstanding policies, it must "show that there are good reasons for the new policy" and provide a "detailed justification" for adopting its proposed policy.[149] Agencies must consider "the advantages *and* the disadvantages of agency decisions" before taking action.[150] If an agency fails to meet these requirements, the action can be set aside as arbitrary and capricious.[151] That is so even where a federal agency believes its prior policy was unlawful, and that a new policy is remedying that prior illegality; it must still engage in the broader reasoned decisionmaking that the APA requires.[152] But the Department has failed to engage in reasoned decisionmaking here.

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Institute of Labor Economics (April 2018), at 10, https://repec.iza.org/dp11469.pdf.

[142] Information provided by NYSDOH; *see also Fast Facts on Health Insurance for Immigrants*, NSYDOH (Sept. 2015), https://tinyurl.com/ccfd5sd7.

[143] Information provided by the Minnesota Department of Human Services.

[144] *See Governor Highlights Expanded Eligibility for NJ FamilyCare Health Care Coverage as Administration Continues Efforts to Cover All Kids*, N.J. Dep't of Human Servs. (Jan 18, 2023), https://tinyurl.com/24rxdyb5.

[145] *Kansas*, No. 1:24-cv-150 at ECF 156-12 at ¶ 11.

[146] 90 Fed. Reg. at 13,010.

[147] *Kansas*, No. 1:24-cv-150 at ECF 69.

[148] *State Farm*, 463 U.S. at 52.

[149] *FCC v. Fox Television Stations*, 556 U.S. 502, 515 (2009).

[150] *Michigan v. EPA*, 576 U.S. 743, 753 (2015).

[151] *See Fox Television Stations*, 556 U.S. at 537.

[152] *See, e.g., Dep't of Homeland Security v. Regents of the Univ. of Calif.*, 591 U.S. 1, 29-30 (holding that agency's change in course from policy it deemed was illegal still required reasoned decisionmaking, including consideration of reliance interests); *Nat'l Lifeline Ass'n*, 921 F.3d at 1111 (APA's standard of reasoned decisionmaking applies to changes in policy, and agency must show "there are good reasons for the new policy") (cleaned up); *Open Soc'y Inst. v. U.S. Citizenship & Immigr. Servs.*, 573 F. Supp. 3d 294, 321 (D.D.C. 2021) (when reviewing an agency's change in policy, the "touchstone" is that the agency's explanation must "enable" a reviewing court to conclude it was the product of reasoned decisionmaking) (cleaned up).

**a. The Department failed to consider myriad benefits of the 2024 Rule**

In contrast to the comprehensive and carefully considered 2024 Rule, the Department's current plan to exclude DACA recipients from access to ACA exchanges relies upon an inadequate analysis. Simply put, the Department ignores multiple important benefits that it previously, and recently, found would result from allowing DACA recipients to purchase health insurance plans from the marketplace, all of which formed the basis for the 2024 Rule.[153] Indeed, the Department acknowledges that the proposal "may result in costs to the Federal Government and to States" due to increased emergency medical care for DACA recipients "who become uninsured as a result of this rule."[154] The Department never explains why incurring these costs would be justified, but more fundamentally, the Proposed Rule never accounts for the loss of the many other benefits the Department and commenters identified as flowing from the 2024 Rule.

While an agency "need not always provide a more detailed justification than what would suffice for a new policy created on a blank slate," "[s]ometimes it must," including when "its new policy rests upon factual findings that contradict those which underlay its prior policy."[155] A "reasoned explanation is needed for disregarding facts and circumstances that underlay . . . the prior policy," and it "would be arbitrary and capricious to ignore such matters."[156] In its proposal, the Department simply ignores the fact that increased access to health insurance results in better public health outcomes for the individual and the public generally, increased financial stability and productivity at work and school, and reduced uncompensated care costs for the States—all of which are consistent with the purpose of the ACA.[157] The Department's failure to adequately explain its proposal, and its complete disregard of nearly all the factual findings in the 2024 Rule, renders its proposal arbitrary and capricious in multiple ways, as discussed below.

First, as the Department anticipated just last year, "[i]ndividuals without health insurance are less likely to receive preventive or routine health screenings and may delay necessary medical care, incurring high costs and debts."[158] In support of this finding, the Department pointed to survey data that showed "48 percent of respondents" delaying "medical care due to their immigration status," with "71 percent of respondents unable to pay medical bills or expenses."[159] These types of outcomes "have downstream impacts that further disrupt individuals' health and financial stability," affecting "their ability to work or study."[160] Delays in care not only lead to "negative health outcomes" like "longer hospital stays and increased mortality," but the delays can result in unpaid medical bills, which puts individuals "at higher risk of food and housing

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[153] *See* 89 Fed. Reg. at 39,395 (explaining goal of 2024 Rule was to effectuate "the broad aims of the ACA to increase access to health coverage"); *id.* at 39396 (detailing harms associated with lack of health insurance coverage, as well as benefits that stem from DACA recipients' increased access to health insurance).

[154] 90 Fed. Reg. at 13,010.

[155] *Fox Television Stations*, 556 U.S. at 5161.

[156] *Id.* at 515-16.

[157] 89 Fed. Reg. at 39,395-96 (explaining why the 2024 Rule is consistent with the ACA, and detailing the benefits of increased access to health insurance).

[158] 89 Fed. Reg. at 39,396.

[159] *Id.*

[160] *Id.*

insecurity."[161] Given that "over 200,000 DACA recipients served as essential workers during the COVID-19 [public health emergency],"—including "43,500 DACA recipients who worked in health care and social assistance occupations" with "10,300 in hospitals and 2,000 in nursing care facilities"—it is crucial that these individuals have access to affordable and adequate health insurance.[162] The Department fails to grapple with the impact of reducing DACA recipients' access to affordable and adequate health insurance, noting only that it "anticipate[s] the majority who lose" access to the ACA exchanges "would become uninsured," which "may result in costs to the Federal Government and to States to provide limited Medicaid coverage for the treatment of an emergency medical condition to DACA recipients who have a qualifying medical emergency and who become uninsured as a result of this rule."[163] Rather than address the downstream impacts of so many people losing their health insurance in one fell swoop, the Department tries to summarily minimize the harms to DACA recipients, the States, and the Federal Government.[164]

Second, and by comparison, in 2024 the Department found that "increasing access to health insurance would improve the health and well-being of many DACA recipients currently without coverage."[165] Beyond these improved health outcomes, DACA recipients "could be even more productive and better economic contributors to their communities and society at large with improved access to health care."[166] In support of this conclusion, the Department cited to a 2016 study, which found that "a worker with health insurance is estimated to miss 77 percent fewer days than an uninsured worker."[167] Now, the Department fails to address these benefits, even though they formed the basis for the 2024 Rule, and does nothing to engage with the harms that come from DACA recipients' losing access to the ACA exchanges. Short of acknowledging in an unrelated section elsewhere in the proposal that "[a]n increase in the rate of uninsurance may . . . cause an overall reduction to labor productivity,"[168] the Department does nothing to engage with the impacts of its proposal on DACA recipients, their families, and the communities they live in.

Third, in 2024 the Department found that allowing DACA recipients to access affordable, quality health insurance on the ACA exchanges "align[ed] with the goals of the ACA," to "lower the number of people who are uninsured in the United States and make affordable health insurance available to more people."[169] Because "DACA recipients represent a pool of relatively young, healthy adults," who are "younger than the general Exchange population," inclusion of DACA recipients in the marketplace may have "a slight positive effect on the [ACA exchanges'] risk pools."[170] This improvement to risk pools "could result in cost savings for health insurance issuers in the form of lower claims costs and for individuals in the form of lower health insurance

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[161] *Id.*
[162] *Id.* (noting that at "the height of the pandemic, essential workers were disproportionately likely to contract COVID-19").
[163] 90 Fed. Reg. at 13,010.
[164] *Id.*
[165] 89 Fed. Reg. at 39,396; *id.* at 39,403.
[166] 89 Fed. Reg. at 39,396.
[167] *Id.*
[168] 90 Fed. Reg. at 13,025.
[169] 89 Fed. Reg. at 39,396.
[170] *Id.*

premiums."[171] In its current proposal, the Department acknowledges that "[b]ecause DACA recipients are young" and "generally tend to be healthier," excluding them from ACA exchanges "would have a small negative impact on the individual market risk pool," without saying anything more on the subject,[172] failing to explain why it is reasonable to forego this benefit of the 2024 Rule.

Fourth, and as discussed above, the Proposed Rule disregards the harms that it would work on the States. As State Attorneys General, we are particularly concerned with the impact that the Proposed Rule would have on public health in our States and on our States' ability to absorb uncompensated care costs. *See supra* pp.19-23. Because DACA recipients remain ineligible for Medicaid, access to the private market is a crucial way of ensuring that more of our residents can receive affordable and adequate health insurance. States that operate ACA exchanges experience an increase in user fees that help fund the state-run exchanges; the total user fee collected by States operating their own exchanges increases when there are more enrollees.[173] Consistent with the Department's findings in 2024, increased access to health insurance means that our states will see improved public health outcomes, healthier and more productive residents, and lower uncompensated care costs. While the Department acknowledges that "the majority who lose" access to the marketplace "would become uninsured," it tries to minimize the costs to the States and Federal Government, noting this increase in uninsured individuals "may result in costs . . . to provide *limited* Medicaid coverage for the treatment of an emergency medical condition to DACA recipients who have a qualifying medical emergency and who become uninsured as a result of this rule."[174] But this cursory analysis does not account for the fact that uninsured individuals are more likely to put off preventive and routine health screenings, resulting in more serious health outcomes with "longer hospital stays and increased mortality."[175] These more serious and expensive health care costs will either put individuals at a higher risk of food and housing insecurity, or result in the States having to absorb the cost. Those are costs that the Department has yet to seriously grapple with.

In sum, allowing DACA recipients to purchase health insurance from the marketplace allows DACA recipients to seek routine and preventive care, results in less emergency medical care, decreases the spread of contagious diseases, increases worker productivity, brings in tax revenue to our States, improves the risk pool leading to cost savings for consumers, and decreases the need for States to absorb uncompensated care costs for uninsured individuals. *See supra* pp. 19-23. These are all significant and concrete benefits that the Department recognized and discussed in detail in the rulemaking leading up to the 2024 Rule. All of these benefits derive from the Department changing the definition of "lawfully present" to include DACA recipients and, thus, effectuating the goal of the ACA. The Department's current failure to even consider these benefits, or the impact of its proposal depriving the States of these benefits, is arbitrary and capricious and

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[171] 89 Fed. Reg. at 39,429.
[172] 90 Fed. Reg. at 13,010.
[173] *Kansas*, ECF 156-6 at ¶¶ 14-16 (noting that, in New Jersey, "the total user fee collected by [the State] correspondingly decreases as the number of enrollees decreases").
[174] 90 Fed. Reg. at 13,010 (emphasis added).
[175] 89 Fed. Reg. at 39,396.

shows a blatant disregard for public health and the goal of increasing access to health services, which the Department is charged with protecting.[176]

**b. The Department failed to account for reliance interests.**

At no point in the Proposed Rule does the Department acknowledge that DACA recipients and States have reliance interests following the 2024 Rule. Because the Department is "not writing on a blank slate" with its proposal, "it [i]s required to assess whether there were reliance interests, determine whether they were significant, and weigh any such interests against competing policy concerns."[177] The Department's "failure" to "even address[] the options of . . . accommodating particular reliance interests" is "arbitrary and capricious in violation of the APA."[178]

In 2024, the Department cited evidence supporting its findings that "[i]ndividuals without health insurance are less likely to receive preventive or routine health screenings," and "may delay necessary medical care."[179] This makes sense because "[m]any doctors will not even see a patient without first seeing proof of insurance."[180] It is reasonable to assume that DACA recipients who have been able to purchase health insurance on the ACA exchanges have sought treatment they were previously putting off, like chemotherapy or surgery to address chronic pain.[181] Additionally, DACA recipients who already purchased insurance on the ACA exchanges and who need regular bloodwork because of health conditions like heart disease or cancer by now assume those testing costs would be covered by their insurance—and without coverage they will have to resume paying out of pocket, or the State will again have to resume absorbing the cost.[182]

It is not just DACA recipients who have developed reliance interests following the 2024 Rule, but our States and residents. As noted, *supra* pp. 19-21, States incur significant costs for the care of uninsured residents at public hospitals and through annual subsidies intended to defray the cost of healthcare services provided to uninsured individuals. The greater the number of uninsured residents, the more States spend on uncompensated care.[183] It follows, with DACA recipients eligible for health insurance via the ACA exchanges, that our States anticipated a decrease in the

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[176] U.S. Department of Health and Human Services (HHS), https://tinyurl.com/bdwr5knz (last visited April 9, 2025).
[177] *Regents*, 591 U.S. at 33 (citation omitted).
[178] *Id.*
[179] 89 Fed. Reg. at 39,396.
[180] *Hector v. Raymond*, 692 So.2d 1284, 1288 (La. App. 3 Cir. 1997).
[181] *See* Rachel Garfield & Katherine Young, *How Does Gaining Coverage Affect People's Lives? Access, Utilization, and Financial Security among Newly Insured Adults*, Kaiser Family Foundation (June 19, 2015), https://tinyurl.com/323r257j (those who newly gained coverage in 2014 were "more likely to be linked to regular care, less likely to postpone care when they need it, and more likely to use preventive services than those who remained uninsured."); *cf.* JPMorgan Chase & Co. Institute, *Deferred Care: How Tax Refunds Enable Healthcare Spending* (January 2018), https://tinyurl.com/46r7zpsb (finding that "[c]onsumers immediately increased their total out-of-pocket healthcare spending by 60 percent in the week after receiving a tax refund").
[182] *See, e.g.*, *Kansas*, ECF 49-4 at ¶¶ 9-13 (small business owner without access to employer-sponsored insurance requires regular cancer-related bloodwork).
[183] *Id.*, ECF 156-5 at ¶¶ 16-25; ECF 165-8 at ¶¶ 10-25.

number of uninsured individuals and an improvement in public health. *See supra* pp. 19-23. For States that operate their own ACA exchange, an increase in the number of insurance enrollees results in an increase in the user fees that the States use to fund those state-based exchanges.[184] The 2024 Rule already resulted in increased enrollment in health insurance plans,[185] and our States planned for an uptick in user fees for state-based exchanges. If the Proposed Rule were finalized, our States would again have to absorb higher uncompensated care costs for uninsured individuals, risk greater harms to public health, and would experience a decrease in user fees from insurance premiums. Further, States that manage their own ACA exchanges incurred compliance costs, and would now incur *additional* compliance costs as the Department whipsaws to remove this group of otherwise eligible ACA exchange participants after welcoming them in just last year.

The Department does nothing to engage with the possibility that the 2024 Rule has already engendered these reliance interests.[186] It fails to make note that such reliance interests could exist, and does not solicit any comments on the subject. The Department is not required "to consider all policy alternatives" in its rulemaking, but it must, at the very least, consider the reliance interests at stake when it is changing course.[187] The Department's failure to do so makes its proposal arbitrary and capricious.

**c. The Department failed to consider reasonable alternatives.**

The Department also acted in an arbitrary and capricious manner by failing to meaningfully consider reasonable alternatives that preserve DACA recipients' access to health insurance. Consistent with bedrock principles of administrative law, if there are "significant and viable and obvious alternatives" that address rising health care costs but reduce harm to DACA recipients, the Department needs to explain sufficiently why it did not adopt them.[188] Failure to give these alternatives serious consideration would therefore fall far short of a requisite justification.[189] That is what happened here: the Department failed to explore multiple significant alternatives to their

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[184] *Id.*, ECF 156-6 at ¶¶ 14-16 (noting that, in New Jersey, "for each individual who ceases to be enrolled in a health benefits plan in New Jersey, including plans sold on [the state-based exchange]" the State "loses user fee revenue").

[185] *See e.g.*, *id.* at ECF 156-7 at ¶ 17 (as of January 2025, California estimates that over 1,868 DACA recipients have enrolled in a plan). Data on record with the New Jersey Department of Banking and Insurance (DOBI) indicates that, in New Jersey, 519 DACA recipients have enrolled in a plan for the 2024-2025 open enrollment period.

[186] *Regents*, 591 U.S. at 31 (noting that regardless of the "strength of any reliance interests," "consideration must be undertaken by the agency in the first instance").

[187] *Id.* at 33 (citation omitted).

[188] *Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46, 59 (D.C. Cir. 2015) (cleaned up); *see also Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, 591 U.S. 657, 708-08 (2020) (Kagan, J., concurring in the judgment).

[189] *See City of Brookings Mun. Tel. Co. v. FCC*, 822 F.2d 1153, 1169 (D.C. Cir. 1987) (agency must provide a "reasoned explanation" for rejecting "reasonable alternatives"); *Perez v. Mortg. Bankers Ass'n*, 575 U.S. 92, 106 (2015) ("APA requires an agency to provide a more substantial justification when … its prior policy has engendered serious reliance interests that must be taken into account.") (cleaned up).

chosen action—including making "more limited" changes to the existing policy—and thus failed to provide any reasoned explanation for rejecting them.[190]

First, the Department should have considered minimizing harm to DACA recipients by "grandfathering" in DACA recipients who have already purchased health insurance plans from an ACA exchange. The Department has done so before by grandfathering certain health insurance plans that existed before the ACA was enacted "to help people keep existing health plans that are working for them;"[191] it should consider doing so again now. The Department's own analysis suggests that this approach would have a positive impact on the individual market risk pool and reduce the number of uninsured.[192] And it would certainly reduce the harm to the significant reliance interests of those who have already purchased plans from the exchanges and potentially made major healthcare decisions based on that insurance.[193] But the Department did not even consider these interests, much less the possibility of preserving access to healthcare of DACA recipients.

Second, the Department could have permitted (or at least could have considered permitting) state ACA exchanges to choose to allow DACA recipients to enroll on their own exchanges, if those States have concluded that doing so will benefit their populations and the ACA exchanges themselves. Such discretion has ample precedent, as a total of 23 States (and Washington, D.C.) have exercised discretion to extend CHIP coverage to pregnant individuals regardless of their immigration status.[194] Similarly, 41 States (and D.C.) have exercised their discretion to expand Medicaid coverage to nearly all adults with incomes up to 138% of the Federal Poverty Level.[195] Nine states also provide eligible residents with premium tax credits or cost-sharing reductions in addition to the incentives provided by the federal government.[196] But the Proposed Rule did not consider any such alternative, or any other alternatives for that matter. It simply reverses the 2024 Rule without making any allowances or exceptions.[197]

Third, although the Department makes brief reference to the Fifth Circuit's 2025 decision in *Texas v. United States*,[198] it failed to consider the clear alternative left available by that decision.

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[190] *See Nat'l Shooting Sports Found., Inc. v. Jones*, 716 F.3d 200, 216 (D.C. Cir. 2013); *see also Regents*, 591 U.S. at 30 ("reasoned analysis" must include consideration of more limited alternatives "within the ambit of the existing policy") (cleaned up).

[191] *Amendment to Regulation on "Grandfathered" Health Plans under the Affordable Care Act*, Centers for Medicare & Medicaid Servs., https://tinyurl.com/4ytbur4e (last updated Sept. 10, 2024).

[192] *See* 90 Fed. Reg. at 13,010.

[193] *See* Garfield & Young, *supra* note 181.

[194] Akash Pillai et al., *State Health Coverage for Immigrants and Implications for Health Coverage and Care*, Kaiser Family Foundation (May 1, 2024), https://tinyurl.com/5m425hzx.

[195] *Status of State Medicaid Expansion Decisions*, Kaiser Family Foundation (Feb. 12, 2025), https://tinyurl.com/4uxa7k7y.

[196] *Which states offer additional financial assistance for Marketplace plans?*, Kaiser Family Foundation, https://tinyurl.com/4x2zexyu (last visited Apr. 7, 2025).

[197] *See* 90 Fed. Reg at 13,010-11.

[198] 90 Fed. Reg. at 12,954 n.37 (citing *Texas v. United States*, 126 F.4th 392, 420-21 (5th Cir. 2025)).

The Department emphasizes that the Fifth Circuit concluded that DHS's 2022 DACA Final Rule[199] substantively violated the Immigration and Nationality Act.[200] (The Department's analysis is quite brief; after quoting from a prior Fifth Circuit decision finding DACA unlawful,[201] the Department says only that "[u]pon further reconsideration, we now believe it was improper for HHS to define 'lawfully present' under the ACA in a way that departed from the longstanding understanding of that term with respect to DACA recipients."[202]). But the Department fails to then grapple with the remainder of the 2025 *Texas* opinion, which made clear that the aspect of DACA that forebears removal for recipients survives ("severing the . . . forbearance provisions from the work authorization provisions") and also that the entirety of DACA—including work authorization and the remaining associated features, like Social Security—would survive in every State other than in Texas alone (choosing to "narrow the scope of the injunction to Texas," finding that the injuries Texas alleged were "redressable by a geographically limited injunction").[203] The Department should therefore have considered an alternative that tracks the geographic scope of DACA as it remains in effect after *Texas*. Where individuals can obtain only forbearance and not obtain work authorization or the other benefits associated with "lawful presence" under federal law, then they might be unable to access ACA exchanges tied to "lawful presence" too. But where individuals in light of *Texas* are unquestionably still able to access work authorization and other benefits that are associated with "lawful presence," it makes eminent sense and supports uniformity across policies to allow those individuals to access ACA exchanges as well. The Department did not even consider this alternative, let alone explain its shortcomings, despite otherwise citing to the *Texas* 2022 decision.

These errors in failing to consider reasonable alternatives are especially egregious in light of the underlying statutory obligation in Section 1554 of the ACA to avoid issuing any rule that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care" or "impedes timely access to health care services."[204] Despite its direct regulation of ACA exchanges and ACA provisions, the Department's Proposed Rule fails to even mention Section 1554 in the context of DACA recipients, much less consider DACA recipients' ability to obtain medical care or timely access to health care services.[205] Here, the Department had a statutory obligation to avoid creating "unreasonable barriers" to health care. It did not do so, instead adopting a blanket reversal without at least *considering* reasonable alternatives. That is textbook arbitrary decisionmaking.

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[199] *Deferred Action for Childhood Arrivals*, 87 Fed. Reg. 53,152 (Aug. 30, 2022).
[200] *Texas*, 126 F.4th at 417.
[201] 90 Fed. Reg. at 12,954 (quoting *Texas v. United States*, 50 F.4th 498, 526 (5th Cir. 2022).
[202] 90 Fed. Reg. at 12,954.
[203] *Texas*, 126 F.4th at 419-21.
[204] 42 U.S.C. § 18114(1)-(2).
[205] *See* 90 Fed. Reg. at 13,010-11 (Proposed Rule's analysis of DACA recipients). *Contra* 89 Fed. Reg. at 39,402 (2024 Rule's discussion of unique barriers to health care that DACA recipients experience).

**4. The Regulatory Impact Analysis fails to accurately assess the effect of the Proposed Rule in reversing the 2024 Rule.**

The Department asserts that the Proposed Rule will ultimately be a cost-saving measure, returning ACA eligibility to the pre-2024 Rule standard. However, even a cursory review of the Department's costs analysis reveals its inadequacies as related to the exclusion of DACA recipients from Marketplace eligibility. The Proposed Rule acknowledges the Department's obligation to "assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity)."[206] The Proposed Rule falls woefully short of this required calculus. As articulated above, the Proposed Rule's reversal of the 2024 Rule ultimately results in fewer people with health insurance, exacerbating State and Federal expenditures, harming individual and community health, and impeding DACA recipients' ability to access healthcare, contrary to law.

As to benefits, the Proposed Rule suggests that the reduced enrollment resulting from denying DACA recipients access to ACA exchanges results in an annual APTC cost saving of $34 million and an annual BHP cost saving s of $3.2 million, for a total of $37.2 million in savings.[207] As to benefits, the Proposed Rule fails to quantify significant costs. It conspicuously leaves unquantified both the "small negative impact on the individuals market risk pool"[208] and, most notably, as articulated below, the "costs to the Federal Government and States to provide limited Medicaid coverage for the treatment of an emergency medical condition to DACA recipients who have a qualifying medical emergency and who will become uninsured as a result of the rule."[209] And the Proposed Rule recognizes that "the majority" of beneficiaries of the 2024 Rule would lose coverage,[210] thus exacerbating costs to the Federal Government and States.

As a result of the Proposed Rule "the majority [of DACA recipients] who lose. . . coverage would become uninsured."[211] Lapses in insurance coverage can have a negative effect on public health, especially in States with large populations of DACA recipients. In a 2021 survey of over 1,000 DACA recipients, 61% of respondents identified their immigration status as a "significant barrier" to receiving health insurance and health care, 47% reported delaying medical care due to immigration status, and 67% indicated that they or a family member were unable to pay medical bills or expenses.[212] Uninsured adults are less likely to receive preventive services for chronic conditions like cardiovascular disease, cancer, and diabetes.[213] And uninsured DACA recipients are also often hesitant to enroll their U.S.-born children in Medicaid and CHIP, resulting in

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[206] 90 Fed. Reg. 13,005
[207] 90 Fed. Reg. at 13,010.
[208] *Id.*
[209] *Id.*
[210] *Id.*
[211] *Id.*
[212] Nat'l Immigr. Law Center, *Tracking DACA Recipients' Access to Health Care*, at 2 (June 1, 2022), https://tinyurl.com/ypdmtrzw.
[213] U.S. Dep't of Health and Human Servs., *Access to Health Services*, Office of Disease Prevention and Health Promotion, https://tinyurl.com/5n7s2cu7 (last visitedApril 8, 2025).

decreased enrollment relative to those with U.S.-born parents.[214] Lack of insurance also poses a grave threat to public health at the national level. One study found that "wider insurance gaps exacerbated local COVID-19 outbreaks and resulted in more cases, hospitalizations, and death than experienced by jurisdictions with better coverage" such that "[r]educing the number of [individuals within the country] without health insurance is a crucial and underappreciated component of pandemic preparedness."[215] This is especially important because, as the 2024 Rule noted, over 200,000 DACA recipients served as essential workers during the COVID-19 pandemic, including 43,500 DACA recipients who worked in health care and social assistance occupations. Of those working in health care settings, at least 10,300 served in hospitals and 2,000 in nursing care facilities.[216] Moreover, individuals without health insurance are less likely to have access to regular outpatient care, leading to greater rates of hospitalization. These problems redound at the local level, especially in smaller rural communities, where "[h]igh uninsured rates contribute to rural hospital closures and greater financial challenges for rural hospitals, leaving individuals living in rural areas at an even greater disadvantage to accessing care."[217] As such, high rates of uninsured individuals can easily threaten the public health of the greater community.[218]

Beyond compliance costs,[219] States will incur significant costs and burdens to their medical systems as a result of the Proposed Rule. The Proposed Rule is likely to increase States' spending on social services by increasing reliance on emergency and charity-healthcare costs. Indeed, the Proposed Rule anticipates that it would have the effect of excluding young, generally healthier DACA recipients from the individual market, causing a negative impact on the market risk pool. Further, because the Proposed Rule recognizes that DACA recipients will become uninsured, the costs will be passed to "the Federal Government and States to provide treatment."[220] States are obligated to pay certain emergency healthcare costs of undocumented immigrants who otherwise meet Medicaid eligibility criteria.[221] Removing access to health insurance for most DACA recipients, therefore, imposes an increased burden on States.[222] The Proposed Rule ignores thorough research that increases in the number of insured individuals has "decreased uncompensated care costs (UCC) overall and for specific types of hospitals, including those in rural areas."[223]

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[214] Samantha Artiga & Anthony Damico, *Nearly 20 Million Children Live in Immigrant Families that Could Be Affected by Evolving Immigration Policies*, Kaiser Family Foundation (Apr. 18, 2018), https://tinyurl.com/37dwfce9.

[215] Travis Campbell et al., *Exacerbation of COVID-19 mortality by the fragmented United States healthcare system: A retrospective observational study*, The Lancet Regional Health (May 12, 2022), https://tinyurl.com/mr26zt3r.

[216] 89 Fed. Reg. at 39,396.

[217] Jennifer Tolbert et al., *Key Facts about the Uninsured Population*, Kaiser Family Foundation (Dec. 18, 2023), https://tinyurl.com/2s3jmmbm.

[218] *Id.*

[219] *See* 90 Fed. Reg. 13,010-11.

[220] 90 Fed. Reg. 13,010.

[221] *Id.*

[222] *Id.*

[223] *See e.g.*, Guth & Meghana Ammula, Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021, Kaiser Fam. Found. 2 (2021); Benjamin D. Sommers et al., Three-Year Impacts of the Affordable Care Act: Improved Medical

Not only does the Proposed Rule ignore the aforementioned economic costs stemming from a lack of health coverage and the benefits of increased health coverage, it ignores essential socioeconomic facts about the DACA recipient population. DACA recipients attend public and private universities and are employed by companies, nonprofit organizations, and government agencies and institutions, all of which benefit from their skills and productivity. They help grow the economy and contribute an estimated $6.2 billion in federal taxes and $3.3 billion in State and local taxes each year.[224] In fact, a 2022 study indicated that Texas's DACA recipients—one of the largest DACA populations in the nation—have a collective spending power of $3.7 billion, and Texas would stand to lose around $139.7 million in annual State and local taxes if the DACA program ended entirely.[225] Important here, "[e]xtending health coverage to noncitizens, including undocumented immigrants, may not be as costly for States as it would be [for] citizens. Studies have shown that immigrants' medical expenditures are roughly one-half to two-thirds that of citizens," and "have a lower per capita expenditure for public and [private] insurers, providing a low-risk pool."[226]

The minimal savings cited by the Proposed Rule[227] are negligible when compared against the benefit to States with DACA recipients in their insurance pool, the loss of revenue for state-based exchanges, and the increased costs to States for covering the emergency medical costs for the newly uninsured DACA recipients. The Department cannot possibly fulfill its obligation to maximize net benefits when it fails to quantify such significant costs in the RIA. This is evident given the Proposed Rule's consideration of regulatory alternatives[228] plainly fails to consider or engage with any reasonable alternatives that would avoid these significant costs. In short, the analysis and cost savings outlined in the Proposed Rule's RIA is, at best, inaccurate, misleading, and woefully incomplete.

## III. GENDER-AFFIRMING CARE SHOULD CONTINUE TO BE PERMITTED AS AN ESSENTIAL HEALTH BENEFIT

The Proposed Rule would unlawfully exclude coverage for gender-affirming care[229] as an EHB and should be withdrawn for three reasons: ***First***, gender-affirming care is essential healthcare and the Proposed Rule represents a dangerous incursion into the practice of medicine;

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Care and Health Among Low-Income Adults, 36 Health Affs. 1119, 1124 (2017), https://tinyurl.com/49uvdame.

[224] 89 Fed. Reg. at 39,399.

[225] Skyler Korgel, *Celebrating a Decade of DACA in Texas*, Every Texan (Sept. 29, 2022), https://tinyurl.com/4m8vyh8f.

[226] Matthew Buttegens & Urmi Ramchandani, *The Health Coverage of Noncitizens in the United States, 2024*, Urban Institute (May 2023), https://tinyurl.com/3j5x7csa.

[227] *See* 90 Fed. Reg. at 13,010-11.

[228] 90 Fed. Reg. at 13,026-28.

[229] "Sex-trait modification" as used in the Proposed Rule is defined to mirror the definition of "chemical and surgical mutilation" as included in Executive Order 14187. *See* p. 154. This letter will refer to what the Proposed Rule calls "sex-trait modification" as "gender-affirming care", which is the appropriate term and which the Proposed Rule acknowledges refers to the same categories of healthcare. *See id.*

***Second***, the exclusion of gender-affirming care from EHB coverage is contrary to law because it violates the Equal Protection Clause and Section 1557 of the ACA; and ***Third***, the Proposed Rule is arbitrary and capricious because it fails to consider important facts, including the widespread coverage of gender-affirming care by employer-based health plans, in its proposal to exclude gender-affirming care from EHB coverage.

## A. Background

### 1. Importance of Essential Health Benefits

The ACA requires certain individual and small group health plans to cover a set of EHBs which must be "equal to the scope of benefits provided under a typical employer plan."[230] These EHBs are "protected by cost-sharing limits and count towards a plan's actuarial value."[231] This means the categories protected as EHBs may not have any annual or lifetime dollar limit under the state plans. Per the Department, the "items and services" covered must come from the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.[232]

Before the ACA, insurance plans could exclude certain key services from coverage. "For example, in 2011, 62 percent of enrollees had individual-market plans [that] didn't cover maternity care; 34 percent had plans that didn't cover substance use treatment; 18 percent had plans that didn't cover mental health; and 9 percent had plans that didn't cover prescription drugs."[233] By including EHBs as part of the minimum standard that must be provided, the ACA reduced these disparities and improved coverage for those who previously did not have access to these services.[234] Mandating coverage for EHB categories also improves coverage for those individuals

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[230] Kaiser Family Foundation, New Rule Proposes Changes to ACA Coverage of Gender-Affirming Care, Potentially Increasing Costs for Consumers (Mar. 24, 2025), https://tinyurl.com/2637fye3.

[231] *Id.*

[232] Centers for Medicare and Medicaid Servs., Information on Essential Health Benefits (EHB) Benchmark Plans, https://tinyurl.com/3jbebvzc (last updated Jan. 14, 2025).

[233] Center on Budget and Policy Priorities, Essential Health Benefits Under Threat, http://cbpp.org/ehbs (last visited Apr. 9, 2025).

[234] Sarah Lueck, *If "Essential Health Benefits" Standards Are Repealed, Health Plans Would Cover Little*, Ctr. on Budget & Policy Priorities (Mar. 23, 2017), https://tinyurl.com/44b8e9z2 (explaining that the consequences of repealing EHBs would include leaving people with pre-existing conditions without healthcare coverage, women being charged more than men, and lead to many people with health insurance to have prohibitively expensive bills); Lois K. Lee, et al., *Women's Coverage, Utilization, Affordability, And Health After The ACA: A Review Of The Literature*, 39 HEALTH AFFAIRS 387, 390 (2020), https://tinyurl.com/3adau3rm.

with pre-existing conditions, as it prevents insurers from screening these individuals out of critical care.[235]

The ACA and its effectuating regulations permit significant latitude to the states in determining how EHBs are defined.[236] As such, states submit their "benchmark" plans to the Department for approval. As the name suggests, EHBs are a minimum standard, and benchmark plans can choose to offer "additional health benefits, like vision, dental, and medical management programs (for example, for weight loss)."[237] Each state maintains a benchmark plan on file with the Department, against which private insurers must compare plans to ensure compliance with the standards set forth therein. Further, if a state has not updated its benchmark plan to match federal requirements, private insurers must also review plans for compliance with federal EHB mandates.

**2. Coverage of Gender-Affirming Care as EHBs**

Gender-affirming care is a catch-all term for medical and psychosocial healthcare "'designed to support and affirm an individual's gender identity' [one's internal sense of one's gender], when it conflicts with the gender they were assigned at birth.'"[238] Gender-affirming care may include treatment such as surgery, prescription drugs, and mental health treatment, which fall within statutorily defined EHB categories. As such, states have made different coverage decisions with respect to whether to specifically name gender-affirming care in their EHB benchmark plans.

For example, in 2021, the Department approved the state of Colorado's benchmark plan that explicitly included gender-affirming care as an EHB.[239] The plan, which went into effect in 2023, was the first to formally include gender-affirming care in a state benchmark plan.[240] In response to the inclusion of gender-affirming care as an EHB, HHS Secretary Xavier Becerra stated: "Health care should be in reach for everyone; by guaranteeing transgender individuals can access recommended care, we're one step closer to making this a reality . . . I am proud to stand with Colorado to remove barriers that have historically made it difficult for transgender people to access health coverage and medical care." Echoing these sentiments, then-CMS Administrator Chiquita Brooks-LaSure commented: "Health care should be accessible, affordable and delivered equitably to all…To truly break down barriers to care, we must expand access to the full scope of health care, including gender-affirming surgery and other treatments, for people who rely on coverage

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[235] Center for American Progress, *10 Ways the ACA Has Improved Health Care in the Past Decade* (Mar. 23, 2020), https://tinyurl.com/24usu69u.

[236] Center on Budget and Policy Priorities, *supra* note 233.

[237] Jared Ortaliza & Cynthia Cox, *The Affordable Care Act 101*, Kaiser Family Found. (May 28, 2024), https://tinyurl.com/yz5utdrn.

[238] *What is gender-affirming care? Your questions answered*, Am. Assoc. Med. Colleges (Apr. 12, 2022), https://tinyurl.com/yrm9wn6f.

[239] Centers for Medicare & Medicaid Servs., Biden-Harris Administration Greenlights Coverage of LGBTQ+ Care as an Essential Health Benefit in Colorado (Oct. 12, 2021), https://tinyurl.com/4bczc5wj.

[240] Colorado Dept. of Regulatory Agencies, Gender-Affirming Care Coverage Guide, https://tinyurl.com/umw3329c.

through Medicare, Medicaid & CHIP and the Marketplaces…." Twenty-four states also expressly *prohibit* providers from excluding transgender-related healthcare.[241]

For states that require coverage for gender-affirming care, the Proposed Rule would have considerable consequences. Indeed, the Proposed Rule states that "if any State separately mandates coverage for sex-trait modification outside of its EHB-benchmark plan, the State would be required to defray the cost of that State mandated benefit as it would be considered in addition to EHB."[242] As a result, according to the Department, states with laws that mandate coverage outside of its EHB benchmark plan will suddenly be responsible for defraying the costs of covering those services under certain scenarios.[243]

### B. The Department Should Not Exclude Gender-Affirming Care as an EHB.

As an initial matter, gender-affirming care is essential healthcare for transgender individuals. Gender-affirming care has proven benefits for transgender individuals, including greatly improved mental health and overall well-being of gender diverse, transgender, and nonbinary children and adolescents.[244] Further, given the scope of what is currently included in EHBs, there is no principled way to exclude gender-affirming care, which may include prescription drugs, mental health treatment, and surgery, from the scope of EHBs. The only explanation for banning this care from coverage as an EHB is sheer animus toward transgender, nonbinary, and gender diverse individuals who may seek to access this care. Thus, the exclusion of gender-affirming care is contrary to law in violation of the APA. The exclusion of gender-affirming care from EHBs is also arbitrary and capricious, as in the past twenty years, coverage for gender-affirming care has increased significantly and coverage for gender-affirming care in employer-sponsored plans is comparable to many other benefits currently considered EHBs.[245] This expansion of coverage marks a recognition by health plans that this treatment has considerable benefits and can improve overall health outcomes for its recipients. The failure of the Proposed Rule to consider these benefits and to improperly state that gender-affirming care is not typically covered is arbitrary and capricious in violation of the APA. The Proposed Rule should be withdrawn.

#### 1. Gender-Affirming care has important benefits.

Gender-affirming care is essential medical treatment for transgender individuals and those experiencing gender dysphoria, a medical condition characterized by an incongruence between gender identity and sex assigned at birth. Gender dysphoria can cause clinically significant distress

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[241] Movement Advancement Project, Healthcare Laws and Policies: Private Insurance Nondiscrimination Laws, Bans on Exclusions of Transgender Health Care, and Related Policies (Apr. 26, 2024), https://tinyurl.com/39h489an.

[242] 90 Fed. Reg. at 12,987.

[243] Kaiser Family Foundation, New Rule Proposes Changes to ACA Coverage of Gender-Affirming Care, Potentially Increasing Costs for Consumers, *supra* note 230.

[244] *Id.*

[245] Kaiser Family Foundation, 2024 Employer Health Benefits Survey (Oct. 9, 2024), https://tinyurl.com/46t4msuh; Human Rights Campaign Foundation, Corporate Equality Index 2025: Rating Workplaces on Lesbian, Gay Bisexual, Transgender and Queer Equality (Jan. 2025), https://tinyurl.com/53dwc7mb.

and may result in "symptoms of depression and anxiety, substance use disorders, a negative sense of well-being and poor self-esteem, and an increased risk of self-harm and suicidality."[246] Major medical associations—including the American Medical Association, American Psychiatric Association, American College of Physicians, American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, and the American College of Obstetricians and Gynecologists—recognize the overwhelming evidence "that evidence-based, gender-affirming care for transgender children and adolescents is medically necessary and appropriate."[247] Even when transgender individuals are not experiencing gender dysphoria, gender-affirming care may be lifesaving preventative mental health care.[248] Gender-affirming care is essential healthcare, and prohibitions on this medical care are a "dangerous intrusion into the practice of medicine" and violate the "sanctity of the patient-physician relationship."[249]

**2. The exclusion of Gender-Affirming Care from EHBs is contrary to law.**

The exclusion of gender-affirming care is contrary to law in violation of the APA for the additional reason that it discriminates against the undersigned States' residents in violation of the Equal Protection Clause and Section 1557 of the ACA.

**a. The Proposed Rule violates the Equal Protection Clause.**

At the outset, the Proposed Rule plainly classifies on the basis of sex and transgender status. It thus triggers heightened scrutiny under the Equal Protection Clause;[250] yet HHS offers no legitimate justification for the Rule.

**(1) The Proposed Rule classifies based on sex.**

The Proposed Rule would prohibit insurers from covering certain healthcare services as EHBs only if those services "attempt to transform an individual's physical appearance to align

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[246] Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 513-14 (5th ed., text rev. 2022); Garima Garg et al., *Gender Dysphoria*, StatPearls (July 11, 2023), https://tinyurl.com/yj333bw8.

[247] *Medical Association Statements in Support of Health Care for Transgender People and Youth*, GLAAD (June 26, 2024), https://tinyurl.com/2thfbh4m. Moira Szilagyi, *Why We Stand Up for Transgender Children and Teens*, Am. Acad. of Pediatrics Voices Blog (Aug. 10, 2022), https://tinyurl.com/4v7m9b72.

[248] *Why Gender-Affirming Care Should Be Part of Preventive Mental Health Care for Trans People*, Univ. of Wash. Dept. of Epidemiology (July 14, 2023), https://tinyurl.com/yp4pfnp4.

[249] Press Release, Am. Med. Ass'n, AMA To States: Stop Interfering in Health Care of Transgender Children (Apr. 26, 2021), https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children.

[250] *See, e.g., Hecox v. Little*, 104 F.4th 1061, 1073-1080 (9th Cir. 2024); *Kadel v. Folwell*, 100 F.4th 122, 142-156 (4th Cir. 2024); *Grimm v. Gloucester Cty. Sch. Bd.*, 972 F.3d 586, 607-608 (4th Cir. 2020); *Doe v. Horne*, 115 F.4th 1083, 1102-1107 (9th Cir. 2024); *Karnoski v. Trump*, 926 F.3d 1180, 1200-1202 (9th Cir. 2019); *Massachusetts v. U.S. Dep't of Health & Hum. Servs.*, 682 F.3d 1, 8-9 (1st Cir. 2012).

with an identity that differs from his or her sex" or "attempt to alter or remove an individual's sexual organs to minimize or destroy their natural biological functions"—but not for any other purposes.[251] The Department drives this point home by soliciting comments on whether it should incorporate "*explicit* exceptions" into the final rule to ensure that the targeted healthcare services (e.g., puberty blockers, hormone treatments, and surgeries) remain eligible for EHB-status when used to treat any other medical condition, "such as precocious puberty, or therapy subsequent to traumatic injury."[252]

The Proposed Rule is thus "a line drawn on the basis of sex, plain and simple."[253] This is "textbook sex discrimination."[254] With or without any "explicit exceptions," the description of "sex trait modification" reveals that an insurer must know the sex of the patient to determine whether a particular health care service qualifies as an EHB. As an example, consider the provision of testosterone to a sixteen-year-old who identifies as a male and who wishes to align his appearance to his male identity. The Proposed Rule would prohibit an insurer from covering that care as an EHB if the patient was assigned female at birth because it would "transform [his] physical appearance to align with an identity that differs from his . . . sex." But it would allow an insurer to cover that exact same care if the patient was assigned male at birth. Similarly, it would be impossible to know whether any particular surgery was undertaken to "alter or remove an individual's sexual organs to minimize or destroy their natural biological functions"—and thus banned as an EHB under the Rule—without knowing the patient's assigned sex.

The Proposed Rule further discriminates on the basis of sex by reinforcing sex stereotypes and punishing gender nonconformity.[255] It would allow insurers to include as EHBs medical care that aligns a person's appearance with an identity that corresponds to their sex assigned at birth while forcing them to exclude medical care that aligns a person's appearance with an identity that differs from their sex assigned at birth. The Rule thus presumes there is one set way to live as the male and female sexes and penalizes transgender, nonbinary, and gender diverse people for not comporting with those stereotypes by limiting their coverage options.[256]

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[251] 90 Fed. Reg. at 12,986.
[252] 90 Fed. Reg. at 12,987 (emphasis added).
[253] *Doe v. Ladapo*, 676 F. Supp. 3d. 1205, 1217 (N.D. Fl. 2023).
[254] *Kadel*, 100 F.4th at 153.
[255] "Many courts … have held that various forms of discrimination against transgender individuals constitute sex-based discrimination for purposes of the Equal Protection Clause because such policies punish transgender persons for gender non-conformity, thereby relying on sex stereotypes. In so holding, these courts have recognized a central tenet of equal protection in sex discrimination cases: that states 'must not rely on overbroad generalizations' regarding the sexes." *Grimm*, 972 F.3d at 608-609 (internal citations omitted).
[256] *See Kadel*, 100 F.4th at 154 (holding that "a policy that conditions access to gender-affirming surgery on whether the surgery will better align the patient's gender presentation with their sex assigned at birth is a policy based on gender stereotypes"). An example from *Kadel* illustrates this point: "[W]hile mastectomies are available for both people assigned male at birth and those assigned female at birth, when they are conducted for gender-affirming purposes, they are only available to those assigned male at birth [and would be excluded under the Proposed Rule]. This difference in coverage is rooted in a gender stereotype: the assumption that people who have been assigned female at birth are supposed to have breasts, and that people assigned male at birth are not. No doubt, the majority of those assigned female at birth have breasts, and

The Proposed Rule similarly penalizes another segment of the population—intersex people—without even recognizing that they exist.[257] Intersex people may have variations in chromosomes, external genitalia, hormones, and reproductive organs, among other characteristics, that make them neither "male" nor "female."[258] When an intersex person receives gender-affirming care to align their external appearance or reproductive organs with their gender identity, they are not really transforming their appearance "to align with an identity that differs from [their]…sex" because they have traits that correspond with both "male" and "female." However, the Proposed Rule would limit or grant coverage for an intersex person's gender-affirming care based on what their birth certificate happens to say, or, more practically, what gender identity they are raised to inhabit. If an intersex person has a birth certificate that says "female" (and was raised accordingly) and identifies as male, this Proposed Rule would limit coverage for gender-affirming care, like hormone therapy, that aligns their appearance with a male gender identity. However, if this person's birth certificate happened to be marked as "male" (and they were raised accordingly), the Proposed Rule would not limit coverage for that same hormone therapy. That an intersex individual's insurance coverage for the same care would hinge on whether they adhere to certain sex stereotypes prior to receiving gender-affirming care is clearly discriminatory.

**(2) The Proposed Rule makes impermissible classification based on transgender status.**

The Proposed Rule triggers heightened scrutiny for the additional reason that it targets transgender people. As explained above, the Rule only excludes medical care that aims to address the incongruity between sex assigned at birth and gender identity. Yet that incongruity lies at "the very heart of transgender status."[259] It is not legally significant that the Rule was written to avoid the word "transgender." The Equal Protection Clause looks beyond creative drafting that ensures a discriminatory law would technically apply to all groups to examine whether it would exclusively or predominantly affect only one.[260] Such is the case here. By targeting medical care that enables a person to live in an identity different than their sex assigned at birth, the Proposed Rule plainly and unlawfully targets transgender, nonbinary, and gender diverse people.

**(3) The Proposed Rule cannot survive any level of scrutiny.**

To survive heightened scrutiny, "the government must show that the classification serves important governmental objectives and that the discriminatory means employed are substantially

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the majority of those assigned male at birth do not. But we cannot mistake what is for what must be. And because gender stereotypes can be so ingrained, we must be particularly careful in order to keep them out of our Equal Protection jurisprudence." *Id.*

[257] The fact that the Proposed Rule does not even consider the needs of intersex people further shows that it is arbitrary and capricious, in violation of the APA. *See State Farm*, 463 U.S. at 43.

[258] *Improving Health Care for Intersex People*, Fenway Health (Oct. 26, 2020), https://tinyurl.com/mt9jtv3y.

[259] *Kadel*, 100 F.4th at 146; *see Hecox*, 104 F.4th at 1080 ("A 'transgender' individual's gender identity does not correspond to their sex assigned at birth[.]").

[260] *See Kadel*, 100 F.4th at 148 and cases cited.

related to the achievement of those objectives."[261] None of the objectives identified in the Rule survive this demanding standard. Indeed, the Department claims to have issued the Proposed Rule "because sex-trait modification is not typically included in employer health plans and therefore cannot legally be covered as an EHB."[262] Yet the Rule does not provide sufficient evidence or any analysis to support this point; and as described below, it is readily disproven.[263]

The Proposed Rule separately suggests that the Department is "concerned about the scientific integrity of claims made to support [the use of gender-affirming care] in health care settings."[264] Incredibly, the Rule does not cite *any* evidence to support this claim and, in failing to do so, cannot "articulate a satisfactory explanation for its action."[265] And in any event, every major medical organization in American has publicly supported the types of care targeted by the Rule.[266]

The Proposed Rule discriminates against people who do not conform to the Trump Administration's conception of what it means to be "male" and "female." That is not a legitimate state interest, much less an "important" one.[267] The Proposed Rule will not survive any level of scrutiny and must be withdrawn.

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[261] *Id.* at 156 (internal quotation marks and citation omitted).

[262] 90 Fed. Reg. at 12,986.

[263] In the same vein, the Proposed Rule alludes to "some stakeholders [that] do not believe that sex-trait modification services fit into any of the 10 categories of EHB and, therefore, do not fit within the EHB framework even if some employers cover such services." 90 Fed. Reg. 12,987. But it does not identify those alleged stakeholders or provide any more information about their alleged belief, making it impossible for the States to fully respond to this claim. In any event, as multiple States have determined, gender-affirming care fits easily within the EHB categories. *See supra* pp. 41-42; 42 U.S.C. § 18022(b)(1) (defining the 10 EHB categories as ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care).

[264] 90 Fed. Reg. at 12,987.

[265] *See State Farm.*, 463 U.S. at 43 ("the agency must examine the relevant data and articulate a satisfactory explanation for its action, including a rational connection between the facts found and the choice made") (internal quotation omitted).

[266] "Organizations who have formally recognized this include the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American Medical Association, American Psychiatric Association, and at least a dozen more." *Dekker v. Weida*, 679 F. Supp. 3d 1271, 1285 (N.D. Fla. 2023). To the extent the Department means to refer back to the Trump Administration's apparent disdain for standards set forth by the World Professional Association for Transgender Health ("WPATH"), *see* Exec. Order No. 14,187, Protecting Children from Chemical and Surgical Mutilation, 90 Fed. Reg. 8,771 (Jan. 28, 2025), multiple courts have recognized those standards provide the "generally accepted" protocols for treating gender dysphoria. *Kadel*, 100 F.4th at 136-137; *Edmo v. Corizon, Inc.*, 935 F.3d 757, 769-770 (9th Cir. 2019).

[267] Government action motivated by a "bare . . . desire to harm" a disfavored group cannot survive any level of scrutiny. *Romer v. Evans*, 517 U.S. 620, 634-635 (1996).

**b. The Proposed Rule violates Section 1557 of the ACA.**

In addition to violating the equal protection rights of States' residents, the Proposed Rule contravenes the non-discrimination mandate of the ACA.[268] As relevant here, Section 1557(a) provides that "an individual shall not, on the ground prohibited under . . . title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.) . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance . . . ." Title IX prohibits discrimination on the basis of sex and, as many courts have recognized, transgender status.[269] The reason for this is simple: "it is impossible to discriminate against a person for being . . . transgender without discriminating against that individual based on sex."[270] Section 1557 imposes those same safeguards on federally funded health care entities.[271] Yet the Proposed Rule tosses those safeguards aside, allowing or prohibiting insurers from covering medical care as an EHB based on whether the care aligns with the person's sex assigned at birth. The law does not countenance such flagrant sex-based classifications and stereotypes.

**3. The Exclusion of Gender-Affirming Care from EHBs is arbitrary and capricious.**

The "arbitrary-and-capricious standard requires that agency action be reasonable and reasonably explained."[272]An agency action fails to meet this test where, among other things, "the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or [made a decision that] is so implausible that it could not be ascribed to a difference in view or the product of agency expertise."[273] The Proposed Rule violates a number of these APA principles.

To date, the Department has explicitly prohibited EHB coverage for only a limited number of services: abortion, non-pediatric dental or eye exam services, long-term nursing care, and non-medically necessary orthodontia.[274] However, even for those services, an EHB plan may cover them should a state so choose.[275] For example, non-pediatric dental care, which cannot be required to be covered as an EHB, is permitted to be covered as part of an EHB benchmark plan should a

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[268] *See* 42 U.S.C. § 18116 ("Section 1557").

[269] *See A.C. v. Metropolitan Sch. District of Martinsville*, 75 F.4th 760, 768-769 (7th Cir. 2023); *Grimm*, 972 F.3d at 616-617.

[270] *Bostock v. Clayton Cty.*, 590 U.S. 644, 660 (2020). Though *Bostock* interpreted Title VII of the Civil Rights At of 1964, its analysis applies with equal force to Title IX both because Congress modeled Title IX after Title VI and because in either context "the discriminator is necessarily referring to the individual's sex to determine incongruence between sex and gender, making sex a but-for cause for the discriminator's action." *Grimm*, 972 F.3d at 616-617.

[271] *See Kadel*, 100 F.4th at 164.

[272] *Prometheus Radio Project*, 592 U.S. at 423.

[273] *State Farm*, 463 U.S. at 43.

[274] 45 C.F.R. § 156.115(d); https://tinyurl.com/mr3f37yh (noting that abortion, non-pediatric dental or eye exam services, long-term nursing care, and non-medically necessary orthodontia are excluded from EHB inclusion).

[275] *Id.*

state choose to do so.[276] The Department has not sufficiently justified why gender-affirming care should be treated similarly to those other services explicitly excluded, as opposed to the litany of services that are covered as EHBs under law, and none of the purported justifications provided meet the appropriate standard.

**a. EHB Coverage is not as limited as the Proposed Rule suggests.**

As justification for excluding gender-affirming care from EHBs, the Proposed Rule argues that gender-affirming care "is not typically included in employer-sponsored plans," so should be left out of EHB coverage.[277] The Proposed Rule fails to cite data supporting this claim, and unsurprisingly, EHB coverage for gender-affirming care is not as limited as the Proposed Rule maintains. Employer plans are the most dominant source of healthcare coverage in the United States, and a substantial number of them offer gender-affirming care coverage.[278] A 2024 survey run by the Kaiser Family Foundation (KFF) found that 50 percent of companies with 5,000 or more workers were able to certify that they specifically cover gender-affirming hormone therapy.[279] A little less than half of all workers covered by employer plans in the United States (43 percent) work for companies with 5,000 or more workers. Even after broadening to all large employers (companies with 200 or more workers that offer health benefits), which employ over 72 percent of American workers with job-based coverage, around one fourth (24 percent) stated that they cover gender-affirming hormone therapy.[280]

The analogous KFF survey from 2023 reported similar findings regarding employer coverage for gender-affirming surgery.[281] Over 60 percent of companies with 5,000 or more workers stated that they provide coverage for gender-affirming surgery; 12 percent were unsure about whether they provide the same coverage. As was the case with employer coverage for gender-affirming hormone therapies, a little less than one fourth (23 percent) of all large employers, with 200 or more workers, were certain that they provide gender-affirming surgery. 40 percent did not know whether offered health benefits included such surgery.

A significant proportion of American workers with employer healthcare plans have coverage for gender-affirming healthcare services, and this number has grown over time. According to the Human Rights Watch's Corporate Equality Index 2025 Report, 72 percent of Fortune 500 companies offer "transgender-inclusive healthcare benefits," which includes hormone therapies.

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[276] *Id.*

[277] 90 Fed. Reg. at 12,986.

[278] Human Rights Campaign Foundation, Corporate Equality Index 2025: Rating Workplaces on Lesbian, Gay Bisexual, Transgender and Queer Equality (Jan. 2025), https://tinyurl.com/53dwc7mb.

[279] Kaiser Family Foundation, 2024 Employer Health Benefits Survey (Oct. 9, 2024), https://tinyurl.com/46t4msuh. Eighteen percent of companies of this size did not know if they offer such coverage. *Id.*

[280] *Id.* Only 31 percent of these large employers stated that they did not offer coverage for gender-affirming hormone therapy; around 45 percent of responding large employers did not know if they covered these services. *Id.*

[281] Kaiser Family Foundation, 2023 Employer Health Benefits Survey (Oct. 18, 2023), https://tinyurl.com/2mshf4hz.

surgeries, and mental health care, up from 0 percent in 2002.[282] The purported basis for excluding gender-affirming care as an EHB—that they are not typically included in employer plans—is factually inaccurate and fails as a foundation for such exclusion.

**b. The fact that health conditions are rare does not warrant exclusion from EHB coverage.**

The Proposed Rule theorizes (again without support) that the lack of employer coverage of gender-affirming care stems from the low utilization of such care.[283] It explains that "less than 1 percent of the U.S. population seeks forms of sex-trait modification."[284] Yet, there is a marked difference between a lack of coverage and infrequent utilization of that coverage. Public and commercial insurance regularly covers healthcare services that are infrequently used. For instance, there were 3,456 patients waiting for heart transplants and 898 patients waiting for lung transplants in the United States in 2024.[285] Although these transplants are exceptionally rare, the vast majority of public and private insurance plans cover them, and transplants themselves are not excluded from EHBs.[286] Thus, even if gender-affirming care coverage were infrequently utilized, the usage rate alone would not be a reason to exclude the care from EHBs.

Health care utilization is determined by a number of factors, including geography, sex, race, and spoken language.[287] The need for health care is a "major determinant" of utilization.[288] Conditions that motivate the use of gender-affirming care coverage are not truly rare; gender dysphoria, for instance, does not even meet the requirements of a "rare" condition, which would typically require that it impact fewer than 200,000 Americans.[289] Indeed, an estimated 0.6% of U.S. residents, or over 2 million Americans, experience gender dysphoria.[290] Also, most public

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[282] Human Rights Campaign Foundation, *supra* note 278.
[283] 90 Fed. Reg. at 12,986-87.
[284] 90 Fed. Reg. at 12,987.
[285] *Detailed Description of Data*, Health Res. and Servs. Admin., https://tinyurl.com/m3nvrvzd (last visited Apr. 8, 2025).
[286] *Heart Disease and Heart Transplant*, WebMD (James Beckerman ed., June 30, 2023) https://tinyurl.com/4kk3ydwu ("More than 80% of commercial insurers and 97% of Blue Cross/Blue Shield plans offer coverage for heart transplants."); *Planning to Pay for a Transplant*, Cystic Fibrosis Found., https://tinyurl.com/3u96vpyh (last visited Apr. 8, 2025) ("Most health insurance and government programs, including Medicaid, will pay for a lung transplant…"); Lindsey Dawson, Kaye Pestaina, & Matthew Rae, *New Rule Proposes Changes to ACA Coverage of Gender-Affirming Care, Potentially Increasing Costs for Consumers*, Kaiser Family Found. (Mar. 24, 2025), https://tinyurl.com/2637fye3 ("There are other cases where a small share of the population uses a service that is generally covered by insurance. For example, there were fewer than 5,000 heart transplants in the US in 2023 (equaling one ten thousandth of a percent of the population) but public and commercial insurance typically covers this service.").
[287] National Academies of Sciences, Engineering, and Medicine, *Factors That Affect Health-Care Utilization, in* Health-Care Utilization as a Proxy in Disability Determination (2018), https://tinyurl.com/mtcsjc7f.
[288] *Id.* The other factors that impact healthcare utilization, like geography, race, and sex, have independent impacts on utilization. *Id.*
[289] *Rare and Orphan Diseases*, Cleveland Clinic, https://tinyurl.com/5eyz4e2b (last visited Apr. 8, 2025).
[290] Danyon Anderson et al., *Gender Dysphoria and Its Non-Surgical and Surgical*

and private insurance plans cover treatment for a variety of conditions that, while not rare in the medical sense, impact fewer people than gender dysphoria. For example, most healthcare plans cover treatment for multiple sclerosis, which affects almost 1 million people in the United States,[291] and major insurance providers also cover treatment for scleroderma, which impacts only around 300,000 Americans.[292] The fact that a condition only impacts a subset of the general population is not, in and of itself, a sufficient reason to exclude it from inclusion in EHBs.

Additionally, those experiencing gender dysphoria are not the only people who need access to, or make use of, gender-affirming care. Transgender, nonbinary, and intersex individuals who do not suffer from gender dysphoria may need or want gender-affirming care so that they may live as their authentic selves. Around 300,000 minors between the ages of 13 and 17 and 1.3 million adults identify as transgender,[293] approximately 1.2 million LGBTQ people in the U.S. identify as nonbinary,[294] and around 5.6 million people in the U.S. are born intersex.[295] Though there are overlapping populations within these gender diverse groups, it is clear that millions of Americans need access to gender-affirming care.

**c. The Proposed Rule fails to account for reliance interests.**

The Proposed Rule is arbitrary and capricious for another, related reason: it does not accommodate or even acknowledge that individuals and States have developed important reliance interests around coverage for gender-affirming care due to the preexisting federal regulatory environment. As in the DACA context, the Department is "not writing on a blank slate" here.[296] States have enjoyed the authority to refine EHB requirements within statutory parameters since the ACA was passed; and the Department has never before sought to interfere with that authority by imposing a nation-wide ban on EHB coverage for gender-affirming care. Far from it, in 2021, the Department affirmatively approved a state benchmark plan that explicitly identified that care as an EHB. As a result, many States have administered their marketplaces and benchmark plans with the expectation that employer healthcare plans would cover gender-affirming care as an EHB; and employers followed suit. If the Proposed Rule takes effect, these States would lose the

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*Treatments*, 10 Health Psychology Res. (Sept. 2022), https://tinyurl.com/tvnvukzw.

[291] Alexandra Benisek, *Covering the Cost of B-Cell Therapy*, WebMD (Oct. 21, 2024), https://tinyurl.com/3urfssdm ("Insurance covers most MS treatments…"); *How Many People Live With Multiple Sclerosis?*, Natl. Multiple Sclerosis Soc'y, https://tinyurl.com/2k8zrd64 (last visited Apr. 8, 2025).

[292] *Who Gets Scleroderma?*, Natl. Scleroderma Found., https://tinyurl.com/3ap44hk9 (last visited Apr. 8, 2025); *Insurance Coverage for Therapeutic Plasma Exchange in the U.S.*, The Scleroderma Education Project, (last visited Apr. 8, 2025).

[293] Press Release, UCLA Williams Inst., New Estimates Show 300,000 Youth Ages 13-17 Identify as Transgender in the U.S. (June 10, 2022), https://tinyurl.com/4h3wdp77.

[294] Press Release, UCLA Williams Inst., 1.2 Million LGBTQ Adults in the U.S. Identify as Nonbinary (June 22, 2021), https://tinyurl.com/ybwr387f.

[295] Rebecca Boone & Jeff McMillan, *How Many Transgender and Intersex People Live in the U.S.? Anti-LGBTQ+ Laws Will Impact Millions*, Associated Press (July 27, 2023), https://tinyurl.com/mvbe6xk8.

[296] *See Regents*, 591 U.S. at 33 (where agency was "not writing on a blank slate, it was required to assess whether there were reliance interests, determine whether they were significant, and weigh any such interests against competing policy concerns") (cleaned up).

flexibility to tailor EHB coverage to the particular needs of their population; and those States that continue to mandate coverage for gender-affirming care—through their State non-discrimination laws or otherwise—would suddenly be required to absorb the associated defrayal costs under 90 Fed. Reg. 12,987. Individuals who currently access gender-affirming care as an EHB through employer healthcare plans also may experience disruptions and increased costs.

However the Department may view these reliance interests, it was obligated to at least acknowledge their existence and consider them when formulating the Proposed Rule.[297] Its failure to do so renders the Rule arbitrary and capricious.

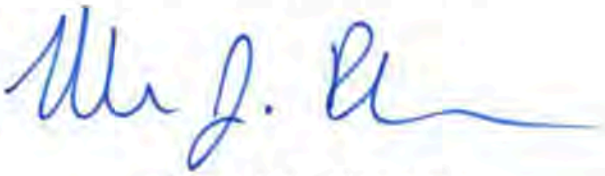
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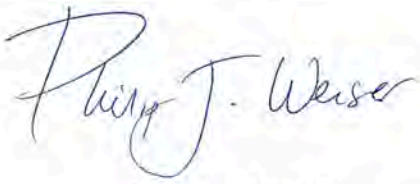
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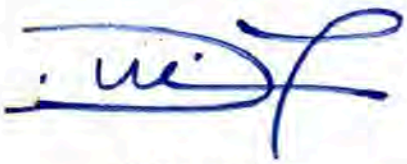
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[297] *Regents*, 591 U.S. at 31.

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April 11, 2025

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

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services

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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 Patient Protection and Affordable Care Act: Marketplace Integrity and Affordability proposed rule. The Commonwealth Fund is a nonprofit, nonpartisan foundation dedicated to affordable, quality health care for everyone. We support independent research on health care issues and make grants to promote better access, improved quality, and greater efficiency in health care, particularly for society's most vulnerable — including people of color, people with low income, and those who are uninsured.

Decades of research demonstrates that health insurance is essential to getting timely health care in the United States. People who are uninsured get far less needed care and live sicker, less productive, and shorter lives. Access to care is critical to preventing chronic disease and improving health outcomes.

The reforms to the individual insurance market enacted by the Affordable Care Act (ACA), together with the law's premium tax credits for marketplace health plans, have transformed the ability of people who lack access to employer-based coverage or Medicaid to buy affordable, comprehensive coverage. Before these reforms were implemented, people with preexisting conditions were out of luck when they sought to buy insurance on their own. Millions of young adults became uninsured when they graduated from high school or college. And insurance companies charged young women much higher premiums than young men and rarely covered maternity care.

The marketplaces in 2025 are strong and competitive. Enrollment is at a historic high of 24 million people. Insurer participation is robust: 96 percent of HealthCare.gov enrollees had a choice of three or more plans in 2024. Enrollment is highest in states that have not expanded Medicaid, including Florida and Texas.

Working families and individuals with low and moderate incomes have been among the most important beneficiaries of the ACA's coverage expansions. They are the least likely to work for employers who

offer coverage and the most in need of a place to get good, affordable health insurance. In states that have not expanded Medicaid, marketplace coverage is now a lifeline for low-income working people.

Still, the United States can improve. An estimated 28 million Americans, or 8.5 percent of the U.S. population, lacked health insurance by the third quarter of 2024. While today's uninsured rate represents a sea change from the years prior to ACA, when twice as many people — 49 million, or 16 percent of the population — lacked health coverage, it is critical that we continue to make coverage gains.

Progress on coverage can be made without major expansions. The Congressional Budget Office (CBO) estimates that more than 60 percent of people who remain uninsured are eligible for subsidized health insurance. This includes more than 4 million uninsured people who were eligible for marketplace premium tax credits in 2023. Making enrollment simple and easing coverage transitions during life events like job loss could help people maintain seamless coverage and access to the health care they need.

Health care affordability is an ongoing concern for working families. A 2023 survey found that more than half of working-age adults said it was very or somewhat difficult to afford their health care costs, including 43 percent of adults with employer coverage and 57 percent of people in marketplace or individual market plans. A 2024 survey found that 23 percent of working-age adults who were insured all year had such high out-of-pocket costs and deductibles relative to their incomes that they were underinsured. Of those, two-thirds were enrolled in employer health plans and 14 percent had marketplace or individual market plans.

To achieve a productive workforce and a high-performing health care system, it is incumbent upon policymakers to ease coverage enrollment barriers and seek to improve the affordability and cost-protection of health plans across the commercial insurance markets that now cover nearly 190 million people. We cannot have a strong workforce if working people and their families lack affordable access to health care.

The following sections of the proposed rule would likely increase the number of people who are eligible for but not enrolled in subsidized coverage, reduce the affordability of health insurance, and increase the number of people who have coverage but are underinsured. Taken together, these effects could reduce access to needed health care, particularly among families with low and moderate incomes.

We offer comments on the following sections of the proposed rule:[1]

- III.B.3.c. Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (Section 155.320)
- III.B.3.d. Income Verification When Tax Data is Unavailable (Section 155.320)
- III.B.3.b. 60-Day Extension to Resolve Income Inconsistencies (Section 155.315)
- III.B.7. Annual Open Enrollment Period (Section 155.410)
- III.B.8. Monthly Special Enrollment Period for APTC-Qualified Individuals with a Projected Household Income at or Below 150 Percent of FPL (Section 155.420)
- III.B.9. Pre-enrollment Verification for Special Enrollment Period (Section 155.420(g))

[1] The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

- III.C.2. Premium Adjustment Percentage (Section 156.130(e))
- III.C.3. Levels of Coverage (Actuarial Value) (Sections 156.140, 156.200, 156.400).

**Section III.B.3.c Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (Section 155.320)**

**Section III.B.3.d. Income Verification When Tax Data is Unavailable (Section 155.320)**

These sections propose to cease accepting an applicant's attestation of income when tax data indicate their recent income is under 100 percent of the federal poverty level or tax data are unavailable.

When someone applies for an APTC, their eligibility is based on their projected income for the coming year and recent tax return data provided by the Internal Revenue Service (IRS). If their projected income is lower than that indicated in the tax data, the marketplace flags their application as a "data matching issue," or DMI. The applicant will then be asked to provide more information to support their income projection; otherwise, eligibility will be determined by the tax data. This is because the APTCs are larger the lower someone's income is.

The proposed rule would add a DMI for cases where an applicant's projected income is between 100 and 400 percent of the federal poverty level (FPL) and the tax data show their income to be less than 100 percent FPL. This is because in states that have not expanded Medicaid, the thought is that people who are caught in the Medicaid coverage gap (incomes too high to qualify for the state's existing Medicaid program and too low to qualify for an APTC) will have an incentive to inflate their income so they can get health insurance.

The Department of Health and Human Services (HHS) also adopted this rule in 2019. However, a Maryland district court overturned the rule in *City of Columbus, et al. v. Cochran*, finding that HHS had not provided adequate justification or response to public comments that had questioned the change.

HHS is proposing to reinstate the policy with this rule. This change will add a new burden on people with low income whose employers do not provide health insurance and who are not eligible for Medicaid in nonexpansion states. These individuals would be required to provide pay stubs and other information to support their income projections. Many people at this income level have multiple jobs and are in families working for multiple employers.

Because of multiple employment sources, variable hours, and seasonal employment, people with low income face unique challenges in estimating annual income. One analysis found that workers in the lowest income quintile had more than double the degree of income variability compared to workers in other income groups. This means that projected income and actual annual income are distinct concepts for families with lower incomes.

This policy runs at cross-purposes with the goal of enabling people to enroll in the coverage that, by law, they are eligible for. Experience with Medicaid and other federal programs shows that administrative hurdles decrease the likelihood of enrollment. HHS estimates that the two new policies would reduce enrollment by nearly 500,000 people. Based on earlier estimates of enrollment loss due to DMIs, the number of people blocked from coverage they are eligible for is likely to be higher.

HHS estimates these proposals will add more than 2 million DMIs per year, dramatically increasing administrative costs for the marketplaces – by more than $120 million, according to their own estimates.

If HHS is concerned about low-income people enrolling in coverage their incomes are too low for, the issue could be resolved, without erecting new barriers to coverage and care, in one of two ways:

- The 10 states that have not expanded Medicaid eligibility could move forward, eliminating the coverage gap and covering 1.4 million uninsured people.
- Congress could revise the ACA statute to allow people with incomes under 100 percent of poverty in nonexpansion states to become eligible for marketplace coverage.

Given the potential for coverage disruptions, particularly for those with low income, and the large administrative burden for the marketplaces, we recommend not moving forward with this proposal.

**Section III.B.3.b. 60-Day Extension to Resolve Income Inconsistencies (Section 155.315)**

CMS is also proposing to require applicants to submit a manual request for additional time to resolve a DMI rather than providing applicants with an automatic extension of 60 days, the current policy. This change would make DMIs harder to resolve. The automatic extension should be retained for the following reasons:

First, if the changes described above are adopted the exchanges will see a substantial increase in the number of applicants with DMIs and, consequently, a major burden on exchanges to review documents. As the agency sheds critical staff who monitor contractor performance in reviewing DMI documents, it seems prudent to retain the automatic 60 day extension to allow more time for applicants and the exchanges to resolve the DMI. Further, automatic extensions would relieve the exchanges of the additional paperwork burden of reviewing extension requests.

**Section III.B.7. Annual Open Enrollment Period (Section 155.410)**

CMS proposes to shorten the annual open enrollment period (OEP) for the federally facilitated marketplace exchange (FFE) from 76 to 45 days. Further, in a break from historic deference to state flexibility, the proposed rule would prohibit the state-based marketplace exchanges (SBE) from using a longer OEP. If finalized, all marketplace OEPs would be required to run from November 1 to December 15. CMS supports this proposed change by suggesting that extending the OEP past December 15 contributes to adverse selection. CMS also asserts that a longer OEP does not help boost enrollment and contributes to consumer confusion.

However, data from the SBEs suggest that longer open enrollment periods increase enrollment among younger and healthier enrollees and therefore strengthen marketplace risk pools. Stronger risk pools mean lower premiums and less cost to the federal government.

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 consistent across all years and time periods: the later in the OEP that consumers enroll, the healthier they are.

New York's SBE has had similar results. In the final month of New York State of Health's 2017 OEP, which ended January 31, more than 135,000 individuals enrolled in marketplace health plans. New York found that younger enrollees made up a higher share of total enrollment than they did earlier in the OEP.

This proposed change in OEP dates will also impose significant costs on the FFE and SBEs. By CMS's own estimates, it would take each SBE 4,000 hours to develop and code changes to their IT systems, at a cost of almost $7.8 million. This estimate does not include the costs of outreach to consumers.

Reducing the length of OEPs will lower enrollment among the healthiest and youngest enrollees. Doing this could cause premiums to rise and federal expenditure on tax credits to climb, while also increasing administrative costs for the marketplaces.

Rather than finalize this proposal, we recommend maintaining the current OEP duration of November 1 through January 15 and continuing to provide SBEs with flexibility to determine their own OEP dates.

**Section III.B.8. Monthly Special Enrollment Period for APTC-Qualified Individuals with a Projected Household Income at or Below 150 Percent of FPL (Section 155.420)**

CBO estimates there were 4.4 million uninsured people in 2023 who were eligible for premium tax credits for coverage purchased through the marketplaces. To help these individuals, HHS in 2021 established a monthly special enrollment period (SEP) for people at or below 150 percent of poverty ($23,475 for an individual, $48,225 for a family of four). The availability of this SEP has helped low-income working people enroll in affordable health insurance coverage and get access to needed health care.

However, CMS suggests that this SEP (referred to here as the "low-income SEP") has contributed to improper enrollments, driven largely by unscrupulous brokers and web brokers seeking commissions. CMS also suggests that this SEP has increased adverse selection, leading to a less healthy risk pool. The agency also suggests that the low-income SEP lacks a statutory basis.

Federal officials have broad authority to create SEPs in the ACA marketplaces and have established several over time. These include SEPs for when people lose jobs along with their employer health insurance, become ineligible for Medicaid, or experience a life-changing event like marriage or divorce. While the proposed rule suggests that SEPs have been fraudulently used, the evidence shows that they have been chronically underutilized. One study found that each year an estimated 33.5 million people experience a life-changing event that ends their coverage and makes them eligible for an SEP, but fewer than 15 percent enroll in marketplace plans.

There isn't evidence that the low-income SEP has caused the increase in fraudulent enrollments experienced by the FFE in 2024. The cause of enrollments made without consumer consent can be traced to brokers and agents in the FFE who are taking advantage of system vulnerabilities that are unique to the FFE. Federal regulators have taken numerous steps to close system loopholes, increase oversight and enforcement, tighten verification procedures, and ameliorate harm to consumers. And there are more steps that can be taken. But preventing enrollment fraud by making it harder to enroll throws the baby out with the bathwater and fails to address the real source of the problem.

By CMS's own estimates, fraud associated with unauthorized enrollments and plan-switching for people with incomes under 150 percent of poverty is concentrated in states that have chosen not to expand Medicaid eligibility. There isn't evidence of any meaningful fraud in the SBE states, all but two of which have implemented the low-income SEP and made it available to consumers for a number of years. None of these SBEs have reported problems with fraud. Indeed, Covered California reports that SEPs have become a critical source of enrollment, with more consumers signing up via the SEP than during the annual OEP. Yet there is no evidence of any meaningful fraud, as Covered California has in place

comprehensive safeguards to ensure that brokers obtain consumer consent before completing an enrollment. Similarly, the Massachusetts Connector, which has long had a year-round SEP for low- and moderate-income individuals, has identified "zero consumer reports among the 1.2 million calls to its customer service center in 2024" of unauthorized enrollments.

The experience of SBEs suggests that the low-income SEP has not contributed to adverse selection. For example, Massachusetts has long offered year-round enrollment to people who qualify for Connector Care, their marketplace for low- and moderate-income individuals. Massachusetts Health Connector officials report they have "not experienced adverse selection within the program," and their "risk scores have been healthier than for insurers off-Marketplace."

The low-income SEP provides a path to coverage for millions of uninsured people who are eligible for subsidized coverage and need timely access to health care. Owing to the potential for this proposal to pose a barrier to people enrolling in coverage and obtaining needed care, we recommend not finalizing this proposal.

**Section III.B.9. Pre-enrollment Verification for Special Enrollment Period (Section 155.420(g))**

Given the multiple sources of health insurance coverage in the U.S., transitions in coverage are inevitable. Unfortunately, many people who experience life events that trigger a coverage transition, such as a job loss, spend time uninsured. In 2024, 12 percent of the U.S. adult working-age population experienced a gap in their health insurance.

SEPs are aimed at preventing such gaps in coverage, and federal and state policy ideally would aim to increase, rather than decrease, their use. As noted above, just 15 percent of the 33.5 million people who experience life-altering events that qualify them for a SEP actually use them.

Yet CMS proposes to impose additional documentation requirements on consumers seeking to enroll in marketplace coverage through a SEP. Additionally, although CMS has traditionally deferred to the SBE's knowledge of their local markets in their creation and use of SEPs, the proposed rule would require all marketplaces, including SBEs, to conduct pre-enrollment eligibility verification for at least 75 percent of new enrollments through SEPs.

The policy risks triggering further declines in Americans' use of the SEPs and driving up coverage gaps and uninsured rates. This would leave millions of people unable to pay for health care should they need it and expose them to catastrophic medical debt. A study of the Massachusetts health insurance exchange found that adding one additional step to the enrollment process prompted a 33 percent decline in enrollment, predominantly among young, healthy, and economically disadvantaged people. The effect was equivalent to a 57 percent increase in the annual premium. Removing paperwork burdens, on the other hand, has been found to significantly increase enrollment and continuity of coverage among healthy, younger individuals.

CMS projects $7.2 million in new costs to consumers complying with the new SEP verification standards. It projects one-time costs of $60 million for five SBEs to add verification standards and an annual new cost of $1,736,615 per SBE, not including costs associated with consumer communications, outreach, and assister training.

Given the persistence of coverage gaps in our health insurance system and the chronic underutilization of SEPs by the millions of people who are eligible for them, the proposed change would be administratively costly for little expected benefit.

**Section III.C.2. Premium Adjustment Percentage (Section 156.130(e))**

**Section III.C.3. Levels of Coverage (Actuarial Value) (Sections 156.140, 156.200, 156.400)**

Health care affordability is an ongoing concern for American working families. A 2023 survey found that more than half of working age adults said it was very or somewhat difficult to afford their health care costs, including 43 percent of adults with employer coverage and 57 percent of people in marketplace or individual market plans. A 2024 survey found that 23 percent of working age adults who were insured all year had such high out-of-pocket costs and deductibles relative to their incomes that they were underinsured. Of those, two-thirds were enrolled in employer health plans and 14 percent were in marketplace or individual market plans.

Rather than trying to improve the affordability and cost protection of commercial health insurance plans, which cover nearly 190 million people, the proposed rule makes changes that will raise premiums and out-of-pocket costs for consumers.

First, CMS proposes to change the rules for calculating the "premium adjustment percentage," a measure of premium growth used to make annual updates to several ACA coverage parameters. The change would result in higher out-of-pocket costs for individuals with commercial health insurance (including the estimated 160 million people with employer-based insurance), smaller premium tax credits for marketplace enrollees, and larger payments under the ACA's employer shared responsibility provision.

Under the ACA, the premium adjustment percentage is used to update the maximum annual limit on out-of-pocket costs under employer, marketplace, and individual market health plans. The Internal Revenue Service uses the premium adjustment percentage to update individual contributions for marketplace enrollees receiving the APTCs. It is also used for updating other ACA parameters, like the employer shared responsibility payment.

Under current regulations, the premium adjustment percentage measures premium growth by looking at changes in the cost of employer-sponsored coverage. CMS proposes changing the calculation to also include coverage in the individual market. But the premium adjustment percentage is intended to measure underlying trends in health insurance premiums, not the effect of the policy changes made in the individual market.

The change would result in a premium adjustment percentage that would be about 4.5 percent higher in 2026. This would result in higher annual limits on out-of-pocket costs for people in employer and marketplace plans and higher premiums for people who receive tax credits in the marketplaces compared to current policy. In 2026, the new approach would increase the annual out-of-pocket limit to $10,600 for self-only coverage and $21,200 for family coverage, a 15 percent increase over 2025, and a 4 percent increase over 2026 using the current methodology.

One study estimates that a family of four earning $85,000 a year would pay $313 more in premiums under the policy change, and $900 more in out-of-pocket costs, were it to reach the out-of-pocket maximum. This means that this family would pay more for less coverage.

The proposed rule could also increase out-of-pocket costs for marketplace enrollees by providing insurers with greater flexibility in meeting the actuarial value (AV) requirements for plans sold in the marketplaces. The AV of a plan is the average share of medical spending paid by the plan; it reflects a plan's cost-sharing elements, such as deductible size, copayments, coinsurance, and out-of-pocket limits. Plans sold in the marketplaces can fall into four AV tiers: bronze (60% AV), silver (70% AV), gold (80% AV), or platinum (90% AV). In addition, people with income under 250 percent of poverty are eligible for cost-sharing-reduction silver plans with AVs of 94 percent, 87 percent, and 73 percent. depending on income.

Because there may be differences in AV estimates for plans, the ACA grants HHS the flexibility to allow variation around these levels, or de minimis variation. Under the original regulations post-ACA, HHS limited de minimis variation to +2/–2 percentage points. During the first Trump administration, HHS changed the limits to +2/–4 for all plans and +5/–4 for bronze plans. The Biden administration subsequently changed the limits back to +2/–2 and, to better protect consumers in plans with the highest cost sharing, HHS changed the de minimis limits for bronze plans to +5/–2. In addition, HHS set limits on silver level plans of +2/0 and CRS silver plans of +1/0. This was to ensure that people enrolling in these plans received the full value of marketplace tax credits entitled to them by law.

Now HHS is proposing to revert to the limits of +5/–4 for bronze plans and +2/–4 for all plans beginning in 2026. In addition, it would drop the limit of +2/0 on silver plans and allow de minimis variation of +1/–1 for CSR plans. The rule acknowledges that these latter changes could decrease the amount of APTCs for some consumers, as well as increase out-of-pocket cost exposure across the marketplaces.

One study estimates that a silver plan with an AV of 66 percent, as opposed to 70 percent, would increase out-of-pocket costs for a family of four earning $85,000 by $714.

Given the likelihood of the proposed rule raising premiums and out-of-pocket costs for consumers, we recommend not finalizing this proposal.

We appreciate CMS's efforts to gain and respond to stakeholder input for this proposed rule. We encourage CMS to continue to seek input from a broad set of stakeholders, including state-based marketplaces, insurers, and researchers.

Please contact Sara R. Collins (src@cmwf.org) with any questions regarding our comments on the Marketplace Integrity and Affordability Proposed Rule. For general questions about this response or inquiries for the Commonwealth Fund, please contact Christina Ramsay (cr@cmwf.org).

Sincerely,

Sara Collins, Ph.D., Senior Scholar & Vice President, Health Care Coverage and Access & Tracking Health System Performance, The Commonwealth Fund

Christina Ramsay, M.P.H., Program Officer, Policy, The Commonwealth Fund

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

500 L'Enfant Plaza SW
Washington, DC 20024
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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

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[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.

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[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.

Center on Budget and Policy Priorities

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**April 11, 2025**

**To: Centers for Medicare & Medicaid Services (CMS), the Department of Health and Human Services (HHS)**

**RE: Proposed Rule, Patient Protection and Affordable Care Act (ACA); Marketplace Integrity and Affordability, CMS-9884-P**

To Whom it May Concern:

The Center on Budget and Policy Priorities (CBPP) is a nonpartisan research and policy organization that advances federal and state policies to help build a nation where everyone — regardless of income, race, ethnicity, sexual orientation, gender identity, ZIP code, immigration status, or disability status—has the resources they need to thrive and share in the nation's prosperity. Founded in 1981, the Center combines rigorous research and analysis and effective advocacy to shape debates and affect policy, both nationally and in states. We appreciate the opportunity to comment on this proposed rule.

The Affordable Care Act (ACA) has been a huge success in expanding health coverage to more people and improving people's access to care. It drove the uninsured rate down from 14.4 percent in 2013, before Medicaid expansion and financial assistance in the marketplace became available, to just below 8 percent in 2023.[1] But growth in marketplace enrollment since 2014 has been uneven. Enrollment grew from 8 million to 12 million people between 2014 and 2017, then stalled between 2017 and 2021 during President Trump's first term. After multiple efforts to repeal the ACA in Congress failed, the Trump Administration implemented a series of administrative changes that stifled marketplace enrollment; for example, the Administration sharply decreased resources for marketplace enrollment assistance and advertising, shortened enrollment periods, and instituted more restrictive marketplace enrollment procedures that made it harder for people to enroll.[2]

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[1] Thomas Buchmueller, *et al.*, "Improving Access to Affordable and Equitable Health Coverage: A Review from 2010 to 2024," ASPE Office of Health Policy, June 7, 2024, https://aspe.hhs.gov/sites/default/files/documents/9376755db2480ad7288aaa5ec38f3d8c/improving-access-to-coverage.pdf

[2] CBPP, "Sabotage Watch: Tracking Efforts to Undermine the ACA," February 2, 2021, https://www.cbpp.org/sabotage-watch.

Beginning in 2021, enhanced premium credits, greater federal investment in marketplace enrollment assistance and marketing, and policy changes designed to facilitate enrollment (including a return to longer enrollment periods and new special enrollment periods) contributed to a sharp increase in marketplace enrollment.[3] From 2021 to 2024, marketplace enrollment rose by 77 percent —from 12 million to more than 21 million.[4] Groups of people that have faced barriers to coverage in the past have seen some of the greatest gains from improved marketplace policies. Marketplace plan selections by Black people and Latino people roughly tripled between 2020 and 2024,[5] and people with incomes between the poverty level and twice the poverty level more than doubled during the same period.[6] Small business owners and self-employed people also accounted for a large and growing proportion of marketplace enrollees.[7]

Now, recent Administration actions are threatening these gains by slashing resources for enrollment assistance and through multiple policies proposed in this rule, which would create significant barriers to enrollment for eligible people and make coverage less affordable. For example, under the rule, people would need to submit new paperwork when tax return information is unavailable and when they attest to increased income above the poverty level, and people who qualify for a $0 premium and are automatically enrolled in a plan would be charged $5 per month that they don't owe for their coverage.

The Administration seeks to justify these new burdens on applicants by claiming that millions of people have been improperly enrolled by agents and brokers. Yet it does little to build on prior actions directed at unscrupulous agents and brokers, and it instead increases red tape and administrative burdens for people seeking coverage. CMS itself admits that "eligible enrollees may lose coverage as a result of the administrative burdens imposed by the provisions of this rule."

The rule proposes new interpretations of the ACA that seek to invalidate policies that increased enrollment by reducing administrative barriers. For example, the rule proposes to eliminate the special enrollment period (SEP) for people with low incomes and institute changes in how income is verified. The Administration attempts to justify another proposal to raise premium costs for most marketplace enrollees (via a change in the premium adjustment percentage), which it estimates would lead at least 80,000 people to drop coverage, by denying that making coverage accessible and affordable are proper policy objectives. These attempted justifications ignore the significant

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[3] Jennifer Sullivan, "Policies Designed to Strengthen ACA Marketplaces Succeed, But Are Under Threat," CBPP, March 3, 2025. https://www.cbpp.org/blog/policies-designed-to-strengthen-aca-marketplaces-succeed-but-are-under-threat

[4] Buchmueller, *op cit.*

[5] HHS, Office the Assistant Secretary for Planning and Evaluation, "HealthCare.gov Plan Selections by Race and Ethnicity, 2015-2024," https://aspe.hhs.gov/reports/healthcaregov-plan-selections-race-ethnicity-2015-2024

[6] CMS, "2024 Marketplace Open Enrollment Period Public Use Files," https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files

[7] Treasury Department, "Affordable Care Act Marketplace Coverage for the Self-Employed and Small Business Owners," Sept. 23, 2024. https://home.treasury.gov/system/files/131/ACA-Mkt-Coverage-Self-Employed-Small-Business-Owners-09232024.pdf

flexibility the ACA provides to implement its provisions in a manner aligned with the goals of the law: making coverage accessible and affordable.

The rule also unnecessarily requires state-based marketplaces (SBMs) to adopt many of the proposed changes, despite SBMs finding that longer and more open enrollment periods (OEPs), less burdensome verification practices, and other policies and practices they have adopted consistent with the statute have been effective for individuals and their markets and pose no issues in terms of program integrity.[8] Consistent with the statute and longstanding practice, CMS should continue to grant SBMs flexibility to go beyond federal standards for open and special enrollment periods, verification processes, and re-enrollment procedures in ways that strengthen access and protections for applicants and enrollees.

CMS's rush to make these proposed changes effective only adds to the uncertainty and chaos of the current moment. Most of the changes would take effect for the federally facilitated marketplace either immediately when the rule is final or for Plan Year (PY) 2026. Notably, the improved premium tax credits are scheduled to expire in late 2025 and impact people's premiums for 2026, unless legislation is enacted to extend them. With uncertainty about such legislation likely to continue further into this year, we urge CMS to reduce chaos and confusion in 2026 by delaying implementation of any proposed changes it finalizes from this rule until at least PY 2027.

As of this writing, more than 22,000 comments have been submitted on this proposed rule. Yet CMS already released a final actuarial value calculator on March 26 that treats some of the proposed changes (i.e., the changes to the premium adjustment percentage and *de minimis* ranges) as final, before the agency had a chance to consider commenters' views.[9] This, along with an abbreviated comment period of just 23 days (from publication of the proposed rule to the deadline of April 11), demonstrate a worrying lack of interest in collecting and analyzing public input. We urge the agency to extend the comment period so that commenters have the time to provide more detailed responses, including on CMS's request for comments on the Regulatory Impact Analysis.

Thank you for the opportunity to comment.

Sincerely,

Claire Heyison, Senior Policy Analyst
Sarah Lueck, Vice President for Health Policy
Gideon Lukens, Senior Fellow and Director of Research and Data Analysis
Nicole Rapfogel, Senior Policy Analyst
Jennifer Sullivan, Director of Health Coverage Access

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[8] State Health and 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.

[9] CMS, Center for Consumer Information & Insurance Oversight, "Revised Final 2026 Actuarial Value (AV) Calculator Methodology," March 26, 2025. https://www.cms.gov/files/document/revised-final-2026-av-calculator-methodology-002pdf.

*Justification for Harmful Policy Changes Rests on Flawed Analysis*

The proposed rule justifies many of its provisions by repeatedly referencing, as well as updating, estimates from a Paragon Health Institute report[10] that purported to find that 4-5 million people with incomes between 100 and 150 percent of the poverty level were improperly enrolled in the marketplace, getting higher premium tax credits (PTCs) than they should. But the methods employed by Paragon are flawed, and the 4-5 million estimate is baseless. While the rule acknowledges some of these flaws and solicits recommendations on how to improve the estimates, Paragon's analytical approach is fundamentally unsound and not capable of producing a credible estimate of improper enrollment even if improvements were made.

First, the Paragon analysis misinterprets the PTC eligibility process and ignores the role of income volatility. The PTC is structured to reduce people's premium costs as they incur them, which means that eligibility must be determined in advance. People generally project their incomes in the fall for the coming year, and eligibility is verified using electronic data when available. When people file their tax returns, their PTCs are recalculated based on actual income instead of projected income. Based on this recalculation, they may be able to claim a higher credit, or alternatively, must repay part of their credit. Inevitably, some people who reasonably project incomes between 100 and 150 percent of the federal poverty level (FPL) end up earning incomes outside of that range. That is especially true of people with volatile incomes, such as those in low-paid jobs with unpredictable hours, self-employed and gig economy workers, and people who experience a hardship like job loss or illness. So, if an individual projected their income to be $16,000 for the following year (just above the poverty level), and it turned out to be $15,000 (just below the poverty level), Paragon's analysis counts them as improperly enrolled, when in fact they were eligible for PTCs based on their expected income.

Second, the analysis ignores the fact that households and income are defined differently across the two data sets that it compares. The survey data definition includes all people living in the same household. For PTC eligibility, a household is limited to people who file taxes together on a single return, along with some dependent filers in other households. It is impossible to precisely adjust the survey household definition to the PTC eligibility definition, but methods to better align the two definitions lead to vast increases in the number of people with low incomes who would be counted as eligible for PTCs using Paragon's approach.[11] Likewise, a variety of income streams included in the survey data definition of household income are not included in the definition of income used to determine eligibility for PTCs. This makes many eligible PTC enrollees appear ineligible based on income measured using survey data.[12]

Third, the analysis improperly compares data from different years. Paragon used 2022 survey data to measure potential enrollment, a time when the pandemic-related Medicaid continuous coverage

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[10] Brian Blase and Drew Gonshorowski, "The Great Obamacare Enrollment Fraud," Paragon Health Institute, June 2024, https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud/.

[11] Alarcon et al., "Defining Family for Studies of Health Insurance Coverage," SHADAC, August 2021, https://shadac-pdf-files.s3.us-east-2.amazonaws.com/s3fs-public/publications/2021%20IHU%20Defining%20families%20brief.pdf.

[12] U.S. Treasury Department, "ACA Income Eligibility for Medicaid and the Exchange Subsidy: Comparing CPS and Administrative Tax Data," November 8, 2012, https://appam.confex.com/appam/2012/webprogram/Paper3086.html.

protection was in effect, meaning that many people remained in Medicaid even if their income or other eligibility factors changed. But Paragon used 2024 administrative data to measure marketplace enrollment after the continuous coverage protection expired, capturing data from a year when many people transitioned from Medicaid into marketplace plans. Many enrollees counted by Paragon as ineligible using 2022 data are in fact eligible in 2024. The proposed rule updates the analysis using survey data for 2023, but this does not solve the problem because it still captures a time when the continuous coverage protection was in effect or in the early stages of unwinding.

Finally, both coverage type and income in the American Community Survey (ACS) suffer from substantial measurement error. For instance, people with marketplace coverage often report they have something else, such as Medicaid.

Both the proposed rule and Paragon acknowledge some of these flaws. For example, Paragon notes that by using a consistent definition of income, Treasury estimates suggest "that 50 percent additional people could be between 100 percent and 150 percent of poverty…" compared to the ACS. Both the proposed rule and Paragon also discount their own estimates, stating that misestimation is acceptable because the analysis is focused more on comparisons across states. If that's the case, it's unclear why the proposed rule repeatedly references the 4-5 million nationwide estimates and uses that estimate to motivate broad, nationwide policies that reduce coverage and raise costs for nearly all marketplace enrollees.

As a result of these and other flaws, each of which has a huge impact on Paragon's calculation and the proposed rule's similar calculation, the headline number does not represent a meaningful – much less, accurate – estimate of anything. Many analysts have made data adjustments to survey definitions of income and households to better approximate the definitions used for eligibility purposes, but even these adjustments rest on complex and sometimes arbitrary assumptions and highly uncertain data imputations. They would improve some of the flaws but could not fix an analysis that directly compares counts in survey and administrative data in the manner of Paragon and the proposed rule's calculations. There is simply too much measurement error and guesswork: the ACS data will never be comparable enough to the CMS administrative data to make Paragon's approach analytically defensible.

Yet the rule uses Paragon's faulty calculations, and updates those calculations, to call for sweeping recommendations that would raise marketplace premium costs across the board and take away coverage from millions of people.

*Coverage Denials for Failure to Pay Premiums for Prior Coverage (§ 147.104(i))*

CMS proposes letting insurance companies deny coverage to people who have prior premium debt and to allow the companies to apply payments that an enrollee makes for a new policy to past debt before applying the payment to a new enrollment. This change would reinstate a harsher version of policies finalized under the previous Trump administration in 2017, undoing recent protections implemented in the Notice of Benefit and Payment Parameters (NBPP) for 2023. Unlike the policy in place under the previous Trump administration, which allowed insurance companies to only consider premium debt from the previous 12 months, this proposal does not limit the lookback

period, meaning that insurers could withhold coverage or charge people based on even older premium debt. This proposal would also allow issuers to attribute premium payments to debt owed to any other issuer in the same controlled group.

We oppose the proposed changes, which would violate the guaranteed availability requirement of the ACA, create barriers to coverage, and disproportionately affect people with low incomes. Section 2702 of the Public Health Services Act requires guaranteed availability of health coverage, establishing that issuers in a market "must accept" every employer and individual who applies with only some exceptions specified in statute. The 2017 rule incorrectly re-interpreted the statute to allow issuers to deny coverage to individuals or employers who owe past-due premiums to the issuer or another issuer in the same controlled group. There is no statutory exception to guaranteed availability that would permit issuers to delay or deny new coverage when a person has failed to pay premiums in the past. In other words, open enrollment is truly open – a chance to newly enroll in a plan regardless of prior premium debt. The legal right to guaranteed availability remains in place for both the individual and group markets.[13] CMS should therefore not finalize a new interpretation of this provision that conflicts with the law.

CMS states that recent enrollment data suggest people are "manipulating guaranteed availability and grace periods" but fails to provide evidence to substantiate this claim. Although the proportion of enrollees whose coverage was terminated due to nonpayment of premiums declined between 2017 and 2020, CMS notes that due to data limitations, CMS is unable to attribute changes in enrollment behavior to the previous policy that allowed issuers to deny coverage to people for nonpayment of premiums and to apply premium payments to past due premium debt.

CMS also claims that allowing issuers to apply premium payments made for a new policy to past-due premiums from a prior policy would strengthen the risk pool and lower gross premiums. CMS notes that when these policies were in effect between 2017-2022, they "may have" contributed to an improved risk pool by encouraging healthier people who may otherwise have dropped coverage to remain enrolled. However, CMS offers no evidence to support this claim, and we disagree that the policy would generally have the effect of keeping healthier people enrolled who may have otherwise stopped payment if they anticipated they would not need covered health services for the rest of the plan year. Individuals who have an acute need for health care services are more likely to attempt to comply with these requirements because for them the consequences of losing coverage are more severe.

CMS claims that enrollment loss from the proposed changes would be "minimal" because a large proportion of enrollees receive advance premium tax credits (APTCs) and therefore would not experience financial hardship because of the proposed changes. This is not accurate. Many people

[13] In 2012, HHS proposed a rule that would have continued to allow issuers in the small-group market to refuse to issue coverage to small employers if they could not meet minimum contribution or minimum participation requirements. In the final rule, HHS said that "after further consideration," issuers would not be permitted to deny new coverage to small employers because they failed to meet minimum participation or contribution requirements during the annual open enrollment period created by the ACA, because to do so would be a violation of the guaranteed availability provision. See Federal Register, Vol. 78, No. 39, February 27, 2013, pp. 13416. Issuers could refuse to *renew* coverage if a small business failed to meet minimum participation or contribution requirements (because these remained as exceptions to the guaranteed renewability provision post-ACA), but they could not refuse to issue new coverage within the annual open enrollment period.

who receive APTCs have very low incomes and lack the funds that would be needed to pay multiple months of past-due premiums while also paying the premium to effectuate coverage for a new year. As a result, under this proposal, such individuals would lose marketplace coverage. Of the 10.8 million enrollees in 2024 with income greater than 150 percent FPL (these individuals do not qualify for a $0 premium benchmark plan), more than half (57 percent) had income less than 250 percent FPL.[14] And, even individuals eligible for $0 premium plans may choose to enroll in a plan that requires them to pay a portion of the premium out of pocket. The implications of this proposed change could affect marketplace enrollees at any income level.

This proposal would impose a substantial burden on enrollees, both subsidized and unsubsidized, who may miss premium payments for a variety of reasons. Some people intentionally stop paying their premiums because their eligibility changes – for example, they become eligible for Medicaid – without understanding the need to terminate their marketplace plan or how to terminate it. People may be unaware they have entered a grace period and have built up premium debt, for example if an insurer fails to provide notice or the notice is unclear or never received. Others may be unable to pay in a particular month. In 2023, across people of all incomes, nearly one in three people had less than $500 in a checking or savings account,[15] and 18 percent of adults could not pay an emergency expense of $100.[16] The average monthly marketplace premium paid by enrollees in February 2024 was $105; one or two months of back premiums plus a binder payment for a new year of coverage could easily drain or exceed the savings of many individuals, and make it impossible for some to maintain coverage.

Under this CMS proposal, people in difficult financial straits would once again face the prospect of losing access to health coverage unless they can come up with whatever amount of money the insurer says they owe before the opportunity to enroll has passed. The impact of this change would be exacerbated by CMS's proposed plans to shorten the length of the annual OEP by 31 days, giving people significantly less time to come up with their past-due premiums and binder payment and complete the enrollment or reenrollment process.

It is reasonable for insurers to expect people to pay their share of premiums for the months that they provided coverage to an enrollee. But insurers already have recourse to collect back premiums from people who owe them by demanding payment and using debt collection processes. It is overly harsh to hold people's access to health coverage hostage in the meantime. Insurers are also protected under current rules because they can terminate coverage (after the applicable grace period), which generally limits the premium shortfall for the company to no more than one month. Insurers can also collect APTC for that month, which in most cases covers a large majority of the premium, particularly if most nonpayment occurs among lower-income people. In addition, for

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[14] CMS, 2024 marketplace open enrollment period public use files, https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files

[15] Consumer Financial Protection Bureau, "Making Ends Meet in 2023," December 2023, https://www.consumerfinance.gov/data-research/research-reports/making-ends-meet-in-2023-insights-from-the-making-ends-meet-survey/.

[16] Federal Reserve, "Report on the Economic Well-Being of U.S. Households in 2023," May 2024, https://www.federalreserve.gov/publications/files/2023-report-economic-well-being-us-households-202405.pdf

people enrolled in subsidized marketplace plans, insurers receive an average of more than 80 percent of the premium amount from the federal government.[17]

In the preamble, CMS says that the proposal "would not permit an issuer to condition the effectuation of new coverage on payment of past-due premiums by any individual other than the person contractually responsible for the payment of premium." This raises additional questions and concerns about the policy and its impact. For instance, if the policy is a child-only policy, is a child considered contractually responsible for the premium? If so, the premium debt for a family could block a child from getting coverage and could potentially follow a young person into adulthood and block them from getting coverage years into the future unless they pay up. In the marketplace context, is the "contractually responsible" person only the lead applicant or does this term extend to other members of the family covered on the same policy? For instance, if a member of a couple was the lead applicant and the couple later divorced and applied for coverage separately, would insurers be able to collect back premium debt from one or both parties before granting coverage? If the statement about "contractual" responsibility was intended to be a limitation on the impact of this harmful proposal, we note that no such limitation appears in the proposed rule text.

We urge CMS not to finalize this proposal. We note that allowing insurance companies to implement such a proposal in various ways (related to the lookback period, notice requirements, and other issues) raises risks that it will be applied unevenly, with the potential of greater harm to people with low incomes and pre-existing conditions, thus undermining uniform federal protections. CMS has proposed making this change effective when the rule is final; if the agency does opt to finalize it, we urge you not to make it effective until at least PY 2027.

*Definitions; Deferred Action for Childhood Arrivals (§ 155.20)*

We oppose the proposal to change the lawfully present definition that would end eligibility for people with Deferred Action for Childhood Arrivals (DACA) for purposes of enrollment in a QHP, eligibility for PTC, APTC, and cost-sharing reductions (CSRs), and for Basic Health Program (BHP) coverage. Deferred action is a long-standing administrative mechanism dating back to at least the 1960s. The current CMS rule recognizes that people with deferred action are indeed lawfully present in the U.S. and there is no reason to exclude people with this one category of deferred action from the definition of lawfully present.[18] This exclusion will unjustly keep people from affordable health coverage and will over-complicate the eligibility and enrollment processes.

CMS was correct in finalizing a rule that included people with DACA in the lawfully present definition. CMS has the authority to define who is lawfully present under the ACA. In writing the

[17] Effectuated Enrollment: Early 2024 Snapshot and Full Year 2023 Average, CMS, https://www.cms.gov/files/document/early-2024-and-full-year-2023-effectuated-enrollment-report.pdf

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

ACA, Congress expressed a broad aim to increase access to health coverage and by adopting a definition including people with DACA — as it includes all other forms of deferred action in its definition — CMS was acting in accordance with the ACA's goals. The DACA policy itself was intended to provide recipients with a degree of stability and assurance that would allow them to obtain education and lawful employment. Giving people with DACA the opportunity to purchase health coverage in ACA marketplaces is consistent with the goals of the policy that created DACA in the first place.

If CMS excludes people with DACA from the lawfully present definition, it will create confusion and administrative burden to disenroll those who have signed up for coverage and will overcomplicate future outreach and enrollment processes that will have to take this unusual exclusion into account. For example, all outreach and enrollment materials (including application questions) that describe who meets the immigration-related eligibility standard will have to include language indicating that while people with deferred action are eligible, those with deferred action for childhood arrivals are not. This is confusing for individuals with all types of deferred action and for the variety of people who conduct outreach and education about ACA enrollment including medical providers and community-based groups that don't have a lot of expertise in immigration policy.

We agree with CMS's decision to maintain the remaining provisions finalized in the 2024 rule that clarified the lawfully present standard. We agree that these technical changes and clarifications in the rule have minimal impact yet are helpful in creating a more workable application process and corrected the past interpretation that inadvertently excluded some narrow groups from enrolling in coverage despite having a lawful immigration status.

*Standards for Termination of an Agent's, Broker's, or Web-broker's Exchange Agreements for Cause (§155.220(g)(2))*

We are dismayed to learn that CMS has reversed suspensions of agents and brokers identified as enrolling people without authorization, as we continue to hear about cases of unauthorized enrollment by agents and brokers from enrollment assisters in federally facilitated marketplace states. We support clearer standards such that CMS can rapidly and objectively identify noncompliant agents, brokers, and web-brokers for termination, which we believe will help protect marketplace enrollees and members of the public from unauthorized enrollment in the future. Thus, we support the proposal to define the standard of proof required for CMS to assess agent, broker, and web-broker noncompliance with federal regulations as a "preponderance of the evidence" standard and to evoke enforcement authority if noncompliance is found. We believe this would be clearer than the current regulatory language and would give CMS more objective standards upon which to base any enforcement action.

However, we believe additional action is necessary to rein in ill-intentioned agents, brokers, and web-brokers, who are responsible for unauthorized enrollment activity in recent years. CMS claims to be "committed to holding noncompliant agents, brokers, and web-brokers accountable to protect Exchanges and consumers," but this "preponderance of the evidence" standard is the only provision in the rule that has direct implications for agents, brokers, and web-brokers. Evidence suggests that certain agents, brokers, web-brokers, and marketing firms have exploited existing marketplace and

PTC rules for their own personal financial gain.[19] Efforts to reduce unauthorized enrollment should make it harder for these individuals to exploit the system, not harder for eligible applicants and enrollees to get and retain coverage. Yet, most of the provisions in this proposed rule that CMS claims are necessary to reduce "improper enrollments" are directed at applicants and enrollees, who are not responsible for the recent rise in unauthorized enrollment.

We also note that many of the proposals in this rule that would harm eligible people's ability to enroll in or switch plans would apply in all states, including those with SBMs, even though there is no evidence of unauthorized enrollment in those states.[20] Unauthorized enrollment is a problem unique to states that use HealthCare.gov and is likely driven by vulnerabilities in the Direct Enrollment (DE) and Enhanced Direct Enrollment (EDE) pathways that are unique to HealthCare.gov; entities that stand to reap large financial benefit from generating fast commissions have identified ways to enroll people or switch them from one qualified health plan (QHP) to another without their knowledge or consent. Additionally, proliferation of third-party marketing organizations that earn money by generating "leads" for agents and brokers (or related DE or EDE entities) can convince people to share just enough information about themselves – name, zip code, and date of birth – that the information can then be used to enroll the person in marketplace coverage through HealthCare.gov.

We applaud CMS's actions over the past nine months to examine the sources of unauthorized enrollment, to assist people harmed by these breaches, and to make changes to HealthCare.gov to prevent future harm. Instead of placing additional challenges in the path of millions of eligible marketplace applicants and enrollees, CMS should take additional steps to rein in the ability of agents, brokers, and web-brokers to access and use individuals' personally identifiable information to change their plan or enroll them in a new plan without their knowledge or consent. CMS should:

- Require HealthCare.gov enrollees to specify which agents/agencies or brokers have permission to access their account information and block other agents/agencies or brokers from accessing the account. Enrollees should have the ability to add or remove specific agents or brokers from their list of approved entities at any time. If an agent or broker is not on the enrollee's list of approved entities, they should not be permitted access to the account.
- Require agents and brokers to share the individual's HealthCare.gov account login information and the HealthCare.gov call center phone number with all clients they assist.

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[19] Department of Justice, "President of Insurance Brokerage Firm and CEO of Marketing Company Charged in $161M Affordable Care Act Enrollment Fraud Scheme," February 19, 2025, https://www.justice.gov/opa/pr/president-insurance-brokerage-firm-and-ceo-marketing-company-charged-161m-affordable-care; CMS Statement on System Changes to Stop Unauthorized Agent and Broker Marketplace Activity, July 19, 2024, https://www.cms.gov/newsroom/press-releases/cms-statement-system-changes-stop-unauthorized-agent-and-broker-marketplace-activity

[20] Justin Giovannelli and Stacey Pogue, "Policymakers Can Protect Against Fraud in the ACA Marketplaces Without Hiking Premiums," Commonwealth Fund, March 5, 2025, https://www.commonwealthfund.org/blog/2025/policymakers-can-protect-against-fraud-aca-marketplaces-without-hiking-premiums

- Require EDEs to notify the applicant or enrollee when an agent or broker creates an account and/or generates login credentials on their behalf. CMS should also require EDE entities to allow applicants to start or modify their application online.
- Require agents and brokers to use CMS's recently updated model consent form and scripts for documenting consumers' review and consent.
- Hold individuals affected by unauthorized plan switches harmless for any medical bills that exceed the cost-sharing amount the person would otherwise have paid under the plan they actively chose.
- Add metrics to assess consumer experiences and outcomes as part of CMS's required pre-implementation audit and routine monitoring for EDE websites to assess compliance with business, privacy, and security requirements. Possible metrics could include rates of data matching issues (DMIs) or missing Social Security Numbers, rates of applicants who are eligible for CSRs that enroll in silver plans, and rates of mid-year plan changes. In addition, the audits should be expanded to include upstream EDE entities.
- Routinely monitor which enrollment platforms were used by enrollees who receive an SEP because of misrepresentation or misconduct by entities providing enrollment assistance.
- Require HealthCare.gov to send enrollees notices about plan changes and include information about what the enrollee should do if they did not authorize the change.
- Continue to invest in robust marketing of HealthCare.gov, especially during open enrollment, and take additional steps to improve HealthCare.gov's search engine optimization, to help people who are looking for health insurance find the correct website and reduce chances that people will be misled into sharing their personal information with scam websites (which can then sell or misuse their data).
- Modify the Find Local Help portion of HealthCare.gov, making it clearer that (1) agents and brokers are paid through commissions and may have financial incentives to recommend one plan over another; and (2) that Navigators and assisters are not compensated based on enrollment volume and must provide non-biased information and help with the full scope of enrollment in insurance affordability programs, including Medicaid.
- Enhance the HealthCare.gov website to allow agents, brokers, Navigators, and Certified Application Counselors (CACs) to create dashboards to more easily track enrollment activity among individuals they assist. This would allow all enrollment assisters to conduct better outreach from one year to the next, to provide more individualized service, and to detect unauthorized enrollment activity earlier, and would add new efficiencies for Navigators. A 2022 survey of agents and brokers found that 60 percent of brokers who use private websites to enroll people in ACA marketplace coverage say they would use HealthCare.gov if it offered similar functionality to these private websites.[23] If agents and brokers saw HealthCare.gov as a competitive alternative to private enrollment websites, this could help reduce unauthorized enrollment activity.

*Failure to File Taxes and Reconcile APTC Process (§ 155.305(f)(4))*

We oppose the proposal to revoke the existing requirement that marketplaces find an individual ineligible for APTC if the individual has not reconciled their APTC for two-consecutive tax years

(referred to as "failure to reconcile" or FTR). CMS proposes modifying the FTR requirement to apply to individuals who have not reconciled their APTC for one tax year.

The FTR policy is not a statutory requirement, and we continue to believe that it is excessively punitive to withhold affordable health coverage as a tax enforcement measure when the Internal Revenue Service (IRS) has all its standard tax enforcement tools available. In previous rulemaking, CMS acknowledged that the FTR policy is burdensome both for enrollees and marketplaces and could result in enrollees losing access to affordable coverage due to inaccurate data or a misunderstanding of the requirement.[21] Many people are flagged unnecessarily, in part because the data transferred to the marketplace by the IRS is not fully up to date and may not capture people who filed their tax return late or by mail. These delays are likely to grow given the administration has reportedly ordered a hiring freeze and large-scale staff reductions at the IRS.[22]

Further, it is inappropriate to withhold affordable coverage as a program integrity measure. ACA marketplaces already utilize several mechanisms to ensure program integrity, including identity verification, data matching, and internal financial controls. The FTR policy is also redundant to existing IRS capabilities to recoup unpaid tax obligations. When a person who has claimed APTC does not file or submits their tax return without reconciling APTC, the taxpayer receives notice of their need to reconcile (a 12C letter). The IRS also can reconcile the APTC by issuing a substitute return (an IRS-generated return prepared for non-filers with a filing requirement) or through the collections process, with standard financial penalties.

We disagree with CMS's assertion that people are incentivized to not file and reconcile because they are allowed to continue receiving APTC for an additional year without filing. In our experience working with marketplace enrollees and enrollment assisters, enrollees typically do not know the details of marketplace rules, particularly new rules like the two-year FTR policy (which CMS just began to implement in 2024), nor do people learn the interlocking effects of multiple complex rules (like FTR and APTC repayment caps) for purposes of gaming the system for personal gain. As explained above, there are many reasons why the relatively small number of marketplace enrollees with FTR status do not file and reconcile, and sufficient enforcement tools already exist for the IRS to recoup unpaid taxes from tax filers without CMS also withholding access to marketplace health insurance through an FTR process.

We therefore maintain our position that there is little cause to continue to rely on the FTR process at all, given its flaws. The harm of the policy outweighs any benefit. There is certainly no cause to take away coverage from people more quickly than the current 2-year FTR policy already does.

Should CMS choose to move forward with resuming the FTR process as proposed, the agency should track information on the impact of the FTR policy by race/ethnicity, household income, and

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[21] Proposed NBPP for 2024, December 21, 2022. https://www.govinfo.gov/content/pkg/FR-2022-12-21/pdf/2022-27206.pdf

[22] Josephine Cureton, "Targeting of the IRS Undermines DOGE's Supposed Goals," CBPP, March 24, 2025, https://www.cbpp.org/timelines/executive-action-watch/29718; Fatima Hussein, "The IRS is drafting plans to cut as much as half of its 90,000-person workforce, AP sources say," March 4, 2025, https://apnews.com/article/irs-doge-layoffs-tax-season-0659e4b439400bf66023273f6a532fa0.

other demographic factors to determine whether certain groups are more likely to lose marketplace coverage because of a one-year FTR process.

Finally, we recommend that if CMS chooses to implement this policy as proposed, sufficient time should be provided to update marketplace systems. When CMS restarted FTR on a two-year basis, it took more than a year between when the change was finalized and when the systems changes needed to go live with the process were complete. At least as much time should be provided for this change, particularly for SBMs.

*60-Day Extension to Resolve Income Inconsistency (§ 155.315)*

CMS proposes to eliminate the automatic 60-day extension currently granted to people with a DMI for household income. We oppose this proposed change.

At the time the 60-day automatic extension was proposed, CMS noted that the 90-day DMI resolution period is often an insufficient amount of time for applicants to provide documents, for CMS to review the documents and request additional information if needed, and for the applicant to obtain and submit the additional documentation.

CMS also noted at that time that the automatic 60-day extension was expected to improve the risk pool. People who do not have an immediate health care need are less likely to complete onerous documentation processes; providing people extra time to verify income increases the likelihood that they will complete the process successfully and maintain their APTC. People who lose APTC because they do not resolve a DMI on time are less likely to remain covered because they cannot afford their premiums without the APTC. And CMS notes that the age group most likely to lose their APTC due to an expired income DMI are young people ages 25-35, a group with a lower health risk profile. If the proposal is finalized, we expect these individuals will be more likely to drop marketplace coverage. This will negatively impact the risk pool, increasing premiums for both subsidized and unsubsidized enrollees.

Providing acceptable verification of projected income, particularly for jobs that may be seasonal, for self-employment, and/or for multiple members of a household can be a complex, time-consuming process. As CMS has previously noted, marketplace applicants with low incomes are disproportionately likely to experience an income DMI and less likely to successfully resolve it. While the proposal would reinstate the availability of extensions to the DMI resolution period if the applicant requests it and has demonstrated a good faith effort to resolve the DMI during the 90-day resolution period, removing the automatic extension disproportionately burdens applicants with low incomes.

We disagree with the CMS's assertion that the automatic extension did not provide meaningful benefit to consumers and weakened program integrity. CMS states that a similar proportion of people resolved their DMI during the 60-day extension period in 2024 as did in 2022 before the automatic extension was in place. But the proportion in 2024 could have been lower had the automatic extensions not been in place. CMS should also provide data on the proportion of DMIs resolved during the extension period for multiple years, which would provide a clearer picture of long-term trends.

*Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§155.320(c)(3)(iii))*

CMS proposes to require marketplaces to generate an income inconsistency for applicants who attest to household income between 100 and 400 percent of FPL but for whom other data available to the marketplace indicate the individual has income less than 100 percent of FPL. We oppose this proposal.

CMS notes that some agents, brokers, and web-brokers are propelling unauthorized enrollment, but this proposal would make the enrollment process more difficult for *all* applicants (including applicants in states with SBMs, where unauthorized enrollment is virtually unheard of). This would cause more people to go uninsured and harm the risk pool, while failing to target the entities responsible for unauthorized enrollments. The United States District Court for the District of Maryland decided *City of Columbus, et al. v. Cochran*, No. 523 F. Supp. 3d 731 (D. Md. 2021) and vacated earlier CMS revisions to income verification, stating that "CMS's decision to prioritize a hypothetical risk of fraud over the substantiated risk that its decision result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic." CMS claims that the circumstances have changed since this decision in ways that justify reimposing burdensome income verification requirements. We strongly disagree. CMS asserts that an unacceptable number of applicants – "potentially millions of applicants" – purposefully inflate their income to qualify for APTC, but as noted above, this claim rests on a flawed analysis.

This proposal would increase the number of marketplace applicants who must submit paperwork to resolve a DMI. Increasing paperwork requirements poses an administrative barrier that makes it less likely that applicants will complete the process and maintain coverage, particularly healthy applicants without an immediate health care need, who may opt to forgo enrollment altogether because of the time and hassle required to submit verification paperwork. Previously, CMS has shared data suggesting that income DMIs have a negative impact on access to coverage, health equity, and the risk pool. Data from PY 2022 demonstrate that income DMIs have a disproportionate impact on households with attested income less than $25,000. CMS has also previously shared data showing that income DMI expirations are "higher than expected" among Black or African American consumers and that younger people (in the 25 to 35 age range) were the age group most likely to lose their APTC eligibility because of an income DMI. A policy that presents barriers to coverage for people with low incomes, Black people, and younger people is problematic, as these groups have historically had higher uninsurance rates than average.

It can be difficult for people with very low income to obtain written documentation of their income projections. Many people with low incomes work part-time or in hourly positions, where an employer may be reluctant to certify anticipated year-end income. Many people rely on multiple part-time or part-year jobs, including people who depend on seasonal employment at the end of the year to make ends meet. Many work in cash industries, such as food service, where tip-income makes up the largest portion of their earnings. In all these cases, documentation from an employer may be hard to obtain, which could lead to loss of APTC and loss of insurance for working individuals.

Regardless of someone's ability to gather statements from employers to justify the income attestation, the process itself may be too confusing or daunting for people to pursue. This is particularly true of people with low literacy or numeracy.

Creating additional administrative hurdles could have a potentially large impact on marketplace enrollment. In 2024, approximately 44 percent of marketplace enrollees had income between 100 and 150 percent of poverty, and many likely had income that fell below the poverty line in certain months of the year. Having a volatile or difficult-to-document income should not be conflated with an intentional attempt to mischaracterize income. If an individual makes an inaccurate projection of their income, they will be responsible for repaying any APTC received for which they are ultimately ineligible, up to the relevant repayment cap for their income. The APTC repayment caps exist to protect low-income enrollees from large, unexpected tax bills; CMS does not provide evidence to substantiate its claim that enrollees are intentionally misstating income with knowledge of the repayment caps to evade paying higher premiums for coverage. Reports from enrollment assisters and research on health insurance literacy suggest that many enrollees struggle to understand even basic insurance concepts such as deductibles and out-of-pocket costs, let alone the complexities of APTC eligibility or repayment rules.[23]

CMS requests comments on the reasonable compatibility threshold. We support maintaining the current threshold, in which the marketplace accepts an individual's income attestation if the difference between the attestation and the income available in the data hub is within 50 percent of the income information available in the data hub or is $12,000 or less. We oppose any efforts to narrow the reasonable compatibility threshold. Lowering the percentage would have a disproportionate impact on people with low incomes. Proving that income is within, for example, 25 percent of $15,000 (roughly the FPL for an individual for the 2025 coverage year), means someone has to come within $3,750 of their attested income, while someone with attested income of $60,000 (roughly four times FPL for and individual for the 2025 coverage year) has a $15,000 window. The current use of a wide percentage band (50 percent) paired with a set dollar amount is a fair approach. It provides a reasonable income band for applicants with low incomes, while also capping the range for higher income applicants.

*Income Verification When Tax Data is Unavailable (§ 155.320(c)(5))*

We oppose the proposal to require people to provide documentation to verify income if the IRS does not have tax return data available for the individual. Currently individuals in this circumstance are permitted to attest to projected annual income, rather than the situation triggering an income DMI.

As CMS has stated previously, there are many reasons that the IRS may not have tax return data for an individual including changes in family composition, changes in filing status, name changes, and an individual not having a filing requirement for the year in question. This proposed change

[23] Jean Edward, Amanda Wiggins, Malea Hoepft Young, and Mary Kay Rayens, "Significant Disparities Exist in Consumer Health Insurance Literacy: Implications for Health Care Reform," *Health Literacy Research and Practice*. 2019 Nov 5;3(4):e250–e258, https://pmc.ncbi.nlm.nih.gov/articles/PMC6831506/

would undo recent simplifications, shifting the burden back onto applicants. CMS suggests that verifying income for individuals in this situation is necessary to protect individuals from accumulating unnecessary tax liabilities. But the APTC eligibility system is based on a projection of future income, with processes in place to reconcile tax liabilities the following year, based on actual income. Triggering income DMIs for individuals in this situation adds an administrative burden at the time of enrollment, which may deter the individual from completing the process, but it does not protect the individual from tax liabilities; income can still change throughout the year.

CMS says it believes that allowing marketplaces to accept attestation of projected income from individuals when tax data are not available "played a key role in weakening the Exchange eligibility system," but provides no further evidence to support this statement. Bad-actor agents, brokers, and web-brokers have no way to know whether IRS data are available for an individual and no mechanism for targeting this group for unauthorized enrollment.

If finalized as proposed, this requirement would result in an increase in income DMIs that are harder to resolve (given the same reasons for not having tax data), which could weaken the risk pool and result in fewer eligible individuals completing the enrollment process when they find the new obstacles insurmountable. And for some number of people with immediate health care needs, the proposed policy would reinstate a barrier to enrollment that individuals with immediate health care needs would be more likely to resolve than other individuals, which would result in fewer eligible individuals completing the enrollment process, contrary to the goals of the ACA.

CMS also claims that prior to 2024, half of all resolved income DMIs generated as a result of IRS data being unavailable for a person were resolved within 90 days and cites this as proof that the process successfully stopped ineligible people from enrolling. However, CMS does not offer data to support this statement; a person cannot be assumed to be ineligible simply because they fail to resolve a DMI. CMS should provide additional data, such as the number of income DMIs generated (prior to 2024) because IRS data were unavailable for a person, the resolution rate for these kinds of DMIs, and information about the attested income versus actual income of those individuals to provide at least some supporting evidence that their attestation was so off-target as to be considered fraudulent.

We disagree with CMS's claim that the current policy violates statutory requirements for verifying income and addressing income inconsistencies under the ACA. Section 1411(c)(4)(B) of the ACA does in fact provide broad flexibility to modify verification methods when such modifications will reduce the administrative costs and burdens on the applicant. The statute outlines a variety of steps related to the exchange and verification of information (including the DMI process) and then clearly grants the Secretary flexibility when the process might otherwise burden applicants or when the methods of exchange and verification can be simplified to the benefit of applicants. In addition, current rules for accepting applicant attestation of projected income do not suspend the verification process, as the proposed rule claims. Requiring applicants to attest under penalty of perjury to their projection of income for the coming year and checking that information against available data sources for any conflicting information is a reasonable method of collecting income information, similar to widely used self-attestation practices in Medicaid.

*Annual Eligibility Redetermination (§ 155.335)*

We strongly oppose CMS's proposal to charge some people a premium they do not owe if they are automatically re-enrolled into a marketplace plan. Under this proposal, people who enroll in a plan that costs $0 after APTC is applied would instead be charged $5 a month if they are automatically re-enrolled in coverage, until they return to the marketplace to update their information and actively select a plan. In the proposed rule, CMS notes that when a similar change was proposed in the 2021 NBPP, all but one commenter opposed it. This proposal would cause confusion among enrollees, resulting in overpayment and coverage loss. At no point during the past 11 years have marketplace enrollees been penalized for failing to actively re-enroll in a plan. Moreover, many marketplace enrollees are likely familiar with auto re-enrollment processes through employer sponsored insurance (ESI) or Medicaid Managed Care, which do not penalize people who do not to actively select a plan during open enrollment (for ESI) or at the end of the year (for Medicaid). Many people who enroll in a plan with a $0 premium and are charged $5 a month will likely assume that their premiums increased and could pay insurance companies up to $60 a year in premiums that they do not owe. Others will assume that they will continue to owe $0 a month and lose coverage after their three-month grace period. These individuals would be locked out of marketplace coverage until the next OEP, unless they qualify for an SEP.

This proposal would cause particularly severe coverage losses among people who are automatically re-enrolled into a plan offered by a different issuer than the plan that they had in the previous year (this can happen if no health plans offered by the same issuer are available).[24] CMS has confirmed that the $5 additional premium would be considered a binder payment.[25] Because the proposed rule would shorten the OEP such that it would end on December 15, this means that enrollees would have as little as two weeks – during the holiday season – to figure out why they were charged an additional $5 premium and either pay it or update their information. If they fail to do so, they will lose coverage for the entire year.

The change would put people with low incomes at risk of coverage loss unnecessarily. With the enhanced premium subsidies in place, people with incomes between 100 and 150 percent FPL are eligible for at least two silver plans and multiple bronze plans with a $0 net premium. If the enhanced PTCs expire at the end of 2025, lower-income consumers would still be more likely to be

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[24] When a person is automatically re-enrolled into a QHP, the marketplace will prioritize re-enrolling them in the same QHP as they had the previous year. If that QHP is no longer available, the marketplace will automatically re-enroll the person into a QHP that is as similar as possible to the plan they had the previous year. However, if no health plans from the same issuer are available, the marketplace may automatically re-enroll a person in a plan offered by a different issuer. If a person is automatically re-enrolled into a QHP offered by the same issuer as the plan they had the previous year, they will be eligible for a grace period of up to three months if they do not pay their first month's premium in full by the payment due date. If the person has not paid their full past-due premium amount by the end of the grace period, their coverage will be terminated. However, if a person is automatically re-enrolled into a QHP offered by a different issuer, they must pay the first month's premium to effectuate coverage (this is sometimes known as a binder payment). If the person fails to pay the binder payment in full by the payment due date (typically January 1), their coverage for the entire year will be terminated. See 45 CFR § 155.335(j).

[25] "For consumers who were alternately enrolled to a different issuer because their current year coverage is no longer available through the FFE, they would be subject to a binder payment. Thus, if they did not pay the binder by the payment deadline, their future year coverage would be cancelled." Email on file with CBPP.

offered a $0 net premium plan because they receive a higher income-based subsidy that can stretch to cover the full cost of a plan. For example, data from the OEP for PY 2021 (the last open enrollment before the enhanced PTCs went into effect), show that a 40-year-old person with income of $20,000 could get a $0 net premium plan in 84 percent of counties, compared to one percent of counties for a similar person making $40,000.[26]

CMS says that enrollees are unlikely to be terminated for nonpayment of premiums due to this provision because the amount of the adjusted premium is low. However, in the 2026 NBPP, the agency noted that in 2023, 81,383 enrollees lost coverage due to nonpayment of premium amounts of $5 or less.[27] That number would likely be much higher if it included people who enrolled in plans with a $0 net premium.[28]

Moreover, there are already reasonable limits on auto re-enrollment. Currently, marketplace enrollees who do not actively select a health plan at the end of the year are automatically re-enrolled into the same or a similar health plan for the following year. In these instances, the marketplace uses tax data to redetermine eligibility and adjust APTC amounts. People who fail to actively re-enroll for two consecutive years and have no recent income data are required to return to the marketplace and update their application.

CMS fails to address key operational considerations that this proposal would involve. For example, it is not clear how the marketplace would be able to charge the additional $5 premium, as people enrolled in a $0 net premium plan do not need to input payment information when they enroll in coverage. Issuers could mail people a bill, but this mechanism would not necessarily be more effective at informing people that they were automatically re-enrolled compared to current practice; enrollees already receive multiple letters during open enrollment encouraging them to return to the marketplace to select a plan, as well as communications from issuers after automatic re-enrollment.

The justification for this proposal is highly flawed. In the proposed rule, CMS states that, "Because enrollees [who are automatically re-enrolled into a plan with a net $0 premium] do not receive a monthly premium bill requiring action on their part, they may not be aware they are enrolled. This lack of awareness allows agents, brokers, and web-brokers to continue earning monthly commission payments from issuers for these enrollments." But our understanding, as noted previously, is that people who select a plan with a $0 net premium receive notices from the plan issuer after enrolling.

Furthermore, CMS suggests that automatic re-enrollment is damaging to consumers because people are being automatically re-enrolled into marketplace coverage without their knowledge,

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[26] Daniel McDermott and Cynthia Cox, "How ACA Marketplace Premiums Are Changing by County in 2021," KFF, November 11, 2020. https://web.archive.org/web/20201112000827/https://www.kff.org/private-insurance/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2021/.

[27] "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2026; and Basic Health Program, CMS-9888-F," January 15, 2025, https://www.federalregister.gov/documents/2025/01/15/2025-00640/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2026-and.

[28] In the proposed rule, CMS states that "2.68 million enrollees were automatically re-enrolled in a QHP for benefit year 2025 with APTC that fully covered their premium."

despite having insurance through other sources. To support this claim, CMS cites evidence that the Medicaid continuous coverage provision temporarily increased multiple sources of coverage. However, there is no such evidence that automatic re-enrollment in the marketplaces increased multiple sources of coverage for people with subsidized QHP coverage.

First, studies of the Medicaid continuous coverage provision link people's actual coverage with self-reports to provide evidence that the temporary continuous coverage provision led to dual enrollment of Medicaid enrollees. There is no such study for QHP enrollment. Instead of citing research, CMS tabulates survey data purporting to show an increase in undercounting of subsidized QHP enrollment. But even this circuitous logic is flawed: subsidized QHP enrollment is so poorly measured in surveys that most organizations don't bother to tabulate it.[29]

CMS also cites Congressional Budget Office (CBO) projections of increases in dual enrollment. But this too relates to the temporary Medicaid continuous coverage provision, not QHP enrollment. CBO projects that the number of enrollees with multiple sources of coverage has already dropped to 20.1 million in 2025, down from 28.7 million in 2023 at the start of Medicaid unwinding and will remain relatively flat thereafter.[30] During this 2025 and later period of flat enrollment in multiple sources of coverage, CBO projects a drop in subsidized marketplace enrollment from 21.3 million in 2025 to 13.4 million by 2030. In short, the timing of the increase and decrease in multiple enrollment lines up with the Medicaid continuous coverage provision, not with provisions driving QHP enrollment.

Should CMS finalize this proposal, we urge the agency to update the Eligibility Determination Notice and the Marketplace Open Enrollment and Annual Redetermination Notices to explain the consequences of automatic renewal for people with $0 premium plans. CMS should also ensure the ACA marketplace call center is adequately staffed, as people will undoubtably be confused about why they owe a $5 premium or lost coverage after enrolling in a plan with a $0 net premium.

The proposed rule also solicits comments on more extreme proposals that would disallow APTC for people who automatically re-enroll in marketplace coverage (as was proposed in the 2021 NBPP) or eliminate auto-reenrollment entirely for people who receive any amount of APTC. These proposals are unduly punitive and would cause large scale coverage loss. In 2024, approximately 6.6 million people were automatically re-enrolled in marketplace coverage, representing 31 percent of people who enrolled in a marketplace plan during the OEP.[31] As CMS stated in its 2021 Payment Notice, these proposals would likely increase premiums because people who are automatically re-

[29] For example: KFF, "State Health Facts: Health Insurance Coverage of the Total Population," 2023, https://www.kff.org/other/state-indicator/total-population/.

[30] CBO, "Health Insurance and Its Federal Subsidies: CBO and JCT's June 2024 Baseline Projections," June 2024, https://www.cbo.gov/system/files/2024-06/51298-2024-06-healthinsurance.pdf.

[31] CMS, "2024 OEP State-Level Public Use File," https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files.

enrolled in a health plan are expected to be healthier than those who return to the marketplace each year to actively select a plan.[32]

As we noted in our comment on the proposed 2021 NBPP, there are serious questions about whether this proposal is legal at all under §§ 1411 and 1412 of the Affordable Care Act. Section 1411 is the sole source of authority for marketplaces to make an eligibility determination for APTC, and section 1412 is the sole source of authority to pay (or not pay) APTC. The statute provides no pathway by which an Exchange can lawfully provide an amount of APTC that differs from the amount that an enrollee is eligible to receive.

*Annual Eligibility Redetermination (§ 155.335(j))*

We oppose CMS's proposal to rescind the ability for marketplaces to automatically re-enroll bronze QHP enrollees who are eligible for CSRs into a silver QHP with a lower or equivalent net premium under the same product and QHP issuer even if the enrollee's previous bronze plan is available. Under current regulations, CSR-eligible enrollees who are "crosswalked" from a bronze plan to a silver plan pay equivalent or lower premium costs and experience significantly lower out-of-pocket costs under their new plan, with minimal or no changes to their plan's design or network. For example, in 2025, the median deductible for a silver plan for a CSR-eligible enrollee with income below 150 percent FPL is just $9, compared to $7,323 under a bronze plan.[33]

Choosing a health insurance plan is complicated, especially in the nongroup market where people have, on average, a hundred plan options to choose from.[34] One study of more than 15,000 adults found that just over half had low health insurance literacy, as measured by knowledge of basic insurance terms like "premium," "deductible," and "maximum annual out-of-pocket spending." More than half of respondents did not know the deductible amount for their current insurance plan.[35] A separate study found that people who self-reported as having low health insurance literacy were more likely to report poor experiences enrolling in nongroup coverage, with nearly half reporting that they spent more than two hours selecting a plan.[36] In a small, qualitative study of people enrolled in nongroup coverage, respondents shared that the task of synthesizing a large amount of information from multiple sources resulted in information overload and frustration. People with low health insurance literacy were more likely to "forgo researching plans, default to

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[32] Katie Keith, "ACA Round-Up: Risk Adjustment, Exchange Blueprint, SHOP, And New Memo," Health Affairs, June 24, 4019, https://www.healthaffairs.org/content/forefront/aca-round-up-risk-adjustment-exchange-blueprint-shop-and-new-memo.

[33] CCIIO, "Plan Year 2025 Qualified Health Plan Choice and Premiums in HealthCare.gov Marketplaces," October 25, 2024, https://www.cms.gov/files/document/2025-qhp-premiums-choice-report.pdf.

[34] *Ibid.*

[35] Edward J, Wiggins A, Young MH, Rayens MK. Significant Disparities Exist in Consumer Health Insurance Literacy: Implications for Health Care Reform. *Health Lit Res Pract.* 2019 Nov 5;3(4):e250-e258. doi: 10.3928/24748307-20190923-01.

[36] Hero JO, Sinaiko AD, Kingsdale J, Gruver RS, Galbraith AA. Decision-Making Experiences Of Consumers Choosing Individual-Market Health Insurance Plans. *Health Aff (Millwood).* 2019 Mar;38(3):464-472. doi: 10.1377/hlthaff.2018.05036.

remaining in their existing plan, or choose randomly among low-premium plans."[37] Low health insurance literacy and difficulty selecting a plan could explain why many marketplace enrollees with greater health care needs (as measured by the CMS Hierarchical Condition Category risk score) enroll in less generous coverage, exposing themselves to high out-of-pocket costs.[38] Removing the bronze-to-silver crosswalk will make selecting a plan more difficult and expose people to greater out-of-pocket costs unnecessarily. Marketplace enrollees who are more likely to have low health insurance literacy – including people with low incomes and people with limited English proficiency[39] – are more likely to be helped by navigators[40] and will face additional challenges in plan selection due to CMS's decision to cut navigator funding by 90 percent.

The bronze to silver crosswalk policy is meant to ameliorate the high financial cost of enrolling in a suboptimal plan, and data from SBMs shows that it works. In 2022, Covered California implemented a bronze to silver crosswalk policy, recognizing that many people enrolled in bronze plans could enroll in a silver CSR plan with the equivalent or lower premiums. After the crosswalk, 93 percent of eligible enrollees were in silver CSR plans.[41] A separate analysis predicted this policy would reduce enrollees' deductibles by $2,000 and save enrollees $1,200 in annual premium costs, on average.[42]

CMS now has data on the bronze-to-silver crosswalk policy in the federally facilitated marketplace (FFM) from two OEPs but does not cite any of that data to support its proposed changes. Instead, CMS assumes that increased enrollment in QHPs means that more people are aware they can access a more generous silver plan at a lower cost, reducing the need for a bronze-to-silver crosswalk. But people can be aware that marketplace coverage is more affordable than it has been in previous years without understanding that silver plans generally provide greater value than bronze plans. CMS also states that removing the bronze-to-silver crosswalk policy would be beneficial, as it would protect enrollees from APTC repayment liability should their income increase mid-year. However, auto-reenrolling from one bronze plan into another can also increase a person's tax liability if the person

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[37] Faugno E, Gilkey MB, Cripps LA, et al. "Pick a Plan and Roll the Dice": A qualitative study of consumer experiences selecting a health plan in the non-group market. Health Policy Open. 2023 Dec 2;5:100112. doi: 10.1016/j.hpopen.2023.100112.

[38] This study was conducted before the enhanced PTCs went into effect, so premium costs likely also contributed to the phenomenon of people with greater health needs selecting bronze plans. Treasure G, Anderson DM, Hatcher L, et al. Plan Selection, Enrollee Risk, and Health Spending on the Patient Protection and Affordable Care Act Individual Marketplaces, 2019. *JAMA Netw Open.* 2023;6(3):e234529. doi:10.1001/jamanetworkopen.2023.4529.

[39] Edward J, Wiggins A, Young MH, Rayens MK. Significant Disparities Exist in Consumer Health Insurance Literacy: Implications for Health Care Reform. *Health Lit Res Pract.* 2019 Nov 5;3(4):e250-e258. doi: 10.3928/24748307-20190923-01.

[40] Karen Pollitz, Jennifer Tolbert, Kaye Pestaina, and Salem Mengistu, "2022 Survey of ACA Marketplace Assister Programs and Brokers," KFF, October 17, 2022, https://www.kff.org/affordable-care-act/report/2022-survey-of-aca-marketplace-assister-programs-and-brokers/.

[41] Jessica Altman, "Executive Director's Report," Covered California, November 17, 2022, https://board.coveredca.com/meetings/2022/November/ED%20Report%20-%20November%202022%20-%20Final.pdf.

[42] David M Anderson, Petra W Rasmussen, Coleman Drake, "Estimated Plan Enrollment Outcomes After Changes to US Health Insurance Marketplace Automatic Renewal Rules," July 16, 2021, https://doi.org/10.1001/jamahealthforum.2021.1642.

is placed in a plan with a higher monthly premium than their current year plan due to annual increases in the cost of coverage, as CMS notes in the final NBPP for 2024.[43]

*Premium Payment Threshold (§ 155.400)*

CMS proposes to remove the option for issuers to use gross premium percentage or fixed-dollar premium payment thresholds. These new options were made available for PY 2026 and beyond and provide issuers additional flexibility to help enrollees who miss nominal premium payments to remain covered. Under the proposal, issuers would be limited to a net premium percentage-based premium payment threshold. CMS says this will reduce the number of people enrolled without their knowledge or consent by increasing the number of people whose coverage is terminated for nonpayment of premiums. CMS estimates that this change would result in more than 184,000 policy terminations among people who owe $10 or less.

We do not support the proposed change. The existing options for issuers to accept percentage of gross premiums and fixed dollar amount premium payment thresholds at 155.400(g)(2) and (3) protect people, particularly people with very low incomes, from barriers to enrollment and loss of coverage.

Robust evidence spanning decades in Medicaid and CHIP shows that premiums are a barrier to obtaining and maintaining coverage.[44] And a growing body of evidence shows similar results in marketplace plans. One study showed that people who enrolled in zero-dollar premium plans (before those plans became more prevalent because of the enhanced PTC) stayed enrolled for 23 to 46 days longer compared to those with a premium; they were also more likely to be enrolled at 12 months.[45] In Massachusetts, observations of its pre-ACA marketplace found that one-quarter of its enrollees whose premiums increased from $0 to $3 per month did not pay, evidence pointing to the hassle costs of paying even a nominal premium.[46] As premiums rose to $10 per month, enrollees showed more financial strain, as evidenced by additional plan switching.

The number of people with *de minimis* premiums is not trivial. One study found that 404,000 HealthCare.gov enrollees had small positive premiums of less than 0.5 percent of gross premium (an

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[43] "Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024, CMS–9899–F," April 27, 2023, https://www.federalregister.gov/d/2023-08368/p-845.

[44] Samantha Artiga, Petry Ubri, and Julia Zur, The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings, KFF, June 1, 2017, https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-issue-brief. (See footnotes 5 through 39.)

[45] Coleman Drake, Sih-Ting Cai, David Anderson, and Daniel W. Sacks, Financial Transaction Costs Reduce Benefit Take-Up: Evidence from Zero-Premium Health Plans in Colorado, October 22, 2021, https://ssrn.com/abstract=3743009 or http://dx.doi.org/10.2139/ssrn.3743009.

[46] Adrianna McIntyre, Mark Shepard, and Myles Wagner, "Can Automatic Retention Improve Health Insurance Market Outcomes?", *AEA Papers and Proceedings*, 2021, 111: 560-566, https://scholar.harvard.edu/files/mshepard/files/automaticRetention_McIntyreShepardWagner_aeaPandP.pdf.

average of about $3 per month).[47] This study estimates that eliminating this premium would increase enrollment by 48,000. CMS data corroborates the significant effect of small premiums, noting that in 2023, more than 81,000 total policies were terminated for nonpayment of less than $5 and that another 103,000 individuals lost coverage for deficiencies of between $5 and $10. These data show that thousands of people suffer the harsh penalty of coverage loss for minimal unpaid premiums.

The PTC enhancements in effect since 2021 have resulted in 42 percent of enrollees paying zero-dollar premiums[48] and nearly 9.4 million enrollees having net premiums of $10 or less.[49] Data from the CMS Assistant Secretary for Planning and Evaluation suggests that the enhanced PTC, along with other policy changes, increased marketplace coverage across all racial and ethnic groups, with the largest gains among Black and Latino enrollees.[50]

Eliminating the option to use gross premium percentage or fixed-dollar premium payment thresholds would worsen barriers to enrollment and result in loss of coverage, especially among those with low incomes. A few dollars each month is virtually meaningless to issuers and there is scant evidence that people who would be unenrolled due to nonpayment are fraudulently enrolled. However, even nominal premium payments can lead people to lose coverage, primarily due to the hassle of payment or lack of awareness. Further, if enhanced PTCs expire at the end of 2025, many more people will be enrolled in plans with nominal premiums (rather than $0 premiums) in future years, exacerbating the risk of disenrollment due to nonpayment of small premium amounts. CMS argues that limiting premium payment thresholds to net premium percentage-based calculations would reduce fraudulent enrollments. However, these new premium payment threshold options were set to take effect in 2026. CMS's claims that more flexible premium payment thresholds, which have yet to take effect, are tied to existing fraud are implausible. Thus, limiting premium payment threshold methods would hurt people with low incomes and drive coverage losses without achieving the purported goal of reducing fraud.

*Annual Open Enrollment Period (§ 155.410)*

We strongly oppose CMS's proposal to reduce the length of the OEP by 31 days for the FFM and SBMs. CMS proposes for the OEP to run from November 1 to December 15 beginning with the OEP for PY 2026, instead of the current OEP from November 1 to January 15. The limited OEP would reduce coverage rates, threaten affordable access to health insurance, especially for those unknowingly enrolled in more costly plans, and place an undue burden on individuals and families

[47] Matthew Fiedler, "Eliminating small Marketplace premiums could meaningfully increase insurance coverage," Brookings Institution, June 29, 2022, https://www.brookings.edu/articles/eliminating-small-marketplace-premiums-could-meaningfully-increase-insurance-coverage/.

[48] CMS, Health Insurance Marketplaces 2024 Open Enrollment Report, https://www.cms.gov/files/document/health-insurance-exchanges-2024-open-enrollment-report-final.pdf.

[49] CMS, 2024 Marketplace Open Enrollment Period Public Use Files, https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files.

[50] ASPE, HealthCare.gov Enrollment by Race and Ethnicity, 2015-2023, March 22, 2024, https://aspe.hhs.gov/sites/default/files/documents/a1e8128c1b9996fd5a7eb98d0860d572/aspe-2023-race-ethnicity-marketplace.pdf.

with low incomes, all while imposing significant costs to the FFM and SBMs to change their IT systems and conduct outreach to consumers.

CMS argues that limiting the OEP is necessary to protect the stability of the market and reduce adverse selection. While CMS presumably has data about the risk profiles of enrollees after December 15, it has failed to provide justification for their claims that market stability and adverse selection are problems associated with a longer OEP. The people with significant health needs who need the costliest care are likely to be early enrollers; with a shorter enrollment period and more hassles to enrollment, lower-risk enrollees who are on the fence about coverage may not enroll. In fact, among people who enrolled in Covered California (California's state-based marketplace) during the OEP each year from 2020 to 2025, those who enrolled after December 15 have consistently had lower prospective risk scores than those who enrolled before December 15.[51] Similarly, in New York, marketplace enrollees who enrolled in the final month of the 2017 OEP, which ended January 31, were younger than those who enrolled earlier.[52] While not all younger enrollees are healthier than older enrollees, younger age tends to indicate lower risk.

A longer OEP also provides a longer period for outreach and advertising to educate people about their options on the marketplace, which can have a positive impact on the risk pool. One study of an enrollment deadline reminder letter intervention in California demonstrated that increasing public awareness of open enrollment encouraged lower-risk enrollees to enroll in coverage they may have otherwise forgone; those who enrolled in response to the letters were 37 percent less costly to insure.[53]

Eliminating January open enrollment would have particularly significant consequences for individuals and families with low incomes. When enrollees who qualify for PTCs are automatically re-enrolled in plans for the following year with lower subsidies, they may not be aware of their higher premiums until they receive their first bill in early January. Under the current system, they can change plans to a more affordable option before the January 15 deadline. If CMS finalizes its plan to end the OEP on December 15, people with low and moderate incomes who can't afford higher premiums may needlessly lose access to health coverage for the entire plan year. Currently, people who don't enroll by December 15 lose one month of coverage; however, if December 15 is the end of the OEP, they will miss out on an entire year of coverage. While CMS dismisses this concern, stating that fewer than 3 percent of federal marketplace enrollees switched to a lower cost plan for

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[51] State Health and Value Strategies, "New CMS Proposed Rule: ACA Marketplace Integrity," presented April 1, 2025, https://www.shvs.org/wp-content/uploads/2025/04/New-CMS-Proposed-Rule-on-ACA-Marketplace-Integrity_Final.pdf

[52] New York State of Health, "Comment on 45 CFR Parts 147, 155 and CMS 156; Patient Protection and Affordable Care Act; Market Stabilization [CMS-9929-P]; Comment ID: CMS-2017-0021-3014," March 7, 2017, https://www.regulations.gov/comment/CMS-2017-0021-3014 https://www.regulations.gov/comment/CMS-2017-0021-3014.

[53] Richard Domurat, Isaac Menashe, and Wesley Lin, "The Role of Behavioral Frictions in Health Insurance Marketplace Enrollment and Risk: Evidence from a Field Experiment," *American Economic Review* 111 (5), 2021, pp. 1549-74, https://www.aeaweb.org/articles?id=10.1257/aer.20190823

PY 2025 between December 15 and January 15, nearly half a million people would be affected by this policy change.

We have particular concerns about reducing the length of the OEP in PY 2026. Given the enhanced PTCs are scheduled to expire at the end of 2025, many consumers may find themselves automatically re-enrolled in plans with higher premium costs and lower subsidies if the enhancements are not extended. Without the opportunity to switch plans when they notice the premium increase in early January, many people with low and moderate incomes will be unable to afford coverage and have no opportunity to enroll in a more affordable alternative. If the proposal is finalized, implementation should be delayed until at least PY 2027.

Additionally, the holiday season from Thanksgiving to News Year's is a financially stressful time for families with low and moderate incomes. Research demonstrates that when people have limited decision-making capacity, in this case due to financial stress, they are unable to make decisions or make poor choices.[54] If the OEP were to end on December 15, struggling families would have to enroll amid holiday stress or risk losing out on coverage for the entire plan year.

If the OEP is cut by 31 days, navigators and enrollment assisters, who are already struggling to provide support to all who need it, would have even less time to help people find and enroll in the best and more affordable health coverage for them. Many of the suggested changes in this proposed rule would drive confusion and coverage losses among enrollees that would require additional navigator support. Over the past four years, navigators, who conduct outreach and provide free, unbiased application and enrollment help, received robust federal funding in the states with a federally operated marketplace. Navigators often help people who face the greatest barriers to enrollment — including those with limited English proficiency and limited access to the internet — complete the enrollment process.[55] However, in February 2025, CMS announced a 90 percent reduction in funding for the federally-funded Navigator program.[56] CMS argues "the extended OEP requires enrollment assisters to stretch budget resources over an additional month;" however, the 2025 federal funding cuts to the Navigator program will already leave enrollment assisters unable to serve all the potential enrollees that need support. If CMS decides to end the OEP on December 15, navigators who are already underfunded and stretched thin would have even less time to provide the additional support potential enrollees need. Subsequently, potential enrollees would find themselves uninsured or enrolled in subpar or expensive plans, despite qualifying for marketplace plans and subsidies.

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[54] Katherine Swartz and John A. Graves, "Shifting The Open Enrollment Period For ACA Marketplaces Could Increase Enrollment And Improve Plan Choices," *Health Affairs*, Vol. 33 No. 7, July 2014, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.0007.

[55] Jennifer Sullivan, "Policies Designed to strengthen ACA Marketplaces Succeed, But Are Under Threat," Center on Budget and Policy Priorities, March 3, 2025, https://www.cbpp.org/blog/policies-designed-to-strengthen-aca-marketplaces-succeed-but-are-under-threat.

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

*Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Projected Household Income at or Below 150 Percent of the Federal Poverty Level (§ 155.420)*

CBPP strongly opposes the proposal to eliminate the monthly SEP for people with incomes at or below 150 percent FPL (also known as the low-income SEP). This SEP provides an important, year-round path to coverage for people who are eligible for significant financial help purchasing coverage on the marketplace. CMS claims that the low-income SEP contributes to adverse selection and unauthorized enrollment, and that these risks supersede any potential benefit to enrollees. Yet, several states allow year-round marketplace enrollment for people with low incomes and have not experienced adverse selection as a result, nor have they experienced widespread unauthorized enrollment.

The low-income SEP has simplified enrollment for millions of individuals, helping them overcome challenges enrolling in health coverage. In 2024, nearly one in four marketplace enrollees had annual incomes between 100 percent and 150 percent of the federal poverty line, or about $15,000 and $22,000 for an individual.[57] People in this group have incomes that overlap with or are only a little higher than the incomes of people receiving Medicaid, which allows people to enroll in health coverage at any point during the year. And they may have children who are covered through CHIP, which also has year-round enrollment. Many marketplace enrollees may therefore be accustomed to a continuous enrollment cycle and less familiar with the marketplace's more restrictive structure. In contrast, prior to the implementation of the low-income SEP, people in this income band had to know they experienced a qualifying event that triggers one of approximately 15 time-limited SEPs and then take action to claim it, usually within 60 days, in order to enroll in marketplace coverage outside of the annual OEP. As discussed previously, people with low incomes are more likely to have low health insurance literacy than people with higher incomes,[58] and therefore may be less likely to have information about SEPs or know to seek out enrollment assistance.

CMS presumably has three full years of data on the low-income SEP but does not provide evidence to support its claim that people who enroll in the marketplace using the low-income SEP have greater risk profiles or use more health services than those who enroll during open enrollment. Its assertion that "Many consumers can also wait [to enroll] and know, if they do become sick, they would qualify for the 150 percent FPL SEP" is also without merit. To support these claims, CMS points to increased enrollment among people with incomes below 150 percent FPL; a lawsuit involving agent and broker fraud; and increased consumer complaints, none of which indicate adverse selection.

CMS's assumption that year-round open enrollment causes adverse selection also runs counter to states' experiences. Seventeen of the 20 SBMs have adopted the low-income SEP or otherwise

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[57] KFF, "State Health Facts: Marketplace Plan Selections by Household Income," 2024, https://www.kff.org/affordable-care-act/state-indicator/marketplace-plan-selections-by-household-income-2/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[58] Edward J, Wiggins A, Young MH, Rayens MK. "Significant Disparities Exist in Consumer Health Insurance Literacy: Implications for Health Care Reform," *Health Lit Res Pract.* 2019 Nov 5;3(4):e250-e258. doi: 10.3928/24748307-20190923-01.

permitted year-round enrollment in the marketplace for people with low incomes, and none have reported signs of adverse selection.[59] Moreover, they have not been impacted by the recent increases in unauthorized enrollment activity that the FFM has experienced.[60] Instead of restricting enrollees' access to coverage, these states have successfully prevented widespread fraud by making it more difficult for agents and brokers to make changes to enrollees' applications or plan selections without the person's input or knowledge. For example, in Colorado and Pennsylvania, consumers must create an account and grant agents or brokers permission to make changes to their application. In California, the marketplace sends a one-time password to the consumer, who must then pass it on to an agent or broker to allow them to make changes.[61] All but one SBM (Georgia) bans EDE, which enables insurers and brokers to enroll people in plans or switch their plans without the consumer needing to take any action.[62] EDE is allowed in FFM states, and tellingly, broker-initiated plan changes and agent-of-record switches dropped precipitously after CMS took steps to prevent brokers from changing a person's coverage through EDE channels.[63] Because these safeguards have not been in place in the FFM, the low-income SEP has contributed to an environment ripe for bad actors to seek a high volume of quick commissions. But the solution is not to reduce the availability of SEPs, which would increase coverage gaps for low-income people, it is to reduce the ability of agents and brokers to abuse them for financial gain.

CMS requests comment on whether navigators and certified application counselors (CACs) may be partially responsible for the uptick in unauthorized enrollment activity, suggesting that they may be motivated to enter incorrect information on an enrollee's application to because of empathy for their clients or motivation to meet CMS's project goals. CMS goes so far as to state that navigators and CACs "may even believe it is their mission to encourage or allow applicants to aggressively understate their income to gain more affordable coverage." For the past eight years, CBPP has met regularly with enrollment assisters from 10-12 FFM states to better understand marketplace enrollment on the ground. Without exception, the navigators in this group have been consummate

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[59] California, Colorado, Georgia, Kentucky, Maine, Maryland, New Jersey, New Mexico, Pennsylvania, Rhode Island, Vermont, Virginia, and Washington have adopted the federal low-income SEP. Minnesota and New York allow year-round enrollment for people with low incomes through their Basic Health Programs. Connecticut and Massachusetts have adopted the federal low-income SEP and also allow year-round marketplace enrollment for people with incomes above 150 percent FPL who qualify for state affordability initiatives.

In the District of Columbia, childless adults with incomes up to 215 percent FPL and adults with children with income up to 221 percent FPL are eligible for Medicaid. Idaho and Nevada have not adopted the low-income SEP. Data on file with CBPP.

[60] State Health and 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.

[61] Julie Appleby, "ACA health insurance plans are being switched without enrollees' OK," NPR, April 1, 2024, https://www.npr.org/sections/health-shots/2024/04/01/1241747442/aca-health-insurance-brokers-obamacare-fraud.

[62] Tara Straw, ""Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm," CBPP, March 15, 2019, https://www.cbpp.org/research/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes-them-to.

[63] CMS, "CMS Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity," October 17, 2024, https://www.cms.gov/newsroom/press-releases/cms-update-actions-prevent-unauthorized-agent-and-broker-marketplace-activity.

professionals, dedicated to helping people in their communities get health coverage while adhering to high standards for compliance with state and federal law. Navigators in this group began raising the alarm about unauthorized enrollments and plan switches in the ACA marketplace before the issue rose to national prominence. Staff from the Center for Consumer Information and Insurance Oversight met with this group on two occasions (once in 2023 and once in 2024) to hear more about what navigators were seeing among their clients affected by unauthorized enrollment and to work collaboratively on solutions. Navigators described spending hours with frustrated consumers, helping them file reports with CMS and state departments of insurance and working with the marketplace resolve each person's situation. Navigators are also acutely aware that misestimating a person's income or failing to report changes in income can result in a substantial repayment burden for the individual at tax time. While there have been numerous media reports, as well as at least one court filing and at least one Department of Justice investigation of agent and broker misconduct,[64] we are unaware of a single case in which navigators or CACs have knowingly steered people to submit inaccurate information on their marketplace applications.

Finally, the proposed rule asserts that CMS does not have authority to implement a monthly SEP for people with low incomes. We disagree. The ACA directs the Secretary to establish SEPs in circumstances similar to those in Medicare Part D. CMS argues that the low-income SEP is dissimilar to Medicare Part D SEPs, but that's not accurate. Medicare Part D has a similar low-income SEP that allows people with low incomes to change plans once per month or drop Medicare Advantage and join traditional Medicare with a Part D drug plan. The Medicare Part D statute, similar to the ACA, lists certain specific SEPs that the Secretary must set up at a minimum; not all Medicare Part D SEPs are specified in statute. The low-income SEP is indeed similar to an SEP in Medicare Part D.

*Pre-enrollment Verification for Special Enrollment Period (§ 155.420(g))*

We strongly oppose the proposal to require marketplaces to conduct pre-enrollment eligibility verification for at least 75 percent of special enrollments for people newly enrolling in marketplace coverage. It is unnecessary, and CMS should not finalize it. We are unaware of evidence that SEPs introduce a meaningful degree of adverse selection or that additional verification would protect

[64] See: Daniel Chang, "Fraudsters Are Duping Homeless People Into Signing Up for ACA Plans They Can't Afford ," KFF Health News, "June 13, 2023, https://kffhealthnews.org/news/article/fraudsters-duping-homeless-people-aca-obamacare-plans; Julie Appleby, "Rising Complaints of Unauthorized Obamacare Plan-Switching and Sign-Ups Trigger Concern," KFF Health News, April 8, 2024, https://kffhealthnews.org/news/article/aca-unauthorized-obamacare-plan-switching-concern/; Ashlynn Webb, "Thousands claim rogue agents and brokers added or changed health insurance behind their back," WFTV.com, November 21, 2024, https://www.wftv.com/news/local/thousands-claim-rogue-agents-brokers-added-or-changed-health-insurance-behind-their-back/SLAWOYGHC5ATJHTOB7SNU17171/; DOJ, "President of Insurance Brokerage Firm and CEO of Marketing Company Charged in $161M Affordable Care Act Enrollment Fraud Scheme," February 19, 2025, https://www.justice.gov/opa/pr/president-insurance-brokerage-firm-and-ceo-marketing-company-charged-161m-affordable-care.

against adverse selection. In fact, some states have found that people who enroll through an SEP have similar or lower risk profiles than people who enroll during open enrollment.[65]

If SEPs were contributing to adverse selection, it would likely be because *too few eligible people* are using SEPs to enroll.[66] A large body of evidence from Medicaid and other programs shows that adding steps for people to take before they can enroll in a program can discourage them from completing the process,[67] and people with few anticipated health care needs are likely less motivated to complete enrollment hurdles than those with expensive health conditions. Notably, a study published by the American Economic Association found that adding one single additional step to the enrollment process prompted a 33 percent decline in enrollment, predominantly among young, healthy, and economically disadvantaged people.[68] Federal data suggest that increasing verification burden on applicants reduced SEP enrollment by 20 percent from 2015 to 2016, and younger people (who also tend to be healthier) were less likely to complete the process.[69] The federal government should not be trying to reinstate this policy.

CMS states that its review of pre-enrollment verification policies in 2017 found that the process did not impose substantial barriers on applicants or enrollees but also notes that 10 percent of people subject to pre-enrollment verification ultimately did not submit the paperwork required for enrollment. If the same rate were to apply in 2025, it would mean that approximately 2.4 million people would be shut out of marketplace coverage due to a failure to submit paperwork. CMS also cites data submitted by the Blue Cross Blue Shield Association in 2022, which found that in "more than 25 percent" of its 33 health plans, loss ratios after risk adjustment for SEP enrollments relative to open enrollment enrollments increased from an average of 1.03 in 2019 to 1.17 in 2021.[70] We note that in 2021, CMS enacted a six-month SEP, from February 15 through August 15, making SEP data from that year highly anomalous.

New York State of Health, "Comment on 45 CFR Parts 147, 155 and CMS 156; Patient Protection and Affordable Care Act; Market Stabilization [CMS-9929-P]; Comment ID: CMS-2017-0021-3014," March 7,

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[65] State Health and 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.

[66] Laurel Lucia, "How Do We Make Special Enrollment Periods Work?," Health Affairs, February 16, 2016, https://www.healthaffairs.org/content/forefront/do-we-make-special-enrollment-periods-work.

[67] Jennifer Wagner and Judith Solomon, "States' Complex Medicaid Waivers Will Create Costly Bureaucracy and Harm Eligible Beneficiaries," Center on Budget and Policy Priorities, May 23, 2018, https://www.cbpp.org/research/health/states-complex-medicaid-waivers-will-create-costly-bureaucracy-and-harm-eligible and "Hassle Factors," Ideas 42, https://www.ideas42.org/blog/principle/hassle-factors-2/.

[68] Shepard M, Wagner M, "Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment," *American Economic Review* 2025, 115(3): 772–822 doi: 10.1257/aer.20231133.

[69] "Pre-Enrollment Verification for Special Enrollment Periods," CCIIO Factsheet, 2016, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Pre-Enrollment-SEP-fact-sheet-FINAL.PDF.

[70] Blue Cross Blue Shield Association, "Comment on 45 CFR Parts 144, 147, 153, 155, 156 and 158, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 [CMS-9911-P]; Comment ID: CMS-2021-0196-0222," January 28, 2022, https://www.regulations.gov/comment/CMS-2021-0196-0222.

2017, https://www.regulations.gov/comment/CMS-2017-0021-3014
https://www.regulations.gov/comment/CMS-2017-0021-3014.

CMS also argues that imposing new documentation requirements on consumers will help curtail SEP enrollments made without individuals' consent. However, there is no evidence that adding bureaucratic headaches to the people's lives will serve as an impediment to the brokers and web-brokers set on committing fraud. Currently, many SBMs require consumers seeking to enroll via many SEPs to attest, upon penalty of perjury, that they qualify for the SEP in question. Yet no SBM has reported any meaningful fraud in their markets, and CMS has provided zero evidence of any abuse of this process.

Before setting any SEP verification threshold for marketplaces, CMS should provide compelling information supporting the need for such a change and justification for the specific threshold it is proposing. It should also describe what it will do to increase enrollment among SEP-eligible people. CMS should also clarify that less burdensome, effective methods of SEP verification are allowed and even preferred to pre-enrollment verification.

Should CMS finalize this proposal, it should explicitly prohibit pre-enrollment verification for SEPs for survivors of domestic violence, abuse or spousal abandonment; people recently released from incarceration; and people impacted by FEMA-declared emergencies and major disasters. Individuals in these circumstances are in vulnerable situations where they may need urgent access to medical care and their situations could make it difficult for them to access needed documentation in a timely manner. In the preamble to the rule, CMS states that the FFM will conduct pre-enrollment verifications for SEPs in line with its operations prior to the 2023 NBPP.[71] However, this limitation is not included in the proposed regulatory text, which states only that "…an Exchange must conduct pre-enrollment verification of applicants' eligibility for special enrollment periods under this section."

*Prohibition on Coverage of Sex-trait Modification as an EHB (§ 156.115(d))*

CMS proposes to prohibit issuers from offering gender-affirming care as an essential health benefit (EHB). By excluding this care from state EHB requirements, this proposal will raise health care costs and encourage denials and other limits on medically necessary care, including hormone therapy and other medical interventions for persons diagnosed with gender dysphoria.[72] By targeting care for individuals with gender dysphoria — while expressly proposing to create exceptions to cover this care for other indications — this proposal exceeds CMS's authority to define EHBs. Such limits are not only unlawful; they are unconscionable.

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[71] Prior to the implementation of the 2023 NBPP, the FFM conducted pre-enrollment verification for five SEPs: marriage, adoption, moving to a new coverage area, loss of minimum essential coverage, and Medicaid/CHIP denial.

[72] Lindsey Dawson, Kaye Pestaina, and Matthew Rae, "New Rule Proposes Changes to ACA Coverage of Gender-Affirming Care, Potentially Increasing Costs for Consumers," KFF, 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.

First, issuing a blanket nationwide rule that would prevent insurers from covering treatment for people with gender dysphoria as EHB is contrary to the requirement that EHBs be defined in a way that protects individuals from discriminatory benefit designs. It is also inconsistent with existing laws and policies, including Section 1557 of the ACA, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act, that prohibit discrimination against people with gender dysphoria, as the courts have recognized.[73]

Second, the proposal goes beyond the limit imposed by the ACA that ties EHBs to coverage in typical employer plans. CMS claims, without evidence, that treatment for gender dysphoria is not typically covered in employer plans. This is false. CMS points to low utilization of gender-affirming care as evidence that treatment for gender dysphoria is not covered by these plans; however, low utilization is explained by, and is consistent with, the small size of the transgender population and variation in individual medical needs. Only 0.6 percent of people over the age of 13 are transgender, and under expert standards of care, treatment for gender dysphoria is highly individualized.[74] There are many other services, such as heart transplants, that are infrequently used by the population at large but are commonly covered by employer-based, major medical health insurance.

Survey data and state policies show that in fact, gender-affirming care is commonly covered by employer plans and other types of health plans, as well. In the 2025 Corporate Equality Index, the Human Rights Campaign Foundation found that 72 percent of Fortune 500 businesses (and 91 percent of businesses listed on the Corporate Equality Index) offer health plans that cover treatment for gender dysphoria. As a result, over 1,300 major employers nationwide cover this care, 28 times as many businesses as in 2009.[75] Similarly, coverage for gender dysphoria is widespread among state employee plans (24 states and DC), Medicaid (27 states, Puerto Rico, and DC), the Health Insurance Marketplaces (55 percent of plans across all 50 states covered this care in PY 2025), and state-regulated coverage (24 states and DC prohibit exclusions of coverage for gender dysphoria).[76]

Third, CMS's proposal risks disrupting coverage and access to care for all consumers, regardless of their diagnosis. CMS seeks to discriminatorily exclude from EHB items and services when administered or prescribed for the medically necessary treatment of gender dysphoria. However, the medical services associated with this treatment are not unique to transgender people and are frequently needed by people who are not transgender for treatment of other conditions. Services that may be needed for the treatment of gender dysphoria are found across almost every category of

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[73] Prescott v. Rady Children's Hosp. (S.D.C.A. 2016), Flack v. Wisconsin Dept. of Health Srvs. (W.D. Wis. 2018), Boyden v. Conlin (W.D. Wis. 2018), Tovar v. Essentia Health (D. Minn. 2018), Williams v. Kincaid, 45 F.4th 759, 766 (4th Cir. 2022)

[74] Jody L. Herman, Andrew R. Flores, and Kathryn K. O'Neill, "How Many Adults and Youth Identify as Transgender in the United States?," UCLA School of Law Williams Institute, June 2022. https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/.

[75] Human Rights Campaign, "Corporate Equality Index 2025: Rating Workplaces on Lesbian, Gay, Bisexual, Transgender, and Queer Equality," January 2025. https://www.hrc.org/resources/corporate-equality-index.

[76] Out2Enroll, "Summary of Findings: 2025 Marketplace Plan Compliance with Section 1557 of the Affordable Care Act," https://drive.google.com/file/d/1fpSNyaZVfC25o3zXnYBWUVaYRWokwbwg/view; Comm. Ricardo Lara et al., Letter to Secretary Xavier Becerra., "Re: Proposed rule Section 1557 of the Affordable Care Act RIN 0945-AA17, Docket ID number HHS-OCR-2022-0012," September 30, 2022, https://www.insurance.ca.gov/0400-news/0100-press-releases/2022/upload/joint-Letter-Final_ACA_SECTION_1557_NPRM_sign-on_letter_2022-2.pdf.

EHB and, as the proposed rule itself recognizes, are routinely covered for a variety of indications. If this proposed rule is finalized, issuers would need to determine when and how to cover a range of widely covered, medically necessary services — including mental and behavioral health care, prescription drugs, and surgical care (e.g., a hysterectomy) — based on diagnosis, significantly complicating claims and utilization management processes.

This proposal would also disrupt the balance CMS has established between safeguarding access to a minimum level of services across the country and state flexibility to address the health care needs of their populations. Since CMS established the EHB benchmark process, the agency has often used its authority to define EHBs to create national coverage standards as minimum requirements, but it has never utilized the EHB framework to force states to categorically exclude benefits that target populations with a particular condition. The existing approach, which this proposed rule would eviscerate, has been an essential tool that appropriately affords states the opportunity to use EHBs as a tool to ensure that coverage is nondiscriminatory and responsive to the needs of their populations. CMS's proposed exclusion of gender-affirming care will inflict higher costs, limit access to care, and cause harm to transgender people, who already experience discrimination and coverage denials at an unprecedented level. This proposal should be withdrawn.

*Premium Adjustment Percentage (§ 156.130(e))*

We oppose the proposal to change the formula for determining the annual premium adjustment percentage that determines the maximum annual limitation on cost sharing and other parameters and that is also used by the IRS to calculate applicable percentages to determine premium tax credits.

If adopted by the IRS, the proposed change would reduce PTCs and thereby increase net premiums in 2026 for many of the more than 20 million people who receive PTCs. That would make coverage less affordable for millions of people – for instance, a family of four making $85,000, or 264 percent FPL, would see the annual net premium for benchmark coverage rise from $6,918 to $7,231, an increase of $313. CMS estimates a coverage loss of 80,000 people. It is likely that half or more of the people who drop marketplace coverage will become uninsured.[77] The rule acknowledges that the increase in the number of uninsured may increase uncompensated care costs and worsen health outcomes; it does not mention that these people would also be more likely to incur medical debt and face worse financial outcomes.[78]

[77] Based on projections from the Urban Institute, which estimate that over half of the people who drop marketplace coverage due to expiration of premium tax credit enhancements, which would also contribute to an effective net premium increase, would become uninsured. Jessica Banthin *et al.*, "Who Benefits from Enhanced Premium Tax Credits in the Marketplace?" Urban Institute, June 17, 2024, https://www.urban.org/research/publication/who-benefits-enhanced-premium-tax-credits-marketplace

[78] Jennifer Tolbert *et al.*, "Key Facts about the Uninsured Population," KFF, December 18, 2024, https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

In addition to the direct effects on those losing coverage, this could also hurt the marketplace risk pool, causing premiums paid by unsubsidized enrollees to increase because, as CMS recognizes, enrollment among healthier enrollees may decline.

The proposal would also increase limits on total out-of-pocket costs for millions of people, including millions on employer-sponsored plans with out-of-pocket limits at or near the maximum.[79] For example, a family of four could face an additional $900 in medical bills if a family member became seriously ill or injured in 2026. For a family with marketplace coverage, this would be on top of an increase in annual net premiums ($313 for a family of four making $85,000). This would burden people who experience costly illnesses or injuries, who are disproportionately people with pre-existing health conditions.

Marketplace enrollees who receive CSRs would also face higher out-of-pocket maximums. For example, a family of four making $66,000 a year could face an additional $700 of medical bills if a family member is seriously ill or injured in 2026 (see table).

| Actuarial value of cost sharing reduction plan variant (income eligibility range) | Maximum annual limitation on cost sharing for PY 2026 | | | | | |
|---|---|---|---|---|---|---|
| | Self-only coverage | | | Other than self-only coverage | | |
| | Current Rules | Proposal | Increase due to proposal | Current Rules | Proposal | Increase due to proposal |
| 94% (100-150% FPL) | $3,350 | $3,500 | $150 | $6,700 | $7,000 | $300 |
| 87% (150-200% FPL) | $3,350 | $3,500 | $150 | $6,700 | $7,000 | $300 |
| 73% (200-250% FPL) | $8,100 | $8,450 | $350 | $16,200 | $16,900 | $700 |

The arguments presented for the proposal do not justify the harm. The proposal would measure premium growth across all private plans excluding Medigap and property and casualty insurance, a measure temporarily used for PY 2020 and 2021. Reinstating this approach would increase the premium adjustment percentage by 4.53 percent in PY 2026.

CMS explains that this measure would better capture premium growth in the entire market because premiums remained relatively stable between the individual and ESI markets during the COVID-19 public health emergency. However, this reasoning does not address the flaw in this premium growth measure, which existed when it was first implemented and also exists now: it would increase costs for consumers by incorporating one-time increases in individual market premiums that occurred as insurers adjusted to the ACA and as the ACA's temporary reinsurance program phased out.

Moreover, if Congress does not extend the PTC enhancements, they will expire at the end of 2025, likely affecting premium growth rates. The Congressional Budget Office estimates that, relative to extending the enhancements, not extending them will increase gross benchmark

[79] KFF, "2024 Employer Health Benefits Survey," October 9, 2024, https://www.kff.org/health-costs/report/2024-employer-health-benefits-survey/

premiums by 4.3 percent in 2026, 7.7 percent in 2027, and by 7.9 percent, on average, over the 2026-2034 period.[80]

This proposal would expose consumers to premium fluctuations in the individual market driven by the early years of the ACA implementation and the potential expiration of the PTC enhancements. This is in direct conflict with "accuracy," one of the four criteria (comprehensiveness, availability, transparency, accuracy) CMS claims to have considered when finalizing these parameters because it incorporates one-time fluctuations in premiums from policy changes – and not from broader market trends – into the premium growth measure.

Another criterion, comprehensiveness, is not a sufficient justification for raising consumer costs. The current measure already reflects premium trends for well over 80 percent of all private market consumers.[81] And the most recent National Health Expenditures projections estimate that premiums for ESI and all private plans, minus Medigap, will grow at similar rates from 2026-2032 (5.0 and 4.9 percent, respectively).[82] Both of these factors also make it unlikely that future trends in marketplace premiums will contribute to a lower long-term growth rate, as suggested in the preamble of the proposed rule.

*Levels of Coverage (Actuarial Value) (§§ 156.140, 156.200, 156.400)*

The proposed rule would increase *de minimis* ranges, allowing plans to have lower actuarial values (AVs). The main impact of this policy would be to make marketplace coverage more expensive for enrollees.

Benchmark silver plans are the basis for calculating PTC amounts. By allowing benchmark silver plans to have AVs as low as 66 percent, down from the current minimum of 70 percent for silver plans, PTCs will be reduced for many of the over 20 million marketplace enrollees who receive them. These enrollees will be faced with the choice of either paying higher out-of-pocket premiums for the same AV plan or paying the same premium for a lower AV plan with higher deductibles, copays, and other out-of-pocket expenses.

For example, suppose a typical family of four makes $85,000 and is purchasing the benchmark plan in their local area with 70 percent AV, which has a gross premium of $19,068 (the 2025 national average for this family). If the benchmark plan instead had a 66 percent AV, as permitted

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[80] Phillip L. Swagel, Letter to Chairman Wyden, Ranking Member Neal, Honorable Shaheen, and Honorable Underwood, Congressional Budget Office, December 5, 2024, https://www.cbo.gov/publication/59230

[81] Centers for Medicare & Medicaid Services, National Health Expenditure projections, updated September 10, 2024, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected. Employer plan enrollment as a share of total private health insurance enrollment is projected to remain between 84 and 86 percent from 2026 through 2032.

[82] *Ibid.*

under the proposed rule, the family's premium tax credit would fall by $714.[83] The family would be left with hard choices:

1) Remain in the benchmark plan and pay the same premium cost, but due to the 4 percentage-point decline in the plan's AV, now face $714 more in expected out-of-pocket costs in the form of deductibles, copays, and/or coinsurance.
2) Pay higher premiums to purchase a plan that maintains the same AV to avoid an increase in other expected out-of-pocket costs.

These cost increases would come on top of the reduced PTCs and higher annual cost sharing limitations that would result from increasing premium adjustment percentages, discussed above. And even people with CSRs – who have the lowest incomes among marketplace enrollees – would not be shielded from harm. People with CSR variant plans would see their minimum AV decrease up to one percentage point, while at the same time they would face higher annual limitations on cost sharing and greater premium contributions.

While CMS cites "increased issuer participation and improved coverage options" as benefits, no evidence is provided for these claims. In fact, marketplaces offer more options than ever, with record high participation among insurers, record high enrollment, and premiums that have grown more slowly than employer-based coverage.[84] The proposed change in *de minimis* standards would worsen coverage options by making marketplace coverage more expensive for enrollees. Moreover, because healthier people are more likely to drop coverage when net premiums rise,[85] the proposed change would weaken the risk pool, leading to higher gross premiums for subsidized and unsubsidized enrollees alike.

[83] The calculation is $19,068 × 85% × (4/90.85). This example assumes that medical costs comprise 85 percent of gross premiums, with the other 15 percent consisting of administrative costs and profits. The reduction in actuarial value reduces medical costs. The average actuarial value of a silver plan, including CSR silver plans, is assumed to be 90.85 percent based on 2024 marketplace enrollment data.

[84] Linda Blumberg and John Holahan, "The ACA's Transformation of Private Health Insurance," Urban Institute, May 3, 2024, https://www.urban.org/research/publication/acas-transformation-private-health-insurance.

[85] American Academy of Actuaries, "Ensuring Access, Affordability, Choice, and Competition in the Individual Health Insurance Market," March 2025, health-brief-2025-EnsuringAccessIndHealthMarket.pdf.

Center on Health Policy at BROOKINGS

April 11, 2025

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

Administrator Mehmet Oz
Centers for Medicare and Medicaid Services

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

Dear Secretary Kennedy and Administrator Oz:

Thank you for the opportunity to comment on HHS' Marketplace Integrity and Affordability proposed rule.[1] This letter makes three points about the analysis that supports the proposed rule:

1. Abundant evidence shows that, contrary to HHS' assumptions, administrative burdens created by HHS' changes to the Marketplace enrollment process would deter eligible people from enrolling, reducing insurance coverage and increasing insurance premiums.
2. HHS does not meaningfully justify its claim that its proposed changes to special enrollment period (SEP) policies would sharply reduce premiums, and HHS is ignoring evidence that could allow it to make a more evidence-based assessment of these policies.
3. HHS' methods for estimating the extent of improper enrollment have serious flaws. Some other approaches that lack these flaws do suggest that there are a relatively large number of Marketplace enrollees with incomes just above 100% of the federal poverty level (FPL) in Medicaid non-expansion states. However, it is not clear how much such enrollment there is or how much of that enrollment is improper. Moreover, even to the extent that some is improper, it points to a narrower and more specific problem than the one HHS suggests exists.

The remainder of this letter examines these points in greater detail.

**Larger administrative burdens will deter eligible enrollees, increasing premiums**

HHS' analysis of the proposed rule assumes that greater administrative burdens due to changes in Marketplace enrollment processes will have no effect on enrollment among eligible enrollees.[2] This approach is at odds with a wealth of evidence from health insurance markets and beyond.

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[1] The views expressed in this letter are my own and do not necessarily reflect the views of the Brookings Institution or anyone affiliated with the Brookings Institution other than myself. I thank Christen Linke Young and Richard Frank for helpful comments on a draft of this letter, as well as Paris Rich Bingham and Rasa Siniakovas for excellent research and editorial assistance, respectively.

[2] In discussing the potential limitations of the regulatory impact analysis, HHS explains that it has not assessed these impacts: "Likewise, this range may underestimate the actual number of individuals impacted, as eligible enrollees may lose coverage as a result of the administrative burdens imposed by the provisions of this rule."

Notably, multiple high-quality studies have shown that adding steps to the health insurance enrollment process, as many of HHS' proposals would do, substantially reduces enrollment.[3] Similarly, many studies have found that imposing small premium obligations, as some of HHS' other proposals would do, also generates large reductions in enrollment.[4] This is most likely not because those small premium payments pose a substantial financial burden, but instead because they add another step to the enrollment process: remitting the small premium payment. Importantly, this evidence is drawn from settings where there is little reason to believe that HHS' present concerns about inappropriate enrollments were relevant, so the findings of these studies almost surely reflect reductions in enrollment among *eligible* individuals.

It is also worth noting that evidence from many contexts beyond health insurance also shows that making processes more administratively burdensome can have large effects on benefit enrollment decisions. Notably, this has been clearly demonstrated for employer retirement programs, student aid programs, and food assistance programs.[5] In short, the evidence that even seemingly modest administrative burdens can have large enrollment effects is robust and pervasive.

Eligible enrollees deterred by increased administrative burdens very likely use less health care, on average, than those who continue to enroll. Economic theory implies that health insurance is most valuable to those with greater health care needs and, in turn, that enrollees with lesser health care needs are most likely to leave the market when the financial or non-financial cost of enrolling rises. And, indeed, this is borne out empirically. Some of the studies of increased administrative burdens

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[3] Mark Shepard and Myles Wagner, "Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment," *American Economic Review* 115, no. 3 (March 2025): 772–822, https://doi.org/10.1257/aer.20231133; Keith Marzilli Ericson et al., "Reducing Administrative Barriers Increases Take-Up of Subsidized Health Insurance Coverage: Evidence from a Field Experiment," *The Review of Economics and Statistics*, March 5, 2025, 1–32, https://doi.org/10.1162/rest_a_01573.

[4] Laura Dague, "The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach," *Journal of Health Economics* 37 (September 2014): 1–12, https://doi.org/10.1016/j.jhealeco.2014.05.001; Adrianna McIntyre, Mark Shepard, and Myles Wagner, "Can Automatic Retention Improve Health Insurance Market Outcomes?," *AEA Papers and Proceedings* 111 (May 2021): 560–66, https://doi.org/10.1257/pandp.20211083; Adrianna McIntyre, Mark Shepard, and Timothy J. Layton, "Small Marketplace Premiums Pose Financial And Administrative Burdens: Evidence From Massachusetts, 2016–17," *Health Affairs* 43, no. 1 (January 2024): 80–90, https://doi.org/10.1377/hlthaff.2023.00649; Coleman Drake et al., "Financial Transaction Costs Reduce Benefit Take-up Evidence from Zero-Premium Health Insurance Plans in Colorado," *Journal of Health Economics* 89 (May 1, 2023): 102752, https://doi.org/10.1016/j.jhealeco.2023.102752.

[5] Brigitte C. Madrian and Dennis F. Shea, "The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior," *The Quarterly Journal of Economics* 116, no. 4 (November 1, 2001): 1149–87, https://doi.org/10.1162/003355301753265543; Raj Chetty et al., "Active vs. Passive Decisions and Crowd-Out in Retirement Savings Accounts: Evidence from Denmark," *The Quarterly Journal of Economics* 129, no. 3 (August 1, 2014): 1141–1219, https://doi.org/10.1093/qje/qju013; Eric P. Bettinger et al., "The Role of Application Assistance and Information in College Decisions: Results from the H&R Block Fafsa Experiment," *The Quarterly Journal of Economics* 127, no. 3 (August 1, 2012): 1205–42, https://doi.org/10.1093/qje/qjs017; Amy Finkelstein and Matthew J Notowidigdo, "Take-Up and Targeting: Experimental Evidence from SNAP," *The Quarterly Journal of Economics* 134, no. 3 (August 1, 2019): 1505–56, https://doi.org/10.1093/qje/qjz013; Eric Giannella et al., "Administrative Burden and Procedural Denials: Experimental Evidence from SNAP," *American Economic Journal: Economic Policy* 16, no. 4 (November 2024): 316–40, https://doi.org/10.1257/pol.20220701.

described above directly estimate the health care use of people deterred by greater burdens; they find that the deterred enrollees do indeed use less care, potentially markedly less.[6] Similarly, increasing the financial cost of enrollment also disproportionately deters enrollees who use less care.[7] This implies that the loss of eligible enrollees in response to increased administrative burdens would worsen the individual market risk pool and, thus, increase premiums.

The discussion above makes clear that it is not possible to credibly estimate the proposed rule's effects on Marketplace enrollment and premiums without considering the effects of increased administrative burdens. Moreover, the evidence reviewed above provides the information needed to account for these types of effects, so it would be feasible for HHS to remedy this flaw.

**HHS' estimates for SEP policy changes have little clear basis and ignore useful evidence**

HHS' claim that the proposed rule would reduce premiums is (depending on the scenario) either mostly or entirely accounted for by its assumptions that changes to SEP policies would reduce premiums. In particular, HHS assumes that removing the current monthly SEP for people with incomes below 150% of the FPL would reduce premiums by 3.4%, and it assumes that the proposed rule's SEP verification provisions would reduce premiums by an additional 0.5%.[8]

The basis for HHS' estimates is opaque, at best. In the main text of the proposed rule, HHS references a prior estimate that the monthly SEP policy would increase premiums by "3 to 4 percent" in the absence of the IRA subsidies, but then provides a revised range of "0.5 to 3.6 percent."[9] In the regulatory impact analysis, however, HHS reverts to its discarded "3 to 4 percent" estimate,[10] before adopting 3.4% as its point estimate. At no point does HHS explain the methods or assumptions underlying any of these estimates. Similarly, the methods or assumptions underlying the proposed rule's estimate that the proposed rule's SEP verification provisions would reduce premiums by 0.5% do not appear to be explained anywhere in the proposed rule.

It is clearly possible that the proposed rule's SEP provisions would reduce premiums by preventing some people with relatively high health care needs from enrolling in coverage.[11] However, this is

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[6] Shepard and Wagner, "Do Ordeals Work for Selection Markets?"; McIntyre, Shepard, and Wagner, "Can Automatic Retention Improve Health Insurance Market Outcomes?"

[7] Martin B. Hackmann, Jonathan T. Kolstad, and Amanda E. Kowalski, "Adverse Selection and an Individual Mandate: When Theory Meets Practice," *American Economic Review* 105, no. 3 (March 2015): 1030–66, https://doi.org/10.1257/aer.20130758; Amy Finkelstein, Nathaniel Hendren, and Mark Shepard, "Subsidizing Health Insurance for Low-Income Adults: Evidence from Massachusetts," *American Economic Review* 109, no. 4 (April 2019): 1530–67, https://doi.org/10.1257/aer.20171455.

[8] 90 FR 13024

[9] 90 FR 12982

[10] 90 FR 13009

[11] Indeed, prior to implementation of the monthly SEP, I conducted an analysis that concluded this policy would increase premiums. See Matthew Fiedler, "Comments on a CMS Proposal to Allow Year-Round Marketplace Enrollment for Low-Income People" (Brookings Institution, August 2, 2021), https://www.brookings.edu/opinions/comments-on-a-cms-proposal-to-allow-year-round-marketplace-enrollment-for-low-income-people/.

far from guaranteed. If the monthly SEP is allowing people who are relatively inattentive to their health insurance—a group that is plausibly relatively healthy—to enroll even if they miss open enrollment, then eliminating it could *increase* premiums rather than reduce them. Similarly, like other policies that increase administrative burden, requiring SEP enrollees to submit additional documentation would deter some eligible enrollees who use relatively little health care from enrolling, which could partially or fully offset any effects from removing ineligible enrollees.

HHS could provide more compelling estimates by analyzing data it holds on recent years' experience under alternative SEP policy regimes. In particular, HHS could examine how the volume of enrollment during open enrollment versus during SEPs changed after relaxation of SEP verification processes and implementation of the monthly SEP. It could also use risk adjustment data to examine how the average claims risk of these two types of enrollees changed over time. If the SEP policies are assumed not to affect the pace of enrollment during open enrollment, these trends could form the basis for a "difference-in-differences" estimate of the effect of these policies changes on the amount and risk mix of SEP enrollment and, in turn, the effect of these past SEP policy changes on the risk pool. Even if this assumption is rejected, alternative assumptions could be made, and the resulting estimates would likely be far superior to simply ignoring this evidence, as HHS opted to do for the purposes of the analysis presented in the proposed rule.

**HHS' methods for estimating the prevalence of improper enrollments are flawed**

To support assertions that improper Marketplace enrollments are widespread, HHS repeatedly cites an analysis published by the Paragon Health Institute, which HHS then updates in the rule's regulatory impact analysis.[12] HHS' updated analysis compares administrative tallies of the number of plan selections among people with incomes between 100 and 150% of the FPL to an estimate of the corresponding "eligible population" derived using 2023 American Community Survey (ACS) data. In states where the number of plan selections exceeds its estimate of the eligible population, HHS treats the excess as improper enrollments, yielding an estimate that there were "as many as 4.4 million erroneous or improper enrollments" in 2024.

As HHS itself notes in the proposed rule, this methodology has substantial limitations for measuring improper enrollments since its ACS-based measure of the eligible population has serious shortcomings.[13] Perhaps the most fundamental problem is that eligibility for advance payments of the premium tax credits is based on a Marketplace applicant's *projected* income, not the enrollee's actual income for the year, which is what is measured in the ACS data. Considering the substantial income volatility experienced by low-income enrollees,[14] the distribution of

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[12] Brian Blase and Drew Gonshorowski, "The Great Obamacare Enrollment Fraud" (Paragon Health Institute, June 2024), https://paragoninstitute.org/wp-content/uploads/2024/06/The-Great-Obamacare-Enrollment-Fraud_FOR_RELEASE_V2.pdf.

[13] 90 FR 13021

[14] Lauren Bauer, Chloe N. East, and Olivia Howard, "Low-Income Workers Experience the Most Earnings and Work Hours Instability" (The Hamilton Project), accessed April 7, 2025, https://www.hamiltonproject.org/publication/post/low-income-workers-experience-by-far-the-most-earnings-and-work-hours-instability/.

projected income need not neatly align with the distribution of actual income. Other significant problems include that HHS' analysis relies on the wrong measure of income and family size, that survey data like the ACS can be subject to significant measurement error, and that HHS is relying on ACS data that incorporates only part of the effects of Medicaid unwinding. Together with the other limitations of this methodology catalogued in the proposed rule, this implies that this analysis offers an unreliable basis for HHS' conclusion that improper enrollments are widespread.

Other research using methods that avoid the many problems of the Paragon methodology does suggest that there are a relatively large number of Marketplace enrollees with attested incomes just above 100% of the FPL in Medicaid non-expansion states, the income threshold at which enrollees become eligible for Marketplace coverage rather than falling in the "coverage gap."[15] In particular, using data for 2015-2017, this analysis found that there were many more enrollees just above 100% of the FPL (e.g., between 100 and 110% of the FPL) than there are slightly farther above this threshold (e.g., between 110 and 120% of the FPL) in these states. This finding suggests the presence of the eligibility threshold at 100% of the FPL is influencing enrollees' income estimates. However, it is not at all clear that applying this methodology to updated data would produce an estimate of "excess" enrollment comparable to HHS' current estimate.

It is also important to note that, while this finding does suggest that enrollees' income estimates are influenced by the 100% of the FPL threshold, it does not necessarily mean that all or even most of these "excess" enrollments are improper. While this pattern could arise if enrollees are purposely misstating their income, it could also arise in other ways. For example, if enrollees submit an initial good-faith estimate and then realize that they have forgotten to report some smaller sources of income only if found ineligible, that could generate precisely this pattern despite all enrollees operating in good faith. Alternatively, if some enrollees adjust their labor supply in response to the eligibility threshold, that could also contribute to such a pattern.

A final note is that even to the extent that these "excess" enrollments are improper, it points to a narrow and specific issue pertaining to how enrollees near the 100% of FPL threshold estimate their income. This could potentially justify some proposals in the proposed rule focused narrowly on verifying enrollee income estimates (although HHS would still need to weigh the intended effect of rooting out ineligible enrollees against the likelihood that new documentation requirements would deter eligible enrollees as well). But it is unlikely it could justify many of the HHS assertions and proposals in the proposed rule that rely on this evidence to support the claim that there is a much wider-ranging improper enrollment problem.

Thank you for the opportunity to comment on the proposed rule. I hope that this information is helpful to you. If I can provide any additional information, I would be happy to do so.

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[15] 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* 11, no. 1 (January 2025): 63–90, https://doi.org/10.1086/727785.

Sincerely,

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April 11, 2025

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

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

The Honorable 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 Mr. Kennedy and Dr. Oz:

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

This proposed rule represents a sharp reversal of previous policy without sufficient new evidence, without a reasonable connection to the justifications provided, and without considering key reliance interests.

Virtually every provision individually is harmful to consumers and/or inconsistent with the best reading of the statute. In addition, the proposals are justified with flawed analysis with respect to the major goals cited: reducing improper enrollment and improving the risk pool. And even to the extent that real problems exist under current policy (including evidence of fraud by brokers), the proposals bear no reasonable relationship to solutions that would address these problems. There are ways to address concerns about fraud by agents and brokers, but the rule omits such measures.

The rule also undermines state autonomy, imposes needless costs on states, and requires states to make changes on infeasible timelines, often in ways that would reverse policies on which they have relied for years.

Finally, the rule fails to provide a meaningful opportunity to comment, due to both the short comment period and the Centers for Medicare and Medicaid Services' ("CMS") failure to make publicly available key data that the agency has access to.

We urge CMS to go back to square one on this rule. It should perform credible analysis, reconsider its proposals in light of this analysis, release such analysis, and provide a meaningful comment period to consider or challenge it, and delay any effective dates to allow for this process and a workable implementation timeline.

This comment is organized into three sections.

- The first provides comments on specific proposals of the rule.
- The second provides comments on the rule's regulatory impact analysis and analytical claims generally.
- The third raises additional concerns about procedural issues in promulgating the rule.

# Comments On Specific Proposals

The rule generally includes three categories of proposals, which we consider in turn:

- Proposals that reduce affordability and benefits
- Proposals that impose administrative burdens and reduce opportunities to enroll
- Proposals that narrow eligibility for coverage

## *Proposals that Reduce Affordability and Benefits*

### Changing the Premium Adjustment Percentage to Increase Consumers' Premium Contributions and Out-of-Pocket Costs (Section 156.130(e))

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. The change 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.

Under the ACA, the premium adjustment percentage is used to update the maximum annual limit on out-of-pocket cost-sharing ("MOOP") under employer-sponsored and individual market health plans. The Internal Revenue Service ("IRS") uses the premium adjustment percentage to update individual contributions for Marketplace enrollees receiving the PTC. It is also used to update other ACA parameters, like the employer shared responsibility payment.

Under current regulations, the premium adjustment percentage measures premium growth by looking at changes in the cost of employer-sponsored coverage. CMS proposes to change the calculation to also include coverage in the individual market. Either way, the calculation looks at changes to premiums dating back to 2013, before most of the ACA had taken effect.

Under the proposed new methodology, the premium adjustment percentage for 2026 would be about 4.5% higher than under the current methodology. This would mean a similar increase in the MOOP and employer payments for 2026, resulting in an overall increase of about 15% over 2025's levels. In addition, if the IRS adopts CMS's premium adjustment percentage methodology, as is required under current IRS regulations, consumers receiving Marketplace subsidies could expect to pay 4.5% higher premiums for a benchmark silver plan than under the current methodology. Together with the actuarial value change discussed below, this change would expose a typical family to an additional $900 in cost-sharing and $313 in premiums annually. CMS estimates that this would reduce federal PTC spending by $1.27 billion and enrollment by 80,000 individuals in 2026. The MOOP change would permit insurance companies to impose higher deductibles and other cost-sharing on not only Marketplace enrollees but also the 160 million people with employer-sponsored coverage.

*The proposal is contrary to Congress's intent for the premium adjustment percentage to account for underlying trends in the cost of health coverage.*

The premium adjustment percentage is intended to measure underlying trends in health insurance premiums, not the effect of the policy changes made in the ACA itself. Individual market premiums experienced a discrete period of volatility when the Marketplaces came online and due to subsequent policy changes, including changes in the PTC itself. Indeed, the existence of a temporary reinsurance program guaranteed premium increases as the program phased out–premium changes that are unrelated to any trends in health spending. As a result, looking at individual market premiums back to 2013 artificially inflates premium growth over time. Group market premiums are insulated from ACA policy changes and have been far more stable, making them the only accurate premium metric of actual trends in health care spending.

*The proposal is contrary to the ACA purpose of expanding coverage and affordability.*

In enacting the ACA, Congress's stated purpose was to expand access to affordable coverage options. By making premiums and cost-sharing less affordable, this proposal would undermine that goal and thus is inconsistent with the intent of Congress.

*The proposal will worsen the risk pool and increase premiums for unsubsidized enrollees.*

Increasing premiums for subsidized enrollees and worsening the value of coverage is expected to deter enrollment of healthier enrollees, as described in more detail below. This will worsen the average risk pool and increase premiums, contrary to CMS's purported goal of increasing affordability in promulgating this regulation.

For the foregoing reasons, we urge CMS not to finalize this proposal.

**Reduced Plan Generosity and Premium Tax Credits (Sections 156.140, 156.200, 156.400)**

CMS proposes to change the de minimis ranges for health plans' actuarial values ("AV") in the individual and small-group markets. Under the ACA, insurers in the individual and small group markets are required to offer plans with specified levels of generosity (called "actuarial value"), labeled bronze (covering 60% of an average enrollee's costs), silver (70%), gold (80%), and platinum (90%). However, insurers have some flexibility in meeting these actuarial value levels. In the proposed rule, CMS would change the de minimis ranges to permit lower-value plans at each metal level:

**Figure 1. Proposed Changes to De Minimis Ranges for AV.**

| Plan Level or Type | Current range | Proposed range |
|---|---|---|
| Bronze | +2/-2 | +2/-4 |
| Expanded Bronze* | +5/-2 | +5/-4 |
| Silver | +2/-2 | +2/-4 |
| Cost-sharing reduced Silver variations | +1/0 | +1/-1 |
| On-Marketplace Silver | +2/0 | +2/-4 |
| Gold | +2/-2 | +2/-4 |
| Platinum | +2/-2 | +2/-4 |

CMS argues that giving issuers greater flexibility to increase cost-sharing for consumers will reduce premiums, improve the risk pool, and reduce the risk that issuers will exit the market. CMS estimates that gross premiums would decrease by 1%, on average, as a result of this change. CMS acknowledges that widening the de minimis range for on-Marketplace silver plans will reduce Advanced Premium Tax Credits ("APTC") for consumers and thus increase net premiums. This is because APTCs are based on the premiums for the second lowest-cost silver plan in the market, and plans with lower actuarial values generally have lower premiums.

As a result, the proposed change will result in higher costs for the vast majority of Marketplace enrollees. That is, due to smaller APTCs, recipients will have the choice of 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, reaching $1.4 billion in plan year 2029.

Moreover, any resulting reduction in premiums for unsubsidized enrollees will be due to less-generous coverage, which exposes enrollees to higher deductibles and other cost sharing. This sort of shrinkflation does not help consumers. Indeed, under the current de minimis ranges, most consumers, subsidized and unsubsidized alike, who wish to pay lower premiums and risk higher cost-sharing can already do so by purchasing a plan at a lower metal level.

CMS also argues, without providing evidence, that increasing the de minimis range will improve the Marketplace risk pool. In fact, the opposite is likely to occur. That's because it will *increase* premiums for comparable coverage for subsidized enrollees, who represent most of the risk pool. Reducing APTCs by an estimated $1.2 billion in plan year 2026 will make coverage less affordable for most enrollees. The evidence is clear that those most likely to drop their insurance due to an increase in premiums are healthy individuals; sicker individuals are more willing to tolerate higher premiums because they need the coverage. This proposed change would thus lead to a smaller, sicker Marketplace risk pool. Accounting for that effect, the rule will ultimately raise gross premiums for unsubsidized individuals as well.

An additional rationale that CMS provides for the proposed changes to de minimis ranges is that issuers have threatened to leave the Marketplace if they are not accorded greater flexibility. Even if such threats have occurred, there is no evidence that issuers will actually withdraw from the Marketplaces. Since the Biden administration tightened the de minimis ranges in the 2023 Notice of Benefit and Payment Parameters, issuer participation has only increased. In 2022, an average of 9.2 issuers participated in the ACA Marketplaces. That number grew to 9.4 in 2023 and 9.6 in 2025. The Marketplaces have not only benefited from new issuers entering the market, but many existing issuers have also expanded their service areas since the tighter de minimis ranges were implemented. Thus, there is no evidence that the narrower de minimis ranges are reducing participation.

For the foregoing reasons, we urge CMS not to finalize the proposal to widen de minimis ranges.

## Prohibiting Coverage for Treatment of Gender Dysphoria (Section 156.115(d))

CMS proposes to prohibit issuers in the individual and small-group markets from covering what it refers to as "sex trait modification" as part of essential health benefits ("EHB"), beginning in plan year 2026. CMS asserts, without evidence, that the items and services associated with the treatment of gender dysphoria are not typically covered in employer-sponsored health plans. However, as described below, available evidence indicates that the majority of employer-sponsored health plans do in fact offer such coverage. Section 1302(b) of the ACA requires the Secretary of Health and Human Services to ensure that the scope of EHB be "equal to the scope of benefits provided under a typical employer plan." In doing so, the Secretary is prohibited from making coverage decisions or designing benefits in ways that discriminate against individuals because of a disability and must account for the health care needs of diverse segments of the population.

We urge CMS not to finalize this proposal because it is discriminatory. The proposal will also raise consumer costs, impose new administrative burdens on plans and issuers, and reduce access to medically necessary items and services that have been recommended by virtually all major U.S. medical associations. Barring plans from covering treatment for gender dysphoria as EHB will expose policyholders who need these services to higher out-of-pocket costs. Transgender individuals, on average, have lower incomes than cisgender individuals, making higher costs a greater barrier to getting the care they need.

CMS's stated rationale for removing gender-affirming care from EHB is grounded in a false premise: that employer-based insurance does not generally cover such services. In fact, the opposite is true. KFF, the publisher of the preeminent annual survey of employer health plans, finds that "[c]overage of gender affirming care services in employer plans is fairly common." In the 2025 Corporate Equality Index, the Human Rights Campaign Foundation found that 72% of Fortune 500 businesses (and 91% of businesses listed on the Corporate Equality Index) offer coverage of treatment for gender dysphoria. Similarly, coverage for gender dysphoria is widespread among state employee plans (24 states and Washington, DC), and 14 states and DC prohibit exclusions of coverage for gender dysphoria in state-regulated plans.

The proposed rule notes that current federal rules prohibit issuers from including as part of EHB non-pediatric eye exam services, long-term/custodial nursing home care, or non-medically necessary orthodontia.[1] Such services are generally not covered in the commercial market, major medical health plans. Unlike these other services listed in 45 C.F.R. § 156.115(d), the medications and services used to treat gender dysphoria are commonly covered in major medical health plans, including by 55% of insurers that offered 2025 Marketplace plans. Indeed, this proposal would be the first time that CMS prohibited states from including in EHB benchmark services that clearly fall within the 10 statutory EHB categories–a substantial imposition on state autonomy.

CMS acknowledges that individual and small-group market plans cover treatment for gender dysphoria, noting that 0.11% of enrollees in non-grandfathered individual and small group market plans used this type of care in 2022 and 2023. CMS interprets this utilization level to indicate that treatment for gender dysphoria is not covered by these plans. But in fact, the relatively low utilization rate is explained by the small size of the transgender population and the fact that individual medical needs vary. Data from a UCLA School of Law Williams Institute report show that only 0.6% of people over the age of 13 are transgender, and, under expert standards of care, treatment for gender dysphoria is highly individualized. There are many other services, such as heart transplants, that are infrequently used by the population at large but are commonly covered by employer-based, major medical health insurance.

The proposed rule would also be difficult for issuers to implement because many of the items and services used to treat gender dysphoria cut across multiple EHB categories and are also

[1] For plan years 2026 and prior, federal rules also prohibited issuers from including routine non-pediatric dental services in EHB. CMS lifted that prohibition in the 2025 Notice of Benefit & Payment Parameters, effective for plan year 2027.

used to treat other medical conditions. If this proposed rule is finalized, issuers would need to determine when and how to cover a range of widely covered, medically necessary services—including mental and behavioral health care, prescription drugs, and surgical care (e.g., a hysterectomy)—based on diagnosis, significantly complicating claims and utilization management processes.

These challenges in differentiating whether common treatments are aimed at a specific diagnosis could delay or interfere with a wide range of patients receiving these treatments—compounding the already deep frustration that patients and their providers have with insurers' utilization management practices and diminishing the value of enrollees' coverage.

Furthermore, preventing plans and issuers from covering treatment for people with gender dysphoria as an 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 existing laws and policies, including 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.[2]

## *Increased Administrative Burdens and Reduced Opportunities for Enrollment*

### Shortening the Opportunity to Enroll (Section 155.410)

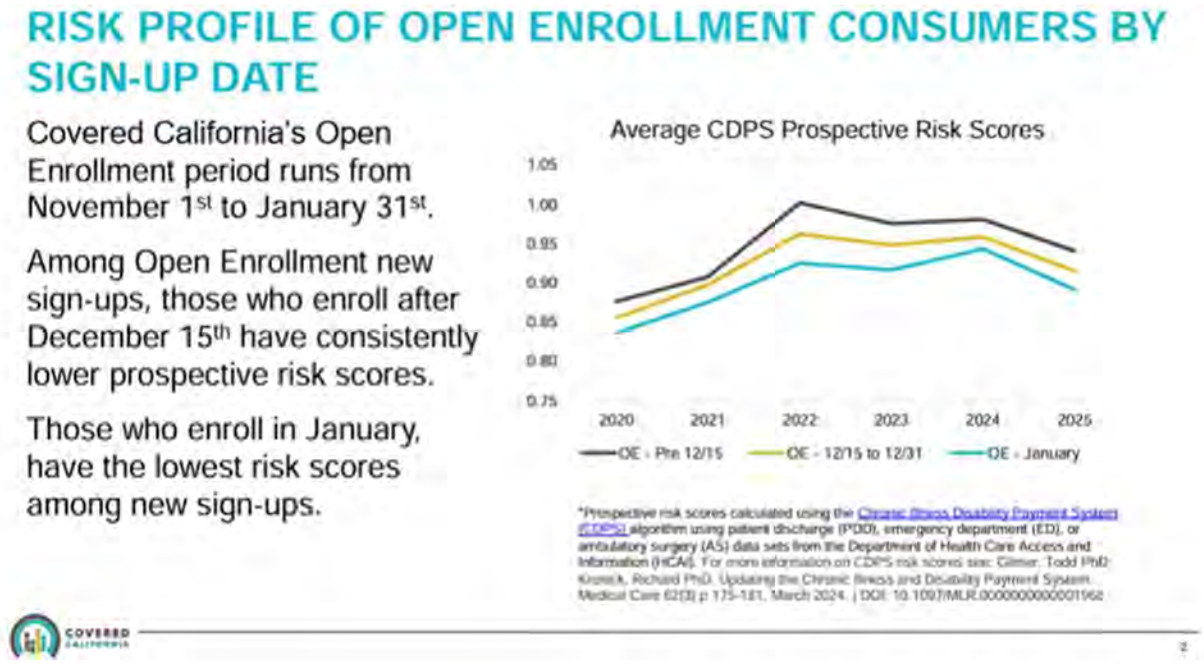
CMS proposes to shorten the annual open enrollment period ("OEP") for the federally facilitated exchange ("FFE") from 76 to 45 days. Further, in a break from historic deference to state flexibility, the proposed rule would prohibit the state-based exchanges ("SBE") from having a longer OEP. If finalized, all Marketplace OEPs would be required to run from November 1-December 15. CMS supports this proposed change by suggesting, contrary to available evidence, that extending the OEP past December 15 contributes to adverse selection. CMS also asserts that a longer OEP does not help boost enrollment and contributes to "consumer confusion." However, the agency provides no evidence to support these claims.

#### *Available data contradict CMS's claims.*

In fact, 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 December 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. See Fig. 2.

[2] Bostock v. Clayton County, 590 U.S. 644 (2020) (holding that discrimination based on gender identity constitutes sex discrimination).

**Figure 2. Risk Scores for Covered California Enrollees During OEP, Plan Years 2020-2025.**




*Source:* https://hbex.coveredca.com/data-research/library/CoveredCA_OE_SEP_Data_Snapshot_20250403.pdf

Covered California's longer OEP (which runs until January 31) has in fact resulted in a healthier risk pool over time. *See also* Figure 2.

Similarly, in the final month of New York State of Health's ("NYSOH") 2017 OEP, which ended January 31, more than 135,000 individuals enrolled in Marketplace health plans. Using age as a proxy for risk status, New York found that younger enrollees made up a higher share of total enrollment in January than they did earlier in the OEP. Enrollees ages 55-64 comprise a larger proportion of Marketplace enrollees before January as opposed to after. NYSOH has also found that a greater share of consumers enroll in Platinum and Gold plans earlier during OEP versus the final month of enrollment, when Bronze and Silver enrollment is predominant. This suggests that those enrolling in January are healthier than those who enroll early in the OEP.

Although CMS presumably has data about the relative risk profile of January enrollees for the FFE, it fails to provide this data to support its assertions about adverse selection. This may be because, as in the SBEs, sicker individuals or those expecting significant health expenditures are more motivated to sign up for coverage early in the OEP. Those who are healthy are less motivated to enroll, and more likely to be deterred by financial and time constraints during the busy holiday period.

*The proposed policy change will impose major costs on SBEs.*

If finalized, this proposed change in OEP dates will impose significant new costs on the FFE and SBEs alike. By CMS's own estimates, it would take each SBE 4,000 hours to develop and code changes to their IT systems, at a cost of almost $7.8 million. This cost estimate does not take into account the expenditures for SBEs and issuers associated with the required outreach to consumers and training of consumer assisters. The proposed rule provides no justification for extending the FFE OEP deadline to SBEs and constraining state autonomy.

The SBEs are in a better position than the federal government to assess their market and the needs of their consumers. As noted above, many maintain a longer OEP than the FFE because they have found that it boosts enrollment among young, healthy individuals. *See* Figure 2. Indeed, as the current director of the Center for Consumer Information and Insurance Oversight ("CCIIO") has previously noted: "states are in a better position [than the federal government] to assess the situation. This promotes a stable marketplace."

*Other important policy considerations weigh against finalizing the proposed policy change.*

There is also evidence that the holiday period that runs from Thanksgiving to New Year's Eve is a time of financial constraint, particularly for the low- and moderate-income families that enroll in the ACA Marketplaces. Giving these families until January 15 to enroll avoids imposing additional stress during this time. SBE enrollees may face additional confusion since many SBEs have maintained the same OEP duration for many years. For example, NYSOH's OEP has extended to January 31 since 2016.

Furthermore, CMS acknowledges that many current Marketplace enrollees could face significant premium increases for plan year 2026–both as a result of other provisions of this proposed rule and if Congress fails to extend the enhanced premium tax credits originally provided in the American Rescue Plan Act of 2021 and extended through 2025 in the Inflation Reduction Act of 2022. Many of these enrollees may not learn of those premium changes until they receive their first bill for 2026, which may be well after December 15. Ending OEP on December 15 would leave them without the necessary time to make plan changes.

At the same time, CMS has slashed Navigator grants by 90%, leaving these critical consumer assisters 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 these consumer assisters, 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.

We therefore urge CMS not to finalize this proposal, to maintain the current OEP duration of November 1-January 15, and to continue to provide SBEs with 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 harms and confusion consumers will face if Congress does not extend the enhanced APTCs.

## Eliminating a Critical Enrollment Opportunity for Low-Income Individuals (Section 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") (or an annual income of $23,475 for an individual, $48,225 for a family of four). In its 2025 Proposed Notice of Benefit and Payment Parameters, CMS found that the availability of this SEP has helped low-income consumers access affordable health insurance coverage and maintain access to care. However, CMS suggests that this SEP (referred to here as the "low-income SEP") has contributed to improper enrollments, driven largely by unscrupulous brokers and web-brokers seeking commissions. CMS also suggests, without evidence, that this SEP has increased adverse selection, leading to a less-healthy risk pool. The agency further posits that the low-income SEP lacks a statutory basis.

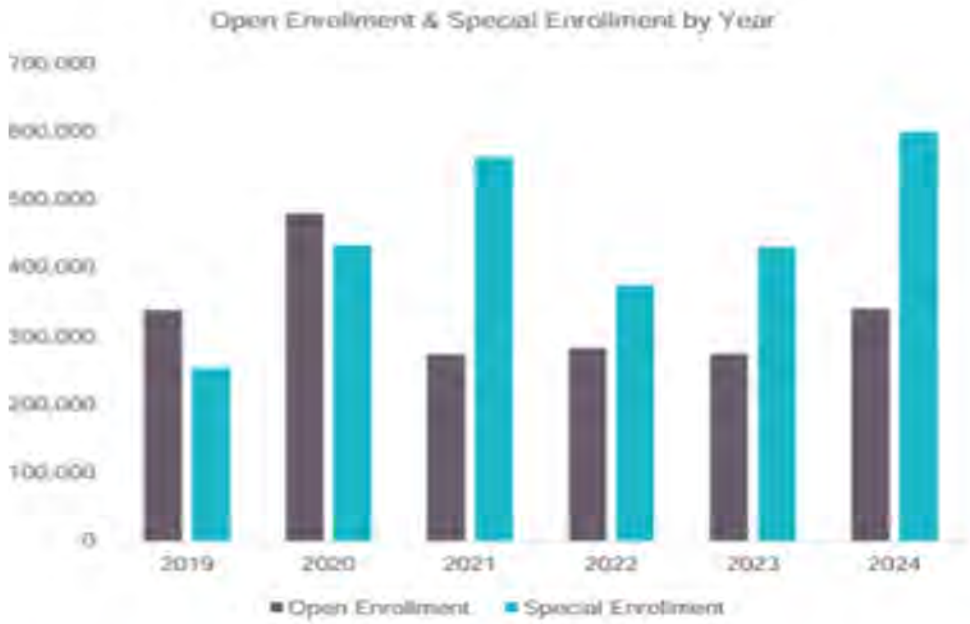
We urge CMS not to finalize this proposal. The low-income SEP has helped over one million individuals overcome challenges enrolling in health coverage. These challenges are particularly acute for lower-income individuals who may lack access to necessary information, face greater employment and household 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.

There is no evidence that the existence of the low-income SEP has caused the increase in fraudulent enrollments experienced by the FFE in 2024. In fact, CMS traced the cause of enrollments and plan switches made without consumer consent to brokers and agents in the FFE taking advantage of system vulnerabilities that are unique to the FFE. CMS's proposed policy solutions seem poorly targeted to address the true problem of broker and agent fraud. Attempting to deter fraudulent enrollments by making it harder for people to obtain insurance coverage is like "trying to prevent car theft by making it more difficult for people to own cars."

By CMS's own estimates, fraud associated with unauthorized enrollments and plan switches for people under 150% FPL is concentrated in states that use the FFE and that have chosen not to expand Medicaid under the ACA. There is no evidence of any meaningful fraud in the SBE states, all but one of whom have expanded Medicaid and all but two have implemented the low-income SEP and have had it available to consumers for multiple years. None of these SBEs have reported problems with fraud. Indeed, Covered California reports that SEPs have become a critical source of enrollment, with more consumers signing up via SEP than during the annual OEP. See Figure 3. Yet there is no evidence of any meaningful fraud, due to Covered

California's comprehensive safeguards to ensure that brokers obtain consumer consent before completing an enrollment. Similarly, the Massachusetts Connector, which has long had a year-round SEP for low- and moderate-income individuals, has identified "zero consumer reports among the 1.2 million calls to its customer service center in 2024" of unauthorized enrollments.

**Figure 3. Covered California OEP and SEP Enrollment, Plan Years 2019-2024.**




*Source:* https://hbex.coveredca.com/data-research/library/CoveredCA_OE_SEP_Data_Snapshot_20250403.pdf

There is also no evidence that the low-income SEP has contributed to adverse selection. Although CMS has access to data that would indicate the risk status of people who enroll through SEPs compared to the OEP, data supporting that contention are notably absent from this proposed rule.

More strikingly, the experience of SBEs suggests that the people enrolling through low-income SEPs are, in fact, younger and lower-cost on average than those who enroll via OEP. For example, Massachusetts has long offered year-round enrollment to people who qualify for ConnectorCare, the state's Marketplace program for low- and moderate-income individuals. Massachusetts Health Connector officials report that they have "not experienced adverse selection within the program," and their "risk scores have been healthier than for insurers off-Marketplace."

Data included in a comment submitted by the Vermont Marketplace show that per-member-per-month costs associated with SEP enrollees are 8% lower than non-SEP enrollments, and that costs are lower-than-average among enrollees in an equivalent position to those who qualify for the FFE's under-150 SEP.

Covered California has found that the prospective risk scores of consumers enrolling through SEPs was equal to or lower than those enrolling through the OEP each year from 2020 to 2024. See Figure 4.

**Figure 4. Covered California Average Risk Scores for OEP and SEP Enrollees, Plan Years 2020-2025.**

| | Open Enrollment | Special Enrollment |
|---|---|---|
| 2020 | 0.86 | 0.85 |
| 2021 | 0.89 | 0.87 |
| 2022 | 0.96 | 0.93 |
| 2023 | 0.95 | 0.94 |
| 2024 | 0.96 | 0.96 |
| 2025* | 0.92 | |

*Source:* https://hbex.coveredca.com/data-research/library/CoveredCA_OE_SEP_Data_Snapshot_20250403.pdf

DC Health Link, in reviewing 2019-2021 enrollment, found that the age of the SEP population remained consistent with the population that enrolled during open enrollment, and in some cases was even younger. See Fig. 5.

**Figure 5. Ages of SEP and OEP Enrollees in DC Health Link, Plan Years 2019-2021**

| Age | 2019 Open Enrollment % | 2019 SEP % | 2020 Open Enrollment % | 2020 SEP % | 2021 Open Enrollment % | 2021 SEP % |
|---|---|---|---|---|---|---|
| < 18 | 10% | 10% | 10% | 10% | 9% | 10% |
| 18-25 | 5% | 7% | 10% | 9% | 10% | 9% |
| 26-34 | 34% | 40% | 39% | 44% | 42% | 44% |
| 35-44 | 22% | 22% | 20% | 18% | 19% | 19% |
| 45-54 | 15% | 12% | 11% | 10% | 11% | 9% |
| 55-64 | 13% | 9% | 9% | 8% | 8% | 8% |
| 65+ | 1% | 1% | 1% | 1% | 1% | 1% |
| TOTAL | 100% | 100% | 100% | 100% | 100% | 100% |

*Source: https://hbx.dc.gov/sites/default/files/dc/sites/hbx/page_content/attachments/DC%20HBX%202023%20NBPP%20Comments%20Final%201-27-22.pdf

Similarly, Massachusetts Connector officials have found that the average age of people enrolling through a SEP is 38—younger than the average age of enrollees overall, which is 41.

Even if Congress does not extend the enhanced APTCs this year, households with income at or below 150% FPL are still likely to find Marketplace plans with $0 premiums, further mitigating the risk of adverse selection. CMS's own data show that in 2020, before the enhanced APTCs were provided, 900,000 people were enrolled in fully subsidized bronze plans where the net premium was $0. About 77% of people at or below 150% FPL had access to a $0 premium bronze plan and 16 percent had access to a $0 premium silver plan. The availability of such plans to low-income consumers significantly mitigates the risk of adverse selection (because there is nothing to be gained by delaying enrollment), a fact CMS fails to take into account in its current rulemaking.

CMS does not provide an estimate of the cost to SBEs of implementing this proposed change, incorrectly stating that no SBE has implemented the low-income SEP. In fact, 18 SBEs—all but Idaho and Nevada—have implemented this SEP. The agency further proposes to require the removal of this SEP from SBEs immediately upon the effective date of the final rule. Requiring SBEs to remove this SEP from their eligibility and enrollment systems would result in significant costs, not only in terms of the necessary IT system changes but also to change current consumer communications, outreach, and training programs for consumer assisters. Furthermore, the requirement to implement this change in 60 days would be extremely challenging if not impossible.

As CCIIO's Director has observed, states are in a better position than the federal government to understand their markets and customer needs. Given that SBEs have reported neither fraud nor adverse selection arising from the low-income SEP, there is simply no rational basis to require the SBEs to eliminate this SEP.

CMS also posits that it lacks statutory authority to establish the low-income SEP, citing to the list of SEPs enumerated in sections 1311(c)(6)(C) and (D) of the ACA. However, section 1311(c)(6)(C) provides ample authority for this SEP. Specifically, it provides that "the Secretary *shall require* an Exchange to provide for…other special enrollment periods under circumstances similar to such periods under" Medicare Part D. Section 1860D-1(b)(3)(C) of the Social Security Act provides the Secretary with authority to establish SEPs for Medicare Part D enrollment, including the explicit authority to establish SEPs for "extraordinary circumstances," a broad term that the statute does not define. This alone creates the necessary authority.

CMS argues that the low-income SEP is dissimilar to Part D SEPs in statute. But in fact, Medicare Part D has a similar low-income SEP, which allows people with low incomes to change plans once per month or to drop Medicare Advantage and join traditional Medicare with a Part D drug plan. The Medicare Part D statute, similar to the ACA, lists certain specific SEPs that the Secretary must set up as a minimum; not all Medicare Part D SEPs are specified in statute. Thus, the low-income Marketplace SEP is indeed similar to a SEP in Medicare Part D.

More generally, Congress enacted the ACA with the goal of expanding access to health insurance. To effectuate this goal, section 1321(a) of the ACA provides the Secretary with broad authority to set standards for the offering of health plans through the Marketplaces, including standards relating to enrollment.

The authority in Section 1311(c)(6)(C) has been used dozens of times by CMS and by SBEs for all sorts of circumstances, including many that provide an enrollment opportunity for designated groups of applicants, such as during Medicaid unwinding and after certain natural disasters. Creating the low-income SEP is fully consistent with these precedents and the underlying authority. Asserting otherwise would represent a stark reversal from years of widespread practices.

## Added Paperwork for Consumers Using a Special Enrollment Period (Section 155.420(g))

CMS proposes to impose additional documentation requirements on consumers seeking to enroll in Marketplace coverage through a SEP. Additionally, although CMS has traditionally given SBEs deference in the establishment and verification of SEPs, the proposed rule would require all Marketplaces, including SBEs, to conduct pre-enrollment eligibility verification for at least 75% of new enrollments through SEPs.

In proposing this change, 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. Without providing evidence, CMS asserts that new documentation burdens will improve, not worsen, the Marketplace risk pools. In fact, CMS's own analysis in this proposed rule found that "younger, often healthier, consumers submit acceptable documentation to verify their SEP eligibility at much lower rates than older consumers."

CMS appears to assume, without any basis, that providing pre-enrollment documentation is easy for consumers, and that all consumers have "ready access" to the necessary official documents. In fact, a considerable body of research has found that paperwork and other administrative hurdles to enrollment in coverage programs serve as a strong deterrent to enrollment among people who are otherwise eligible for the coverage. Younger, healthier individuals are more likely to be deterred from enrolling, leading to a less-healthy risk pool. For example, a study published by the American Economic Association found that adding one single additional step to the enrollment process prompted a 33 percent decline in enrollment, predominantly among young, healthy, and economically disadvantaged people. Removing paperwork burdens, on the other hand, has been found to significantly increase enrollment and continuity of coverage among healthy, younger individuals.

CMS also argues that imposing new documentation requirements on consumers will help curtail SEP enrollments made without consumer consent. However, there is no evidence that adding bureaucratic headaches to the lives of consumers will serve as an impediment to the brokers

and web-brokers set on committing fraud. Many SBEs use an applicant's self-attestation as the primary mechanism for verifying SEP eligibility, yet no SBE has reported any meaningful fraud in their markets. SBEs are also in close communication with their participating issuers and are in a better position than the federal government to identify and address any concerns about how the SEP verification process is being used. Currently, many SBEs require consumers seeking to enroll via many SEPs to attest, upon penalty of perjury, that they qualify for the SEP in question. CMS has provided no evidence of any abuse of this process.

CMS's proposal would extend the new paperwork requirements across all Marketplaces, not just the FFE. Such a requirement would pose a significant, unfunded mandate on the SBEs. CMS estimates that the proposed changes would result in an annual new cost of $1,736,615 per SBE, not including costs associated with consumer communications, outreach, and assister training. Although CMS proposes allowing SBEs to submit a request for an alternative verification process, submitting such requests to CMS also poses significant, unnecessary burdens on SBE staff. Because CMS provides no evidence to support either the use of SEPs to commit fraud in the SBEs, nor evidence of adverse selection, there is no rational basis to take away SBEs' traditional flexibility to determine the SEP verification processes that work for their issuers and markets.

We urge CMS not to finalize this proposal.

## Denying APTC for Failure to Reconcile (Section 155.305(f)(4))

CMS's proposal would change a recently instituted policy, under which consumers are only denied future APTC after IRS reports that they have not filed and reconciled past APTC for two years—referred to as failure to file and reconcile ("FTR"). If finalized, CMS's proposal would deny a consumer APTC if the IRS reports that they had not reconciled APTC for a single year, instead of the two years under the current policy.

Under the ACA, consumers receive APTC based on their projected income and then must file a tax return to reconcile APTC against the PTC they are ultimately due. An individual who fails to reconcile is subject to all of the IRS's normal enforcement tools for failing to properly file a return. FTR rules—created in CMS regulations—provided an additional penalty: individuals who failed to reconcile would also be denied APTC. But this FTR penalty appears nowhere in the statute.

FTR rules have long raised concerns about administrative burdens and fairness. IRS privacy rules generally prohibit Exchanges from providing applicants with information about their FTR status, even when denying them APTC on that basis—a recipe for consumer confusion and frustration. Consumers can also be incorrectly targeted for FTR denial due to delays or errors in processing tax returns. This is especially likely for individuals who file paper returns, which may disproportionately affect filers who are older and lower-income, and those who amend their returns. Delays and errors are also possible in the process the IRS must perform to share FTR information with Exchanges through the federal data services Hub. When these errors occur,

resolving them is complicated by the Exchanges' inability to discuss the reason for the denial. More generally, completing the forms to properly reconcile APTC is a complex process that may frustrate even those taxpayers attempting to comply.

To address these concerns, CMS adopted a new policy, effective for coverage year 2025, under which the Exchange denies APTC only when the IRS reports that a consumer has failed to reconcile for two consecutive years. This approach mitigates concerns about delayed or missing IRS data, consumer confusion, and administrative burden. In adopting this rule, CMS noted that this middle ground would "properly balance consumer protections and program integrity concerns, and therefore support that we should continue to improve the FTR process rather than repeal it entirely."

In addition, the IRS recently made an administrative change that minimizes the risk that consumers could fail to reconcile in the first place. If a consumer received APTC and then attempts to e-file a return without reconciling, the IRS will now bounce back that return. This policy increases the likelihood that any appearance of an FTR flag is due to IRS delay or error. CMS does not mention this recent change and does not appear to have considered it. This measure is in addition to the IRS's long-standing enforcement mechanisms for individuals who fail to properly file a return or pay taxes that are due, which can include the withholding of tax refunds and liens and levies.

CMS estimates that its proposal would deny APTC to between 265,000 and 424,000 consumers and reduce APTC spending by between $1.16 billion and $1.86 billion in 2026. Of course, CMS justifies this change by claiming 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 an FTR status allows ineligible enrollees to accumulate tax liabilities." But the agency offers no data to support this claim. Its claim about "further analysis of enrollment data" is cited generally to the CMS webpage listing public use files—no specific statistics are cited. Similarly, CMS asserts that "[a]fter reviewing the tax filing data, we remain concerned that enrollees are accumulating tax liabilities due to misestimating their income." But no tax statistics are provided. CMS also asserts that those with FTR status account for a substantial number of those improperly enrolled. But it similarly provides no data to support this assertion.

CMS does not address the premium impact of this change. But given that sicker individuals are more motivated to overcome administrative burdens to enroll in coverage than healthier ones, it would likely worsen the risk pool and increase premiums.

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 in order to remain eligible for APTC in 2026. This implementation timeline may be infeasible for some SBEs and for the IRS, both of which have historically required years to implement new FTR rules.

We urge CMS not to finalize this proposal.

## Junk Charges for Automatic Re-Enrollment (Section 155.335)

CMS proposes an unlawful approach to calculating APTC for certain consumers at automatic re-enrollment. Specifically, the agency proposes that Marketplaces will first make an eligibility determination for APTC following the terms of the statute, and then if APTC is sufficiently large, arbitrarily reduce the amount of APTC made available so that the consumer owes $5 in premium until the consumer returns to the Marketplace for an active enrollment. The ACA prohibits the imposition of this junk charge, which has no basis in statute.

### *The ACA specifies how APTC must be calculated.*

Automatic re-enrollment is the process by which a consumer from the prior year who has not actively submitted an application and enrolled in coverage for the upcoming benefit year is re-enrolled. In determining eligibility for APTC during the re-enrollment process, agency action is governed by several sections of the ACA.

Section 36B of the Internal Revenue Code (as added by the ACA) specifies a series of criteria and calculations used in determining premium tax credit amounts. ACA section 1411 directs the Secretary of the U.S. Department of Health and Human Services ("HHS") to "establish a program… for determining… in the case of an individual claiming a premium tax credit or reduced cost-sharing under Section 36B of such Code or section 1402 whether the individual meets the income and coverage requirements of such sections." Section 1412(a) directs the Secretary to "establish a program under which… advanced determinations are made under section 1411." And section 1412(c) directs that the federal government "shall make the advanced payment under this section of any premium tax credit allowed under section 36B."

In other words, section 36B is the sole statutory instruction in how to calculate a premium tax credit amount. The program established under section 1411 must determine eligibility under section 36B. And once an individual has been determined eligible under section 1411, the federal government "shall make" payments in the amount "allowed under section 36B," as required under section 1412. In other words, the statute makes payment of the full amount mandatory.

### *There is no statutory authority to alter an eligibility determination.*

CMS has expressed a policy concern about consumers for whom APTC fully covers their premium, such that they owe nothing out-of-pocket each month. The agency thus proposes that when a Marketplace has conducted an eligibility determination that results in that outcome, the Marketplace must arbitrarily reduce APTC so that the consumer owes a premium of $5. Section 1412 clearly forecloses this outcome. Section 1412(c) requires payment of the amount "allowed under section 36B," not some other amount determined arbitrarily by CMS. It is true that ACA section 1411(f)(1)(B) provides general authority for the agency to "establish procedures" for eligibility redeterminations, as CMS notes. But nothing in that section confers authority to make

the advance determination of eligibility but then pay less than the amount dictated by the eligibility determination; rather the Marketplace "shall" pay the amount of APTC established pursuant to the eligibility determination process. Whatever policy concerns the agency may have, the text of the statute is clear and provides no discretion for a Marketplace to impose a $5 junk charge that is squarely contrary to the express provisions of the law.

These same prohibitions apply to an alternative proposal that CMS discusses, under which APTC would be removed in its entirety. A decision to apply no APTC at all for consumers determined eligible under section 1411 transparently violates the requirement that the federal government "shall make the advanced payment." If an individual has been determined eligible, APTC must be paid.[3] Similarly, these same concerns would apply if CMS attempted to direct Marketplaces not to re-enroll all consumers who qualify for APTC. If a Marketplace conducts an eligibility determination, section 1411 specifies that it must evaluate eligibility for APTC. And once an eligibility determination has occurred, the Marketplace is bound by the results—CMS has no statutory authority to direct the Marketplace to do anything different.

*CMS fails to address important policy considerations.*

Beyond the fact that the proposal violates the statute, CMS's analysis of the issue ignores a number of important policy considerations. These changes will require significant action on the part of state-based Marketplaces—requiring them to expend technical resources and damage their brand by charging consumers money they should not owe—despite no evidence of a problem. Further, in this rule, CMS proposes shortening the Marketplace OEP to end on December 15, which makes it impossible for consumers who notice the junk charge only as they are about to lose coverage to avoid paying it while keeping coverage for the rest of the year.

Finally, CMS does not quantify or grapple with the risk pool impacts of this proposal. Enrollment will fall as a result of this barrier: one study found that premiums less than $10 led to a 14 percent decrease in enrollment. As discussed extensively below, young and healthy consumers are at the greatest risk of failing to notice the junk premium charge and losing coverage as a result, while those with significant health care needs will likely resolve the issue more quickly. Indeed, real-world evidence underscores that supporting automatic re-enrollment rather than imposing small premium burdens is associated with retention of healthier consumers. CMS's proposal will worsen the risk pool and drive up premiums for unsubsidized consumers.

[3] We note that this circumstance is completely different from other cases where a consumer may lose APTC at automatic enrollment. In those cases, the Marketplace is making a determination *pursuant to section 1411* that the individual does not "meet[] the income and coverage requirements" of section 36B. Here, CMS is proposing the Marketplace would make a determination under section 1411 that a person is eligible and calculate an amount under section 36B, and then reject or alter that determination and apply a different amount of APTC or no APTC at all. It may not do so. Section 1412 requires the payment of APTC in the amount for which the consumer has been determined eligible.

## Imposing Higher Deductibles at Re-Enrollment (Section 155.335)

CMS proposes to end a policy that lowers deductibles and cost-sharing for enrollees at automatic re-enrollment. Under current policy, if an individual who is being automatically enrolled into a bronze plan can be moved into a silver plan (with lower deductibles and other cost-sharing), with the same network and from the same issuer, and with the same or lower premium, then they will be automatically re-enrolled into the silver plan. This maximizes consumer value and promotes consumer retention in coverage. The arguments CMS advances for changing the policy are not supported by evidence.

CMS's primary justification is that consumer awareness of APTC generosity has increased and therefore support to help enroll consumers in plans with lower deductibles is not necessary. Yet the agency offers no empirical evidence of such an improvement in understanding. Instead, polling data show that public awareness of the existence of APTC at all—much less the nuances of metal levels and recent changes—remains quite low. The agency also points to alleged harms from consumer confusion but offers no plausible reason why a consumer would be "confused" by being enrolled into a plan that is identical to her prior coverage, except for the fact that it has lower deductibles and cost-sharing. Indeed, the agency has provided no plausible justification for making this change and should not finalize the policy.

## More "Data Matching Issues" and More Paperwork Burden (Section 155.320)

CMS proposes two policies that will generate more paperwork related to income verification, especially for low-income people: generating a "data matching issue" ("DMI") when IRS data show income below 100% FPL, and generating a DMI in the absence of IRS data. These changes will have the effect of making it more burdensome and less efficient for low-income people and those with variable incomes or family circumstances (like small business owners and the self-employed) to receive benefits to which they are entitled. For this reason, the policy changes will deter enrollment of healthy people. The proposed changes are also expected to meaningfully worsen the Marketplace risk pool and increase premiums for unsubsidized enrollees. Indeed, a 2019 version of one of these policies was struck down under the APA. The court found that CMS's decision to "prioritize a hypothetical risk of fraud over the substantiated risk that its decision [would] result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic."[4] While CMS claims that "new" data show that the package of policies is justified, it offers no data supporting this view. In fact, the available data *undermine* the policy rationale for the proposals. Further, CMS's claims that the statute requires these changes are specious.

[4] City of Columbus v. Cochran, 523 F. Supp. 3d 731, 763 (2021).

*The proposed changes will cause a significant increase in administrative burden that will worsen the risk pool and increase premiums.*

The CMS proposal to generate DMIs when IRS data is absent or shows income below 100% FPL will place substantial new administrative burdens on people and on state and federal Marketplaces. Together, the proposals will generate an estimated 2.7 million new income DMIs (550,000 for tax data below 100% FPL and 2.1 million for missing tax data)—requiring 2.7 million people, many of whom live just above the FPL, to track down and submit paperwork in order to buy health insurance. Every year, CMS expects that people will spend $66 million dealing with the paperwork requests, and state and federal Marketplaces will spend $155 million in reviewing these documents. An estimated 480,000 people, most of whom are likely eligible, will lose health insurance because they fail to successfully navigate the process.

As discussed above, this is exactly the kind of administrative burden that deters enrollment of younger and healthier enrollees and causes problematic adverse selection. An enrollee with heart disease who is taking multiple expensive medications is *far* more motivated to track down a stack of documents to prove their income than a healthy 30-year-old enrolling in coverage for the financial security it provides. CMS has long underscored that coverage losses associated with DMIs are concentrated among the young, a pattern that CMS acknowledges continues to this day. Recent data from Massachusetts document the same pattern. Deterring these younger and healthier people from enrolling worsens the risk pool and increases premiums—further deterring enrollment of healthy unsubsidized enrollees. This "spiral" is exactly the kind of practice that CMS purports to be trying to avoid in this rule.

CMS briefly acknowledges these impacts but asserts that it is moving forward regardless because of concerns about fraud and improper enrollments. Yet CMS provides no analysis quantifying the scale of the premium increases associated with this large new administrative burden and attendant losses of coverage. Without acknowledging and assessing the adverse impacts on the risk pool and on premiums, CMS has not provided sufficient justification for the proposed additional paperwork burdens being placed on Marketplace consumers. Thus, the agency cannot make such a tradeoff in any non-arbitrary way. This is doubly true because, as discussed below, CMS's purported evidence of large-scale fraud in fact shows nothing of the kind.

*CMS's policy is based on faulty analysis that could justify the opposite conclusion as the one reached by the agency.*

CMS asserts that it needs to impose these major burdens on people because the status quo—under which CMS has focused on ways to simplify enrollment—has facilitated fraud and improper enrollment. CMS provides analysis that the agency claims demonstrates these problems at a meaningful scale. However, the analysis does not support that conclusion.

Marketplace financial assistance is based on *projected* annual income for the year. This is not a knowable number that is measured in any surveys or on one's tax return; it is a subjective projection based on the household's expectations. As described in more detail below, CMS

fundamentally misunderstands this distinction in its analysis of Marketplace enrollment patterns. In focusing on enrollment of individuals who end up having an annual income below 100% FPL, CMS claims that such an enrollment is "improper." This is simply untrue; if an enrollee had a reasonable basis for expecting that her future income would be above 100% FPL, then her enrollment is wholly legitimate, even if their income turns out to be below 100% FPL at the end of the year. CMS's claim that enrollment near the poverty level is "136 percent higher than the total population of potential enrollments" is false: the accurate denominator in such a calculation is the number of people who have reason to believe they will have income above 100% FPL, not the smaller number based on the post hoc results that are used in the calculation on which CMS relies.

Indeed, challenges in estimating annual income are especially acute for the low-income people targeted by CMS's policies, a fact which the agency entirely fails to address. One detailed analysis of earnings variability among low-income workers found that more than half experienced significant variability in income, a proportion that is greater than higher income workers. Moreover, the actual magnitude of this income variability is quite striking, with workers in the lowest quintile having more than double the magnitude of variability than all other income groups. (For low-income workers, the standard deviation of monthly income was 85% of the mean—so that someone who earned an average of $1000 per month had so much variation month-to-month that a month where their income was anything from $150 to $1850 would be within a single standard deviation.) Multiple other analyses find this same basic pattern. Against this factual backdrop, it is clear that projected income and actual annual income are fundamentally distinct concepts, especially for low-income people. The agency's acknowledgement that variability exists does not mitigate the fact that the agency's assertions regarding improper enrollment are based on that faulty premise.

Moreover, the agency's data on changes in certain enrollment patterns over time show the exact opposite of what it claims. CMS presents a table that examines the rate at which people at different income levels end the year with more APTC than the PTC calculated based on their actual end of year income. It finds that after CMS made changes to prevent unnecessary income DMIs (changes that this proposed rule would undo), the rate at which low-income people received more APTC than PTC did increase. But CMS ignores that the rate for low-income people remained *less than half* of the rate for higher income people. While there are certain structural differences between PTC calculations for high-income and low-income people, this analysis undercuts their claims that improper enrollments are concentrated among low-income people. This is especially true because income variability is so much greater for this population. Instead, to the extent that these data are a useful metric, they suggest just the opposite: that the agency was right to be concerned that aspects of their 2019-era enrollment policies were "punitive," and that changes to decrease administrative burdens were justified. Far from these data showing that the agency has more basis for acting than they did in 2019, the analysis shows that it has even less justification than it thought.

*Claims that the ACA requires change are wrong.*

Finally, CMS claims that it is required to make one or both of these changes because its current policy violates the ACA. In fact, the law clearly authorizes the status quo.

To advance its argument to the contrary, CMS claims that statutory language that provides "flexibility" for the agency to "modify the program" "for the exchange and verification of information" somehow does not actually provide flexibility to modify verification. This rests on two assertions: (1) that the statute only authorizes modifications if those modifications affect *both* "exchange" and "verification" of information, and (2) that the status quo is too significant a departure to be understood as agency action to "modify" these rules. Both claims are inconsistent with the ACA's statutory language.

To start, section 1411 of the ACA establishes a process for obtaining information related to eligibility and using that information to verify eligibility. Under a subsection labeled "Actions Relating to Verification," section 1411 establishes the DMI process that is at issue in this section of the proposed rule. In a separate subsection, the statute provides the flexibility noted above to "modify the methods used under the program established by this section for the Exchange and verification of information." This clearly authorizes modifications related to "verification." Yet CMS argues that what Congress really meant was that modifications were only allowed if they were directly related to rules for how information is *both* exchanged and verified. If Congress had meant this, they would have said so. They did not.

Similarly, CMS's claims that modifications under current policy are not actually modifications are baseless. The current rule modifies the circumstances under which a DMI is triggered and considers information adequately verified without paperwork in more circumstances. This is squarely a "modification" of the general rule and is precisely the sort of modification to reduce administrative burdens that was envisioned by the statute.

Thus, CMS cannot justify the proposals in the rule to generate new DMIs with claims that they are required by the statute to adopt these changes.

## Making Data Matching Issues Harder to Resolve (Section 155.315)

CMS also proposes to make DMIs harder to resolve by requiring a manual request for additional time to resolve a DMI rather than automatically extending the clock by 60 days. CMS justifies this primarily by arguing that the statutory language noted above that provides "flexibility" related to "verification" does not provide statutory authority for current policy. That argument fails for all the reasons noted above: the time period for resolving a DMI is clearly an aspect of verification, and so modifying it is clearly authorized under the statute.

CMS also fails to grapple with a number of critical aspects of this policy. First and foremost, the changes described above will result in a substantial increase in the number of income DMIs generated and a major additional burden in reviewing documents. As the agency sheds critical staff who, among other things, monitor contractor performance in reviewing DMIs documents

timely and make adjustments as needed, it is not at all clear whether the agency has a plan to ensure that consumers are not harmed by contractor back-ups caused by agency actions. Without automatic clock extensions, this inefficiency could cause consumers to lose coverage through no fault of their own. CMS also fails to address the additional information collection burden associated with requesting 60-day extensions.

## *Limiting Eligibility for Coverage*

### Terminating Coverage for Thousands of DACA Recipients (Section 155.20)

CMS proposes to reverse its policy relating to Deferred Action for Childhood Arrivals ("DACA") recipients by re-defining the term "lawfully present" to exclude DACA recipients for the purposes of enrollment in Marketplace and Basic Health Program ("BHP") coverage, premium tax credits, and cost-sharing reductions. This proposed change in definition would go into effect upon the effective date of the final rule, prompting DACA recipients currently enrolled in Marketplace or BHP coverage to lose eligibility mid-year. This change will cause significant disruptions in the form of interrupted and canceled health care services, increased exposure to catastrophic medical bills for this financially vulnerable population, and greater uncompensated care costs for providers. Some current Marketplace or BHP enrollees could lose coverage while in the middle of a course of treatment.

We urge CMS not to finalize this proposal and to retain its current definition of "lawfully present" to include DACA recipients. HHS has generally interpreted "lawfully present" to include those granted deferred action by the Department of Homeland Security ("DHS"). Although HHS excluded DACA recipients from the definition of lawfully present in 2012—after DHS first announced its DACA policy earlier that year—since then DHS issued regulations formalizing its DACA policy. Among other policies, DHS's DACA final rule reiterated the agency's view that a non-citizen who has been granted deferred action is deemed "lawfully present" for purposes of Social Security benefits.

CMS reconsidered its Marketplace and BHP policies in light of the DHS 2022 rule, and in 2024 the agency finalized a rule that would no longer treat DACA recipients differently than other people granted deferred action. Not only does this ensure equitable treatment across this population, the 2024 final rule better aligns with the goals of the ACA to reduce the numbers of uninsured and improve access to affordable health coverage.

In several sections of the preamble to this proposed rule, CMS expresses concerns about adverse selection in the ACA Marketplaces. Yet the proposal to end coverage for DACA recipients would remove from the risk pool a population that is healthier, on average, than the general population. A 2024 analysis of federal survey data found that the majority of immigrants likely eligible for DACA are working and have self-reported excellent or very good health.

CMS estimates that 10,000 DACA recipients will lose their Marketplace coverage and 1,000 will lose BHP coverage if this proposed rule is finalized. However, this may be an underestimate of the harm. In the final 2024 rule that includes DACA recipients in the definition of lawfully present, CMS estimated that about 100,000 people with DACA would benefit from access to Marketplace coverage and subsidies. Although only a small proportion of those may be enrolled in Marketplace or BHP coverage for plan year 2025, this is likely because the policy is new, and many DACA recipients may not have known about their new coverage options in time to enroll. Additionally, litigation over the DHS and HHS DACA rules has likely contributed to confusion among DACA recipients about their right to enroll in Marketplace or BHP coverage.

Furthermore, CMS's proposed change will place considerable burdens on SBEs and the two BHP states, requiring them to reverse current processes and change their systems, mid-year, to terminate coverage for existing enrollees and halt future enrollment for DACA recipients. Additionally, CMS's estimates of the time and cost burden for SBEs and the BHP states do not appear to take into account expenditures related to customer outreach and education, changing call center scripts and website copy, and training for call center workers and consumer assisters.

### Reducing State and Insurer Flexibility on Premium Payment Thresholds (Section 155.400(g))

CMS proposes to revoke the recently finalized policy to give insurers additional options to avoid terminating coverage when enrollees underpay premiums by a de minimis amount. Specifically, CMS would eliminate the options, finalized in the plan year 2026 payment notice, to provide fixed-dollar thresholds and gross premium percentage thresholds. This change has not yet taken effect.

Long-standing regulations permit insurers to set a minimum percentage of the consumer's premium share (a "net premium percentage threshold") that they will accept for purposes effectuating enrollment (referred to as a "binder payment") or avoiding triggering a three-month grace period or termination. For example, if a consumer's full premium is $400, of which APTC covers $300, and the issuer permits a net premium threshold of 95%, the consumer satisfies the threshold so long as they pay at least $95 (95 percent of the $100 net premium).

This threshold provides relief where a consumer makes a nearly complete payment. But it does not help if the consumer owes only a minimal amount and pays a smaller share. For example, if the full premium was $400, APTC was $398, and the consumer paid none (or even $1.50) of their $2 share, a net premium threshold of 95% would not protect the consumer, since they would not have paid 95% of their $2 net premium.

To address such situations, the 2026 payment notice created two additional threshold options. First, insurers could set a threshold of no less than 98 percent for the combined premium paid by APTC and the consumer (a "gross premium percentage threshold"). Second, insurers could set a dollar value for permissible non-payment (a "fixed-dollar threshold"), which had to be no

more than $10. The rule also clarified that, for the existing option (the net premium percentage threshold), a threshold of at least 95 percent of the net premium would be considered reasonable.

Current rules include some significant constraints on the new options. Both apply for purposes of triggering grace periods and coverage loss, but not for binder payments. As a result, an enrollee with even a very small or nominal premium must make a payment to effectuate coverage. Second, insurers may offer only one of the percentage-based thresholds. Finally, all of the options are based on the accumulated non-payment. For example, if the insurer has a dollar-value threshold of $5 and a consumer underpays by $3 for two consecutive months, the accumulated shortfall of $6 is considered as exceeding the $5 threshold.

Offering such thresholds is generally optional for insurers, and states may also limit them using insurance regulatory authority.

CMS now proposes to eliminate both new threshold options before they take effect, preemptively reducing the flexibility afforded to states and insurers. Insurers' flexibility would be limited to offering only net premium percentage thresholds. As a result, de minimis non-payments would continue to result in coverage loss. CMS estimates that this change would reduce APTC payments by about $820 million in 2026.

The agency justifies this proposal based on continued reports of enrollment fraud tied to brokers, which they say indicate that anti-fraud measures to date have been insufficient. CMS notes that it received 7,134 consumer complaints of improper enrollments in December 2024, an increase from 5,032 in December 2023, and that complaints in 2024 overall were up from 2023.

This explanation does not reasonably support the proposal for several reasons. First, CMS's measures to reduce broker fraud were phased in over the course of 2024, so the annual figures shed little light on their impact. Indeed, CMS released data in October finding "a dramatic and sustained drop across several key metrics that indicate that Marketplace system changes that were implemented in July 2024 are having the desired effect of successfully preventing consumers from being switched to different plans or enrolled in coverage without their informed consent." Moreover, CMS provides no evidence that this fraud—which has been tied to brokers—is related to premium payment thresholds. Such a connection seems especially unlikely given that the options CMS proposes to abolish have not yet taken effect, so they clearly have played no role in fraud to date.

## Allowing Coverage Denials for Past-Due Premiums (Section 147.104(i))

CMS proposes to allow issuers to condition new coverage on the repayment of outstanding premium debt for prior coverage. This policy is confusing for consumers, violates the statute, and will worsen Marketplace risk pools.

Under current policy, issuers are permitted to pursue traditional payment collection activities to collect on past-due premiums that an enrollee failed to pay; however, when a consumer makes a payment to the issuer for a *new* enrollment, the issuer must accept their new enrollment and cannot treat that payment as if it were payment for an *old* debt. To allow otherwise would be confusing for consumers. Marketplace consumers are generally engaging in an e-commerce-like transaction in which they have gone to a website, selected an item for purchase, and then visited another website and provided payment information in order to complete the purchase. CMS proposes to allow the issuer to accept the consumer's payment—but *not* actually sell them the item and instead keep the payment for an unrelated debt. Consumers in this situation could feel tricked into payment, and CMS is proposing to permit this once again.

Indeed, CMS has historically—and correctly—interpreted the statute to prohibit this behavior. Section 2702 of the PHS Act specifies that the issuer "must accept every… individual in the state that applies." The statute notes one limited exception to this requirement, relating to the time of year in which the enrollment occurs. No exceptions are available related to past due premium collections. Thus, an issuer that takes a consumer's payment but refuses the enrollment on the grounds that the funds have been applied to an old debt has violated the guaranteed availability requirements of section 2702. CMS was historically correct to articulate that the statute prohibits this behavior, and the statutory language clearly forecloses the atextual exception that is proposed.

Moreover, allowing these coverage denials will worsen Marketplace risk pools and raise premiums for all consumers, including the unsubsidized. These effects are the exact opposite of CMS's articulated goals in this proposed rule. A large body of literature demonstrates that young and healthier enrollees are far more price sensitive than older and sicker enrollees. These young and healthy individuals are more likely to decline to enroll if they make a payment—which they expect is their full premium payment—and yet are told they need to make an even greater payment to enroll. Moreover, these young and healthy enrollees are far more likely to have fallen out of coverage in the first place for past nonpayment of premiums. Deterring this group from returning to the Marketplace will only worsen the overall risk pool. In the proposed rule preamble, CMS notes that the proportion of enrollees terminated for nonpayment of premiums fell in a prior time period in which a version of this policy was in place. That analysis, however, ignores the fact that overall Marketplace enrollment also fell during this time period and premiums rose significantly—suggesting that a combination of policies led to fewer healthy enrollees retaining coverage and Marketplace coverage remaining only for those more at risk of health events, who are more likely to pay premiums throughout. CMS fails to account for these negative effects on this risk pool in their analysis of the proposed rule.

## Holding Agents, Brokers, and Web-Brokers Accountable for Unauthorized Enrollments (Section 155.220(g)(2))

CMS proposes to clarify the standards under which it would pursue a termination of an agent, broker, or web-broker's (collectively, "broker") Marketplace agreement. Specifically, CMS would

use a "preponderance of the evidence" standard of proof in order to assess whether a broker is in compliance with relevant laws, regulatory requirements, and agreement terms and conditions.

We support CMS's efforts to clarify the standard of proof it uses to assess brokers' conduct and pursue cases of suspected fraud or misconduct. We also appreciate CMS's recent efforts to mitigate the risk of unauthorized enrollments or plan switching, including the July 2024 action requiring a 3-way call with the Marketplace before a new broker can change an enrollee's existing plan. Following this action, broker-initiated plan changes dropped nearly 70%, and the redirection of commissions from a consumer's original broker to a new one (an indicator of potential misconduct) fell almost 90%. We further applaud the rule finalized in January 2025 clarifying CMS's authority to pursue actions against fraud or misconduct directed or facilitated by broker agencies.

However, we are concerned that CMS, without notifying the public, has reinstated the certifications of brokers that it previously suspended. This places consumers at continued risk of being victims of fraudulent enrollments or plan switching and sends a signal to the broker community that they will not be held accountable for misconduct. We are also extremely concerned about the past and possible future reductions in the CCIIO workforce and their impact on efforts to identify improper enrollments and conduct enforcement actions against brokers who have failed to properly gain consumer consent for an enrollment or plan change.

CMS seeks comment on further actions it should take to mitigate the harms associated with unauthorized enrollments and plan switching. We offer the following recommendations:

- CMS should provide an exceptional circumstances SEP, beginning when a consumer learns that he or she has been improperly switched to a new plan, to enroll in the plan of their choice.
- CMS should ensure that consumers are held harmless for any APTCs paid towards a plan for which their consent to enroll cannot be documented.
- CMS should work with participating issuers to stop payment of broker commissions on enrollments where consumer consent cannot be adequately documented.
- CMS should share information about troubling patterns of broker behavior with state insurance regulators prior to the final adjudication of a case. While we recognize that the details of an investigation cannot be made public, state insurance regulators are responsible for the licensure of brokers within their states. Therefore, regulators can and should be important partners with CMS in protecting consumers from broker misconduct.
- CMS should conduct consumer testing on its model consent form and scripts. Once tested, CMS should require the use of these forms and scripts by brokers for documenting consumers' review and confirmation of consent.

# Comments on the Regulatory Impact Analysis

The proposed rule includes a regulatory impact analysis that is central to its justification for the package overall and specific proposals. CMS requests comments on all aspects of the analysis. This section responds to those requests. It addresses two central elements of the analysis: claims about improper enrollment and claims about the rule's impact on the individual market risk pool.

The analysis is lengthy but frequently unclear about its specific methods and the data it relies on. It is also poorly connected to the proposals in the rule and thus does not provide a reasonable basis for finalizing the rule.

## *Analysis of Improper Enrollment*

The rule says that its primary purpose is to address the large number of improper enrollments that CMS claims exist. This is reflected in the reference to "integrity" in the rule's title and the numerous places in which CMS justifies its proposals on that basis.

CMS estimates that there were 4 to 5 million "improper" enrollments overall in 2024. It arrives at this figure by comparing actual enrollment in each state based on 2024 administrative enrollment data to estimates of the eligible population in each state based on 2023 survey data from the Census Bureau, trended forward to 2024. CMS finds that enrollment exceeds estimated eligibility in nine states, and the excesses in these states add up to 4.4 million. This methodology follows a Paragon paper, "The Great Obamacare Fraud." CMS also cites extensively documented data on consumer complaints about broker fraud.

CMS next estimates improper enrollments in 2026 by reducing the 2024 figure to account for the expiration of the PTC enhancements. CMS claims that the expiration of the enhancements will eliminate more than half of improper enrollments. CMS then appears to claim that the proposals in this rule will eliminate all remaining improper enrollments—reducing enrollment by between 750,000 and 2 million people. CMS further claims that the reduction in enrollment would only affect those improperly enrolled; in other words, the proposals will have no effect on legitimate enrollment. This final claim is addressed in the next section of this comment, focusing on risk pool effects of the proposals.

CMS's state-by-state estimates find that excess enrollment is highly concentrated in FFE states, especially non-expansion states. Indeed, 8 of the 9 states that were found to have take-up over 100% were non-expansion FFE states at the time of the data. None was an SBE state.

**CMS's analysis of improper enrollment suffers from numerous flaws that undermine its credibility as a reasonable basis for rulemaking.**

The recent well-documented fraud by brokers is a legitimate and serious program integrity problem. CMS must have the resources and authority to investigate and take action against

fraudulent actions that compromise the integrity of marketplace programs. Indeed, it has already taken multiple steps to do so, as discussed below.

That said, CMS's analysis of "improper enrollments" contains numerous flaws that undermine its credibility and call into question the justifications for the rule's proposals. CMS concedes numerous shortcomings with its methodology, including that it does not account for recent CMS actions to improve program integrity, enrollees' uncertainty around their expected income, the tendency of survey respondents to understate income, and "the imprecision inherent in the use of survey data." CMS seeks comment on ways to improve its estimate, and on its proposals.

We respectfully submit the following suggestion to improve the analysis:

- **CMS should revise its analysis to avoid inaccurately describing individuals who enroll consistent with statutory rules as ineligible.** As we discuss in the section on denying APTC for FTR, CMS's analysis mis-applies eligibility rules in a way that leads it to overstate improper enrollment. Under the ACA, Marketplace financial assistance is based on *projected* annual income for the year. A consumer can receive APTC if they reasonably project that their income for the coverage year will be within the eligible range–for example, because they currently have a job in which they expect to earn 150% of FPL for the year, or they own a small business that is expected to produce that much profit. Because the reasonable projection standard is built into the rules, the consumer does not become "improperly enrolled" if they unexpectedly lose their job or realize a smaller-than-expected profit. Thus CMS's calculations of the "take-up rate" use the wrong denominator: it uses the number of people reporting eligible income for the year, but it should use the number of people who reasonably expected that they would have eligible income. (Measuring this correct figure is challenging, but that doesn't justify grounding policy changes in inaccurate figures.) Given that FPL is quite low—just over $15,000 for a single person for 2025 coverage—it is not unreasonable for people to think that their income could reach that level.

  It's also important to note that challenges in estimating annual income are especially acute for the low-income people targeted by CMS's policies, which means that the difference between the *correct* measure of the potentially eligible population and the number CMS uses will be especially wide. One detailed analysis of earnings variability among low-income workers found that more than half experienced significant variability in income, greater than higher income workers. The actual magnitude of this income variability is quite striking, with workers in the lowest quintile having more than double the magnitude of variability than all other income groups. (For low-income workers, the standard deviation of monthly income was 85% of the mean—so that someone who earned an average of $1,000 per month had so much variation month-to-month that a month where their income was anything from $150 to $1,850 would be within a single standard deviation.) Multiple other analyses find this same basic pattern.

This uncertainty point is reinforced by a paper by former and current Congressional Budget Office authors cited by CMS in the rule. The paper notes that "[g]iven 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 household 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." CMS's analysis omits this qualification of the paper's findings.

- **The analysis should not calculate improper enrollment by comparing actual enrollment data to survey-based estimates of the eligible population.** CMS's estimate of improper enrollment relies on the conceptually incorrect method of comparing the actual enrollment data to estimates of the eligible population based on survey data. This approach creates several methodological problems, some of which CMS recognizes in the rule.
    - As CMS notes, the survey asks about income for the prior year, not the individual's reasonable expectation as to their income for the upcoming one. As noted above, the latter is what is relevant to eligibility.
    - Survey data generally understate incomes, as CMS notes in the rule. This inflates the number of people reporting income below the APTC eligibility range.
    - The survey data come from 2023. At this time the Medicaid continuous coverage requirement was in effect, which increased Medicaid enrollment by millions of people—many of whom would otherwise have qualified for subsidized Marketplace coverage. This reduces CMS's estimates of the number "eligible" for subsidized Marketplace coverage and thus exaggerates the number of improper enrollments.
    - The survey data used in the analysis that CMS cites uses a different family unit than is used for APTC eligibility.

  Given these flaws, any efforts to estimate improper enrollments should use a different method. For example, research could be undertaken based on a sampling of actual enrollees. This is the method commonly employed by oversight agencies like GAO.

- **CMS's analysis should not ignore the effects of recent policy changes to address fraud.** Over the course of 2024 and into early 2025, CMS instituted numerous changes to protect consumers from unauthorized enrollments and plan switching in the FFE. The effects of these changes are not reflected in the enrollment counts used for CMS's analysis, since they are based on data from the OEP for 2024. These measures include the following:

    - Adding a documentation requirement for agents and brokers to show that individuals have consented to enroll.

- Imposing a requirement that prevented new brokers from changing existing coverage through enhanced direct enrollment ("EDE") channels until the Marketplace documented consumer consent through a 3-way call.
- Re-allocating staff to review and address consumer complaints as quickly as possible.
- Adding a requirement for agent and brokers to provide an SSN for applicants.
- Updating Marketplace IT systems to detect suspicious activity and prevent fraud
- Arming consumers with resources and information to better identify and protect themselves from unauthorized enrollments.
- Providing brokers with model consent notices and scripts to ensure their consumer clients are fully informed and that consent is adequately documented.
- Finalizing (in January 2025) rules clarifying CMS's authority to suspend brokers from facilitating enrollments and extending CMS's enforcement authority to broker agencies that direct or facilitate improper behavior by brokers, agents, or web-brokers.
- Several technical safeguard changes across enrollment platforms to protect against misuse of broker credentials.

There is evidence that these measures are working. After implementing the 3-way-call rule, broker-initiated plan changes dropped nearly 70% and changes that redirected a commission from a consumer's original broker to a new one—an indicator of potential misconduct—fell almost 90%. As CMS noted in October, "Marketplace system changes that were implemented in July 2024 are having the desired effect of successfully preventing consumers from being switched to different plans or enrolled in coverage without their informed consent." The current CCIIO director also recently noted that these measures are working.

- **CMS should wait until it can release more reliable results before proposing policy changes based on them.** CMS admits that its estimates of improper enrollment are deeply flawed and yet proceeds to propose policy changes justified by those estimates. This order of operations indicates a rulemaking process that is not grounded in careful analysis. CMS repeatedly asserts that changes are worth doing despite their downsides because there are so many improper enrollments.[5] Flaws in the improper enrollment figures undermine this central justification for the rule. These flaws also deny the public a meaningful opportunity to comment, since they lack information about the true scope and nature of the problem.

[5] For example, regarding the DMI policy when tax data are unavailable, CMS notes: "Considering the amount of improper enrollments under the current policy, we believe this administrative burden of requiring people with an income DMI due to unavailable IRS data to provide documentation to verify income are more than offset by the program integrity benefits." Regarding shortening the period to resolve a DMI, CMS notes: "However, we must weigh this potential positive impact on the risk pool against the substantial increase in APTC expenditures that we identified from ineligible people who stay enrolled and receive APTC for an additional 60 days. We believe the cost to taxpayers and decline in program integrity outweigh any possible benefit to the risk pool."

**Even if CMS's estimates of improper enrollment were credible, they would not provide a reasonable basis for many of the proposals in the rule.**

- **CMS should not require nationwide changes because it finds no evidence of improper enrollment in the vast majority of states.** CMS's analysis claims that there is excess enrollment in just 9 states, all of which use the FFE and all but one of which hadn't expanded Medicaid at the time the analysis was conducted. As such, the primary basis for the proposals in the rule is absent in 41 states. CMS finds excess enrollment in none of the 16 SBE states included in the analysis. Indeed, CMS finds an average take-up in the SBE states of just 32%—nowhere near the over 100% take up found in those 9 FFE states.

  This geographic trend is consistent with previously reported information about key FFE shortcomings involving brokers, EDE, and lead generators. It's also consistent with SBEs' experience on the ground, as noted in several comment letters and in comments at a recent NAIC meeting by Idaho insurance commissioner Dean Cameron. These comments confirm that SBEs are not seeing widespread complaints about fraud. And this dog-that-didn't-bark is meaningful—as CMS's experience shows, when this fraud exists, people complain, because it often leads to them losing other coverage, such as Medicaid.

  Despite this lack of evidence of improper enrollment in over four-fifths of states, the rule would force numerous changes nationwide. As discussed in comments by SBEs, this is a substantial imposition on state resources and autonomy that is not justified by CMS's data.

- **CMS should afford states flexibility and deference to manage their insurance markets.** The importance of state flexibility has been articulated by CCIIO Director Peter Nelson when, in 2024, he wrote, "States deserve more trust to protect consumers than the feds. Critics of state authority over health insurance take the untenable position that the federal government knows best and cares more. But state regulators live next door to the consumers they serve. They know the communities, the hospital systems, the provider shortage (and surplus) areas, the local economies, insurer footprints, and enrollee experiences better and more intimately than the federal government ever can. States have more incentive to keep a watchful eye on insurers and address policy problems without delay. Citizens can more easily hold states accountable when they don't."

- **Since CMS finds that improper enrollments are concentrated in FFE states, it should focus solutions on what FFE states are doing differently.** CMS's analysis finds that "take-up" rates in 2024 are high in FFE states, averaging 106% due to exceptionally high values in a few large states. Take-up rates are especially high in states that have not expanded Medicaid, averaging 179%. Again, this is consistent with

previously reported information about key FFE shortcomings involving brokers, EDE, and lead generators.

Given that the problem appears confined to a small group of states, it makes sense to consider what these states are doing differently and address those discrepancies. For example, while most SBEs maintain and operate their own agent and broker portals for assisted enrollments, the FFE allows enhanced direct enrollment entities to provide an enrollment platform for agents and brokers. In 2024, only FFE states used enhanced direct enrollment, which is known to be a key source of the problem. The FFE sees clear evidence of problems with agent and broker behavior in their use of enhanced direct enrollment platforms

Yet CMS does not include proposals that would address the known FFE issues, such as strengthening the FFE actions already taken, bringing FFE practices in line with SBEs practices, ensuring adequate regulation and enforcement of regulations governing EDE entities, regulating lead generators, and other options that target the actual problem rather than imposing new burdens on consumers. Instead, they force Marketplaces to make changes that lack a clear connection to the known problems.

In short, the proposals bear no reasonable connection to their stated justification and should be considered only if a suitable justification is provided.

## *Analysis Relating to Risk Pool Effects of the Rule*

CMS's second main justification for the proposed rule is that it would reduce premiums overall. CMS notes that this would encourage unsubsidized enrollment and help such enrollees, which CMS claims is especially important to the strength of the market.

Specifically, CMS claims that the proposed rule would improve the risk pool and thus reduce premiums by between 0.9% and 5.4%, depending on how much it reduces enrollment. The methodology for calculating the enrollment change is not entirely clear, but it appears to be based primarily on the assumption that the proposals would eliminate all improper enrollment while leaving all other enrollment unaffected—both extremely aggressive assumptions.

CMS estimates a range of potential enrollment reduction equal to its estimated range of improper enrollments in 2026, which—as discussed above—is three-quarters of a million to 2 million. CMS concedes that "this range may underestimate the actual number of individuals impacted, as eligible enrollees may lose coverage as a result of the administrative burdens imposed by the provisions of this rule." But it proceeds with its calculations as though no such coverage loss would occur.

CMS projects that this attrition of three quarters of a million to two million improperly enrolled people would likely hurt the risk pool, in part because individuals improperly enrolled by brokers may be unaware that they were enrolled and thus make little use of the coverage. Relying on

this projection, it estimates that eliminating improper enrollment would change premiums by between -0.5% and +4%. CMS then combines this range with several risk pool improvements that it claims will result from measures in the proposed rule. Specifically, CMS estimates that eliminating the under-150 SEP would reduce premiums by 3.4%, that expanding SEP verification would reduce premiums by 0.5%, and that the AV de minimis change will reduce premiums by 1%. Summing those figures arrives at the projected range of improvement—from 0.9% to 5.4%. CMS then assumes that the imposition of new administrative burdens will not cause eligible individuals to lose coverage, and thus that the range of a 0.9% to 5.4% improvement is the total impact.

CMS requests comments on this analysis and on the proposals it supports.

## CMS's analysis of the risk pool effect of the rule suffers from numerous flaws that undermine its credibility as a reasonable basis for rulemaking.

CMS's method for calculating the risk pool effects (and coverage effects) of its proposals is flawed in crucial ways that undermine the calculation's accuracy. The method makes unsupported assumptions, ignores key effects, fails to provide available data, and relies heavily on its flawed calculations about improper enrollment, as discussed above. The analysis could be improved in the following ways:

- **The risk analysis should not rely on the rule's deeply flawed estimate of improper enrollments, as discussed above.** Instead, CMS should improve that analysis, as discussed above, and then use better estimates of improper enrollment as the basis for its projections about coverage and the risk pool.

- **The analysis should not assume that the proposed rule would be 100% successful in eliminating improper enrollment.** CMS begins its methodological discussion by noting that "[o]ne approach to estimate the possible reduction in erroneous and improper enrollments under the proposed changes in this rule is to [use its estimate of total improper enrollments]." It then proceeds to follow this approach without explaining why it makes sense. The key assumption at work here—that the proposed rule would eliminate all improper enrollment—is implausible for several reasons. First, achieving a 100% success rate in eliminating improper payments is unheard of in any context—CMS provides no examples of it being achieved. Second, CMS offers no basis for such a bold assumption in this case. It provides no microsimulation analysis modeling the proposals, nor any scenario analysis for how its proposals would stop brokers in various situations. Third, as discussed above, CMS's proposals do not address many of the problems that are known to be leading to improper enrollments in the FFE. To produce a more accurate estimate, CMS should drop this assumption of perfection and engage in analysis of how its specific proposals would affect consumers.

- **The analysis should not make the implausible assumption that increasing administrative burdens will have no effect on enrollment and thus coverage**

**losses will be limited to people who weren't eligible to begin with. CMS should further recognize that the eligible people deterred from enrolling by these administrative burdens will be disproportionately healthy, and thus that these new administrative burdens will hurt the risk pool.** The rule asserts repeatedly that only improperly enrolled people will lose coverage. This appears to be based on two errors. First, CMS's estimates assume that increasing administrative burdens would lead to no coverage loss (and thus no risk pool impact) among eligible people. The proposed rule includes a wide array of proposals that increase administrative burdens on eligible people seeking to enroll, including new paperwork requirements under the DMI and SEP verification proposals, less margin of error for complying with administrative requirements under the FTR and premium payment threshold proposal, and narrower enrollment opportunities. A substantial body of evidence (including those listed below) indicates that administrative burdens reduce take-up among eligible people. In addition, this attrition disproportionately affects lower-risk individuals, since sicker people are more likely to fight through the burdens to stay covered.

- A Mcintyre, Shepard, & Layton study finds that states that implemented nominal monthly premiums saw enrollment fall by 14%.
- A 2025 study in the American Economic Review finds that imposing administrative burdens to enrollment "differentially exclud[es] young, healthy, and economically disadvantaged people."
- An American Economic Association study on auto-retention finds "that automatic retention has a sizable impact,...differentially retaining healthy, low-cost individuals."
- Commonwealth Fund report (Policy Innovations in the Affordable Care Act Marketplaces)
- A KFF brief (Key Facts about the Uninsured Population) describes how almost 20 percent of uninsured nonelderly adults cite the difficulty or complexity of signing up as a reason for their lack of health insurance coverage
- National Bureau of Economic Research report (Reducing Administrative Barriers Increases Take-up of Subsidized Health Insurance Coverage)
- 2016 Urban Institute research report (Helping Special Enrollment Periods Work under the Affordable Care Act)

There is also evidence to this effect from SBEs, as discussed below.
CMS makes no effort to address or refute this overwhelming evidence. It simply assumes that administrative burdens will not reduce enrollment.

This claim also appears to be predicated on the high estimates for improper enrollment, discussed above. Given that improper enrollments are likely much smaller than CMS estimates, it's implausible that all coverage losses would fall in this group.

- **CMS should tabulate and release the data it clearly possesses on the coverage and risk effects of its proposals.** The proposed rule repeatedly asserts impacts from its proposals without providing directly relevant data that it clearly has access to. For

example, the central basis for the claim of risk pool improvement is the estimate that eliminating the under-150 SEP would improve the risk pool by 3.4%. To support this estimate, CMS cites the estimate it made at the time it issued the regulation that created the SEP; at that time, CMS thought it would hurt the risk pool. However, CMS should have access to data obtained from the actual experience with implementing and utilizing the SEP, which could readily be used to calculate the risk profile of enrollees using it. But CMS does not provide such data. CMS explains this omission by arguing that releasing such information would not cleanly capture the risk impact of eliminating the SEP, since some people could switch to a different SEP. Still, it could provide an extremely relevant data point. Similarly, CMS could readily calculate the risk profile of individuals enrolling during the open enrollment period after Dec. 15, individuals losing coverage due to DMIs, individuals losing coverage due to FTR, and individuals re-enrolling with a zero premium. That CMS withholds such information likely suggests that available data do not support its case. CMS should release this information to permit a clearer understanding of the impacts of its proposals.

- **CMS's analysis fails to incorporate available evidence from state-based Marketplaces, which undermines its assumptions.** While CMS has not released FFE data directly applicable to its proposals, several SBEs have released such data. Their evidence directly contradicts CMS's assumptions and analysis. For example:
  - Actuarial data from California show that enrollees using SEPs generally have about the same risk profile as OEP enrollees. The California data also show that individuals using the OEP after Dec. 15 have a better risk profile than those enrolling earlier during OEP.
  - Actuarial data from the Massachusetts Connector show that their population with the most SEP eligibility generally has lower risk than other enrollees. Additionally, consumers enrolling through an SEP tend to be slightly younger than those enrolling through an OEP.
  - Enrollment data from the Massachusetts Connector show that younger individuals are slightly more likely to receive a non-income response from the IRS.
  - Enrollment data from New York show younger enrollees were more likely to enroll late in the open enrollment period.
  - DC Health Link found that the age of the SEP population remained consistent with the population that enrolled during open enrollment, and in some cases was even younger. See Fig. 5.

- **CMS should heed its own previous analysis suggesting that its current proposals would harm the risk pool.** For example, in eliminating data matching issues where tax data are missing in the 2024 NBPP, HHS noted that ending such DMIs would "strengthen the risk pool." However, the proposed rule does not acknowledge that reinstituting such DMIs would harm the risk pool. CMS has not even attempted to justify this change in position.

- **The analysis should recognize that adding administrative burdens is especially likely to be harmful amidst substantial cuts to staff that are needed to help resolve them.** Imposing additional administrative hurdles leads to more consumers needing help in meeting requirements to avoid losing coverage. But recent and ongoing funding and workforce reductions will mean less of this help. Recent cuts to Navigators will mean less enrollment support for consumers in resolving all of these issues. CMS staff reductions could mean less capacity to process DMI and SEP-V documentation. IRS staff reductions could mean less support for consumers facing FTR issues and fewer staff to ensure that returns are quickly processed and that Hub data are quickly updated to reflect processed returns. In addition to ignoring the prospect of coverage losses due to administrative burdens, CMS also ignores the fact that these losses could be exacerbated by staffing reductions. CMS's analysis should be revised to consider the impact of these cuts on coverage losses due to administrative burdens.

- **CMS's estimates regarding the risk pool and improper enrollment should be internally consistent.** Throughout multiple parts of its rule, CMS claims that the real-world impact of terminating 2 million people from coverage will be small, at times suggesting that most of these enrollments are from people who were enrolled without their knowledge. For all the reasons described above, that is certainly not true. CMS's proposals will result in families losing coverage on which they depend and to which they are entitled. But if CMS believes its claim to be true, then it would cause a very large *increase* in premiums that the agency is not accounting for. As a stylized example, if CMS's actions were to result in 2 million such enrollments being eliminated, premiums would increase for remaining enrollees by a staggering 9%. CMS has no basis for any of the claims about premium reductions made in its analysis, but they certainly cannot sustain those claims in the face of a 9% impact pointing the other direction.

- **CMS should recognize that its proposed rule would very likely increase premiums overall and reduce unsubsidized enrollment.** Given the numerous flaws discussed above with CMS's risk pool analysis and overwhelming countervailing evidence, it is almost certain that the proposed rule would in fact hurt the risk pool and increase premiums overall. In addition, several of the new administrative burdens would interfere with not just subsidized enrollment but unsubsidized enrollment as well. As a result, unsubsidized enrollment would be very likely to fall as well.

- **CMS should abandon its claim that the interests of subsidized and unsubsidized enrollees are at odds.** CMS seems to concede that its proposals would harm subsidized enrollees. To justify this, it attempts to make the case that the interests of subsidized and unsubsidized enrollees are somehow in conflict, and that making subsidies smaller and harder to get will somehow help the unsubsidized. This view is in conflict with decades of experience with health policy. Efforts to provide good coverage at a premium that doesn't account for health risk, without a strong financial incentive to enroll—such as strong subsidies—has uniformly led to an adverse selection death spiral. The best thing for unsubsidized people is a good risk pool, which requires strong

> subsidies that are easy to get and thus induce healthier people to enroll. This is the hard-earned lesson that became the basis for health reform in Massachusetts under Governor Mitt Romney and then for the ACA.

# Comments on Procedural Issues Under the Rule

The proposed rule suffers from several problems of administrative procedure and law that, individually and together, deny the public a meaningful opportunity to comment. These problems must be addressed before the rule can be finalized.

## The rule fails to provide readily available information that is directly relevant to understanding the proposals.

As noted above, the rule fails in numerous places to provide data that are clearly relevant to understanding the proposals and that CMS has access to. For example, CMS certainly has the data needed to calculate the risk profile of individuals who lose coverage under DMI and FTR policies. Yet it does not reveal this information. Instead, it repeatedly claims generally that its proposals are supported by "analysis" without citing specific data, sometimes citing generally to "public use files" or "tax filing data." (Indeed, as noted above publicly available data and data from SBEs often indicate the opposite of what CMS claims.) Withholding this information on which CMS purports to rely denies the public a reasonable opportunity to comment.

## The rule and subsequent CMS actions indicate a premeditated intent to finalize the proposals without meaningfully considering comments.

The rule includes the following statement disparaging commenters and the comment process:

> We acknowledge that a higher number of comments can suggest a position we should consider more closely. However, we must also consider that many parties who comment on rulemaking may represent the will of special interests who do not necessarily represent all special interests or the general public interest in the faithful and efficient administration of the statute. It is not uncommon to receive comments that only represent one side and no opposing comments that might represent other special interests or a more general interest in good governance or the equities of the taxpayer. As our constitutional role is to faithfully execute the statute, we are responsible for considering all comments, as well as perspectives that may not be fully represented in comments, within the context of what the statute requires.

We are aware of no precedent for a statement like this. Its disparagement of commenters as "special interests" shows a disrespect for the notice and comment process required by the Administrative Procedure Act ("APA"). Its threat of dismissing prevailing public views suggests a premeditated intent to finalize the rule's proposals regardless of comments.

CMS confirmed this intent when, during the comment period, it released a revised final actual value calculator reflecting the changes in the proposed rule, which commits the agency to finalize certain policies as proposed.

In short, CMS has made clear that it does not intend to meaningfully consider comments, as required by the APA.

In addition, we note that by deciding to finalize certain provisions of the rule before consideration of public comments, CMS has also restricted the administrative record on which the agency can rely in defending their choices regarding those provisions as non-arbitrary. CMS had decided and committed the agency to finalize many of the policies in the rule before the comment period for the proposed rule had closed. Therefore, any analysis that CMS conducts in response to comments—and any explanation that appears in the final rule preamble—is a post hoc justification. Such analysis will have occurred entirely *after* CMS had committed the agency to finalize the policies as proposed and cannot be treated as analysis that the agency considered in the course of reaching a non-arbitrary decision to finalize. CMS will generally be limited to the analysis that it provided in the preamble to the proposed rule, unless the agency can make a specific showing that any additional considerations were weighed internally by the agency before release of the AV calculator. Attempts to cite the final rule preamble for this purpose have been foreclosed by the agency.

## The public comment period is too short to provide meaningful comments—especially given the request for detailed comments on analytical claims—and should be extended.

CMS provides an unusually short comment period for the rule, despite its great complexity. The comment period is just 23 days from when the rule was published in the Federal Register (March 19, 2025) to the deadline on April 11.

The short comment period is especially troubling because of CMS's request for comments on the methods and results in the regulatory impact analysis. Such analysis requires detailed modeling work, which is impossible in the timeframe provided. CMS should extend the comment period, providing a minimum of 90 days from the announced extension.

The short comment period is likely connected to speedy effective dates for several provisions. Many of the proposed changes would be impossible for Exchanges to implement in the timespan contemplated. When it announces an extension of the comment period, CMS should also delay these proposed effective dates.

Sincerely,

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April 11, 2025

**Submitted via www.regulations.gov**

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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

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[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

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[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.istor.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,

Anna Rodriguez

Policy Counsel, Governing for Impact
Email: arodriguez [at] governingforimpact.org

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

| | |
|---|---|
| CITY OF COLUMBUS, *et al.*,<br><br>*Plaintiffs*,<br><br>v.<br><br>ROBERT F. KENNEDY, JR., *et al.*,<br><br>*Defendants*. | Case No. 1:25-cv-2114 |

**ADDENDUM OF ADMINISTRATIVE RECORD MATERIALS CITED IN PLAINTIFFS' MEMORANDUM IN SUPPORT OF THEIR MOTION FOR SUMMARY JUDGMENT**

**(VOLUME 2 OF 2)**

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Association for Community Affiliated Plans
Mission driven. People focused.

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Leanne Berge, Chair | Margaret A. Murray, Chief Executive Officer

April 11, 2025

Robert F Kennedy
Secretary
Department of Health and Human Services

Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services

Peter Nelson
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services

Submitted electronically via: www.regulations.gov

RE: CMS-9884-P

Dear Director Nelson:

The Association for Community Affiliated Plans (ACAP) respectfully submits comments in response to the Request for Information on Patient Protection and Affordable Care Act: Marketplace Integrity and Affordability Rule.

ACAP is a national trade association representing 84 not-for-profit Safety Net Health Plans. Our member plans provide coverage to more than 30 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP), Medicare Special Needs Plans for dually eligible individuals, the Basic Health Program, and the ACA Marketplaces. Of ACAP's Safety Net Health Plan (SNHP) Members and Partner Plans, 29 offer qualified health plans (QHPs) serving over 1.4 million enrollees in the Marketplaces.

ACAP has chosen to respond to a subset of proposals in this rule that are particularly relevant to our Exchange plans. ACAP appreciates the Administration's desire to strengthen the integrity of the Marketplaces; our comments are designed to ensure market stability for SNHPs and the consumers they serve. ACAP member plan enrollees generally have low-incomes, and we

emphasize that the comments herein support SNHPs in their efforts to serve these vulnerable communities.

We wish to note the following overarching themes throughout our comments:

**Cost to Consumers:** CMS notes that the proposed regulation was promulgated in response to President Trump's Executive Order on January 20, 2025 entitled "Delivering Emergency Price Relief for American Families and Defeating the Cost-of-Living Crisis." We are extremely grateful for CMS' focus on reducing costs for consumers and wish to note that the high costs of health care have a significant impact on not just low, but middle-income families cost of living burden. As the cost of health insurance increases, many consumers are forced to choose between purchasing coverage and affording basic necessities such as food, gas, and housing. ACAP's analysis finds some of the proposed regulatory changes presented in this rule would reduce costs to consumers, however, others may significantly increase costs to consumers. We are concerned that the latter proposals are at odds with the President's Executive Order and urge CMS to reconsider those provisions.

**State Autonomy & Flexibility:** States' abilities to govern as they see fit, based on the needs of their residents, have long been a conservative value and priority. While we recognize that the Federal government may, in certain circumstances, appropriately supersede state flexibility, we wish to note that a number of the proposed changes would hinder such state flexibility without meeting that higher bar. The Affordable Care Act permitted states to establish their own exchanges specifically so that they would be able to respond to differing needs of their residents; however, the proposed rule would eliminate many such flexibilities associated with a State Based Exchange (SBE) instead of the Federally Facilitated Exchange (FFE). We urge CMS not to place additional federal restrictions on SBEs.

**Effective Dates:** CMS proposes varying effective dates, with some provisions effective immediately. ACAP agrees that some should be effective immediately, but any provisions that would impact plan design or rates for PY 2026 should be delayed to PY 2027. ACAP's member plans have already begun developing products for PY 2026, with QHP application filing deadlines in some states due as early as April 25, just 10 business days after comments on this rule are due to CMS. Many additional states having filing deadlines of May 15. Even if CMS is able to respond to comments and issue a final rule in short order, this would lead to significant operational issues and business uncertainty. Such changes are likely to have a disproportionate impact on ACAP's member Safety Net Health Plans, which tend to be smaller plans that are unable to make sweeping, wholescale changes in short order. Accordingly, we urge CMS to delay implementation of many of the provisions in the proposed rule until the following plan year and work to finalize any PY 2026 changes as expeditiously as possible.

**Summary of ACAP's Comments**

Our comments are summarized in brief below, in the order in which they are presented in the proposed rule.

**Coverage Denials for Failure to Pay Premiums for Prior Coverage:** ACAP would support a modified proposal in which issuers are permitted the option, but not requirement, to condition enrollment in coverage on payment of past-due premiums from the previous 12 months only. ACAP urges CMS to require consumer notice if an issuer chooses to institute this policy and to delay the effective date so that appropriate notice can be given to consumers during 2026 Open Enrollment.

**Deferred Action for Childhood Arrivals:** ACAP objects to CMS' proposed change to eliminate DACA recipients' eligibility to enroll in Exchange coverage as it is expected to have a negative impact on the individual market risk pool and increase costs for all consumers.

**Standards for Termination of Agents, Brokers, or Web-Brokers:** ACAP applauds CMS' commitment to eliminating broker fraud and urges CMS to consider ways in which it could require brokers to act in the best interests of their customers, such as a fiduciary responsibility.

**Income Verification:** ACAP urges CMS to delay its income verification proposals until after it can review data from upcoming years and address other methodological issues impacting its estimates, as well as to ensure that issuers have adequate time to consider the impacts of the proposals on the risk pool and adjust premiums accordingly.

**Annual Eligibility Redetermination: APTCs:** ACAP strongly opposes CMS' proposal to require that any consumers receiving full APTC payments who do not actively reverify their income instead be charged $5 per month until they do so. ACAP also strongly opposes CMS' alternate proposal, which would remove full APTC until re-verification. In addition to significant consumer confusion, loss of coverage, and resulting destabilization of the risk pool, there will be a significant business impact including financial and operational burden on ACAP's member SNHPs. We also urge CMS to wait until PY 2027 to move forward with any variation of this proposal, as automatic re-enrollment into $0 plans will be significantly reduced if Congress does not extend the Enhanced PTCs.

**Premium Payment Threshold:** ACAP objects to CMS' proposal to eliminate the gross percentage and fixed dollar premium payment thresholds. We believe program integrity concerns

related to these provisions are minimal and urge CMS to retain this greater flexibility for issuers to determine whether and what type of premium payment threshold to institute, based on what they believe is most appropriate for their enrollee characteristics and actuarial calculations.

**Annual Open Enrollment Period:** ACAP strongly objects to CMS' proposal to shorten the annual open enrollment period to 45 days, running from November 1 to December 15 of a given year. Regardless, if CMS moves forward with its proposal, we urge it to delay the effective date until PY 2027 given the uncertainty as to whether Enhanced PTCs will be extended after December 31, 2025. Finally, ACAP urges CMS to preserve state flexibility and to continue allowing SBEs to set their own open enrollment timelines.

**Monthly SEP for Consumers Below 150 Percent FPL:** ACAP supports CMS' proposal to eliminate the 150 percent FPL SEP. ACAP's member SNHPs have experienced both adverse selection from SEP abuse as well as seen a substantial and problematic increase in unauthorized plan enrollments and unauthorized plan switches and applauds CMS' efforts to address these issues through this policy change.

**Pre-Enrollment Verification for Special Enrollment Periods:** ACAP supports CMS goal of increasing SEP verifications and would support a modified version of its current proposal. We urge CMS to adjust the 75 percent requirement to provide some flexibility or instead permit Exchanges to verify the SEPs that are most at risk of abuse. We also urge CMS not to limit state flexibility and to permit SBEs to continue to establish their own pre-enrollment verification standards.

**Prohibition on Coverage of Sex-Trait Modification as an EHB:** ACAP objects to CMS' proposal to prohibit coverage for sex-trait modification as an essential health benefit (EHB) beginning in PY 2026. Issuers will be faced with significant financial and operational burden associated with the systems and utilization management changes necessary, as sex-trait modification does not fall outside the 10 EHB categories but rather is made up of numerous services that span multiple EHB categories and are otherwise used regularly for reasons other than sex-trait modifications. ACAP is further concerned by the timeline for PY 2026 implementation and urges a delay in the effective date if CMS moves forward with the proposal.

**Premium Adjustment Percentage:** ACAP opposes CMS' proposed change to the premium adjustment percentage methodology. If CMS moves forward with this proposal, we urge CMS to delay its effective date until PY 2027, as an immediate effective date would lead to significant operational and business implications for issuers. Changes that impact product design, including

cost sharing and out-of-pocket limits, are exceedingly difficult to implement within a short timeframe.

**Levels of Coverage (Actuarial Value):** ACAP does not object to CMS proposal to permit greater downward variation in AV de minimis ranges, as it will provide needed plan design flexibility for some issuers.

## Expanded Comments

ACAP's comments are expanded below, with additional background.

### Coverage Denials for Failure to Pay Premiums for Prior Coverage

CMS proposes to allow issuers the option to condition new coverage on repayment of outstanding debt from previous years by changing the interpretation of guaranteed availability of coverage. The proposal would allow issuers to attribute past-due premium payments to the initial premium an enrollee must pay to effectuate coverage.

ACAP's member SNHPs have seen abuses by consumers stopping paying premiums and entering the grace period after an expensive treatment or entering the grace period during the last 90 days of the year in order to avoid paying premiums. ACAP supported a similar optional proposal in 2017 that was limited to the previous 12 months of coverage.

ACAP strongly recommends that this proposal be limited to premiums due from the past 12 months of coverage, as was the case in the Market Stabilization Rule from 2017. While some consumers may game the system by not paying premiums during the final months of the year, we also know that others stop due to legitimate financial hardship. This rule has the potential to disproportionately affect low-income individuals; while CMS notes that it believes the "amount most individuals owe in past-due premiums is relatively small and…would not impose a substantial burden," studies show that even a small increase in premium costs can lead to a loss in coverage.[i] Additionally, if consumers do experience a significant financial hardship that leaves them unable to pay significant premiums, ACAP does not believe that should prevent them from being able to purchase coverage into perpetuity. Accordingly, if CMS finalizes this proposal, we urge CMS to limit the amount to past-due premiums that an issuer may require payment to those accrued during the past 12 months. Further, there would be significant operational difficulty and

cost associated with tracking and billing past-due amounts from previous years, long after issuers have closed out their book of business for a given year.

ACAP also opposes making past-due premium collections a requirement for plans. Instead, it should remain an optional policy. We believe that plans should be able to set such thresholds based on their enrollee characteristics and that plans should be permitted to write off such debt if they choose to. Additionally, some SBEs perform premium collection, making the requirement administratively challenging for issuers in that do not have premium collection capabilities.

We also urge CMS to require issuers provide notice to consumers about the consequences of non-payment of premiums on any application materials and notices regarding payment of past due premiums. We believe it is important that consumers are informed about any requirements that would prevent them from purchasing coverage in future years. This is especially important information for consumers in states that have a limited number of QHP issuers, as 4% of consumers in FFE states have just one or two QHPs available to them.[ii] CMS also notes that it believes such provisions from the Market Stabilization Rule may have contributed to an improved risk pool by encouraging healthier consumers to stay enrolled for the balance of the year; without such notices, we cannot expect this proposal to have that same effect.

Finally, CMS proposes that this provision would become effective on the date the final rule becomes effective. ACAP has serious concerns about a mid-year policy change and urges CMS to delay the effective date to apply to PY 2027 policies. An immediate effective date would impact consumers' abilities to purchase policies during the 2026 Open Enrollment Period, effectively changing the terms of the consumer's current policy. Adequate notice should be given to consumers so that they are aware of the potential impact of dropping coverage (via notice requirements as part of the PY 2026 enrollment application) and adequate time should be provided to issuers to make appropriate system and operational changes.

*ACAP would support a modified proposal in which issuers are permitted the option, but not requirement, to condition enrollment in coverage on payment of past-due premiums from the previous 12 months only. ACAP urges CMS to require consumer notice if an issuer chooses to institute this policy and to delay the effective date so that appropriate notice can be given to consumers during 2026 Open Enrollment.*

**Deferred Action for Childhood Arrivals (DACA)**

CMS proposes to change its definition of "lawfully present" so that DACA recipients are no longer considered lawfully present for purposes of enrollment in a QHP, eligibility for PTC, APTC, CSRs, and for BHP coverage. ACAP opposes this policy change as it would have a

negative impact on the risk pool and premiums for all consumers are expected to rise as a result. As CMS notes in its Regulatory Impact Analysis, because DACA recipients are young, they generally tend to be healthier, and that excluding them from the Exchanges would have a negative impact on the individual market risk pool. Further, if DACA recipients are unable to enroll in Exchange coverage, they are more likely to go uninsured, which is expected to have the effect of increasing uncompensated care at emergency rooms. Such costs are ultimately absorbed into hospital operating costs and have the effect of raising provider reimbursement costs for all forms of coverage—subsidized or not—and increasing costs to all insured Americans.

*ACAP objects to CMS' proposed change to eliminate DACA recipients' eligibility to enroll in Exchange coverage as it is expected to have a negative impact on the individual market risk pool and increase costs for all consumers.*

**Standards for Termination of Agents, Brokers, or Web-Brokers**

CMS proposes to address issues of broker fraud and noncompliance by applying a "preponderance of the evidence" standard of proof when considering terminating an agent, broker, or web-broker's Exchange agreements. CMS further states that it will provide greater specificity and precision in the Exchange agreements for PY 2026 and beyond regarding impermissible conduct, as well as requirements for collecting and documenting consumer consent.

We applaud CMS' continued focus on this important issue and commitment to addressing fraud by unscrupulous brokers. While ACAP's member plans have many positive broker relationships that provide critical enrollment assistance to their customers, unscrupulous brokers have recently made unauthorized enrollments and unauthorized plan switches ubiquitous. ACAP's member plans have had to deal with the fallout of confused consumers, operational issues, and QHP enrollments that needed to be termed. In conjunction with new guidance instituted in 2024, which made it harder for brokers to perform unauthorized plan switches, we are optimistic that CMS' efforts will severely limit fraud and noncompliance moving forward, however, we also urge caution that burdensome administrative requirements could also hinder brokers' efforts to work with consumers. We have previously supported CMS' provision of guidance and requirements on the collection, documentation, and retention of documentation of consumers' consent and eligibility. Such documentation can be used as proof—or lack thereof—of compliance with enrollment applications, as well as to hold consumers harmless if warranted. We urge CMS to ensure that consumers who are fraudulently enrolled in coverage, and for which documentation showing consumer consent cannot be provided by the agent or broker of record,

are able to choose new coverage through an exceptional circumstances SEP and be held harmless for any APTC paid.

CMS also requests information on what other measures it should pursue to enhance oversight of agents, brokers, and web brokers. ACAP urges CMS to consider additional rulemaking that would require agents, brokers, and web-brokers to act in the best interests of their customers, such as through a fiduciary responsibility. We know that many unscrupulous brokers act in their own best interests, rather than that of their clients, when they perform unauthorized enrollments or unauthorized plan switches, however, it goes beyond that. Because their incomes are commission driven, there is a strong incentive to simply enroll consumers in plans that would provide the greatest financial renumeration, however, such plan may not be in the consumer's best interest—based on premiums, benefits, and more. Accordingly, we urge CMS to consider ways in which it could implement a policy that would require brokers to act in their customer's best interest.

*ACAP applauds CMS' commitment to eliminating broker fraud and urges CMS to consider ways in which it could require brokers to act in the best interests of their customers, such as a fiduciary responsibility.*

**Income Verification**

CMS proposes to require income verification to show proof that an individual's income is equal to or greater than 100 percent FPL when IRS data suggests their income is actually less than 100 percent FPL. CMS also proposes to remove the requirement that Exchanges accept an enrollee's self-attestation of projected annual household income. ACAP believes these two potential changes are intertwined and so has chosen to address them both at once.

As we discuss elsewhere, ACAP strongly supports CMS working to eliminate special enrollment period (SEP) fraud and abuse, which has led to adverse selection issues. CMS' proposals on income verification are also relevant to that proposal, however, in this case we believe there is a greater nuance that must be considered for income verification.

First, CMS notes that new evidence shows that millions of applicants are inflating their incomes. We agree that there may be an incentive for consumers to do so, particularly in states that have not expanded Medicaid. However, while we understand that there may be some consumers who overestimate their income, we believe that millions of consumers doing so is an overestimate, based on methodological and data issues. We also know that it is not uncommon for low-income consumers, particularly those who work in hourly, gig, or seasonal employment to have

difficulty predicting their annual income, and may reasonably assume they will be able to work additional hours in the coming year, receive a promotion, or a variety of other things that could increase wages. As long as PTC eligibility is conditioned on the upcoming year's income, there must be ways to account for changes to income that an enrollee may be aware of but are not included in previous year's tax data. CMS references a recommendation from GAO that it should implement a verification process for "when attested income amounts *significantly* exceed income amounts reported by IRS or other third-party sources." As such, in conjunction with the fact that many low-income enrollees' incomes are variable, CMS may want to consider a threshold amount after which point it verifies income, such as a certain percentage or dollar amount above the previous year's income, rather than simply a blanket verification at 100 percent FPL. For example, it would not be unreasonable that someone whose reported income was 99 percent FPL could have an estimated income the following year of 110 percent FPL—which would represent not even a $1,000 difference. ACAP believes it is important to balance verification requirements with ensuring that lower-income consumers who should legitimately receive PTCs are able to do so. We urge CMS in its efforts to ensure that consumers who should not receive tax credits do not inappropriately receive them, not overcorrect to the point where consumers who are eligible are prevented from receiving APTCs, without which they are unlikely to be able to afford health insurance at all. For example, it is unlikely that a consumer earning $15,000 annually could afford a full monthly health insurance premium up front and wait until tax reconciliation for repayment. Further, if these policies go into effect and large numbers of consumers lose coverage, issuers including ACAP's member SNHPs, will need time to consider the risk pool impact and adjust premiums accordingly.

Further, ACAP believes that reports of millions of ineligible consumers inflating their incomes in order to receive PTCs are overestimated. Specifically, a 2024 report[iii] alleges widespread enrollment "fraud" in the health insurance Marketplace in the form of consumers overestimating their incomes, and that millions more consumers enrolled in $0 coverage with maximal APTCs than were eligible for them. However, given that CMS uses the same methodology for which the report relies, we wish to note that there are—as even CMS notes—a variety of issues embedded in it. Additionally, the methodology does not take into account recent policy changes tied to enrollment years. Given these issues, we urge CMS to refrain from making policy decisions based on such analysis. Specifically, the report—and CMS' Impact Assessment—has a variety of limitations[iv] that should be considered:

- **Compares data from different data sets.** CMS acknowledges that use of different data sets is a limitation. Namely, the methodology uses: the Census Bureau's American Community Survey 2022 data, which is self-reported; Treasury tax data from 2020; and Marketplace public use file enrollment data. These different data sources do not allow for a direct comparison since there are differences between verified data and self-reported survey

responses as well as differences in how the sources measure income and household size. For example, Census data counts anyone living in a single household as one unit, while tax data counts individuals as one household based on whether they file singly instead jointly, even if they live in the same household. Additionally, Census data includes income sources like workers compensation or educational assistance, which are not included as income for tax data purposes." By comparing these two datasets, the report identifies consumers as "ineligible" even though they may well be eligible based on actual enrollment rules.

- **Compares data from two different years and does not adjust for the impact of Medicaid redeterminations.** Further, we are concerned that by comparing the number of low-income consumers eligible for the tax credits using 2022 data (before Medicaid redeterminations began in 2023) with actual enrollment data from 2024, the analysis necessarily will produce an inaccurate result. Medicaid redeterminations resulted in a significant increase in consumers eligible for PTCs. Given that over 25 million consumers were disenrolled from Medicaid as a result of the continuous coverage redeterminations, it is highly likely that many of those enrollees became newly eligible for maximum APTCs. Given that CMS' Table 15 does not adjust for this in its comparison of enrollments to 2023 and 2024 potential enrollee data, we urge CMS to adjust for this in its analysis and wait for additional years of the survey data used to determine eligibility, in order to determine whether the increases seen in 2024 were in fact improper or largely in response to a change in policy that made consumers more consumers eligible for $0 coverage.
- **Does not account for changes made by CMS to address broker fraud.** Finally, 2024 saw widespread fraud by unscrupulous agents and brokers that enrolled consumers in coverage without the consumers' knowledge or consent as a way to increase commissions. The prevalence of these actions undoubtedly inflated Marketplace enrollment. In response, CMS instituted new policies and procedures to curb unauthorized enrollments and unauthorized plan switches, although that is not reflected in CMS' analysis. Even more so, however, there are other proposals within this rule that will further limit improper enrollments by brokers and web-brokers—helping address this issue. Accordingly, we believe CMS should wait until data is available showing the full impact of these changes before making additional changes to verification rules for consumers that may have a data mismatch showing that in the previous year they made less than the poverty level.

For all of these reasons, ACAP believes that concerns driving the desire to change the income verification process for consumers whose tax data shows they previously earned under 100 percent FPL may be overstated. We urge CMS to update its analysis to correct for these methodological issues and delay implementation of any changes that would limit the ability of consumers whose tax data says they make less than 100 percent FPL to access APTCs if they have reason to believe their income will increase for the coming year.

Finally, but not insignificantly, we also urge CMS to delay the effective date of these proposals because if implemented, some consumers will lose coverage and issuers need sufficient time to understand the impact of such coverage losses on the risk pool and adjust rates accordingly.

*ACAP urges CMS to delay its income verification proposals until after it can review data from upcoming years and address other methodological issues impacting its estimates, as well as to ensure that issuers have adequate time to consider the impacts of the proposals on the risk pool and adjust premiums accordingly.*

**Annual Eligibility Redetermination: APTCs**

CMS proposes to prevent enrollees from automatically reenrolling in coverage that is fully covered by APTCs without taking action to confirm their eligibility information. Specifically, CMS proposes that any enrollee whose premium would be $0 after APTCs must submit an application for an updated eligibility determination or they will be charged a $5 per month premium for every month that the enrollee does not update their eligibility determination. This proposal would be effective for PY 2026 for FFE states and PY 2027 for SBEs. CMS also seeks comment on whether $5 is a meaningful enough incentive for consumers to reverify their income, or if APTCs should be fully rescinded for such consumers until they reverify their income eligibility. CMS asks whether the risk of program integrity concerns outweigh the benefit of automatic re-enrollment.

CMS notes that because there is no monthly bill, consumers may not realize that they are enrolled in a fully subsidized QHP, particularly because of situations in which an agent, broker, or web-broker improperly enrolled them without their knowledge. CMS also notes that consumers may be at risk of a surprise tax liability if they have stayed enrolled in $0 coverage but their income has increased. CMS notes that this policy would have applied to nearly 2.7 million consumers for the most recent open enrollment period. CMS also notes that Census undercount data suggests that many consumers have remained in $0 plans without their knowledge, while also acknowledging that such data may be inaccurate because of consumer confusion about what type of insurance they have. Such consumer confusion is well illustrated by the fact that one of ACAP's own senior staff working on Exchange policy received a census survey last year and did not know whether to respond stating individual market coverage or employer coverage because the District of Columbia has a merged individual and small group market. We urge CMS not to make policy decisions based on assumptions from census data that is known to be confusing and unreliable.

ACAP strongly urges CMS to reconsider its proposal to charge $5 per month to any enrollees

receiving $0 coverage who do not return to the Exchanges to confirm their eligibility. First and foremost, this proposal will create significant burden and cost for ACAP's not-for-profit member plans. When asked, one ACAP member noted that it would cost more to change the systems and send the paperwork than the $5 premium. In addition, the $5 is not an extra $5 that the issuer would be receiving—but rather the same $5 that would have come from APTCs and that will, in most cases, go back to the consumer at tax reconciliation, leading to a net loss for issuers. Any costs associated with system updates, mailing invoices, and collecting the $5 premium will be a loss to the issuer and an increase in issuers' administrative funds, which must already be limited under medical loss ratio (MLR) requirements. Such costs will need to be offset and will therefore necessitate an increase in premiums across the board – both for consumers receiving APTCs and consumers that self-pay the full cost of premiums.

Further, issuers will need to account for changes to the risk pool that will result from the consumer confusion associated with receiving a $5 bill for coverage that they know is supposed to be $0 and thus dropping off coverage or entering their grace period and eventually having their coverage terminated. It is safe to expect that healthier consumers are more likely let coverage lapse if they believe their premiums have increased, which will again have a resulting destabilizing impact on the risk pool and require issuers to factor those changes into rates—again increasing premiums across the board and continuing the cycle. Instead, the current reenrollment process helps stabilize the risk pool by retaining lower risk enrollees who are the least likely to actively re-enroll. CMS notes in its impact assessment that it believes that the number of enrollees who would have their coverage terminated due to non-payment of the $5 premium is low "given the nominal expense associated with the proposed APTC adjustments." We disagree, as even $5 is not nominal for the lowest-income Marketplace consumers. Study after study has shown that consumers are extremely price-sensitive, and that even a nominal increase in premiums can lead consumers to drop coverage.[v]

From a consumer confusion standpoint, ACAP also has noted that CMS is not providing any guidance for notice requirements that would help educate consumers that they still may be eligible for $0 coverage and that $5 is not necessarily their new cost. If CMS moves forward with this proposal, we encourage CMS to first provide guidance on consumer notification requirements so that consumers have some awareness of the requirements and that some issuers do not use this as a way to back-door cherry-pick enrollees.

ACAP strongly opposes CMS' alternate proposal of the complete withholding of APTCs from a consumer who was previously receiving $0 coverage. It is highly unlikely that any consumer receiving $0 coverage in one year would have such an income increase that they would no longer qualify for any premium tax credits and we believe that the consumer confusion and business impacts on our member SNHPs outweigh the potential that some consumers would re-verify

their income information. Instead, consumers who receive such a large premium bill are likely to ignore it—effectively entering the grace period and losing coverage and destabilizing the risk pool. We believe such a destabilization of the risk pool, with up to 2.7 million enrollees being impacted, far outweighs any other considerations. In addition, as CMS notes, it "is likely to create a significant debt to the issuer, since the enrollee is unlikely to be able to pay the full gross premium." It could cause significant, long-term harm to the consumer since it would also impact their ability to effectuate new QHP coverage due to the proposal that would allow issuers to attribute past-due premiums to effectuate new coverage. This could be devastating to a consumer who thinks that the bill is a mistake and disregards it, for example.

CMS notes that this proposal is to address one of the "most concerning" reasons for improper enrollment: agents, brokers, and web-brokers improperly enrolling a consumer into a QHP with $0 premiums. However, CMS is instituting a number of other provisions herein, which, in conjunction with CMS' actions in 2024 to curb unauthorized plan switching, should have a significant impact on such unscrupulous behavior. We urge CMS to wait until additional years of data are available to determine whether there continues to be an issue with nefarious behavior from brokers before instituting this policy, which would have a significant, broad impact on millions of consumers who are legitimately receiving APTCs. Along the same lines, CMS notes that it is concerned that some consumers will have inadvertently remained enrolled even after obtaining other coverage, which may lead to a tax liability. However, there are a limited number of consumers who will be impacted by this issue with duplicate coverage, and it is their responsibility to cancel their Exchange coverage in such a scenario or risk paying back the tax liability. Similarly, we also do not believe that this concern outweighs the concern of millions of consumers who might otherwise lose coverage if this proposal is finalized.

Finally, it remains to be seen whether the Enhanced PTCs will be extended; if they are not extended by Congress, the number of consumers eligible for a $0 plan will drop significantly and be largely limited to consumers who have purchased bronze plans, as all consumers—even those at just 100 percent FPL—would be required to pay a percentage of their income (1.82 percent for 2025) for the second-lowest-cost silver plan and the issue of automatic re-enrollment into silver plans would become moot. We urge CMS to wait until PY 2027, after the scheduled expiration of the Enhanced PTCs, to see whether and how Congress acts before finalizing this proposal.

We also believe that CMS could achieve its stated goal by other means, particularly if tax or other income data is available, and urge CMS to consider alternatives before moving forward with this proposal.

*ACAP strongly opposes CMS' proposal to require that any consumers receiving full APTC payments who do not actively reverify their income instead be charged $5 per month until they do so. ACAP also strongly opposes CMS' alternate proposal, which would remove full APTC*

*until re-verification. In addition to significant consumer confusion, loss of coverage, and resulting destabilization of the risk pool, there will be a significant business impact including financial and operational burden on ACAP's member SNHPs. We also urge CMS to wait until PY 2027 to move forward with any variation of this proposal, as automatic re-enrollment into $0 plans will be significantly reduced if Congress does not extend the Enhanced PTCs.*

**Premium Payment Threshold**

CMS proposes to remove recent flexibilities that would allow issuers to adopt a 98 percent or greater gross premium percentage or $10 or less fixed dollar premium payment threshold in addition to the 95 percent or greater net premium payment threshold option. CMS proposes this reversal in order to ensure that consumers do not remain enrolled in coverage for extended periods of time without paying at least some premium, in particular as a measure to guard against improper enrollments.

ACAP supported CMS' proposal to allow these additional issuer flexibilities as part of the 2026 Notice of Benefit and Payment Parameters. In keeping with this, we now object to CMS' proposal to reverse policy and eliminate the gross percentage and fixed dollar premium payment thresholds. Specifically, we supported greater flexibility for issuers to determine whether and what type of premium payment threshold to institute based on what they believe is most appropriate for their enrollee characteristics and actuarial calculations.

CMS' policy has the potential to cause disruptions in coverage and care for consumers over nominal dollar amounts. While CMS raises program integrity concerns in its reasoning, we believe that program integrity concerns are minimal for a number of reasons. First, given that binder payments must be made in full in order to effectuate enrollment, we believe that guards against any concerns of unauthorized enrollments by agents, brokers, and web-brokers, as consumers will need to pay their first month's premium. Second, issuers do not generally make public whether they have a premium payment threshold in place, so there is little risk of being incentivized to enroll in any particular plan in the hopes of abusing premium-payment thresholds. Third, while CMS relies on consumer complaint data from December 2024 to justify concern of improper enrollments, that figure represents a drop in consumer complaints by more than 30,000 from just 10 months earlier. The December 2024 consumer complaint number has dropped to nearly the number from the previous year, which shows that already significant progress has been made to crack down on unauthorized enrollments and plan switches, which, as discussed earlier, will be bolstered by new policies implemented in this rule. Further, of the 7,134 complaints received in December of 2024, it is unclear how many of those are related to coverage purchased for the 2025 coverage year – it is likely that many are in fact related to older.

PY 2024 coverage issues that consumers did not become aware of until they went to enroll in PY 2025 coverage, and do not necessarily reflect an active issue.

*ACAP objects to CMS' proposal to eliminate the gross percentage and fixed dollar premium payment thresholds. We believe program integrity concerns related to these provisions are minimal and urge CMS to retain this greater flexibility for issuers to determine whether and what type of premium payment threshold to institute, based on what they believe is most appropriate for their enrollee characteristics and actuarial calculations.*

**Annual Open Enrollment Period**

CMS proposes to limit the annual open enrollment period (OEP) to 45 days, running from November 1 to December 15 each year. CMS notes that limiting open enrollment may help reduce consumer confusion by aligning OEP with that of some other forms of coverage, that it could help support program integrity, but it does not, however, provide comprehensive justification for its proposal to shorten open enrollment to 45 days.

CMS states that changing the OEP end date from January 15 to December 15 would not have a negative impact on a consumer's opportunity to enroll in QHPs through an Exchange. We respectfully disagree and oppose CMS' proposal. Limiting OEP will, by its very nature, limit consumers' ability to enroll in coverage. A review of the 2025 OEP National Snapshots released by CMS shows that 7.6 million consumers enrolled between the 3rd Marketplace Snapshot released on December 20, 2024 and the final Snapshot, released on January 17, 2025. While some of these consumers might well purchase coverage earlier if future OEPs are limited, we believe that would cause significant consumer confusion and that not all would.

It is our understanding that often healthier consumers wait to enroll, while sicker consumers have a greater incentive to enroll early, which suggests that shortening OEP risks degrading the risk pool. Analysis from Covered California, for example, shows a decreasing risk score of consumers enrolling in coverage prior to December 15 compared to those purchasing coverage from December 15 to December 31, and even lower risk scores for consumers purchasing coverage in January. ACAP urges CMS to retain the current OEP in order to support a balanced risk pool and lower premiums for all consumers.

Additionally, the operational impact on issuers would be tremendous. Issuers as well as navigators, agents, and brokers are already stretched thin during OEP; enrolling another 7 million people into the first 45 days of open enrollment would be quite difficult and resource intensive. It also runs the risk of consumers being less likely to enroll in the right plan for their

needs, as agents and brokers may have more limited time to help with plan selection, for example. ACAP's member plans have noted that they have heard from their broker partners that they have struggled to enroll everyone during even the most recent open enrollment period, and that the shortened OEP would be a burden. ACAP's member plans also note that they have seen significant enrollment gains between December 15 and January 15. Reducing the OEP by 30 days—a 40 percent reduction—will cause significant operational burden for small issuers, such as ACAP's members.

Consistency is important to ACAP's member plans from a business continuity standpoint. We wish to note that all but 4 OEPs have been 75 days or longer. In fact, twice as many OEPs have been 75 days or longer compared to those that have lasted only 45 days. A review of the data show that enrollment dropped nationwide during three of the four years with a 45 day OEP, with the fourth year showing only a slight increase in enrollment despite it being the first OEP after the beginning of the COVID 19 pandemic.[vi]

In addition to the business and operational burden as well as consumer confusion, we believe it remains important that consumers who are automatically re-enrolled in coverage have the opportunity to change plans after January 1. A consumer may be perfectly happy with their health plan choice and want to remain in it, only to learn after receiving their January invoice that their costs have increased, particularly if their plan's position relative to the second-lowest silver plan in their market has changed or there has been a change in premiums across the board. While CMS notes that only a "small number" of consumers have taken advantage of this time to change plans, we are interested to know the actual and relative numbers and urge CMS to share this data for additional consideration. We do think, however, that it is important to retain this option for consumers who many otherwise be inadvertently impacted.

CMS also solicits comment on whether to delay this provision until 2027 OEP given the uncertainty around the extension of the Enhanced Premium Tax Credits, as they are currently set to expire at the end of December 2025. If CMS does decide to move forward with shortening open enrollment, ACAP urges CMS to delay such a change until the 2027 OEP, as consumers may need additional time to change plans if the tax credits are not extended. Without such flexibility, consumers may well be liable for significant, unexpected premium increases in order to keep their insurance coverage current.

Finally, CMS also proposes to require SBEs adopt the shortened, 45-day open enrollment period and solicits comments on whether states should be permitted to extend their open enrollment period through a blanket SEP. ACAP objects to CMS' proposal and urges CMS to let states continue to set their own open enrollment periods and establish SEPs where appropriate. For example, in the case of a natural disaster, consumers in the affected state may need additional time to enroll in coverage or to track down and provide income documentation. We believe it is

important to retain this flexibility. In cases such as this, we believe states are best positioned to establish guardrails and timelines that best meet the needs of their population and we urge CMS not to limit state flexibility.

*ACAP strongly objects to CMS' proposal to shorten the annual open enrollment period to 45 days, running from November 1 to December 15 of a given year. Regardless, if CMS moves forward with its proposal, we urge it to delay the effective date until PY 2027 given the uncertainty as to whether Enhanced PTCs will be extended after December 31, 2025. Finally, ACAP urges CMS to preserve state flexibility and to continue allowing SBEs to set their own open enrollment timelines.*

**Monthly SEP for Consumers Below 150 Percent FPL**

CMS proposes to eliminate the monthly SEP for APTC-eligible individuals with a projected annual household income at or below 150 percent of the FPL. CMS notes that the availability of this SEP has substantially increased improper enrollments and led to adverse selection from consumers waiting until they are sick to enroll in coverage.

ACAP supports CMS' proposal to remove the 150 percent FPL SEP. ACAP's member plans have firsthand experience of adverse selection from consumers who purchase coverage through a special enrollment period (SEP) as well as a rise in improper enrollments and urge CMS to finalize this proposal.

When the 150 percent FPL SEP was first proposed, ACAP tentatively supported it in order to improve access to coverage for low-income individuals, while cautioning CMS that the SEP was ripe for abuse and urging CMS to continue to monitor it for abuse and issue new rulemaking if warranted. ACAP's member plans are key components of the health care safety net and have long supported policies that support safety net coverage and care, as this SEP was intended to do. However, plan year 2024 saw a significant increase in unauthorized plan enrollments and unauthorized plan switches by unscrupulous brokers—exactly the kind of abuse ACAP worried about when this SEP was first proposed. The 150 percent FPL SEP has enabled brokers to enroll consumers in plans or switch their plans—sometimes every month—without their knowledge or consent. While it remains to be seen whether Congress will extend the Enhanced PTCs that have enabled consumers under 150 percent FPL to receive $0 coverage, we believe that the combination of the two policies has made it too easy for unscrupulous brokers or others to abuse the SEP. If the Enhanced APTCs remain in place, this proposal will be particularly effective in reducing fraudulent enrollments and plan switches.

A key tenet of a robust individual market is having a balanced risk pool, which can only happen if consumers do not wait until they are sick to enroll in coverage. Many of ACAP's member plans have experienced adverse selection from consumers enrolling through an SEP; in particular numerous ACAP member plans have noticed a trend of high utilizers enrolling through an SEP only to shortly thereafter receive a costly procedure, such as an organ transplant, dialysis, cancer treatment, or utilize a high-cost specialty drug. While some, but not all, such high utilizers that have entered mid-year have $0 coverage, we believe that limiting this year-round SEP will limit such abuse and help to stabilize the risk pool.

*ACAP supports CMS' proposal to eliminate the 150 percent FPL SEP. ACAP's member SNHPs have experienced both adverse selection from SEP abuse as well as seen a substantial and problematic increase in unauthorized plan enrollments and unauthorized plan switches and applauds CMS' efforts to address these issues through this policy change.*

**Pre-Enrollment Verification for Special Enrollment Periods**

CMS proposes to require that Exchanges conduct pre-enrollment verification of eligibility for 75 percent of all new enrollments through SEPs (other than loss of minimum essential coverage, for which verification is already conducted). CMS notes that current SEP verification requirements do not provide enough protection against misuse and abuse, while also noting that verification requirements can also have the unintended consequence of undermining the risk pool by imposing a barrier that may deter healthy consumers from enrolling.

As with the 150 percent FPL SEP, ACAP member plans have seen significant adverse selection and possible abuse of SEPs. ACAP would support a modified version of CMS' proposal and urges CMS to consider the following changes before finalizing their proposal: (1) adjust the 75 percent requirement to provide some flexibility or instead permit Exchanges to verify the SEPs that are most at risk of abuse, and (2) permit SBEs to continue to establish their own pre-enrollment verification standards.

First, we concur that current SEP rules are ripe for abuse that can lead to adverse selection, as has been experienced by our member plans. And while plans cannot always tell what SEP a consumer has enrolled through, one member plan shared the story of an enrollee who enrolled through a SEP for a December 1 start date and then received a liver transplant on December 24 of the same year. This particular consumer did not receive any APTCs so it was not the case of someone enrolling through the aforementioned 150 percent FPL SEP. We have also noticed that plans with broad provider networks or formularies, such as a number of ACAP's member plans, are particularly at risk of seeing SEP abuse from consumers who wait until they get sick to

purchase—or switch to—robust coverage.

Second, we concur with CMS that burdensome verification requirements can pose a barrier for healthier consumers to complete, ultimately disadvantaging the risk pool. These two competing goals must be adequately balanced in any successful policy proposal. Accordingly, we wish to note for CMS that we are concerned that the broad 75 percent SEP verification requirements may not have their intended effect. Operationally, a generic threshold may be both difficult to implement and not effective, as it could lead to SEP verification based on volume or ease of verification in order to meet the 75 percent threshold, rather than verification of SEP types that have the most fraud. ACAP would recommend, for example, instead starting with SEP verification requirements for SEP types that tend to have the most instances of fraud or abuse. We urge CMS to reconsider its proposal to ensure its effectiveness before finalizing.

Finally, we also recommend that CMS permit SBEs to retain their own verification rules. SBEs will experience high operational burden and cost to change their SEP verification rules. States also are best positioned to take into account local issues and decisions that may impact the opening of a SEP—such as during a natural or man-made disaster,[vii] for which verification may be difficult if not impossible for consumers, but that if are left unverified would risk making the SBE unable to meet the 75 percent threshold.

*ACAP supports CMS goal of increasing SEP verifications and would support a modified version of its current proposal. We urge CMS to adjust the 75 percent requirement to provide some flexibility or instead permit Exchanges to verify the SEPs that are most at risk of abuse. We also urge CMS not to limit state flexibility and to permit SBEs to continue to establish their own pre-enrollment verification standards.*

**Prohibition on Coverage of Sex-Trait Modification as an EHB**

CMS proposes to prohibit coverage for sex-trait modification as an essential health benefit (EHB) beginning in PY 2026. As a result, PTCs cannot include the cost of such services nor would they be subject to annual or lifetime cost sharing limitations. CMS notes that sex-trait modification was not generally included in the small group EHB-benchmark plans chosen by states in 2014.

ACAP objects to CMS' proposal for a number of operational and financial reasons. First and foremost, sex-trait modification is not a defined term referring to a specific benefit or service, nor is it a category of services. Rather, sex-trait modification refers to any number of services based on *why* they are performed, and which span multiple EHB categories. The actual services

that are performed to complete sex-trait modification are also performed for many other reasons—such as a hysterectomy to treat or prevent cancer, infection, or even endometriosis; or hormone therapy to treat menopause, cancer, any number of endocrine disorders, or as part of continued treatment after a hysterectomy. It is vital to ensure that implementation of this proposal does not place undue burden or delay on access to potentially life-saving care.

CMS' proposal would require issuers to in some way filter their claims to exclude certain services only in certain cases; the operational burden of doing so would be tremendous for ACAP's member SNHPs, particularly when it comes to pharmacy claims. Implementing such a policy would require significant, expensive systems changes and the ongoing cost of filtering such services or implementing a prior authorization requirement would far exceed the cost of providing such services. This poses a particularly significant financial burden on small, regional and single-state issuers, such as ACAP's member plans. Issuers will be forced to raise premiums, ultimately increasing costs for consumers.

CMS' notes that some states may require sex-trait modification as a benefit mandate, which would require states defray the cost. Again, the ongoing cost of implementing this provision would cost more than the benefit cost that states would be required to defray—adding to already slim administrative costs based on MLR requirements. Further, some states have not established a benefit mandate for sex-trait modification but have made clear that denial of such coverage would go against broader, existing nondiscrimination rules. Issuers would need additional guidance as to how to implement conflicting requirements in such cases.

Finally, ACAP is concerned about the tight timeframe for implementation by PY 2026 and would urge delay if CMS moves forward with its proposal. Implementing new systems and utilization management processes is resource intensive and will be difficult to implement in short order, especially given tight timeframe from when this rule will be finalized and when QHP applications and rates are due.

*ACAP objects to CMS' proposal to prohibit coverage for sex-trait modification as an essential health benefit (EHB) beginning in PY 2026. Issuers will be faced with significant financial and operational burden associated with the systems and utilization management changes necessary, as sex-trait modification does not fall outside the 10 EHB categories but rather is made up of numerous services that span multiple EHB categories and are otherwise used regularly for reasons other than sex-trait modifications. ACAP is further concerned by the timeline for PY 2026 implementation and urges a delay in the effective date if CMS moves forward with the proposal.*

**Premium Adjustment Percentage**

CMS proposes to update the premium adjustment percentage (PAP) methodology to capture premium changes in the individual market in addition to the employer sponsored insurance premiums. The resulting impact will raise costs for consumers significantly. Not only will consumer premiums increase, but cost sharing and maximum out of pocket (MOOP) limits would rise by 15 percent compared to 2025 premiums and an additional 4.4 percent compared to the PAP methodology finalized in the 2026 NBPP.

ACAP opposes CMS proposal to update the PAP methodology due it is impact on premiums and cost sharing and the resulting impact on enrollment. Specifically, the proposed PAP methodology will result in a downward pressure in enrollment and upward pressure on claims. That combination runs the risk of leading to a spiral of a worsening risk pool and increased premiums.

CMS notes that in its decision-making, it has revisited its rationale of aligning the PAP methodology in order to make health coverage accessible and affordable for consumers of all income levels. It states that policy objectives of making coverage more accessible and affordable or reducing the burden on taxpayers is not appropriate for this policy. We disagree, as CMS is specifically issuing this rule in response to the Executive Order to deliver price relief for American families, whereas this provision would specifically increase prices for individuals and families.

If implemented, ACAP urges CMS to delay the effective date until PY 2027. Issuers have already begun working on actuarial calculations and product design for PY 2026, which would be impacted by a change to the PAP methodology. Changes that impact product design parameters, such as cost sharing and MOOP, are extremely difficult to implement last minute. Issuers' QHP applications are due in some states just over one month from the comment submission deadline, so any change to the parameters as set out in the 2026 NBPP will result in significant operational and business uncertainty as well as significant cost to issuers.

*ACAP opposes CMS' proposed change to the premium adjustment percentage methodology. If CMS moves forward with this proposal, we urge CMS to delay its effective date until PY 2027, as an immediate effective date would lead to significant operational and business implications for issuers. Changes that impact product design, including cost sharing and out-of-pocket limits are exceedingly difficult to implement within a short timeframe.*

**Levels of Coverage (Actuarial Value)**

CMS proposes to change the de minimis ranges for PY 2026 to +2/-4 percentage points for all QHPs other than expanded bronze plans, for which it proposes a de minimis range of +5/-4. CMS also proposes to remove the de minimis range requirements of +2/0 percentage points for silver QHPs and permit a de minimis variation for silver CSR-variant plans of +1/-1.

ACAP does not object to CMS' proposal to permit greater AV de minimis variation, as it would provide issuers with needed flexibility in their plan design. While we acknowledge that permitting a greater downward variation in AV can make it harder to distinguish between metal tiers, from an actuarial standpoint we recognize that additional flexibility may be needed for plan design purposes. We do wish to note, however, that 2026 plan design is already underway, as QHP applications are due in many states just over one month from the comment submission deadline so we urge CMS to finalize any changes with expediency.

*ACAP does not object to CMS proposal to permit greater downward variation in AV de minimis ranges, as it will provided needed plan design flexibility for some issuers.*

**Conclusion**

ACAP thanks CMS for its willingness to consider the aforementioned issues. If you have any additional questions or comments, please do not hesitate to contact Heather Foster (202-204-7508 or hfoster@communityplans.net).

Sincerely,

/s/
Margaret A. Murray
Chief Executive Officer

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[i] The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[ii] https://www.cms.gov/files/document/2025-qhp-premiums-choice-report.pdf

[iii] The Great Obamacare Enrollment Fraud https://paragoninstitute.org/private-health/the-great-obamacare-enrollment-fraud/

[iv] KAC Response to Paragon Paper: Full Report https://americanscovered.org/wp-content/uploads/2025/02/Paragon-Response-Report-FINAL.pdf

[v] Fierce Healthcare, Even $1 Premium Discourages Low-Income Individuals From Coverage: Study https://www.fiercehealthcare.com/payers/even-1-premium-discourages-low-income-individuals-coverage-because-hassle-factor-study; and
Eliminating Small Marketplace Premiums Could Meaningfully Increase Insurance Coverage https://schaeffer.usc.edu/research/eliminating-small-marketplace-premiums-could-meaningfully-increase-insurance-coverage/; and
The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[vi] KFF State Health Facts https://www.kff.org/affordable-care-act/state-indicator/marketplace-enrollment/

[vii] Massachusetts instituted an SEP in 2018 in response to a natural gas explosion: https://www.mahealthconnector.org/wp-content/uploads/AdminBulletin01-18.pdf; an SEP For TX, LA, FL, GA, and SC in response to Hurricanes Harvey and Irma https://www.cms.gov/newsroom/press-releases/cms-announces-special-enrollment-periods-americans-impacted-recent-hurricanes; an SEP was instituted in North Carolina in response to Hurricane He https://www.hendersonville.com/news/2025/01/people-impacted-by-hurricane-helene-granted-special-enrollment-period-for-aca-health-insurance/; and an SEP was instituted in California in response to the recent wildfires https://www.coveredca.com/apply/emergency/

DCBS | Department of Consumer and Business Services

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April 11, 2025

Submitted Electronically Only: http://www.regulations.gov
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9884-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-9884-P

Greetings:

This letter comes to you on behalf of the State of Oregon Department of Consumer and Business Services, Oregon's insurance regulator, and the Oregon Health Authority, the agency that oversees the Oregon Health Insurance Marketplace – Oregon's state-based exchange on the federal platform. We send this letter to comment on the Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability proposed rules issued on March 12, 2025 and published in the Federal Register on March 19, 2025.

We appreciate the opportunity to comment on the proposed rules. However, we continue to urge the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS) to provide the full 60-day comment period to which we are entitled. Thirty days from public exposure and 23 days from publication in the Federal Register for public review and comment is insufficient, given the new requirement to provide data, the number of policy and process changes that must be carefully considered – not only on their own merits – but also for their potential impact on other regulations and state laws, and the layers of review required before submission. Not only does Executive Order 12866 ("each agency should afford the public a meaningful opportunity to comment on any proposed regulation, which in most cases should include a comment period of not less than 60 days") require a 60-day comment period due to the complexity and impact of the proposed rules, as a practical matter, a 60-day comment period is necessary for the states and other concerned parties to provide well-informed and thoughtful comments supported by the data HHS now requires.

## III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule

In general, HHS's proposed changes individually and taken together will reduce enrollment in the individual market, especially through the exchanges. As HHS concedes, the additional barriers suggested by most of these proposals will have a chilling effect on the enrollment of younger, healthier individuals. Generally, while sicker individuals will jump through any and all hoops to get coverage, younger, healthier people will not. This will degrade the risk pool and lead to higher premium prices, cause higher rates of uninsurance and underinsurance, and result in higher premium-tax-credit (PTC) costs for the federal government.

HHS relies on a Paragon Institute study to demonstrate the need to crack down on consumers who are misstating their incomes and on "unscrupulous brokers" enrolling individuals in plans without their consent. However, the Paragon study clearly shows that not every state is experiencing a problem with taxpayers misstating their incomes. Not only is Oregon not experiencing this problem, it also has not experienced the plan switching issues which have occurred in other states. This proves that states with well-regulated insurance markets and well-run exchanges should be allowed the authority and flexibility to continue to operate in the best interests of their citizens and their markets. As stated by Center for Consumer Information and Consumer Oversight (CCIIO) Director Peter Nelson, HHS should give "states the power and flexibility to oversee rules and requirements because states are in a better position to assess the situation. This promotes a stable marketplace."[1]

Finally, while HHS identifies a problem of fraudulent enrollments as the basis of its proposals, the impact of the proposed rules focus on restricting taxpayers' ability to enroll rather than punishing or reigning in the agents, brokers, and web brokers (brokers) responsible for the problem HHS posits. And, as the Paragon Institute points out, enhanced direct enrollment (EDE) entities are a significant problem that need more oversight. Instead of the regulations proposed that will inhibit legitimate enrollment, Oregon recommends aggressive enforcement of criminal penalties for brokers and EDE entities complicit in the fraud and a requirement for consumers to verify their identity and confirm plan switches made by brokers before they become effective.

### A. Part 147 - Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

#### 1. Coverage Denials for Failure to Pay Premiums for Prior Coverage (§ 147.104(i))

Oregon opposes the proposal to remove §147.104(i), which prohibits issuers from attributing payment of premium for new coverage to past-due premiums from prior coverage. The proposed rule does not provide adequate evidence that allowing issuers to

[1] Nelson, P. & Hinderaker, J.; Summer 21 Issue of Thinking Minnesota; https://www.americanexperiment.org/magazine/article/qa-no-place-like-home.

require payment of premium debt from prior contracts outweighs CMS's prior finding that this policy creates obstacles to accessing health insurance that disproportionately impact low-income individuals.

If the change is finalized, Oregon recommends limiting issuers to requiring payment of premium debt from prior plan years to the preceding 12 months as a condition of effectuation. Allowing issuers to pursue debt from past years without limitation could lead some consumers to build insurmountable levels of premium debt, effectively barring them from the commercial insurance market.

B. Part 155 - Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

1. Definitions; Deferred Action for Childhood Arrivals (DACA) (§ 155.20)
If HHS finalizes this proposal, Oregon urges HHS to provide a safe harbor for DACA recipients, protecting them from repayment of advance PTCs (APTC) paid in between the effective date of the rule and the termination of their coverage by the relevant exchange. Ideally, HHS would delay the effective date of this provision until January 1, 2026 to give affected people time to obtain other coverage and to give exchanges time to notify and help transition impacted people to other coverage. Additionally, state exchanges will need some time to operationalize this proposal and remove DACA recipients from their rolls because it's unclear how state exchanges can determine the DACA status of any particular individual.

2. Standards for Termination of an Agent's, Broker's, or Web-broker's Exchange Agreements for Cause (§ 155.220(g)(2))

HHS has requested comments on the following questions:

- What are States' oversight practices with respect to impermissible conduct by agents, brokers, and web-brokers for the State Exchanges? How are such standards working?

Oregon has a well-regulated insurance market, which is likely the reason Oregon has not experienced issues related to fraudulent plan switching.

- Are there other measures HHS should take to assist consumers who have been enrolled in QHP coverage through the FFEs or SBE-FPs, or switched to different coverage, without their consent to ensure they are held harmless for improper enrollments that are the result of noncompliant behavior by agents, brokers, and web-brokers?

Victims of fraudulent plan switching should be given a special enrollment period that provides for coverage retroactive to the day of the fraudulent switch. The special enrollment period should begin the day the consumer learns of the fraudulent enrollment. HHS should transfer any APTCs paid or credited after the switch to the consumer's original insurer, and victims should be given additional time to pay any premiums not covered by the APTCs.

3. Verification Process Related to Income Eligibility for Insurance Affordability Programs (§§ 155.305, 155.315, and 155.320)

a. Failure to File Taxes and Reconcile APTC Process (§ 155.305(f)(4))

i. Delay of FTR Process until after 2-consecutive years of FTR removed

ii. Conforming Change to Requirements

If HHS finalizes these proposals, Oregon urges HHS to delay implementation until plan year 2027 to give exchanges the necessary time to make operational and systems changes to accommodate the proposals and time to advertise and educate consumers on the new requirements. Delayed implementation will help to ensure there is enough time to help impacted consumers learn of the change, locate and gather and/or obtain necessary documents, and make the necessary filings in time to avoid PTC ineligibility. This additional time is an especially important consumer protection measure in light of the 90% reduction in navigator funding planned for next year and the significant cuts planned to the United States Postal Service, HHS, and the Internal Revenue Service. Additionally, given the fact that the failure to reconcile process was only recently changed from one year to two years, there is significant potential for consumer confusion over new contradictory notices, assuming the notices are even generated, mailed, and received according to the timelines proposed, given the significant reduction in staffing and resources to the agencies responsible for these processes.

b. Income Verification When Tax Data is Unavailable (§ 155.320(c)(5))

As noted previously, Oregon has not experienced and is not expected to experience the problems with fraudulent enrollments that HHS uses to justify this proposal. Again, states with well-regulated insurance markets and well-run exchanges do not benefit from one-size-fits-all regulatory structures. Burdensome federal regulation will not improve Oregon's insurance market or its exchange. As an alternative, Oregon suggests that HHS establish parameters for implementation of this rule so that if data show that fraudulent enrollments or income misstatements in a state meet an established threshold, self-attestations of income become prohibited in that state until they fall below the established threshold.

4. Annual Eligibility Redetermination (§ 155.335)

Oregon questions the legal authority for HHS's proposal to withhold *any* amount of APTCs paid on behalf of a taxpayer who has been determined legally entitled to the entire APTC amount. While section 1411(f)(1)(B) of the Patient Protection and Affordable Care Act (ACA) gives HHS the authority to "establish procedures" to redetermine "eligibility on a periodic basis in appropriate circumstances," it does not give HHS the authority to withhold money it is legally obligated to pay on behalf of every individual who automatically reenrolls without a redetermination finding that they are not entitled to the full APTC amount. Withholding payment is not a procedure to redetermine eligibility. While withholding money from a taxpayer may or may not prompt an individual to go through the redetermination process, it is not in itself a procedure to

redetermine eligibility, which is only what the statute allows. Additionally, section 1411(f)(1)(B) of the ACA gives HHS authority to establish redetermination procedures only "in appropriate circumstances." Requiring *every* taxpayer who automatically reenrolls to undergo redetermination simply because they choose automatic reenrollment exceeds this statutory authority. Such an interpretation would make meaningless the automatic reenrollment process.

HHS seeks to support its proposed amendment to 45 CFR § 155.335 by citing the Census Current Population Survey (CPS) and the National Health Interview Survey (NHIS) showing discrepancies between the data reported by survey respondents and HHS data. HHS theorizes that the differences in the data are due to the existence of millions of taxpayers who have fully subsidized exchange coverage but do not know it. It should be noted that the CPS and NHIS are *annual* surveys while the effectuated enrollment data HHS compares them to are for a *specific moment in time and monthly averages* respectively.

Oregon opposes the proposed amendment because it is neither supported by the law nor by the data. If HHS finalizes the proposal, Oregon urges HHS to delay implementation until plan year 2027 to give exchanges the necessary time to make operational and systems changes to accommodate the proposal and time to advertise and educate consumers on what would be an entirely new requirement for consumers. Delayed implementation will help to ensure there is enough time to help impacted consumers learn of and prepare for the change to avoid the adverse impact of noncompliance. This additional time is especially important as a consumer protection measure because of the cumulative reduction in consumer support planned for next year with the 90% reduction in navigator funding as an example.

5. Annual Open Enrollment Period (§ 155.410)

Oregon opposes HHS's proposal to shorten the open enrollment period (OEP) for all states and as noted above, agrees with CCIIO Director Nelson that HHS should "give states more flexibility to come up with their own solutions . . . [because] states [a]re closer to the ground and therefore [know] their markets better than Washington kn[ows] their markets."[2] Consistent with all of Oregon's prior comments on market integrity and Notice of Benefit and Payment Parameter proposed rules, Oregon believes the states are in the best position to know what works for their markets. As Director Nelson put it, HHS should give the "states the power and flexibility to oversee rules and requirements because states are in a better position to assess the situation. This promotes a stable marketplace."[3] States know their markets better and should have the flexibility and authority to extend open enrollment beyond the federal minimum whether through a longer OEP or through an OEP combined with a special enrollment period.

[2] *Id.*
[3] *Id.*

HHS states that its concerns about adverse selection warrant a shorter OEP. HHS notes that it previously agreed with comments from state exchanges that longer OEPs in the states did not lead to adverse selection. HHS now discounts these comments because the states did not provide evidence in support of these comments. However, HHS has not provided any proof to support its assertion that adverse selection is resulting from longer OEPs and has not provided any evidence to demonstrate to what extent adverse selection exists, if at all. In accordance with 5 U.S.C § 706(2), Oregon supports HHS providing proof that the current OEP is problematic or that a shortened OEP would benefit the markets and consumers.

Contrary to HHS's assertion that there is no clear benefit to the current, longer OEP, there are at least three clear benefits that outweigh a theoretical concern about adverse selection that is not supported by the evidence. (1) An extended open enrollment gives a consumer time to switch plans if, as HHS points out, the consumer auto-enrolled and later learned that the premium changed. (2) An extended open enrollment gives a consumer who enrolls in a plan based on the provider network listed on HealthCare.gov and who later learns that their providers of choice are actually not in the plan's network time to switch plans. Based on the consumer complaints Oregon has received and the work it has done cross-checking HealthCare.gov network lists with carriers, it's clear that, at least in Oregon, the HealthCare.gov lists are usually out of date and are frequently wrong. This leads consumers to choose plans that don't cover their doctors in network or sometimes at all. (3) As HHS concedes, an extended open enrollment period results in a better risk pool and a more stable market because younger, healthier people tend to enroll later. Ultimately, this lowers the cost of premiums and the amount the federal government is obligated to pay in PTCs.

HHS states that it believes changing the OEP will eliminate consumer confusion. Unfortunately, changing the OEP will increase consumer confusion. Seventy-five percent of all OEPs have been 76 days or longer. Consumers have relied upon a longer open enrollment period for eight out of the last 12 years and have specifically grown accustomed to the current OEP, which has been in effect for the last four consecutive OEPs.

In summary, Oregon opposes the proposed amendment because it encroaches on the authority of states to operate and regulate their markets, it limits the flexibility of state exchanges, it will lead to consumer confusion and consumer harm, and there are clear benefits of the current OEP. If HHS finalizes the proposal, Oregon urges HHS to delay implementation of this proposal until plan year 2027 to give exchanges the necessary time to make operational and systems changes to accommodate the proposal and time to advertise and educate consumers on what would be an entirely new requirement for many of them. This additional time is especially important as a consumer protection measure in light of the 90% reduction in navigator funding planned for next year. Additionally, as HHS alludes, the end of enhanced PTCs will likely result in a number of consumers auto-enrolled into plans with unexpected premiums, necessitating additional time for them to change to lower cost plans.

6. Part 156 —Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

a. Prohibition on Coverage of Sex-trait Modification as an EHB (§ 156.115(d))

Oregon opposes the proposal to amend §156.115(d) to prohibit coverage of "sex-trait modification," also described as "gender-affirming care" as an essential health benefit (EHB) by issuers of non-grandfathered individual and small group market health insurance coverage.

The proposal deviates from the long-established procedures for states to set and update EHB, without taking into account that there may be local variation in how "sex-trait modification" is covered by health benefit plans. In Oregon, all commercial health benefit plans, including employer sponsored plans, are required to cover gender-affirming care by state law. This has been true since at least 2013, pursuant to Oregon Insurance Division Bulletin INS 2012-1 (which has since been superseded by DFR 2016-1) which required coverage of gender-affirming care under the state's insurance non-discrimination law and has since been codified under HB 2002 (2023) as ORS 743A.325.

The relevant inquiry for what should be considered EHB should remain what is covered by a typical employer sponsored plan in that state. A declaration that a particular service must be excluded from EHB is inconsistent with the prior application of the law by CMS and the plain text of the ACA.

The proposed rule argues that coverage of gender-affirming care by employer plans is rare because the population that seeks gender-affirming treatment is small, by reference to EDGE data. This is not an appropriate method to establish the rate at which a service is covered. By analogy, consider the coverage of treatment for any rare disease: by the same logic as is presented to justify the proposed rule, we could conclude that most health insurance does not cover treatment for rare diseases.

Furthermore, Oregon finds that the definitions of "male" and "female" presented in the proposed rule would exclude many individuals who are not transgender, including intersex individuals, and individuals who have had surgeries to remove parts of their reproductive systems to treat cancers and other illness unrelated to gender identity. CMS has requested comments on areas where a medical condition other than gender dysphoria may require "sex-trait modifying" treatment. As currently drafted, there is a risk that the rule would bar coverage of treatments for precocious puberty, menopause, perimenopause, and low testosterone in men.

Finally, Oregon recommends that CMS not proceed with this amendment until the various lawsuits enjoining application of Executive Order 14146 are resolved.

7. Premium Adjustment Percentage (§ 156.130(e))

Oregon opposes the proposal to change the methodology for calculating the premium adjustment percentage (PAP). The justification for the proposed rule indicates that the proposed methodology would result in a PAP 7.2 percentage points higher than the PAP published under the current methodology. With enhanced PTCs scheduled to expire at the end of 2025, many consumers are expected to experience a premium shock that could destabilize the individual insurance market. Changing the PAP methodology in a way that increases the required consumer contribution to monthly premiums will only exacerbate this problem.

If the proposed change to the methodology is to be adopted, Oregon urges HHS to delay implementation of the proposal until the market is able to recover from the impact of the expiration of the enhanced PTCs.

a. Maximum Annual Limitation on Cost Sharing for PY 2026
Oregon opposes the proposal to increase the plan year 2026 maximum annual limitation on cost sharing, which would represent a 4.4 percent increase relative to the previously published 2026 plan year parameters. This change would significantly increase the cost burden on consumers with individual market insurance, with the potential to exacerbate existing affordability challenges with premiums and inflation generally.

b. Reduced Maximum Annual Limitation on Cost Sharing for PY 2026

Oregon opposes this proposal. Increasing the maximum cost-sharing limitation does not increase affordability. In addition, HHS has already released a final actuarial value calculator and premium adjustment percentage guidance for Plan Year 2026. Unless a change improves affordability, HHS should refrain from changing plan design guidance after it has been disseminated because such changes create additional work for states and carriers, as they must re-evaluate plan designs and determine if modifications are required. Moreover, this particular proposal will allow carriers to offer plans that are significantly poorer quality, without giving states enough time to set standards and maintain plan quality. Oregon suggests that HHS abandon this proposal for the 2026 plan year.

8. Levels of Coverage (Actuarial Value) (§§ 156.140, 156.200, 156.400)

Oregon opposes the proposal to modify the de minimis ranges for individual and small group plans. The current methodology allows for a much more effective 'apples-to-apples' comparison of the coverage offered at different metal tiers. Widening the de minimis range, particularly on the negative side, could allow plans of different tiers to have actuarial values within 4 percentage points of each other. This creates a risk of consumer confusion while shopping plans and could lead to a consumer purchasing a plan that is less generous than they expected if it is on the low end of the 'de minimis' range.

The department and the Oregon exchange appreciate the opportunity to comment. If HHS has questions about these comments, please contact either of us at the email addresses below.

Sincerely,

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FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

April 11, 2025

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

*Submitted electronically via regulations.gov*

**RE: CMS–9884–P: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability**

Dear Administrator Oz,

As a long-time leading national, non-partisan voice for health care consumers, Families USA appreciates the opportunity to respond to the Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability proposed rule (herein after "Proposed Rule").

Families USA seeks to ensure that hard-working families across America obtain and maintain access to affordable, high-quality health insurance coverage. To date, CMS has made significant strides in the Federal Marketplace and State-Based Exchanges under the Affordable Care Act to enroll more than 23.6 million people in affordable marketplace coverage.[1] However, many of the policies proposed in this rule would reverse this progress, directly undermining access to health care coverage and the health and financial security of our nation's families.

**As such, Families USA urges you to reconsider CMS' proposed changes, and to redraft the rule with these comments in mind—especially pertaining to the harmful impact these changes would have on consumers seeking to purchase affordable health care coverage.**

We offer detailed comments on individual sections of the Proposed Rule below, but must first raise deep concerns with the overarching frame of CMS' stated intentions, assumptions, and process: 1) While Families USA shares the concerns raised by CMS related to broker fraud, the rule does not offer targeted solutions but rather broad obstacles that will impact state-based marketplaces and the ability of consumers to access health care, even when there is no

documentation of fraud. 2) To the extent that part of the justification for this rule is to offset the impact of the potential lapse in enhanced premium tax credits on the insurance risk pools in the marketplace, the best approach would be for Congress to simply renew the tax credits, and for CMS to pull back this rule accordingly. 3) The scope of the changes in this Proposed Rule with its multiple components requires a longer public comment period with sufficient time to garner the perspectives and impact of all impacted stakeholders.

To be more detailed in our overarching concerns with the approach taken in this rule, Families USA agrees with CMS on the need to address the issue that some brokers, agents, and lead generators have been responsible for large-scale unauthorized enrollments and abuse of the marketplace in certain states.[2] A lawsuit alleging fraud and RICO violations by several web-brokers and lead generators is pending,[3] and the U.S. Department of Justice recently charged the president and CEO of an insurance broker firm with fraud.[4] In general, these brokers and agents change consumers' health plans without authorization in order to increase their commission. This directly harms consumers and families by weakening the quality of their health care coverage and increasing consumers' financial exposure to potentially uncovered health care services.[5] **But the Proposed Rule does not offer appropriate targeted solutions to address this real concern. Importantly, this unauthorized enrollment occurred *only* in certain states: states where brokers and agents are allowed to enroll people in plans using private websites, without the consumer visiting HealthCare.gov or a state-based marketplace.[6] Efforts to address this fraud and/or abuse should therefore be focused on the use of these private websites and on strengthening regulation and oversight of the brokers, agents, and lead generators who are driving the abuses. To that end, most of the proposed policy changes contained in this rule are misguided in addressing concerns about abuse within the marketplaces and fail to target real fraud in the program. Instead, if finalized, this Proposed Rule will only serve to create obstacles for everyday Americans seeking to enroll in subsidized marketplace coverage which will result in reductions in legitimate enrollment, especially for low-income applicants.**

The Proposed Rule also makes the premature assumption that the enhancements to premium tax credits will expire at the end of the year, as is the case under current law, and assumes that the higher costs of coverage will discourage healthy people from enrolling in the marketplace. The Proposed Rule uses this hypothesis to justify many of its changes. As such, the best solution to address these issues is to work with Congress to extend the tax credits beyond December 2025, which is actively being discussed by bipartisan lawmakers. Such an extension would obviate many of the concerns regarding possible changes to risk pools noted in the justification. **Either way, but especially if Congress acts to extend the enhanced premium tax credits, we urge CMS to significantly revise this rule to ensure stability in the ACA marketplace.**

Finally, we are deeply concerned that given the depth and breadth of changes being proposed to both the Federal Marketplace and State-Based Exchanges, including an aggressive timeline for implementation, CMS has not provided sufficient time for health care stakeholders to provide public comment. A mere 30-day public comment period is often insufficient in allowing

diverse stakeholders impacted by the proposed changes to provide meaningful feedback to the federal government. There has been a longstanding commitment from both Republican and Democratic administrations, including President Trump's first administration, to uphold meaningful public comment periods that are commensurate with the scope of the changes being proposed. **Given the importance of CMS policy changes on the health and wellbeing of millions of Americans, we urge CMS to provide more appropriate length comment periods that match the scope of the policy changes being proposed.**

Our additional detailed comments focus on the following sections of the Proposed Rule:

- III. A. 2. Coverage Denials for Failure to Pay Premiums for Prior Coverage
- III. B. 1. Definitions; Deferred Action for Childhood Arrivals
- III. B. 2. Standards for Termination of an Agent's, Broker's, or Web-broker's Exchange Agreements
- III. B. 3. Verification Process Related to Income Eligibility for Insurance Affordability Programs
- III. B. 4. Annual Eligibility Redetermination
- III. B. 7. Annual Open Enrollment Period
- III. B. 8. Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Projected Household Income at or Below 150 Percent of the Federal Poverty Level
- III. C. 1. Prohibition on Coverage of Sex-trait Modification as an EHB
- III. C. 2. Premium Adjustment Percentage

III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule A. Part 147- Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets 2. Coverage Denials for Failure to Pay Premiums for Prior Coverage

**Families USA strongly opposes CMS' proposal to allow health insurance issuers to require applicants to pay past-due premiums from prior health care coverage before effectuating new coverage.**

**This proposed policy change is a solution in search of a problem which, if finalized, would strip away health care coverage from our nation's families, threatening the health and financial security of more than 20 million Americans who rely on the ACA marketplace for health insurance.** It is well-established that health insurance issuers already have various methods at their disposal to collect past-due premiums that cause less harm to consumers than directly denying coverage until payments are made. For example, CMS noted in its 2023 Notice of Benefit and Payment Parameters Final Rule that issuers have the ability to pursue such methods to recoup payments including through debt collection. CMS even went so far as to say that issuers are *not* permitted to forgive outstanding past-due premiums.[7] Given that issuers already have the ability to recoup these payments under current federal law, this proposal to allow issuers to collect these payments as a condition of enrolling in coverage can only be seen as a thinly veiled attempt to weaken access to the health coverage the American people rely on through the Affordable Care Act.

Reducing access to health coverage not only forces families to forgo needed medical care, often threatening their ability to manage chronic diseases,[8] but it also increases their financial exposure to expected and unexpected health care costs.[9] Given that nearly half of Americans have less than $500 in their savings account, any threats to health care coverage will only serve to force more people into medical debt and further threaten the health and financial security of our nation's families.[10] Not only do coverage losses place a significant financial burden on consumers and their access to care, they also directly increase the amount of uncompensated care that hospitals must deliver and may increase general health care spending in the long run.[11]

We are also concerned that this proposed change fails to include any requirements to notify consumers about past-due payment or propose a process that would enable consumers to dispute any liabilities or establish a payment plan. **We strongly recommend that for any proposal regarding a potential loss in coverage, CMS must take every available step to try to prevent that worst-case scenario. In a rule such as this, that would include requiring insurers and Exchanges to send multiple advance notices to consumers about any past-due premiums, providing time for consumers to dispute any liabilities, giving options for consumers to make a payment plan, and allowing consumers to reenroll in coverage while they are in the repayment process.**

**Given that CMS already has options under federal law to pursue past-due premiums, and the extreme potential for coverage loss and resulting harm to families and providers under this provision of the Proposed Rule, Families USA urges CMS not to adopt this policy.**

III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule B. Part 155-Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act 1. Definitions; Deferred Action for Childhood Arrivals

**Families USA strongly opposes CMS' proposal to reverse the definition of "lawfully present" in 45 CFR 152.2 to exclude Deferred Action for Childhood Arrivals (DACA) recipients and make them ineligible to purchase health care coverage through the ACA Marketplace.**

Under federal law, individuals who are "lawfully present" are eligible to purchase and enroll in health care coverage offered through the Affordable Care Act marketplace. Traditionally, "lawfully present" individuals included green card holders, asylees, refugees, and those with certain non-immigrant visas. In May 2024, the Department of Health and Human Services (HHS) finalized the rule 'Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, and a Basic Health Program', which included DACA recipients within the definition of "lawfully present." CMS estimated that roughly 100,000 DACA recipients would newly enroll in health insurance under this rule.[12] For this relatively small group of people who have only known the United States as

home, this would make a huge difference: They became eligible to purchase health insurance with their own money, and thus become enrolled in ACA marketplace coverage, as well as qualify for tax credits to make premiums more affordable.

This change was an essential improvement: Ensuring that DACA recipients have access to health coverage can improve health care access and outcomes for this population and also prevents health systems from acquiring additional uncompensated care costs.[13] Since DACA was established in 2012, DACA recipients have been ineligible for federally-funded health insurance programs such as Medicaid and CHIP. Without access to affordable care through the marketplaces, the high cost of health care coverage is often inaccessible for low-income DACA recipients.[14] [15]

Chronic uninsured rates amongst DACA recipients can lead to worse health outcomes for this population and end up costing the health system, and those who pay into it, more in the long run. It is well established that uninsured adults often experience worse health outcomes due to forgoing necessary care or receiving poorer quality care.[16] Health care coverage enables people to seek regular preventive care and manage chronic conditions and disease, and ensures some level of protection against financial exposure to high health care costs.[17] Importantly, when uninsured individuals do seek care, they are often sicker and require more costly medical intervention. In addition, these sicker patients often seek care in emergency departments—the highest cost care settings—which can drive up.[18]

Moreover, the inclusion of DACA recipients into the health insurance market improves health care costs for all consumers, contributing to larger risk pools that establish greater predictability and stability around premium calculations.[19] Because the DACA population is young (under the age of 45) and considered to be in good overall health, it is likely that the inclusion of DACA recipients into insurer risk pools could help to lower insurance premiums.[20]

**Families USA encourages CMS to maintain ACA Marketplace eligibility for DACA recipients to ensure this population is able to access necessary health care to stay healthy and continue contributing to the workforce and economy, all while improving health insurance risk pools by increasing the number of healthy beneficiaries.**

III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule B. Part 155-Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act 2. Standards for Termination of an Agent's, Broker's, or Web-broker's Exchange Agreements

**Families USA agrees that fraudulent and unauthorized enrollments by agents, brokers, and web-brokers must be stopped, and supports the provision in the Proposed Rule that would apply a "preponderance of evidence" standard as proof for establishing a reason for terminating agent/broker/web-broker Exchange agreements.** This provision builds on current rules that allow the federally facilitated marketplace to immediately *suspend* an agent or broker

for suspected fraud that may cause imminent or ongoing harm to consumers or that risks the accuracy of eligibility determinations, and then to *terminate* the agent's, broker's, or web-broker's agreement upon finding a violation of HHS standards or agreements, if the matter is not resolved within 30 days from the date of notice (45 CFR 155.220(g)(5) and (k)(3)). Setting an explicit evidentiary standard, as proposed, will further help CMS protect consumers from bad actors.

This provision builds on important policy change finalized by CMS in the 2026 Notice of Benefit and Payment Parameters, in which CMS strengthened its compliance reviews, established greater authority to suspend the ability of an agent or broker to transact business with the Exchange (45 CFR 155.220(k)), and updated model consent forms that can be used to document consumer review and confirmation of enrollment changes. Taken together, these changes mark an important step forward in strengthening oversight and accountability over the fraud and abuse driven by brokers and agents in the marketplace.

Importantly, CMS asks for input on other approaches to assist consumers who were switched to a different health plan by brokers or agents without their consent. Families USA offers the following:

- **If CMS continues to allow enhanced direct enrollment, rules should:** obligate brokers to act in the best interest of consumers, require documentation of consumer consent before a broker receives a commission, and require lead generators to register with the marketplace and meet marketing standards.[21] [22]
- To prevent unauthorized plan switches, Families USA further recommends that, once tested, **CMS *require* use of its updated model consent form and its scripts for documenting consumers' review and confirmation of enrollment changes**.
- When consumers are wrongfully switched into a different plan, **CMS should retroactively enroll the consumer in their original plan and/or provide an exceptional circumstances special enrollment period**, beginning the date that the consumer learns of an unauthorized switch, to enroll in the plan of their choice. Rules should assure that the consumer is held harmless for any medical bills that might exceed the cost-sharing amount the consumer would have otherwise incurred in the plan they chose.

- **CMS should consider ways to better regulate health plan gifts and wellness rewards programs.** We understand from one informant that some agents or brokers use promises of gifts, such as groceries or prepaid cash cards, as inducements for consumers to change their plans.[23] Such gifts are offered by some health plans as an incentive to participate in wellness activities, such as participating in a wellness screening or "learning new ways to be healthy."[24] However, malicious agents or brokers may misrepresent those rewards programs, disappointing consumers who do not actually qualify and potentially leaving them in a plan that does not meet their needs.[25]

III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule B. Part 155-Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act 3. Verification Process Related to Income Eligibility for Insurance Affordability Programs

*a. Failure to File Taxes and Reconcile APTC Process*

**Families USA strongly opposes CMS' proposal to reinstate a policy that ended in 2023, which would require Exchanges to determine a tax filer ineligible for a premium tax credit** if: (1) HHS notifies the Exchange that the tax filer (or their spouse, if the tax filer is a married couple) received an APTC for a prior year for which tax data would be utilized for verification of income, and (2) the tax filer or tax filer's spouse did not comply with the requirement to file a federal income tax return and reconcile APTC for that year. Under current rules, this process uses two consecutive years rather than the proposed one year as the period of time assessed for reconciling noncompliance with filing federal income tax returns and the receipt of premium tax credits. If finalized, this rule would make it hard—and in some cases impossible—for many self-employed marketplace enrollees to retain coverage.

Many marketplace enrollees are self-employed, independent contractors or small business owners with complicated tax returns due to many income sources and expenses.[26] The Department of Treasury reported that 3.3 million self-employed workers and small business owners were covered by the marketplace at some point during the year in 2022, amounting to 28% of all 21–64-year-old marketplace enrollees.[27] Many self-employed workers pay taxes by April 15, but utilize the standard extension to October to file tax return paperwork, which is specifically allowed for sole proprietorships.[28] IRS data shows that in the 2024 tax filing season, 24 million returns were filed between April 19 and December 27, which does not leave sufficient time to be processed prior to the November 1-December 15 open enrollment period for marketplace verification.[29]

Further, amidst current federal worker layoffs unfolding on a massive scale, it is unclear whether IRS and HHS will retain sufficient staff capacity to provide accurate and timely notices about failure to reconcile tax returns with APTCs, or be able to promptly resolve questions and disputes that might arise to adequately support employees in navigating these tax complexities, particularly as it pertains to health care. The two-year deadline for reconciliation was originally established to address the operational challenges that marketplaces faced in receiving accurate and timely information about tax filing status,[30] and to prevent the occurrence of those problems in the coming year. We are deeply troubled that CMS does not provide sufficient data to justify reducing the length of time for reconciliation. While the rule does cite to enrollment public use files, [31] the rule fails to provide any data about the number of enrollees who do not reconcile and are ineligible for APTCs. The 2025 and 2026 Notices of Benefits and Payment Parameters have already required marketplaces to send further notice to marketplace enrollees who fail to reconcile their APTC, informing them that they are at risk of losing their

premium tax credits.[32] It is too early to determine whether these measures alone will be sufficient to address the problems that are the stated concern of this proposed provision.

**As a result, Families USA strongly opposes the proposal to reduce the length of time for reconciliation.** While we urge CMS not to finalize this provision, out of deep concern for the impact this change would have on consumers, we offer the following recommendations to mitigate harm, should this provision be finalized:

1) Establish a termination clause in the rule which would revert to the two-year file and reconciliation period if operational challenges make it difficult to provide timely notice and dispute resolution to enrollees.
2) At a minimum, people terminated due to failure to reconcile must be provided an exceptional circumstance special enrollment period to reenroll in marketplace coverage with current income information.

**Further, Families USA understands the need to protect enrollees from an extended tax liability. To do that, Families USA urges CMS and IRS to provide more outreach about the need to update income information and revisit plan selections annually**. For example, CMS and IRS should work together to provide clear information in large font with 1095-A forms stating that if you receive this form, you are required to file or may lose access to advance credits in the future. CMS and IRS should work with tax software providers to ensure that further information is provided on all major platforms that people use to file their taxes and to file for extensions. Information should also be provided in materials sent by health plans to enrollees. Free help should be provided with the complicated tax form 8962 which is used to reconcile APTCs. **Reinstating navigator funding that was cut by the administration earlier this year would help with such outreach.**

*b. 60-Day Extension to Resolve Income Inconsistency (§ 155.315); c. Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii)); and d. Income Verification When Tax Data is Unavailable (§ 155.320(c)(5))*

Separately, CMS also proposes removing the automatic 60-day extension for applicants to resolve data matching issues (DMIs) for income inconsistency, and requires marketplaces to generate DMIs when tax data shows an applicant's income is below 100% of the Federal Poverty Level or when tax data is unavailable. When a marketplace generates a DMI related to income inconsistency for an applicant, the marketplace sends that applicant a notice to submit required documents to verify their income.

**Families USA urges CMS not to adopt the proposed policy changes to the income eligibility verification process.** We strongly believe that the changes will harm a significant portion of low-income enrollees with volatile income. CMS estimates that these policies could deny nearly 500,000 enrollees access to subsidized health coverage, and would afford little flexibility for consumers while imposing significant administrative burdens on the Federal and State-Based

Exchanges.[33] This policy change is likely to disproportionately impact lower-income enrollees, who are more likely to experience high income volatility (a "change in circumstances" under the law), which make prior year tax returns an inaccurate prediction of their current income.[34] This same income volatility may present a significant burden on lower-income individuals in presenting the requisite income documentation in a timely fashion. For these individuals, proper income documentation may require collecting dozens of individual paystubs to substantiate their income projection.

III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule B. Part 155-Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act 4. Annual Eligibility Redetermination

CMS is proposing to amend the annual eligibility determination process to prevent enrollees from being automatically re-enrolled in fully subsidized coverage with advanced premium tax credits without taking additional action to confirm their eligibility. Beginning with annual redeterminations for 2026 for Federal Exchange plans and 2027 for State Exchanges, individuals who would be automatically re-enrolled in fully subsidized coverage and have not submitted updated eligibility documents would instead be billed a premium of $5 per month until they submit such documentation, at which point the full subsidization of their coverage through enhanced tax credits would resume. CMS is also considering whether to automatically re-enroll this subset of enrollees without any APTC to push attendees to submit updated eligibility documentation.

**Families USA strongly opposes the proposal to require $5 premium payment for automatically re-enrolled enrollees who have not yet submitted updated eligibility documentation to receive advanced premium tax credits.**

Rather than substantially improving the enrollment process, this proposed policy change will create additional obstacles for consumers seeking to purchase affordable coverage through the federal and state-based marketplaces. While CMS suggests in the Proposed Rule that existing automatic re-enrollment processes may increase the risk of improper enrollments, CMS does not provide sufficient evidence to substantiate this claim. Instead, CMS acknowledges in the Proposed Rule that the change to automatic renewals would increase paperwork for many low-income people, creating additional enrollment barriers. In fact, CMS estimates that 2.68 million marketplace enrollees in the federal marketplace, and an unknown number in state marketplaces, would have been impacted during the most recent annual redeterminations period for 2025 coverage if this policy was in place.[35]

For consumers impacted by this proposed change, the proposed $5 premiums on an anticipated $0 premium plan may cause confusion. This would be compounded by the likelihood that some consumers will miss notices or have difficulty paying electronically.[36] Families USA believes this policy will ultimately cause great harm to health care consumers by reducing enrollment, creating unnecessary confusion for enrollees, and increasing premiums in

the both the short- and long-term. **As such, we strongly urge CMS not to finalize this proposed change.**

III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule B. Part 155 – Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act 7. Annual Open Enrollment Period

CMS is proposing to amend the duration of the annual Open Enrollment Period (OEP) in which qualified individuals may apply for or change coverage in a Qualified Health Plan (QHP) through the Federal Health Care Marketplace or State-Based Exchanges. If finalized, the OEP would begin on November 1 and end on December 15, a total of 45 days, shortening the current duration of the OEP by 31 days. This proposed change would also prevent states from establishing longer enrollment periods as determined by their own population needs.

This proposed policy change marks a return to policy finalized in the Notice of Benefit and Payment Parameters for 2017, which also established a 45-day OEP from November 1 to December 15, which remained in effect for 2018, 2019, 2020, and 2021. In the Notice of Benefit and Payment Parameters for 2022, CMS finalized a change which extended the OEP to 76 days, lasting from November 1 to January 15, which remains in effect today.

**Families USA opposes this reversal of current policy, and recommends that CMS maintain the current Open Enrollment Period duration of November 1 to January 15, without change, and continue to allow state-based marketplaces to provide open enrollment periods that best serve residents in their states.** Many consumers who purchase coverage through the federal or state-based Exchanges benefit from the current 75-day duration of the OEP, or for longer periods in some states, as we detail below. For instance, given the additional financial challenges and time constraints faced by many parents, families, and small business owners during the holiday season, many people might find it much easier to shop for and compare plans after the holidays.

*On adverse selection during Open Enrollment*

To the extent that CMS proposes this change out of concerns around mitigating adverse selection in a longer OEP, the data tells a different story. Data from CMS shows that nearly 800,000 new consumers purchased coverage on the marketplace between January 4 and January 15 of 2025, almost one-fifth of all new marketplace consumers.[37] This may include younger, healthy, first-time enrollees who might use additional time to learn about their coverage options from family, friends, or professional services, and whose enrollment serves to improve the risk pool and decrease premium costs. This is evidenced by data from Covered California which shows that people who enroll in January have the lowest risk scores among new sign-ups.[38] In 2025, roughly 470,000 existing enrollees nationally utilized this 31-day period to switch plans or end coverage, which includes individuals automatically re-enrolled into unexpectedly expensive coverage. A longer enrollment period also allows people more time to get assistance from navigators: In the federal marketplace, navigators helped more than 90,000

people enroll in QHPs in 2024 while also helping nearly 86,000 people resolve problems with marketplace coverage or Medicaid.[39] Consumer Assistance Programs, certified assisters, and navigators in state-based Exchanges can also assist more consumers during a longer OEP.[40]

In addition, other proposed policies in this rule (discussed in section III. B. 3.), if adopted, would establish tighter enrollment and income verification requirements that may result in changes to the expected monthly contribution for coverage for some marketplace enrollees. Increases to expected monthly contributions may motivate these enrollees to switch to a less expensive plan during the longer OEP. By ending the OEP on December 15, some of these enrollees may not have enough time to shop for alternative options for affordable coverage.

Evidence from state-based marketplaces as well as prior premium data does not validate adverse selection concerns. As mentioned above, the OEP lasted 45 days between 2018 and 2021, and was extended to 76 days in 2022. However, the average benchmark premium decreased from $452 to $438 between 2021 and 2022, and the average lowest-cost silver and gold premiums also decreased over the same period.[41]

It stands to reason that consumers living with chronic illnesses or who rely on expensive medications will be more motivated to proactively enroll in the marketplace, while relatively healthy consumers may wait to enroll at their convenience. Indeed, a study showed that extending enrollment periods during 2021 improved risk scores across the market.[42] For small business owners or the self-employed, the holiday season may be a particularly busy time of year. Offering an additional 31 days to research different plans or contact navigators for assistance is crucial to maintaining affordable coverage. Similarly, young adults may wait until after school semesters end to enroll in coverage—in fact, in 2025, CMS' young adult "week of action" to encourage enrollment took place the first week of January.[43]

Taken together the evidence is clear: Rather than primarily addressing improper plan switching and adverse selection, this policy change may inadvertently result in reductions to enrollment and cost-conscious plan switching.

III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule B. Part 155-Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act 8. Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Projected Household Income at or Below 150 Percent of the Federal Poverty Level

**Similarly, Families USA strongly opposes CMS' proposal to remove the monthly Special Enrollment Period (SEP) for qualified individuals with a projected annual income at or below 150% of the Federal Poverty Level (FPL)**. We strongly disagree with CMS' justification that this SEP ("the 150 percent FPL SEP") has increased the level of improper enrollments and increased the risk for adverse selection by incentivizing consumers to wait until they are sick to enroll in coverage. Data from Covered California shows that the prospective risk scores of SEP enrollees

are equal to or lower than those of Open Enrollment enrollees, and that SEP enrollees tend to be younger than their Open Enrollment counterparts.[44] This evidence does not substantiate the risk of adverse selection cited by CMS in the Proposed Rule.[45] Rather, it suggests that SEP enrollment may actually improve the risk pool.

Importantly, the 150 percent FPL SEP was established in the 2022 Notice of Benefit and Payment Parameters Final Rule, and was then made available without limitation for individuals making equal to or less than 150% of the Federal Poverty Level in the Notice of Benefit and Payment Parameters Final Rule for 2025.[46] Currently, more than 9.4 million people—more than 40% of all marketplace enrollees—report income between 100 and 150% of the FPL.[47] This special enrollment period for individuals at 150% FPL is a critical safety net for vulnerable populations including those living in the "coverage gap" in states that have not expanded Medicaid, as well as those in expansion states with volatile income who churn between Medicaid and marketplace coverage.[48]

*Medicaid Churn*

Consistent access to enrollment periods is especially important for individuals who churn between Medicaid and marketplace coverage. Enrollees can become ineligible for Medicaid when they experience changes in income or circumstances: a new job, a moderate wage increase, or changes to household dependents. Churn has been estimated to impact as many as 21% of Medicaid enrollees annually.[49] In states that have expanded Medicaid eligibility, people are eligible for Medicaid with incomes up to 138% of the FPL. When their incomes rise above this level, they need to be able to enroll in the marketplace. When people realize they have lost Medicaid coverage due to churn, which may not occur until they seek care, many will look to enroll in subsidized marketplace coverage.

Federal regulations give people up to 90 days following termination of their Medicaid coverage to enroll in marketplace coverage, but this period is not sufficient for many. Therefore, the 150 percent FPL SEP has been crucial to maintain access to health care coverage.[50] Prior to the existence of the 150 percent FPL SEP, just 3-4% of people losing Medicaid were able to transition to a federal or state marketplace plan.[51] While some transfers of information between Medicaid and the marketplace are automatic, people moving between these two programs must still submit additional information to the marketplace, such as documenting they have no affordable offer of employer-based coverage, which may delay marketplace enrollment.[52]

Delayed determinations of Medicaid ineligibility also cause people to delay marketplace applications. Though Medicaid applicants are supposed to receive determinations about their eligibility within 45 days of submitting an application, data shows that many determinations take longer across most states.[53] Issues with mailed notices[54] as well as electronic ones[55] also prevent people from learning about Medicaid terminations promptly. A survey of adults who had Medicaid coverage prior to April 2023 showed that 58% of those who tried to renew their coverage experienced some problem, such as long call center wait times or problems

submitting and processing documents.[56] These sorts of barriers delay Medicaid eligibility decisions, and therefore delay marketplace applications for those found to be just above Medicaid income guidelines. Additionally, continuous enrollment through the 150% FPL SEP is essential to ensuring that people affected by delays in eligibility determinations are able to access a new source of affordable coverage, regardless of receiving short notice about termination of Medicaid coverage. If passed, the proposed change to eliminate the 150 FPL SEP would result in many of these people becoming uninsured, leading many to skip needed primary and preventive care and ultimately imposing a higher burden on the health care system when they need to seek complex care in more expensive settings down the line.[57]

*"Coverage Gap" Populations in Non-Expansion States*

This SEP is of particular importance for individuals below 150% of the FPL in the 10 states that have not expanded Medicaid coverage to adults up to 138% of the FPL. Following adoption of this special enrollment period, enrollment in marketplace plans increased by 100% or more between 2020 and 2024 in seven states that have not yet expanded Medicaid: South Carolina, Kansas, Georgia, Florida, Mississippi, Alabama, and Texas.[58] People at this income level often work in jobs that do not provide health insurance. They therefore do not get notices from employers about their option to enroll in the marketplace and they receive no other notice similar to the model notices that employees receive.[59] Further, if their incomes rise above the poverty line in the middle of the year, no notice informs either them or the marketplace that their change of income qualifies them for a special enrollment period or for marketplace coverage—thus, they would not be adequately served by the 60-day special enrollment period for people newly eligible for premium tax credits.

**Families USA recommends that CMS do not finalize the proposed changes that would eliminate the Special Enrollment Period for APTC-eligible individuals with a projected household income at or below 150% of the Federal Poverty Level.**

III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule C. Part 156-Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges 1. Prohibition on Coverage of Sex-trait Modification as an EHB

**Families USA strongly opposes the prohibition on coverage of "sex-trait modification" as an essential health benefit (156.115 (D)). These essential health care services provide Americans with care that improves mental health outcomes and quality of life.**

CMS proposes that states would be prohibited from including "sex-trait modification" as essential health benefits (EHBs) for ACA marketplace plans starting in Plan Year 2026. This Proposed Rule would limit transgender individuals' access to the health care they need—care that improves mental health, including by reducing rates of depression, and overall improved wellbeing.[60] If finalized, this rule would be a major step backward from existing CMS policy

which has given states discretion to include gender-affirming care as part of their EHB benchmark plans, and would undermine evidence-based medicine and current standards of care as determined by a diverse range of medical societies and associations.[61] [62]

Section 1554 of the Affordable Care Act denies the Secretary of Health and Human Services from promulgating any regulation that creates unreasonable barriers to individuals to obtain appropriate medical care.[63] The American Medical Association, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Psychiatric Association consider gender-affirming care as a standard level of care.[64] Blocking states from listing these services as an EHB would create an unreasonable barrier to appropriate care.

Additionally, Section 1557 of the Affordable Care Act serves as the civil rights enforcement provision under the law and prevents discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities.[65] Section 1557 sets certain statutory health care rights for patients and allows patients to file legal complaints when their rights are denied. Under law, Section 1557 provides patients with nondiscrimination protections based on gender identity and sexual orientation, including protections for transgender people's access to care and coverage.[66] The Proposed Rule denying "sex-trait modification" as an essential benefit opens up providers, insurers, and the Administration to legal challenges for violating nondiscrimination laws.

Care provided to transgender individuals is life-saving care, and in states that have chosen to include gender-affirming care as an EHB, costs have been insignificant. Less than 1% of the U.S. population seeks trans health care services and the costs of providing such care is negligible.[67] A review of commercial health insurance claims data found that only 0.11% of enrollees utilize trans health care services, and the cost of this care amounts to only $0.06 per member per month.[68]

This care is particularly important given that the transgender population in America suffers from high rates of depression, substance use disorder, and suicidal ideation, much of which is mitigated by gender-affirming health care.[69] The U.S. spends $13 billion on suicide-related medical care and over $35 billion on substance use disorder treatment each year.[70] Prevalence of lifetime suicide attempts and clinical depression among transgender individuals are 40% and 52%, respectively—rates that are nine and six times greater than the general U.S. population, respectively.[71] Access to gender-affirming health care, including both hormone therapy and surgical care, significantly reduces moderate to severe depression and suicidal ideation in young trans adults.[72] The health supporting benefits of gender-affirming care are widely recognized by the medical profession and should be accessible to all Americans.

Further, this proposal directly undermines the 2019 HHS Notice of Benefits and Payment Parameters which gives states the flexibility to establish new standards to update their EHB benchmark plans and is counter to this administration's stated goals of managing chronic illness and disease.[73] The authority granted to states to update their EHB benchmark plans allows them to respond to new medical information and scientific studies to inform best practices

around health care coverage and access for health care consumers in the state. For example, through Colorado's approved EHB request, the state was able to set clear standards around trans health care coverage for insurers and ensure comprehensive coverage for patients, based on evidence linking trans health care with statistically significant reductions in depression, anxiety, gender dysphoria, as well as improvements in quality of life.[74] [75]

**Families USA strongly urges CMS to maintain states' authority to include gender-affirming and trans-specific health care in their EHB Benchmark plans, allowing plans to respond to and address new scientific research.**

Additionally, Families USA opposes use of the term "sex-trait modification" in law or regulation. There are existing definitions and terminology for the health care services to treat gender dysphoria that transgender individuals commonly seek.[76] Likewise, we object to banning coverage for any specific health care services used to treat gender dysphoria such as hormone therapy and surgical care, which are also used to treat other conditions including cancer treatments and endocrine disorders.[77]

III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule C. Part 156-Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges 2. Premium Adjustment Percentage

**Families USA opposes changing the premium adjustment methodology for Plan Year 2026 and beyond.** As the preamble notes, a change in methodology would apply to the following, raising costs for consumers:

- The maximum annual limit on cost-sharing (MOOP), 156.130(a); and
- The cost at which employer-based coverage is considered unaffordable and people can instead use premium tax credits in the marketplace. (155.605 (d) and if likewise adopted by the Treasury department, 26 CFR Part 1)

Further, if the Department of Treasury/IRS uses the same methodology to update premium contributions for individuals receiving premium tax credits, as has been the practice, individuals receiving an APTC would be charged 4.5% more for premiums of a benchmark plan,[78] and that cost increase would be in addition to the increases they will receive if enhanced premium tax credits expire. **As a result, Families USA opposes this change, as detailed below.**

*CMS' Original Formula for Premium Adjustment*

CMS proposes to adjust premiums, maximum out-of-pocket-limits, and minimum essential coverage formulas based on the growth in both employer-sponsored insurance (ESI) and "direct payment" premiums, returning to a formula that it abandoned in 2022.

The preamble notes that in past years, CMS decided to adjust premiums and maximum out-of-pocket limits based only on the growth in ESI premiums because those would not be skewed by

premium fluctuations during initial implementation of the individual market. Later, after a brief period (2019-2021) in which the premium adjustment factor also included direct market premiums, CMS returned to its original formula for reasons that continue to hold true today:

a) A higher premium growth factor would lead to higher costs for consumers and lower enrollment. A lower premium growth factor makes health coverage more accessible and affordable for consumers of all income levels.
b) Premiums in the individual market are more influenced by economic uncertainty and predictions of risk than ESI premiums. As CMS wrote in 2021, "We believe using the NHEA ESI premium measure aligns with the statutory language at section 1302(c)(4) of the ACA, as ESI meets the definition of "health insurance coverage" and represents the vast majority of the market, overlapping very significantly with the private health insurance data used for benefit years 2020 and 2021."[79]
c) Medical loss ratio rebates in the individual market (totaling approximately $550 million in 2024[80]) indicate that individual market premium prices are still higher than the cost of care plus reasonable administrative costs.

We do not yet know if enhanced premium tax credits will be extended by Congress, nor how enrollees and the marketplace will respond if it is the first year since 2021 that premium tax credits are unavailable to people over 400% of the FPL and reduced for others. Thus, there is compelling reason to reduce volatility in the market in order to retain a large enrollee base.

Further, the proposed formula would include short-term health plans, fixed indemnity plans, and other plans that do not provide full health insurance in the computation of premium growth. There is no justification for including these plans which have no benefit requirements and therefore could vary greatly in price from year to year.

As the preamble shows, the proposed changes to the formula would directly increase consumers' costs—even though affordability is an explicit purpose of the Affordable Care Act.

**Families USA strongly opposes this change, which CMS acknowledges would increase the amount that marketplace enrollees pay for cost-sharing; and that if the IRS also adopts the change, would increase premiums for people with premium tax credits.**

*Large price increases for coverage*

The maximum limit on cost sharing for self-only coverage would increase to $10,600, a 15.2% increase from Plan Year 2025; and for family coverage would increase to $21,200. As noted, this is $450 higher for individuals, and $900 higher for families, than would have been the case under the previously published methodology. Families with income up to 200% of federal poverty who faced major illness could have out-of-pocket expenses of $7,000 per year, in addition to the higher premiums they would face if the IRS follows the same premium adjustment methodology and enhanced premium tax credits expire.

If enhanced tax credits expire and the premium adjustment formula is simultaneously changed, people will immediately experience large price increases:[81] [82]

- Premiums for an individual earning about $34,000 (just over twice the poverty line) would increase $1,197 annually from the expiration of enhanced tax credits, plus another $157 (4.53%) from the change in the premium adjustment formula. Additionally, their maximum out-of-pocket cost in a silver plan would increase by $350.[83]
- Premiums for a 50-year-old individual earning just over $60,000 (411% of federal poverty) would increase $3,065 from the expiration of enhanced tax credits. Additionally, their maximum out-of-pocket cost in a silver plan would increase by $1,400 over 2025 levels, of which $550 is from the proposed change in the formula.[84]
- A family of four at an annual income of about $70,000 (twice the poverty line) would experience a premium increase of $2,769 from enhanced premium tax credits going away, plus an additional $211 from the change in the premium adjustment formula. On top of that, their maximum out-of-pocket cost in a silver plan would increase by $700.[85]

**Families USA opposes decreases in allowed actuarial value that would compound problems with health care affordability (156.140, 156.200, and 156.400)**

*Proposed de minimis range changes*

CMS proposes that the actuarial value of silver plans could vary between a de minimis range of +2/-4 percentage points from 70, an increase from the current range of +2/0. Since the second lowest cost silver plan is the "benchmark" for premium tax credits,[86] this means that people with premium tax credits would be faced with a plan that covers a far lower share of their costs than today. We strongly disagree with CMS' justification for decreasing the value of silver plans: CMS asserts in the preamble that unsubsidized enrollees will be discouraged from enrolling in higher actuarial value plans because these plans have higher premium costs and that this may negatively affect risk pools. However, this argument is a misleading justification for lowering the value of silver plans, since all enrollees continue to have options to buy lower value/lower cost bronze plans in the marketplace, and those plans are part of the same risk pool as silver, gold, and platinum plans.[87]

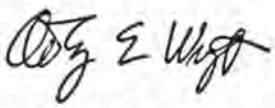
**Increased cost burdens would fall heavily on low- to middle-income groups that can least afford additional expenses.** Median wages have not increased in real dollars from 2020 to 2024.[88] Since 2000, rents have risen faster than median income in almost all parts of the country.[89] Large proportions of households report difficulties paying for utilities, food, housing, and medical expenses.[90] [91]Already, a third of marketplace enrollees report that they delay or skip care or drugs due to affordability, and increases in their cost sharing will worsen this problem.[92] If this Proposed Rule is finalized, people with income just over the federal poverty

line will face higher health care expenses at the same time that they may experience cuts in food assistance[93] or other benefits.

**In conclusion, the Proposed Rule on Marketplace Integrity would force many Americans to pay more for health coverage, get less value from their health coverage, or lose health coverage altogether.**

Families USA appreciates the opportunity to comment on this proposed Marketplace Integrity rule and urges CMS to reconsider the many proposals highlighted in our comments that would make marketplace coverage less affordable and less accessible for millions of Americans. If there are any further questions, please contact Cheryl Fish-Parcham, Director of Private Coverage at Families USA, at cparcham@familiesusa.org.

Sincerely,



Anthony Wright
Executive Director

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April 11, 2025

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The Honorable Mehmet Oz
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**Re: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability (CMS-9884-P)**

Dear Secretary Kennedy and Administrator Oz:

Thank you for the opportunity to submit comments on the Marketplace Integrity and Affordability Proposed Rule.

The undersigned organizations represent millions of patients and consumers facing serious, acute and chronic health conditions across the country, including individuals who rely on the patient protections provided under the Affordable Care Act (ACA). Our organizations have a unique perspective on what patients need to prevent disease, cure illness and manage chronic health conditions. Our breadth enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion.

In March of 2017, our organizations agreed upon three overarching principles to guide any work to reform and improve the nation's healthcare system. These principles state that: (1) healthcare should be

accessible, meaning that coverage should be easy to understand and not pose a barrier to care; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare must be adequate, meaning healthcare coverage should cover treatments patients need, including all the services in the essential health benefit (EHB) package.

Less than two months after finalizing the rules of the road for the marketplaces in 2026, the Department has put forward this new slate of proposals. Some policies would reverse these 2026 rules, others would depart from long-established policies relied on by consumers and stakeholders for years. Some of these changes would take effect immediately. The asserted reason for this destabilizing approach is to bring premium relief to consumers and reduce waste, fraud, and abuse.

We share these goals but do not believe the Department's proposals will achieve them. New policies that invent a premium obligation for low-income consumers in order to test their commitment to coverage; that change the rules for calculating premium costs in a manner that hikes premiums and out-of-pocket costs for millions of marketplace consumers; that erode the value of marketplace plans, thereby raising (again) costs for the people who count on that coverage — these proposals would not improve affordability, they would undermine it. Rules that limit and outright remove enrollment options, and that create red tape for low-income consumers, would not reduce burdens, or waste, or fraud, or abuse — they would make comprehensive coverage more difficult to obtain. In fact, the best way of ensuring affordable premiums would be to retain the enhanced premium tax credit. While that is a decision for Congress, we strongly urge this Administration to openly support this policy.

Even though the Department observes repeatedly (and correctly) that bad-actor agents and brokers are the drivers of fraud and improper enrollment, that the proposed rule would do nothing to increase oversight or to improve compliance, and proposes nothing to crack down on those bad actors. Instead, the Department proposes to crack down on consumers. In the name of program integrity, the Department is issuing these proposed regulations that, by its own account, will deprive up to two million people of coverage, while quietly reinstating the agents and brokers it previously suspended due to program integrity concerns.

The Department's proposals place consumers at risk without any reasonable basis to do so and should not move forward. We offer additional comments and recommendations regarding specific provisions of the rulemaking below.

**Reducing Open Enrollment Nationwide (§ 155.410(e))**

The Department previously established a minimum period for marketplace open enrollment, running from November 1 of the year prior to the plan year through January 15. It did so in recognition that an open enrollment period (OEP) that extends into January — and, significantly, past the December 15 date by which existing enrollees are automatically reenrolled in a plan (if they have not otherwise selected a plan or terminated coverage) — offers numerous benefits to consumers.

A longer OEP gives consumers — existing enrollees, un-enrolled healthy individuals, and members of underserved communities who may face additional barriers to coverage, alike — a better chance, during a busy time of year, to learn about their options and select a plan suited to their needs. The Department concluded, based on the experiences of the state-based marketplaces (SBMs), that an OEP ending in January does, in fact, facilitate higher enrollment. It observed that a January 15 OEP end date provides consumers who are auto-enrolled on December 15 into a plan with higher costs an opportunity to receive more information from their new plan and to switch to more affordable coverage if they choose. And it

noted that the additional time to enroll provided by an OEP ending in January would increase the likelihood that Navigators and other consumer assisters would be able to fully assist all the consumers who seek their help — something some were unable to do within a 6-week OEP ending in December. Notably, the Department acknowledged, when it set the November 1 – January 15 OEP, the theoretical possibility that a longer OEP could introduce adverse selection into the market, to the extent some individuals would choose to forgo December enrollment and sign-up for coverage in January only after needing care. But it saw no evidence to suggest this would occur.

The Department still does not see evidence of adverse selection from the November 1 – January 15 OEP; the proposed rule makes no attempt to show it exists. It simply asserts that the threat of adverse selection is sufficiently grave that it is suddenly necessary to reduce open enrollment by a month — not just in the federal marketplace, but in all state-run marketplaces, too. We disagree with the Department's conclusion and urge that its proposal not be finalized.

It is difficult to reconcile the Department's reversal with states' actual experiences. SBMs that have allowed open enrollment into January see consumer interest but have not faced adverse selection.[1] To the contrary, they have found that consumers who enroll later tend to be younger and healthier than those who enroll early.[2]

An OEP that extends into January promotes a larger and healthier risk pool and with it, market stability. For the Department to conclude, without evidence, that circumstances now require a far narrower enrollment window risks creating the very instability it says it hopes to avoid. For the Department to go so far as to force this policy on SBMs, many of which chose a January OEP end date based on their assessment of the particular benefits and risks to their markets and their consumers, and in the context of their own experiences, lacks any reasonable basis.

**Eliminating the Special Enrollment Period for Marketplace- and Premium Tax Credit-Eligible Consumers with Low Incomes (§ 155.420(d)(16))**

In light of evidence that many uninsured individuals had not enrolled in marketplace coverage because they were unaware of their insurance options or eligibility for federal premium assistance, the Department established a special enrollment period (SEP) for certain consumers at low incomes. The SEP, designed particularly for marketplace- and premium tax credit-eligible individuals with projected household incomes at or below 150 percent of the federal poverty level, was intended to provide these otherwise eligible consumers with additional opportunities to enroll in low-cost coverage.

This SEP has helped many low-income Americans secure affordable coverage, a benefit the Department does not seriously dispute. Rather, it claims that the SEP is also responsible for a large number of "improper" enrollments and therefore must be eliminated immediately.

The Department uses the term "improper" enrollment to mean 1) fraud and misconduct by third parties — bad-actor agents and brokers — and 2) low-income Americans who it asserts are "taking advantage."

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With respect to fraud and misconduct by third parties: the Department is absolutely correct that some agents and brokers have enrolled consumers or switched their enrollment without consent. These practices are deeply concerning and were not isolated incidents: as the Department observes, there were large numbers of consumer complaints about this in early and mid-2024, from across the states that use the federal marketplace and its "enhanced direct enrollment" (EDE) pathway.

In response, the Department took numerous steps to fix systems vulnerabilities with the EDE-marketplace interface, tighten verification procedures, and increase oversight and enforcement, including by suspending hundreds of brokers. These actions appear to have reduced significantly both the incidence and risk of agent and broker misconduct. We deeply appreciate this work and strongly support continued efforts to improve oversight and enforcement.[3]

But better oversight and enforcement are not what the Department has proposed. The proposed rule looks past the bad-actor agents and brokers who fraudulently enroll people and instead targets the consumers they have hurt. In the Department's telling, fraud in the federal marketplace has occurred because — and will occur "so long as" — consumers have access to plans with low premiums, and low-income consumers have access to the low-income SEP. But there is no reasonable basis for these assumptions.

Thanks to legislation enacted in 2021 and 2022, marketplace premiums are more affordable nationwide; meanwhile, nearly all states — those that use the federal marketplace[4] as well as those that operate their own enrollment platforms[5] — have implemented the low-income SEP. Were the Department correct in its assessment of the dangers of the low-income SEP, we would expect to see that fraud is a significant problem across the country. But, in fact, agent and broker misconduct is not an issue in the SBMs.[6] The problem of fraudulent enrollment was concentrated in states that rely on HealthCare.gov and EDE. We note that the Department appears to be unaware that most SBMs have implemented the low-income SEP and bases its assessment of the costs and benefits of eliminating the enrollment period on this misunderstanding.

The Department ultimately pivots from its assertion that affordable, accessible coverage encourages agents and brokers to engage in misconduct to a related claim: that even if fraud by third parties were eliminated, there still would be consumers below the poverty level who would falsely represent their income in order to "take advantage" of health insurance. Even if there were no fraud, the Department's prescription is the same: end the low-income SEP.

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[3] Partnership to Protect Coverage. *Response to CMS-9895-P*. Available at: https://www.protectcoverage.org/siteFiles/45396/01%2008%202024%20PPC%202025%20NBPP%20Comments%20FINAL.pdf

[4] The Commonwealth Fund, *Policy Innovations in the Affordable Care Act Marketplaces*. November 21, 2023. Available at: https://www.commonwealthfund.org/publications/issue-briefs/2023/nov/policy-innovations-affordable-care-act-marketplaces

[5] The Commonwealth Fund, *ACA State Marketplace Models and Key Policy Decisions*. Interactive Map. Updated March 14, 2025. Available at: https://www.commonwealthfund.org/publications/maps-and-interactives/aca-state-marketplace-models-and-key-policy-decisions

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

The Department's view that there are too many people enrolled in marketplace coverage is based on a flawed estimate of the number of eligible consumers between 100-150 percent FPL and the untenable assumption that all actual enrollments above this estimate are improper. Among its shortcomings, this analysis ignores that eligibility for the advanced premium tax credit and for the low-income SEP is based on *projected* annual household income.

While a person's expectation of what their household will earn over the course of the year *might* end up matching their actual income, it might not, and there is nothing inherently improper about failing to hit that target. For many millions of Americans, and particularly for those with lower incomes, it is exceedingly hard to project what the annual income of your entire household will be. For millions of people who are self-employed, perform seasonal work, or otherwise provide labor or services on demand, income may vary dramatically over the course of the year in ways that are not necessarily predictable and not within the worker's control. Millions more Americans earn hourly wages but have limited or no input on the number of hours they work. The result, as research demonstrates, is that most low-income workers[7] experience significant instability in work hours and income, with large and often unpredictable swings[8] from one month to the next.[9]

And yet — the Department's proposal to scrap the low-income SEP is premised on the notion that a low-income American whose annual household income winds up being different from what they expected has done something improper and is "taking advantage." We fundamentally disagree and urge the Department not to finalize its proposal.

Finally, we offer comment on the legal basis for the low-income SEP. Section 1311(c)(6) of the ACA establishes a statutory floor for marketplace enrollment periods. It identifies the minimum SEPs that the Department must establish; it nowhere purports to limit the Department to these, alone. Section 1321(a), meanwhile, provides the Department broad authority to establish standards regarding the marketplaces and qualified health plans (QHPs). The statutory basis for the low-income SEP is sound.

**Increasing Paperwork Requirements for Consumers to Enroll in Coverage (§§ 155.320(c)(3)(iii) and (c)(5), 155.420(g))**

The proposed rule's approach to the enrollment process is similar to its approach to enrollment periods. The Department recognizes that there are bad-actor agents and brokers who have engaged in misconduct, but directs its regulatory efforts exclusively to making enrollment more burdensome for consumers.

The Department would require individuals to submit additional paperwork before they can enroll using an SEP. It would also deny a premium tax credit to certain low-income consumers whose projection of annual household income cannot be immediately verified with old tax return data. This latter policy would apply to (1) people who, according to old tax data, had income below the poverty line, but who project

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[7] Bauer, Lauren et al. *Low-income workers experience –by far—the most earnings and work hours instability*. Brookings. January 9, 2025. Available at: https://www.brookings.edu/articles/low-income-workers-experience-by-far-the-most-earnings-and-work-hours-instability/

[8] JPMorgan Chase&Co Institute. *Weathering Volatility 2.0: A monthly Stress Test to Guide Savings*. October 2019. Available at: https://www.jpmorganchase.com/content/dam/jpmc/jpmorgan-chase-and-co/institute/pdf/institute-volatility-cash-buffer-report.pdf

[9] Hannagan, Anthony and Jonathan Morduch. *Income Gains and Month-to-Month Income Volatility*. NY Wagner Research Paper No. 2659883. September 13, 2015. Available at: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2659883

that they will earn more than that amount in the coming year; and (2) people for whom IRS systems cannot find a tax return match. (As the Department knows, this happens for a host of reasons, including changes in family size or filing status, name changes, or other mismatches in demographic information.)

The Department would pursue this course even though it acknowledges that making it harder for people to enroll in coverage may deter some people from enrolling. Its own research shows the burdens are likely to deter young and healthy people (but not individuals with immediate coverage and care needs), and therefore lead to a sicker and more expensive insurance market.[10]

The Department's first response is, again, to assert fraud and improper enrollment — while, again, doing nothing to target actual agent and broker misconduct, and basing its improper enrollment argument on the assumption that low-income Americans below the poverty line who expect to earn more next year are program integrity risks. Its second response is to assert that the burden it acknowledges it is imposing is not actually substantial and really "should not" be a barrier to enrollment. The Department assumes that the various administrative burdens it is proposing to establish will have zero effect on enrollment. This assumption is at odds with extensive research[11] regarding the impact of administrative burden and application hassles and complexities,[12] which demonstrate[13] both that the Department's approach will reduce enrollment and (by discouraging healthy people from signing up) weaken the risk pool.[14]

We urge the Department not to adopt these proposals.

**Premium Obligation for Low-Income Enrollees (§ 155.335)**

The Department proposes to single-out low-income enrollees who, under federal law, are eligible for a large APTC, and require them to pay an invented $5 premium until they return to the marketplace and actively re-enroll in coverage. The proposal is contrary to the statute and the Department's asserted interest in improving coverage affordability and the health of the individual market risk pool.

Section 36B of the Internal Revenue Code specifies the criteria and calculations used to determine premium tax credit amounts. The provisions of the ACA — sections 1411 and 1412 — that establish the programs for determining an individual's eligibility for advanced payments of the premium tax credit require that an eligible individual's APTC be calculated pursuant to section 36B and paid out in accordance with that calculation. The federal government cannot create a premium obligation (of $5 or any other amount) by reducing the amount of APTC a consumer is eligible for pursuant to 36B, nor by refusing to

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[10] Centers for Medicare and Medicaid Services. *Pre-Enrollment Verification for Special Enrollment Periods Fact Sheet*. Available at: https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/pre-enrollment-sep-fact-sheet-final.pdf

[11] Ericson, Keith, et. Al. *Reducing Administrative Barriers Increases Take-up of Subsidized Health Insurance Coverage: Evidence from a Field Experiment*. National Bureau of Economic Research. January, 2023. Available at: https://www.nber.org/system/files/working_papers/w30885/w30885.pdf

[12] Tolbert, Jenniver, et. Al. *Key Facts about the Uninsured Population*. KFF. December 2024. Available at: https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

[13] McIntyre, Adrianna et. Al. *Small Marketplace Premiums Pose Financial and Administrative Burdens: Evidence From Massachusetts, 2016-17*. Health Affairs, Vol 43, No.1. January 2024. Available at: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2023.00649?journalCode=hlthaff

[14] Shepard, Mark and Myles Wagner. *Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment*. American Economic Review. March 2025. Available at: https://pubs.aeaweb.org/doi/pdfplus/10.1257/aer.20231133

pay out this allowed amount. Whatever its policy rationale, the Department does not have authority to charge low-income consumers a premium they do not actually owe.

Were the Department to do so, it would undermine its asserted goal of improving coverage affordability and the health of the individual market risk pool. Research shows that even small premium burdens act to depress enrollment, particularly by healthy consumers.[15] The effect of the Department's proposal would be to reduce coverage take-up in a manner that would make coverage more expensive for those who remain in the market.

**Removing Flexibility Over Premium Payment Thresholds (§ 155.400(g))**

The Department recently finalized rules that give issuers greater flexibility to effectuate a consumer's coverage, or allow an enrollee to remain in coverage, if their premium payment meets or exceeds a predetermined threshold. We supported these changes, which promote continuity of comprehensive coverage. Consumers who intend to obtain and maintain health insurance may, due to other financial pressures or simple error, fall behind on owed premium by a de minimis amount. Issuers should not be required to deny or terminate coverage in these cases, and the Department's recent rule changes, which would take effect in 2026, provided additional commonsense flexibility to issuers to enable them to avoid such outcomes.

Now the Department proposes to reverse itself and remove these flexibilities before they take effect, due to concern about fraud by bad-actor agents and brokers. Yet there is no evidence that agent and broker fraud had anything to do with premium payment thresholds, or that these flexibilities — which are just that, flexibilities that issuers can use but are not required to use — have been abused by anyone. The Department should allow the premium payment threshold flexibilities to take effect, monitor for abuse, and modify the policy if modification is supported by the evidence.

**Restricting Guaranteed Availability of Coverage (§ 147.104(i))**

We are disappointed that the Department has once again proposed allowing issuers to deny coverage to people who the issuer says owe it, or a related entity, premiums. We are especially alarmed that Department would go even further by removing any time limit within which an asserted premium debt could be used to deny a consumer coverage.

The guaranteed availability provision codified in the Public Health Service Act clearly requires issuers to make coverage available to all individuals who apply. This is a fundamental protection for the patients and consumers we represent, as well as for all Americans with chronic conditions. There is no basis to support a regulatory restriction on statutory guaranteed availability rights in the case of an individual who has been terminated from coverage due to nonpayment of premiums and who later returns to the marketplace for coverage. By permitting issuers to condition enrollment on payment of premiums for a prior period of coverage (long) since terminated, the proposal would grant significant authority to issuers at the expense of consumers and in violation of the guaranteed availability of coverage requirement.

**Terminating Health Coverage for DACA Recipients (§ 155.20)**

Young people granted deferred action under the Deferred Action for Childhood Arrivals (DACA) policy are, like all other people granted deferred action by the federal government, permitted under existing law and

[15] McIntyre, Adrianna, Mark Shepard, and Myles Wagner. *Can Automatic Retention Improve Health Insurance Market Outcomes?*. American Economic Association Papers and Proceedings. Vol. 111. May 2021. Available at: https://www.aeaweb.org/articles?id=10.1257/pandp.20211083

regulations to enroll in marketplace coverage if they are otherwise eligible. The Department proposes to revoke eligibility for these individuals, insisting that it is not required to treat everyone with deferred action the same. We strongly disagree with this position and, for the reasons we have explained previously,[16] urge the Department not to finalize this proposal.

**Changing the Premium Adjustment Percentage (§156.130(3))**

The Department proposes to change how the "premium adjustment percentage" is calculated, a measure intended to reflect health care cost growth that is used to determine what consumers pay toward premiums and out-of-pocket costs. Rather than continuing to rely on premium growth in the employer-sponsored market — the dominant source of coverage in the U.S. — the Department proposes to include individual market premiums in the calculation. Unlike employer coverage, individual market premiums are much more volatile and susceptible to frequent policy changes, not unlike the dramatic shifts in policy reflected in this proposed rule.

The result of including individual market premiums in the calculation is that the premium adjustment percentage will be about 4.5 percent higher than under the current methodology. Under this approach, premium tax credits will be reduced and marketplace consumers will pay more toward their premiums. For example, a family of four earning $85,000 a year would have to pay $313 more for their marketplace premiums in 2026.[17] This will deter lower-cost, healthier individuals from enrolling in the marketplace, worsening the risk pool and increasing premiums for all marketplace enrollees.

In addition, the limit on out-of-pocket costs will be 4.5 percent higher, or $900 for a family plan and $450 more for an individual plan. This increase will hit not just marketplace enrollees but also the more than 150 million people enrolled in employer-sponsored coverage. The increased costs will disproportionately impact patients who use more health care services and do not include the out-of-pocket costs paid for non-covered or out-of-network care. Some individuals facing these enormous costs will choose to forgo necessary care, leading to costly and dangerous complications. We strongly oppose this proposed change and urge the Department not to finalize it.

**Preventing Automatic Reenrollment of Certain Consumers into Cheaper Coverage (§155.335)**

The Department previously adopted a policy under which a current bronze plan enrollee who will be automatically reenrolled in coverage and who is eligible for cost-sharing reductions (CSRs) will be placed into a silver tier plan with CSRs, provided the new plan has a lower or equivalent premium (after accounting for PTCs), is from the same issuer, and has the same provider network. The Department now proposes to end this policy, meaning marketplace enrollees who would have benefited from enrolling in coverage with much lower cost-sharing will be reenrolled in plans with the highest deductibles and other cost-sharing. For example, families with income up to two times the poverty level will be reenrolled in a plan with a $21,200 maximum out-of-pocket limit rather than a plan with a $7,000 limit on out-of-pocket costs.

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[16] Partnership to Protect Coverage, Response to (CMS-9894-P). June 23, 2023. Available at: https://www.protectcoverage.org/siteFiles/43076/06%2023%2023%20PPC_DACA%20NPRM%20Comments_FINAL.pdf

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

The Department recognizes that the current policy helps consumers who are not aware of the "benefits of silver enrollment for CSR-eligible enrollees" but asserts, without any justification, that consumers are now aware of those benefits and the availability of enhanced premium tax credits. In fact, polling data show that public awareness of just the existence of marketplace financial assistance — much less the nuances of metal levels and other policy changes — remains quite low.[18] What's more, the Department recently cut funding for Navigators — who provide consumers with just the type of plan cost-sharing and benefit information consumers need to understand their plan choices — by 90 percent.[19] Assuming, that consumers now know more about their plan choices while dramatically reducing resources to help them understand them will mean many more consumers will, unnecessarily, pay significantly more to obtain care. We strongly oppose this proposed change and urge the Department not to finalize it.

**Reducing Plan Generosity (§§156.140, 156.200, 156.400)**

To facilitate consumer decision-making and promote the affordability and adequacy of coverage, non-grandfathered individual and small group market health plans must be offered only at specified levels of value. Plans at a particular value tier must adhere to the actuarial value (AV) requirements specified for the tier by law, and may not vary from the prescribed AV except by a de minimis amount.

The current, rigorous definition of "de minimis variation" aligns with the language of the statute and advances the objectives for which the AV protections were enacted in the first place. The proposed, more permissive approach to what constitutes a de minimis variation in AV blurs the distinctions between the coverage tiers, significantly reducing the utility of the gold/silver/bronze nomenclature used to describe the plans and making it more difficult for consumers to compare their options and make informed decisions. (For example, the proposal would allow the sale of a 66 percent AV silver plan that is ostensibly supposed to provide an AV of 70 percent, which would be nearly indistinguishable from an expanded bronze plan that could have an AV as high as 65.)

In addition, the proposed de minimis ranges will give issuers the flexibility to reduce the generosity of their silver plans in order to lower premiums. This will result in lower gross premiums for the benchmark plan that is the basis for establishing the value of PTCs and in turn, a smaller premium tax credit. Consumers will therefore be faced with the difficult choice of buying a less generous plan with their reduced PTC, thereby paying more to obtain care, or paying higher premiums to have a silver plan with an AV comparable to their plan under the more rigorous de minimis standard. We strongly oppose this proposed change and urge the Department not to finalize it.

**Narrowing State Options for Defining Essential Health Benefits (§156.115(d))**

CMS proposes to override state authority to define essential health benefits (EHB) by prohibiting issuers in the individual and small-group markets from covering what it refers to as "sex trait modification" as part of EHB. The stated rationale for doing so — that these services are not generally covered in a typical employer plan — is not supported by the evidence. KFF, in its annual survey of employer health plans,

[18] American Cancer Society Cancer Action Network. *Survivor Views on Enhanced Premium Tax Credits*. January 28, 2025. https://www.fightcancer.org/policy-resources/survivor-views-enhanced-premium-tax-credits

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

finds that "[c]overage of gender affirming care services in employer plans is fairly common."[20] A Human Rights Campaign Foundation survey found that 72 percent of Fortune 500 businesses offer coverage of treatment for gender dysphoria.[21]

The proposed rule also fails to take into account the fact that many of the items and services used to treat gender dysphoria cut across multiple EHB categories and are also used to treat other medical conditions, making the proposed change not only discriminatory but also difficult for issuers to implement. If this proposed rule is finalized, issuers would need to determine when and how to cover a range of widely covered, medically necessary services — including mental and behavioral health care, prescription drugs, and surgical care (e.g., a hysterectomy) — based on diagnosis, significantly complicating claims and utilization management processes.

Further, federal law requires that EHBs be defined in a way that protects individuals from discriminatory benefit design. Such an exclusion is also inconsistent with other existing laws and policies, including Section 1557 of the ACA, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act.

For these reasons, we urge the Department not to finalize this proposal.

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Thank you for the opportunity to provide these comments. If you have any questions, please contact Theresa Alban at the Cystic Fibrosis Foundation at talban@cff.org.

Sincerely,

AiArthritis
American Cancer Society Cancer Action Network
American Heart Association
American Kidney Fund
American Lung Association
Arthritis Foundation
Cancer*Care*
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation of America
Hemophilia Federation of America
Immune Deficiency Foundation
Lupus Foundation of America
Muscular Dystrophy Association
National Alliance on Mental Illness (NAMI)
National Bleeding Disorders Foundation
National Coalition for Cancer Survivorship
National Multiple Sclerosis Society
National Patient Advocate Foundation
National Psoriasis Foundation
Pulmonary Hypertension Association
Susan G. Komen
The AIDS Institute
The Leukemia & Lymphoma Society
WomenHeart: The National Coalition for Women with Heart Disease

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

[21] Human Rights Campaign, *Corporate Equality Index 2025*. Available at: https://www.hrc.org/resources/corporate-equality-index

CMS Newsroom

Press Releases Oct 17, 2024

# CMS Update on Actions to Prevent Unauthorized Agent and Broker Marketplace Activity

Affordable Care Act

Share

The Centers for Medicare & Medicaid Services (CMS) continues to exercise its full statutory and regulatory authority to protect the integrity of the Federally-facilitated Marketplaces (FFMs), which includes the FFM platform and State-based Exchanges that operate on the Federal Platform (SBE-FPs), and to protect consumers from unauthorized changes to their FFM enrollments. This includes reviewing and addressing consumer complaints as quickly as possible, updating Marketplace systems to prevent unauthorized changes with as little disruption to consumer access to FFM enrollment as possible, arming consumers with resources and information to help them avoid and report unauthorized plan changes by agents and brokers, and suspending and terminating the Marketplace Agreements of agents or brokers who have engaged in fraud or abusive conduct. The agency continues to conduct robust oversight and monitoring of agents and brokers on the FFM and is evaluating additional technological solutions to preserve access to high-quality, person-centered, and affordable health care coverage – a critical priority for CMS and the Biden-Harris Administration.

## Consumer Information

Protecting the millions of people served by CMS programs remains the agency's top priority. CMS continues to leverage a broad array of resources to warn FFM consumers about potentially fraudulent agent or broker activity and misleading marketing websites.

Consumers who believe they may have been the victim of unauthorized FFM agent or broker activity should call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) to resolve any coverage issues promptly.

**Technological Updates to Secure Marketplace Systems**

Beginning July 19, 2024, CMS began blocking agents and brokers from making changes to a consumer's FFM enrollment unless the agent or broker is already associated with the consumer's enrollment. If a consumer would like to work with an agent or broker not already associated with their profile, the consumer must conduct a three-way call with the Marketplace Call Center and the "new" agent or broker. The consumer can also submit the change to their enrollment directly through the Marketplace Call Center, HealthCare.gov, or an approved Classic Direct Enrollment or Enhanced Direct Enrollment partner website with a consumer pathway. Throughout October 2024, CMS will implement updates to enhance the FFM's ability to block agents and brokers from making changes to a consumer's FFM enrollment without the consumer's engagement.

**Data Updates**

In recent months, CMS has observed a dramatic and sustained drop across several key metrics that indicate that Marketplace system changes that were implemented in July 2024 are having the desired effect of successfully preventing consumers from being switched to different plans or enrolled in coverage without their informed consent. Casework associated with consumer reports of unauthorized plan changes has dropped by approximately 30% since the changes went into effect, and the overall number of plan changes associated with an agent or broker has decreased by nearly 70%.

The changes implemented on July 19, 2024, also served to prevent unauthorized changes to agent and broker commission information. While consumers were often unaware of this type of change when made by agents and brokers, the opportunity to make such changes provided a significant financial incentive for

non-compliant agents and brokers to make this type of unauthorized change. Since July 19, 2024, changes to agent or broker commission information have decreased nearly 90%. This means that since the July 19, 2024, system change was made, any updates to the agent or broker on a policy enabling the agent or broker to receive a commission for assisting the consumer have been made exclusively through the Marketplace Call Center, HealthCare.gov, or an approved Classic Direct Enrollment or Enhanced Direct Enrollment partner website with a consumer pathway, ensuring that consumers are aware of and consent to these changes to their Marketplace enrollment commission information.

From January 2024 through August 2024, CMS received 90,863 complaints that consumers had their FFM plan changed without their consent (also known as an "unauthorized plan switch"). The agency has resolved 90,376 (99.45%) of these complaints and remains committed to addressing new and unresolved cases. CMS is currently resolving these cases within approximately 16 calendar days of receipt.

From January 2024 through August 2024, CMS received 183,553 complaints that consumers were enrolled in FFM coverage without their consent (also known as an "unauthorized enrollment"). The agency has resolved 183,095 (99.75%) of these complaints and remains committed to addressing new and unresolved cases. CMS is currently resolving these cases within approximately 52 days of receipt.

From June 2024 through October 2024, CMS suspended 850 agents and brokers' Marketplace Agreements for reasonable suspicion of fraudulent or abusive conduct related to unauthorized enrollments or unauthorized plan switches. These agents and brokers are now prohibited from participating in Marketplace enrollment, including receiving related commissions.

For additional historical context, please see CMS' statements from July 19, 2024, and May 6, 2024, as well as the agency's consumer assistance infographic.

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# HOW DID TAKE-UP OF MARKETPLACE PLANS VARY WITH PRICE, INCOME, AND GENDER?

BENJAMIN HOPKINS
JESSICA BANTHIN
ALEXANDRA MINICOZZI

## ABSTRACT

We estimate the demand for subsidized insurance in the Affordable Care Act marketplaces using administrative enrollment data for the 39 states that used Healthcare.gov between 2015 and 2017. Our results expand the existing literature on marketplace take-up, the extensive margin, in several important ways. First, we provide the first estimates of price elasticities based on administrative data from states with Federally Facilitated Marketplaces, which accounted for three-quarters of all marketplace enrollment and include states that did not expand Medicaid. Our estimates suggest that price elasticities may be lower in our sample of states than in states such as California (a major data source for other studies), which expanded Medicaid and pursued policies that may have increased price sensitivity. Our analysis also yields new evidence suggesting that many people in the coverage gap in non-expansion states obtain subsidies by reporting income just above the federal poverty line at the time of enrollment, especially in Florida. Finally, we update the existing literature describing higher demand for insurance coverage by women by estimating the difference in take-up rates by gender while controlling for eligibility for subsidies, finding that these gender differences persist among both young and older adults.

**KEYWORDS:** ACA marketplace, demand elasticity, take-up elasticity, women's health insurance coverage, advanced premium tax credits
**JEL CLASSIFICATION:** H51, I13, J16

## I. Introduction

During the 2023 open enrollment period, more than 16 million people selected a plan from the health insurance marketplace established by the Patient Protection and Affordable Care Act (ACA) (CMS 2023). As premiums and health-care costs rise and state and federal governments continue to change policies related to the nongroup market, the fundamental decision to take up marketplace insurance or not—that is, the extensive margin of demand—remains an important area of investigation. Price elasticities are essential for projecting the

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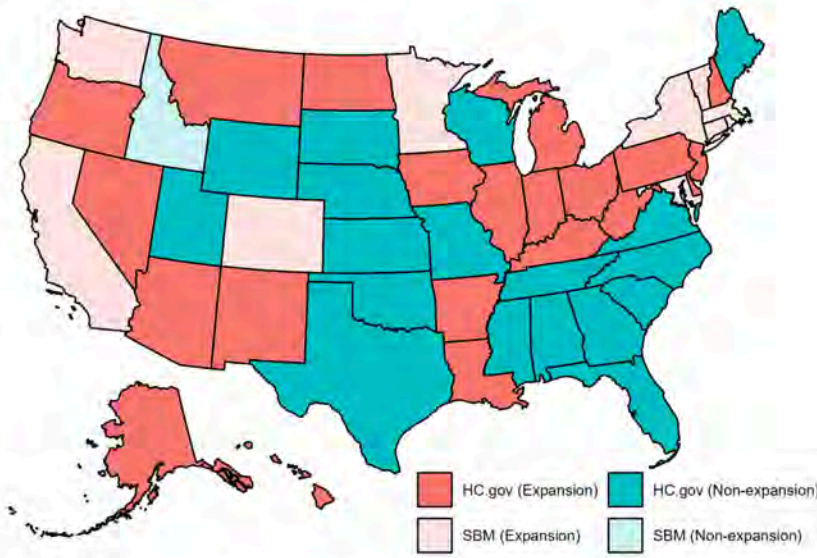



**FIGURE 1.** States that used Healthcare.gov to determine eligibility and manage enrollment between 2015 and 2017 and their Medicaid expansion status in 2017. Hawaii used Healthcare.gov in 2016–17 and Kentucky in 2017. HC.gov = Healthcare.gov; SBM = state-based marketplace. Sources: Healthcare.gov enrollment data and the Kaiser Family Foundation.

effects of legislation like the American Rescue Plan Act and the Inflation Reduction Act, which enhanced the generosity of premium tax credits (PTCs) and extended eligibility for those credits to people with income above 400 percent of the federal poverty line (FPL).[1] Meanwhile, to design policies that effectively promote useful coverage among the remaining uninsured, it is critical to understand who is (and is not) enrolling in marketplace insurance and why.

Our study addresses these questions by estimating and analyzing the take-up rate of marketplace insurance in the 39 states that used Healthcare.gov between 2015 and 2017 and accounted for the majority (70.8 percent) of enrollment over that period (CMS 2017, 2018, 2022b). These states are shown in Figure 1. We estimate the take-up rate of marketplace insurance by combining unique, individual-level administrative data on marketplace enrollment in the Federally Facilitated Marketplace (FFM) with a method for estimating the number of people who may have been eligible to receive PTCs from survey data. To generate demand elasticities, we estimate a linear probability model of take-up rates as a function of premiums and other explanatory variables. We also show how the provisions of the ACA manifest in take-up rates of marketplace insurance, revealing some unexpected outcomes (people in the

1 The American Rescue Plan Act temporarily enhanced PTCs and expanded eligibility for credits in March 2021 for two years through 2022. The Inflation Reduction Act extended those provisions through 2025.

coverage gap are able to obtain PTCs) and shedding light on some predictable ones (women take up marketplace insurance at higher rates than men).

Our price elasticity estimates—which are smaller than most existing estimates—are uniquely suited to predicting the effects of the numerous changes in federal policy concerning the ACA marketplaces that will be proposed or enacted in the next several years because of the quality and scope of the data we use to estimate them. Our analysis is the first to estimate price elasticities using household-level administrative data from the FFM, a sample that includes states that did not expand Medicaid. The existing literature on the extensive margin of demand for marketplace insurance is mainly based on national household survey data (Frean et al. 2017), which can contain reporting errors, or administrative data from California (Tebaldi 2022; Saltzman 2019, 2021; Saltzman et al. 2021; Tebaldi et al. 2022), which for many reasons is an unusual state. Another paper, Ryan et al. (2022), studied the demand for individual insurance using 2015 enrollment data from a single broker that operated nationally, while Abraham et al. (2017) studied the internal margin of demand in the ACA marketplaces using 2014 to 2015 aggregate enrollment data from the FFM. In addition to using more comprehensive data covering more states than previous work, we also expand the definition of potential enrollees beyond the uninsured, unlike other studies, to include those with individual market plans outside of the ACA marketplaces. The denominator better reflects the environment in which most Americans are deciding whether to forego insurance or purchase an on- or off-marketplace plan.

We also show that take-up rates are unusually high among very low-income households and provide evidence that this results from households in the so-called coverage gap—that is, with income less than 100 percent FPL in states that did not expand access to Medicaid—obtaining subsidized marketplace insurance. Because income volatility is high among low-income families (Hannagan and Morduch 2015), many people who received advanced PTCs based on the reasonable expectation that they would earn more than the FPL end up earning less. It is also likely that people with very low income in states that have not expanded Medicaid have a greater incentive to overestimate their annual incomes because of the lack of alternative sources of affordable coverage.

Finally, while it has long been noted that women appear to value health insurance more than men and obtain insurance at higher rates (Salganicoff and Sobel 2016; Gunja et al. 2017), there are no current estimates of such higher take-up rates for women versus men in the nongroup market that accurately account for eligibility for subsidies. More than half of adult marketplace enrollees are women (53.7 percent of 2022 open enrollment period plan selections; CMS 2022a). Yet, we find that more men than women are eligible for subsidies and the predominance of women in the marketplace is because women take up marketplace insurance at noticeably higher rates than men. Further, we find that the differential in take-up holds for all ages, not just for women of childbearing ages.

The remainder of our paper is organized as follows. Section II provides background on the ACA health insurance marketplaces. Section III describes our data and our method for estimating the number of people who may have been eligible for PTCs, and Section IV outlines our empirical approach. Section V presents our results, with subsections on net and gross price elasticities, take-up near the coverage gap, and take-up of marketplace insurance by women. Section VI highlights key sensitivity analysis we conducted. Section VII concludes

with a discussion of our results and demonstrates the utility of our price elasticities with a back-of-the-envelope estimate of the effects of the American Rescue Plan Act and Inflation Reduction Act on coverage. Details on our imputation of eligibility for PTCs are included in Online Appendix A and additional sensitivity analyses in Online Appendix B.

## II. Background

The ACA established health insurance marketplaces through which any US citizen or lawfully present individual may purchase health insurance plans offered by private issuers. The act also established rules governing plan design, premiums, premium and cost-sharing reduction subsidies, and processes for enrolling and accessing the subsidies.

Issuers may offer plans in four metal tiers—bronze, silver, gold, and platinum—with approximate actuarial values of 60 percent, 70 percent, 80 percent, and 90 percent, respectively. Some marketplace enrollees are eligible for cost-sharing reduction subsidies if they enroll in a silver plan, which decreases their cost-sharing and increases the actuarial value of their plan from 70 to 94 if their family income is between 100 and 150 percent FPL, 87 if it is between 151 and 200 percent FPL, and 73 if it is between 200 and 250 percent FPL.[2] Partly because these subsidies are available only to enrollees in silver plans, 73 percent of people who enrolled in marketplace insurance through Healthcare.gov between 2015 and 2017 purchased a silver plan.

The plans issued through the marketplaces must provide coverage for 10 categories of essential health benefits, including maternity and newborn care. Previously, maternity benefits were not offered at all, or only as a rider.[3] In addition, all private insurance plans, including marketplace plans, must cover certain preventive care services without cost-sharing. Some of these benefits may appeal relatively more to women than to men; mammograms, for example, can be expensive if not covered by insurance (Borsky et al. 2019). Essential health benefits requirements are defined by each state.

Under the ACA's rating rules, issuers may charge people different premiums for the same plan depending on where they live, whether they smoke, and the number and age of the household members enrolled in the plan. Notably, issuers are not permitted to charge people different premiums based on their gender or their expected health spending. Marketplace enrollees may be eligible to receive premium tax credits (PTCs) that reduce their out-of-pocket premiums.[4] Between 2015 and 2017 this included individuals and

2 Lawfully present immigrants who have income below 100 percent FPL and are not eligible for Medicaid owing to their immigration status are eligible for a 94 AV silver plan. In addition, American Indians and Alaska Natives who are members of federally recognized tribes are eligible to enroll in plans with zero or limited cost-sharing.

3 According to the National Women's Law Center, as of 2012 maternity coverage was largely unavailable in states that did not mandate the coverage. As of July 1, 2012, only nine states mandated maternity coverage in the individual market (Garrett 2012).

4 PTCs are available only to people purchasing nongroup plans through the marketplace. In 2017, about 6 million people enrolled in nongroup insurance outside of the marketplaces, and many of these enrollees

families with modified adjusted gross income (MAGI) between 100 and 400 percent FPL who were US citizens or lawfully present in the United States and who did not have access to coverage from other sources such as Medicaid, Medicare, or an employer and were not currently enrolled in Department of Veterans Affairs (VA) coverage like the Veterans Health Care program or the Civilian Health and Medical Program of the VA. The amount of the PTC depends on enrollees' income, where they live, and the plan they select. Some people are eligible for premium-free bronze plans (Branham et al. 2021). Access to premium-free plans is linked to higher take-up and effectuation rates (Drake and Anderson 2020; Drake et al. 2021).

Most subsidized enrollees receive their PTCs in "advance" by paying the subsidized premium for their plan during the year in which they are covered. The amount of this advanced PTC is based on the expected income they report when they select a plan (usually during the annual open enrollment period). When filing their federal income tax returns, enrollees must reconcile the difference between the PTC they are entitled to (based on their actual income) and the PTC they were advanced (based on their expected income). Enrollees whose actual income was less than expected and above the income eligibility floor for a credit receive a credit for the difference on their tax returns. Enrollees whose actual income exceeded expectations repay the difference up to a cap that varies between a few hundred or a few thousand dollars depending on their income and their filing status (CBPP 2020).[5] Enrollees whose actual income was less than expected and below the income eligibility floor (e.g., 100 percent FPL in a state that did not expand Medicaid) are not required to repay the credits they received. People with income below the poverty line but above their state's Medicaid income eligibility threshold thus have an incentive to overestimate their actual income at the time of enrollment. That is, if they enroll in a marketplace plan and subsequently report MAGI below 100 percent FPL when they file their tax return (the following year), they are eligible for the full advanced PTC, which can be quite large.[6]

Our study includes the 39 states that relied on Healthcare.gov to manage eligibility determinations and enrollment for their residents between 2015 and 2017 (see Figure 1).[7] The remaining states (and the District of Columbia) implemented many policies designed to promote enrollment in the marketplaces. Notably, all had expanded access to Medicaid before 2015, whereas 21 of the 39 Healthcare.gov states had not.

Many prior studies of the ACA marketplace have used data from California, but its policies complicate efforts to extrapolate results from those studies to the rest of the country. California has been one of the most proactive states in the country in promoting marketplace enrollment (Robinson et al. 2015). Many of its policies likely increase the price sensitivity and

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were otherwise eligible for marketplace subsidies, especially in states that allowed for grandfathered or transitional plans or where major insurers in the pre-ACA nongroup market did not participate in the marketplaces (CBO 2019; Lurie and Pearce 2019).

5 In 2015 to 2017, enrollees had to repay the full advanced PTC if their actual income exceeded 400 percent FPL.

6 According to Form 8962, tax filers in this situation are eligible for PTCs.

7 There are a handful of states that operate their own state-based marketplace but use Healthcare.gov to determine eligibility and manage enrollment. These states are included in our data.

take-up of consumers. To ease plan selection and increase price competition, California standardizes plan designs. To enhance the attractiveness of plans for enrollees, especially those who are healthier than average, it requires all silver plans to cover physician visits before the deductible applies. California frequently extends the open enrollment period, which may result in higher effectuation rates by low-income enrollees (Drake et al. 2021). Finally, it engages in extensive marketing that may drive higher take-up rates in general, affect differences in take-up between populations, and make consumers more sensitive to net premiums. So, while California is a major market and presents an interesting case study of methods designed to increase take-up of marketplace coverage, it is not representative of the rest of the country.

## III. Data

We use microdata from the Centers for Medicare and Medicaid Services for actual marketplace enrollment and the American Community Survey (ACS) for potential marketplace enrollment and factors affecting demand for marketplace plans. The estimated take-up rate of marketplace plans is simply the ratio of actual marketplace enrollment to estimated potential marketplace enrollment. Marketplace premiums come from Healthcare.gov's Qualified Health Plan (QHP) Landscape file.

### A. ACTUAL MARKETPLACE ENROLLMENT

For marketplace enrollment, we use confidential microdata on all FFM enrollees who selected a plan during an open or special enrollment period and effectuated their enrollment by paying their first month's premium between 2015 and 2017. The data also include enrollees' modified adjusted gross income relative to the federal poverty line (MAGIPOV)[8] and dates of insurance coverage, which we use to calculate full-year-equivalent enrollment (i.e., person-years). Because enrollees who do not request an advanced PTC are not required to report their income to Healthcare.gov, income is censored in the data for 6.5 percent of enrollees. We presume these enrollees were ineligible for the credit. There were a total of 18.4 million full-year-equivalent effectuated enrollees in states that used Healthcare.gov between 2015 and 2017. When we exclude children, the elderly, and those ineligible for subsidies, total full-year-equivalent enrollment is 14.6 million. A majority of these enrollees were women (56 percent).

### B. POTENTIAL MARKETPLACE ENROLLMENT

We rely on the 2013–17 American Community Survey five-year public-use microdata sample to estimate the number of (and characteristics of) potential marketplace enrollees

8 After enrollees report their expected income and select a plan, they go through a process of income verification. In 2015, the FFM adjusted advanced PTC and/or cost-sharing reduction subsidy amounts for 232,000 households that were not able to verify their reported income (CMS 2015). If a household's income changes after enrollment, they are expected to report the change. Fourteen percent of enrollees reported a change in income during the calendar year.

between 2015 and 2017. The five-year 2013–17 ACS sample size is approximately 5 percent of the US population (15.8 million person-records).

We classify an ACS respondent as a potential marketplace enrollee if they meet four conditions chosen to mimic the income and minimum essential coverage standards for PTC eligibility. First, they are between the ages of 20 and 64. Second, they do not report being enrolled in health insurance through an employer, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or TRICARE. Third, they are not eligible for Medicaid or CHIP based on their age and imputed income, including through pregnancy pathways.[9] Finally, their MAGI is less than 400 percent FPL in their state, above 138 percent FPL in states that expanded Medicaid, and above 80 percent FPL in states that did not. We use a cutoff below 100 percent FPL in non-expansion states because our analysis strongly suggests that many people with income below 100 percent FPL in non-expansion states obtain advanced PTCs, as discussed in Section V.[10] In our sensitivity analyses, we test the robustness of our estimated price elasticities to this assumption.

We are unable to exclude three types of ACS respondents who were ineligible to receive PTCs: unauthorized immigrants, people currently enrolled in VA health care, and those who declined an offer of affordable, minimum essential coverage from their employer. Our empirical model includes explanatory variables to mitigate the impact of these data limitations in measuring eligibility. We also may fail to exclude some people who have Medicaid coverage but do not report it on the ACS (Boudreaux et al. 2015). On the other hand, we were unable to include ACS respondents who were ineligible for Medicaid solely because of their immigration status and therefore eligible for PTCs.

### C. INSURANCE PREMIUMS

Lastly, we use Healthcare.gov's QHP Landscape file data set to obtain premiums for the lowest-cost silver, second-lowest-cost silver (SLCS), and lowest-cost bronze plans in each county. For each marketplace unit (usually a family), we impute the gross and net premiums per enrollee for these plans. The net premium is the gross premium minus the combined PTC and self-employed health insurance tax deduction. As regions sometimes contain more than one county, we calculate the unit's average net premiums across the counties in their region, weighted by counties' shares of the under 65 population in the region.[11]

9 We considered a woman to be eligible for Medicaid through the pregnancy pathway if she gave birth in the previous 12 months and had income between the limits for childless adults and for the pregnancy pathway in her state. We classified only one-third of these women as potential marketplace enrollees because most probably would have enrolled in Medicaid after their first trimester and been disenrolled two months postpartum. In each year, we excluded about half a million women from the population of potential enrollees for this reason.

10 We chose 80 percent FPL specifically because it yields take-up rates roughly equal to (but higher than) the ratio for those with income between 138 percent and 250 percent FPL (see Table 1).

11 For regions, we group 1,648 public-use microdata areas into 894 regions. A public-use microdata area is a census-defined region containing approximately 100,000 people. We group some public-use microdata areas so that each region is represented by at least 10 potential marketplace enrollees, and thus characteristics of potential enrollees are more precisely estimated.

## IV. Empirical Approach

We study the rate at which potential enrollees take up marketplace insurance (see Table 1). Estimated take-up rates are calculated by dividing actual, full-year-equivalent marketplace enrollment (from administrative data) by estimated potential enrollment (from the ACS) between 2015 and 2017. Neither data source is sufficient to estimate take-up rates on its

**TABLE 1.** Marketplace enrollment, potential enrollment, and take-up rates by sex, 2015–17

| | Female | | | Male | | |
|---|---|---|---|---|---|---|
| | Enrollment (millions) | Potential enrollment (millions) | Take-up (%) | Enrollment (millions) | Potential enrollment (millions) | Take-up (%) |
| Overall | 8.2 | 23.7 | 34 | 6.4 | 28.0 | 23 |
| Year | | | | | | |
| 2015 | 2.6 | 7.9 | 33 | 2.0 | 9.3 | 22 |
| 2016 | 2.9 | 7.9 | 36 | 2.3 | 9.3 | 24 |
| 2017 | 2.7 | 7.9 | 35 | 2.2 | 9.4 | 23 |
| Age | | | | | | |
| 20 to 34 | 2.1 | 8.8 | 23 | 1.7 | 12.0 | 14 |
| 35 to 44 | 1.4 | 5.1 | 27 | 1.1 | 6.2 | 18 |
| 45 to 54 | 2.0 | 5.0 | 39 | 1.6 | 5.4 | 29 |
| 55 to 64 | 2.8 | 4.8 | 58 | 2.1 | 4.4 | 47 |
| MAGIPOV | | | | | | |
| 80% to 137% FPL | 2.0 | 4.7 | 42 | 1.4 | 4.9 | 28 |
| 138% to 250% FPL | 4.6 | 11.7 | 40 | 3.7 | 14.0 | 27 |
| 251% to 400% FPL | 1.6 | 7.4 | 21 | 1.3 | 9.2 | 15 |
| Medicaid expansion | | | | | | |
| Expansion states | 2.4 | 6.8 | 36 | 2.0 | 8.4 | 24 |
| Non-expansion states | 5.7 | 16.9 | 34 | 4.4 | 19.6 | 23 |
| Non-expansion states (above 138% FPL) | 3.8 | 12.3 | 31 | 3.1 | 14.7 | 21 |

Sources: Healthcare.gov, the 2013–17 American Community Survey, and authors' calculations.
Note: This table summarizes enrollment and potential enrollment in states that used Healthcare.gov for enrollment between 2015 and 2017 for people between the ages of 20 and 64 and with MAGIPOV between 80 and 400 percent FPL in non-expansion states other than Florida and between 138 and 400 percent FPL in expansion states and Florida. People are considered potential enrollees if they do not report being enrolled in health insurance through an employer, Medicare, Medicaid, CHIP, or TRICARE, and are not eligible for Medicaid based on income and/or pregnancy. MAGIPOV = ratio of modified adjusted gross income to the federal poverty line.

own; the administrative data do not count potential enrollment and the ACS data do not disaggregate nongroup enrollment into on- and off-marketplace enrollment.[12]

We estimate that the overall take-up rate of marketplace insurance between 2015 and 2017 in the FFM was 28 percent.[13] Take-up of marketplace insurance by women exceeded that by men in all years, age categories, and income categories in our sample. Although there were more male potential enrollees than female, take-up of marketplace insurance was so much higher for women than men that there were more female enrollees than male. As expected, take-up was also higher among older potential enrollees and those eligible for cost-sharing reduction subsidies. Finally, take-up rates were lower in states that did not expand Medicaid, especially when comparing take-up among those with income above 138 percent FPL.

To estimate the effect of price and gender on take-up of marketplace insurance, we fit a linear probability model of take-up rates. Motivated by the patterns in take-up evident in Table 1, we aggregate the microdata on individuals to obtain counts of actual marketplace enrollees and potential marketplace enrollees by cells, defined by gender, age, income, and region group $i$ and year $t$.[14] We model take-up rates ($T_{it}$) as a function of the average net premium per potential enrollee per month for a SLCS plan ($P_{it}$),[15] a vector of explanatory variables ($X_{it}$), and a vector of fixed effects for age and gender category ($\mu_{AG}$), income category ($\mu_I$), region ($\mu_R$), and year ($\mu_Y$).

$$T_{it} = \beta_0 + \alpha P_{it} + \beta_1 X_{it} + \mu_{AG} Age_i \times Gender_i + \mu_I Income_i + \mu_R Region_i + \mu_Y Year_t + \epsilon_{it} \quad (1).$$

Explanatory variables are defined using only people potentially eligible for marketplace subsidies. Table 2 provides the age and MAGIPOV distributions of potential enrollees in our sample, and Table 3 provides summary statistics on the explanatory variables in our model.[16]

12 To the extent that nongroup enrollees purchased plans off the marketplace but were otherwise eligible for PTCs, they would be included as potential enrollees and would reduce the take-up rate of marketplace plans.

13 Our estimated marketplace take-up rates are biased downward because, like other survey-based analyses, estimated potential eligibility for PTCs is overstated when Medicaid enrollment is underreported.

14 Our age groups are 20–34, 35–44, 45–54, and 55–64. Our income groups are 80–138 percent FPL (in non-expansion states only), 139–250 percent FPL, and 251–400 percent FPL. We exclude enrollees and potential enrollees outside of these age and income categories from our analysis.

15 While SLCS plans are central to the design of marketplace subsidies, households are arguably more responsive to the premiums of the lowest-cost silver plans. Our results are robust to using lowest-cost silver premiums rather than SLCS premiums.

16 The effects of price and gender on take-up were not notably different when we estimated a version of our model that includes the share of potential enrollees in different racial and ethnic groups. Consistent with other analyses, we found underrepresentation of Hispanics and non-Hispanic Blacks and overrepresentation of non-Hispanic Asians in the marketplaces, even after controlling for other factors. Further work (with better measures of marketplace enrollment by race and ethnicity) is required to explore why some groups take up at higher rates.

**TABLE 2.** Sample age and MAGIPOV distribution, by gender

| | Female (%) | Male (%) |
|---|---|---|
| Age | | |
| 20 to 34 | 37 | 43 |
| 35 to 44 | 22 | 22 |
| 45 to 54 | 21 | 19 |
| 55 to 64 | 20 | 16 |
| MAGIPOV | | |
| 80% to 137% FPL | 20 | 17 |
| 138% to 250% FPL | 49 | 50 |
| 251% to 400% FPL | 31 | 33 |

Source: 2013–17 American Community Survey.
Note: This table provides the age and MAGIPOV distribution among potential marketplace enrollees in states that used Healthcare.gov for enrollment between 2015 and 2017. MAGIPOV = ratio of modified adjusted gross income to the federal poverty line.

We use our estimate of the coefficient on net premiums to calculate demand elasticities with respect to gross and net premiums; unlike some previous analysis (Saltzman 2019), we do not instrument for price. Because we limit our analysis to people who would be eligible for subsidies based on their income and include region fixed effects in our model, the coefficient on net premiums in our model is primarily identified by variation from the age- and income-based expected contribution formula rather than regional variation in gross premiums. This approach addresses a potential source of omitted variables bias: the joint correlation across rating areas between gross premiums, demand, and factors like the health of potential enrollees or concentration of health-care markets. In Section VI we show that variations of our model with state (rather than region) fixed effects yield similar results. So as not to conflate the effect of prices with other factors that vary with income, our model includes income category fixed effects and other variables such as the share of people with access to a premium-free bronze plan.[17] In Online Appendix B, we show that our model is also robust to alternative specifications of income and the inclusion of variables controlling for the effect of cost-sharing reduction subsidies and exemptions from the individual mandate penalty.

17 If we had access to more recent data, we would need to modify our empirical model to include the share of people with access to free silver plans (to account for the enhanced subsidies) and would slightly expand our definition of who is a potential enrollee (to account for looser income verification rules).

**TABLE 3.** Sample means, by gender

| Explanatory variable | Source | Female | Male |
|---|---|---|---|
| Average net premium per enrollee per month | Imputed using the ACS, TAXSIM, and the QHP Landscape file | 139.3 | 141.3 |
| Share who gave birth in the past 12 months | ACS | 2.2 | 0.0 |
| Average age | ACS | 41.0 | 39.1 |
| Share with access to a free bronze plan | Imputed using the ACS, TAXSIM, and the QHP Landscape file | 29.9 | 26.4 |
| Average MAGIPOV | Imputed using the ACS and TAXSIM | 211.7 | 215.7 |
| Share who are unauthorized immigrants | Imputed using the ACS | 11.9 | 13.9 |
| Share ever enrolled in VA health care | ACS | 1.0 | 3.8 |
| Share in household where nobody speaks English very well | ACS | 7.5 | 9.9 |
| Share married | ACS | 44.2 | 35.1 |
| Average marketplace unit size | Imputed using the ACS and TAXSIM | 2.5 | 2.2 |
| Average number of Medicaid or CHIP-eligible children in the marketplace unit | Imputed using the ACS and TAXSIM | 0.5 | 0.4 |

Note: This table provides the source and means of the explanatory variables in our model among potential marketplace enrollees in states that used Healthcare.gov for enrollment between 2015 and 2017. We use NBER's TAXSIM program to compute marginal income tax rates (Feenberg and Coutts 1993). MAGIPOV = ratio of modified adjusted gross income to the federal poverty line.

The age and gender category fixed effects ($\mu_{AG}$) in our model measure the gap in the take-up of marketplace insurance between women and men after accounting for observable factors. As shown in Table 3, many factors that are arguably correlated with take-up rates are also correlated with gender. For example, the share of potential enrollees who gave birth to a child in the past year captures the effect of covering pregnancy, childbirth, and newborn care on take-up of marketplace insurance by women who are not eligible for Medicaid through the pregnancy pathway. In Online Appendix B, we show that the gender gap is not noticeably affected when we interact the effect of marriage with gender or include variables that measure access to an unaffordable offer of employment-based insurance or the self-employed health insurance deduction.

We use cluster-robust standard errors for inference, clustering by region. Our primary motivation for doing so is that, as discussed, net prices and take-up rates may be correlated across regions owing to variables that are omitted from our model. Because we include region fixed effects in our model, these clustered standard errors may be too conservative. However, we chose to use them to address the possibilities that the effect of net prices on take-up is heterogeneous across rating areas or that fixed effects do not perfectly control for within-region correlation (Abadie et al. 2017; Cameron and Miller 2015).

Our sample includes cells with take-up rates higher than 100 percent for some groups. This occurs most often among groups with relatively high take-up rates: women between the ages of 55 and 64 and people with incomes below 138 percent FPL. Although there are many reasons that estimated take-up rates might exceed 100 percent, two are especially worth noting. First, sampling and measurement error reduce the precision of our estimates of the number of potential enrollees. Second, low-income enrollees have an incentive to overreport their income, but survey respondents do not. In some cases, we can account for extremely high take-up rates. For example, Maine and Wisconsin exhibited very high take-up rates in the group below 138 percent FPL but we were able to modify our definition of potential enrollment in these states to account for their unusually high Medicaid income limit (108 percent FPL). In one case, however, take-up rates were implausibly high for reasons we cannot explain. In Florida one-third of cells for potential enrollees with income between 80 and 138 percent FPL exhibit take-up rates above 100 percent (versus 4 percent of cells in the remaining states). We drop the Florida cells from our sample because we could not establish a convincing criterion for classifying people as potential enrollees and accurately defining the denominator.[18] That exclusion reduces the share of cells in our sample with take-up rates above 100 percent by about half. For our remaining sample, estimated take-up rates exceed 100 percent for cells (year, region, gender, age groups, and income group) account for 1.7 percent of potential enrollees.[19]

## V. Results

In this section, we discuss the results of our analysis. We first present the coefficient estimates from our main model and then discuss the relationship of take-up with price, income, and gender in turn.

The estimates from our main model specification are presented in Table 4. The coefficients in our model have the expected sign, reasonable magnitudes, and relatively small standard errors. In summary, we find that the predicted take-up of marketplace plans increases

18 The fact that so many of the Florida cells below 138 percent FPL showed take-up rates over 100 percent indicates that we are substantially underestimating the population of low-income potential enrollees and that our dependent and explanatory variables suffer from measurement error. As a large state, Florida accounted for about half of the cells below 138 percent FPL in our sample before we excluded them and were thus very influential in our estimated elasticities. In our judgement, it was better to make this exclusion to our sample than to allow the estimates to be driven by poorly measured outliers. It is unclear why Florida has such high take-up rates of marketplace coverage. One qualitative study from 2015 reported that insurance agents, so-called pop-up brokers, and community leaders had been very active in encouraging sign-ups in the first two years of the marketplace, especially in South Florida (Wishner et al. 2015). The authors also reported that "many low-income consumers who were enrolled through those brokers sought help from assisters after the close of the [open enrollment] because of numerous problems relating to their applications, including that their income had been erroneously reported as over 100 percent of poverty, which deemed them eligible for tax credits" (Wishner et al. 2015, 10). A recent media story describes similar activity in Florida (Chang 2023).

19 We reestimated our model capping take-up rates at 100 percent FPL and, as expected, found that the coefficient estimates on variables, like net premiums, that are strongly correlated with income and take-up shrank slightly while other coefficient estimates remained essentially unchanged.

**TABLE 4.** Predicted linear probability model of take-up of marketplace plans

| | Main |
|---|---|
| Gender gap: 20- to 34-year-old women vs. men | 6.65[a] |
| | (0.29) |
| Gender gap: 35- to 44-year-old women vs. men | 5.90[a] |
| | (0.28) |
| Gender gap: 45- to 54-year-old women vs. men | 8.30[a] |
| | (0.33) |
| Gender gap: 55- to 64-year-old women vs. men | 9.50[a] |
| | (0.48) |
| Average net premium per enrollee per month | −0.04[a] |
| | (0.01) |
| Share with access to a premium-free bronze plan | 0.07[a] |
| | (0.01) |
| Average MAGIPOV | 0.04[a] |
| | (0.01) |
| Average age | 1.09[a] |
| | (0.14) |
| Share who gave birth in the past 12 months | 0.07[b] |
| | (0.04) |
| Share who are unauthorized immigrants | −0.14[b] |
| | (0.06) |
| Share ever enrolled in VA health care | −0.12[a] |
| | (0.03) |
| Share in household where nobody speaks English very well | −0.13[a] |
| | (0.02) |
| Average marketplace unit size | 2.72[a] |
| | (0.42) |
| Average number of Medicaid or CHIP-eligible children in the marketplace unit | −4.01[a] |
| | (0.55) |
| Share married | 0.03[b] |
| | (0.01) |
| Cells | 51,768 |
| $R^2$ | 0.75 |
| Year fixed effects | Yes |

**TABLE 4.** *Continued*

| | Main |
|---|---|
| Region fixed effects | Yes |
| Age-gender fixed effects | Yes |
| MAGIPOV fixed effects | Yes |

Note: Fixed-effect estimates are not shown. MAGIPOV = ratio of modified gross income to the federal poverty line; PUMA = public-use microdata area. Robust standard errors are in parentheses. Standard errors are clustered by region (i.e., groups of PUMAs). $^{a}p < 0.01$, $^{b}p < 0.05$.

with the average age, income, and household size of potential enrollees as well as the share with access to premium-free bronze plans, who gave birth in the prior year, and were married. Predicted take-up declines with average net premiums and number of Medicaid or CHIP-eligible children in the marketplace unit and the share of potential enrollees who were unauthorized immigrants,[20] ever enrolled in VA health care, or lived in a household where nobody "speaks English very well."

## A. PRICE

A.1. NET PREMIUM ELASTICITIES. We estimate that the overall elasticity of demand for marketplace insurance with respect to the net premium per enrollee of a benchmark plan is −0.21 (see Table 5). The semi-elasticity with respect to a $120 annual increase in the net premium per enrollee is estimated to be −1.4 percent.

We calculate elasticities at the mean, as shown in equation 2, where $\hat{E}$ is the elasticity of demand for marketplace insurance with respect to the average net premium per enrollee of a benchmark plan, $\bar{P}$ is the average net premium per enrollee of a benchmark plan, $\bar{\hat{T}}$ is the average predicted take-up rate, and $\hat{\alpha}$ is the estimated premium coefficient from the linear probability model (equation 1).

$$\hat{E} = \frac{\widehat{\partial T}}{\partial P}\frac{\bar{P}}{\bar{\hat{T}}} = \hat{\alpha}\frac{\bar{P}}{\bar{\hat{T}}} \quad (2).$$

We estimate elasticities at the mean rather than mean elasticities because mean elasticities are not robust to outliers. Our linear probability model predicts take-up rates that are negative or close to zero for 4.9 percent of cells yielding positive (or very large) estimated elasticities for those cells and causing mean elasticities to be poor measures of overall price responsiveness.

20 We used the method described in Borjas (2017) to impute whether an ACS respondent is an unauthorized immigrant. We are not confident enough in the precision of this imputation to use it to classify ACS respondents as potential enrollees or not, but it is sufficient to estimate the conditional correlation between take-up rates and being an unauthorized immigrant.

**TABLE 5.** Price elasticities and semi-elasticities of demand for marketplace insurance with respect to a 1 percent or $10 per month increase in net and gross premiums

| Group | Net price elasticity | Net price semi-elasticity (%) | Gross pric elasticity | Gross price semi-elasticity (%) |
|---|---|---|---|---|
| Overall | −0.21 (−0.26, −0.16) | −1.4 (−1.7, −1.1) | −0.05 (−0.06, −0.04) | −0.2 (−0.3, −0.2) |
| Women | −0.19 (−0.23, −0.14) | −1.2 (−1.5, −0.9) | −0.04 (−0.05, −0.03) | −0.2 (−0.2, −0.1) |
| Men | −0.25 (−0.31, −0.19) | −1.6 (−2.0, −1.2) | −0.06 (−0.07, −0.04) | −0.3 (−0.3, −0.2) |
| 20 to 34 years old | −0.35 (−0.44, −0.27) | −2.5 (−3.1, −1.9) | −0.14 (−0.17, −0.11) | −0.6 (−0.8, −0.5) |
| 35 to 44 years old | −0.30 (−0.37, −0.23) | −2.0 (−2.5, −1.5) | −0.10 (−0.12, −0.07) | −0.4 (−0.5, −0.3) |
| 45 to 54 years old | −0.20 (−0.25, −0.15) | −1.3 (−1.6, −1.0) | −0.03 (−0.04, −0.02) | −0.1 (−0.2, −0.1) |
| 55 to 64 years old | −0.14 (−0.17, −0.11) | −0.8 (−1.0, −0.6) | −0.00 (−0.01, −0.00) | −0.0 (−0.0, −0.0) |
| States that expanded access to Medicaid | −0.25 (−0.31, −0.19) | −1.4 (−1.7, −1.0) | −0.06 (−0.08, −0.05) | −0.3 (−0.4, −0.2) |
| States that did not expand access to Medicaid | −0.19 (−0.24, −0.15) | −1.4 (−1.7, −1.1) | −0.04 (−0.05, −0.03) | −0.2 (−0.2, −0.1) |

Note: This table reports elasticities and semi-elasticities of demand for marketplace insurance with respect to a change in the net or gross premium per enrollee of a benchmark plan for potential enrollees in states that used Healthcare.gov for enrollment between 2015 and 2017. Elasticities are calculated at the mean (i.e., based on the average premium and predicted take-up rate for each subgroup). Elasticities and semi-elasticities are calculated with respect to 1 percent and $10 per month increases in prices, respectively. The 95 percent confidence intervals are displayed in parentheses and calculated using the Krinsky-Robb method with 1,000 draws (Krinsky and Robb 1986).



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In Table 5, we present elasticity estimates for several different subpopulations of interest, based on gender, age, or Medicaid expansion status. Since we assumed that net premium has a linear relationship with take-up and did not interact it with age, gender, or Medicaid expansion status, the differences in elasticities for subgroups reflect the fact that comparable dollar increases in premiums or percentage point increases in take-up rates constitute larger percentage changes for some subgroups than others. Using this method, we estimate that net price elasticities are smaller for women than for men (difference = 0.06, 95 percent CI [0.05, 0.08]), for 55- to 64-year-old than 20- to 34-year-old potential enrollees (difference =0.21, 95 percent CI [0.16, 0.26]), and for potential enrollees in states that did not expand Medicaid than for those in states that did (difference = 0.11, 95 percent CI [0.08, 0.13]).

As anticipated, our estimated elasticity of −0.21 is larger in magnitude than the elasticity of −0.09 reported by Frean et al. (2017). They estimate the elasticity of overall nongroup coverage with respect to premium tax credits (PTCs) using variation in nongroup coverage rates in the American Community Survey before and after the introduction of the ACA marketplaces. Because their take-up includes people purchasing off-marketplace and thus ineligible for the credits (unlike our analysis), we anticipated that their estimate would be more inelastic (smaller in magnitude).

Our estimate of the net price semi-elasticity, −1.4 percent, is just below the bounds of −6.7 percent and −1.8 percent reported in Table 3 of Tebaldi et al. (2022). It is smaller in magnitude than the −3.4 percent to −2.2 percent range of point estimates reported in that paper and those in Table 4 of Tebaldi (2022), which range between −6.9 percent for 26- to 31-year-olds and −3.1 percent for 62- to 64-year-olds. Tebaldi (2022) studies California, where—for reasons discussed in the Section II—consumers may be more price sensitive relative to potential enrollees in FFM states.

Ryan et al. (2022) report semi-elasticities of the uninsured rate of 5.4 percent and 0.8 percent with respect to a smaller $100 increase in net silver premiums for enrollees earning less than 250 percent or between 250 and 400 percent FPL, respectively. We do not model the decision to enroll in off-marketplace insurance as they do, so we cannot calculate a directly comparable estimate using our model. However, at 0.5 percent, our implied estimate for the semi-elasticity of the share of potential enrollees who are uninsured or enrolled in off-marketplace insurance with respect to a $120 increase in net benchmark premiums seems small in magnitude compared with their estimates.[21] This is consistent with their proposition that "consumers who use third-party platforms to select insurance plans may be among the more price-sensitive consumers" (Ryan et al. 2022, 277).

While our focus is on the ACA marketplaces, we note that our estimates are higher than price elasticities of between −0.12 and −0.17 with respect to out-of-pocket prices in the market for employer-based insurance for households with income below 300 percent FPL and −0.01 to −0.10 for households with income below 200 percent FPL reported by Abraham and Feldman (2010) and Blumberg et al. (2001), respectively.

21 We calculate semi-elasticities of the uninsured rate by multiplying the semi-elasticity of the take-up rate by negative one times the odds of taking up marketplace insurance.

A.2. GROSS PREMIUM ELASTICITIES. We estimate that the overall elasticity of demand for marketplace insurance with respect to the gross premium is −0.05. The semi-elasticity with respect to a $120 annual increase in the net premium per enrollee is −0.2 percent.

As with net premiums, we calculate elasticities with respect to gross premiums at the mean. Since we do not directly estimate the relationship between gross premiums and take-up, we simulate the average net premium under a 1 percent increase in gross premiums. This allows us to calculate the partial effect of gross premiums on net premiums and, by extension, the elasticity of marketplace demand with respect to gross premiums. In the formula below, $\bar{P}_G$ is the average gross premium and $\bar{P}_{1\%}$ is the simulated average net premium under a 1 percent increase in gross premiums.

$$\hat{E}_G = \frac{\widehat{\partial T}}{\partial P_G}\frac{\bar{P}_G}{\hat{\bar{T}}} = \frac{\widehat{\partial T}}{\partial P}\frac{\widehat{\partial P}}{\partial P_G}\frac{\bar{P}_G}{\hat{\bar{T}}} = \hat{\alpha}\left(\frac{\bar{P}_{1\%} - \bar{P}}{1.01\bar{P}_G - \bar{P}_G}\right)\frac{\bar{P}_G}{\hat{\bar{T}}} \quad (3).$$

Our estimate of the gross price elasticity is smaller in magnitude than the estimates of −0.24, −0.60, and −1.1 to −1.2 reported by Saltzman et al. (2021), Saltzman (2021), and Saltzman (2019), respectively. Some of the difference might be attributed to the fact that, like Tebaldi (2022), these papers study California. Furthermore, Saltzman (2021) and Saltzman et al. (2021) limit their analysis to people who were ever enrolled in the marketplaces and therefore have a demonstrated interest in marketplace coverage; compared with those who have not, this population may be more sensitive to changes in marketplace premiums. Differences in how shocks to the gross premium were measured may also contribute.[22]

## B. INCOME

In Section III, we said that we consider some potential enrollees in the coverage gap—those who have income below 100 percent FPL in states that did not expand Medicaid—to be effectively eligible for PTCs. In this section, we show why and then briefly discuss the relationship between take-up and income in our model.

The enrollment data strongly suggest that some people in the coverage gap were able to obtain advanced PTCs, perhaps by overreporting their income at the time of enrollment. As shown in Figure 2, there were far more enrollees in non-expansion states with income near the FPL than with slightly higher income, even though PTCs and cost-sharing reduction subsidies were not substantially higher for this group.[23] We do not observe a similar spike in enrollment near 138 percent FPL in expansion states.[24]

22 In particular, the elasticities reported by Saltzman (2019) are market-share weighted averages of the elasticity of marketplace take-up with respect to the gross premium of each plan in the marketplaces. A shock to the price of any plan other than the reference plan is therefore fully passed through to potential enrollees, resulting in higher elasticities with respect to the gross premiums for those plans, especially for low-income households.

23 Florida exhibits this pattern to a far greater extent than any other non-expansion state. In other non-expansion states, there were 1.9 as many enrollees with MAGIPOV between 100 and 109 percent FPL as those with MAGIPOV between 110 and 119 percent between 2015 and 2017; in Florida, there were 2.9 times as many.

24 Figure 2 shows enrollees with income below 138 percent FPL in expansion states. There are at least two reasons why someone in this situation might enroll in marketplace insurance. First, people who are ineligible for Medicaid solely because of their immigration status are eligible for PTCs. Second, Medicaid eligibility is

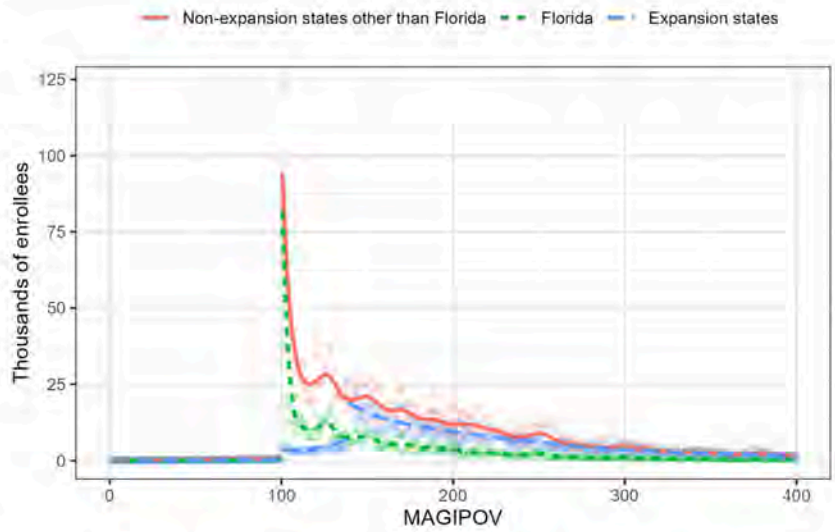



**FIGURE 2.** Average annual marketplace enrollment by the ratio of modified adjusted gross income to the federal poverty line in states that did and did not expand Medicaid eligibility, 2015–17. This figure shows the MAGIPOV distribution of marketplace enrollees in states that used Healthcare.gov for enrollment between 2015 and 2017. Points represent the average annual enrollment in MAGIPOV bins with a width of one, e.g., 100 to 100.9 percent FPL. Lines represent the predicted density estimates from a local linear regression with a triangular kernel (McCrary 2008). MAGIPOV = ratio of modified adjusted gross income to the federal poverty line. Source: Healthcare.gov.

The precise incomes reported by marketplace enrollees suggests that they were aware of the cutoff for PTC eligibility at the FPL. Consider single-person households in non-expansion states in 2015, for whom the lower bound for eligibility for the PTCs was $11,670. As shown in Figure 3, so many enrollees reported income between $11,670 and $12,500 to Healthcare.gov that actual marketplace enrollment was 136 percent of estimated potential enrollment in that range. Furthermore, many of these enrollees reported MAGI precisely equal to $11,670, $11,700, or $12,000, suggesting that they were aware of the cutoff for PTC eligibility and reported just enough income to exceed it. Other spikes correspond to round values, like $15,000, or inflation-adjusted round values from 2014.

Taken together, these facts suggest that many people who eventually earned less than 100 percent FPL reported that they expected to earn more than this amount when enrolling in marketplace insurance and were able to receive PTCs. This implies that many people who earned less than the FPL (or, in the ACS, reported earning less) were effectively eligible for PTCs.

based on monthly income while PTC eligibility is based on annual income; some households with variable income may earn too much to qualify for Medicaid in a month but be eligible for PTCs based on their annual income.

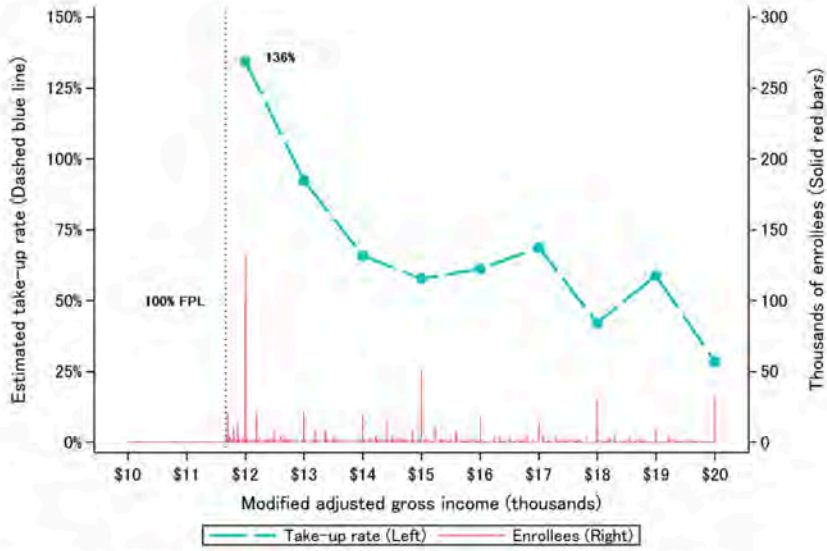



**FIGURE 3.** Actual and estimated potential marketplace enrollment by modified adjusted gross income for single-person households in Healthcare .gov, states that did not expand Medicaid, 2015. This figure shows the distribution of the actual incomes reported by single marketplace enrollees in states that did not expand Medicaid in 2015 (right axis) and their estimated take-up rates by income group (left axis). When calculating the ratio of actual and potential enrollment, modified adjusted gross income is rounded to the nearest $1,000. Sources: Healthcare.gov and authors' calculations.

As shown in Table 1, take-up of marketplace insurance is decreasing in income, even after treating some people in the coverage gap as potential enrollees. Our model includes several explanatory variables consistent with this pattern. As expected, potential enrollees who face lower net premiums and have access to a premium-free bronze plan enroll at higher rates than others, while the income effect offsets these factors for lower-income potential enrollees. Cost-sharing reduction subsidies surely increase take-up for lower-income households as well and are captured by MAGIPOV category fixed effects and the average MAGIPOV variable. Similarly, the effect of being exempt from the individual mandate because of income, affordability, or membership in an exempt group is captured by income category and region fixed effects. In our sensitivity checks in the Online Appendix, we explore the robustness of our results to alternate specifications of income-related variables.

### C. GENDER

Much of the gap in take-up between women and men shown in Table 1 can be explained by factors in our model (particularly age and income), but an unexplained gap remains of

between 6.1 and 9.7 percentage points depending on age. Age differences between female and male potential enrollees account for much of the 11 percentage point gender difference in overall take-up rates. As shown in Figure 4—which displays the marginal effect of age and gender on take-up—predicted take-up rates are strongly increasing in age; for example, the predicted difference in take-up between 20- to 34-year-old and 55- to 64-year-old males is 33.4 percentage points. The stark gradient in take-up rates and price elasticities by age (see Tables 1 and 5) is at least partly explained by the fact that older individuals tend to have higher health spending but do not face commensurately higher prices (Orsini and Tebaldi 2017). Since female potential enrollees tend to be older than male potential enrollees (see Tables 2 and 3), age accounts for much of the overall difference in take-up rates between women and men. Income differences between female and male potential enrollees also contribute to the gender gap in take-up rates. As shown in Tables 2 and 3, female potential enrollees tended to have lower MAGIPOV than men.

## VI. Sensitivity Analyses

In this section, we discuss the sensitivity analyses we conducted regarding how we define effective eligibility for PTCs for those with income below 100 percent FPL and the potential bias from omitted variables like the healthiness of potential enrollees or concentration of local health-care markets.

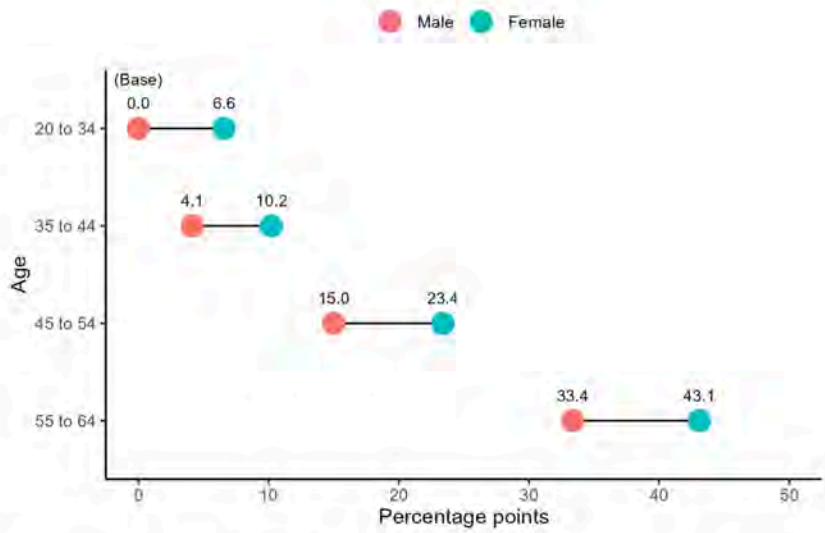



**FIGURE 4.** Difference in predicted marketplace take-up by age and gender category. Differences are calculated relative to 20- to 34-year-old males using the average age in each age and gender category. Sources: Healthcare.gov, the 2013–17 American Community Survey, and authors' calculations.

### A. EFFECTIVE ELIGIBILITY FOR PTCS BELOW 100 PERCENT FPL

We explored two alternative approaches to handling the large number of enrollees who reported income just above 100 percent FPL in the marketplace enrollment data. In our first alternative approach, we instead estimated the linear probability model excluding everyone with income below 100 percent FPL in the ACS from our counts of potential enrollees (rather than our preferred approach of excluding those with MAGI less than 80 percent FPL). This approach increased estimated take-up rates for the cells in our sample with income below 138 percent FPL and left all cells for the higher income categories unchanged. This increase in the take-up rate for all cells in the lowest income group resulted in higher overall net price elasticities (−0.33, 95 percent CI [−0.39, −0.27]; see Online Appendix Table B3).

Our second approach was to exclude all actual and potential enrollees with income below 105 percent FPL from our sample since most of the excess enrollment in the marketplace enrollment data appeared to be people reporting income between 100 and 105 percent FPL. This approach requires us to throw out information in the ACS and marketplace enrollment data but spares us from having to decide how many households with income below 100 percent in the ACS were effectively eligible for PTCs. The overall net price elasticity from this approach (−0.30, 95 percent CI [−0.36, −0.24]) was lower than the estimate using a 100 percent FPL cutoff, confirming that it is important to account for the large number of enrollees who reported income just above 100 percent FPL in the marketplace enrollment data.

### B. OMITTED VARIABLES BIAS

Omitted variables like the health of potential enrollees or the concentration of local healthcare markets that are correlated with gross premiums and take-up rates might bias our premium elasticity towards zero in a model with state fixed effects. As discussed, we included region fixed effects in our main model to address that possibility. We are not unduly concerned about omitted variable bias, however, because our analysis excludes people with MAGI above 400 percent FPL. Thus about 85 percent of our potential enrollees could receive subsidies, which means they would not face the gross premium and would have paid nearly the same amount in net premiums for a SLCS or bronze plan even if gross premiums were to change marginally. Furthermore, the ACA's risk adjustment program reduces the incentive for insurers to increase premiums in areas with less healthy potential enrollees.

Consistent with this argument, we estimate similar or larger elasticities when we include state fixed effects rather than region fixed effects with alternative methods for controlling for the healthiness of potential enrollees (see Online Appendix Table B4). In these models, we include three additional variables that may be correlated with both price and demand across regions: the share of potential enrollees in the ACS in 2013 who were enrolled in nongroup insurance prior to the creation of the marketplaces, the share exempt from the individual mandate penalty, and the share living in a rural area.[25] With state fixed effects and these additional variables, the estimated elasticity was slightly higher (−0.24, 95 percent CI [−0.29, −0.19]). We then estimated the model with state fixed effects and two sample

25 This variable was created based on county-level data from the 2010 census rural-urban classification.

restrictions that further decreased the share of potential enrollees affected by regional variation in SLCS premiums. First, we excluded those with MAGIPOV above 350 percent FPL because many unsubsidized potential enrollees had MAGIPOV above this level, and the coefficient on net premiums increased slightly further (−0.27, 95 percent CI [−0.32, −0.21]), consistent with the finding that lower-income people are more price sensitive. Second, we excluded people between the ages of 20 and 34 with income above 250 percent FPL because they are more likely to be unsubsidized, and the coefficient on net premiums decreased (−0.15, 95 percent CI [−0.22, −0.08]), perhaps because young potential enrollees are very price sensitive (see Table 5).

## VII. Discussion of Results

Our study makes three important contributions to the literature on the ACA marketplaces. First, we provide the first estimates of price elasticities based on administrative data from states with FFMs, which accounted for three-quarters of all marketplace enrollment. Our estimates suggest that price elasticities may be lower in these states than others like California that expanded access to Medicaid and pursued policies, like plan standardization, that may have increased price sensitivity. Second, we present evidence suggesting that many people in the coverage gap in non-expansion states obtain subsidies by reporting income just above the FPL at the time of enrollment, especially in Florida. Third, we show that more men are eligible for marketplace subsidies than women but that women take up marketplace insurance at higher rates, and that this difference occurs among both younger and older adults. Observable factors related to both gender and marketplace rules explain only some of the difference.

### A. ELASTICITY ESTIMATES

Our net and gross price elasticity estimates can be used for evaluating different types of policies and models. Net price elasticities are useful for evaluating policies that induce across-the-board changes in out-of-pocket premiums, such as a change in the expected contribution that subsidized enrollees pay, and for validating structural microsimulation models of health insurance coverage, such as the Congressional Budget Office's HISIM2 model or the Urban Institute's HIPSIM model, complementing other published estimates. Gross price elasticities are useful for evaluating the effect of policies that induce across-the-board changes in gross premiums, such as mandating coverage of a new benefit.

To demonstrate how our net price elasticities estimates might be applied, we roughly estimated how marketplace enrollment would have increased in FFM states if the expected contribution rates in the American Rescue Plan Act of 2021 had applied in 2017.[26] According to the Centers for Medicare and Medicaid Services, there were 7.2 million full-year-equivalent enrollees in FFM states in 2017, of whom 6.2 million received an advanced PTC. Using the ACS, we estimate that net premiums per enrollee would have decreased

26 The American Rescue Plan Act temporarily made people with income above 400 percent FPL newly eligible for PTCs and increased PTCs for people with income below 400 percent FPL by decreasing expected contributions (and removing the adjustment to that contribution that happens over time).

by an average of 52.6 percent for potential enrollees who could have received a PTC in 2017 and by 18.7 percent for people who could not have received a PTC but would be eligible under the policy (including those with income above 400 percent FPL). The share of potential enrollees who could have received a PTC who were eligible for a premium-free bronze plan would have increased by 100.7 percent. Our estimates imply that total enrollment would have been 1.1 million (15.3 percent) higher in 2017 under these net prices and rates of access to premium-free plans.[27] Roughly 0.7 million (10.3 percent) of this coverage estimate is attributable to price decreases and the remaining 0.4 million (5.0 percent) to increased access to premium-free bronze plans.

This coverage estimate is lower than comprehensive, published estimates of the effect of the American Rescue Plan Act on marketplace enrollment (2.3 million in 2022 estimated by the Congressional Budget Office) because (1) it applies to a subset of the market, (2) it does not consider other policies in the act (which increased coverage), and (3) it does not account for employer responses to the act (CBO 2022). First, the Congressional Budget Office's estimate is national while ours is limited to FFM states (which accounted for 73.7 percent of marketplace enrollment in 2017). Second, the act did more than increase subsidies; it also made many people eligible for premium-free silver plans—which did not exist in 2017 and which are more attractive than premium-free bronze plans because they have higher actuarial values—and established a year-round special enrollment period for people with income below 150 percent FPL. Third, the increase in subsidies was large enough that some employers would no longer have found it necessary to offer health insurance to attract and retain employees.

Because our estimates are based on data from 2015 to 2017 and the marketplace has since changed in meaningful ways, there are limitations to how the results can be applied. Listed below are but a few of the many changes: Insurer participation has increased; more states have expanded Medicaid and/or become state-based marketplaces; federal funding for cost-sharing reductions were cut, resulting in "silver loading"; access to premium-free silver plans has increased; a new class of "extended bronze" plans has entered the markets; standardized plans have been introduced in 2017, rescinded in 2019, and reintroduced in 2023; and federal spending on advertising and outreach has fluctuated substantially. Depending on the context in which our elasticity estimates are being applied, policy analysts must consider these factors and others.

### B. TAKE-UP AMONG PEOPLE IN THE COVERAGE GAP

We show that some people in the coverage gap were nevertheless able to obtain subsidized marketplace coverage. 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 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. People without other options for

27 Our estimates imply a take-up elasticity of 0.08 with respect to access to premium-free bronze plans.

affordable coverage have a strong incentive to estimate that their income will exceed the FPL and receive advanced PTCs, knowing they would not have to repay those subsidies if it doesn't. That incentive to overestimate income has increased as people with income near the FPL have become eligible for larger subsidies (owing to the temporary reductions in expected contributions currently in place). Moreover, in 2021, income verification requirements for low-income marketplace enrollees were loosened such that enrollees are no longer required to provide further income verification if administrative sources suggest that their income is below the FPL.

### C. WOMEN'S ENROLLMENT

Our analysis shows that there are more women enrolled in the marketplaces than men because subsidy-eligible women take up marketplace insurance at a relatively higher rate than their male counterparts, not because more women are eligible for subsidies than men. We find that subsidy-eligible women are more likely to take up marketplace coverage than men even when controlling for income, age, and many additional factors that affect take-up rates.

Women may be more likely to take up marketplace coverage than men because they face higher expected health-care costs but do not pay higher premiums (Yamamoto 2013). Prior to the ACA, women were typically charged higher rates than men, but in the marketplace insurers are not permitted to charge women and men different premiums.[28] Discussions of this rationale tend to focus on the substantial costs of childbirth, including prenatal, delivery and postnatal care, and reproductive health more generally (Rae et al. 2022) and the inclusion of maternity and newborn care as an essential health benefit that must be included in all marketplace plans. Researchers have found that the ACA increased coverage among women and expanded access to care, access to contraception, preventive care, and pregnancy-related care, and improved perinatal outcomes for women (Lee et al. 2020). Our estimate of the effect of childbirth on take-up rates is consistent with these findings.

However, we find that the differential in take-up rates by gender does not wane at older ages. Differences in health-care spending do not explain the gap at older ages; depending on the source of the data, health-care spending by men approaches that of women after age 45 and exceeds it at some point just below or above age 60 (Yamamoto 2013). At older ages, marketplace plans may be more attractive to women than to men because of the preventive care services that must be covered without cost-sharing under ACA rules (Skopec and Banthin 2022). Preventive care services recommended for adult women beyond childbearing age include some costly cancer screenings such as mammograms. Mammograms may start as early as age 40 based on doctors' recommendations and are recommended annually for women aged 50 and older. Preventive care guidelines for men include many screenings

28 According to the National Women's Law Center (2012), in states that did not ban gender rating, women were often charged substantially more than men of the same age. They find that, even with maternity coverage excluded, nearly a third of the plans they examined charged 25- to 40-year-old women at least 30 percent more than men for the same coverage. As of 2012, 14 states had taken steps to ban or limit gender rating in the individual market (Garrett 2012).

but only colorectal cancer screening is a particularly expensive service.[29] Mammograms can be expensive procedures when digital technology is used. So, if a woman between age 45 and 64 intends to follow recommendations and get an annual mammogram, coverage for this benefit may raise the value of insurance.

In the decade or so since the Affordable Care Act first changed the market for nongroup insurance, the market has matured and stabilized. Insurers are earning profits, participating at rates sufficient to allow enrollees a choice of plans in almost all rating areas, and many enrollees are consistently reenrolling in the following year. Even if there weren't interest in future changes to policy affecting the nongroup market, the pending expiration of the extended and enhanced PTCs and the end of the continuous eligibility provisions for Medicaid will cause a shift in marketplace enrollment. The analyses in this paper will help inform how potential enrollees will respond to future changes.

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# Over 24 Million Consumers Selected Affordable Health Coverage in ACA Marketplace for 2025

Affordable Care Act Marketplace

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*ACA Marketplace National Enrollment Snapshot*

The Centers for Medicare & Medicaid Services (CMS) is committed to a robust Marketplace Open Enrollment process for consumers so they can effortlessly purchase quality, affordable health care coverage. CMS reports that 24.2 million[1] consumers selected plan year 2025 coverage through the Marketplaces during the 2025 Marketplace Open Enrollment Period, including 3.9 million new consumers. That represents more than double the number of enrollees compared to the 2021 Open Enrollment Period.

“The number of people signing up for Marketplace coverage has surpassed 24 million, an all-time high, breaking last year’s record. I’m proud of the work done by the Biden-Harris Administration and the U.S Department of Health and Human Services over the past four years to help more people access quality, affordable health care and bring down the uninsured rate,” said Health and Human Services (HHS) Secretary Xavier Becerra. “Since the law was enacted, 50 million people — or one in seven Americans — have signed up for coverage through the Marketplace. Now, Congress must do its job so those millions of Americans remain covered. The tax credit that has helped people purchase coverage will expire at the end of 2025 unless Congress makes it permanent or extends it.

Congressional inaction would result in costs going up. More than five million people could lose their coverage entirely, and millions of other hard-working Americans could face premium increases of more than 50%. The Affordable Care Act belongs to the American people. Let's keep it that way."

"The record-breaking success of this year's Marketplace Open Enrollment speaks volumes about the Affordable Care Act's past, present, and future serving the American people by connecting our communities to high-quality, person-centered, affordable health care coverage. That priority can and should continue to generate broad, bipartisan support, as it has under the Biden-Harris Administration," said CMS Administrator Chiquita Brooks-LaSure.

CMS Administrator Brooks-LaSure added: "This record-breaking enrollment is also a testament to the importance of the enhanced financial assistance available through 2025. This additional help has made all the difference for people seeking affordable insurance. For example, a young professional just starting out making $30,000 a year would have previously been expected to contribute around $165 per month but can now pay no more than $50 per month, with even cheaper plans available. Just a little extra help can mean less financial stress for millions of enrollees across the country."

Thanks to the Biden-Harris Administration, consumers had greater plan choices for 2025, as well as other important supports. The Inflation Reduction Act of 2022, for example, means many middle-income people and families who were previously ineligible for financial assistance have access to lower premiums after tax credits, and many modest-income Americans now have more help paying for premiums. Because of the enhanced and expanded tax credits, four out of five HealthCare.gov consumers could find a plan for $10 or less per month. The enhanced tax credits remain available through 2025 but are set to expire in 2026 without Congressional action.

Marketplace Open Enrollment on HealthCare.gov ran through January 15. Consumers who enrolled by midnight local time on January 15 got coverage that will start February 1, 2025. State-based Marketplace enrollment deadlines vary. State-specific deadlines and other information are available in the State-based Marketplace Open Enrollment Fact Sheet.

**Marketplace Enrollment Snapshot Overview:**

| Marketplace and Consumer Type | Cumulative 2025 OEP Plan Selections |
|---|---|
| **Total: All Marketplace Plans** | 24,166,491 |
| **New Consumers** | 3,938,907 |
| **Returning Consumers[2]** | 20,227,584 |
| Total: HealthCare.gov Marketplace Plans | 17,128,890 |
| New Consumers | 2,841,205 |
| Returning Consumers | 14,287,685 |
| Total: State-based Marketplace (SBM) [3] Plans | 7,037,601 |
| New Consumers | 1,097,702 |
| Returning Consumers | 5,939,899 |

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[1] These metrics reflect available data through January 15, 2025 for Federally Facilitated Marketplaces (FFMs) and State-based Marketplaces on the federal platform (SBM-FP), and through January 11, 2025 for State-based Marketplaces (SBMs), except for some SBMs. The following SBMs report data through the end of their OEPs: Georgia (January 15, 2025), Idaho (October 15, 2024 to December 16, 2024), Kentucky (January 16, 2025), Maryland (January 15, 2025), Minnesota (January 15, 2025), New Mexico (January 15, 2025), Pennsylvania (January 15, 2025), Vermont (January 15, 2025), and Washington (January 15, 2025). Rhode Island reports data through December 7, 2024. As of the snapshot's reporting deadline, the remaining SBMs had not finalized their end of OEP data or remained open.

[2] The "returning-consumers" metric in this report includes consumers who have returned to their respective Marketplaces through the reporting date and selected a plan, and consumers who have been automatically re-enrolled for 2025 coverage based on their 2024 enrollment or a suggested alternative plan.

[3] In addition to reported Qualified Health Plan (QHP) selections, Minnesota and Oregon have a Basic Health Program (BHP), which provides coverage to consumers with household incomes at or below 200% and above 133% of the federal poverty level (FPL), who are not eligible for Medicaid or CHIP, and otherwise would be eligible for a QHP. New York has also implemented a new coverage program, the Essential Plan (EP) Expansion, under a section 1332 waiver. The EP Expansion generally mirrors the state's previously utilized BHP with expanded eligibility for certain residents with estimated household incomes up to 250% of the FPL. See https://www.cms.gov/files/document/ny-1332-amendment-fact-sheet.pdf for more information about New York's EP Expansion. As of January 11, 2025, Oregon had 32,239 individuals enroll in a BHP, and New York had 1,641,960 individuals enroll in the EP Expansion under the state's approved section 1332 waiver program. Minnesota's BHP data was not available at the time of this report.

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# Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment†

*By* Mark Shepard and Myles Wagner*

*Are application hassles, or "ordeals," an effective way to limit public program enrollment? We provide new evidence by studying (removal of) an auto-enrollment policy for health insurance, adding an extra step to enroll. This minor ordeal has a major impact, reducing enrollment by 33 percent and differentially excluding young, healthy, and economically disadvantaged people. Using a simple model, we show adverse selection—a classic feature of insurance markets—undermines ordeals' standard rationale of excluding low-value individuals since they are also low-cost and may not be inefficient. Our analysis illustrates why ordeals targeting is unlikely to work well in selection markets.* (*JEL* D82, G22, H75, I13, I18)

Should enrolling in public programs be easy or hard? The desirability of enrollment hassles, or "ordeals," for social programs is a classic—and controversial—question in public economics. On the one hand, there is substantial concern about incomplete take-up of programs intended to help the poor (Currie 2006). A growing body of work argues that the bureaucracy, paperwork, and "administrative burden" of enrollment is a major driver of low take-up and source of frustration with and mistrust of government (Herd and Moynihan 2018).

On the other hand, a classic line of thinking in economics argues that ordeals can be useful ways to *target* assistance toward those who need or value it most (Nichols and Zeckhauser 1982; Besley and Coate 1992). The basic idea follows from the

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logic of revealed preference. Ordeals work like a nonfinancial "price" of enrolling, and as in standard markets, prices screen out people with low value (demand) for a program. By excluding low-value types, the government saves money and can redirect aid toward those who need it most. This influential "self-targeting" idea has spawned an active empirical debate, with some research finding that it holds in practice (Alatas et al. 2016; Dupas et al. 2016), while other work argues that behavioral frictions may undermine its validity (Bhargava and Manoli 2015; Finkelstein and Notowidigdo 2019; Deshpande and Li 2019). Importantly, the debate has been framed almost entirely around the self-targeting question: Do ordeals effectively screen out *low-value* or *low-need* types in a given setting?

In this paper, we ask whether this is the right way to think about targeting in programs where people vary not just in value or need but also in their *costs*. We observe that many programs—and especially insurance programs—share a key feature of "selection markets" that have been widely studied in the economics literature (Einav, Finkelstein, and Mahoney 2021). In these settings, enrollee costs vary substantially and tend to be *correlated* with value, often because both are driven by the same underlying factor, like risk. For instance, in our health insurance data, the highest-risk (sickest) 10 percent of enrollees incur 15 *times* higher medical costs than the healthiest 10 percent (about $1,400 versus $90 per month). Moreover, the healthy are likely to value insurance less, precisely because they have fewer medical needs and use less care. This example illustrates the key correlation in settings with adverse selection: low-value types also tend to be low-cost.

Our paper's central conceptual point is that adverse selection tends to weaken, and when strong enough undermine, the classic self-targeting case for ordeals. When low-value enrollees are also low-cost, excluding them may yield minimal, or even negative, targeting gains. The key question in selection markets is not whether ordeals screen on value, but whether they screen *more strongly* on social value than on costs. This question is theoretically ambiguous and does not follow from the standard revealed preference logic for ordeals.

We formalize this argument with a mix of theory and evidence from a public health insurance program. We use a natural experiment to study descriptively *how much* ordeals matter for take-up and which types of people they screen out. We find that even minor hassles lead to major reductions in take-up among an otherwise uninsured low-income population. Consistent with adverse selection, the excluded group is differentially younger, healthier, and poorer, suggesting ordeals screen out people with low private value (demand) but also low cost of insurance.[1] Using an empirical model estimated with our data, we find that ordeals worsen targeting efficiency, despite successfully screening out low-value types. More generally, we show that adverse selection works alongside behavioral frictions to weaken the (revealed preference) link between demand and efficiency that is key to self-targeting. This makes ordeals relatively poorly suited tools for adverse selection markets.

We begin the paper (in Section I) with a general framework to formalize these ideas about ordeals targeting in selection markets. Ordeals improve welfare if they yield "gains from targeting"—the ability to include efficient (*social value* $>$ *cost*)

[1] This also aligns with the groups most likely to be among the 28 million uninsured in the United States today (Tolbert et al. 2024).

and exclude inefficient (*social value* $<$ *cost*) types—sufficient to outweigh any direct losses from their hassle or administrative costs. We show that targeting gains can be visualized in simple supply/demand-like graphs of marginal value/cost versus quantity enrolled as ordeals vary, analogous to the approach of Einav, Finkelstein, and Cullen (2010) for visualizing welfare in selection markets. As in their graphs, adverse selection implies that the "marginal cost" curve is not flat (as in a nonselection market) but *slopes downward* alongside marginal value, reflecting the positive value-cost correlation driven by enrollee risk. This shrinks the gains from targeting, reflected in a smaller area between marginal value and cost curves above and below their intersection.

We formalize this reduction in what we call the "adverse selection tax," which equals the coefficient in a regression of enrollee (net) cost on social value, or $\hat{\beta} = \text{cov}\left[C_i^{Net}, V_i^{Soc}\right]/\text{var}\left[V_i^{Soc}\right] = \rho \cdot \sigma_C/\sigma_V$.[2] When adverse selection is sufficiently strong (roughly, when $\hat{\beta} > 1$), the marginal cost curve becomes steeper than marginal value, and ordeals induce "*backward sorting*" into insurance even when they correctly sort on value. This idea—analogous to the insights of Marone and Sabety (2022) for menu design and sorting with prices—shows the limits of choice and self-targeting mechanisms in adverse selection markets where demand and efficiency are often misaligned.[3]

In addition, we show a second reason adverse selection tends to undermine ordeals: it makes it more likely that the optimal outcome is *universal*—enrolling or excluding everyone—rather than targeted. We call this second idea "*optimal universality*." Graphically, it occurs when the marginal value ($MV$) curve lies entirely above or below marginal costs ($MC$), so the two do not intersect. This is more likely when both $MV$ and $MC$ have a similar downward slope because value and cost are strongly correlated. For instance, consider a case where social value and net enrollee cost align perfectly: $V_i^{Soc} = \delta \cdot C_i^{Net}$. In this case, net welfare ($= V_i^{Soc} - C_i^{Net}$) equals $(\delta - 1)\, C_i^{Net}$ for all $i$, which is uniformly positive or negative depending on $\delta \gtrless 1$. This example illustrates the key idea of optimal universality: a strong value-cost correlation makes it more likely that targeting using ordeals is counterproductive because universal outcomes are superior.

Having developed this framework, we next turn to an empirical analysis of ordeals that lets us both estimate the key model parameters and also learn descriptively about ordeals' impact for health insurance programs. Our empirical setting is the Massachusetts health insurance exchange, a program offering subsidized insurance to low-income people without access to other coverage.[4] The program featured a

[2] Here, $\rho = \text{corr}\left[C_i^{Net}, V_i^{Soc}\right]$, $\sigma_C = \text{std}\left(C_i^{Net}\right)$, and $\sigma_V = \text{std}\left(V_i^{Soc}\right)$, all evaluated across potential enrollees ($i$). See Section I for the formal definition of social value and net public cost (which is net of fiscal externalities). The adverse selection tax is zero if enrollee costs do not vary ($\sigma_C = 0$) or are uncorrelated with value ($\rho = 0$), and it grows as both of these increase relative to the variation in value.

[3] Conversely, *advantageous* selection—where low-value types have high costs—strengthens the case for ordeals targeting. Because advantageous selection is less common, we do not discuss it in detail. Two settings where it has been found are long-term care insurance (Finkelstein and McGarry 2006) and Medicare supplemental coverage ("medigap") (Fang, Keane, and Silverman 2008).

[4] We study the pre-Obamacare (or ACA) exchange, which operated from 2007 to 2013 and was called Commonwealth Care (or "CommCare"). As a model for the ACA exchanges that followed, CommCare has been a rich source of evidence on demand, competition, and the impact of policies in health insurance markets (see Chandra, Gruber, and McKnight 2011, 2014; Finkelstein, Hendren, and Shepard 2019; Jaffe and Shepard 2020; McIntyre, Shepard, and Wagner 2021; Shepard 2022; Shepard and Forsgren 2023).

unique source of variation in the complexity of enrollment, driven by changing use of an auto-enrollment policy for the program's poorest individuals, who qualified for free insurance. Prior to 2010, the program required only that these individuals *apply* for coverage, submitting paperwork with information to verify eligibility. Approved applicants were then contacted and asked to choose among several plans offered by different insurers (all of which were free). But if they failed to respond—something that occurred surprisingly often—the program *auto-enrolled* them into a plan using a simple algorithm. In essence, this policy used defaults or "choice architecture" (Thaler 2018) to streamline take-up and prevent people from falling through the cracks of the system.

Starting in 2010, the program suspended auto-enrollment. Nonresponsive, or "passive," individuals were no longer enrolled by default; instead, their default became *non-enrollment*. Effectively, this change added an extra step (active plan choice) to the required take-up process. Although not intended to be onerous—people could choose by phone, mail, or online, and all plans remained free—this change is an example of the type of small take-up friction that is common in many US safety net programs.

We use this variation to estimate the causal effect of the ordeal by studying enrollment changes around the 2010 policy shift. We use a difference-in-difference design, comparing changes in new enrollment for the low-income (treatment) group for whom auto-enrollment stops in 2010 versus a slightly higher-income (control) group for whom it was not used throughout. Our rich administrative data let us observe who enrolled actively versus passively prior to 2010, and we can also infer the characteristics of marginal enrollees from compositional changes in enrollment around 2010.

This analysis yields two main findings. First, adding a minor ordeal leads to major reductions in health insurance take-up. Prior to 2010, one-third of low-income new enrollees join the exchange passively via auto-enrollment. When the policy is suspended in 2010, the flow of new enrollment falls by a nearly identical 33 percent. The decline is immediate and persistent, with parallel pre-trends and no concurrent changes for the control group.[5] We also see no evidence of an uptick in active enrollment in 2010, suggesting that passive individuals are unlikely to be deliberately choosing nonresponse (e.g., because they know they will be auto-enrolled). Rather, when subjected to a small hassle, about one-third of eligible individuals simply fail to take up health insurance.

This effect is quite large. For instance, it is similar to the impact of a $470 (or 57 percent) annual premium increase based on prior evidence (Finkelstein, Hendren, and Shepard 2019) and 1.25–2 times larger than the impact of Massachusetts's uninsurance penalty (Chandra, Gruber, and McKnight 2011). It is an order of magnitude larger than the 1–4 percentage point effects observed from lower-touch "nudges" (like outreach and assistance) in recent work on health insurance (Goldin, Lurie, and McCubbin 2021; Domurat, Menashe, and Yin 2021; Ericson et al. 2023). The

[5] Further evidence comes from a temporary reinstatement of the auto-enrollment policy in late 2010. Consistent with the policy having a causal effect, we find that new enrollment spikes back up to its pre-2010 level, then falls back down when auto-enrollment is again suspended in early 2011.

findings suggest that *fully automatic* enrollment—not just incremental incentives and nudges—may be a key step to further reduce uninsurance in the United States.

Our second descriptive finding is that ordeals differentially screen out low-risk individuals, consistent with adverse selection. Relative to active enrollees, passive enrollees are younger and healthier (e.g., 33 percent less likely to be chronically ill) and especially likely to be young men age 19–34. They incur 44 percent lower medical spending per month—most of which (a 36 percent gap) is predictable by their age and diagnosis risk factors. Because of their lower costs, excluding passive enrollees results in a 15 percent higher average-cost risk pool of enrollees.

We also examine the distributional equity implications of ordeals. We find that passive enrollees are more likely to be very low income, to live in disadvantaged neighborhoods, and to live near safety net hospitals and clinics. This is consistent with ordeals differentially impacting the poor (Bertrand, Mullainathan, and Shafir 2004; Mullainathan and Shafir 2013). But it is also consistent with evidence that the poor have lower *demand* for health insurance, potentially because of access to charity care when uninsured (Finkelstein, Hendren, and Luttmer 2019).

Why does a seemingly small hassle matter so much for enrollment? This fact is striking because the benefits of forgone health insurance are likely meaningful.[6] Our evidence is most consistent with behavioral frictions like inattention, forgetting to act, or simply "going with the flow" in insurance choices.[7] We examine but find little evidence of other explanations, including stigma or unawareness of the program (since everyone in our sample has already applied for coverage), "choice overload" that leads to passivity (Iyengar and Kamenica 2010), or passive enrollees already having another form of duplicate insurance.[8]

The final portion of our paper applies the ordeals welfare framework to our setting using the auto-enrollment natural experiment. We specify a rich model allowing for the key features of insurance problem, including heterogeneity in enrollee value (demand), insurer cost (based on medical claims data), and externalities of insurance via savings on uncompensated care. The key empirical challenge—common to most analyses of ordeals—is to infer enrollee value of insurance, given the nonprice nature of the take-up barrier. We address this challenge by estimating demand among a higher-income segment of exchange enrollees who face positive prices, drawing on RD-style premium variation used in prior work (Finkelstein, Hendren, and Shepard 2019). We then project these demand estimates onto the lower-income population at the level of key observables (cells of age, sex, and medical risk scores). We consider various assumptions for the role of unobserved preferences, as well as alternate methods of estimating value directly from observed medical use in our claims data.

[6] Passive enrollees (while healthier than average) do use significant medical care and experience medical shocks. Based on our model estimates and prior work on the value of health insurance (Finkelstein, Hendren, and Luttmer 2019), coverage should be worth about $550 to $1,300 for an average passive enrollee over a typical year-long spell. This is comparable to forgone benefits from failure to take up the EITC or SNAP (Bhargava and Manoli 2015; Finkelstein and Notowidigdo 2019).

[7] Consistent with these ideas, we find that passive nonresponse is more common among immigrants (who may face language barriers), people with signs of address instability, and people transitioning into the exchange from Medicaid (which may involve greater confusion because Medicaid's process is different).

[8] We test this using the state's All Payer Claims Database, where we can see the near universe of health insurance coverage. We see very low rates ($< 4$ percent) of duplicate enrollment in the exchange plus other coverage and no meaningful change in duplication rates around the end of auto-enrollment in 2010.

This exercise yields three main results. First, ordeals do screen out lower-value enrollees. In our baseline estimate, passive enrollees have a private (social) value of coverage that is 28 percent (34 percent) lower than active types. This finding, which is consistent with the classic ordeals rationale of self-targeting, is robust across a wide range of specifications we consider.

Second, adverse selection substantially reduces, or even reverses, the ordeal's targeting gains. Our estimates suggest substantial cost variation and a strong value-cost correlation that implies an "adverse selection tax" that is large and often exceeds 100 percent. Correspondingly, the value-cost *ratio* of passive enrollees is similar to or (in our main specification) higher than active enrollees, suggesting that ordeals induce counterproductive "backward sorting" into insurance. We also examine the robustness of this conclusion to varying distributional equity goals, by applying a social welfare weight $\mu > 1$ to enrollee welfare. We find that with even modest equity concerns ($\mu > 1.3$), it becomes optimal to enroll *both* active and passive individuals. The ordeal is still nonoptimal, but not because sorting is backward, rather because the optimal outcome is universal.

Finally, we use the model to compare auto-enrollment versus subsidies as ways of expanding take-up. We find that the two have similar targeting properties—both enroll a similar young, healthy, and low-cost population—but that auto-enrollment is much more cost-effective because it does not require new spending on inframarginal enrollees. We find that each extra $1 million in public spending covers 55–66 percent more people if used for auto-enrollment rather than subsidies.

*Related Literature.*—Our paper contributes to three main strands of literature. The first studies the nature of ordeals targeting for social programs. Starting from the classic analysis of Nichols and Zeckhauser (1982), the debate has centered around whether ordeals screen out people who value or benefit less from assistance (e.g., Alatas et al. 2016; Dupas et al. 2016; Finkelstein and Notowidigdo 2019) or who benefit just as much but have less ability to navigate a complex process (e.g., Bhargava and Manoli 2015; Deshpande and Li 2019; Homonoff and Somerville 2021). This debate is part of a broader literature asking when nonprice targeting is valuable in social programs (e.g., Kleven and Kopczuk 2011; Lieber and Lockwood 2019). We provide evidence in a new and important setting (health insurance) and highlight that the classic debate misses the key role of cost heterogeneity and adverse selection for this question.

Second, our paper contributes to work evaluating "nudges" to increase take-up of social programs, including health insurance (Goldin, Lurie, and McCubbin 2021; Domurat, Menashe, and Yin 2021; Banerjee et al. 2021; Ericson et al. 2023). Our results suggest a much larger impact of fully *removing* hassles by changing the default to auto-enrollment. This complements prior work on the large impact of auto-enrollment in other settings (e.g., Madrian and Shea 2001; Chetty et al. 2014),[9] as well as evidence that defaults create inertia in choosing *among* insurance plans

[9]Recent work on 401(k) pensions by Choukhmane (2021) finds that while auto-enrollment has a large *initial* impact on enrollment and savings, people who are not auto-enrolled largely catch up by saving more in the future. Unlike pensions, health insurance is a domain where failure to enroll can have immediate repercussions if an individual gets sick and incurs medical bills. This suggests auto-enrollment is likely to be a consequential policy for health insurance.

(Handel 2013; Ericson 2014; Polyakova 2016; Brot-Goldberg, Layton et al. 2023). Default effects are a key example of a broader set of "choice frictions" that have been shown to be prevalent in health insurance markets (Abaluck and Gruber 2011, 2023; Bhargava, Loewenstein, and Sydnor 2017). Our paper shows that defaults are also important policies for insurance take-up.

Finally, our paper contributes to the literature asking why uninsurance is so persistent in the United States. A large prior literature has analyzed the impact of financial prices and subsidies for incomplete take-up (Gruber 2008; Dague 2014; Frean, Gruber, and Sommers 2017; Finkelstein, Hendren, and Shepard 2019). We show that ordeals and hassles are also likely to be a key barrier, given the United States' fragmented and nonautomatic health insurance system. There is growing interest in the role of complexity, transaction costs, and "administrative burden" in shaping enrollment, with emerging evidence that this matters for Medicaid take-up (Aizer 2007; Arbogast, Chorniy, and Currie 2022; Wu and Meyer 2023) and for ACA health insurance marketplaces (Drake et al. 2023; McIntyre, Shepard, and Layton 2024). We show, likewise, that imposing even modest hassles leads to non-enrollment by a large share of people, especially the young, healthy, and poor, who are disproportionately uninsured today. Our results suggest that as long as take-up is voluntary, getting to universal coverage will likely require some form of auto-enrollment. They also illustrate the surprising power of a feasible form of auto-enrollment that has recently been considered or implemented in several states' ACA exchanges.[10]

*Outline of Paper.*—Section I presents a conceptual framework for ordeals targeting with adverse selection. Section II discusses the setting, the auto-enrollment policy, and our data. Section III shows our main results on enrollment impacts, and Section IV presents targeting results. Section V implements our empirical model using the auto-enrollment variation. Finally, Section VI concludes.

## I. Conceptual Model: Adverse Selection and Ordeals Targeting

In this section, we present a simple framework for the economics of ordeals in programs characterized by adverse selection, that is, where enrollee value and costs are positively correlated. Adverse selection is a classic feature of insurance, where individual risk (e.g., health status) is the primary driver of the value-cost correlation. But it is also relevant more generally for transfer programs with varying benefit amounts (e.g., by income or family size) since people who receive smaller benefits also cost less to the government. Our central point is that adverse selection reduces—and may even reverse—the efficiency of the standard ordeals rationale of screening out *low-value* types since low-value enrollees may not be *inefficient* enrollees.

This section formalizes this argument using a simple model based on the classic insights of Nichols and Zeckhauser (1982), as well as the more recent ordeals framework of Finkelstein and Notowidigdo (2019). Our key innovation is to connect ordeals to the economics of selection markets, visualized using the graphical

[10]This includes Massachusetts, which reinstated a similar form of auto-enrollment in April 2022, partly based on discussions with them about this research.

framework of Einav, Finkelstein, and Cullen (2010). Our analysis also connects to recent insights about "backward sorting" in selection markets (Marone and Sabety 2022), in which prices also lead to inefficient sorting between insurance options.

### A. *Model Setup*

Consider a population of individuals who qualify for a public program—in our setting, free health insurance—but have not yet enrolled. For each individual $i$, the program generates social value of

$$V_i^{Soc} = \mu_i W_i + E_i, \tag{1}$$

where $W_i$ is the program's private welfare to enrollee $i$ (willingness to pay, or WTP), $\mu_i$ is the marginal social welfare weight on individual $i$ (capturing distributional equity concerns), and $E_i$ is the social value of any externalities from $i$'s participation in the program. A Kaldor-Hicks efficiency welfare criterion would involve $\mu_i = 1$ for all $i$, but it may be natural to think of $\mu_i > 1$ for safety net programs where beneficiaries are lower income. For our empirical work, we simplify by treating $\mu_i$ as a constant $\mu$ for everyone who qualifies for the program, but in principle, $\mu_i$ could vary across eligible groups to capture distributional goals.

For individual $i$, the program involves net government cost $C_i^{Net} = C_i - FE_i$, which equals direct costs $(C_i)$ minus any offsetting fiscal externalities $(FE_i)$.[11] We assume $C_i^{Net} > 0$ so that there is a real fiscal trade-off of expanding enrollment. Both social value and cost may vary across individuals, potentially creating a rationale for targeting.

The government seeks to target enrollment to maximize total social benefits net of costs. Mathematically, if $A_i \in \{0, 1\}$ indicates whether $i$ is enrolled, the government seeks to maximize net social welfare, or $SW = \sum_i \left(V_i^{Soc} - C_i^{Net}\right) \cdot A_i$. We define $\gamma_i$ as the net contribution to social welfare of enrolling individual $i$:

$$\text{(Net Welfare)} \quad \gamma_i = V_i^{Soc} - C_i^{Net} = \left(\mu_i W_i + E_i\right) - C_i^{Net}. \tag{2}$$

If the government had full information, it would optimally enroll everyone for whom $\gamma_i \geq 0$ and exclude those with $\gamma_i < 0$. Equivalently, if we define $R_i \equiv V_i^{Soc}/C_i^{Net}$ as the enrollee's "social value-cost ratio," the government optimally enrolls everyone with $R_i \geq 1$ and excludes those with $R_i < 1$.[12] The metric $\gamma_i$ is a useful targeting index that shows how a government would optimally prioritize enrollment with

[11] In our empirical setting we think of these variables as follows. $W_i > 0$ is the benefits of insurance to the individual; $C_i > 0$ is the government's direct subsidy cost for insuring them; and $E_i, FE_i \geq 0$ are savings on (uninsured) uncompensated care borne by private hospitals $(E_i)$ and the government $(FE_i)$. The nature of $C_i$ depends on how insurance is provided. We assume either direct public provision (relevant in programs like Medicaid) or zero-profit contracting with private insurers (which we find to be roughly true in the Massachusetts exchange), which implies that $C_i$ equals $i$'s expected insured medical costs.

[12] The social value-cost ratio is closely related to the marginal value of public funds (MVPF) metric (Hendren 2016), which is also a (policy-level) benefit-cost ratio.

full information. In practice, however, the government has limited information, so it must use blunt policies like ordeals, which we turn to next.

*Ordeals and Take-Up.*—The government has access to a screening mechanism—in our setting, an ordeal—that it uses to limit take-up. Ordeals work by imposing a "friction," $\eta_i \geq 0$, that individuals must overcome to enroll. The friction may vary across individuals and could involve both real costs (e.g., the time and effort of completing paperwork) and behavioral frictions that limit take-up (e.g., inattention). We assume the government can adjust the "intensity" of the ordeal through its policy choices (e.g., how much paperwork to impose). A simple specification that captures this idea is $\eta_i = \sigma \cdot h_i$, where $\sigma \geq 0$ is the ordeal's intensity (a policy choice) and $h_i \geq 0$ captures a person's experienced hassle cost per unit ordeal. The policy of no ordeal is equivalent to setting $\sigma = 0$.

In addition to the ordeal, people may have behavioral biases that affect demand, e.g., biased beliefs about their risk type (Spinnewijn 2017). We denote the bias by $\varepsilon_i$, and the utility governing take-up as $U_i \equiv W_i - \varepsilon_i$, where $\varepsilon_i > 0$ captures undervaluation and $\varepsilon_i < 0$ overvaluation. With the ordeal in place, people take up the program if

$$\text{(3)} \qquad \text{(Take-Up)} \qquad U_i = \underbrace{W_i}_{\text{True WTP}} - \underbrace{\varepsilon_i}_{\text{Bias}} \geq \underbrace{\sigma \cdot h_i}_{\text{Ordeal friction}}.$$

A comparison of the conditions for who should optimally enroll ($\gamma_i \geq 0 \Leftrightarrow \mu_i W_i + E_i - C_i^{Net} \geq 0$) versus actual take-up ($W_i - \varepsilon_i - \sigma h_i \geq 0$) shows that there may be both under- and overenrollment among differing groups. All else equal, underenrollment is more likely for disadvantaged groups (with high welfare weights, $\mu_i > 1$), for people with positive externalities ($E_i > 0$) or undervaluation bias ($\varepsilon_i > 0$), and for people with low cost ($C_i^{Net}$) relative to WTP. Overenrollment is more likely for the opposite cases. Imposing an ordeal improves targeting if it reduces overenrollment more than it exacerbates underenrollment, in a sense that we formalize below.[13]

We denote the share of people who enroll given an ordeal of intensity $\sigma$ as $D(\sigma) = \Pr(W_i - \varepsilon_i \geq \sigma h_i)$. The share excluded is $1 - D(\sigma)$. The ordeal splits potential enrollees into two groups. For any variable $X_i$ (e.g., value or cost), we denote averages for screened-in enrollees as $\bar{X}_1(\sigma) \equiv E[X_i | W_i - \varepsilon_i \geq \sigma h_i]$, and for excluded individuals as $\bar{X}_0(\sigma) \equiv E[X_i | W_i - \varepsilon_i < \sigma h_i]$.

[13] One way to understand misallocation is to define the "wedge" between optimal enrollment versus take-up utility (absent the ordeal) as

$$\text{(4)} \qquad \Delta_i \equiv \gamma_i - U_i = [(\mu_i - 1)W_i + E_i + \varepsilon_i] - C_i^{Net}.$$

In an ideal world, this take-up wedge would be zero, ensuring that people enrolled if and only if $\gamma_i \geq 0$. Imposing an ordeal works like a reduction in take-up utility, so it shifts the wedge from $\Delta_i$ to $(\Delta_i + \sigma h_i)$. This will tend to improve welfare if the distribution of $(\Delta_i + \sigma h_i)$ is closer to zero than the distribution of $\Delta_i$. This point is related to the result of Allcott et al. (2022) that "nudges" tend to improve welfare if they reduce the *variance* of net wedges between socially optimal and actual consumption of a good.

In addition to their impact on take-up, ordeals may impose "direct" or "excess" costs, including both hassle/psychological costs to enrollees and administrative costs to the government. The nature of these costs depends on the specifics of the ordeal and the model of behavior and welfare (Ericson 2020).[14] Rather than specify it in detail, we write the ordeal's total direct/excess cost as a general function, $L(\sigma) \geq 0$, which we assume is weakly positive. As we show below, direct costs are separable from the effect of ordeals on social welfare via *targeting* (who is enrolled versus excluded), which is our focus in this paper.

### B. *When Are Ordeals Optimal?*

We now lay out the general conditions under which an ordeal is desirable, which we relate to adverse selection in the next subsection. Consider an ordeal of strength $\sigma$ that generates enrollment $D(\sigma)$. Net social welfare under this policy is

$$SW_{Ordeal}(\sigma) = D(\sigma) \cdot \underbrace{\left[\bar{V}_1^{Soc}(\sigma) - \bar{C}_1^{Net}(\sigma)\right]}_{=\bar{\gamma}_1(\sigma)} - L(\sigma), \tag{5}$$

where $L(\sigma) \geq 0$ is the total direct cost of the ordeal via hassles and administrative costs. To be welfare improving, an ordeal must at least be superior to two trivial alternate policies:

- **Shutting down the program (no enrollment)**, which results in $SW_0 = 0$, and
- **Enrolling everyone (full enrollment)**, which results in $SW_1 = E[\gamma_i] \equiv \bar{\gamma}$.

Relative to these alternatives, the ordeal's extra social welfare is $\Delta SW_{Ordeal}(\sigma) = SW_{Ordeal}(\sigma) - \max\{0, \bar{\gamma}\}$, or:[15]

$$\Delta SW_{Ordeal}(\sigma) = \underbrace{\min\left\{D(\sigma)\,\bar{\gamma}_1, \left[1 - D(\sigma)\right] \cdot \left(-\bar{\gamma}_0\right)\right\}}_{\text{Gains from Targeting, } GT(\sigma)} - \underbrace{L(\sigma)}_{\text{Direct cost}}, \tag{6}$$

where we now suppress the dependence of $\bar{\gamma}_{0/1}(.)$ on $\sigma$ for conciseness. The first term in expression (6) is the ordeal's "gains from targeting," or $GT(\sigma)$. This captures how effectively the ordeal screens or "targets" enrollment to positive net-welfare individuals ($\gamma_i > 0$), relative to the alternatives of full exclusion and inclusion. We show below that $GT(\sigma)$ corresponds exactly to areas between (appropriately defined) marginal value and cost curves of an ordeal, allowing us to display these

[14] In the classic model, ordeals impose a "real" hassle cost on enrollee $i$ of $\sigma h_i$, which is identical to their impact on take-up behavior, but no costs on non-enrollees (who need not incur the hassle) or administrative costs for the government. Thus, in the classic setup, $L(\sigma) = D(\sigma) \cdot \sigma \bar{h}_1(\sigma)$. However, Ericson (2020) notes that policies like defaults may impact take-up through behavioral frictions like inattention that do not involve real welfare costs for (already-attentive) enrollees. Additionally, some barriers like stigma may impose psychological costs even on non-enrollees. The general $L(\sigma)$ allows our model to capture any of these cases.

[15] To derive this, we use the fact that $\bar{\gamma}$ is the welfare of the average enrollee in the full population, so for any $\sigma$, $\bar{\gamma} = D(\sigma) \cdot \bar{\gamma}_1(\sigma) + \left[1 - D(\sigma)\right] \cdot \bar{\gamma}_0(\sigma)$. Note that our analysis implicitly normalizes the size of the full population (enrollees plus non-enrollees) to be 1.0.

gains graphically. The second term, $L(\sigma)$, is the ordeal's total direct costs, which need not be incurred if the government simply excludes or includes everyone.

The key takeaway of this expression is that an ordeal is desirable only if it achieves positive gains from targeting large enough to exceed the ordeal's direct costs. Positive gains from targeting, in turn, requires that included groups be favorable (positive net welfare) and excluded groups be unfavorable (negative net welfare):

$$(7) \qquad \text{(Positive Gains from Targeting)} \qquad \bar{\gamma}_1(\sigma) > 0 > \bar{\gamma}_0(\sigma).$$

A necessary condition for (7) is that the ordeal induces "effective targeting" between included and excluded groups, or $\Delta\gamma \equiv \bar{\gamma}_1 - \bar{\gamma}_0 > 0$. We call the term $\Delta\gamma$ the "*targeting efficacy*." It is straightforward to show that $GT(\sigma) > 0$ only if $\Delta\gamma > 0$ and that $GT(\sigma)$ is an increasing function $\Delta\gamma$.[16]

There are two reasons the gains from targeting condition in (7) may fail, both of which, we will argue, become more likely with adverse selection. The two reasons are

- **Backward Sorting:** $\bar{\gamma}_1(\sigma) < 0 < \bar{\gamma}_0(\sigma)$. The ordeal sorts "backward" by including inefficient and excluding efficient enrollees. Note that this implies ineffective targeting, or $\Delta\gamma < 0$.
- **Optimal Universality:** Either $\bar{\gamma}_1, \bar{\gamma}_0 > 0$ or $\bar{\gamma}_1, \bar{\gamma}_0 < 0$. It is better to simply include or enroll everyone, rather than screening with the ordeal. Note that this may be true even if targeting is "effective" ($\Delta\gamma > 0$).

In our empirical work, we analyze these conditions for a *particular* ordeal (at a given intensity $\sigma$) since this is what we observe. Conceptually, with more variation, these conditions could be assessed *globally* across all $\sigma > 0$ for a given ordeal, which is what we depict in our graphs below.

*The Classic Ordeals Debate.*—How do these conditions for ordeal desirability relate to the classic ordeals debate? The classic rationale for ordeals going back to Nichols and Zeckhauser (1982) is that they result in "self-screening" or "self-targeting," in which people who highly value the program enroll, while low-value types drop out. Intuitively, hassle costs screen consumers just like prices in standard markets, with high-value consumers willing and low-value consumers unwilling to buy a good. In its classic formulation, self-screening is a statement about screening on private welfare, $W_i$. Under self-screening,

$$(8) \qquad \text{(Self-screening)} \qquad \Delta W \equiv \bar{W}_1 - \bar{W}_0 > 0.$$

[16] The gains from targeting from (6) yields

$$GT(\sigma) = D(\sigma)\big[1 - D(\sigma)\big] \cdot \Delta\gamma - K(\bar{\gamma}),$$

where $K(\bar{\gamma}) \equiv \max\Big\{\big[1 - D(\sigma)\big] \cdot \bar{\gamma}, -D(\sigma) \cdot \bar{\gamma}\Big\} \geq 0$ is a (nonnegative) correction that captures the fact that targeting is less desirable when a program's overall average welfare ($\bar{\gamma}$) is either very positive or very negative. Because the second term subtracts a nonnegative value, $GT(\sigma) > 0$ only if $\Delta\gamma > 0$.

In a model without behavioral biases ($\varepsilon_i = 0$) and homogeneous hassle costs ($h_i = \bar{h}\ \forall i$), self-screening must hold as a consequence of rational choice. The classic critiques of self-screening, therefore, focus on ways that biases or hassles may be larger for high-value types—in our notation, $\text{cov}[W_i, \varepsilon_i] > 0$ and/or $\text{cov}[W_i, h_i] > 0$. For instance, work on the "psychology of scarcity" argues that the poor, for whom social programs are especially valuable, may also experience the largest biases and hassle costs of overcoming ordeals (Bertrand, Mullainathan, and Shafir 2004; Mullainathan and Shafir 2013).[17]

Notice, however, that self-screening on *private* welfare ($W_i$) is not equivalent to favorable screening on *social value*, $V_i^{Soc} = \mu_i W_i + E_i$. This distinction is often missed in ordeals analyses that do not clearly delineate private versus social value. We say that an ordeal achieves favorable *social value sorting* if

$$\text{(9)} \qquad \text{(Social value sorting)} \qquad \Delta V^{Soc} \equiv \bar{V}_1^{Soc} - \bar{V}_0^{Soc} > 0.$$

In addition to the ways self-screening can fail, social value sorting can fail if ordeals differentially exclude people with high-welfare weights ($\mu_i$) or with large positive externalities ($E_i$). This is likewise consistent with the "psychology of scarcity" ideas if ordeals differentially screen out poorer individuals (for whom $\mu_i$ is larger in standard welfare functions).

However, we emphasize that the right metric of targeting is not private welfare or even social value but net social welfare, $\gamma_i = V_i^{Soc} - C_i^{Net}$, or what we have called favorable *targeting efficacy*:

$$\text{(10)} \quad \text{(Targeting efficacy)} \quad \Delta\gamma \equiv \bar{\gamma}_1 - \bar{\gamma}_0 = \underbrace{\left(\bar{V}_1^{Soc} - \bar{V}_0^{Soc}\right)}_{\text{Social Value sorting}} - \underbrace{\left(\bar{C}_1^{Net} - \bar{C}_0^{Net}\right)}_{\text{Cost sorting}} > 0.$$

It is straightforward to see that targeting efficacy and value sorting coincide only in the special case where there is no offsetting sorting on costs. This is reasonable for programs with *constant costs* or more generally where costs are *uncorrelated* with value. For example, this might be reasonable for slots in a public childcare program or for a welfare program that gives everyone the same benefit amount. But it is unlikely to apply to insurance programs and other settings characterized by cost heterogeneity and adverse selection, which we turn to next.

### C. *Ordeals Targeting and Adverse Selection*

How do the conditions for ordeals being optimal relate to adverse selection? In this subsection, we use our model to analyze the social welfare impact of ordeals. We show that the targeting impacts of ordeals can be visualized in a simple graphical framework, following the approach of Einav and Finkelstein (2011) for selection markets. This lets us visualize the role of adverse selection for the gains from targeting and therefore the desirability of ordeals.

[17] In a related vein, Spinnewijn (2015, 2017) argue that behavioral biases tend to reduce the slope of the social value curve relative to demand, making revealed preference sorting less efficient.

While the classic ordeals debate has tended to focus on the wedge between individual choice and enrollees' true private welfare ($W_i$) or true social value ($V_i^{Soc}$), we use our framework to illustrate how the economics of adverse selection can create an analogous wedge between $V_i^{Soc}$ and *net* social welfare, $\gamma_i = V_i^{Soc} - C_i^{Net}$. Thus, even when ordeals successfully induce self-screening and favorable value sorting, adverse selection can erode or even reverse the gains from targeting.

*Adverse Selection and Targeting.*—Adverse selection is a feature typically associated with insurance and other "selection markets," where it is known to unravel trade and distort market outcomes. However, the underlying features driving adverse selection may also be relevant for thinking about targeting in social programs. These two key features are

1. **Cost Heterogeneity:** $C_i^{Net}$ varies across enrollees (with variance $\sigma_C^2 > 0$).
2. **Value-Cost Correlation:** $C_i^{Net}$ correlates positively with $V_i^{Soc}$, or $\rho = \text{corr}\left[V_i^{Soc}, C_i^{Net}\right] > 0$.[18]

These two features characterize many insurance programs where an individual's value (demand) and cost are both heavily driven by their risk. For instance, in health insurance, sicker individuals tend to have both higher value for insurance and higher expected costs. Adverse selection tends to result in $\bar{C}_1^{Net} - \bar{C}_0^{Net}$ having the same sign as $\bar{V}_1^{Soc} - \bar{V}_0^{Soc}$. Under adverse selection, positive value sorting ($\bar{V}_1^{Soc} - \bar{V}_0^{Soc} > 0$) is not enough for an ordeal to be desirable; it is possible to have small or even negative targeting efficacy ($\Delta\gamma \approx 0$ or $\Delta\gamma < 0$) if sorting on costs is sufficiently large.

While we focus on adverse selection, *advantageous* selection may be relevant in some settings, like long-term care insurance. Under advantageous selection, costs vary ($\sigma_C^2 > 0$), but the value-cost correlation is negative ($\rho < 0$). As a result, ordeals will generally target more effectively than without selection since low-value types (who self-screen out) will also have high costs.

*Graphical Analysis.*—We show that the gains from targeting under adverse selection can be illustrated using the familiar graphical framework of Einav, Finkelstein, and Cullen (2010) for welfare in selection markets. The intuition is that different levels of the intensity of an ordeal, given by $\sigma$ in our framework, trace out marginal value and marginal cost curves in much the same way as different prices generate demand and marginal cost curves in the original Einav, Finkelstein, and Cullen (2010) analysis. For a given ordeal of strength $\sigma$, we define the marginal social value curve $MV(\sigma) = E\left[V_i^{Soc} | W_i - \varepsilon_i = \sigma h_i\right]$ as the expected social value of those for whom a marginally stronger ordeal would cause not to enroll. Likewise, we define the marginal cost curve as $MC(\sigma) = E\left[C_i^{Net} | W_i - \varepsilon_i = \sigma h_i\right]$. It is straightforward to see that the conditional means in equation (10) ($\bar{V}_1^{Soc}$, $\bar{V}_0^{Soc}$, $\bar{C}_1^{Net}$ and $\bar{C}_0^{Net}$) are the average values of $MV(\sigma)$ and $MC(\sigma)$ to the left and right of $D(\sigma)$.

[18] In many settings, this condition is presented as a positive correlation between direct costs $C_i$ and private welfare $W_i$. For the purpose of this discussion, we assume that $W_i$ and $V_i^{Soc}$ are highly correlated, as are $C_i$ and $C_i^{Net}$, so these conditions are aligned.

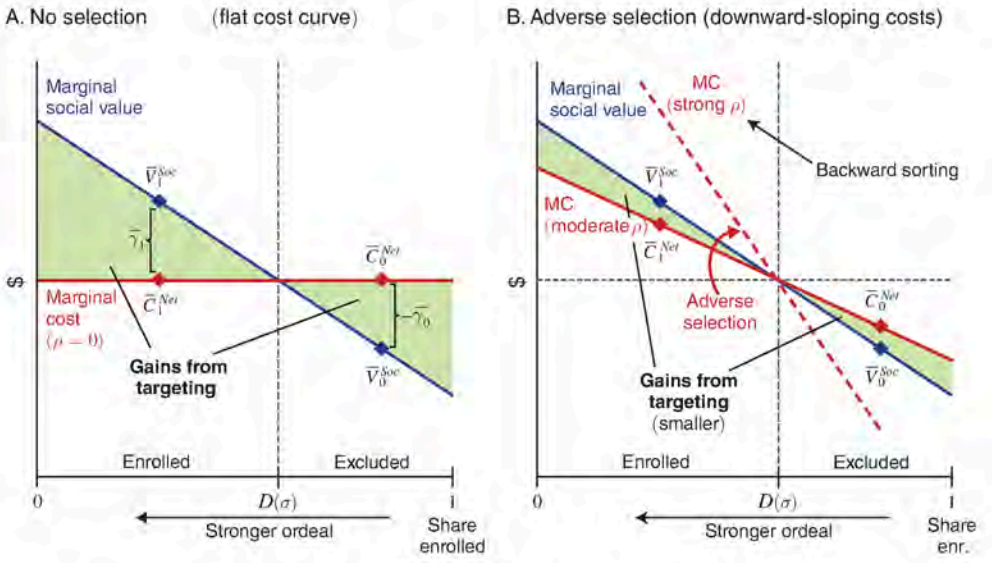



FIGURE 1. GAINS FROM ORDEALS TARGETING WITH NO SELECTION VERSUS ADVERSE SELECTION

*Notes:* The figure shows the gains from targeting from ordeals in two cases: (i) the "standard" ordeals case without selection (a flat marginal cost curve, panel A) and (ii) with adverse selection (downward-sloping cost curve, panel B). Both panels depict enrollee value and cost curves for marginal enrollees as the ordeal strengthens and enrollment drops (moving right to left), using a setup similar to Einav, Finkelstein, and Cullen (2010). The green shaded areas are the "gains from targeting," which shrink or become negative under adverse selection.

The key impact of adverse selection in this framework is to make the marginal cost curve *downward sloping* since low-value types also have low costs. This, we argue, reduces or reverses an ordeal's gains from targeting, potentially leading to backward sorting. Further, it makes it more likely that $MV(\sigma)$ lies entirely above or below $MC(\sigma)$, the condition for optimal universality.

Figure 1 illustrates this adverse selection logic graphically, showing how adverse selection reduces or reverses the gains from targeting. The curves in each panel depict the marginal social value (blue) and cost (red) curves as the ordeal gets stronger (moving right to left), an ordeals version of standard demand and marginal cost curves from Einav, Finkelstein, and Cullen (2010). The diamonds are average value and cost for included/excluded enrollees under an ordeal, optimally set to maximize targeting gains. Both panels show the same downward-sloping marginal value curve, reflecting the case in which the ordeal favorably sorts on social value, $\bar{V}_1^{Soc} - \bar{V}_0^{Soc} > 0$. The areas between the value and cost curves, shaded in green, correspond to the gains from targeting, $GT(\sigma)$,[19] and are increasing in $\Delta\gamma = \bar{\gamma}_1 - \bar{\gamma}_0$, as shown in the graph.

Panel A illustrates the classic ordeals case with *no selection* (i.e., where costs are constant or uncorrelated with value), represented by a flat marginal cost curve that intersects marginal value at an interior point. As a result, targeting efficacy $(\bar{\gamma}_1 - \bar{\gamma}_0)$

[19] Technically, gains from targeting equals the smaller of the two shaded triangles.

is equivalent to social value sorting ($\bar{V}_1 - \bar{V}_0$) because there is zero sorting on cost. An ordeal, therefore, achieves positive gains from targeting as long as the value curve is downward sloping, that is, $\Delta V^{Soc} > 0$. This is the key idea underlying the classic "self-screening" and "social value sorting" rationales for ordeals described above.

Panel B shows how this changes with *adverse selection*. The marginal value curve remains downward sloping, but now the marginal cost curve is also downward sloping, capturing the positive value-cost correlation. We show a case where the $MC(\sigma)$ curve rotates around its intersection point with $MV(\sigma)$, so the two curves continue to intersect. Because of this rotation, the gains from targeting (as shown in the green shaded area) are substantially reduced (when $\rho$ is modest) and may be negative (when $\rho$ is large). The key question for targeting efficacy is no longer whether the marginal value curve is downward sloping but whether it is *steeper* than marginal costs. In the case illustrated by the dashed red curve—where $MC(\sigma)$ is steeper than $MV(\sigma)$—the ordeal leads to "*backward sorting*." In this case, the ordeal targets inversely from what is desirable: those who are enrolled have negative surplus, while those who are excluded have positive surplus. This type of backward sorting is closely related to the idea that price-based sorting may also be inefficient in insurance markets (Marone and Sabety 2022).[20]

Figure 2 shows a second way adverse selection may undermine the optimality of ordeals: by leading to "optimal universality." We show both the no-selection and "modest" adverse selection $MC(\sigma)$ curves from the prior figure but now consider what happens if the $MV(\sigma)$ is higher, e.g., because society places a higher welfare weight ($\mu$) on program enrollees. With no selection, a more modest but still positive ordeal is optimal because the marginal value and cost curves continue to intersect. But with adverse selection, the *MV* curve lies *entirely above MC*, implying that full enrollment (zero ordeal) is optimal. The same idea applies in reverse if the marginal value curve is lower (via a lower $\mu$), with adverse selection making it more likely that no enrollment is optimal (see Supplemental Appendix Figure A.1). Intuitively, adverse selection makes these "universal" optima more likely because the similar downward slope of *MV* and *MC* makes them less likely to intersect within a given range.

*Mathematical Analysis.*—We now formalize these arguments. We start with the claim that adverse selection reduces or reverses the gains from targeting—the sorting argument shown in Figure 1, panel B. Note that given estimates of $V_i^{Soc}$ and $C_i^{Net}$, we can quantify the value-cost relationship by considering the linear projection of enrollee costs onto value: $C_i^{Net} = \bar{C} + \hat{\beta} \times V_i^{Soc} + \omega_i$, where $\bar{C}$ is the mean of net costs and $\omega_i$ is a residual capturing cost heterogeneity orthogonal to value. This projection can always be performed and results in the standard regression coefficient $\hat{\beta} = \rho \cdot \sigma_C / \sigma_V$, where $\sigma_C$ and $\sigma_V$ are the standard deviations of cost and value, and

[20] Sorting may be improved if ordeals (or prices) can be targeted only at high-cost enrollees (Bundorf, Levin, and Mahoney 2012), but this is typically not done because it would be inequitable to the sick. In a different context, the fact that "prior authorization" hassles are targeted at high-cost prescription drugs may explain why these yield savings in excess of their costs (Brot-Goldberg, Burn et al. 2023).

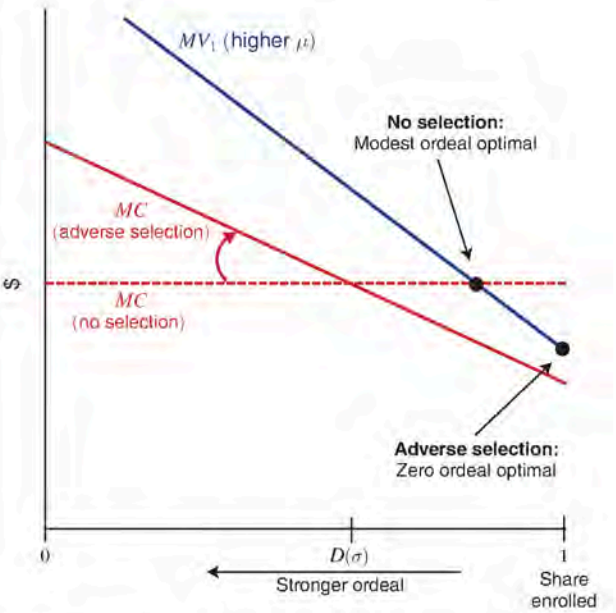



FIGURE 2. OPTIMAL UNIVERSALITY WITH ADVERSE SELECTION

*Notes:* The figure shows how adverse selection increases the likelihood of "optimal universality" when the social marginal value ($MV$) curve is shifted upward (relative to Figure 1) due to a higher social welfare weight, $\mu$. With no selection, the new marginal value curve ($MV_1$) still intersects marginal cost ($MC$), implying that a (more modest) ordeal is still optimal. With adverse selection, $MV_1$ lies entirely above $MC$, implying full enrollment (zero ordeal) is now optimal.

$\rho \in [-1, 1]$ is the value-cost correlation. Applying this projection to the terms for targeting efficacy in (10) yields[21]

$$(11) \qquad \underbrace{\bar{\gamma}_1 - \bar{\gamma}_0}_{\text{Targeting Efficacy}} = \underbrace{\left(\bar{V}_1^{Soc} - \bar{V}_0^{Soc}\right)}_{\text{Social Value sorting}} \times \underbrace{\left[1 - \overbrace{\left(\rho \cdot \frac{\sigma_C}{\sigma_V}\right)}^{\text{Adverse Selection Tax } (\tilde{\beta})} - \widetilde{\Delta\omega}\right]}_{\text{Correction for value-cost correlation}},$$

where $\widetilde{\Delta\omega} \equiv (\bar{\omega}_1 - \bar{\omega}_0)/\left(\bar{V}_1^{Soc} - \bar{V}_0^{Soc}\right)$ captures the ordeal's sorting on idiosyncratic costs. We call $\tilde{\beta}$ the "adverse selection tax" since it captures the degree to which adverse selection (a large covariance between value and costs) "taxes away" the welfare gains from favorable sorting on value.

Equation (11) formalizes the relationship between social value sorting $\left(\bar{V}_1^{Soc} - \bar{V}_0^{Soc}\right)$ and the true targeting efficacy, $\bar{\gamma}_1 - \bar{\gamma}_0$. If program costs are either constant across enrollees ($\sigma_C = 0$) or uncorrelated with enrollee value ($\rho = 0$), social welfare gains are approximately equal to value sorting. However, as cost heterogeneity ($\sigma_C$) and the value-cost correlation ($\rho$) grow more positive—precisely the two key features of adverse selection laid out above—the adverse selection tax

[21] We get this from applying the projection to get $\bar{C}_1^{Net} - \bar{C}_0^{Net} = \tilde{\beta} \times \left(\bar{V}_1^{Soc} - \bar{V}_0^{Soc}\right) + (\bar{\omega}_1 - \bar{\omega}_0)$, which can be rearranged to yield the expression in (11).

grows, and gains from targeting are diminished. Further, if $\hat{\beta}$ grows large enough that

$$\hat{\beta} = \rho \cdot \frac{\sigma_C}{\sigma_V} > 1 - \widetilde{\Delta\omega}, \tag{12}$$

the correction term becomes negative, and the ordeal leads to backward sorting (on social welfare) despite favorable sorting on value. This corresponds to a "steeper" marginal cost than marginal value curve in Figure 1, panel B. If $\widetilde{\Delta\omega} \geq 0$—which occurs if an ordeal does not screen, or screens unfavorably, on idiosyncratic costs (the case we usually find in our empirical work)—a sufficient condition for backward sorting is $\hat{\beta} > 1$, or $\rho > \sigma_V/\sigma_C$.

This analysis provides insight into why ordeals will generally work poorly in settings with strong adverse selection, where $\hat{\beta} > 1$. In these settings, *any* ordeal that sorts favorably on value will sort *backward* on efficiency, unless it happens to screen in people with low *idiosyncratic* costs ($\widetilde{\Delta\omega} < 0$), something that while possible, is not implied by economic theory. More generally, even modest adverse selection ($\hat{\beta} \in (0, 1]$, or $\rho \in (0, \sigma_V/\sigma_C]$) "taxes" away the gains from value sorting in proportion to $\hat{\beta}$, making the real welfare gains much smaller.[22]

We now formalize the claim that adverse selection makes optimal universality more likely, as depicted in Figure 2. As in the figure, we consider how shifts in marginal social value driven by a higher/lower social welfare weight ($\mu$) affect the optimality of a given ordeal with strength $\sigma$.[23] For the ordeal to yield targeting gains per condition (7), it must be the case that $\bar{\gamma}_1(\sigma) > 0 > \bar{\gamma}_0(\sigma)$, or $\bar{V}_1^{Soc}(\sigma;\mu) - \bar{C}_1^{Net}(\sigma) > 0 > \bar{V}_0^{Soc}(\sigma;\mu) - \bar{C}_0^{Net}(\sigma)$, where we highlight that $\bar{V}_1^{Soc}$ and $\bar{V}_0^{Soc}$ are both (increasing) functions of $\mu$. These inequalities, therefore, implicitly define a range of $\mu$ over which the ordeal is desirable: $\mu \in [\mu^*_{min}, \mu^*_{max}] \equiv \left[\left(\bar{C}_1^{Net} - \bar{E}_1\right)/\bar{W}_1, \left(\bar{C}_0^{Net} - \bar{E}_0\right)/\bar{W}_0\right]$ as long as $\mu^*_{min} \leq \mu^*_{max}$. Relative to no selection ($\bar{C}_1^{Net} = \bar{C}_0^{Net}$), adverse selection rotates the cost curve, making $\bar{C}_1^{Net} > \bar{C}_0^{Net}$, which pushes upward $\mu^*_{min}$ and downward $\mu^*_{max}$. Thus, adverse selection *narrows the range* of social preferences $[\mu^*_{min}, \mu^*_{max}]$ over which ordeals are preferred to universal policies. (See Supplemental Appendix Figure A.1 for a visualization of this argument.) Further, for sufficiently strong adverse selection, this range becomes null, implying that there is no $\mu$ at which the ordeal is optimal.

*Broader Implications for Transfer Programs.*—While our emphasis has been on insurance programs, our framework also sheds light on many *transfer* programs where recipient value and public costs are naturally correlated via the (varying) *benefit amounts*, which are both a benefit to enrollees and a cost to the government. For instance, in many means-tested programs, benefit amounts vary with enrollee income or family status. This suggests that the logic of correlated value and costs may apply,

[22] One reason $\hat{\beta}$ is likely to be large in low-income populations is that $\sigma_V$ (at least for private WTP) tends to be small because marginal utility of consumption is high, while $\sigma_C$ is much larger, reflecting variation in health needs.

[23] We make this argument for a particular $\sigma$, but an analogous argument applies across a *full range* of values of $\sigma$ to show that adverse selection makes it more likely that the $MV(\sigma)$ and $MC(\sigma)$ curves do not intersect over this range.

and self-targeting may not translate into significant welfare gains. Instead, the desirability of ordeals may depend on whether low-benefit-amount enrollees also tend to be those the government wishes to screen out for other reasons (e.g., because they are less poor, so have a lower social welfare weight).

Our analysis can help interpret the findings in past work. For instance, both Finkelstein and Notowidigdo (2019) (studying SNAP) and Bhargava and Manoli (2015) (studying the EITC) find that hassles on average screen out people who receive smaller benefit amounts from these programs. But the normative implications are different. In SNAP, low-benefit types are generally *higher-income* individuals, for whom economic need is less. But in the EITC, low-benefit types were generally *lower-income* individuals *without kids*, for whom need may be high. By contrast, ordeals screening works well in programs that distribute supplies with *equal costs* for all participants, as in free chlorine solution for water treatment (Dupas et al. 2016).

*Connection to Economics of Nudges.*—Our analysis of ordeals relates to the broader economics of "nudges" (Thaler and Sunstein 2008) and similar nonprice interventions. Although the vast majority of this literature focuses on empirical impacts and positive economics, recent work by Allcott et al. (2022) unpacks the welfare implications of nudges. Their work emphasizes that simple *average treatment effects* on demand or adoption of ostensibly beneficial goods or behaviors may be a misleading guide to welfare. Instead, the key welfare question is whether a nudge reduces *choice distortions*, by inducing people to consume or behave more in line with what is socially optimal.[24] A nudge improves social welfare only if it reduces (more than it exacerbates) baseline under- and overconsumption of a good relative to the social optimum.

This aligns closely with our analysis of take-up and targeting with ordeals for social programs. An ordeal improves welfare only if it corrects (more than it exacerbates) errors of overenrollment (enrolling $\gamma_i < 0$ types) and of underenrollment (excluding $\gamma_i > 0$ types) that occur with alternate policies like full inclusion and exclusion. This is exactly what is captured by our targeting efficacy statistic, $\Delta\gamma = \bar{\gamma}_1 - \bar{\gamma}_0$, and by our expression for "gains from targeting" in (6). Indeed, there is a close parallel between our model and the setup of Allcott et al. (2022),[25] suggesting a deep connection between the welfare economics of nudges and ordeals. This also suggests that thinking about nudges through the lens of *optimal targeting* may be a fruitful way to understand their welfare impacts.

[24] Allcott et al. (2022) show that this occurs when a nudge reduces the *variance* of "net distortions," or the (individual-specific) wedge between choice utility and social welfare arising from behavioral biases, externalities, and other factors like markups and taxes. These wedges may be either positive or negative, so a smaller variance implies behavior more in line with social welfare.

[25] Importantly, we allow $C_i^{Net}$ to vary (whereas marginal cost is fixed in their model) because we are studying a selection market. Finally, their model is more complex because it allows prices to endogenously adjust to nudges (via their impact on supply/demand), which necessitates an analysis of price pass-through impacts that we can ignore.

## II. Setting, Auto-Enrollment Policy, and Data

### A. *Massachusetts Exchange Setting*

*CommCare Exchange.*—We study Commonwealth Care ("CommCare"), a subsidized insurance exchange in Massachusetts that operated from 2006 to 2013 before shifting form in 2014 at the ACA's implementation. CommCare covered low-income adults with family income below 300 percent of the federal poverty level (FPL, or "poverty") and without access to insurance from another source, including an employer or public program (i.e., Medicare or Medicaid). We focus on the population with income below 100 percent of FPL for whom the auto-enrollment policy applied. Given eligibility rules for other programs, this group is almost entirely childless adults age 19–64.[26]

CommCare offered generous insurance at heavily subsidized premiums. The program specified a detailed benefit structure (i.e., cost sharing rules and covered medical services) that private insurers were required to follows. Each insurer offered a single plan with the standardized benefits but could differ in its network of hospitals and doctors. For the below-poverty group we focus on, benefits were equivalent to Medicaid—that is, broad covered services with essentially no patient cost sharing (the actuarial value is 99.5 percent)—and all plans were fully subsidized ($0 premium). This setup is similar to Medicaid managed care programs. As in Medicaid, there is no financial cost to insurance, and the only barriers are enrollment hassles. An important difference from Medicaid, however, is that CommCare does *not* have retroactive coverage; coverage starts the first day of the month *after* completing enrollment.[27] Therefore, enrollment delays have a meaningful impact, including the risk of getting acutely ill and incurring medical debts before enrollment takes effect.

*Application and Enrollment Process.*—It is well-known that there is substantial "churn" into and out of eligibility for different forms of health insurance, e.g., due to job changes, income fluctuation, or family status changes. Therefore, many people newly need health insurance and apply for public coverage. For CommCare, the enrollment process involves two steps, as shown in Figure 3. Step 1 is to apply for eligibility. This requires completing a six-page application that asks about income, demographics, family status, and access to other health insurance (see Supplemental Appendix H for snapshots of the form). The state used this information to determine eligibility for Medicaid or CommCare (dual eligibility should not occur) and to sort people into income-based subsidy groups in CommCare. Although the application form is a meaningful hassle, many individuals get help from a social worker or medical staffer in completing it, often just after having visited a medical provider while uninsured.

[26] Medicare covers seniors age 65+, and Massachusetts Medicaid covers children up to 300 percent of FPL, parents with dependent children up to 133 percent of FPL, and pregnant women up to 200 percent of FPL. In addition to the nonelderly, CommCare covered a small number of immigrants age 65+ not eligible for Medicare. As we discuss below, we drop immigrant enrollees from our sample.

[27] By contrast, Medicaid covers medical bills incurred prior to enrollment, typically with a 90-day retroactive period. As a result, Medicaid eligibles have a form of "conditional coverage" that is not available from CommCare.

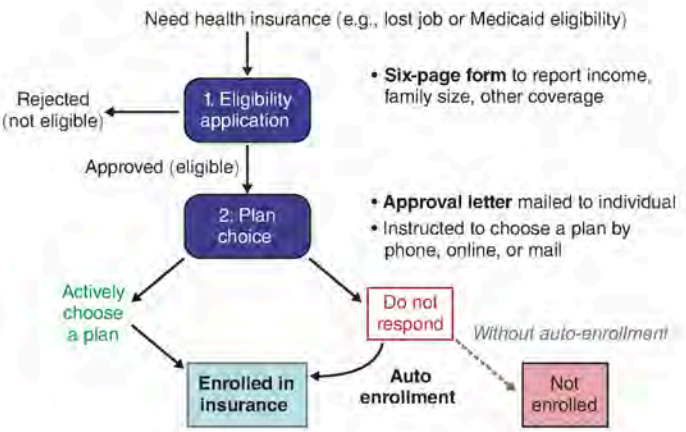



FIGURE 3. ENROLLMENT PROCESS AND AUTO-ENROLLMENT POLICY

*Notes:* The figure diagrams the enrollment process for the Massachusetts health insurance exchange we study (CommCare). Prospective enrollees who need health insurance must follow a two-step process. First, they apply for eligibility, completing a six-page form with information on income, family status, and other coverage. Second, if approved, they are mailed an approval letter and asked to choose a (free) health plan by phone, online, or mail. The auto-enrollment policy applies to approved individuals who do not respond to this approval letter within 14 days ("passive" individuals). With auto-enrollment (the policy from 2007 to 2009), they are auto-enrolled into a state-selected plan; without auto-enrollment (post-2010 policy), they are not enrolled unless and until they actively respond.

The second enrollment step is to choose a plan. After determining eligibility, the state notified an individual (by mail and/or email) and provided information on available plans and associated premiums. Supplemental Appendix H shows this two-page approval letter. To complete enrollment, individuals were asked to choose a plan by calling, going online, or circling a plan choice and returning it by mail. Relative to the initial application, this step was quite simple. However, without auto-enrollment, individuals still had to take action to enroll. Moreover, the action needed to be taken *independently* in response to the approval letter, which could be lost, misunderstood, or forgotten.

### B. *Auto-Enrollment Policy and Timeline*

*Auto-Enrollment Policy.*—CommCare's auto-enrollment policy set the default outcome for people determined eligible (step 1 of the process) but who did not respond when asked to choose a plan (step 2; see Figure 3). The policy applied only to below-poverty enrollees, for whom all plans were free.[28] This allowed regulators to borrow a policy widely used in Medicaid managed care that "auto-assigns" passive new enrollees into a state-selected plan. Aggregate statistics suggest that

[28] Auto-enrollment was generally not used for above-poverty enrollees because premiums varied across plans and were typically nonzero, raising concerns about auto-enrolling people into plans that generated a financial debt for them. There were two limited exceptions of auto-enrollment for 100–150 percent of poverty enrollees, both of which are excluded from our main sample (see discussion below): (i) for reenrollees prior to 2010 who reenrolled with a gap of less than 12 months and (ii) for new enrollees during the single month of December 2007 (fiscal year 2008m6).

auto-assignment in Medicaid is very common: the median state auto-assigns 45 percent of new enrollees (Smith et al. 2015). However, we are not aware of any *causal* evidence on this policy's impact on take-up, likely because of a lack of variation in its use.

Auto-enrollment applied when individuals entered the market, but with different rules for two groups: (i) "new enrollees" joining for the first time and (ii) "reenrollees" joining after a gap in coverage. We focus our main analysis on new enrollees. New individuals were mailed a coverage approval letter and given 14 days to actively choose a plan before being auto-enrolled if they failed to respond. This lets us observe mode of enrollment (active versus passive) directly in our administrative data.[29]

There was one notable exception to the process for new enrollees near CommCare's inception in 2007 when the state "auto-converted" a large population from its pre-RomneyCare uncompensated care pool (UCP). These individuals did not complete a new eligibility application but were determined eligible based on information from their original UCP application, often completed months beforehand. Consistent with the long lag, many of these UCP individuals failed to respond and were auto-enrolled, creating a large spike in auto-enrollment in early 2007. Because of these distinct circumstances, we focus our main analysis on the "steady-state" auto-enrollment period (fiscal years 2008–2009), with the initial period (2007) analyzed for comparison and robustness.[30]

*Policy Timeline.*—We examine auto-enrollment policy changes during fiscal year (FY) 2010 (which ran from July 2009 to June 2010). Facing a Great Recession–related budget shortfall, CommCare needed to cut spending. The program had raised enrollee premiums and copays the prior year, and it was eager to avoid doing so again. Suspending auto-enrollment provided an alternative to reduce enrollment and therefore subsidy spending. The exchange did so as of the start of FY 2010, with (because of a lagged impact) a final group of passive enrollees joining in 2010m1 (July 2009). These cuts proved quite effective, and CommCare unexpectedly came in under budget during 2010. As a result, the program temporarily reinstated auto-enrollment in the final three months of FY 2010. After this, facing continued budget pressures, it was permanently canceled in 2011.

These changes give us variation to estimate the causal impact of auto-enrollment. To be valid, it is important that there not be other concurrent shocks or policy changes that affect enrollment around the same time. Based on background research and discussions with the exchange administrator, this appears to be true, with one exception: an eligibility cut for noncitizen enrollees in 2010m4 (October 2009), two months after the auto-enrollment suspension. To avoid biasing our results, we

[29] By contrast, most reenrollees were *immediately* auto-enrolled in their former plan (without a 14-day window to actively choose), and auto-reenrollment was also used for some above-poverty enrollees (our control group). For these reasons, we exclude reenrollees from our main sample, reporting effects on them in robustness analysis (see Supplemental Appendix B.2).

[30] Supplemental Appendix C.5 compares our main targeting analysis for the 2008–2009 sample (see Section IVA) to the results for 2007. Interestingly, while auto-enrollment is much more common in early 2007, we find very similar targeting (active versus passive enrollee characteristics) in both periods.

exclude noncitizen enrollees from our sample in all periods.[31] Aside from this, other enrollment-relevant policies did not change.[32] Nonetheless, to address any unobserved demand shocks, we also use a control group of higher-income enrollees not subject to auto-enrollment.

*Other Policy Details.*—Although our analysis focuses on enrollment impacts, other policy details are of interest, including rules for plan auto-assignment. The plan assignment rule had two parts. Passive enrollees with prior enrollment with an insurer in the past 12 months (either in CommCare or Medicaid) were auto-assigned to that insurer. Other new enrollees were randomly assigned to plans, with probability shares following a schedule giving more weight to plans with lower (state-paid) premiums. After enrollment, all new/reenrollees (both active and passive) could freely switch plans within 60 days of starting coverage. In practice, the vast majority (96 percent of passive and 98 percent of active enrollees) stick with their initial plan, consistent with other work finding that default health plan assignment is very sticky (Brot-Goldberg, Layton et al. 2023).

These policies raise two interesting issues that we have not explored in this paper. First, random assignment could allow for inferring causal plan effects, as in recent work on Medicaid (Geruso, Layton, and Wallace 2020). In practice, we find evidence of slight demographic imbalance across plans, suggesting the presence of hard-to-observe exceptions to random assignment. We therefore have not pursued this topic further. Second, giving higher probability weights to lower-price insurers should affect competitive incentives. This topic is interesting but would require a different research design to study; we therefore leave it for future work.

### C. *Data and Descriptive Statistics*

*Exchange Admin Data and Sample Definition.*—Our primary data come from deidentified CommCare administrative records for fiscal years 2007–2014, spanning November 2006 to December 2013 (Massachusetts Health Connector 2014). For all enrollees, we observe a panel of individual-level demographics and monthly plan enrollment, linked to insurance claims and risk scores. Observed demographics include age, gender, zip code of residence, and family income as a percentage of the poverty line. Insurance claims let us measure individuals' medical conditions and health care use and costs while enrolled. Importantly, the data include a flag for whether each new enrollee is auto-enrolled or actively chooses a plan. This lets us

[31] The eligibility change was for legal immigrant residents (typically green card holders) who had not yet cleared their "five-year bar" requirement to receive federal Medicaid matching funds—a group the state calls "aliens with special status" (AWSS). Starting in October 2009, the AWSS group was not eligible to newly enroll in CommCare, and existing AWSS enrollees were shifted into a parallel program. We observe a flag for AWSS status and enrollment in this parallel program, which lets us exclude these individuals from the sample in all periods.

[32] The start of 2010 did see the entry of a new insurer (CeltiCare). But for the below-poverty group, this expanded the choice set of available free plans, which should (if anything) increase enrollment, pushing in the opposite direction of our findings. In practice, CeltiCare had a narrow network and was not popular, with only 1.5 percent of below-poverty active choosers selecting it during 2010–2011. We therefore view the new availability of CeltiCare as having a negligible impact.

construct the key variables for our main analysis: monthly counts, characteristics, and outcomes for passive and active enrollees.[33]

We are interested in the policy's impact on enrollment totals and composition. For enrollment impacts, the main outcome of interest is counts of new enrollees joining CommCare per month (a flow measure). We use our panel data and a simple model to translate this into an effect on steady-state enrollment (a stock measure). For composition, we use variables on demographics, diagnoses, and medical spending during an individual's enrollment spell.

We make several limitations to our main CommCare analysis sample. First, we limit attention to new enrollees who (when they joined the market) were in one of two income groups: (i) the 0–100 percent of poverty "treatment" group and (ii) a 100–200 percent of poverty "control" group not subject to auto-enrollment. Second, we exclude from our sample noncitizen enrollees who (as described above) faced an eligibility cutback in October 2009, shortly after the auto-enrollment change (in August 2009). Finally, we limit our main sample period to FY 2008–2011 for analyses of the treatment group and to 2009–2011 for difference-in-differences (DD) regressions comparing treatment and control groups. We exclude 2007 because of the different nature of auto-enrollment during that year (see discussion above). For DD regressions, we further exclude 2008 because of other policy changes that affected the control group in mid-to-late 2008.[34] We end our analysis in 2011 because of a change in plan choice rules for the treatment group at the start of 2012 (see Shepard 2022).

*Other Datasets.*—We draw on two additional datasets for specific pieces of our analysis:

- **American Community Survey (ACS):** For context on uninsurance in Massachusetts, we use the ACS (Ruggles et al. 2015) to estimate the CommCare-eligible uninsured population by income group, following a method used by Finkelstein, Hendren, and Shepard 2019. Details are in Supplemental Appendix A.1.
- **Massachusetts All-Payer Claims Database (APCD):** We use the state's APCD (version 3.0, with data for 2009–2013) (Massachusetts CHIA 2014) to examine whether CommCare enrollees are enrolled in duplicate private insurance, as a possible reason for failing to actively enroll. The APCD is well suited for this purpose because it lets us observe a near-universe of Massachusetts health insurance plans and measure simultaneous coverage. Supplemental Appendix D describes the data construction method and shows that the APCD's enrollment counts for CommCare closely match our administrative data.

[33] We observe this flag for the FY 2007–2009 period when auto-enrollment is in effect, but due to a technical issue, it is missing during the policy's temporary reinstatement in April–June 2010. For this latter period, we report only aggregate data for all enrollees.

[34] Specifically, for individuals above 150 percent of poverty, the state's insurance mandate penalty took effect in December 2007 (FY 2008m6), leading to a spike in new enrollment. Also in December 2007, there was a large auto-enrollment for the 100–150 percent poverty group. For the whole 100–200 percent poverty control group, there was a change in plan premiums and subsidies at the start of FY 2009 (July 2008). Importantly, none of these changes applied to the treatment group, and policy for the control group was stable throughout the 2009–2011 period used in our DD analysis.

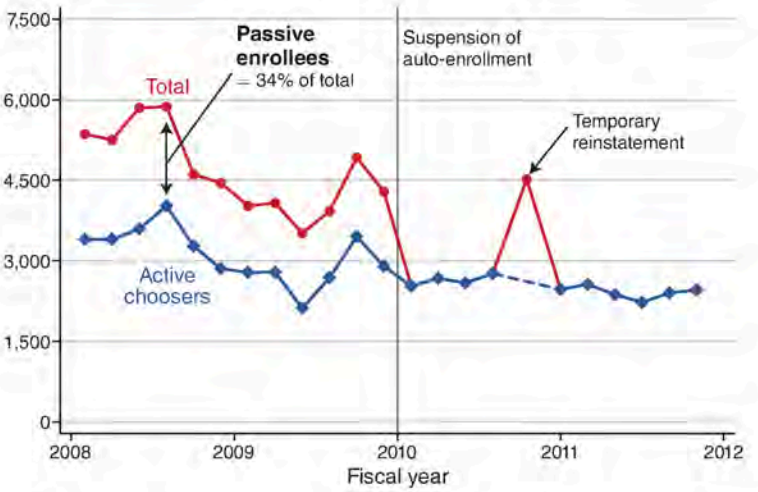



FIGURE 4. ACTIVE VERSUS PASSIVE NEW ENROLLMENT INTO THE MASSACHUSETTS EXCHANGE

*Notes:* The graph shows counts of new enrollees per month for the below-poverty group subject to auto-enrollment. The red series is total new enrollment, the blue is active choosers, and the gap between these is passive auto-enrollment. The vertical line indicates the timing of auto-enrollment's suspension at the start of fiscal year 2010. After this, total enrollment equals active choosers, except for the period of auto-enrollment's temporary reinstatement (during which we lack the flag to separate active versus passive enrollment). Data are bimonthly averages to smooth over fluctuations.

*Descriptive Statistics.*—Figure 4 shows data on new enrollment per month in the treatment group (0–100 percent of poverty) over the main 2008–2011 period.[35] The figure plots both total new enrollment (in red) and the count of active choosers (in blue), with the gap between these being passive enrollees. Passive enrollees represent a sizable 34 percent share of new enrollment during 2008–2009, and new enrollment falls sharply when auto-enrollment was suspended at the start of 2010. The decline is almost identical to the number of passive enrollees during 2008–2009. Moreover, when the policy is briefly reinstated at the end of 2010, enrollment spikes up to a similar level as at the end of 2009. Together, these facts are consistent with auto-enrollment having a causal effect roughly equal to the full number of passive enrollees in the pre-period.

Supplemental Appendix Table A.1 further summarizes enrollment statistics, including enrollment counts for the 100–200 percent of poverty group and on total market enrollment and new versus reenrollment. Supplemental Appendix Table A.2 reports average consumer attributes; we defer a discussion of these to Section IV, where we compare active versus passive enrollees.

[35] The points are bimonthly averages to smooth over noise; see Supplemental Appendix Figure A.2 for the raw monthly data over the full 2007–2011 period. As that figure shows, auto-enrollment spiked during early 2007 because of the autoconversion of the state's uncompensated care pool.

## III. Causal Impact of Auto-Enrollment Policy

This section presents our estimates of the impact on take-up of suspending auto-enrollment in 2010. After presenting results in Section IIIA, we provide context on the magnitude in Section IIIB.

### A. *Impact on Health Insurance Enrollment*

We use the 2010 policy change to estimate the causal impact of auto-enrollment. To do so, we run difference-in-difference regressions on counts of monthly new enrollment, comparing the 0–100 percent of poverty "treatment" group (for whom auto-enrollment is in place through 2009 and suspended in 2010) to the 100–200 percent of poverty "control" group (for whom auto-enrollment was not in place throughout). The DD regression is

$$NewEnr_{g,t} = \alpha_g + \beta_t + \gamma \cdot \mathbf{1}\{g = Treat,\ t \geq 2010\} + \varepsilon_{g,t}, \tag{13}$$

where $NewEnr_{g,t}$ is (scaled) new enrollment for income group $g$ (treatment or control) at time $t$, $\alpha_g$ is a group fixed effect (for the treatment and control groups), $\beta_t$ is a time fixed effect, and $\varepsilon_{g,t}$ is an error. We run (13) on data from 2009 to 2011, excluding the period of temporary reinstatement of auto-enrollment at the end of 2010.[36] The dependent variable is "scaled" new enrollment, equal to a group's raw monthly counts divided by its average new enrollment in the pre-2010 period. This ensuring $NewEnr_{g,t}$ has a mean of 1.0 for each $g$ in the pre-period and lets us interpret estimates as proportional effects. The coefficient of interest is $\gamma$, which is the DD estimate of the impact of turning off auto-enrollment (i.e., adding the active choice ordeal).

Figure 5 plots the data for the regression in (13) and reports the main DD estimate. Panel A shows results for *total* new enrollment (active plus passive). Trends for both groups are parallel in the pre-period, and treatment group enrollment drops sharply and persistently at the policy change. The DD estimate of $\gamma = -0.326$ implies that suspending auto-enrollment reduced new enrollment by 32.6 percent of the pre-period mean. In the reverse direction, new enrollment was 48 percent $(= 0.326/(1 - 0.326))$ higher when auto-enrollment was in place.

Figure 5, panel B shows the impact on the number of *actively choosing* new enrollees. In principle, auto-enrollment might induce some attentive individuals to be "purposely passive" because they know the stakes are low, e.g., if they view CommCare plans as roughly equivalent and are happy to let the regulator select for them.[37] If this were true, we would expect these purposely passive individuals to actively enroll when auto-enrollment stops in 2010, resulting in an uptick in *active*

[36] The time unit ($t$) is bimonthly periods, averaging over new enrollment in pairs of months, which smooths over a few single months when auto-enrollment appears not to have occurred followed by a surge in auto-enrollment the next month. We calculate standard errors using the normal linear model given the small samples sizes but verify that robust standard errors are essentially the same.

[37] Enrollees were informed about the auto-enrollment policy in the coverage approval letter, which stated, *"If you do not choose a health plan by [date], the Connector will choose one for you."* After early 2010, this language was removed, and enrollees were sent periodic reminder letters if they had qualified but not enrolled in coverage.

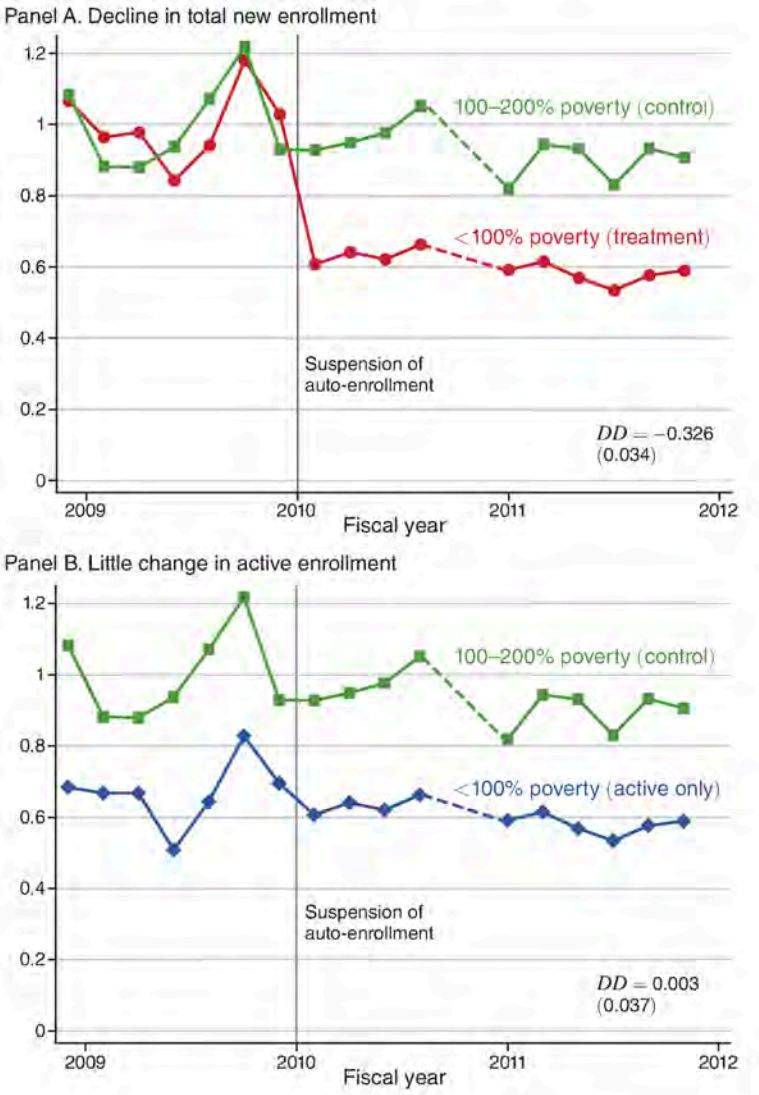



FIGURE 5. ENROLLMENT IMPACT OF AUTO-ENROLLMENT'S SUSPENSION

*Note:* The figure shows scaled new enrollment per month into CommCare and estimates of the DD specification (13) for estimating the causal effect of auto-enrollment's suspension. Each panel compares trends for below-poverty enrollees (the treatment group) versus 100–200 percent of poverty enrollees (the control group, not auto-enrolled). Each income group's series is rescaled by dividing by the group's pre-period mean new enrollment, which makes DD estimates interpretable as a proportional change. The temporary reinstatement period is excluded (as indicated with dashed lines). Panel A shows that total new enrollment falls sharply (by 32.6 percent) for the treatment group at the start of 2010, consistent with a causal effect of the policy. Panel B shows that the number of active new enrollees is flat through the policy change.

enrollment. Instead, Figure 5, panel B shows that there was no change in active new enrollment around the policy change, with a DD estimate of almost exactly zero ($\gamma = 0.003$) and no sign of an uptick in the two years following the policy change. As a further test, Supplemental Appendix Figure A.3 shows that we see no evidence of compositional changes in the characteristics of active enrollees, which we would expect if some people shifted to active choice.

This evidence suggests two facts about the ordeal of requiring active plan choice to get insurance. First, failure to actively enroll is unlikely to have been a strategic or purposeful decision; instead, passivity is more likely due to inattention or misunderstanding of enrollment rules. Second, active choice is unlikely to involve significant costs to inframarginal enrollees. If it did, we would expect some to substitute toward passivity when auto-enrollment is an option.

*Effect on Steady-State Enrollment.*—The results so far are on the *flow* of new enrollees, which falls immediately when auto-enrollment ends. The *stock* of total enrollment, however, changes more gradually, as existing enrollees exit, while fewer new enrollees enter each month. To estimate the impact on steady-state enrollment, Supplemental Appendix B.3 uses the data to calibrate a simple stock-flow model. We find that suspending auto-enrollment reduces steady-state enrollment by 24 percent; or in the reverse direction, enrollment is 32 percent higher with auto-enrollment in place. (This estimate is slightly smaller than the impact on new enrollment because passive enrollees have shorter durations.) The estimates from the stock-flow model are highly consistent with the raw data on the stock of below-poverty enrollment, which falls by 23 percent from late 2009 to the end of 2011 (Supplemental Appendix Figure A.7).

*Robustness: Alternate Specifications and Effects on Reenrollment.*—These estimates are quite robust to alternate specifications and control groups. Supplemental Appendix Table A.3 shows that the estimated 33 percent fall in new enrollment is little changed when we (i) use alternate income groups as controls (e.g., 100–150 percent FPL only, or 100–300 percent FPL), (ii) use no control group (a simple pre/post difference), and (iii) include the "temporary reinstatement" period in the regressions. Additionally, while the analysis so far has been limited to new enrollees, Supplemental Appendix B.2 shows that there are similar impacts on the number of reenrollees joining the exchange after a break in coverage. We find that reenrollment falls 35–39 percent at the start of 2010, very similar to the 32.6 percent fall for new enrollment. We therefore conclude that our main estimates on new enrollees are representative of the policy's overall impact.

### B. *Magnitude: Comparison to Other Take-Up Policies*

How should we interpret the magnitude of the impact of auto-enrollment—a 48 percent increase in new enrollment and 32 percent increase in steady state? Several benchmarks provide context for this estimate. First, relative to other "nudge" interventions to increase health insurance take-up, these are very large impacts. Several recent randomized experiments have tested nudges like reminder mailings/phone calls, simplified plan information, and a simpler take-up process (Domurat, Menashe, and Yin 2021; Myerson et al. 2021; Ericson et al. 2023). These studies find take-up impacts of 1–4 percentage points among a similar passive population (people who have qualified for coverage but not chosen a plan).[38] Similarly, evidence from

[38] Goldin, Lurie, and McCubbin (2021) study a similar mail outreach intervention on uninsured individuals identified in tax filings. They likewise find a modest take-up impact of +1.1 percentage points, though even this small impact led to a meaningful decline in mortality among the marginally insured.

Aizawa and Kim (2020) suggests that a threefold increase in government advertising of ACA Marketplaces would increase market-level enrollment by 1.3 percentage points (or 7.6 percent). By contrast, our auto-enrollment policy leads to an *order of magnitude larger* impact: nearly complete take-up among the passive group and a 30–50 percent increase in the total enrolled population. These results suggest that while information and simplification matter, *making enrollment the default* may be critical to substantially boost take-up.

A second benchmark is the impact of financial incentives. Our estimated steady-state impact of auto-enrollment is nearly identical to the 33 percent effect of subsidies that reduce enrollees' premiums by $39–$40 per month, or $468–$480 per year (a 57 percent average reduction), in prior evidence from the Massachusetts exchange (Finkelstein, Hendren, and Shepard 2019). It is somewhat larger than the 20–26 percent impact of introducing Massachusetts's uninsurance penalty (Chandra, Gruber, and McKnight, 2011).[39] Therefore, auto-enrollment has an impact comparable to sizable changes in financial incentives.

Despite its large impact, the targeted nature of the auto-enrollment policy—applying only to people who had already qualified for coverage—meant that its impact on overall uninsurance was more modest. Using ACS data, we estimate that Massachusetts had about 300,000 uninsured people in 2009, of whom about 62,000 had incomes below poverty and were likely CommCare eligible. Relative to this denominator, auto-enrollment's 14,900-person impact (see Supplemental Appendix B.3) represents a 24 percent decline in the eligible uninsured population.

## IV. Targeting Implications of Auto-Enrollment

In this section, we study the targeting implications of auto-enrollment. Who are the marginal enrollees, and how do they compare to inframarginal (active) enrollees? How does auto-enrollment affect the market risk pool? What mechanisms may explain passive individuals' failure to actively enroll? These questions matter both for the policy's positive economic implications and for its welfare interpretation. Section IVA provides descriptive evidence on targeting implications, comparing marginal (passive) versus inframarginal (active) enrollees on characteristics related to the value and cost of insurance. Section IVB shows evidence that auto-enrollment is unlikely to be (invalidly) enrolling individuals with duplicate private health insurance. Section IVC assesses mechanisms, both rational and behavioral, for why a small hassle deters so many people from taking up free coverage.

### A. *Targeting Implications and Impact on Market Risk Pool*

To study the targeting implications of auto-enrollment—that is, inferring its marginal versus inframarginal enrollees—we employ two methods. The first is motivated by our finding in Section IIIA that the number and composition of active

[39] Evidence from the ACA—which involves a somewhat higher-income population than in CommCare—suggests smaller impacts of both subsidies and uninsurance penalties (see, e.g., Frean, Gruber, and Sommers 2017; Lurie, Sacks, and Heim 2019). The 32 percent impact of auto-enrollment is even larger relative to subsidies and penalties based on these ACA estimates.

enrollees is unaffected by the end of auto-enrollment in 2010. This suggests that passive behavior is in a sense "exogenous" to the policy environment. If correct, this means that *observed passive* enrollees (prior to 2010) are also *marginal* enrollees who would not have enrolled without the policy in place.[40] Thus, we are in the fortunate position of directly observing who is a marginal versus inframarginal enrollee (something that is rarely true in the targeting literature). A simple comparison of passive versus active enrollees, therefore, should faithfully characterize marginal versus inframarginal individuals. We use this method for our main analysis, controlling for entry timing using cohort fixed effects.[41]

Our second method uses the *policy change* to infer marginal enrollee characteristics from compositional changes in new enrollment at the start of 2010. This method has the advantage of not requiring the assumption of exogenous passivity. However, it is statistically much less powerful and may suffer problems if enrollee attributes are trending over time. We therefore implement it as a robustness check, using the simple active versus passive comparison for our main estimates.

*Characteristics of Passive Enrollees.*—Table 1 shows the results from our main method comparing passive versus active enrollees. Overall, the results suggests four main patterns about passive (relative to active) enrollees:

**Younger, Healthier, and More Male:** Passive enrollees are younger by 3.8 years on average and are 22 percent more likely to fall into the youngest age (19–34) group. They are also more likely to be male, with an especially large share (44 percent higher) of young men age 19–34, a group often called "young invincibles" in insurance discussions. Likewise, passive enrollees are healthier, with 33 percent lower rates of any chronic illness and 49 percent lower rates of severe chronic illness. Overall, passive enrollees have 36 percent lower medical risk scores, a measure of predicted medical costs based on age, sex, and diagnoses.[42] Figure 6 visualizes these patterns in a different way by plotting the passive enrollment rate by age, sex, and risk score groups. Passive rates decline with age and risk, though they exceed 20 percent even for the oldest and sickest groups.

**Lower Medical Costs:** Consistent with their youth and health, passive enrollees incur 44 percent lower monthly medical costs ($228 per month versus $408 for active enrollees) and are more likely to have 0 spending. The slightly larger gap for spending (−44 percent) relative to risk score (−36 percent) suggests passive enrollees may also be unobservably healthy. Because the government pays insurers

[40] More generally, one could think of passive enrollees as falling into two groups: (i) "always passives," who are passive regardless of the policy, and (ii) "conditional passives," who are passive under auto-enrollment but make sure to actively enroll when it is gone. Our evidence in Section IIIA suggests that there are few if any conditional passives in our setting.

[41] This lets us control for any time trends (e.g., medical cost growth) that could affect results if passive rates vary over time. In practice, these fixed effects have little impact on results. The specific method is as follows. Let $Y_{i,c}$ be a characteristic/outcome for new enrollee $i$ who joins CommCare in entry cohort $c$ (i.e., in a given year-month). We regress $Y_{ic} = \alpha_c + \delta \cdot \mathbf{1}\{Passive_i\} + \varepsilon_{i,c}$, which includes a cohort fixed effect ($\alpha_c$). Table 1 reports the mean for active enrollees ($\bar{Y}_{active}$), the adjusted mean for passive enrollees ($= \bar{Y}_{active} + \delta$), and the difference between the two ($\delta$).

[42] We use the HHS-HCC risk score (silver-CSR version), as used in the ACA Marketplaces, calculated based on diagnoses observed on claims during an enrollee's first 12 months enrolled.

TABLE 1—TARGETING IMPLICATIONS: COMPARING ACTIVE VERSUS PASSIVE ENROLLEES

| Variable | Active Enr. (1) | Passive Enr. (2) | Diff (3) | (SE) (4) | % Diff (5) |
|---|---|---|---|---|---|
| *Panel A. Age and sex* | | | | | |
| Average age (years) | 35.6 | 31.8 | −3.8 | (0.1) | −11 |
| Age 19–34 | 0.535 | 0.652 | +0.118 | (0.003) | +22 |
| Age 35–54 | 0.339 | 0.271 | −0.068 | (0.003) | −20 |
| Age 55+ | 0.126 | 0.077 | −0.049 | (0.002) | −39 |
| Share male | 0.538 | 0.625 | +0.087 | (0.003) | +16 |
| Male age 19–34 | 0.286 | 0.411 | +0.125 | (0.003) | +44 |
| *Panel B. Health status and medical spending* | | | | | |
| Any chronic illness | 0.641 | 0.427 | −0.215 | (0.003) | −33 |
| Severe chronic illness | 0.158 | 0.081 | −0.077 | (0.002) | −49 |
| Risk score (HCC) | 1.011 | 0.644 | −0.367 | (0.015) | −36 |
| Average cost ($/month) | $408 | $228 | −$181 | (5.6) | −44 |
| Any spending (> $0) | 0.894 | 0.709 | −0.185 | (0.003) | −21 |
| *Panel C. Income and area disadvantage* | | | | | |
| Income/poverty line | 0.248 | 0.200 | −0.049 | (0.004) | −19 |
| High-disadvantage area | 0.320 | 0.401 | +0.082 | (0.003) | +25 |
| Share Black (in zip code) | 0.082 | 0.106 | +0.024 | (0.001) | +29 |
| Share Hispanic (in zip code) | 0.137 | 0.162 | +0.025 | (0.001) | +18 |
| Near safety net hosp./CHC | 0.371 | 0.458 | +0.087 | (0.003) | +23 |
| *Panel D. Duration enrolled* | | | | | |
| Average (month) | 16.5 | 11.9 | −4.6 | (0.1) | −28 |
| Share 1–3 months | 0.154 | 0.228 | +0.075 | (0.002) | +48 |
| Share 12+ months | 0.559 | 0.441 | −0.119 | (0.003) | −21 |
| Share 16+ months | 0.297 | 0.168 | −0.129 | (0.003) | −43 |

*Notes:* The table shows differences in characteristics/outcomes for passive versus active enrollees in our main sample of below-poverty new CommCare enrollees during FY 2008–2009. Estimates control for entry cohort fixed effects and (for all variables except "Duration" in panel D) are weighted averages by months enrolled (capped at 12 months). Health and cost measures are based on claims during the enrollee's first 12 months enrolled. Chronic illnesses follow a classification of ICD-9 diagnosis codes shared with us by David Cutler. Risk score is based on the HHS-HCC model (silver-CSR version) used for risk adjustment in the ACA, renormalized to have mean 1.0 in the CommCare data. Income refers to family income as a share of the federal poverty level. High-disadvantage areas are zip codes (ZCTAs) in the seventy-fifth percentile or higher of the social deprivation index (SDI) produced by the Robert Graham Center (2005-2000) based on ACS data (see https://www.graham-center.org/maps-data-tools/social-deprivation-index.html), which also includes data on zip code–level shares of Black and Hispanic people. "Near safety net hospital or Community Health Center (CHC)" refers to the share of enrollees living in zip codes within two miles of one of these facilities (Google Maps API 2013).

using risk-adjusted capitation, passive enrollees' lower risk scores imply that the government also incurs lower costs to cover them.[43]

**More Economically Disadvantaged:** Passive enrollees are more disadvantaged across several metrics. Their incomes are slightly lower (20 percent versus 25 percent of poverty). Their differences in neighborhood characteristics (based on zip code) are larger. Passive enrollees are 25 percent more likely to live in a zip code in

[43] Up to 2009, CommCare used a crude risk adjustment system that varied rates by age-sex-region cells. Under this system (which we can observe), the average government payment for passives was 8 percent less than for active enrollees ($344 versus $373 per month). Starting in 2010, the program shifted to a stronger diagnosis-based risk adjustment, similar to the HCC risk scores we report. Although we lack full data until 2011 on CommCare's risk adjuster, the 36 percent lower HCC scores suggest rates would be substantially lower for passives.

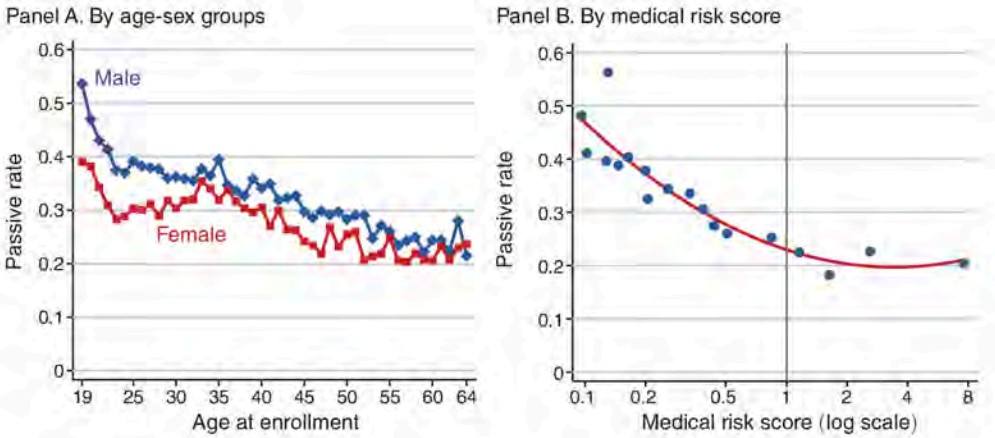



FIGURE 6. PASSIVE ENROLLMENT RATE BY AGE, GENDER, AND MEDICAL RISK

*Notes:* The figure plots variation in the passive enrollment rate—the share of new enrollees who join passively—by age-sex groups (panel A) and medical risk score bins (panel B). The data are for our main sample: new enrollees in the relevant below-poverty income group during fiscal years 2008–2009. The medical risk score is the HHS-HCC risk score (silver-CSR version) used by the ACA Marketplaces, calculated based on diagnoses observed on claims during the first 12 months of enrollment.

the top quartile of the Social Deprivation Index, a measure based on census data.[44] Their zip codes include a higher share of Black and Hispanic residents.

**Shorter Durations:** Passive enrollees are enrolled for shorter periods, with average durations 4.6 months (or 28 percent) shorter. Although we do not observe the reason for these shorter spells, an analysis of the time pattern of exits (see Supplemental Appendix C.2) suggests a combination of two factors: (i) a higher rate of brief 1–3 month spells and (ii) a higher exit rate during annual eligibility redetermination (12–14 months into the spell). The latter is consistent with a failure to complete redetermination paperwork, another administrative hassle.

A natural question is whether measured risk differences are driven by passive enrollees' shorter durations (see "Shorter Durations" above), which limits the period over which medical conditions can be observed in claims data. In practice, this does not appear to be a major source of bias. Supplemental Appendix C.1 shows that health differences are robust to using shorter measurement periods (including using just the first month enrolled) and to examining a balanced panel of active and passive enrollees enrolled for the same duration.

In line with their residence in lower-income neighborhoods, passive enrollees are also more likely to live nearby (within two miles) a safety net hospital or community health center. This proximity raises the question of whether they use

[44] We use the Social Deprivation Index (SDI) developed by the Robert Graham Center (see https://www.graham-center.org/maps-data-tools/social-deprivation-index.html, accessed January 1, 2025). SDI is an index of area-level deprivation derived from ACS data, based on income, education, housing, employment, and other demographics. We define "high disadvantage" as neighborhoods in the top quartile of the SDI based on the national distribution.

more "uncompensated care"—an important social cost of uninsurance (Finkelstein, Mahoney, and Notowidigdo 2018) that we include in our model in Section I. Supplemental Appendix C.3 presents analysis to test this idea. A limitation is that we cannot directly observe care used by active versus passive individuals when *uninsured*. However, based on care use when insured, passive enrollees obtain a larger share of their care from standard sources of uncompensated care, including emergency rooms and safety net hospitals.

*Interpreting the Differences.*—Overall, this evidence is consistent with the two main features of our ordeals targeting framework in Section I: *self-targeting* and *adverse selection*. Consistent with self-targeting, passive enrollees (those screened out by ordeals) have attributes consistent with lower demand (value) for health insurance. This includes the young and healthy, who on average need less medical care, and shorter-duration enrollees, who may only have a brief need for public coverage (e.g., between jobs). Demand for health insurance also tends to be low among the poor (Finkelstein, Hendren, and Luttmer 2019; Finkelstein, Hendren, and Shepard 2019; Tebaldi forthcoming).

But consistent with adverse selection, these same low-demand individuals also incur much lower costs. Passive enrollees incur 44 percent lower monthly medical costs, and including their shorter durations, their average per spell costs are 60 percent lower. This is natural in an adverse selection market where both value and costs are driven by an enrollee's medical risk (and by their enrolled duration). As a result, our theory suggests that *self-targeting* may not translate into *socially* beneficial targeting. We evaluate this idea more formally using our empirical model in Section V.

*Robustness: Inference Using the Policy Change (and Risk Pool Impacts).*—As a robustness check, we use the 2010 policy change to infer marginal enrollees. Prior to 2010, new enrollees include both active and passive individuals; afterward, only active choosers enroll. Marginal enrollees' characteristics, therefore, can be inferred from the *compositional* change at the start of 2010. To implement this, we run DD regressions analogous to equation (13) but with a dependent variable of characteristics/outcomes of new enrollees. Regressions are run on individual-level data, clustering standard errors at the income group-by-month level.

Figure 7 shows the raw data and DD estimates for two key risk pool variables: average risk score (panel A) and average cost (panel B) for new enrollees. There is a clear increase in both measures for the treatment group (red) relative to controls (green) after auto-enrollment is suspended.[45] The effects are large, with DD estimates suggesting a 0.146 increase in average enrollee risk (implying 14.6 percent higher costs) and $57.6 increase in average monthly cost (also about a 15 percent increase). This implies that marginal enrollees screened out are lower risk and lower-cost, just as we found in Table 1. We can further compare the methods quantitatively by calculating what Table 1 predicts for the analogous change in average

[45] Counterintuitively, prior to 2010, the controls have higher risk scores but similar costs to the treatment group, and this pattern flips in 2010+. This occurs because CommCare provided more generous benefits to the treatment group, including dental care and slightly lower copays, which results in higher costs partly through a moral hazard effect (see Chandra, Gruber, and McKnight 2014).

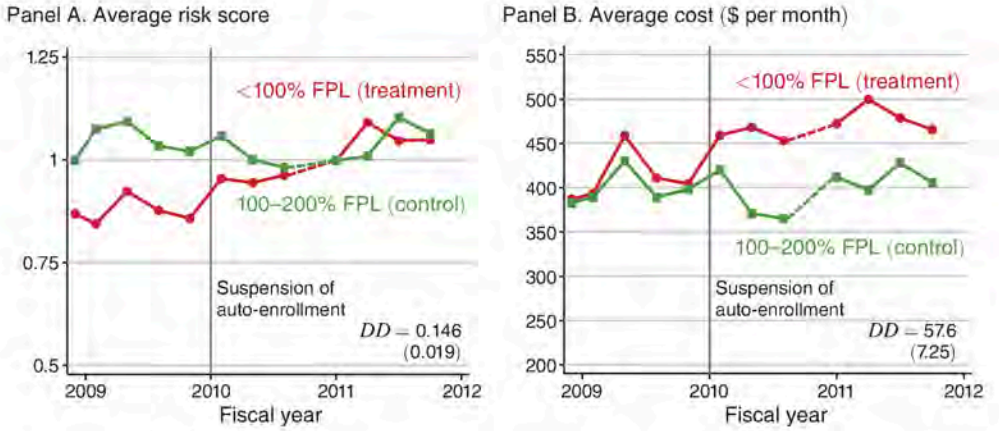



FIGURE 7. EFFECT OF AUTO-ENROLLMENT SUSPENSION ON ENROLLEE RISK POOL

*Notes:* The figure shows data on average risk score (panel A) and monthly medical costs (panel B) for new enrollees, and estimates of the DD specification (13) using quarterly time periods. Each panel shows trends for below-poverty enrollees (the treatment group) versus 100–200 percent of poverty enrollees (the control group). The temporary reinstatement period is excluded (as indicated with dashed lines). When auto-enrollment is suspended, average risk score rose by 14.6 percent of the market average (which is 1.0), and average medical costs rose by $57.60 per month, also about a 15 percent increase. Both are consistent with the suspension of auto-enrollment resulting in higher-cost risk pools.

risk score and cost, assuming that passive behavior is exogenous.[46] This exercise predicts a 0.119 increase in average risk score and $58.8 increase in average cost, which are very close to (and statistically indistinguishable from) the DD estimates in Figure 7.[47]

### B. *Do Passive Enrollees Have Duplicate Private Insurance?*

A relevant question for the targeting implications of auto-enrollment is whether it enrolls people who *already* have private health insurance, making CommCare duplicative. Although duplication is not supposed to occur—CommCare applicants must attest to not having access to any other health insurance (including any *offer* of job-based coverage)—enforcement could be imperfect. If auto-enrollment "overenrolls" individuals who already have other coverage, it would be a failure of "statutory targeting" based on program eligibility rules, something that has been observed for transfer programs in a developing country context (Alatas et al. 2016).

[46] To do so, note that for any variable $Y$, $\bar{Y}_{Pre2010} = s_P \bar{Y}_P + (1 - s_P)\bar{Y}_A$ and $\bar{Y}_{Post2010} = \bar{Y}_A$, where "$P$" and "$A$" subscripts refer to passive and active enrollees. Therefore, $\Delta\bar{Y} = \bar{Y}_{Post2010} - \bar{Y}_{Pre2010} = s_P \cdot (\bar{Y}_A - \bar{Y}_P)$. We calculate $\Delta\bar{Y}$ using the estimates for $\bar{Y}_A$ and $\bar{Y}_P$ in Table 1 and $s_P = 0.326$ from Figure 5.

[47] Supplemental Appendix C.4 shows a similar robustness analysis for all variables in Table 1; the Supplemental Appendix also describes the methods in greater detail. For all variables, our main method and the DD estimates are directionally similar, always generating estimates of the same sign. Moreover, the methods usually yield quantitatively similar estimates with overlapping confidence intervals.

To test this story, we draw on evidence from the Massachusetts APCD to measure rates of simultaneous duplicate coverage in CommCare and private insurance, a measure of whether "overenrollment" occurred in practice.[48] We define the "duplication rate" as the share of CommCare enrollment months during which the member was simultaneously enrolled in other private insurance.[49] Supplemental Appendix D.1 provides additional details on the data and method.

Overall, we find little evidence of meaningful duplicate coverage in CommCare. The average duplication rate is quite low, just 3.1 percent of enrollee-months, and the rate is even lower at the beginning of enrollment spells when auto-enrollment occurs (see Supplemental Appendix Figure A.13). Moreover, there is little evidence that duplication is higher for passive enrollees. Although we cannot distinguish active versus passive enrollees in the APCD, we can study how duplication rates *change* for new enrollees into CommCare just before versus after auto-enrollment is suspended in 2010. In practice, the duplication rate rises slightly after the policy change, consistent with marginal (passive) enrollees having lower duplication rates. However, duplication rates are low both before and after the change. Our overall conclusion is that duplicate coverage is rare and is unlikely to explain failure to actively take up coverage.

### C. *Mechanisms: Why Do People Fail to Take Up Free Insurance?*

Why do so many people fail to enroll in free health insurance when faced with a small hassle? In this subsection, we provide descriptive evidence to assess the mechanisms involved, including both rational and behavioral explanations. We argue that non-enrollment is unlikely to be explained by fully rational and informed stories, in which individuals are passive because they do not need or benefit from (free) public health insurance. Instead, we argue that behavioral "frictions" are likely involved, with the most likely frictions being inattention and limited understanding of program rules.

*Evidence against Fully Rational Non-enrollment.*—We start by providing evidence against fully rational and informed non-enrollment. We start by noting that several facts about the institutional setup make this a priori less likely. First, everyone in our sample—including passive enrollees—has already *chosen* to apply for public coverage (in step 1 of the process). This suggests that they have some awareness of the program and a desire to enroll. Moreover, the insurance is free and extremely generous, with 0 deductible and close to 0 cost sharing (the actuarial value exceeds 99 percent). Although there are some limits (e.g., on networks), it seems implausible that enrollees would face fewer limits or costs if they were uninsured, the relevant counterfactual.

[48] Ideally, we would want to measure the *counterfactual* of whether CommCare enrollees obtain other insurance if they were (exogenously) kicked out of CommCare. While we cannot measure this counterfactual directly, the observed duplication rate provides suggestive evidence on whether overenrollment is a problem in general.

[49] We do not include duplicate coverage in CommCare plus Medicaid because the two programs use a unified enrollment system, which should automatically prevent duplicate enrollment. Most of the same insurers operate in both programs, and we have some concerns that the insurance type is sometimes mislabeled, which could lead to false positives.

Some simple facts further indicate that passive enrollees are likely to obtain meaningful benefits from health insurance. Although passive enrollees are *relatively* healthy, they are not *uniformly* so. Indeed, over 40 percent have a chronic illness, and 8 percent have a severe chronic illness (Table 1). Their average spending of $228 per month is large relative to their very low incomes (the individual poverty line in 2009 was $903/month). Supplemental Appendix Figure A.11 shows that passive enrollees experience meaningful rates of medical shocks (e.g., high-cost months, emergency hospitalizations) that while less frequent, still occur 60–75 percent as often as for active enrollees. Further, Figure 6 shows that even among the oldest and sickest enrollees, passive rates exceed 20 percent. Thus, while good health is predictive of being passive, it is clearly not the full explanation.

Finally, we argue that access to charity care is unlikely to be a perfect substitute for formal insurance that drives its (true) value down to near zero. First, passive enrollees use a meaningful amount of care in categories that are less available via charity care, including prescription drugs.[50] Second, the prior literature on the value of insurance to the poor suggests that while value is *low*, it is far above *zero*. For instance, a key paper in this literature, Finkelstein, Hendren, and Luttmer (2019), finds that the individual value of insurance is just 20–48 percent of insured medical expenses. Applied to our passive enrollees (who spend $228 per month when insured), this would imply a value of $46 to $109 per month—or $550 to $1,300 over a typical 12-month enrollment spell. This is a sizable amount. For instance, it is comparable to forgone benefits from failing to take up the EITC or SNAP (Bhargava and Manoli 2015; Finkelstein and Notowidigdo 2019) and from losses due to insurance plan choice errors (Abaluck and Gruber 2011; Bhargava, Loewenstein, and Sydnor 2017).

*Evidence on Behavioral Frictions.*—We test two types of behavioral explanations: (i) those in which the *complexity of plan choice* is the key barrier and (ii) those in which *taking action* is the key barrier, for instance, because of inattention or misunderstanding the steps required to enroll. We find little evidence of (i) but suggestive evidence consistent with (ii).

*Choice Overload.*—One reason people might be passive when asked to select a health plan is that they become overwhelmed by the choice, as in models of "choice overload" (Iyengar and Kamenica 2010). We note that choice overload is a priori less likely in the CommCare setting, which featured a relatively simple choice set with at most four to five plans available.[51] Further, the passive enrollment rate is unrelated to the choice set size, which varies across areas due to selective insurer entry. Supplemental Appendix Table A.7 shows that the passive rate varies in a narrow range of 33–35 percent across all choice set sizes, including at 34 percent in

[50] We observe that 25 percent of passive enrollees take a regular prescription medication every month they are enrolled, with an average cost of $45 per month. Over a typical 12-month enrollment spell, these prescription costs alone would add up to $540.

[51] There were four plans prior to 2010, and a fifth (CeltiCare) entered during 2010. This is much simpler than other US insurance programs. For instance, Medicare Advantage features an average choice set with 33 options (see https://www.kff.org/medicare/issue-brief/medicare-advantage-2021-spotlight-first-look), and Medicare Part D feature 25–35 plan options (see https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit).

areas with just a *single* plan (i.e., no real choice). Moreover, passivity does not change significantly when a plan enters or exits a region. We conclude that there is little evidence that choice overload is responsible for passive behavior in this context.

*Inattention or Misunderstanding.*—A second type of reason for passivity is that some people are inattentive or misunderstand the steps required to enroll in coverage.[52] If so, requiring an additional step of action—even a seemingly simple step—will lead some individuals to "fall through the cracks" and not enroll. We present three sets of facts consistent with a role for inattention and/or misunderstanding. These are discussed here, with the underlying analyses presented in Supplemental Appendix C.8.

- **"Lost in the Mail":** A natural reason for inattention is if some people do not receive the approval letter instructing them how to actively enroll. Anecdotally, address errors are a common problem in welfare programs, partly because of greater residential instability in low-income populations. To test for this, we construct a proxy for "address mismatches" based on observing different zip codes in CommCare's enrollment file (based on the address used in administrative mailings) versus on the enrollee's first observed medical claim (submitted by the medical provider, often based on paperwork filled out at a visit). As detailed in Appendix C.8, address mismatch is surprisingly common, occurring for about one-third of enrollees. Moreover, it is predictive of passive behavior. After conditioning on the sample with an observed claim in their first 6 months, the passive rate is 28 percent for mismatched, about 3 percentage points (or 13 percent) higher than for nonmismatched people. This pattern is robust to controlling for demographics, health, and timing of the first claim.
- **Special Barriers:** Misunderstanding may be more common in groups that face special barriers to interacting with the state and learning about take-up rules. This idea is consistent with the evidence, shown above, that socioeconomically disadvantaged groups are more likely to be passive. Another such group is immigrants, who likely face greater language and cultural barriers.[53] Consistent with this, passive rates are higher for immigrants (41 percent rate), about 7 percentage points (or 21 percent) higher than for nonimmigrants (34 percent).
- **Cross-Program Transitions:** Misunderstanding or inattention may be more common when people transition between public programs in which take-up rules differ. We observe two types of transitions in our data: (i) a large shift of enrollees from the state's uncompensated care pool to the CommCare exchange in early 2007 and (ii) regular transitions from Medicaid into CommCare (e.g., due to changes in income, age, or family status). Active plan choice was not required in either the UCP or Medicaid, so there may be greater confusion in

[52] There is substantial evidence of limited attention/understanding and other behavioral frictions for consumer choice *among* health plans (e.g., Abaluck and Gruber 2011; Handel 2013; Ericson 2014; Handel and Kolstad 2015). Thus, it is plausible to think that the same issues might affect whether people enroll in health insurance in the first place.

[53] Immigrants were excluded from our main analysis sample, as discussed in Section IIC. For this analysis, we augment the main sample to re-include them.

these groups about enrollment processes in CommCare. Consistent with this, passive rates are much higher for these transitions. People transitioning from the UCP had a 60 percent passive rate (versus 40 percent for other enrollees at the same time in early 2007). People transitioning from Medicaid have a 39 percent passive rate (versus 31 percent for non-Medicaid enrollees). The latter is partly driven by very high passivity for kids transitioning off of Medicaid at age 19 (Jácome 2020), but passive rates are higher for Medicaid transitions even controlling for age, gender, and health covariates.

## V. Empirical Model and Policy Trade-offs

In this section, we empirically apply our model from Section I to our health insurance setting in Sections VA–VC, using a combination of our administrative data, the auto-enrollment natural experiment, and outside estimates. We use the estimates to assess the question with which we started the paper: How well do ordeals work to target enrollment in health insurance?

### A. *Model Implementation*

Our ordeals welfare framework requires estimates of four objects for enrollees: (i) the direct medical cost of insurance, $C_i$; (ii) the enrollee value of insurance, $W_i$; (iii) social spillovers, $E_i$; and (iv) fiscal externalities, $FE_i$. Together, these let us calculate $V_i^{Soc} = \mu W_i + E_i$ (for various assumptions on the social welfare weight $\mu$) and $C_i^{Net} = C_i - FE_i$, which together are sufficient for net social welfare, $\gamma_i = V_i^{Soc} - C_i^{Net}$.

Our natural experiment and rich insurance claims data let us directly measure the distribution of marginal (passive) and inframarginal (active) enrollees and their medical costs ($C_i$). We assume that the government either directly pays medical expenses (as in traditional Medicare and Medicaid) or engages in zero-profit contracting with private insurers (as we find is roughly true in Massachusetts).[54] In both cases, medical costs for individual $i$ in the claims data are a reasonable estimate of the government's marginal cost when they enroll in insurance (i.e., $C_i$ in the model).[55] With this assumption, our claims data give us a direct estimate of $C_i$ and the average cost for active ($\bar{C}_1$) and passive ($\bar{C}_0$) enrollees.

[54] Supplemental Appendix Table A.9 shows evidence of this zero-profit contracting for the below-poverty population, for whom CommCare negotiated a separate set of payment rates directly with insurers (as opposed to the bidding system used for higher-income groups). The table compares the government's payment and insurer's cost for active and passive enrollees. Insurers earned small overall margins (of about 4 percent, or $16 per enrollee-month), despite overpaying for passive and underpaying for active enrollees. The table also shows that had the exchange paid using more sophisticated risk adjustment, this group-specific over-/underpayment would shrink, but overall profit margins would remain near zero. We interpret this as evidence that (i) CommCare was able to negotiate lower average prices for the below-poverty population as a whole because of the inclusion of healthier auto-enrollees, and (ii) average prices paid approximately reflect average costs.

[55] This relationship is immediate when the government directly pays claims. In the zero-profit contracting case, the relationship follows from the fact that the government's total payments equal insurers' total cost for all enrollees. When $i$ is enrolled, insurers' total costs increase by $C_i$, and to maintain zero profits, the government's extra cost is also $C_i$. Note that this analysis abstracts from any nonmedical administrative costs (for either government or private insurers), which we cannot directly measure in our claims data.

To estimate the remaining items (ii)–(iv), we combine what we do observe with information from other studies and data sources. In what follows, we describe our strategy for estimating each term.

*Uncompensated Care Costs.*—The main component of social and fiscal externalities is uncompensated care, so we start with estimating it. In our data, we observe medical costs when insured, $C_i$.[56] To estimate uncompensated care costs that $i$ would incur if *uninsured*, we proceed in two steps. First, the uninsured use less care than the insured because of moral hazard, which we assume increases costs by a constant factor, $1 + MH$. Second, the uninsured themselves pay only a share, $\phi < 1$, of their medical bills, with uncompensated care covering the other $1 - \phi$. Thus, uncompensated care costs equal

$$C_i^{UC} = \left(\frac{1-\phi}{1+MH}\right) \cdot C_i. \tag{14}$$

Estimating $C_i^{UC}$ requires values for $\phi$ and $MH$. For our baseline estimates, we draw on the analysis of Finkelstein, Hendren, and Luttmer 2019 of the Oregon Health Insurance Experiment. They estimate a moral hazard effect of $MH = 33.3\%$ and an uninsured out-of-pocket share of bills of $\phi = 0.21$, both of which we treat as constant across enrollees.[57] Using this method, therefore, we estimate $C_i^{UC} = 0.59\, C_i$.

We consider two alternatives in sensitivity analysis. First, as extreme upper and lower bounds, we consider $\phi = 0$ (full uncompensated care) and $\phi = 1$ (implying $C_i^{UC} = 0$). Second, we construct new estimates using data from a Massachusetts program, the Health Safety Net (HSN), that covers a subset of medical expenses for uninsured low-income adults. The HSN is an uncompensated care pool that (unlike most similar programs) pays based on formal claims, which are observable in the state's APCD. We use these data, combined with estimates of total uninsurance from the ACS, to estimate uncompensated care costs by age-sex group, which we then project onto our CommCare data. The method involves several assumptions, which we detail in Supplemental Appendix E.

*Social and Fiscal Externalities of Insurance.*—Having estimated uncompensated care costs, we divide its incidence between the government (part of $FE_i$) and private

[56] Technically, we observe *realized* medical spending, which differs from *ex ante* expected costs due to the realization of an *ex post* health shock. We assume throughout that this shock is idiosyncratic and additively separable, so that it averages to zero in any sufficiently large group $g$ (e.g., passive enrollees). Formally, let $C_i$ be realized costs and $E[C_i]$ be expected costs. We assume that $C_i = E[C_i] + \omega_i$, with $E[\omega_i] = 0$ and $\omega_i$ independent of all other variables in the model including group membership. Under these assumptions, $\bar{C}_g = \frac{1}{N_g}\sum_{i \in g} C_i = \frac{1}{N_g}\sum_{i \in g}(E[C_i] + \omega_i) \to \frac{1}{N_g}\sum_{i \in g} E(C_i)$ for large enough $N_g$.

[57] Finkelstein, Hendren, and Luttmer (2019) estimate that in the Oregon experiment, health insurance increases annual medical spending by $900, which is 33.3 percent of the control complier (uninsured) mean of $2700. They estimate that control compliers (the uninsured) spend $569 per year in out-of-pocket expenses, which implies $\phi = 569/2700 = 0.21$. We treat $MH$ and $\phi$ as constant across enrollees, implying $C_i^{UC}$ scales proportionally with insured costs, since it is unclear how to estimate heterogeneity. If anything, the evidence suggests that $C_i^{UC}$ are disproportionately larger for passives, suggesting we may (conservatively) understate their relative efficiency.

providers (part of $E_i$). We assume that the government bears a fixed share, $\psi_G \in [0, 1]$, of costs, which implies

$$FE_i = \psi_G \cdot C_i^{UC} \quad \text{and} \quad E_i = (1 - \psi_G) C_i^{UC}. \tag{15}$$

Note that this assumes no other externalities of insurance besides uncompensated care, which is a conservative assumption.[58] To estimate $\psi_G$, we draw on the evidence from Garthwaite, Gross, and Notowidigdo (2018), who study the impact of uninsurance on hospital uncompensated care costs and profits. They find that for every $1 higher uncompensated care costs, hospitals absorb $0.60–$0.67 in lost profits. In our main estimates, we set $\psi_G = 0.635$, the midpoint of this range.

*Enrollee Value of Insurance.*—Estimating value (or WTP) is challenging in our main sample because of a lack of price variation—all plans are free. Moreover, the presence of frictions raises concerns about inferring low WTP directly from passive behavior, which may be a consequence of enrollees having high frictions (e.g., inattention or forgetfulness). To make progress, we follow the "rational consumer benchmark" approach described by Bernheim and Taubinsky (2018), which has also been implemented by Bronnenberg et al. (2015) and Allcott, Lockwood, and Taubinsky (2019). The approach involves estimating preferences among a well-informed reference population (the "benchmark") in order to impute the WTP of another group. We use price variation for higher-income CommCare enrollees (150–250 percent of poverty) who all pay positive prices, replicating and extending the demand estimation method of Finkelstein, Hendren, and Shepard (2019). We then project these demand estimates onto our below-poverty population at the level of detailed observables (age-sex-risk group cells).

This exercise rests on two assumptions: (i) that higher-income enrollees reveal their WTP when making active choices and (ii) that age-sex-risk observables are sufficient for projecting WTP onto lower-income groups. Assumption (i) is consistent with a model of pure inattention frictions (e.g., forgetting to act) that prevent passive types from enrolling but do not bias demand estimates for active choosers. This assumption implies that demand reveals true WTP *among the sample of higher-income active enrollees* (150–250 percent of poverty).[59] Assumption (ii) allows us to impute this WTP distribution onto our lower-income (0–100 percent of poverty) population of interest, conditional on age-sex-risk cells. However, it is vulnerable to concerns about selection on unobserved preferences. To address this, we examine robustness to alternative assumptions about unobserved sorting, described in greater detail below.

We summarize the method here, with details and estimates presented in Supplemental Appendix F. Finkelstein, Hendren, and Shepard (2019) use RD variation in subsidies and premiums to estimate a demand (WTP) curve for insurance.

[58] For instance, there is evidence that health insurance for kids leads to long-run economic gains that boost future tax revenue (Brown, Kowalski, and Lurie 2020) and that insurance for young adults reduces crime (Jácome 2020). We do not include these since it is unclear how to estimate their distribution for different types of enrollees.

[59] Of course, this benchmark may under-/overstate the value of insurance if higher-income active choosers suffer from behavioral biases or liquidity constraints. Our analysis that scales enrollee welfare by a range of social welfare weights, $\mu$, can partly address this concern.

They observe three income thresholds at which premiums increase discretely: from \$0 to \$39 per month (at 150 percent of poverty), from \$39 to \$77 (at 200 percent of poverty), and from \$77 to \$116 (at 250 percent of poverty). By observing how much enrollment falls at each threshold, they infer points on an insurance demand curve. These can be linearly connected and extrapolated to generate a full demand curve $D(s)$, where $s \in [0,1]$ indexes people from highest to lowest WTP.

To adapt Finkelstein, Hendren, and Shepard's (2019) method to our problem, we make two adjustments. First, we use 2009–2011 data, matching our analysis period. Second, we use the micro-data to estimate demand separately by cell of $g =$ {age group, sex, risk score bin}. We use roughly 5-year age bins and quintiles of HCC risk score, with an additional category for the sickest 5 percent of enrollees. With a demand curve for each cell, $D_g(s)$, we project WTP onto each enrollee $i$ in our below-poverty sample using the average WTP for their $g$ cell, that is, $W_i = E\left[D_{g(i)}(s)\right]$, where the average is over $s$.[60] This method lets us capture WTP heterogeneity via observable factors included in $g$ (age, sex, and medical risk). We also consider several assumptions for *unobserved* sorting between active versus passive enrollees, including no sorting, perfect sorting, and (for our baseline specification) unobserved sorting of "equal magnitude" to observed sorting, in a sense formalized in Supplemental Appendix F.[61]

We consider several alternatives in sensitivity analysis. In addition to variations on the demand-based approach (e.g., no or perfect unobserved sorting), we consider mapping insured medical costs (which we observe) to enrollee WTP using simple relationships estimated in the literature. Specifically, Finkelstein, Hendren, and Luttmer (2019) find that low-income Medicaid enrollees value insurance at 20–48 percent of insured costs (i.e., $W_i = \kappa \cdot C_i$ for $\kappa \in [0.20, 0.48]$); we report estimates for the endpoints of this range. We also consider a plausible lower bound in which WTP equals expected uninsured out-of-pocket (OOP) costs (with no value for risk protection), based on the framework underlying equation (14). This implies $W_i = \left(\frac{\phi}{1+MH}\right) C_i = 0.16\, C_i$ given the values of $\phi = 0.21$ and $MH = 0.333$.

Finally, we examine implied WTP for full insurance from a simple model of homogeneous risk aversion, under a benchmark assumption of no moral hazard or uncompensated care. Specifically, we simulate the value of insurance using observed

[60] Calculating average WTP (the conceptually correct statistic) requires using the linearly extrapolated portion of the demand curve, which comprises about the bottom 30–40 percent of demand. As robustness, we also examine the median and seventy-fifth percentiles of WTP, which are much less likely to be extrapolated. These generate smaller estimates of WTP but similar implications for the *relative* WTP and MVPF for active versus passive enrollees.

[61] Briefly, unobserved sorting relates to the range of $s$ over which we average to calculate $W_i = E\left[D_{g(i)}(s)\right]$. For no sorting, we average over $s \in [0,1]$ for both actives and passives; therefore, WTP is equal for everyone *within* a $g$ cell. For perfect sorting, we assume that within each $g$ cell, actives comprise the highest 67 percent of WTP types ($s \in [0, 0.67]$), while passives comprise the lowest 33 percent of WTP types ($s \in [0.67, 1.00]$), where 33 percent is the overall share of passives in our data. For our baseline specification, we assume "equal" sorting on unobservables and observables. Formally, we calculate the probability that a random active enrollee is in a $g$ cell with higher estimated WTP than a random passive enrollee. This is 56 percent in our data. We then set the averaging ranges of $s$ so that this probability is also 56 percent *within* each $g$ cell (i.e., unobserved sorting), which we show corresponds to $s \in [0, 0.96]$ for actives and $s \in [0.08, 1.00]$ for passives.

medical claims and an exponential utility function with coefficient of absolute risk aversion of $\alpha = 8.6 \times 10^{-5}$ taken from Handel and Kolstad (2015).[62]

*Social Welfare Weight* ($\mu$).—Our key value statistic is the social value of insurance, $V_i^{Soc} = \mu W_i + E_i$, which scales enrollee WTP ($W_i$) by a social welfare weight, $\mu$ (and adds externalities, $E_i$). For simplicity, we use a constant $\mu$ for all eligible individuals, but we consider a range of values to capture distributional goals. Our baseline calculations use $\mu = 1$ (i.e., Kaldor-Hicks efficiency), but we consider a range of $\mu \in [0.5, 3.0]$ for robustness, where $\mu > 1$ allows for a social value of redistribution, while $\mu < 1$ captures tight public budgets.

*Direct Cost of Ordeals,* $L(\sigma)$.—Throughout this exercise, we focus only on the ordeal's targeting implications, that is, the "gains from targeting" piece of their welfare impact in equation (6). Implicitly, we ignore any *direct costs* of the ordeals ($L(\sigma)$), which we do not have a good way to estimate and which we believe are small in our setting. Because direct costs would only reinforce our finding that ordeals do not work well, we view this as a conservative assumption. However, measuring direct costs may be important in other settings where these are likely to be larger.

### B. *Results: Model Estimates and Targeting*

Figure 8 shows our model's baseline estimates and the selection properties of auto-enrollment, comparing active versus passive enrollees in our main sample (as used in Table 1). Figure 8, panel A shows selection on social value, which includes both enrollee value and uncompensated care savings to private providers. Both the mean and the distribution of social value is lower for passive enrollees. On average, passive enrollees have both a lower private value of insurance (about 28 percent less than active enrollees) and use less uncompensated care when uninsured since they are healthier. Their average social benefit is $143 per month, about 34 percent less than for active enrollees at $217 per month. This finding that passive enrollees have lower (private and social) value of insurance than actives holds across every sensitivity analysis we consider, including different assumptions for demand estimation and alternate measures of uncompensated care (see Supplemental Appendix Table A.10). Our estimates, therefore, robustly suggest the active enrollment ordeal screens out low-value types, consistent with self-targeting and favorable sorting on value.

While there is favorable sorting on value, value and costs are also strongly correlated. Figure 8, panel B is a binned scatterplot showing the relationship between social value and net public costs, again comparing active and passive enrollees.[63]

[62] We compute expected utility, $\bar{u}_{g(i)} = E\left[\frac{-1}{\alpha} \cdot \exp(\alpha C_i)\right]$, separately by cells of $g$ = {age group, sex, risk score bin, passive versus active}, taking the expectation over the observed distribution of monthly medical spending $C_i$ within each cell. WTP for individuals in each cell is defined as the certainty equivalent, $W_i = \frac{1}{\alpha} \cdot \log(-\alpha \cdot \bar{u}_{g(i)})$.

[63] At the individual level, we observe realized—not expected—costs. We estimate expected medical costs by taking the mean of monthly realized costs (weighted by number of months enrolled) by cell of $g$ = {age group, sex, risk score bin} interacted with whether the individual was passive or active. Panel B of Figure 8 can therefore be thought of as displaying the joint distribution of social value and expected medical cost at the {age group, sex, risk score bin, active versus passive status}-cell level.

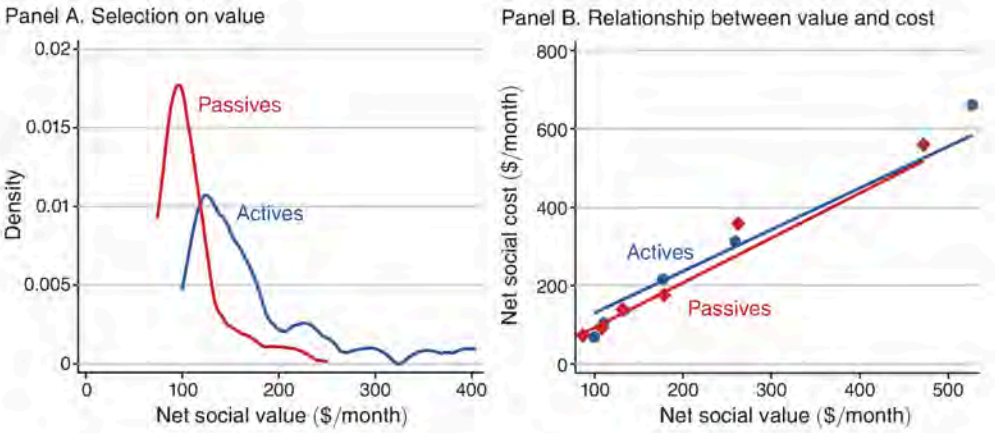



FIGURE 8. MODEL ESTIMATES: SELECTION ON VALUE AND COST

*Notes:* Panel A plots the density of our estimates of social value separately for both active (in blue) and passive (in red) enrollees, under our baseline demand and uncompensated care assumptions. For ease of visualization, only the bottom 90 percent of each distribution is shown in panel A. Panel B illustrates the joint distribution of social value and net costs for active (blue circles) versus passive (red diamonds) enrollees, along with respective best-fit lines. The sample for both figures is our main 2008–2009 new enrollee sample in the below-poverty group, just as in Table 1. See Section VA for the model estimation method. Both figures plot the distribution of estimates (mean WTP and mean costs per month, weighted by number of months enrolled) at the {age group, sex, risk score bin, active versus passive status}-cell level.

There is a strong positive correlation between value and cost that holds similarly for both active and passive enrollees. Moreover, the two best-fit lines are nearly on top of each other, suggesting that the ordeal achieves little sorting on residual costs ($\omega_i$) conditional on value. Instead, passive enrollees are simply low-value types who also have (proportionally) lower costs. In contrast to the standard case considered in the ordeals literature, screening out low-benefit types is insufficient to make the ordeal well targeted.

*Value-Cost Correlation and the Adverse Selection "Tax".*—As discussed theoretically in Section I, a positive value-cost correlation, $\rho$, reduces the social gains from screening out low-value types since they also have low costs. The extent of sorting on cost relative to sorting on value is captured by the term $\hat{\beta} = \rho \cdot \sigma_C/\sigma_V$, which we call the "adverse selection tax" on targeting efficiency. In the classic ordeals case with constant or uncorrelated costs ($\rho = 0$), targeting efficiency is purely a function of value sorting. But as the value-cost correlation and the variance of costs increases, this tax becomes larger, which reduces targeting efficiency relative to sorting on value. Overall, the correction term for cost sorting—or the *rate of selection on cost* ($= \Delta C^{Net}/\Delta V^{Soc}$)—equals the sum of the adverse selection tax and any selection on residual costs ($\omega_i$) uncorrelated with value (see equation 11).

Table 2 shows how this plays out using our estimates of social benefit and cost for both our baseline specification and several alternatives, using $\mu = 1$ for the social welfare weight on beneficiaries. Robustly across all specifications, we find a substantial positive value-cost correlation, $\rho$, which is 0.69 in our main specification. Correspondingly, we find substantial rates of selection on cost for the ordeal, exceeding 100 percent in both our baseline and 3 of the remaining 4 specifications.

TABLE 2—VALUE-COST CORRELATION AND TARGETING

| | Value and cost specification | | | | |
|---|---|---|---|---|---|
| | | Sensitivity analyses | | | |
| | Baseline (1) | No unobserved sorting (2) | Perfect unobserved sorting (3) | WTP = OOP costs (4) | Baseline w/ HSN uncomp. care estimates (5) |
| *Panel A. Joint distribution* | | | | | |
| Value-cost correlation ($\rho$) | 0.70 | 0.69 | 0.67 | 1.00 | 0.21 |
| SD of net cost ($\sigma_C$) | \$246 | \$246 | \$246 | \$246 | \$392 |
| SD of net cost ($\sigma_V$) | \$156 | \$155 | \$183 | \$147 | \$115 |
| *Panel B. Effect of value-cost correlation* | | | | | |
| Adverse selection tax ($\rho \times (\sigma_C/\sigma_V)$) | 110% | 110% | 90% | 167% | 72% |
| Selection on residual cost ($= \Delta\bar{\omega}$) | 42% | 103% | −31% | 0% | 283% |
| Total effect ($\Delta C^{Net}/\Delta V^{Soc}$) | 152% | 213% | 59% | 167% | 354% |

*Notes:* Column 1 shows results from our baseline model estimates, while columns 2–5 show sensitivity to alternative specifications. The sample is our main 2008–2009 new enrollee sample in the below-poverty group, just as in Table 1. See Section VA for the model estimation method. Panel A shows properties of the joint distribution of our estimates of social value $V^{Soc}$ and expected net cost $C^{Net}$, computed at the level of demographic cells defined in Section VA. Panel B shows the implication of the joint distribution for targeting of an ordeal that screens on $V^{Soc}$, under a baseline assumption of Kaldor-Hicks efficiency ($\mu = 1$). The adverse selection tax, defined as the regression coefficient $\rho \cdot \sigma_C/\sigma_V$, gives the rate at which screening on value also generates screening on cost. We also estimate $\Delta\bar{\omega}$, the extent to which the enrollment ordeal selects on residual costs (unexplained by social value), which is relative to $\Delta V^{Soc}$.

The lone exception is the "perfect sorting" specification, which reflects an extreme assumption on how well ordeals sort on unobserved value. But even in the perfect sorting case, we estimate a rate of selection on cost of 58 percent; that is, the social gains from targeting are limited to $1 - 0.58 = 42\%$ of the active-passive difference in value. Thus, our results suggest that adverse selection tends to reduce, and in many cases overturns, the gains from screening out low-value enrollees.

*Value-Cost Ratios and Targeting.*—When the government pays the full cost of insurance, as in CommCare, the value-cost ratio for active and passive enrollees ($\bar{R}_g = \bar{V}_g^{Soc}/\bar{C}_g^{Net}$ for group $g$)—or social benefit per dollar of net government spending—is informative for targeting efficiency. Table 3 shows the value-cost ratios for both active and passive enrollees in our main sample. In our baseline model (with $\mu = 1$, shown in columns 1–2), we find a higher social value-cost ratio for passive enrollees at 1.00, compared to 0.85 for actives. Mechanically, this reflects the correction for value-cost correlation described above: passive enrollees' proportional cost difference (−44 percent) exceeds their difference in social value (−34 percent). Thus, under our baseline specification, the ordeal targets ineffectively ($\Delta\gamma = \bar{\gamma}_1 - \bar{\gamma}_0 < 0$) and results in backward sorting. In principle, it would be optimal to exclude the active enrollees and enroll the passives, but the ordeal does the opposite.

Columns 3–4 of the table show what happens when we allow for distributional concerns by increasing the social welfare weight $\mu$ to 3.0, thus scaling up the social value of enrollee welfare. In this case, it is optimal to cover *both* active and passive enrollees because both their value-cost ratios exceed one. Thus, with $\mu = 3$, we are in the "optimal universality" case discussed in the theory.

TABLE 3—TARGETING IMPACT OF AUTO-ENROLLMENT

| | Baseline ($\mu = 1.0$) | | Higher welfare weight ($\mu = 3.0$) | |
|---|---|---|---|---|
| Value or cost variable ($/month) | Active enrollees (1) | Passive enrollees (2) | Active enrollees (3) | Passive enrollees (4) |
| *Social benefits* | | | | |
| WTP of enrollees (demand estimate, $W_i$) | $129 | $93 | $386 | $280 |
| Spillovers: Private uncomp. care savings ($E_i$) | $88 | $49 | $88 | $49 |
| Total benefits | $217 | $143 | $474 | $330 |
| *Public costs* | | | | |
| Medical spending (gross costs) | $408 | $228 | $408 | $228 |
| Fiscal externality: Public uncomp. care savings ($FE_i$) | −$154 | −$86 | −$154 | −$86 |
| Net public cost ($C_i^{Net}$) | $255 | $142 | $255 | $142 |
| Value-cost ratio ($R_i$) | 0.85 | 1.00 | 1.86 | 2.32 |
| | (Backward sorting) | | (Enrolling both groups optimal) | |

*Notes:* Columns 1 and 2 show our baseline model estimates of the social benefits and costs of insurance for active versus passive enrollees (or inframarginal versus marginal enrollees due to auto-enrollment), while column 3 shows the estimates where enrollee private valuations have been scaled by a social welfare weight of $\mu = 3.0$. The sample is our main 2008–2009 new enrollee sample in the below-poverty group, just as in Table 1. See Section VA for the model estimation method. Enrollee value comes from our demand estimates, using the specification with unobserved sorting equal to observed sorting on WTP.

Supplemental Appendix Table A.10 reports a variety of sensitivity analyses on these targeting results, using different estimates of enrollee value and uncompensated care. As already noted, the finding that (private and social) value is lower for passive enrollees is highly robust, holding in every specification. We also generally find that passive enrollees have similar or larger value-cost ratios, though this finding reverses if sorting on WTP is strong enough (this happens under the "perfect unobserved sorting," and "exponential utility" specifications).

*Robustness: Varying Social Preferences for Equity.*—How do different social preferences for equity change the implications of these targeting findings? Figure 9 examines the net social welfare of different policies for varying values of the social welfare weight on enrollees, $\mu$ (on the x-axis). As noted, a higher $\mu$ indicates a stronger value for distributional equity, given that enrollees are low income. The graph plots social welfare for three policies: (i) the ordeal, (ii) full enrollment, and (iii) no enrollment. If ordeals were optimal—that is, if there were positive gains from targeting—the value of $SW^{Ordeal}$ (dashed blue) would need to be higher than both $SW^{FullEnroll}$ (solid red) and $SW^{NoEnroll} = 0$ (solid black). However, this is never the case: the ordeal is dominated by full enrollment for $\mu > 1.3$, by no enrollment for $\mu < 1.0$, and by both policies for $\mu \in [1.0, 1.3]$.[64]

[64] Supplemental Appendix Table A.11 reports sensitivity of this analysis across different demand and externality assumptions. Across most specifications, we find that the ordeal is never optimal at any value of $\mu$. The exceptions are (i) with perfect unobserved sorting, where the ordeal is assumed to sort extremely well on unobservables and so is optimal for a wide range of $\mu$, and (ii) with the simulated exponential utility for a narrow range of $\mu \in (0.55, 0.73)$.

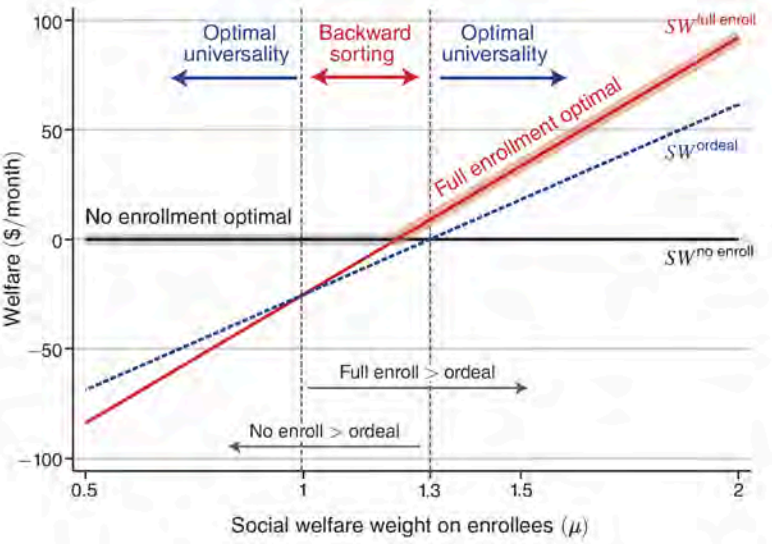



FIGURE 9. OPTIMAL POLICY UNDER VARYING SOCIAL VALUES OF EQUITY ($\mu$)

*Notes:* The figure plots net social welfare of ordeals (blue dashed line) versus full enrollment (red solid) and no enrollment (black solid, which is normalized to zero) under different values for the social welfare weight $\mu$ (the x-axis). Social welfare is average net welfare ($= V^{Soc} - C^{Net}$) per eligible person per month. The graph shows that the ordeal is not optimal for any value of $\mu$; it is dominated by no enrollment for lower values ($\mu < 1.3$) and by full enrollment for higher values ($\mu > 1.0$) and by both policies for $\mu \in [1.0, 1.3]$, which is the region of backward sorting.

The figure illustrates the reasons why ordeals are nonoptimal, as outlined in Section I. When $\mu$ is sufficiently high (above 1.3), the ordeal is undesirable because society wants to cover *both* active and passive enrollees; that is, this illustrates what we called "*optimal universality*." This is likewise true for $\mu < 1.0$, where it is optimal to not enroll both actives and passives. For the small range $\mu \in [1.0, 1.3]$, it would in theory be desirable to exclude the active enrollees, while covering the passives, but ordeals do the opposite. Thus, this case illustrates *backward sorting*.

### C. *Policy Comparison: Auto-Enrollment versus Subsidies*

While the main focus of our paper is on the targeting properties of ordeals, we can also use our estimates to compare the trade-offs of two different take-up policies: auto-enrollment versus subsidies. We think of this as a guide for an insurance policymaker who has extra funds and can choose whether to expand coverage via auto-enrollment (for zero-premium enrollees) or larger subsidies (for higher-income groups). This analysis is relevant to understanding trade-offs under the ACA today, in which 40–50 percent of the uninsured likely qualify for free coverage (Cox and McDermott 2020), while many middle-income uninsured Americans owe premiums that could be reduced via larger subsidies. It also reflects (in reverse) Massachusetts's 2010 situation when it chose to eliminate auto-enrollment, rather than cutting subsidies.

TABLE 4—POLICY COMPARISON: AUTO-ENROLLMENT VERSUS SUBSIDIES

| | Auto enrollment | Subsidy increase (↓ premiums) | | |
|---|---|---|---|---|
| | 0–100% FPL (1) | $39 to $0 150% FPL (2) | $77 to $39 200% FPL (3) | $116 to $77 250% FPL (4) |
| *Panel A. Marginal enrollees* | | | | |
| Enrollment impact | 32% | 34% | 36% | 32% |
| Social benefit ($W_i + E_i$) | $143 | $62 | $116 | $157 |
| Medical costs | $228 | $196 | $268 | $281 |
| Gross subsidy (= costs − premiums paid) | $228 | $196 | $229 | $204 |
| Net public cost (= gross subsidy − FE) | $142 | $122 | $128 | $98 |
| Value-cost ratio (marginals) | 1.00 | 0.51 | 0.90 | 1.60 |
| *Panel B. Transfers to inframarginals* | | | | |
| Premium discount ($/month) | — | $39 | $38 | $39 |
| × inframarginals per marginal | 3.12 | 2.92 | 2.80 | 3.14 |
| = transfer spending per marginal | $0 | $114 | $106 | $123 |
| Value-cost ratio (inframarginals) | — | 1.00 | 1.00 | 1.00 |
| *Panel C. Cost-effectiveness and MVPF cost-effectiveness* | | | | |
| Net public cost per newly insured | $142 | $236 | $235 | $221 |
| ΔInsured per $1 million | 7,024 | 4,238 | 4,261 | 4,530 |
| Overall MVPF of policy | 1.00 | 0.74 | 0.95 | 1.27 |

*Notes:* The table compares auto-enrollment with three subsidy changes generated by premium RDs at three income thresholds: a premium decrease from $39 to $0 per month at 150 percent of poverty (FPL) (column 2), from $77 to $39 at 200 percent of FPL (column 3), and from $116 to $77 at 250 percent of FPL (column 4). For auto-enrollment, results come from our model estimates (Section VA) using the reduced-form variation studied in this paper. For subsidies, estimates come from our calculations using the WTP and cost results reported in Finkelstein, Hendren, and Shepard 2019. Demand for marginal enrollees is assumed to equal the midpoint of the higher and lower premium amounts, and uncompensated care estimates come from applying our model in Section VA to marginal enrollees' costs. Cash transfers are assumed to have an MVPF of 1.0.

For auto-enrollment, we use our model estimates, as just discussed. For subsidies, we use the results of Finkelstein, Hendren, and Shepard (2019). We consider the three subsidy changes in their analysis: reducing premiums from $39 per month to $0 (for enrollees at 150 percent of poverty), from $77 to $39 (at 200 percent of poverty), and $116 to $77 (at 250 percent of poverty).

This analysis yields two main results, shown in Table 4. First, all four take-up policies involve similar enrollment impacts of +32–36 percent. They also all enroll a similar set of low-cost marginal enrollees, with medical costs of $196–$281 per month (well below the market average of $370). Indeed, after subtracting premiums paid, the "gross subsidy" for marginal enrollees is remarkably similar across policies, ranging from $196 to $229. The same is true of the net public cost, after subtracting uncompensated care savings. Overall, this suggests that auto-enrollment and the three subsidy expansions have relatively similar take-up impacts and targeting properties.

Second, however, the two policies differ markedly in their expenditures on inframarginal enrollees. Auto-enrollment spends nothing on inframarginal (active) enrollees, while the subsidies all spend > $100 per marginal enrollee on transfers (the $38–$39 monthly subsidy increase times the ≈ 3 inframarginals per

marginal enrollee). As a result, auto-enrollment is a much more *cost-effective* policy for expanding take-up. Auto-enrollment's net public cost per newly insured is 36–40 percent lower than for subsidies. This implies that each $1 million in public spending covers 55–66 percent more people if used for auto-enrollment rather than subsidies. Therefore, a budget-constrained government wishing to maximize take-up would want to prioritize auto-enrollment over subsidies.

On the other hand, if the government wishes to implement the highest-MVPF policy, the analysis also depends on the relative MVPF of insurance versus cash transfers since subsidies combine the two.[65] Cash transfers have an MVPF of 1 in our model (since we do not include labor supply distortions), while the social value-cost ratio of insurance for marginal enrollees (with $\mu = 1$) ranges from 0.51 to 1.60 for subsidies and is (coincidentally) 1.00 for auto-enrollment. As a result, we find that auto-enrollment's MVPF ($= 1.00$) lies within the range of the three subsidy changes (from 0.74 to 1.24).

## VI. Conclusion

Enrollment ordeals are a pervasive and controversial feature of many public programs, especially safety net programs for the poor. There is a longstanding debate and tension between two views. On the one hand, ordeals are barriers to poverty alleviation programs, which may undermine their goal of helping the poor. In this view, ordeals are inherently harmful, and particularly so when they reduce take-up a lot.

On the other hand, the classic economic ideas of Nichols and Zeckhauser (1982) show how ordeals can *target* public assistance toward those who need or value it most, saving money that can be redeployed toward those in greatest need. In this view, ordeals are harmful only if they fail to target well. Because the "self-targeting" case for ordeals relies on revealed preferences, standard critiques have largely focused on *behavioral frictions* as the main reason ordeals may not target well (Bertrand, Mullainathan, and Shafir 2004; Finkelstein and Notowidigdo 2019).

This paper argues that there is another big-picture reason ordeals self-targeting may not work well: *adverse selection*. We start by observing that in many public programs, enrollees vary in not just their *value* of assistance but also their *cost*. In other words, many programs—including but not limited to those providing insurance—share the key feature of "selection markets" that have been widely studied in the economics literature (Einav, Finkelstein, and Mahoney 2021). We then show

[65] MVPFs are calculated as follows. For auto-enrollment, we assume (conservatively) that the ordeal involves no real welfare costs ($L(\sigma) = 0$), so its MVPF is simply the social value-cost ratio of marginal (passive) enrollees, as in Table 3. For subsidies, the MVPF combines the social value of insurance (for the $\Delta D_S$ marginal enrollees) plus the value of cash discounts to inframarginals ($= \Delta S$ times $D_0$ inframarginals), divided by the total fiscal cost, or

$$MVPF_S = \frac{\overbrace{\Delta D_S \bar{V}_S^{Soc}}^{\text{Insurance for marginals}} + \overbrace{D_0 \Delta S}^{\text{Cash for marginals}}}{\Delta D_S \bar{C}_S^{Net} + D_0 \Delta S} = \underbrace{\kappa_M \times \left( \frac{\bar{V}_S^{Soc} + \bar{E}_S}{\bar{C}_S^{Net}} \right)}_{\text{MVPF of marginals}} + \underbrace{(1 - \kappa_M) \times 1}_{\text{Transfer to inframarginals}}, \tag{16}$$

where $\bar{X}_S$ is the average of each variable $X$ for subsidy-marginals and $\kappa_M \equiv \Delta D_S \bar{C}_S^{Net} / \left( \Delta D_S \bar{C}_S^{Net} + D_0 \Delta S \right)$ is the share of extra spending on marginal enrollees. The equation shows that the MVPF of a subsidy is a weighted average of the MVPF of covering marginal enrollees and the MVPF of a cash transfer to inframarginals (which is 1.0).

that adverse selection tends to undermine the classic self-targeting logic for ordeals. When low-value types—those whom ordeals are designed to screen out—also have low costs (e.g., because they are lower-risk types), targeting gains from excluding them may be minimal or even negative. The key question in selection markets is not whether ordeals screen on value but whether they screen *more strongly* on value than on costs.

We develop a general framework to formalize this idea, visualized using the graphical selection markets model of Einav, Finkelstein, and Cullen (2010) and measured using a parameter we call the "adverse selection tax." We then test it empirically using a natural experiment in a subsidized health insurance program in Massachusetts. We find that eliminating auto-enrollment and adding a small ordeal leads to major 33 percent declines in enrollment. Ordeals differentially exclude precisely the young, healthy, and low-risk types one would expect under adverse selection. These individuals have lower value for insurance (consistent with self-targeting), but they are also much lower-cost. Our model estimates suggest that they are not less efficient, implying that ordeals induced "backward sorting" into insurance, analogous to the findings of Marone and Sabety (2022) for price-based sorting. This occurs because adverse selection is very strong, with a "tax" exceeding 100 percent in our baseline estimates. With distributional equity concerns, health insurance is socially optimal, but it is optimal for all enrollees, including passive types screened out by ordeals, consistent with our idea of "optimal universality."

These findings have broader implications for how policymakers think about enrollment ordeals in social programs. In terms of *take-up* impact, our results suggest that ordeals are a first-order important barrier in health insurance. Even when coverage is free, a large share of people do not enroll when doing so is a hassle. Completely removing ordeals via auto-enrollment has an order of magnitude larger take-up impact than lower-touch "nudges" like reminders and outreach (Domurat, Menashe, and Yin 2021; Goldin, Lurie, and McCubbin 2021; Ericson et al. 2023; Banerjee et al. 2021). Reaching universal coverage in the United States, therefore, may require automatic enrollment in some form.

In terms of *targeting*, our results suggest that the standard case for ordeals is less likely to work well in settings with adverse selection, that is, strongly correlated value and costs. This is clearly relevant for insurance programs, but it may also be relevant more broadly in transfer programs that pay varying benefit amounts to different groups. Fundamentally, adverse selection (like behavioral biases) interrupts the revealed preference link between demand and efficiency that is key to self-targeting. While ordeals are useful tools in some settings, they may not be well suited to health insurance and other adversely selected markets.

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# Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment†

*By* Mark Shepard and Myles Wagner*

*Are application hassles, or "ordeals," an effective way to limit public program enrollment? We provide new evidence by studying (removal of) an auto-enrollment policy for health insurance, adding an extra step to enroll. This minor ordeal has a major impact, reducing enrollment by 33 percent and differentially excluding young, healthy, and economically disadvantaged people. Using a simple model, we show adverse selection—a classic feature of insurance markets—undermines ordeals' standard rationale of excluding low-value individuals since they are also low-cost and may not be inefficient. Our analysis illustrates why ordeals targeting is unlikely to work well in selection markets.* (*JEL* D82, G22, H75, I13, I18)

Should enrolling in public programs be easy or hard? The desirability of enrollment hassles, or "ordeals," for social programs is a classic—and controversial—question in public economics. On the one hand, there is substantial concern about incomplete take-up of programs intended to help the poor (Currie 2006). A growing body of work argues that the bureaucracy, paperwork, and "administrative burden" of enrollment is a major driver of low take-up and source of frustration with and mistrust of government (Herd and Moynihan 2018).

On the other hand, a classic line of thinking in economics argues that ordeals can be useful ways to *target* assistance toward those who need or value it most (Nichols and Zeckhauser 1982; Besley and Coate 1992). The basic idea follows from the

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logic of revealed preference. Ordeals work like a nonfinancial "price" of enrolling, and as in standard markets, prices screen out people with low value (demand) for a program. By excluding low-value types, the government saves money and can redirect aid toward those who need it most. This influential "self-targeting" idea has spawned an active empirical debate, with some research finding that it holds in practice (Alatas et al. 2016; Dupas et al. 2016), while other work argues that behavioral frictions may undermine its validity (Bhargava and Manoli 2015; Finkelstein and Notowidigdo 2019; Deshpande and Li 2019). Importantly, the debate has been framed almost entirely around the self-targeting question: Do ordeals effectively screen out *low-value* or *low-need* types in a given setting?

In this paper, we ask whether this is the right way to think about targeting in programs where people vary not just in value or need but also in their *costs*. We observe that many programs—and especially insurance programs—share a key feature of "selection markets" that have been widely studied in the economics literature (Einav, Finkelstein, and Mahoney 2021). In these settings, enrollee costs vary substantially and tend to be *correlated* with value, often because both are driven by the same underlying factor, like risk. For instance, in our health insurance data, the highest-risk (sickest) 10 percent of enrollees incur 15 *times* higher medical costs than the healthiest 10 percent (about $1,400 versus $90 per month). Moreover, the healthy are likely to value insurance less, precisely because they have fewer medical needs and use less care. This example illustrates the key correlation in settings with adverse selection: low-value types also tend to be low-cost.

Our paper's central conceptual point is that adverse selection tends to weaken, and when strong enough undermine, the classic self-targeting case for ordeals. When low-value enrollees are also low-cost, excluding them may yield minimal, or even negative, targeting gains. The key question in selection markets is not whether ordeals screen on value, but whether they screen *more strongly* on social value than on costs. This question is theoretically ambiguous and does not follow from the standard revealed preference logic for ordeals.

We formalize this argument with a mix of theory and evidence from a public health insurance program. We use a natural experiment to study descriptively *how much* ordeals matter for take-up and which types of people they screen out. We find that even minor hassles lead to major reductions in take-up among an otherwise uninsured low-income population. Consistent with adverse selection, the excluded group is differentially younger, healthier, and poorer, suggesting ordeals screen out people with low private value (demand) but also low cost of insurance.[1] Using an empirical model estimated with our data, we find that ordeals worsen targeting efficiency, despite successfully screening out low-value types. More generally, we show that adverse selection works alongside behavioral frictions to weaken the (revealed preference) link between demand and efficiency that is key to self-targeting. This makes ordeals relatively poorly suited tools for adverse selection markets.

We begin the paper (in Section I) with a general framework to formalize these ideas about ordeals targeting in selection markets. Ordeals improve welfare if they yield "gains from targeting"—the ability to include efficient (*social value* $>$ *cost*)

[1] This also aligns with the groups most likely to be among the 28 million uninsured in the United States today (Tolbert et al. 2024).

and exclude inefficient (*social value* $<$ *cost*) types—sufficient to outweigh any direct losses from their hassle or administrative costs. We show that targeting gains can be visualized in simple supply/demand-like graphs of marginal value/cost versus quantity enrolled as ordeals vary, analogous to the approach of Einav, Finkelstein, and Cullen (2010) for visualizing welfare in selection markets. As in their graphs, adverse selection implies that the "marginal cost" curve is not flat (as in a nonselection market) but *slopes downward* alongside marginal value, reflecting the positive value-cost correlation driven by enrollee risk. This shrinks the gains from targeting, reflected in a smaller area between marginal value and cost curves above and below their intersection.

We formalize this reduction in what we call the "adverse selection tax," which equals the coefficient in a regression of enrollee (net) cost on social value, or $\hat{\beta} = \text{cov}\left[C_i^{Net}, V_i^{Soc}\right]/\text{var}\left[V_i^{Soc}\right] = \rho \cdot \sigma_C/\sigma_V$.[2] When adverse selection is sufficiently strong (roughly, when $\hat{\beta} > 1$), the marginal cost curve becomes steeper than marginal value, and ordeals induce "*backward sorting*" into insurance even when they correctly sort on value. This idea—analogous to the insights of Marone and Sabety (2022) for menu design and sorting with prices—shows the limits of choice and self-targeting mechanisms in adverse selection markets where demand and efficiency are often misaligned.[3]

In addition, we show a second reason adverse selection tends to undermine ordeals: it makes it more likely that the optimal outcome is *universal*—enrolling or excluding everyone—rather than targeted. We call this second idea "*optimal universality*." Graphically, it occurs when the marginal value ($MV$) curve lies entirely above or below marginal costs ($MC$), so the two do not intersect. This is more likely when both $MV$ and $MC$ have a similar downward slope because value and cost are strongly correlated. For instance, consider a case where social value and net enrollee cost align perfectly: $V_i^{Soc} = \delta \cdot C_i^{Net}$. In this case, net welfare ($= V_i^{Soc} - C_i^{Net}$) equals $\left(\delta - 1\right) C_i^{Net}$ for all $i$, which is uniformly positive or negative depending on $\delta \gtrless 1$. This example illustrates the key idea of optimal universality: a strong value-cost correlation makes it more likely that targeting using ordeals is counterproductive because universal outcomes are superior.

Having developed this framework, we next turn to an empirical analysis of ordeals that lets us both estimate the key model parameters and also learn descriptively about ordeals' impact for health insurance programs. Our empirical setting is the Massachusetts health insurance exchange, a program offering subsidized insurance to low-income people without access to other coverage.[4] The program featured a

[2] Here, $\rho = \text{corr}\left[C_i^{Net}, V_i^{Soc}\right]$, $\sigma_C = \text{std}\left(C_i^{Net}\right)$, and $\sigma_V = \text{std}\left(V_i^{Soc}\right)$, all evaluated across potential enrollees ($i$). See Section I for the formal definition of social value and net public cost (which is net of fiscal externalities). The adverse selection tax is zero if enrollee costs do not vary ($\sigma_C = 0$) or are uncorrelated with value ($\rho = 0$), and it grows as both of these increase relative to the variation in value.

[3] Conversely, *advantageous* selection—where low-value types have high costs—strengthens the case for ordeals targeting. Because advantageous selection is less common, we do not discuss it in detail. Two settings where it has been found are long-term care insurance (Finkelstein and McGarry 2006) and Medicare supplemental coverage ("medigap") (Fang, Keane, and Silverman 2008).

[4] We study the pre-Obamacare (or ACA) exchange, which operated from 2007 to 2013 and was called Commonwealth Care (or "CommCare"). As a model for the ACA exchanges that followed, CommCare has been a rich source of evidence on demand, competition, and the impact of policies in health insurance markets (see Chandra, Gruber, and McKnight 2011, 2014; Finkelstein, Hendren, and Shepard 2019; Jaffe and Shepard 2020; McIntyre, Shepard, and Wagner 2021; Shepard 2022; Shepard and Forsgren 2023).

unique source of variation in the complexity of enrollment, driven by changing use of an auto-enrollment policy for the program's poorest individuals, who qualified for free insurance. Prior to 2010, the program required only that these individuals *apply* for coverage, submitting paperwork with information to verify eligibility. Approved applicants were then contacted and asked to choose among several plans offered by different insurers (all of which were free). But if they failed to respond—something that occurred surprisingly often—the program *auto-enrolled* them into a plan using a simple algorithm. In essence, this policy used defaults or "choice architecture" (Thaler 2018) to streamline take-up and prevent people from falling through the cracks of the system.

Starting in 2010, the program suspended auto-enrollment. Nonresponsive, or "passive," individuals were no longer enrolled by default; instead, their default became *non-enrollment*. Effectively, this change added an extra step (active plan choice) to the required take-up process. Although not intended to be onerous—people could choose by phone, mail, or online, and all plans remained free—this change is an example of the type of small take-up friction that is common in many US safety net programs.

We use this variation to estimate the causal effect of the ordeal by studying enrollment changes around the 2010 policy shift. We use a difference-in-difference design, comparing changes in new enrollment for the low-income (treatment) group for whom auto-enrollment stops in 2010 versus a slightly higher-income (control) group for whom it was not used throughout. Our rich administrative data let us observe who enrolled actively versus passively prior to 2010, and we can also infer the characteristics of marginal enrollees from compositional changes in enrollment around 2010.

This analysis yields two main findings. First, adding a minor ordeal leads to major reductions in health insurance take-up. Prior to 2010, one-third of low-income new enrollees join the exchange passively via auto-enrollment. When the policy is suspended in 2010, the flow of new enrollment falls by a nearly identical 33 percent. The decline is immediate and persistent, with parallel pre-trends and no concurrent changes for the control group.[5] We also see no evidence of an uptick in active enrollment in 2010, suggesting that passive individuals are unlikely to be deliberately choosing nonresponse (e.g., because they know they will be auto-enrolled). Rather, when subjected to a small hassle, about one-third of eligible individuals simply fail to take up health insurance.

This effect is quite large. For instance, it is similar to the impact of a $470 (or 57 percent) annual premium increase based on prior evidence (Finkelstein, Hendren, and Shepard 2019) and 1.25–2 times larger than the impact of Massachusetts's uninsurance penalty (Chandra, Gruber, and McKnight 2011). It is an order of magnitude larger than the 1–4 percentage point effects observed from lower-touch "nudges" (like outreach and assistance) in recent work on health insurance (Goldin, Lurie, and McCubbin 2021; Domurat, Menashe, and Yin 2021; Ericson et al. 2023). The

[5] Further evidence comes from a temporary reinstatement of the auto-enrollment policy in late 2010. Consistent with the policy having a causal effect, we find that new enrollment spikes back up to its pre-2010 level, then falls back down when auto-enrollment is again suspended in early 2011.

findings suggest that *fully automatic* enrollment—not just incremental incentives and nudges—may be a key step to further reduce uninsurance in the United States.

Our second descriptive finding is that ordeals differentially screen out low-risk individuals, consistent with adverse selection. Relative to active enrollees, passive enrollees are younger and healthier (e.g., 33 percent less likely to be chronically ill) and especially likely to be young men age 19–34. They incur 44 percent lower medical spending per month—most of which (a 36 percent gap) is predictable by their age and diagnosis risk factors. Because of their lower costs, excluding passive enrollees results in a 15 percent higher average-cost risk pool of enrollees.

We also examine the distributional equity implications of ordeals. We find that passive enrollees are more likely to be very low income, to live in disadvantaged neighborhoods, and to live near safety net hospitals and clinics. This is consistent with ordeals differentially impacting the poor (Bertrand, Mullainathan, and Shafir 2004; Mullainathan and Shafir 2013). But it is also consistent with evidence that the poor have lower *demand* for health insurance, potentially because of access to charity care when uninsured (Finkelstein, Hendren, and Luttmer 2019).

Why does a seemingly small hassle matter so much for enrollment? This fact is striking because the benefits of forgone health insurance are likely meaningful.[6] Our evidence is most consistent with behavioral frictions like inattention, forgetting to act, or simply "going with the flow" in insurance choices.[7] We examine but find little evidence of other explanations, including stigma or unawareness of the program (since everyone in our sample has already applied for coverage), "choice overload" that leads to passivity (Iyengar and Kamenica 2010), or passive enrollees already having another form of duplicate insurance.[8]

The final portion of our paper applies the ordeals welfare framework to our setting using the auto-enrollment natural experiment. We specify a rich model allowing for the key features of insurance problem, including heterogeneity in enrollee value (demand), insurer cost (based on medical claims data), and externalities of insurance via savings on uncompensated care. The key empirical challenge—common to most analyses of ordeals—is to infer enrollee value of insurance, given the nonprice nature of the take-up barrier. We address this challenge by estimating demand among a higher-income segment of exchange enrollees who face positive prices, drawing on RD-style premium variation used in prior work (Finkelstein, Hendren, and Shepard 2019). We then project these demand estimates onto the lower-income population at the level of key observables (cells of age, sex, and medical risk scores). We consider various assumptions for the role of unobserved preferences, as well as alternate methods of estimating value directly from observed medical use in our claims data.

[6] Passive enrollees (while healthier than average) do use significant medical care and experience medical shocks. Based on our model estimates and prior work on the value of health insurance (Finkelstein, Hendren, and Luttmer 2019), coverage should be worth about $550 to $1,300 for an average passive enrollee over a typical year-long spell. This is comparable to forgone benefits from failure to take up the EITC or SNAP (Bhargava and Manoli 2015; Finkelstein and Notowidigdo 2019).

[7] Consistent with these ideas, we find that passive nonresponse is more common among immigrants (who may face language barriers), people with signs of address instability, and people transitioning into the exchange from Medicaid (which may involve greater confusion because Medicaid's process is different).

[8] We test this using the state's All Payer Claims Database, where we can see the near universe of health insurance coverage. We see very low rates (< 4 percent) of duplicate enrollment in the exchange plus other coverage and no meaningful change in duplication rates around the end of auto-enrollment in 2010.

This exercise yields three main results. First, ordeals do screen out lower-value enrollees. In our baseline estimate, passive enrollees have a private (social) value of coverage that is 28 percent (34 percent) lower than active types. This finding, which is consistent with the classic ordeals rationale of self-targeting, is robust across a wide range of specifications we consider.

Second, adverse selection substantially reduces, or even reverses, the ordeal's targeting gains. Our estimates suggest substantial cost variation and a strong value-cost correlation that implies an "adverse selection tax" that is large and often exceeds 100 percent. Correspondingly, the value-cost *ratio* of passive enrollees is similar to or (in our main specification) higher than active enrollees, suggesting that ordeals induce counterproductive "backward sorting" into insurance. We also examine the robustness of this conclusion to varying distributional equity goals, by applying a social welfare weight $\mu > 1$ to enrollee welfare. We find that with even modest equity concerns ($\mu > 1.3$), it becomes optimal to enroll *both* active and passive individuals. The ordeal is still nonoptimal, but not because sorting is backward, rather because the optimal outcome is universal.

Finally, we use the model to compare auto-enrollment versus subsidies as ways of expanding take-up. We find that the two have similar targeting properties—both enroll a similar young, healthy, and low-cost population—but that auto-enrollment is much more cost-effective because it does not require new spending on inframarginal enrollees. We find that each extra $1 million in public spending covers 55–66 percent more people if used for auto-enrollment rather than subsidies.

*Related Literature.*—Our paper contributes to three main strands of literature. The first studies the nature of ordeals targeting for social programs. Starting from the classic analysis of Nichols and Zeckhauser (1982), the debate has centered around whether ordeals screen out people who value or benefit less from assistance (e.g., Alatas et al. 2016; Dupas et al. 2016; Finkelstein and Notowidigdo 2019) or who benefit just as much but have less ability to navigate a complex process (e.g., Bhargava and Manoli 2015; Deshpande and Li 2019; Homonoff and Somerville 2021). This debate is part of a broader literature asking when nonprice targeting is valuable in social programs (e.g., Kleven and Kopczuk 2011; Lieber and Lockwood 2019). We provide evidence in a new and important setting (health insurance) and highlight that the classic debate misses the key role of cost heterogeneity and adverse selection for this question.

Second, our paper contributes to work evaluating "nudges" to increase take-up of social programs, including health insurance (Goldin, Lurie, and McCubbin 2021; Domurat, Menashe, and Yin 2021; Banerjee et al. 2021; Ericson et al. 2023). Our results suggest a much larger impact of fully *removing* hassles by changing the default to auto-enrollment. This complements prior work on the large impact of auto-enrollment in other settings (e.g., Madrian and Shea 2001; Chetty et al. 2014),[9] as well as evidence that defaults create inertia in choosing *among* insurance plans

[9]Recent work on 401(k) pensions by Choukhmane (2021) finds that while auto-enrollment has a large *initial* impact on enrollment and savings, people who are not auto-enrolled largely catch up by saving more in the future. Unlike pensions, health insurance is a domain where failure to enroll can have immediate repercussions if an individual gets sick and incurs medical bills. This suggests auto-enrollment is likely to be a consequential policy for health insurance.

(Handel 2013; Ericson 2014; Polyakova 2016; Brot-Goldberg, Layton et al. 2023). Default effects are a key example of a broader set of "choice frictions" that have been shown to be prevalent in health insurance markets (Abaluck and Gruber 2011, 2023; Bhargava, Loewenstein, and Sydnor 2017). Our paper shows that defaults are also important policies for insurance take-up.

Finally, our paper contributes to the literature asking why uninsurance is so persistent in the United States. A large prior literature has analyzed the impact of financial prices and subsidies for incomplete take-up (Gruber 2008; Dague 2014; Frean, Gruber, and Sommers 2017; Finkelstein, Hendren, and Shepard 2019). We show that ordeals and hassles are also likely to be a key barrier, given the United States' fragmented and nonautomatic health insurance system. There is growing interest in the role of complexity, transaction costs, and "administrative burden" in shaping enrollment, with emerging evidence that this matters for Medicaid take-up (Aizer 2007; Arbogast, Chorniy, and Currie 2022; Wu and Meyer 2023) and for ACA health insurance marketplaces (Drake et al. 2023; McIntyre, Shepard, and Layton 2024). We show, likewise, that imposing even modest hassles leads to non-enrollment by a large share of people, especially the young, healthy, and poor, who are disproportionately uninsured today. Our results suggest that as long as take-up is voluntary, getting to universal coverage will likely require some form of auto-enrollment. They also illustrate the surprising power of a feasible form of auto-enrollment that has recently been considered or implemented in several states' ACA exchanges.[10]

*Outline of Paper.*—Section I presents a conceptual framework for ordeals targeting with adverse selection. Section II discusses the setting, the auto-enrollment policy, and our data. Section III shows our main results on enrollment impacts, and Section IV presents targeting results. Section V implements our empirical model using the auto-enrollment variation. Finally, Section VI concludes.

## I. Conceptual Model: Adverse Selection and Ordeals Targeting

In this section, we present a simple framework for the economics of ordeals in programs characterized by adverse selection, that is, where enrollee value and costs are positively correlated. Adverse selection is a classic feature of insurance, where individual risk (e.g., health status) is the primary driver of the value-cost correlation. But it is also relevant more generally for transfer programs with varying benefit amounts (e.g., by income or family size) since people who receive smaller benefits also cost less to the government. Our central point is that adverse selection reduces—and may even reverse—the efficiency of the standard ordeals rationale of screening out *low-value* types since low-value enrollees may not be *inefficient* enrollees.

This section formalizes this argument using a simple model based on the classic insights of Nichols and Zeckhauser (1982), as well as the more recent ordeals framework of Finkelstein and Notowidigdo (2019). Our key innovation is to connect ordeals to the economics of selection markets, visualized using the graphical

[10] This includes Massachusetts, which reinstated a similar form of auto-enrollment in April 2022, partly based on discussions with them about this research.

framework of Einav, Finkelstein, and Cullen (2010). Our analysis also connects to recent insights about "backward sorting" in selection markets (Marone and Sabety 2022), in which prices also lead to inefficient sorting between insurance options.

### A. *Model Setup*

Consider a population of individuals who qualify for a public program—in our setting, free health insurance—but have not yet enrolled. For each individual $i$, the program generates social value of

$$V_i^{Soc} = \mu_i W_i + E_i, \tag{1}$$

where $W_i$ is the program's private welfare to enrollee $i$ (willingness to pay, or WTP), $\mu_i$ is the marginal social welfare weight on individual $i$ (capturing distributional equity concerns), and $E_i$ is the social value of any externalities from $i$'s participation in the program. A Kaldor-Hicks efficiency welfare criterion would involve $\mu_i = 1$ for all $i$, but it may be natural to think of $\mu_i > 1$ for safety net programs where beneficiaries are lower income. For our empirical work, we simplify by treating $\mu_i$ as a constant $\mu$ for everyone who qualifies for the program, but in principle, $\mu_i$ could vary across eligible groups to capture distributional goals.

For individual $i$, the program involves net government cost $C_i^{Net} = C_i - FE_i$, which equals direct costs $(C_i)$ minus any offsetting fiscal externalities $(FE_i)$.[11] We assume $C_i^{Net} > 0$ so that there is a real fiscal trade-off of expanding enrollment. Both social value and cost may vary across individuals, potentially creating a rationale for targeting.

The government seeks to target enrollment to maximize total social benefits net of costs. Mathematically, if $A_i \in \{0, 1\}$ indicates whether $i$ is enrolled, the government seeks to maximize net social welfare, or $SW = \sum_i \left(V_i^{Soc} - C_i^{Net}\right) \cdot A_i$. We define $\gamma_i$ as the net contribution to social welfare of enrolling individual $i$:

$$\text{(Net Welfare)} \quad \gamma_i = V_i^{Soc} - C_i^{Net} = \left(\mu_i W_i + E_i\right) - C_i^{Net}. \tag{2}$$

If the government had full information, it would optimally enroll everyone for whom $\gamma_i \geq 0$ and exclude those with $\gamma_i < 0$. Equivalently, if we define $R_i \equiv V_i^{Soc}/C_i^{Net}$ as the enrollee's "social value-cost ratio," the government optimally enrolls everyone with $R_i \geq 1$ and excludes those with $R_i < 1$.[12] The metric $\gamma_i$ is a useful targeting index that shows how a government would optimally prioritize enrollment with

[11] In our empirical setting we think of these variables as follows. $W_i > 0$ is the benefits of insurance to the individual; $C_i > 0$ is the government's direct subsidy cost for insuring them; and $E_i, FE_i \geq 0$ are savings on (uninsured) uncompensated care borne by private hospitals $(E_i)$ and the government $(FE_i)$. The nature of $C_i$ depends on how insurance is provided. We assume either direct public provision (relevant in programs like Medicaid) or zero-profit contracting with private insurers (which we find to be roughly true in the Massachusetts exchange), which implies that $C_i$ equals $i$'s expected insured medical costs.

[12] The social value-cost ratio is closely related to the marginal value of public funds (MVPF) metric (Hendren 2016), which is also a (policy-level) benefit-cost ratio.

full information. In practice, however, the government has limited information, so it must use blunt policies like ordeals, which we turn to next.

*Ordeals and Take-Up.*—The government has access to a screening mechanism—in our setting, an ordeal—that it uses to limit take-up. Ordeals work by imposing a "friction," $\eta_i \geq 0$, that individuals must overcome to enroll. The friction may vary across individuals and could involve both real costs (e.g., the time and effort of completing paperwork) and behavioral frictions that limit take-up (e.g., inattention). We assume the government can adjust the "intensity" of the ordeal through its policy choices (e.g., how much paperwork to impose). A simple specification that captures this idea is $\eta_i = \sigma \cdot h_i$, where $\sigma \geq 0$ is the ordeal's intensity (a policy choice) and $h_i \geq 0$ captures a person's experienced hassle cost per unit ordeal. The policy of no ordeal is equivalent to setting $\sigma = 0$.

In addition to the ordeal, people may have behavioral biases that affect demand, e.g., biased beliefs about their risk type (Spinnewijn 2017). We denote the bias by $\varepsilon_i$, and the utility governing take-up as $U_i \equiv W_i - \varepsilon_i$, where $\varepsilon_i > 0$ captures undervaluation and $\varepsilon_i < 0$ overvaluation. With the ordeal in place, people take up the program if

$$\text{(3)} \qquad \text{(Take-Up)} \qquad U_i = \underbrace{W_i}_{\text{True WTP}} - \underbrace{\varepsilon_i}_{\text{Bias}} \geq \underbrace{\sigma \cdot h_i}_{\text{Ordeal friction}} .$$

A comparison of the conditions for who should optimally enroll ($\gamma_i \geq 0 \Leftrightarrow \mu_i W_i + E_i - C_i^{Net} \geq 0$) versus actual take-up ($W_i - \varepsilon_i - \sigma h_i \geq 0$) shows that there may be both under- and overenrollment among differing groups. All else equal, underenrollment is more likely for disadvantaged groups (with high welfare weights, $\mu_i > 1$), for people with positive externalities ($E_i > 0$) or undervaluation bias ($\varepsilon_i > 0$), and for people with low cost ($C_i^{Net}$) relative to WTP. Overenrollment is more likely for the opposite cases. Imposing an ordeal improves targeting if it reduces overenrollment more than it exacerbates underenrollment, in a sense that we formalize below.[13]

We denote the share of people who enroll given an ordeal of intensity $\sigma$ as $D(\sigma) = \Pr(W_i - \varepsilon_i \geq \sigma h_i)$. The share excluded is $1 - D(\sigma)$. The ordeal splits potential enrollees into two groups. For any variable $X_i$ (e.g., value or cost), we denote averages for screened-in enrollees as $\bar{X}_1(\sigma) \equiv E[X_i | W_i - \varepsilon_i \geq \sigma h_i]$, and for excluded individuals as $\bar{X}_0(\sigma) \equiv E[X_i | W_i - \varepsilon_i < \sigma h_i]$.

[13] One way to understand misallocation is to define the "wedge" between optimal enrollment versus take-up utility (absent the ordeal) as

$$\text{(4)} \qquad \Delta_i \equiv \gamma_i - U_i = [(\mu_i - 1)W_i + E_i + \varepsilon_i] - C_i^{Net}.$$

In an ideal world, this take-up wedge would be zero, ensuring that people enrolled if and only if $\gamma_i \geq 0$. Imposing an ordeal works like a reduction in take-up utility, so it shifts the wedge from $\Delta_i$ to $(\Delta_i + \sigma h_i)$. This will tend to improve welfare if the distribution of $(\Delta_i + \sigma h_i)$ is closer to zero than the distribution of $\Delta_i$. This point is related to the result of Allcott et al. (2022) that "nudges" tend to improve welfare if they reduce the *variance* of net wedges between socially optimal and actual consumption of a good.

In addition to their impact on take-up, ordeals may impose "direct" or "excess" costs, including both hassle/psychological costs to enrollees and administrative costs to the government. The nature of these costs depends on the specifics of the ordeal and the model of behavior and welfare (Ericson 2020).[14] Rather than specify it in detail, we write the ordeal's total direct/excess cost as a general function, $L(\sigma) \geq 0$, which we assume is weakly positive. As we show below, direct costs are separable from the effect of ordeals on social welfare via *targeting* (who is enrolled versus excluded), which is our focus in this paper.

### B. *When Are Ordeals Optimal?*

We now lay out the general conditions under which an ordeal is desirable, which we relate to adverse selection in the next subsection. Consider an ordeal of strength $\sigma$ that generates enrollment $D(\sigma)$. Net social welfare under this policy is

$$SW_{Ordeal}(\sigma) = D(\sigma) \cdot \underbrace{\left[\bar{V}_1^{Soc}(\sigma) - \bar{C}_1^{Net}(\sigma)\right]}_{=\bar{\gamma}_1(\sigma)} - L(\sigma), \tag{5}$$

where $L(\sigma) \geq 0$ is the total direct cost of the ordeal via hassles and administrative costs. To be welfare improving, an ordeal must at least be superior to two trivial alternate policies:

- **Shutting down the program (no enrollment)**, which results in $SW_0 = 0$, and
- **Enrolling everyone (full enrollment)**, which results in $SW_1 = E[\gamma_i] \equiv \bar{\gamma}$.

Relative to these alternatives, the ordeal's extra social welfare is $\Delta SW_{Ordeal}(\sigma) = SW_{Ordeal}(\sigma) - \max\{0, \bar{\gamma}\}$, or:[15]

$$\Delta SW_{Ordeal}(\sigma) = \underbrace{\min\left\{D(\sigma)\,\bar{\gamma}_1, \left[1 - D(\sigma)\right] \cdot \left(-\bar{\gamma}_0\right)\right\}}_{\text{Gains from Targeting, } GT(\sigma)} - \underbrace{L(\sigma)}_{\text{Direct cost}}, \tag{6}$$

where we now suppress the dependence of $\bar{\gamma}_{0/1}(.)$ on $\sigma$ for conciseness. The first term in expression (6) is the ordeal's "gains from targeting," or $GT(\sigma)$. This captures how effectively the ordeal screens or "targets" enrollment to positive net-welfare individuals ($\gamma_i > 0$), relative to the alternatives of full exclusion and inclusion. We show below that $GT(\sigma)$ corresponds exactly to areas between (appropriately defined) marginal value and cost curves of an ordeal, allowing us to display these

[14] In the classic model, ordeals impose a "real" hassle cost on enrollee $i$ of $\sigma h_i$, which is identical to their impact on take-up behavior, but no costs on non-enrollees (who need not incur the hassle) or administrative costs for the government. Thus, in the classic setup, $L(\sigma) = D(\sigma) \cdot \sigma \bar{h}_1(\sigma)$. However, Ericson (2020) notes that policies like defaults may impact take-up through behavioral frictions like inattention that do not involve real welfare costs for (already-attentive) enrollees. Additionally, some barriers like stigma may impose psychological costs even on non-enrollees. The general $L(\sigma)$ allows our model to capture any of these cases.

[15] To derive this, we use the fact that $\bar{\gamma}$ is the welfare of the average enrollee in the full population, so for any $\sigma$, $\bar{\gamma} = D(\sigma) \cdot \bar{\gamma}_1(\sigma) + \left[1 - D(\sigma)\right] \cdot \bar{\gamma}_0(\sigma)$. Note that our analysis implicitly normalizes the size of the full population (enrollees plus non-enrollees) to be 1.0.

gains graphically. The second term, $L(\sigma)$, is the ordeal's total direct costs, which need not be incurred if the government simply excludes or includes everyone.

The key takeaway of this expression is that an ordeal is desirable only if it achieves positive gains from targeting large enough to exceed the ordeal's direct costs. Positive gains from targeting, in turn, requires that included groups be favorable (positive net welfare) and excluded groups be unfavorable (negative net welfare):

$$(7) \qquad \text{(Positive Gains from Targeting)} \qquad \bar{\gamma}_1(\sigma) > 0 > \bar{\gamma}_0(\sigma).$$

A necessary condition for (7) is that the ordeal induces "effective targeting" between included and excluded groups, or $\Delta\gamma \equiv \bar{\gamma}_1 - \bar{\gamma}_0 > 0$. We call the term $\Delta\gamma$ the "*targeting efficacy*." It is straightforward to show that $GT(\sigma) > 0$ only if $\Delta\gamma > 0$ and that $GT(\sigma)$ is an increasing function $\Delta\gamma$.[16]

There are two reasons the gains from targeting condition in (7) may fail, both of which, we will argue, become more likely with adverse selection. The two reasons are

- **Backward Sorting:** $\bar{\gamma}_1(\sigma) < 0 < \bar{\gamma}_0(\sigma)$. The ordeal sorts "backward" by including inefficient and excluding efficient enrollees. Note that this implies ineffective targeting, or $\Delta\gamma < 0$.
- **Optimal Universality:** Either $\bar{\gamma}_1, \bar{\gamma}_0 > 0$ or $\bar{\gamma}_1, \bar{\gamma}_0 < 0$. It is better to simply include or enroll everyone, rather than screening with the ordeal. Note that this may be true even if targeting is "effective" ($\Delta\gamma > 0$).

In our empirical work, we analyze these conditions for a *particular* ordeal (at a given intensity $\sigma$) since this is what we observe. Conceptually, with more variation, these conditions could be assessed *globally* across all $\sigma > 0$ for a given ordeal, which is what we depict in our graphs below.

*The Classic Ordeals Debate.*—How do these conditions for ordeal desirability relate to the classic ordeals debate? The classic rationale for ordeals going back to Nichols and Zeckhauser (1982) is that they result in "self-screening" or "self-targeting," in which people who highly value the program enroll, while low-value types drop out. Intuitively, hassle costs screen consumers just like prices in standard markets, with high-value consumers willing and low-value consumers unwilling to buy a good. In its classic formulation, self-screening is a statement about screening on private welfare, $W_i$. Under self-screening,

$$(8) \qquad \text{(Self-screening)} \qquad \Delta W \equiv \bar{W}_1 - \bar{W}_0 > 0.$$

[16] The gains from targeting from (6) yields

$$GT(\sigma) = D(\sigma)\big[1 - D(\sigma)\big] \cdot \Delta\gamma - K(\bar{\gamma}),$$

where $K(\bar{\gamma}) \equiv \max\Big\{\big[1 - D(\sigma)\big] \cdot \bar{\gamma}, -D(\sigma) \cdot \bar{\gamma}\Big\} \geq 0$ is a (nonnegative) correction that captures the fact that targeting is less desirable when a program's overall average welfare ($\bar{\gamma}$) is either very positive or very negative. Because the second term subtracts a nonnegative value, $GT(\sigma) > 0$ only if $\Delta\gamma > 0$.

In a model without behavioral biases ($\varepsilon_i = 0$) and homogeneous hassle costs ($h_i = \bar{h}\ \forall i$), self-screening must hold as a consequence of rational choice. The classic critiques of self-screening, therefore, focus on ways that biases or hassles may be larger for high-value types—in our notation, $\text{cov}[W_i, \varepsilon_i] > 0$ and/or $\text{cov}[W_i, h_i] > 0$. For instance, work on the "psychology of scarcity" argues that the poor, for whom social programs are especially valuable, may also experience the largest biases and hassle costs of overcoming ordeals (Bertrand, Mullainathan, and Shafir 2004; Mullainathan and Shafir 2013).[17]

Notice, however, that self-screening on *private* welfare ($W_i$) is not equivalent to favorable screening on *social value*, $V_i^{Soc} = \mu_i W_i + E_i$. This distinction is often missed in ordeals analyses that do not clearly delineate private versus social value. We say that an ordeal achieves favorable *social value sorting* if

$$\text{(9)} \qquad \text{(Social value sorting)} \qquad \Delta V^{Soc} \equiv \bar{V}_1^{Soc} - \bar{V}_0^{Soc} > 0.$$

In addition to the ways self-screening can fail, social value sorting can fail if ordeals differentially exclude people with high-welfare weights ($\mu_i$) or with large positive externalities ($E_i$). This is likewise consistent with the "psychology of scarcity" ideas if ordeals differentially screen out poorer individuals (for whom $\mu_i$ is larger in standard welfare functions).

However, we emphasize that the right metric of targeting is not private welfare or even social value but net social welfare, $\gamma_i = V_i^{Soc} - C_i^{Net}$, or what we have called favorable *targeting efficacy*:

$$\text{(10)} \quad \text{(Targeting efficacy)} \quad \Delta\gamma \equiv \bar{\gamma}_1 - \bar{\gamma}_0 = \underbrace{\left(\bar{V}_1^{Soc} - \bar{V}_0^{Soc}\right)}_{\text{Social Value sorting}} - \underbrace{\left(\bar{C}_1^{Net} - \bar{C}_0^{Net}\right)}_{\text{Cost sorting}} > 0.$$

It is straightforward to see that targeting efficacy and value sorting coincide only in the special case where there is no offsetting sorting on costs. This is reasonable for programs with *constant costs* or more generally where costs are *uncorrelated* with value. For example, this might be reasonable for slots in a public childcare program or for a welfare program that gives everyone the same benefit amount. But it is unlikely to apply to insurance programs and other settings characterized by cost heterogeneity and adverse selection, which we turn to next.

### C. Ordeals Targeting and Adverse Selection

How do the conditions for ordeals being optimal relate to adverse selection? In this subsection, we use our model to analyze the social welfare impact of ordeals. We show that the targeting impacts of ordeals can be visualized in a simple graphical framework, following the approach of Einav and Finkelstein (2011) for selection markets. This lets us visualize the role of adverse selection for the gains from targeting and therefore the desirability of ordeals.

[17] In a related vein, Spinnewijn (2015, 2017) argue that behavioral biases tend to reduce the slope of the social value curve relative to demand, making revealed preference sorting less efficient.

While the classic ordeals debate has tended to focus on the wedge between individual choice and enrollees' true private welfare ($W_i$) or true social value ($V_i^{Soc}$), we use our framework to illustrate how the economics of adverse selection can create an analogous wedge between $V_i^{Soc}$ and *net* social welfare, $\gamma_i = V_i^{Soc} - C_i^{Net}$. Thus, even when ordeals successfully induce self-screening and favorable value sorting, adverse selection can erode or even reverse the gains from targeting.

*Adverse Selection and Targeting.*—Adverse selection is a feature typically associated with insurance and other "selection markets," where it is known to unravel trade and distort market outcomes. However, the underlying features driving adverse selection may also be relevant for thinking about targeting in social programs. These two key features are

1. **Cost Heterogeneity:** $C_i^{Net}$ varies across enrollees (with variance $\sigma_C^2 > 0$).
2. **Value-Cost Correlation:** $C_i^{Net}$ correlates positively with $V_i^{Soc}$, or $\rho = \text{corr}\left[V_i^{Soc}, C_i^{Net}\right] > 0$.[18]

These two features characterize many insurance programs where an individual's value (demand) and cost are both heavily driven by their risk. For instance, in health insurance, sicker individuals tend to have both higher value for insurance and higher expected costs. Adverse selection tends to result in $\bar{C}_1^{Net} - \bar{C}_0^{Net}$ having the same sign as $\bar{V}_1^{Soc} - \bar{V}_0^{Soc}$. Under adverse selection, positive value sorting ($\bar{V}_1^{Soc} - \bar{V}_0^{Soc} > 0$) is not enough for an ordeal to be desirable; it is possible to have small or even negative targeting efficacy ($\Delta\gamma \approx 0$ or $\Delta\gamma < 0$) if sorting on costs is sufficiently large.

While we focus on adverse selection, *advantageous* selection may be relevant in some settings, like long-term care insurance. Under advantageous selection, costs vary ($\sigma_C^2 > 0$), but the value-cost correlation is negative ($\rho < 0$). As a result, ordeals will generally target more effectively than without selection since low-value types (who self-screen out) will also have high costs.

*Graphical Analysis.*—We show that the gains from targeting under adverse selection can be illustrated using the familiar graphical framework of Einav, Finkelstein, and Cullen (2010) for welfare in selection markets. The intuition is that different levels of the intensity of an ordeal, given by $\sigma$ in our framework, trace out marginal value and marginal cost curves in much the same way as different prices generate demand and marginal cost curves in the original Einav, Finkelstein, and Cullen (2010) analysis. For a given ordeal of strength $\sigma$, we define the marginal social value curve $MV(\sigma) = E\left[V_i^{Soc} | W_i - \varepsilon_i = \sigma h_i\right]$ as the expected social value of those for whom a marginally stronger ordeal would cause not to enroll. Likewise, we define the marginal cost curve as $MC(\sigma) = E\left[C_i^{Net} | W_i - \varepsilon_i = \sigma h_i\right]$. It is straightforward to see that the conditional means in equation (10) ($\bar{V}_1^{Soc}$, $\bar{V}_0^{Soc}$, $\bar{C}_1^{Net}$ and $\bar{C}_0^{Net}$) are the average values of $MV(\sigma)$ and $MC(\sigma)$ to the left and right of $D(\sigma)$.

[18] In many settings, this condition is presented as a positive correlation between direct costs $C_i$ and private welfare $W_i$. For the purpose of this discussion, we assume that $W_i$ and $V_i^{Soc}$ are highly correlated, as are $C_i$ and $C_i^{Net}$, so these conditions are aligned.

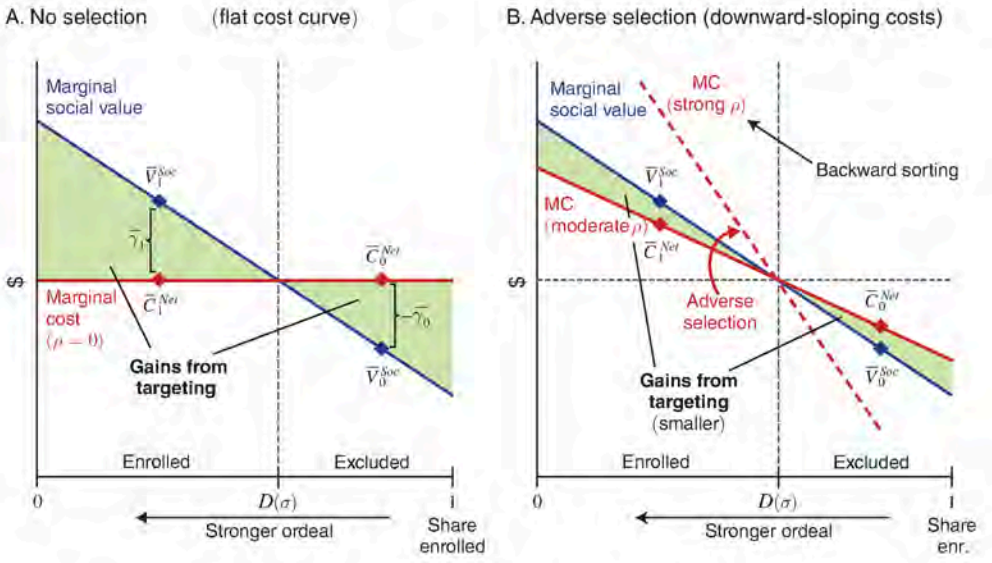



FIGURE 1. GAINS FROM ORDEALS TARGETING WITH NO SELECTION VERSUS ADVERSE SELECTION

*Notes:* The figure shows the gains from targeting from ordeals in two cases: (i) the "standard" ordeals case without selection (a flat marginal cost curve, panel A) and (ii) with adverse selection (downward-sloping cost curve, panel B). Both panels depict enrollee value and cost curves for marginal enrollees as the ordeal strengthens and enrollment drops (moving right to left), using a setup similar to Einav, Finkelstein, and Cullen (2010). The green shaded areas are the "gains from targeting," which shrink or become negative under adverse selection.

The key impact of adverse selection in this framework is to make the marginal cost curve *downward sloping* since low-value types also have low costs. This, we argue, reduces or reverses an ordeal's gains from targeting, potentially leading to backward sorting. Further, it makes it more likely that $MV(\sigma)$ lies entirely above or below $MC(\sigma)$, the condition for optimal universality.

Figure 1 illustrates this adverse selection logic graphically, showing how adverse selection reduces or reverses the gains from targeting. The curves in each panel depict the marginal social value (blue) and cost (red) curves as the ordeal gets stronger (moving right to left), an ordeals version of standard demand and marginal cost curves from Einav, Finkelstein, and Cullen (2010). The diamonds are average value and cost for included/excluded enrollees under an ordeal, optimally set to maximize targeting gains. Both panels show the same downward-sloping marginal value curve, reflecting the case in which the ordeal favorably sorts on social value, $\bar{V}_1^{Soc} - \bar{V}_0^{Soc} > 0$. The areas between the value and cost curves, shaded in green, correspond to the gains from targeting, $GT(\sigma)$,[19] and are increasing in $\Delta\gamma = \bar{\gamma}_1 - \bar{\gamma}_0$, as shown in the graph.

Panel A illustrates the classic ordeals case with *no selection* (i.e., where costs are constant or uncorrelated with value), represented by a flat marginal cost curve that intersects marginal value at an interior point. As a result, targeting efficacy $(\bar{\gamma}_1 - \bar{\gamma}_0)$

[19] Technically, gains from targeting equals the smaller of the two shaded triangles.

is equivalent to social value sorting ($\bar{V}_1 - \bar{V}_0$) because there is zero sorting on cost. An ordeal, therefore, achieves positive gains from targeting as long as the value curve is downward sloping, that is, $\Delta V^{Soc} > 0$. This is the key idea underlying the classic "self-screening" and "social value sorting" rationales for ordeals described above.

Panel B shows how this changes with *adverse selection*. The marginal value curve remains downward sloping, but now the marginal cost curve is also downward sloping, capturing the positive value-cost correlation. We show a case where the $MC(\sigma)$ curve rotates around its intersection point with $MV(\sigma)$, so the two curves continue to intersect. Because of this rotation, the gains from targeting (as shown in the green shaded area) are substantially reduced (when $\rho$ is modest) and may be negative (when $\rho$ is large). The key question for targeting efficacy is no longer whether the marginal value curve is downward sloping but whether it is *steeper* than marginal costs. In the case illustrated by the dashed red curve—where $MC(\sigma)$ is steeper than $MV(\sigma)$—the ordeal leads to "*backward sorting*." In this case, the ordeal targets inversely from what is desirable: those who are enrolled have negative surplus, while those who are excluded have positive surplus. This type of backward sorting is closely related to the idea that price-based sorting may also be inefficient in insurance markets (Marone and Sabety 2022).[20]

Figure 2 shows a second way adverse selection may undermine the optimality of ordeals: by leading to "optimal universality." We show both the no-selection and "modest" adverse selection $MC(\sigma)$ curves from the prior figure but now consider what happens if the $MV(\sigma)$ is higher, e.g., because society places a higher welfare weight ($\mu$) on program enrollees. With no selection, a more modest but still positive ordeal is optimal because the marginal value and cost curves continue to intersect. But with adverse selection, the *MV* curve lies *entirely above MC*, implying that full enrollment (zero ordeal) is optimal. The same idea applies in reverse if the marginal value curve is lower (via a lower $\mu$), with adverse selection making it more likely that no enrollment is optimal (see Supplemental Appendix Figure A.1). Intuitively, adverse selection makes these "universal" optima more likely because the similar downward slope of *MV* and *MC* makes them less likely to intersect within a given range.

*Mathematical Analysis.*—We now formalize these arguments. We start with the claim that adverse selection reduces or reverses the gains from targeting—the sorting argument shown in Figure 1, panel B. Note that given estimates of $V_i^{Soc}$ and $C_i^{Net}$, we can quantify the value-cost relationship by considering the linear projection of enrollee costs onto value: $C_i^{Net} = \bar{C} + \hat{\beta} \times V_i^{Soc} + \omega_i$, where $\bar{C}$ is the mean of net costs and $\omega_i$ is a residual capturing cost heterogeneity orthogonal to value. This projection can always be performed and results in the standard regression coefficient $\hat{\beta} = \rho \cdot \sigma_C / \sigma_V$, where $\sigma_C$ and $\sigma_V$ are the standard deviations of cost and value, and

[20] Sorting may be improved if ordeals (or prices) can be targeted only at high-cost enrollees (Bundorf, Levin, and Mahoney 2012), but this is typically not done because it would be inequitable to the sick. In a different context, the fact that "prior authorization" hassles are targeted at high-cost prescription drugs may explain why these yield savings in excess of their costs (Brot-Goldberg, Burn et al. 2023).

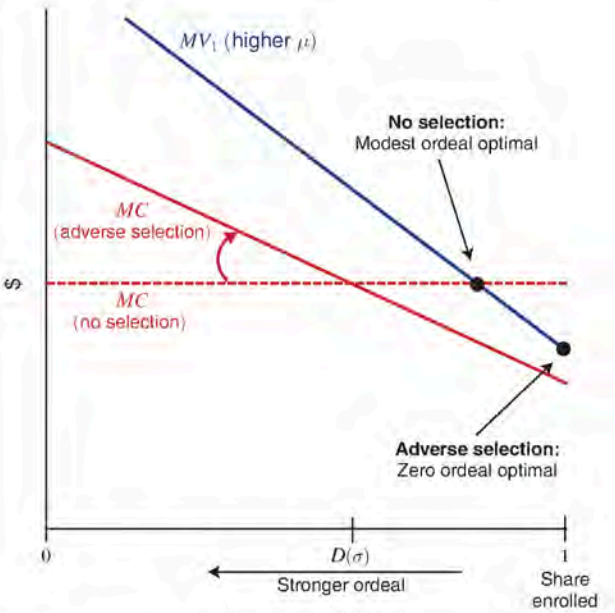



FIGURE 2. OPTIMAL UNIVERSALITY WITH ADVERSE SELECTION

*Notes:* The figure shows how adverse selection increases the likelihood of "optimal universality" when the social marginal value ($MV$) curve is shifted upward (relative to Figure 1) due to a higher social welfare weight, $\mu$. With no selection, the new marginal value curve ($MV_1$) still intersects marginal cost ($MC$), implying that a (more modest) ordeal is still optimal. With adverse selection, $MV_1$ lies entirely above $MC$, implying full enrollment (zero ordeal) is now optimal.

$\rho \in [-1, 1]$ is the value-cost correlation. Applying this projection to the terms for targeting efficacy in (10) yields[21]

$$(11) \qquad \underbrace{\bar{\gamma}_1 - \bar{\gamma}_0}_{\text{Targeting Efficacy}} = \underbrace{\left(\bar{V}_1^{Soc} - \bar{V}_0^{Soc}\right)}_{\text{Social Value sorting}} \times \underbrace{\left[1 - \overbrace{\left(\rho \cdot \frac{\sigma_C}{\sigma_V}\right)}^{\text{Adverse Selection Tax } (\tilde{\beta})} - \widetilde{\Delta\omega}\right]}_{\text{Correction for value-cost correlation}},$$

where $\widetilde{\Delta\omega} \equiv (\bar{\omega}_1 - \bar{\omega}_0)/\left(\bar{V}_1^{Soc} - \bar{V}_0^{Soc}\right)$ captures the ordeal's sorting on idiosyncratic costs. We call $\tilde{\beta}$ the "adverse selection tax" since it captures the degree to which adverse selection (a large covariance between value and costs) "taxes away" the welfare gains from favorable sorting on value.

Equation (11) formalizes the relationship between social value sorting $\left(\bar{V}_1^{Soc} - \bar{V}_0^{Soc}\right)$ and the true targeting efficacy, $\bar{\gamma}_1 - \bar{\gamma}_0$. If program costs are either constant across enrollees ($\sigma_C = 0$) or uncorrelated with enrollee value ($\rho = 0$), social welfare gains are approximately equal to value sorting. However, as cost heterogeneity ($\sigma_C$) and the value-cost correlation ($\rho$) grow more positive—precisely the two key features of adverse selection laid out above—the adverse selection tax

[21] We get this from applying the projection to get $\bar{C}_1^{Net} - \bar{C}_0^{Net} = \tilde{\beta} \times \left(\bar{V}_1^{Soc} - \bar{V}_0^{Soc}\right) + (\bar{\omega}_1 - \bar{\omega}_0)$, which can be rearranged to yield the expression in (11).

grows, and gains from targeting are diminished. Further, if $\hat{\beta}$ grows large enough that

$$\hat{\beta} = \rho \cdot \frac{\sigma_C}{\sigma_V} > 1 - \widetilde{\Delta\omega}, \tag{12}$$

the correction term becomes negative, and the ordeal leads to backward sorting (on social welfare) despite favorable sorting on value. This corresponds to a "steeper" marginal cost than marginal value curve in Figure 1, panel B. If $\widetilde{\Delta\omega} \geq 0$—which occurs if an ordeal does not screen, or screens unfavorably, on idiosyncratic costs (the case we usually find in our empirical work)—a sufficient condition for backward sorting is $\hat{\beta} > 1$, or $\rho > \sigma_V/\sigma_C$.

This analysis provides insight into why ordeals will generally work poorly in settings with strong adverse selection, where $\hat{\beta} > 1$. In these settings, *any* ordeal that sorts favorably on value will sort *backward* on efficiency, unless it happens to screen in people with low *idiosyncratic* costs ($\widetilde{\Delta\omega} < 0$), something that while possible, is not implied by economic theory. More generally, even modest adverse selection ($\hat{\beta} \in (0, 1]$, or $\rho \in (0, \sigma_V/\sigma_C]$) "taxes" away the gains from value sorting in proportion to $\hat{\beta}$, making the real welfare gains much smaller.[22]

We now formalize the claim that adverse selection makes optimal universality more likely, as depicted in Figure 2. As in the figure, we consider how shifts in marginal social value driven by a higher/lower social welfare weight ($\mu$) affect the optimality of a given ordeal with strength $\sigma$.[23] For the ordeal to yield targeting gains per condition (7), it must be the case that $\bar{\gamma}_1(\sigma) > 0 > \bar{\gamma}_0(\sigma)$, or $\bar{V}_1^{Soc}(\sigma;\mu) - \bar{C}_1^{Net}(\sigma) > 0 > \bar{V}_0^{Soc}(\sigma;\mu) - \bar{C}_0^{Net}(\sigma)$, where we highlight that $\bar{V}_1^{Soc}$ and $\bar{V}_0^{Soc}$ are both (increasing) functions of $\mu$. These inequalities, therefore, implicitly define a range of $\mu$ over which the ordeal is desirable: $\mu \in [\mu^*_{min}, \mu^*_{max}] \equiv \left[\left(\bar{C}_1^{Net} - \bar{E}_1\right)/\bar{W}_1, \left(\bar{C}_0^{Net} - \bar{E}_0\right)/\bar{W}_0\right]$ as long as $\mu^*_{min} \leq \mu^*_{max}$. Relative to no selection ($\bar{C}_1^{Net} = \bar{C}_0^{Net}$), adverse selection rotates the cost curve, making $\bar{C}_1^{Net} > \bar{C}_0^{Net}$, which pushes upward $\mu^*_{min}$ and downward $\mu^*_{max}$. Thus, adverse selection *narrows the range* of social preferences $[\mu^*_{min}, \mu^*_{max}]$ over which ordeals are preferred to universal policies. (See Supplemental Appendix Figure A.1 for a visualization of this argument.) Further, for sufficiently strong adverse selection, this range becomes null, implying that there is no $\mu$ at which the ordeal is optimal.

*Broader Implications for Transfer Programs.*—While our emphasis has been on insurance programs, our framework also sheds light on many *transfer* programs where recipient value and public costs are naturally correlated via the (varying) *benefit amounts*, which are both a benefit to enrollees and a cost to the government. For instance, in many means-tested programs, benefit amounts vary with enrollee income or family status. This suggests that the logic of correlated value and costs may apply,

[22] One reason $\hat{\beta}$ is likely to be large in low-income populations is that $\sigma_V$ (at least for private WTP) tends to be small because marginal utility of consumption is high, while $\sigma_C$ is much larger, reflecting variation in health needs.

[23] We make this argument for a particular $\sigma$, but an analogous argument applies across a *full range* of values of $\sigma$ to show that adverse selection makes it more likely that the $MV(\sigma)$ and $MC(\sigma)$ curves do not intersect over this range.

and self-targeting may not translate into significant welfare gains. Instead, the desirability of ordeals may depend on whether low-benefit-amount enrollees also tend to be those the government wishes to screen out for other reasons (e.g., because they are less poor, so have a lower social welfare weight).

Our analysis can help interpret the findings in past work. For instance, both Finkelstein and Notowidigdo (2019) (studying SNAP) and Bhargava and Manoli (2015) (studying the EITC) find that hassles on average screen out people who receive smaller benefit amounts from these programs. But the normative implications are different. In SNAP, low-benefit types are generally *higher-income* individuals, for whom economic need is less. But in the EITC, low-benefit types were generally *lower-income* individuals *without kids*, for whom need may be high. By contrast, ordeals screening works well in programs that distribute supplies with *equal costs* for all participants, as in free chlorine solution for water treatment (Dupas et al. 2016).

*Connection to Economics of Nudges.*—Our analysis of ordeals relates to the broader economics of "nudges" (Thaler and Sunstein 2008) and similar nonprice interventions. Although the vast majority of this literature focuses on empirical impacts and positive economics, recent work by Allcott et al. (2022) unpacks the welfare implications of nudges. Their work emphasizes that simple *average treatment effects* on demand or adoption of ostensibly beneficial goods or behaviors may be a misleading guide to welfare. Instead, the key welfare question is whether a nudge reduces *choice distortions*, by inducing people to consume or behave more in line with what is socially optimal.[24] A nudge improves social welfare only if it reduces (more than it exacerbates) baseline under- and overconsumption of a good relative to the social optimum.

This aligns closely with our analysis of take-up and targeting with ordeals for social programs. An ordeal improves welfare only if it corrects (more than it exacerbates) errors of overenrollment (enrolling $\gamma_i < 0$ types) and of underenrollment (excluding $\gamma_i > 0$ types) that occur with alternate policies like full inclusion and exclusion. This is exactly what is captured by our targeting efficacy statistic, $\Delta\gamma = \bar{\gamma}_1 - \bar{\gamma}_0$, and by our expression for "gains from targeting" in (6). Indeed, there is a close parallel between our model and the setup of Allcott et al. (2022),[25] suggesting a deep connection between the welfare economics of nudges and ordeals. This also suggests that thinking about nudges through the lens of *optimal targeting* may be a fruitful way to understand their welfare impacts.

[24] Allcott et al. (2022) show that this occurs when a nudge reduces the *variance* of "net distortions," or the (individual-specific) wedge between choice utility and social welfare arising from behavioral biases, externalities, and other factors like markups and taxes. These wedges may be either positive or negative, so a smaller variance implies behavior more in line with social welfare.

[25] Importantly, we allow $C_i^{Net}$ to vary (whereas marginal cost is fixed in their model) because we are studying a selection market. Finally, their model is more complex because it allows prices to endogenously adjust to nudges (via their impact on supply/demand), which necessitates an analysis of price pass-through impacts that we can ignore.

## II. Setting, Auto-Enrollment Policy, and Data

### A. *Massachusetts Exchange Setting*

*CommCare Exchange.*—We study Commonwealth Care ("CommCare"), a subsidized insurance exchange in Massachusetts that operated from 2006 to 2013 before shifting form in 2014 at the ACA's implementation. CommCare covered low-income adults with family income below 300 percent of the federal poverty level (FPL, or "poverty") and without access to insurance from another source, including an employer or public program (i.e., Medicare or Medicaid). We focus on the population with income below 100 percent of FPL for whom the auto-enrollment policy applied. Given eligibility rules for other programs, this group is almost entirely childless adults age 19–64.[26]

CommCare offered generous insurance at heavily subsidized premiums. The program specified a detailed benefit structure (i.e., cost sharing rules and covered medical services) that private insurers were required to follows. Each insurer offered a single plan with the standardized benefits but could differ in its network of hospitals and doctors. For the below-poverty group we focus on, benefits were equivalent to Medicaid—that is, broad covered services with essentially no patient cost sharing (the actuarial value is 99.5 percent)—and all plans were fully subsidized ($0 premium). This setup is similar to Medicaid managed care programs. As in Medicaid, there is no financial cost to insurance, and the only barriers are enrollment hassles. An important difference from Medicaid, however, is that CommCare does *not* have retroactive coverage; coverage starts the first day of the month *after* completing enrollment.[27] Therefore, enrollment delays have a meaningful impact, including the risk of getting acutely ill and incurring medical debts before enrollment takes effect.

*Application and Enrollment Process.*—It is well-known that there is substantial "churn" into and out of eligibility for different forms of health insurance, e.g., due to job changes, income fluctuation, or family status changes. Therefore, many people newly need health insurance and apply for public coverage. For CommCare, the enrollment process involves two steps, as shown in Figure 3. Step 1 is to apply for eligibility. This requires completing a six-page application that asks about income, demographics, family status, and access to other health insurance (see Supplemental Appendix H for snapshots of the form). The state used this information to determine eligibility for Medicaid or CommCare (dual eligibility should not occur) and to sort people into income-based subsidy groups in CommCare. Although the application form is a meaningful hassle, many individuals get help from a social worker or medical staffer in completing it, often just after having visited a medical provider while uninsured.

[26] Medicare covers seniors age 65+, and Massachusetts Medicaid covers children up to 300 percent of FPL, parents with dependent children up to 133 percent of FPL, and pregnant women up to 200 percent of FPL. In addition to the nonelderly, CommCare covered a small number of immigrants age 65+ not eligible for Medicare. As we discuss below, we drop immigrant enrollees from our sample.

[27] By contrast, Medicaid covers medical bills incurred prior to enrollment, typically with a 90-day retroactive period. As a result, Medicaid eligibles have a form of "conditional coverage" that is not available from CommCare.

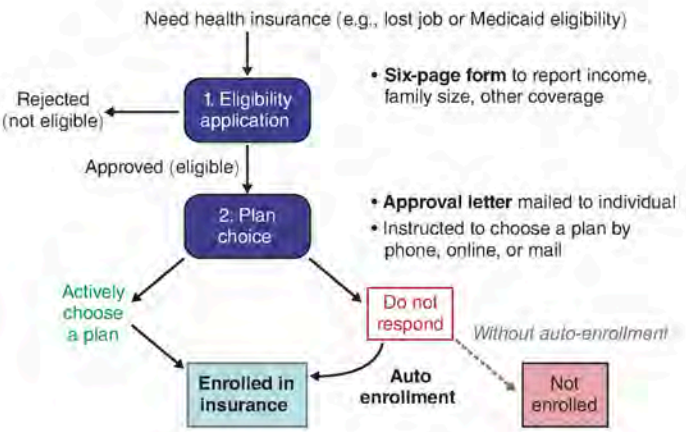



FIGURE 3. ENROLLMENT PROCESS AND AUTO-ENROLLMENT POLICY

*Notes:* The figure diagrams the enrollment process for the Massachusetts health insurance exchange we study (CommCare). Prospective enrollees who need health insurance must follow a two-step process. First, they apply for eligibility, completing a six-page form with information on income, family status, and other coverage. Second, if approved, they are mailed an approval letter and asked to choose a (free) health plan by phone, online, or mail. The auto-enrollment policy applies to approved individuals who do not respond to this approval letter within 14 days ("passive" individuals). With auto-enrollment (the policy from 2007 to 2009), they are auto-enrolled into a state-selected plan; without auto-enrollment (post-2010 policy), they are not enrolled unless and until they actively respond.

The second enrollment step is to choose a plan. After determining eligibility, the state notified an individual (by mail and/or email) and provided information on available plans and associated premiums. Supplemental Appendix H shows this two-page approval letter. To complete enrollment, individuals were asked to choose a plan by calling, going online, or circling a plan choice and returning it by mail. Relative to the initial application, this step was quite simple. However, without auto-enrollment, individuals still had to take action to enroll. Moreover, the action needed to be taken *independently* in response to the approval letter, which could be lost, misunderstood, or forgotten.

### B. *Auto-Enrollment Policy and Timeline*

*Auto-Enrollment Policy.*—CommCare's auto-enrollment policy set the default outcome for people determined eligible (step 1 of the process) but who did not respond when asked to choose a plan (step 2; see Figure 3). The policy applied only to below-poverty enrollees, for whom all plans were free.[28] This allowed regulators to borrow a policy widely used in Medicaid managed care that "auto-assigns" passive new enrollees into a state-selected plan. Aggregate statistics suggest that

[28] Auto-enrollment was generally not used for above-poverty enrollees because premiums varied across plans and were typically nonzero, raising concerns about auto-enrolling people into plans that generated a financial debt for them. There were two limited exceptions of auto-enrollment for 100–150 percent of poverty enrollees, both of which are excluded from our main sample (see discussion below): (i) for reenrollees prior to 2010 who reenrolled with a gap of less than 12 months and (ii) for new enrollees during the single month of December 2007 (fiscal year 2008m6).

auto-assignment in Medicaid is very common: the median state auto-assigns 45 percent of new enrollees (Smith et al. 2015). However, we are not aware of any *causal* evidence on this policy's impact on take-up, likely because of a lack of variation in its use.

Auto-enrollment applied when individuals entered the market, but with different rules for two groups: (i) "new enrollees" joining for the first time and (ii) "reenrollees" joining after a gap in coverage. We focus our main analysis on new enrollees. New individuals were mailed a coverage approval letter and given 14 days to actively choose a plan before being auto-enrolled if they failed to respond. This lets us observe mode of enrollment (active versus passive) directly in our administrative data.[29]

There was one notable exception to the process for new enrollees near CommCare's inception in 2007 when the state "auto-converted" a large population from its pre-RomneyCare uncompensated care pool (UCP). These individuals did not complete a new eligibility application but were determined eligible based on information from their original UCP application, often completed months beforehand. Consistent with the long lag, many of these UCP individuals failed to respond and were auto-enrolled, creating a large spike in auto-enrollment in early 2007. Because of these distinct circumstances, we focus our main analysis on the "steady-state" auto-enrollment period (fiscal years 2008–2009), with the initial period (2007) analyzed for comparison and robustness.[30]

*Policy Timeline.*—We examine auto-enrollment policy changes during fiscal year (FY) 2010 (which ran from July 2009 to June 2010). Facing a Great Recession–related budget shortfall, CommCare needed to cut spending. The program had raised enrollee premiums and copays the prior year, and it was eager to avoid doing so again. Suspending auto-enrollment provided an alternative to reduce enrollment and therefore subsidy spending. The exchange did so as of the start of FY 2010, with (because of a lagged impact) a final group of passive enrollees joining in 2010m1 (July 2009). These cuts proved quite effective, and CommCare unexpectedly came in under budget during 2010. As a result, the program temporarily reinstated auto-enrollment in the final three months of FY 2010. After this, facing continued budget pressures, it was permanently canceled in 2011.

These changes give us variation to estimate the causal impact of auto-enrollment. To be valid, it is important that there not be other concurrent shocks or policy changes that affect enrollment around the same time. Based on background research and discussions with the exchange administrator, this appears to be true, with one exception: an eligibility cut for noncitizen enrollees in 2010m4 (October 2009), two months after the auto-enrollment suspension. To avoid biasing our results, we

[29] By contrast, most reenrollees were *immediately* auto-enrolled in their former plan (without a 14-day window to actively choose), and auto-reenrollment was also used for some above-poverty enrollees (our control group). For these reasons, we exclude reenrollees from our main sample, reporting effects on them in robustness analysis (see Supplemental Appendix B.2).

[30] Supplemental Appendix C.5 compares our main targeting analysis for the 2008–2009 sample (see Section IVA) to the results for 2007. Interestingly, while auto-enrollment is much more common in early 2007, we find very similar targeting (active versus passive enrollee characteristics) in both periods.

exclude noncitizen enrollees from our sample in all periods.[31] Aside from this, other enrollment-relevant policies did not change.[32] Nonetheless, to address any unobserved demand shocks, we also use a control group of higher-income enrollees not subject to auto-enrollment.

*Other Policy Details.*—Although our analysis focuses on enrollment impacts, other policy details are of interest, including rules for plan auto-assignment. The plan assignment rule had two parts. Passive enrollees with prior enrollment with an insurer in the past 12 months (either in CommCare or Medicaid) were auto-assigned to that insurer. Other new enrollees were randomly assigned to plans, with probability shares following a schedule giving more weight to plans with lower (state-paid) premiums. After enrollment, all new/reenrollees (both active and passive) could freely switch plans within 60 days of starting coverage. In practice, the vast majority (96 percent of passive and 98 percent of active enrollees) stick with their initial plan, consistent with other work finding that default health plan assignment is very sticky (Brot-Goldberg, Layton et al. 2023).

These policies raise two interesting issues that we have not explored in this paper. First, random assignment could allow for inferring causal plan effects, as in recent work on Medicaid (Geruso, Layton, and Wallace 2020). In practice, we find evidence of slight demographic imbalance across plans, suggesting the presence of hard-to-observe exceptions to random assignment. We therefore have not pursued this topic further. Second, giving higher probability weights to lower-price insurers should affect competitive incentives. This topic is interesting but would require a different research design to study; we therefore leave it for future work.

### C. *Data and Descriptive Statistics*

*Exchange Admin Data and Sample Definition.*—Our primary data come from deidentified CommCare administrative records for fiscal years 2007–2014, spanning November 2006 to December 2013 (Massachusetts Health Connector 2014). For all enrollees, we observe a panel of individual-level demographics and monthly plan enrollment, linked to insurance claims and risk scores. Observed demographics include age, gender, zip code of residence, and family income as a percentage of the poverty line. Insurance claims let us measure individuals' medical conditions and health care use and costs while enrolled. Importantly, the data include a flag for whether each new enrollee is auto-enrolled or actively chooses a plan. This lets us

[31] The eligibility change was for legal immigrant residents (typically green card holders) who had not yet cleared their "five-year bar" requirement to receive federal Medicaid matching funds—a group the state calls "aliens with special status" (AWSS). Starting in October 2009, the AWSS group was not eligible to newly enroll in CommCare, and existing AWSS enrollees were shifted into a parallel program. We observe a flag for AWSS status and enrollment in this parallel program, which lets us exclude these individuals from the sample in all periods.

[32] The start of 2010 did see the entry of a new insurer (CeltiCare). But for the below-poverty group, this expanded the choice set of available free plans, which should (if anything) increase enrollment, pushing in the opposite direction of our findings. In practice, CeltiCare had a narrow network and was not popular, with only 1.5 percent of below-poverty active choosers selecting it during 2010–2011. We therefore view the new availability of CeltiCare as having a negligible impact.

construct the key variables for our main analysis: monthly counts, characteristics, and outcomes for passive and active enrollees.[33]

We are interested in the policy's impact on enrollment totals and composition. For enrollment impacts, the main outcome of interest is counts of new enrollees joining CommCare per month (a flow measure). We use our panel data and a simple model to translate this into an effect on steady-state enrollment (a stock measure). For composition, we use variables on demographics, diagnoses, and medical spending during an individual's enrollment spell.

We make several limitations to our main CommCare analysis sample. First, we limit attention to new enrollees who (when they joined the market) were in one of two income groups: (i) the 0–100 percent of poverty "treatment" group and (ii) a 100–200 percent of poverty "control" group not subject to auto-enrollment. Second, we exclude from our sample noncitizen enrollees who (as described above) faced an eligibility cutback in October 2009, shortly after the auto-enrollment change (in August 2009). Finally, we limit our main sample period to FY 2008–2011 for analyses of the treatment group and to 2009–2011 for difference-in-differences (DD) regressions comparing treatment and control groups. We exclude 2007 because of the different nature of auto-enrollment during that year (see discussion above). For DD regressions, we further exclude 2008 because of other policy changes that affected the control group in mid-to-late 2008.[34] We end our analysis in 2011 because of a change in plan choice rules for the treatment group at the start of 2012 (see Shepard 2022).

*Other Datasets.*—We draw on two additional datasets for specific pieces of our analysis:

- **American Community Survey (ACS):** For context on uninsurance in Massachusetts, we use the ACS (Ruggles et al. 2015) to estimate the CommCare-eligible uninsured population by income group, following a method used by Finkelstein, Hendren, and Shepard 2019. Details are in Supplemental Appendix A.1.
- **Massachusetts All-Payer Claims Database (APCD):** We use the state's APCD (version 3.0, with data for 2009–2013) (Massachusetts CHIA 2014) to examine whether CommCare enrollees are enrolled in duplicate private insurance, as a possible reason for failing to actively enroll. The APCD is well suited for this purpose because it lets us observe a near-universe of Massachusetts health insurance plans and measure simultaneous coverage. Supplemental Appendix D describes the data construction method and shows that the APCD's enrollment counts for CommCare closely match our administrative data.

[33] We observe this flag for the FY 2007–2009 period when auto-enrollment is in effect, but due to a technical issue, it is missing during the policy's temporary reinstatement in April–June 2010. For this latter period, we report only aggregate data for all enrollees.

[34] Specifically, for individuals above 150 percent of poverty, the state's insurance mandate penalty took effect in December 2007 (FY 2008m6), leading to a spike in new enrollment. Also in December 2007, there was a large auto-enrollment for the 100–150 percent poverty group. For the whole 100–200 percent poverty control group, there was a change in plan premiums and subsidies at the start of FY 2009 (July 2008). Importantly, none of these changes applied to the treatment group, and policy for the control group was stable throughout the 2009–2011 period used in our DD analysis.

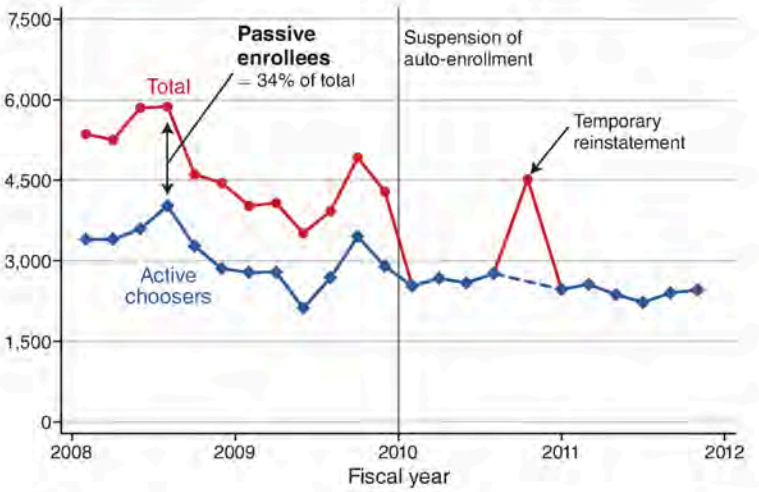



FIGURE 4. ACTIVE VERSUS PASSIVE NEW ENROLLMENT INTO THE MASSACHUSETTS EXCHANGE

*Notes:* The graph shows counts of new enrollees per month for the below-poverty group subject to auto-enrollment. The red series is total new enrollment, the blue is active choosers, and the gap between these is passive auto-enrollment. The vertical line indicates the timing of auto-enrollment's suspension at the start of fiscal year 2010. After this, total enrollment equals active choosers, except for the period of auto-enrollment's temporary reinstatement (during which we lack the flag to separate active versus passive enrollment). Data are bimonthly averages to smooth over fluctuations.

*Descriptive Statistics.*—Figure 4 shows data on new enrollment per month in the treatment group (0–100 percent of poverty) over the main 2008–2011 period.[35] The figure plots both total new enrollment (in red) and the count of active choosers (in blue), with the gap between these being passive enrollees. Passive enrollees represent a sizable 34 percent share of new enrollment during 2008–2009, and new enrollment falls sharply when auto-enrollment was suspended at the start of 2010. The decline is almost identical to the number of passive enrollees during 2008–2009. Moreover, when the policy is briefly reinstated at the end of 2010, enrollment spikes up to a similar level as at the end of 2009. Together, these facts are consistent with auto-enrollment having a causal effect roughly equal to the full number of passive enrollees in the pre-period.

Supplemental Appendix Table A.1 further summarizes enrollment statistics, including enrollment counts for the 100–200 percent of poverty group and on total market enrollment and new versus reenrollment. Supplemental Appendix Table A.2 reports average consumer attributes; we defer a discussion of these to Section IV, where we compare active versus passive enrollees.

[35] The points are bimonthly averages to smooth over noise; see Supplemental Appendix Figure A.2 for the raw monthly data over the full 2007–2011 period. As that figure shows, auto-enrollment spiked during early 2007 because of the autoconversion of the state's uncompensated care pool.

## III. Causal Impact of Auto-Enrollment Policy

This section presents our estimates of the impact on take-up of suspending auto-enrollment in 2010. After presenting results in Section IIIA, we provide context on the magnitude in Section IIIB.

### A. *Impact on Health Insurance Enrollment*

We use the 2010 policy change to estimate the causal impact of auto-enrollment. To do so, we run difference-in-difference regressions on counts of monthly new enrollment, comparing the 0–100 percent of poverty "treatment" group (for whom auto-enrollment is in place through 2009 and suspended in 2010) to the 100–200 percent of poverty "control" group (for whom auto-enrollment was not in place throughout). The DD regression is

$$NewEnr_{g,t} = \alpha_g + \beta_t + \gamma \cdot \mathbf{1}\{g = Treat,\ t \geq 2010\} + \varepsilon_{g,t}, \tag{13}$$

where $NewEnr_{g,t}$ is (scaled) new enrollment for income group $g$ (treatment or control) at time $t$, $\alpha_g$ is a group fixed effect (for the treatment and control groups), $\beta_t$ is a time fixed effect, and $\varepsilon_{g,t}$ is an error. We run (13) on data from 2009 to 2011, excluding the period of temporary reinstatement of auto-enrollment at the end of 2010.[36] The dependent variable is "scaled" new enrollment, equal to a group's raw monthly counts divided by its average new enrollment in the pre-2010 period. This ensuring $NewEnr_{g,t}$ has a mean of 1.0 for each $g$ in the pre-period and lets us interpret estimates as proportional effects. The coefficient of interest is $\gamma$, which is the DD estimate of the impact of turning off auto-enrollment (i.e., adding the active choice ordeal).

Figure 5 plots the data for the regression in (13) and reports the main DD estimate. Panel A shows results for *total* new enrollment (active plus passive). Trends for both groups are parallel in the pre-period, and treatment group enrollment drops sharply and persistently at the policy change. The DD estimate of $\gamma = -0.326$ implies that suspending auto-enrollment reduced new enrollment by 32.6 percent of the pre-period mean. In the reverse direction, new enrollment was 48 percent $(= 0.326/(1 - 0.326))$ higher when auto-enrollment was in place.

Figure 5, panel B shows the impact on the number of *actively choosing* new enrollees. In principle, auto-enrollment might induce some attentive individuals to be "purposely passive" because they know the stakes are low, e.g., if they view CommCare plans as roughly equivalent and are happy to let the regulator select for them.[37] If this were true, we would expect these purposely passive individuals to actively enroll when auto-enrollment stops in 2010, resulting in an uptick in *active*

[36] The time unit ($t$) is bimonthly periods, averaging over new enrollment in pairs of months, which smooths over a few single months when auto-enrollment appears not to have occurred followed by a surge in auto-enrollment the next month. We calculate standard errors using the normal linear model given the small samples sizes but verify that robust standard errors are essentially the same.

[37] Enrollees were informed about the auto-enrollment policy in the coverage approval letter, which stated, *"If you do not choose a health plan by [date], the Connector will choose one for you."* After early 2010, this language was removed, and enrollees were sent periodic reminder letters if they had qualified but not enrolled in coverage.

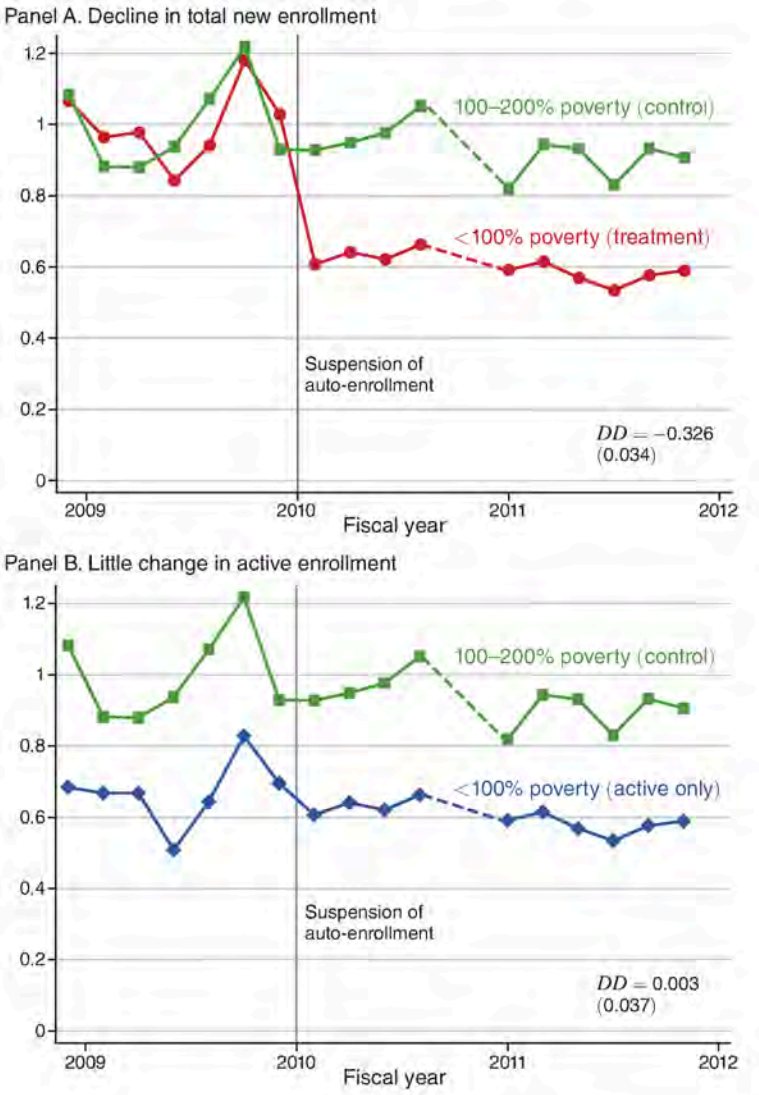



FIGURE 5. ENROLLMENT IMPACT OF AUTO-ENROLLMENT'S SUSPENSION

*Note:* The figure shows scaled new enrollment per month into CommCare and estimates of the DD specification (13) for estimating the causal effect of auto-enrollment's suspension. Each panel compares trends for below-poverty enrollees (the treatment group) versus 100–200 percent of poverty enrollees (the control group, not auto-enrolled). Each income group's series is rescaled by dividing by the group's pre-period mean new enrollment, which makes DD estimates interpretable as a proportional change. The temporary reinstatement period is excluded (as indicated with dashed lines). Panel A shows that total new enrollment falls sharply (by 32.6 percent) for the treatment group at the start of 2010, consistent with a causal effect of the policy. Panel B shows that the number of active new enrollees is flat through the policy change.

enrollment. Instead, Figure 5, panel B shows that there was no change in active new enrollment around the policy change, with a DD estimate of almost exactly zero ($\gamma = 0.003$) and no sign of an uptick in the two years following the policy change. As a further test, Supplemental Appendix Figure A.3 shows that we see no evidence of compositional changes in the characteristics of active enrollees, which we would expect if some people shifted to active choice.

This evidence suggests two facts about the ordeal of requiring active plan choice to get insurance. First, failure to actively enroll is unlikely to have been a strategic or purposeful decision; instead, passivity is more likely due to inattention or misunderstanding of enrollment rules. Second, active choice is unlikely to involve significant costs to inframarginal enrollees. If it did, we would expect some to substitute toward passivity when auto-enrollment is an option.

*Effect on Steady-State Enrollment.*—The results so far are on the *flow* of new enrollees, which falls immediately when auto-enrollment ends. The *stock* of total enrollment, however, changes more gradually, as existing enrollees exit, while fewer new enrollees enter each month. To estimate the impact on steady-state enrollment, Supplemental Appendix B.3 uses the data to calibrate a simple stock-flow model. We find that suspending auto-enrollment reduces steady-state enrollment by 24 percent; or in the reverse direction, enrollment is 32 percent higher with auto-enrollment in place. (This estimate is slightly smaller than the impact on new enrollment because passive enrollees have shorter durations.) The estimates from the stock-flow model are highly consistent with the raw data on the stock of below-poverty enrollment, which falls by 23 percent from late 2009 to the end of 2011 (Supplemental Appendix Figure A.7).

*Robustness: Alternate Specifications and Effects on Reenrollment.*—These estimates are quite robust to alternate specifications and control groups. Supplemental Appendix Table A.3 shows that the estimated 33 percent fall in new enrollment is little changed when we (i) use alternate income groups as controls (e.g., 100–150 percent FPL only, or 100–300 percent FPL), (ii) use no control group (a simple pre/post difference), and (iii) include the "temporary reinstatement" period in the regressions. Additionally, while the analysis so far has been limited to new enrollees, Supplemental Appendix B.2 shows that there are similar impacts on the number of reenrollees joining the exchange after a break in coverage. We find that reenrollment falls 35–39 percent at the start of 2010, very similar to the 32.6 percent fall for new enrollment. We therefore conclude that our main estimates on new enrollees are representative of the policy's overall impact.

### B. *Magnitude: Comparison to Other Take-Up Policies*

How should we interpret the magnitude of the impact of auto-enrollment—a 48 percent increase in new enrollment and 32 percent increase in steady state? Several benchmarks provide context for this estimate. First, relative to other "nudge" interventions to increase health insurance take-up, these are very large impacts. Several recent randomized experiments have tested nudges like reminder mailings/phone calls, simplified plan information, and a simpler take-up process (Domurat, Menashe, and Yin 2021; Myerson et al. 2021; Ericson et al. 2023). These studies find take-up impacts of 1–4 percentage points among a similar passive population (people who have qualified for coverage but not chosen a plan).[38] Similarly, evidence from

[38] Goldin, Lurie, and McCubbin (2021) study a similar mail outreach intervention on uninsured individuals identified in tax filings. They likewise find a modest take-up impact of +1.1 percentage points, though even this small impact led to a meaningful decline in mortality among the marginally insured.

Aizawa and Kim (2020) suggests that a threefold increase in government advertising of ACA Marketplaces would increase market-level enrollment by 1.3 percentage points (or 7.6 percent). By contrast, our auto-enrollment policy leads to an *order of magnitude larger* impact: nearly complete take-up among the passive group and a 30–50 percent increase in the total enrolled population. These results suggest that while information and simplification matter, *making enrollment the default* may be critical to substantially boost take-up.

A second benchmark is the impact of financial incentives. Our estimated steady-state impact of auto-enrollment is nearly identical to the 33 percent effect of subsidies that reduce enrollees' premiums by $39–$40 per month, or $468–$480 per year (a 57 percent average reduction), in prior evidence from the Massachusetts exchange (Finkelstein, Hendren, and Shepard 2019). It is somewhat larger than the 20–26 percent impact of introducing Massachusetts's uninsurance penalty (Chandra, Gruber, and McKnight, 2011).[39] Therefore, auto-enrollment has an impact comparable to sizable changes in financial incentives.

Despite its large impact, the targeted nature of the auto-enrollment policy—applying only to people who had already qualified for coverage—meant that its impact on overall uninsurance was more modest. Using ACS data, we estimate that Massachusetts had about 300,000 uninsured people in 2009, of whom about 62,000 had incomes below poverty and were likely CommCare eligible. Relative to this denominator, auto-enrollment's 14,900-person impact (see Supplemental Appendix B.3) represents a 24 percent decline in the eligible uninsured population.

## IV. Targeting Implications of Auto-Enrollment

In this section, we study the targeting implications of auto-enrollment. Who are the marginal enrollees, and how do they compare to inframarginal (active) enrollees? How does auto-enrollment affect the market risk pool? What mechanisms may explain passive individuals' failure to actively enroll? These questions matter both for the policy's positive economic implications and for its welfare interpretation. Section IVA provides descriptive evidence on targeting implications, comparing marginal (passive) versus inframarginal (active) enrollees on characteristics related to the value and cost of insurance. Section IVB shows evidence that auto-enrollment is unlikely to be (invalidly) enrolling individuals with duplicate private health insurance. Section IVC assesses mechanisms, both rational and behavioral, for why a small hassle deters so many people from taking up free coverage.

### A. *Targeting Implications and Impact on Market Risk Pool*

To study the targeting implications of auto-enrollment—that is, inferring its marginal versus inframarginal enrollees—we employ two methods. The first is motivated by our finding in Section IIIA that the number and composition of active

[39] Evidence from the ACA—which involves a somewhat higher-income population than in CommCare—suggests smaller impacts of both subsidies and uninsurance penalties (see, e.g., Frean, Gruber, and Sommers 2017; Lurie, Sacks, and Heim 2019). The 32 percent impact of auto-enrollment is even larger relative to subsidies and penalties based on these ACA estimates.

enrollees is unaffected by the end of auto-enrollment in 2010. This suggests that passive behavior is in a sense "exogenous" to the policy environment. If correct, this means that *observed passive* enrollees (prior to 2010) are also *marginal* enrollees who would not have enrolled without the policy in place.[40] Thus, we are in the fortunate position of directly observing who is a marginal versus inframarginal enrollee (something that is rarely true in the targeting literature). A simple comparison of passive versus active enrollees, therefore, should faithfully characterize marginal versus inframarginal individuals. We use this method for our main analysis, controlling for entry timing using cohort fixed effects.[41]

Our second method uses the *policy change* to infer marginal enrollee characteristics from compositional changes in new enrollment at the start of 2010. This method has the advantage of not requiring the assumption of exogenous passivity. However, it is statistically much less powerful and may suffer problems if enrollee attributes are trending over time. We therefore implement it as a robustness check, using the simple active versus passive comparison for our main estimates.

*Characteristics of Passive Enrollees.*—Table 1 shows the results from our main method comparing passive versus active enrollees. Overall, the results suggests four main patterns about passive (relative to active) enrollees:

**Younger, Healthier, and More Male:** Passive enrollees are younger by 3.8 years on average and are 22 percent more likely to fall into the youngest age (19–34) group. They are also more likely to be male, with an especially large share (44 percent higher) of young men age 19–34, a group often called "young invincibles" in insurance discussions. Likewise, passive enrollees are healthier, with 33 percent lower rates of any chronic illness and 49 percent lower rates of severe chronic illness. Overall, passive enrollees have 36 percent lower medical risk scores, a measure of predicted medical costs based on age, sex, and diagnoses.[42] Figure 6 visualizes these patterns in a different way by plotting the passive enrollment rate by age, sex, and risk score groups. Passive rates decline with age and risk, though they exceed 20 percent even for the oldest and sickest groups.

**Lower Medical Costs:** Consistent with their youth and health, passive enrollees incur 44 percent lower monthly medical costs ($228 per month versus $408 for active enrollees) and are more likely to have 0 spending. The slightly larger gap for spending (−44 percent) relative to risk score (−36 percent) suggests passive enrollees may also be unobservably healthy. Because the government pays insurers

[40] More generally, one could think of passive enrollees as falling into two groups: (i) "always passives," who are passive regardless of the policy, and (ii) "conditional passives," who are passive under auto-enrollment but make sure to actively enroll when it is gone. Our evidence in Section IIIA suggests that there are few if any conditional passives in our setting.

[41] This lets us control for any time trends (e.g., medical cost growth) that could affect results if passive rates vary over time. In practice, these fixed effects have little impact on results. The specific method is as follows. Let $Y_{i,c}$ be a characteristic/outcome for new enrollee $i$ who joins CommCare in entry cohort $c$ (i.e., in a given year-month). We regress $Y_{ic} = \alpha_c + \delta \cdot \mathbf{1}\{Passive_i\} + \varepsilon_{i,c}$, which includes a cohort fixed effect ($\alpha_c$). Table 1 reports the mean for active enrollees ($\bar{Y}_{active}$), the adjusted mean for passive enrollees ($= \bar{Y}_{active} + \delta$), and the difference between the two ($\delta$).

[42] We use the HHS-HCC risk score (silver-CSR version), as used in the ACA Marketplaces, calculated based on diagnoses observed on claims during an enrollee's first 12 months enrolled.

TABLE 1—TARGETING IMPLICATIONS: COMPARING ACTIVE VERSUS PASSIVE ENROLLEES

| Variable | Active Enr. (1) | Passive Enr. (2) | Diff (3) | (SE) (4) | % Diff (5) |
|---|---|---|---|---|---|
| *Panel A. Age and sex* | | | | | |
| Average age (years) | 35.6 | 31.8 | −3.8 | (0.1) | −11 |
| Age 19–34 | 0.535 | 0.652 | +0.118 | (0.003) | +22 |
| Age 35–54 | 0.339 | 0.271 | −0.068 | (0.003) | −20 |
| Age 55+ | 0.126 | 0.077 | −0.049 | (0.002) | −39 |
| Share male | 0.538 | 0.625 | +0.087 | (0.003) | +16 |
| Male age 19–34 | 0.286 | 0.411 | +0.125 | (0.003) | +44 |
| *Panel B. Health status and medical spending* | | | | | |
| Any chronic illness | 0.641 | 0.427 | −0.215 | (0.003) | −33 |
| Severe chronic illness | 0.158 | 0.081 | −0.077 | (0.002) | −49 |
| Risk score (HCC) | 1.011 | 0.644 | −0.367 | (0.015) | −36 |
| Average cost ($/month) | $408 | $228 | −$181 | (5.6) | −44 |
| Any spending (> $0) | 0.894 | 0.709 | −0.185 | (0.003) | −21 |
| *Panel C. Income and area disadvantage* | | | | | |
| Income/poverty line | 0.248 | 0.200 | −0.049 | (0.004) | −19 |
| High-disadvantage area | 0.320 | 0.401 | +0.082 | (0.003) | +25 |
| Share Black (in zip code) | 0.082 | 0.106 | +0.024 | (0.001) | +29 |
| Share Hispanic (in zip code) | 0.137 | 0.162 | +0.025 | (0.001) | +18 |
| Near safety net hosp./CHC | 0.371 | 0.458 | +0.087 | (0.003) | +23 |
| *Panel D. Duration enrolled* | | | | | |
| Average (month) | 16.5 | 11.9 | −4.6 | (0.1) | −28 |
| Share 1–3 months | 0.154 | 0.228 | +0.075 | (0.002) | +48 |
| Share 12+ months | 0.559 | 0.441 | −0.119 | (0.003) | −21 |
| Share 16+ months | 0.297 | 0.168 | −0.129 | (0.003) | −43 |

*Notes:* The table shows differences in characteristics/outcomes for passive versus active enrollees in our main sample of below-poverty new CommCare enrollees during FY 2008–2009. Estimates control for entry cohort fixed effects and (for all variables except "Duration" in panel D) are weighted averages by months enrolled (capped at 12 months). Health and cost measures are based on claims during the enrollee's first 12 months enrolled. Chronic illnesses follow a classification of ICD-9 diagnosis codes shared with us by David Cutler. Risk score is based on the HHS-HCC model (silver-CSR version) used for risk adjustment in the ACA, renormalized to have mean 1.0 in the CommCare data. Income refers to family income as a share of the federal poverty level. High-disadvantage areas are zip codes (ZCTAs) in the seventy-fifth percentile or higher of the social deprivation index (SDI) produced by the Robert Graham Center (2005-2000) based on ACS data (see https://www.graham-center.org/maps-data-tools/social-deprivation-index.html), which also includes data on zip code–level shares of Black and Hispanic people. "Near safety net hospital or Community Health Center (CHC)" refers to the share of enrollees living in zip codes within two miles of one of these facilities (Google Maps API 2013).

using risk-adjusted capitation, passive enrollees' lower risk scores imply that the government also incurs lower costs to cover them.[43]

**More Economically Disadvantaged:** Passive enrollees are more disadvantaged across several metrics. Their incomes are slightly lower (20 percent versus 25 percent of poverty). Their differences in neighborhood characteristics (based on zip code) are larger. Passive enrollees are 25 percent more likely to live in a zip code in

[43] Up to 2009, CommCare used a crude risk adjustment system that varied rates by age-sex-region cells. Under this system (which we can observe), the average government payment for passives was 8 percent less than for active enrollees ($344 versus $373 per month). Starting in 2010, the program shifted to a stronger diagnosis-based risk adjustment, similar to the HCC risk scores we report. Although we lack full data until 2011 on CommCare's risk adjuster, the 36 percent lower HCC scores suggest rates would be substantially lower for passives.

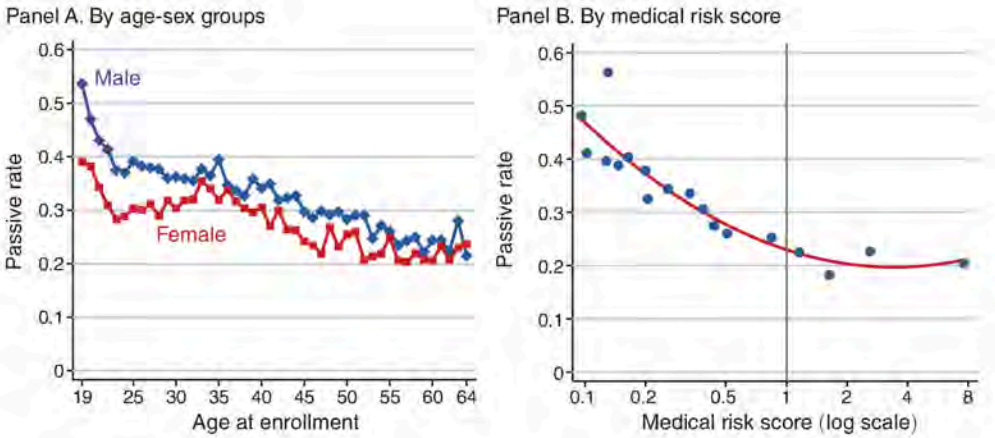



FIGURE 6. PASSIVE ENROLLMENT RATE BY AGE, GENDER, AND MEDICAL RISK

*Notes:* The figure plots variation in the passive enrollment rate—the share of new enrollees who join passively—by age-sex groups (panel A) and medical risk score bins (panel B). The data are for our main sample: new enrollees in the relevant below-poverty income group during fiscal years 2008–2009. The medical risk score is the HHS-HCC risk score (silver-CSR version) used by the ACA Marketplaces, calculated based on diagnoses observed on claims during the first 12 months of enrollment.

the top quartile of the Social Deprivation Index, a measure based on census data.[44] Their zip codes include a higher share of Black and Hispanic residents.

**Shorter Durations:** Passive enrollees are enrolled for shorter periods, with average durations 4.6 months (or 28 percent) shorter. Although we do not observe the reason for these shorter spells, an analysis of the time pattern of exits (see Supplemental Appendix C.2) suggests a combination of two factors: (i) a higher rate of brief 1–3 month spells and (ii) a higher exit rate during annual eligibility redetermination (12–14 months into the spell). The latter is consistent with a failure to complete redetermination paperwork, another administrative hassle.

A natural question is whether measured risk differences are driven by passive enrollees' shorter durations (see "Shorter Durations" above), which limits the period over which medical conditions can be observed in claims data. In practice, this does not appear to be a major source of bias. Supplemental Appendix C.1 shows that health differences are robust to using shorter measurement periods (including using just the first month enrolled) and to examining a balanced panel of active and passive enrollees enrolled for the same duration.

In line with their residence in lower-income neighborhoods, passive enrollees are also more likely to live nearby (within two miles) a safety net hospital or community health center. This proximity raises the question of whether they use

[44] We use the Social Deprivation Index (SDI) developed by the Robert Graham Center (see https://www.graham-center.org/maps-data-tools/social-deprivation-index.html, accessed January 1, 2025). SDI is an index of area-level deprivation derived from ACS data, based on income, education, housing, employment, and other demographics. We define "high disadvantage" as neighborhoods in the top quartile of the SDI based on the national distribution.

more "uncompensated care"—an important social cost of uninsurance (Finkelstein, Mahoney, and Notowidigdo 2018) that we include in our model in Section I. Supplemental Appendix C.3 presents analysis to test this idea. A limitation is that we cannot directly observe care used by active versus passive individuals when *uninsured*. However, based on care use when insured, passive enrollees obtain a larger share of their care from standard sources of uncompensated care, including emergency rooms and safety net hospitals.

*Interpreting the Differences.*—Overall, this evidence is consistent with the two main features of our ordeals targeting framework in Section I: *self-targeting* and *adverse selection*. Consistent with self-targeting, passive enrollees (those screened out by ordeals) have attributes consistent with lower demand (value) for health insurance. This includes the young and healthy, who on average need less medical care, and shorter-duration enrollees, who may only have a brief need for public coverage (e.g., between jobs). Demand for health insurance also tends to be low among the poor (Finkelstein, Hendren, and Luttmer 2019; Finkelstein, Hendren, and Shepard 2019; Tebaldi forthcoming).

But consistent with adverse selection, these same low-demand individuals also incur much lower costs. Passive enrollees incur 44 percent lower monthly medical costs, and including their shorter durations, their average per spell costs are 60 percent lower. This is natural in an adverse selection market where both value and costs are driven by an enrollee's medical risk (and by their enrolled duration). As a result, our theory suggests that *self-targeting* may not translate into *socially* beneficial targeting. We evaluate this idea more formally using our empirical model in Section V.

*Robustness: Inference Using the Policy Change (and Risk Pool Impacts).*—As a robustness check, we use the 2010 policy change to infer marginal enrollees. Prior to 2010, new enrollees include both active and passive individuals; afterward, only active choosers enroll. Marginal enrollees' characteristics, therefore, can be inferred from the *compositional* change at the start of 2010. To implement this, we run DD regressions analogous to equation (13) but with a dependent variable of characteristics/outcomes of new enrollees. Regressions are run on individual-level data, clustering standard errors at the income group-by-month level.

Figure 7 shows the raw data and DD estimates for two key risk pool variables: average risk score (panel A) and average cost (panel B) for new enrollees. There is a clear increase in both measures for the treatment group (red) relative to controls (green) after auto-enrollment is suspended.[45] The effects are large, with DD estimates suggesting a 0.146 increase in average enrollee risk (implying 14.6 percent higher costs) and $57.6 increase in average monthly cost (also about a 15 percent increase). This implies that marginal enrollees screened out are lower risk and lower-cost, just as we found in Table 1. We can further compare the methods quantitatively by calculating what Table 1 predicts for the analogous change in average

[45] Counterintuitively, prior to 2010, the controls have higher risk scores but similar costs to the treatment group, and this pattern flips in 2010+. This occurs because CommCare provided more generous benefits to the treatment group, including dental care and slightly lower copays, which results in higher costs partly through a moral hazard effect (see Chandra, Gruber, and McKnight 2014).

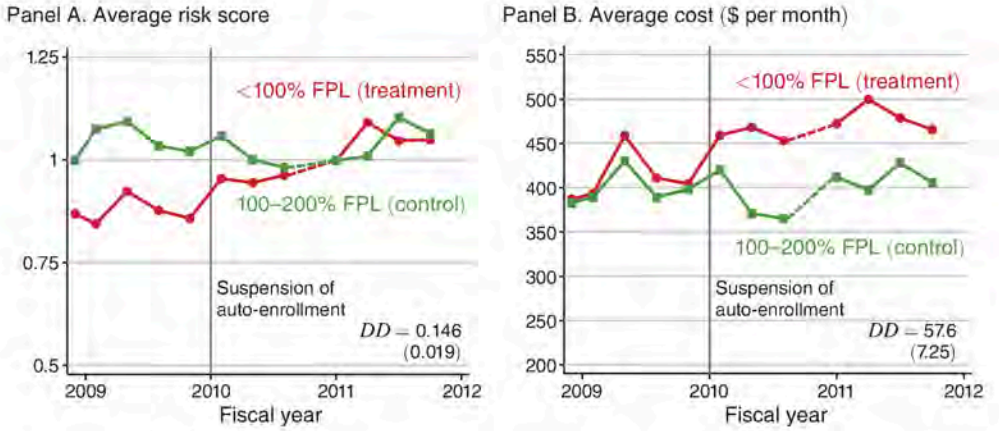



FIGURE 7. EFFECT OF AUTO-ENROLLMENT SUSPENSION ON ENROLLEE RISK POOL

*Notes:* The figure shows data on average risk score (panel A) and monthly medical costs (panel B) for new enrollees, and estimates of the DD specification (13) using quarterly time periods. Each panel shows trends for below-poverty enrollees (the treatment group) versus 100–200 percent of poverty enrollees (the control group). The temporary reinstatement period is excluded (as indicated with dashed lines). When auto-enrollment is suspended, average risk score rose by 14.6 percent of the market average (which is 1.0), and average medical costs rose by $57.60 per month, also about a 15 percent increase. Both are consistent with the suspension of auto-enrollment resulting in higher-cost risk pools.

risk score and cost, assuming that passive behavior is exogenous.[46] This exercise predicts a 0.119 increase in average risk score and $58.8 increase in average cost, which are very close to (and statistically indistinguishable from) the DD estimates in Figure 7.[47]

### B. *Do Passive Enrollees Have Duplicate Private Insurance?*

A relevant question for the targeting implications of auto-enrollment is whether it enrolls people who *already* have private health insurance, making CommCare duplicative. Although duplication is not supposed to occur—CommCare applicants must attest to not having access to any other health insurance (including any *offer* of job-based coverage)—enforcement could be imperfect. If auto-enrollment "overenrolls" individuals who already have other coverage, it would be a failure of "statutory targeting" based on program eligibility rules, something that has been observed for transfer programs in a developing country context (Alatas et al. 2016).

[46] To do so, note that for any variable $Y$, $\bar{Y}_{Pre2010} = s_P \bar{Y}_P + (1 - s_P)\bar{Y}_A$ and $\bar{Y}_{Post2010} = \bar{Y}_A$, where "$P$" and "$A$" subscripts refer to passive and active enrollees. Therefore, $\Delta\bar{Y} = \bar{Y}_{Post2010} - \bar{Y}_{Pre2010} = s_P \cdot (\bar{Y}_A - \bar{Y}_P)$. We calculate $\Delta\bar{Y}$ using the estimates for $\bar{Y}_A$ and $\bar{Y}_P$ in Table 1 and $s_P = 0.326$ from Figure 5.

[47] Supplemental Appendix C.4 shows a similar robustness analysis for all variables in Table 1; the Supplemental Appendix also describes the methods in greater detail. For all variables, our main method and the DD estimates are directionally similar, always generating estimates of the same sign. Moreover, the methods usually yield quantitatively similar estimates with overlapping confidence intervals.

To test this story, we draw on evidence from the Massachusetts APCD to measure rates of simultaneous duplicate coverage in CommCare and private insurance, a measure of whether "overenrollment" occurred in practice.[48] We define the "duplication rate" as the share of CommCare enrollment months during which the member was simultaneously enrolled in other private insurance.[49] Supplemental Appendix D.1 provides additional details on the data and method.

Overall, we find little evidence of meaningful duplicate coverage in CommCare. The average duplication rate is quite low, just 3.1 percent of enrollee-months, and the rate is even lower at the beginning of enrollment spells when auto-enrollment occurs (see Supplemental Appendix Figure A.13). Moreover, there is little evidence that duplication is higher for passive enrollees. Although we cannot distinguish active versus passive enrollees in the APCD, we can study how duplication rates *change* for new enrollees into CommCare just before versus after auto-enrollment is suspended in 2010. In practice, the duplication rate rises slightly after the policy change, consistent with marginal (passive) enrollees having lower duplication rates. However, duplication rates are low both before and after the change. Our overall conclusion is that duplicate coverage is rare and is unlikely to explain failure to actively take up coverage.

### C. *Mechanisms: Why Do People Fail to Take Up Free Insurance?*

Why do so many people fail to enroll in free health insurance when faced with a small hassle? In this subsection, we provide descriptive evidence to assess the mechanisms involved, including both rational and behavioral explanations. We argue that non-enrollment is unlikely to be explained by fully rational and informed stories, in which individuals are passive because they do not need or benefit from (free) public health insurance. Instead, we argue that behavioral "frictions" are likely involved, with the most likely frictions being inattention and limited understanding of program rules.

*Evidence against Fully Rational Non-enrollment.*—We start by providing evidence against fully rational and informed non-enrollment. We start by noting that several facts about the institutional setup make this a priori less likely. First, everyone in our sample—including passive enrollees—has already *chosen* to apply for public coverage (in step 1 of the process). This suggests that they have some awareness of the program and a desire to enroll. Moreover, the insurance is free and extremely generous, with 0 deductible and close to 0 cost sharing (the actuarial value exceeds 99 percent). Although there are some limits (e.g., on networks), it seems implausible that enrollees would face fewer limits or costs if they were uninsured, the relevant counterfactual.

[48] Ideally, we would want to measure the *counterfactual* of whether CommCare enrollees obtain other insurance if they were (exogenously) kicked out of CommCare. While we cannot measure this counterfactual directly, the observed duplication rate provides suggestive evidence on whether overenrollment is a problem in general.

[49] We do not include duplicate coverage in CommCare plus Medicaid because the two programs use a unified enrollment system, which should automatically prevent duplicate enrollment. Most of the same insurers operate in both programs, and we have some concerns that the insurance type is sometimes mislabeled, which could lead to false positives.

Some simple facts further indicate that passive enrollees are likely to obtain meaningful benefits from health insurance. Although passive enrollees are *relatively* healthy, they are not *uniformly* so. Indeed, over 40 percent have a chronic illness, and 8 percent have a severe chronic illness (Table 1). Their average spending of $228 per month is large relative to their very low incomes (the individual poverty line in 2009 was $903/month). Supplemental Appendix Figure A.11 shows that passive enrollees experience meaningful rates of medical shocks (e.g., high-cost months, emergency hospitalizations) that while less frequent, still occur 60–75 percent as often as for active enrollees. Further, Figure 6 shows that even among the oldest and sickest enrollees, passive rates exceed 20 percent. Thus, while good health is predictive of being passive, it is clearly not the full explanation.

Finally, we argue that access to charity care is unlikely to be a perfect substitute for formal insurance that drives its (true) value down to near zero. First, passive enrollees use a meaningful amount of care in categories that are less available via charity care, including prescription drugs.[50] Second, the prior literature on the value of insurance to the poor suggests that while value is *low*, it is far above *zero*. For instance, a key paper in this literature, Finkelstein, Hendren, and Luttmer (2019), finds that the individual value of insurance is just 20–48 percent of insured medical expenses. Applied to our passive enrollees (who spend $228 per month when insured), this would imply a value of $46 to $109 per month—or $550 to $1,300 over a typical 12-month enrollment spell. This is a sizable amount. For instance, it is comparable to forgone benefits from failing to take up the EITC or SNAP (Bhargava and Manoli 2015; Finkelstein and Notowidigdo 2019) and from losses due to insurance plan choice errors (Abaluck and Gruber 2011; Bhargava, Loewenstein, and Sydnor 2017).

*Evidence on Behavioral Frictions.*—We test two types of behavioral explanations: (i) those in which the *complexity of plan choice* is the key barrier and (ii) those in which *taking action* is the key barrier, for instance, because of inattention or misunderstanding the steps required to enroll. We find little evidence of (i) but suggestive evidence consistent with (ii).

*Choice Overload.*—One reason people might be passive when asked to select a health plan is that they become overwhelmed by the choice, as in models of "choice overload" (Iyengar and Kamenica 2010). We note that choice overload is a priori less likely in the CommCare setting, which featured a relatively simple choice set with at most four to five plans available.[51] Further, the passive enrollment rate is unrelated to the choice set size, which varies across areas due to selective insurer entry. Supplemental Appendix Table A.7 shows that the passive rate varies in a narrow range of 33–35 percent across all choice set sizes, including at 34 percent in

[50] We observe that 25 percent of passive enrollees take a regular prescription medication every month they are enrolled, with an average cost of $45 per month. Over a typical 12-month enrollment spell, these prescription costs alone would add up to $540.

[51] There were four plans prior to 2010, and a fifth (CeltiCare) entered during 2010. This is much simpler than other US insurance programs. For instance, Medicare Advantage features an average choice set with 33 options (see https://www.kff.org/medicare/issue-brief/medicare-advantage-2021-spotlight-first-look), and Medicare Part D feature 25–35 plan options (see https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit).

areas with just a *single* plan (i.e., no real choice). Moreover, passivity does not change significantly when a plan enters or exits a region. We conclude that there is little evidence that choice overload is responsible for passive behavior in this context.

*Inattention or Misunderstanding.*—A second type of reason for passivity is that some people are inattentive or misunderstand the steps required to enroll in coverage.[52] If so, requiring an additional step of action—even a seemingly simple step—will lead some individuals to "fall through the cracks" and not enroll. We present three sets of facts consistent with a role for inattention and/or misunderstanding. These are discussed here, with the underlying analyses presented in Supplemental Appendix C.8.

- **"Lost in the Mail":** A natural reason for inattention is if some people do not receive the approval letter instructing them how to actively enroll. Anecdotally, address errors are a common problem in welfare programs, partly because of greater residential instability in low-income populations. To test for this, we construct a proxy for "address mismatches" based on observing different zip codes in CommCare's enrollment file (based on the address used in administrative mailings) versus on the enrollee's first observed medical claim (submitted by the medical provider, often based on paperwork filled out at a visit). As detailed in Appendix C.8, address mismatch is surprisingly common, occurring for about one-third of enrollees. Moreover, it is predictive of passive behavior. After conditioning on the sample with an observed claim in their first 6 months, the passive rate is 28 percent for mismatched, about 3 percentage points (or 13 percent) higher than for nonmismatched people. This pattern is robust to controlling for demographics, health, and timing of the first claim.
- **Special Barriers:** Misunderstanding may be more common in groups that face special barriers to interacting with the state and learning about take-up rules. This idea is consistent with the evidence, shown above, that socioeconomically disadvantaged groups are more likely to be passive. Another such group is immigrants, who likely face greater language and cultural barriers.[53] Consistent with this, passive rates are higher for immigrants (41 percent rate), about 7 percentage points (or 21 percent) higher than for nonimmigrants (34 percent).
- **Cross-Program Transitions:** Misunderstanding or inattention may be more common when people transition between public programs in which take-up rules differ. We observe two types of transitions in our data: (i) a large shift of enrollees from the state's uncompensated care pool to the CommCare exchange in early 2007 and (ii) regular transitions from Medicaid into CommCare (e.g., due to changes in income, age, or family status). Active plan choice was not required in either the UCP or Medicaid, so there may be greater confusion in

[52] There is substantial evidence of limited attention/understanding and other behavioral frictions for consumer choice *among* health plans (e.g., Abaluck and Gruber 2011; Handel 2013; Ericson 2014; Handel and Kolstad 2015). Thus, it is plausible to think that the same issues might affect whether people enroll in health insurance in the first place.

[53] Immigrants were excluded from our main analysis sample, as discussed in Section IIC. For this analysis, we augment the main sample to re-include them.

these groups about enrollment processes in CommCare. Consistent with this, passive rates are much higher for these transitions. People transitioning from the UCP had a 60 percent passive rate (versus 40 percent for other enrollees at the same time in early 2007). People transitioning from Medicaid have a 39 percent passive rate (versus 31 percent for non-Medicaid enrollees). The latter is partly driven by very high passivity for kids transitioning off of Medicaid at age 19 (Jácome 2020), but passive rates are higher for Medicaid transitions even controlling for age, gender, and health covariates.

## V. Empirical Model and Policy Trade-offs

In this section, we empirically apply our model from Section I to our health insurance setting in Sections VA–VC, using a combination of our administrative data, the auto-enrollment natural experiment, and outside estimates. We use the estimates to assess the question with which we started the paper: How well do ordeals work to target enrollment in health insurance?

### A. *Model Implementation*

Our ordeals welfare framework requires estimates of four objects for enrollees: (i) the direct medical cost of insurance, $C_i$; (ii) the enrollee value of insurance, $W_i$; (iii) social spillovers, $E_i$; and (iv) fiscal externalities, $FE_i$. Together, these let us calculate $V_i^{Soc} = \mu W_i + E_i$ (for various assumptions on the social welfare weight $\mu$) and $C_i^{Net} = C_i - FE_i$, which together are sufficient for net social welfare, $\gamma_i = V_i^{Soc} - C_i^{Net}$.

Our natural experiment and rich insurance claims data let us directly measure the distribution of marginal (passive) and inframarginal (active) enrollees and their medical costs ($C_i$). We assume that the government either directly pays medical expenses (as in traditional Medicare and Medicaid) or engages in zero-profit contracting with private insurers (as we find is roughly true in Massachusetts).[54] In both cases, medical costs for individual $i$ in the claims data are a reasonable estimate of the government's marginal cost when they enroll in insurance (i.e., $C_i$ in the model).[55] With this assumption, our claims data give us a direct estimate of $C_i$ and the average cost for active ($\bar{C}_1$) and passive ($\bar{C}_0$) enrollees.

[54] Supplemental Appendix Table A.9 shows evidence of this zero-profit contracting for the below-poverty population, for whom CommCare negotiated a separate set of payment rates directly with insurers (as opposed to the bidding system used for higher-income groups). The table compares the government's payment and insurer's cost for active and passive enrollees. Insurers earned small overall margins (of about 4 percent, or $16 per enrollee-month), despite overpaying for passive and underpaying for active enrollees. The table also shows that had the exchange paid using more sophisticated risk adjustment, this group-specific over-/underpayment would shrink, but overall profit margins would remain near zero. We interpret this as evidence that (i) CommCare was able to negotiate lower average prices for the below-poverty population as a whole because of the inclusion of healthier auto-enrollees, and (ii) average prices paid approximately reflect average costs.

[55] This relationship is immediate when the government directly pays claims. In the zero-profit contracting case, the relationship follows from the fact that the government's total payments equal insurers' total cost for all enrollees. When $i$ is enrolled, insurers' total costs increase by $C_i$, and to maintain zero profits, the government's extra cost is also $C_i$. Note that this analysis abstracts from any nonmedical administrative costs (for either government or private insurers), which we cannot directly measure in our claims data.

To estimate the remaining items (ii)–(iv), we combine what we do observe with information from other studies and data sources. In what follows, we describe our strategy for estimating each term.

*Uncompensated Care Costs.*—The main component of social and fiscal externalities is uncompensated care, so we start with estimating it. In our data, we observe medical costs when insured, $C_i$.[56] To estimate uncompensated care costs that $i$ would incur if *uninsured*, we proceed in two steps. First, the uninsured use less care than the insured because of moral hazard, which we assume increases costs by a constant factor, $1 + MH$. Second, the uninsured themselves pay only a share, $\phi < 1$, of their medical bills, with uncompensated care covering the other $1 - \phi$. Thus, uncompensated care costs equal

$$C_i^{UC} = \left(\frac{1-\phi}{1+MH}\right) \cdot C_i. \tag{14}$$

Estimating $C_i^{UC}$ requires values for $\phi$ and $MH$. For our baseline estimates, we draw on the analysis of Finkelstein, Hendren, and Luttmer 2019 of the Oregon Health Insurance Experiment. They estimate a moral hazard effect of $MH = 33.3\%$ and an uninsured out-of-pocket share of bills of $\phi = 0.21$, both of which we treat as constant across enrollees.[57] Using this method, therefore, we estimate $C_i^{UC} = 0.59\, C_i$.

We consider two alternatives in sensitivity analysis. First, as extreme upper and lower bounds, we consider $\phi = 0$ (full uncompensated care) and $\phi = 1$ (implying $C_i^{UC} = 0$). Second, we construct new estimates using data from a Massachusetts program, the Health Safety Net (HSN), that covers a subset of medical expenses for uninsured low-income adults. The HSN is an uncompensated care pool that (unlike most similar programs) pays based on formal claims, which are observable in the state's APCD. We use these data, combined with estimates of total uninsurance from the ACS, to estimate uncompensated care costs by age-sex group, which we then project onto our CommCare data. The method involves several assumptions, which we detail in Supplemental Appendix E.

*Social and Fiscal Externalities of Insurance.*—Having estimated uncompensated care costs, we divide its incidence between the government (part of $FE_i$) and private

[56] Technically, we observe *realized* medical spending, which differs from *ex ante* expected costs due to the realization of an *ex post* health shock. We assume throughout that this shock is idiosyncratic and additively separable, so that it averages to zero in any sufficiently large group $g$ (e.g., passive enrollees). Formally, let $C_i$ be realized costs and $E[C_i]$ be expected costs. We assume that $C_i = E[C_i] + \omega_i$, with $E[\omega_i] = 0$ and $\omega_i$ independent of all other variables in the model including group membership. Under these assumptions, $\bar{C}_g = \frac{1}{N_g}\sum_{i \in g} C_i = \frac{1}{N_g}\sum_{i \in g}(E[C_i] + \omega_i) \to \frac{1}{N_g}\sum_{i \in g} E(C_i)$ for large enough $N_g$.

[57] Finkelstein, Hendren, and Luttmer (2019) estimate that in the Oregon experiment, health insurance increases annual medical spending by $900, which is 33.3 percent of the control complier (uninsured) mean of $2700. They estimate that control compliers (the uninsured) spend $569 per year in out-of-pocket expenses, which implies $\phi = 569/2700 = 0.21$. We treat $MH$ and $\phi$ as constant across enrollees, implying $C_i^{UC}$ scales proportionally with insured costs, since it is unclear how to estimate heterogeneity. If anything, the evidence suggests that $C_i^{UC}$ are disproportionately larger for passives, suggesting we may (conservatively) understate their relative efficiency.

providers (part of $E_i$). We assume that the government bears a fixed share, $\psi_G \in [0, 1]$, of costs, which implies

$$FE_i = \psi_G \cdot C_i^{UC} \quad \text{and} \quad E_i = (1 - \psi_G) C_i^{UC}. \tag{15}$$

Note that this assumes no other externalities of insurance besides uncompensated care, which is a conservative assumption.[58] To estimate $\psi_G$, we draw on the evidence from Garthwaite, Gross, and Notowidigdo (2018), who study the impact of uninsurance on hospital uncompensated care costs and profits. They find that for every $1 higher uncompensated care costs, hospitals absorb $0.60–$0.67 in lost profits. In our main estimates, we set $\psi_G = 0.635$, the midpoint of this range.

*Enrollee Value of Insurance.*—Estimating value (or WTP) is challenging in our main sample because of a lack of price variation—all plans are free. Moreover, the presence of frictions raises concerns about inferring low WTP directly from passive behavior, which may be a consequence of enrollees having high frictions (e.g., inattention or forgetfulness). To make progress, we follow the "rational consumer benchmark" approach described by Bernheim and Taubinsky (2018), which has also been implemented by Bronnenberg et al. (2015) and Allcott, Lockwood, and Taubinsky (2019). The approach involves estimating preferences among a well-informed reference population (the "benchmark") in order to impute the WTP of another group. We use price variation for higher-income CommCare enrollees (150–250 percent of poverty) who all pay positive prices, replicating and extending the demand estimation method of Finkelstein, Hendren, and Shepard (2019). We then project these demand estimates onto our below-poverty population at the level of detailed observables (age-sex-risk group cells).

This exercise rests on two assumptions: (i) that higher-income enrollees reveal their WTP when making active choices and (ii) that age-sex-risk observables are sufficient for projecting WTP onto lower-income groups. Assumption (i) is consistent with a model of pure inattention frictions (e.g., forgetting to act) that prevent passive types from enrolling but do not bias demand estimates for active choosers. This assumption implies that demand reveals true WTP *among the sample of higher-income active enrollees* (150–250 percent of poverty).[59] Assumption (ii) allows us to impute this WTP distribution onto our lower-income (0–100 percent of poverty) population of interest, conditional on age-sex-risk cells. However, it is vulnerable to concerns about selection on unobserved preferences. To address this, we examine robustness to alternative assumptions about unobserved sorting, described in greater detail below.

We summarize the method here, with details and estimates presented in Supplemental Appendix F. Finkelstein, Hendren, and Shepard (2019) use RD variation in subsidies and premiums to estimate a demand (WTP) curve for insurance.

[58] For instance, there is evidence that health insurance for kids leads to long-run economic gains that boost future tax revenue (Brown, Kowalski, and Lurie 2020) and that insurance for young adults reduces crime (Jácome 2020). We do not include these since it is unclear how to estimate their distribution for different types of enrollees.

[59] Of course, this benchmark may under-/overstate the value of insurance if higher-income active choosers suffer from behavioral biases or liquidity constraints. Our analysis that scales enrollee welfare by a range of social welfare weights, $\mu$, can partly address this concern.

They observe three income thresholds at which premiums increase discretely: from \$0 to \$39 per month (at 150 percent of poverty), from \$39 to \$77 (at 200 percent of poverty), and from \$77 to \$116 (at 250 percent of poverty). By observing how much enrollment falls at each threshold, they infer points on an insurance demand curve. These can be linearly connected and extrapolated to generate a full demand curve $D(s)$, where $s \in [0,1]$ indexes people from highest to lowest WTP.

To adapt Finkelstein, Hendren, and Shepard's (2019) method to our problem, we make two adjustments. First, we use 2009–2011 data, matching our analysis period. Second, we use the micro-data to estimate demand separately by cell of $g =$ {age group, sex, risk score bin}. We use roughly 5-year age bins and quintiles of HCC risk score, with an additional category for the sickest 5 percent of enrollees. With a demand curve for each cell, $D_g(s)$, we project WTP onto each enrollee $i$ in our below-poverty sample using the average WTP for their $g$ cell, that is, $W_i = E\left[D_{g(i)}(s)\right]$, where the average is over $s$.[60] This method lets us capture WTP heterogeneity via observable factors included in $g$ (age, sex, and medical risk). We also consider several assumptions for *unobserved* sorting between active versus passive enrollees, including no sorting, perfect sorting, and (for our baseline specification) unobserved sorting of "equal magnitude" to observed sorting, in a sense formalized in Supplemental Appendix F.[61]

We consider several alternatives in sensitivity analysis. In addition to variations on the demand-based approach (e.g., no or perfect unobserved sorting), we consider mapping insured medical costs (which we observe) to enrollee WTP using simple relationships estimated in the literature. Specifically, Finkelstein, Hendren, and Luttmer (2019) find that low-income Medicaid enrollees value insurance at 20–48 percent of insured costs (i.e., $W_i = \kappa \cdot C_i$ for $\kappa \in [0.20, 0.48]$); we report estimates for the endpoints of this range. We also consider a plausible lower bound in which WTP equals expected uninsured out-of-pocket (OOP) costs (with no value for risk protection), based on the framework underlying equation (14). This implies $W_i = \left(\frac{\phi}{1+MH}\right) C_i = 0.16\, C_i$ given the values of $\phi = 0.21$ and $MH = 0.333$.

Finally, we examine implied WTP for full insurance from a simple model of homogeneous risk aversion, under a benchmark assumption of no moral hazard or uncompensated care. Specifically, we simulate the value of insurance using observed

[60] Calculating average WTP (the conceptually correct statistic) requires using the linearly extrapolated portion of the demand curve, which comprises about the bottom 30–40 percent of demand. As robustness, we also examine the median and seventy-fifth percentiles of WTP, which are much less likely to be extrapolated. These generate smaller estimates of WTP but similar implications for the *relative* WTP and MVPF for active versus passive enrollees.

[61] Briefly, unobserved sorting relates to the range of $s$ over which we average to calculate $W_i = E\left[D_{g(i)}(s)\right]$. For no sorting, we average over $s \in [0,1]$ for both actives and passives; therefore, WTP is equal for everyone *within* a $g$ cell. For perfect sorting, we assume that within each $g$ cell, actives comprise the highest 67 percent of WTP types ($s \in [0, 0.67]$), while passives comprise the lowest 33 percent of WTP types ($s \in [0.67, 1.00]$), where 33 percent is the overall share of passives in our data. For our baseline specification, we assume "equal" sorting on unobservables and observables. Formally, we calculate the probability that a random active enrollee is in a $g$ cell with higher estimated WTP than a random passive enrollee. This is 56 percent in our data. We then set the averaging ranges of $s$ so that this probability is also 56 percent *within* each $g$ cell (i.e., unobserved sorting), which we show corresponds to $s \in [0, 0.96]$ for actives and $s \in [0.08, 1.00]$ for passives.

medical claims and an exponential utility function with coefficient of absolute risk aversion of $\alpha = 8.6 \times 10^{-5}$ taken from Handel and Kolstad (2015).[62]

*Social Welfare Weight* ($\mu$).—Our key value statistic is the social value of insurance, $V_i^{Soc} = \mu W_i + E_i$, which scales enrollee WTP ($W_i$) by a social welfare weight, $\mu$ (and adds externalities, $E_i$). For simplicity, we use a constant $\mu$ for all eligible individuals, but we consider a range of values to capture distributional goals. Our baseline calculations use $\mu = 1$ (i.e., Kaldor-Hicks efficiency), but we consider a range of $\mu \in [0.5, 3.0]$ for robustness, where $\mu > 1$ allows for a social value of redistribution, while $\mu < 1$ captures tight public budgets.

*Direct Cost of Ordeals,* $L(\sigma)$.—Throughout this exercise, we focus only on the ordeal's targeting implications, that is, the "gains from targeting" piece of their welfare impact in equation (6). Implicitly, we ignore any *direct costs* of the ordeals ($L(\sigma)$), which we do not have a good way to estimate and which we believe are small in our setting. Because direct costs would only reinforce our finding that ordeals do not work well, we view this as a conservative assumption. However, measuring direct costs may be important in other settings where these are likely to be larger.

### B. *Results: Model Estimates and Targeting*

Figure 8 shows our model's baseline estimates and the selection properties of auto-enrollment, comparing active versus passive enrollees in our main sample (as used in Table 1). Figure 8, panel A shows selection on social value, which includes both enrollee value and uncompensated care savings to private providers. Both the mean and the distribution of social value is lower for passive enrollees. On average, passive enrollees have both a lower private value of insurance (about 28 percent less than active enrollees) and use less uncompensated care when uninsured since they are healthier. Their average social benefit is $143 per month, about 34 percent less than for active enrollees at $217 per month. This finding that passive enrollees have lower (private and social) value of insurance than actives holds across every sensitivity analysis we consider, including different assumptions for demand estimation and alternate measures of uncompensated care (see Supplemental Appendix Table A.10). Our estimates, therefore, robustly suggest the active enrollment ordeal screens out low-value types, consistent with self-targeting and favorable sorting on value.

While there is favorable sorting on value, value and costs are also strongly correlated. Figure 8, panel B is a binned scatterplot showing the relationship between social value and net public costs, again comparing active and passive enrollees.[63]

[62] We compute expected utility, $\bar{u}_{g(i)} = E\left[\frac{-1}{\alpha} \cdot \exp(\alpha C_i)\right]$, separately by cells of $g$ = {age group, sex, risk score bin, passive versus active}, taking the expectation over the observed distribution of monthly medical spending $C_i$ within each cell. WTP for individuals in each cell is defined as the certainty equivalent, $W_i = \frac{1}{\alpha} \cdot \log(-\alpha \cdot \bar{u}_{g(i)})$.

[63] At the individual level, we observe realized—not expected—costs. We estimate expected medical costs by taking the mean of monthly realized costs (weighted by number of months enrolled) by cell of $g$ = {age group, sex, risk score bin} interacted with whether the individual was passive or active. Panel B of Figure 8 can therefore be thought of as displaying the joint distribution of social value and expected medical cost at the {age group, sex, risk score bin, active versus passive status}-cell level.

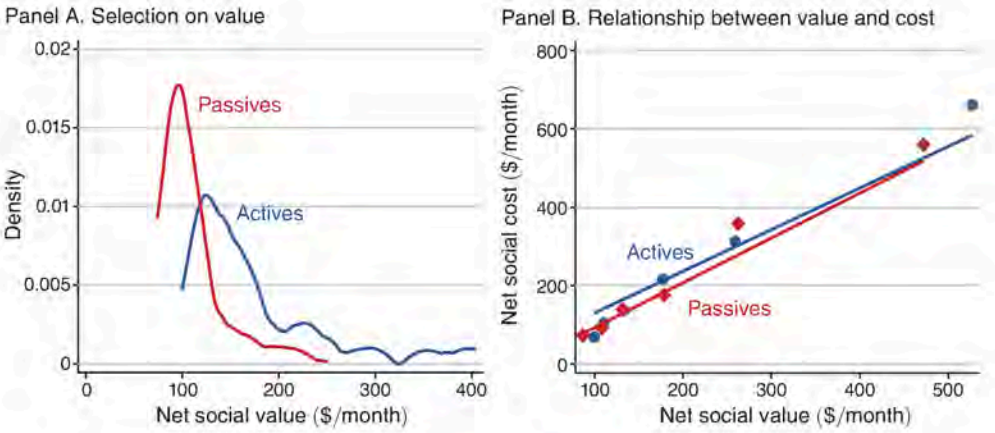



FIGURE 8. MODEL ESTIMATES: SELECTION ON VALUE AND COST

*Notes:* Panel A plots the density of our estimates of social value separately for both active (in blue) and passive (in red) enrollees, under our baseline demand and uncompensated care assumptions. For ease of visualization, only the bottom 90 percent of each distribution is shown in panel A. Panel B illustrates the joint distribution of social value and net costs for active (blue circles) versus passive (red diamonds) enrollees, along with respective best-fit lines. The sample for both figures is our main 2008–2009 new enrollee sample in the below-poverty group, just as in Table 1. See Section VA for the model estimation method. Both figures plot the distribution of estimates (mean WTP and mean costs per month, weighted by number of months enrolled) at the {age group, sex, risk score bin, active versus passive status}-cell level.

There is a strong positive correlation between value and cost that holds similarly for both active and passive enrollees. Moreover, the two best-fit lines are nearly on top of each other, suggesting that the ordeal achieves little sorting on residual costs ($\omega_i$) conditional on value. Instead, passive enrollees are simply low-value types who also have (proportionally) lower costs. In contrast to the standard case considered in the ordeals literature, screening out low-benefit types is insufficient to make the ordeal well targeted.

*Value-Cost Correlation and the Adverse Selection "Tax".*—As discussed theoretically in Section I, a positive value-cost correlation, $\rho$, reduces the social gains from screening out low-value types since they also have low costs. The extent of sorting on cost relative to sorting on value is captured by the term $\hat{\beta} = \rho \cdot \sigma_C/\sigma_V$, which we call the "adverse selection tax" on targeting efficiency. In the classic ordeals case with constant or uncorrelated costs ($\rho = 0$), targeting efficiency is purely a function of value sorting. But as the value-cost correlation and the variance of costs increases, this tax becomes larger, which reduces targeting efficiency relative to sorting on value. Overall, the correction term for cost sorting—or the *rate of selection on cost* ($= \Delta C^{Net}/\Delta V^{Soc}$)—equals the sum of the adverse selection tax and any selection on residual costs ($\omega_i$) uncorrelated with value (see equation 11).

Table 2 shows how this plays out using our estimates of social benefit and cost for both our baseline specification and several alternatives, using $\mu = 1$ for the social welfare weight on beneficiaries. Robustly across all specifications, we find a substantial positive value-cost correlation, $\rho$, which is 0.69 in our main specification. Correspondingly, we find substantial rates of selection on cost for the ordeal, exceeding 100 percent in both our baseline and 3 of the remaining 4 specifications.

TABLE 2—VALUE-COST CORRELATION AND TARGETING

| | Value and cost specification | | | | |
|---|---|---|---|---|---|
| | | Sensitivity analyses | | | |
| | Baseline (1) | No unobserved sorting (2) | Perfect unobserved sorting (3) | WTP = OOP costs (4) | Baseline w/ HSN uncomp. care estimates (5) |
| *Panel A. Joint distribution* | | | | | |
| Value-cost correlation ($\rho$) | 0.70 | 0.69 | 0.67 | 1.00 | 0.21 |
| SD of net cost ($\sigma_C$) | \$246 | \$246 | \$246 | \$246 | \$392 |
| SD of net cost ($\sigma_V$) | \$156 | \$155 | \$183 | \$147 | \$115 |
| *Panel B. Effect of value-cost correlation* | | | | | |
| Adverse selection tax ($\rho \times (\sigma_C/\sigma_V)$) | 110% | 110% | 90% | 167% | 72% |
| Selection on residual cost ($= \Delta\omega$) | 42% | 103% | −31% | 0% | 283% |
| Total effect ($\Delta C^{Net}/\Delta V^{Soc}$) | 152% | 213% | 59% | 167% | 354% |

*Notes:* Column 1 shows results from our baseline model estimates, while columns 2–5 show sensitivity to alternative specifications. The sample is our main 2008–2009 new enrollee sample in the below-poverty group, just as in Table 1. See Section VA for the model estimation method. Panel A shows properties of the joint distribution of our estimates of social value $V^{Soc}$ and expected net cost $C^{Net}$, computed at the level of demographic cells defined in Section VA. Panel B shows the implication of the joint distribution for targeting of an ordeal that screens on $V^{Soc}$, under a baseline assumption of Kaldor-Hicks efficiency ($\mu = 1$). The adverse selection tax, defined as the regression coefficient $\rho \cdot \sigma_C/\sigma_V$, gives the rate at which screening on value also generates screening on cost. We also estimate $\Delta\bar{\omega}$, the extent to which the enrollment ordeal selects on residual costs (unexplained by social value), which is relative to $\Delta V^{Soc}$.

The lone exception is the "perfect sorting" specification, which reflects an extreme assumption on how well ordeals sort on unobserved value. But even in the perfect sorting case, we estimate a rate of selection on cost of 58 percent; that is, the social gains from targeting are limited to $1 - 0.58 = 42\%$ of the active-passive difference in value. Thus, our results suggest that adverse selection tends to reduce, and in many cases overturns, the gains from screening out low-value enrollees.

*Value-Cost Ratios and Targeting.*—When the government pays the full cost of insurance, as in CommCare, the value-cost ratio for active and passive enrollees ($\bar{R}_g = \bar{V}_g^{Soc}/\bar{C}_g^{Net}$ for group $g$)—or social benefit per dollar of net government spending—is informative for targeting efficiency. Table 3 shows the value-cost ratios for both active and passive enrollees in our main sample. In our baseline model (with $\mu = 1$, shown in columns 1–2), we find a higher social value-cost ratio for passive enrollees at 1.00, compared to 0.85 for actives. Mechanically, this reflects the correction for value-cost correlation described above: passive enrollees' proportional cost difference (−44 percent) exceeds their difference in social value (−34 percent). Thus, under our baseline specification, the ordeal targets ineffectively ($\Delta\gamma = \bar{\gamma}_1 - \bar{\gamma}_0 < 0$) and results in backward sorting. In principle, it would be optimal to exclude the active enrollees and enroll the passives, but the ordeal does the opposite.

Columns 3–4 of the table show what happens when we allow for distributional concerns by increasing the social welfare weight $\mu$ to 3.0, thus scaling up the social value of enrollee welfare. In this case, it is optimal to cover *both* active and passive enrollees because both their value-cost ratios exceed one. Thus, with $\mu = 3$, we are in the "optimal universality" case discussed in the theory.

TABLE 3—TARGETING IMPACT OF AUTO-ENROLLMENT

| | Baseline ($\mu = 1.0$) | | Higher welfare weight ($\mu = 3.0$) | |
|---|---|---|---|---|
| Value or cost variable ($/month) | Active enrollees (1) | Passive enrollees (2) | Active enrollees (3) | Passive enrollees (4) |
| *Social benefits* | | | | |
| WTP of enrollees (demand estimate, $W_i$) | $129 | $93 | $386 | $280 |
| Spillovers: Private uncomp. care savings ($E_i$) | $88 | $49 | $88 | $49 |
| Total benefits | $217 | $143 | $474 | $330 |
| *Public costs* | | | | |
| Medical spending (gross costs) | $408 | $228 | $408 | $228 |
| Fiscal externality: Public uncomp. care savings ($FE_i$) | −$154 | −$86 | −$154 | −$86 |
| Net public cost ($C_i^{Net}$) | $255 | $142 | $255 | $142 |
| Value-cost ratio ($R_i$) | 0.85 | 1.00 | 1.86 | 2.32 |
| | (Backward sorting) | | (Enrolling both groups optimal) | |

*Notes:* Columns 1 and 2 show our baseline model estimates of the social benefits and costs of insurance for active versus passive enrollees (or inframarginal versus marginal enrollees due to auto-enrollment), while column 3 shows the estimates where enrollee private valuations have been scaled by a social welfare weight of $\mu = 3.0$. The sample is our main 2008–2009 new enrollee sample in the below-poverty group, just as in Table 1. See Section VA for the model estimation method. Enrollee value comes from our demand estimates, using the specification with unobserved sorting equal to observed sorting on WTP.

Supplemental Appendix Table A.10 reports a variety of sensitivity analyses on these targeting results, using different estimates of enrollee value and uncompensated care. As already noted, the finding that (private and social) value is lower for passive enrollees is highly robust, holding in every specification. We also generally find that passive enrollees have similar or larger value-cost ratios, though this finding reverses if sorting on WTP is strong enough (this happens under the "perfect unobserved sorting," and "exponential utility" specifications).

*Robustness: Varying Social Preferences for Equity.*—How do different social preferences for equity change the implications of these targeting findings? Figure 9 examines the net social welfare of different policies for varying values of the social welfare weight on enrollees, $\mu$ (on the x-axis). As noted, a higher $\mu$ indicates a stronger value for distributional equity, given that enrollees are low income. The graph plots social welfare for three policies: (i) the ordeal, (ii) full enrollment, and (iii) no enrollment. If ordeals were optimal—that is, if there were positive gains from targeting—the value of $SW^{Ordeal}$ (dashed blue) would need to be higher than both $SW^{FullEnroll}$ (solid red) and $SW^{NoEnroll} = 0$ (solid black). However, this is never the case: the ordeal is dominated by full enrollment for $\mu > 1.3$, by no enrollment for $\mu < 1.0$, and by both policies for $\mu \in [1.0, 1.3]$.[64]

[64] Supplemental Appendix Table A.11 reports sensitivity of this analysis across different demand and externality assumptions. Across most specifications, we find that the ordeal is never optimal at any value of $\mu$. The exceptions are (i) with perfect unobserved sorting, where the ordeal is assumed to sort extremely well on unobservables and so is optimal for a wide range of $\mu$, and (ii) with the simulated exponential utility for a narrow range of $\mu \in (0.55, 0.73)$.

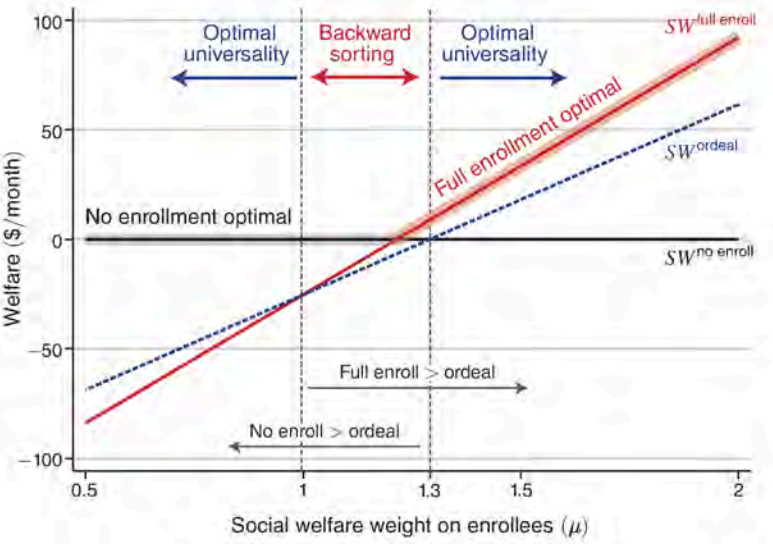



FIGURE 9. OPTIMAL POLICY UNDER VARYING SOCIAL VALUES OF EQUITY ($\mu$)

*Notes:* The figure plots net social welfare of ordeals (blue dashed line) versus full enrollment (red solid) and no enrollment (black solid, which is normalized to zero) under different values for the social welfare weight $\mu$ (the x-axis). Social welfare is average net welfare ($= V^{Soc} - C^{Net}$) per eligible person per month. The graph shows that the ordeal is not optimal for any value of $\mu$; it is dominated by no enrollment for lower values ($\mu < 1.3$) and by full enrollment for higher values ($\mu > 1.0$) and by both policies for $\mu \in [1.0, 1.3]$, which is the region of backward sorting.

The figure illustrates the reasons why ordeals are nonoptimal, as outlined in Section I. When $\mu$ is sufficiently high (above 1.3), the ordeal is undesirable because society wants to cover *both* active and passive enrollees; that is, this illustrates what we called "*optimal universality*." This is likewise true for $\mu < 1.0$, where it is optimal to not enroll both actives and passives. For the small range $\mu \in [1.0, 1.3]$, it would in theory be desirable to exclude the active enrollees, while covering the passives, but ordeals do the opposite. Thus, this case illustrates *backward sorting*.

### C. *Policy Comparison: Auto-Enrollment versus Subsidies*

While the main focus of our paper is on the targeting properties of ordeals, we can also use our estimates to compare the trade-offs of two different take-up policies: auto-enrollment versus subsidies. We think of this as a guide for an insurance policymaker who has extra funds and can choose whether to expand coverage via auto-enrollment (for zero-premium enrollees) or larger subsidies (for higher-income groups). This analysis is relevant to understanding trade-offs under the ACA today, in which 40–50 percent of the uninsured likely qualify for free coverage (Cox and McDermott 2020), while many middle-income uninsured Americans owe premiums that could be reduced via larger subsidies. It also reflects (in reverse) Massachusetts's 2010 situation when it chose to eliminate auto-enrollment, rather than cutting subsidies.

TABLE 4—POLICY COMPARISON: AUTO-ENROLLMENT VERSUS SUBSIDIES

| | Auto enrollment | Subsidy increase (↓ premiums) | | |
|---|---|---|---|---|
| | 0–100% FPL (1) | $39 to $0 150% FPL (2) | $77 to $39 200% FPL (3) | $116 to $77 250% FPL (4) |
| *Panel A. Marginal enrollees* | | | | |
| Enrollment impact | 32% | 34% | 36% | 32% |
| Social benefit ($W_i + E_i$) | $143 | $62 | $116 | $157 |
| Medical costs | $228 | $196 | $268 | $281 |
| Gross subsidy (= costs − premiums paid) | $228 | $196 | $229 | $204 |
| Net public cost (= gross subsidy − FE) | $142 | $122 | $128 | $98 |
| Value-cost ratio (marginals) | 1.00 | 0.51 | 0.90 | 1.60 |
| *Panel B. Transfers to inframarginals* | | | | |
| Premium discount ($/month) | — | $39 | $38 | $39 |
| × inframarginals per marginal | 3.12 | 2.92 | 2.80 | 3.14 |
| = transfer spending per marginal | $0 | $114 | $106 | $123 |
| Value-cost ratio (inframarginals) | — | 1.00 | 1.00 | 1.00 |
| *Panel C. Cost-effectiveness and MVPF cost-effectiveness* | | | | |
| Net public cost per newly insured | $142 | $236 | $235 | $221 |
| ΔInsured per $1 million | 7,024 | 4,238 | 4,261 | 4,530 |
| Overall MVPF of policy | 1.00 | 0.74 | 0.95 | 1.27 |

*Notes:* The table compares auto-enrollment with three subsidy changes generated by premium RDs at three income thresholds: a premium decrease from $39 to $0 per month at 150 percent of poverty (FPL) (column 2), from $77 to $39 at 200 percent of FPL (column 3), and from $116 to $77 at 250 percent of FPL (column 4). For auto-enrollment, results come from our model estimates (Section VA) using the reduced-form variation studied in this paper. For subsidies, estimates come from our calculations using the WTP and cost results reported in Finkelstein, Hendren, and Shepard 2019. Demand for marginal enrollees is assumed to equal the midpoint of the higher and lower premium amounts, and uncompensated care estimates come from applying our model in Section VA to marginal enrollees' costs. Cash transfers are assumed to have an MVPF of 1.0.

For auto-enrollment, we use our model estimates, as just discussed. For subsidies, we use the results of Finkelstein, Hendren, and Shepard (2019). We consider the three subsidy changes in their analysis: reducing premiums from $39 per month to $0 (for enrollees at 150 percent of poverty), from $77 to $39 (at 200 percent of poverty), and $116 to $77 (at 250 percent of poverty).

This analysis yields two main results, shown in Table 4. First, all four take-up policies involve similar enrollment impacts of +32–36 percent. They also all enroll a similar set of low-cost marginal enrollees, with medical costs of $196–$281 per month (well below the market average of $370). Indeed, after subtracting premiums paid, the "gross subsidy" for marginal enrollees is remarkably similar across policies, ranging from $196 to $229. The same is true of the net public cost, after subtracting uncompensated care savings. Overall, this suggests that auto-enrollment and the three subsidy expansions have relatively similar take-up impacts and targeting properties.

Second, however, the two policies differ markedly in their expenditures on inframarginal enrollees. Auto-enrollment spends nothing on inframarginal (active) enrollees, while the subsidies all spend > $100 per marginal enrollee on transfers (the $38–$39 monthly subsidy increase times the ≈ 3 inframarginals per

marginal enrollee). As a result, auto-enrollment is a much more *cost-effective* policy for expanding take-up. Auto-enrollment's net public cost per newly insured is 36–40 percent lower than for subsidies. This implies that each $1 million in public spending covers 55–66 percent more people if used for auto-enrollment rather than subsidies. Therefore, a budget-constrained government wishing to maximize take-up would want to prioritize auto-enrollment over subsidies.

On the other hand, if the government wishes to implement the highest-MVPF policy, the analysis also depends on the relative MVPF of insurance versus cash transfers since subsidies combine the two.[65] Cash transfers have an MVPF of 1 in our model (since we do not include labor supply distortions), while the social value-cost ratio of insurance for marginal enrollees (with $\mu = 1$) ranges from 0.51 to 1.60 for subsidies and is (coincidentally) 1.00 for auto-enrollment. As a result, we find that auto-enrollment's MVPF ($= 1.00$) lies within the range of the three subsidy changes (from 0.74 to 1.24).

## VI. Conclusion

Enrollment ordeals are a pervasive and controversial feature of many public programs, especially safety net programs for the poor. There is a longstanding debate and tension between two views. On the one hand, ordeals are barriers to poverty alleviation programs, which may undermine their goal of helping the poor. In this view, ordeals are inherently harmful, and particularly so when they reduce take-up a lot.

On the other hand, the classic economic ideas of Nichols and Zeckhauser (1982) show how ordeals can *target* public assistance toward those who need or value it most, saving money that can be redeployed toward those in greatest need. In this view, ordeals are harmful only if they fail to target well. Because the "self-targeting" case for ordeals relies on revealed preferences, standard critiques have largely focused on *behavioral frictions* as the main reason ordeals may not target well (Bertrand, Mullainathan, and Shafir 2004; Finkelstein and Notowidigdo 2019).

This paper argues that there is another big-picture reason ordeals self-targeting may not work well: *adverse selection*. We start by observing that in many public programs, enrollees vary in not just their *value* of assistance but also their *cost*. In other words, many programs—including but not limited to those providing insurance—share the key feature of "selection markets" that have been widely studied in the economics literature (Einav, Finkelstein, and Mahoney 2021). We then show

[65] MVPFs are calculated as follows. For auto-enrollment, we assume (conservatively) that the ordeal involves no real welfare costs ($L(\sigma) = 0$), so its MVPF is simply the social value-cost ratio of marginal (passive) enrollees, as in Table 3. For subsidies, the MVPF combines the social value of insurance (for the $\Delta D_S$ marginal enrollees) plus the value of cash discounts to inframarginals ($= \Delta S$ times $D_0$ inframarginals), divided by the total fiscal cost, or

$$MVPF_S = \frac{\overbrace{\Delta D_S \bar{V}_S^{Soc}}^{\text{Insurance for marginals}} + \overbrace{D_0 \Delta S}^{\text{Cash for marginals}}}{\Delta D_S \bar{C}_S^{Net} + D_0 \Delta S} = \underbrace{\kappa_M \times \left( \frac{\bar{V}_S^{Soc} + \bar{E}_S}{\bar{C}_S^{Net}} \right)}_{\text{MVPF of marginals}} + \underbrace{(1 - \kappa_M) \times 1}_{\text{Transfer to inframarginals}}, \tag{16}$$

where $\bar{X}_S$ is the average of each variable $X$ for subsidy-marginals and $\kappa_M \equiv \Delta D_S \bar{C}_S^{Net} / \left( \Delta D_S \bar{C}_S^{Net} + D_0 \Delta S \right)$ is the share of extra spending on marginal enrollees. The equation shows that the MVPF of a subsidy is a weighted average of the MVPF of covering marginal enrollees and the MVPF of a cash transfer to inframarginals (which is 1.0).

that adverse selection tends to undermine the classic self-targeting logic for ordeals. When low-value types—those whom ordeals are designed to screen out—also have low costs (e.g., because they are lower-risk types), targeting gains from excluding them may be minimal or even negative. The key question in selection markets is not whether ordeals screen on value but whether they screen *more strongly* on value than on costs.

We develop a general framework to formalize this idea, visualized using the graphical selection markets model of Einav, Finkelstein, and Cullen (2010) and measured using a parameter we call the "adverse selection tax." We then test it empirically using a natural experiment in a subsidized health insurance program in Massachusetts. We find that eliminating auto-enrollment and adding a small ordeal leads to major 33 percent declines in enrollment. Ordeals differentially exclude precisely the young, healthy, and low-risk types one would expect under adverse selection. These individuals have lower value for insurance (consistent with self-targeting), but they are also much lower-cost. Our model estimates suggest that they are not less efficient, implying that ordeals induced "backward sorting" into insurance, analogous to the findings of Marone and Sabety (2022) for price-based sorting. This occurs because adverse selection is very strong, with a "tax" exceeding 100 percent in our baseline estimates. With distributional equity concerns, health insurance is socially optimal, but it is optimal for all enrollees, including passive types screened out by ordeals, consistent with our idea of "optimal universality."

These findings have broader implications for how policymakers think about enrollment ordeals in social programs. In terms of *take-up* impact, our results suggest that ordeals are a first-order important barrier in health insurance. Even when coverage is free, a large share of people do not enroll when doing so is a hassle. Completely removing ordeals via auto-enrollment has an order of magnitude larger take-up impact than lower-touch "nudges" like reminders and outreach (Domurat, Menashe, and Yin 2021; Goldin, Lurie, and McCubbin 2021; Ericson et al. 2023; Banerjee et al. 2021). Reaching universal coverage in the United States, therefore, may require automatic enrollment in some form.

In terms of *targeting*, our results suggest that the standard case for ordeals is less likely to work well in settings with adverse selection, that is, strongly correlated value and costs. This is clearly relevant for insurance programs, but it may also be relevant more broadly in transfer programs that pay varying benefit amounts to different groups. Fundamentally, adverse selection (like behavioral biases) interrupts the revealed preference link between demand and efficiency that is key to self-targeting. While ordeals are useful tools in some settings, they may not be well suited to health insurance and other adversely selected markets.

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# The Great Obamacare Enrollment Fraud

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# EXECUTIVE SUMMARY

## What This Paper Covers

The Affordable Care Act (ACA) provided large subsidies for lower-income people to buy coverage in the exchanges. President Biden signed legislation that increased these subsidies through 2025, making plans fully-subsidized for enrollees with income between 100 percent and 150 percent of the federal poverty line (FPL). Enrollees in this income range also qualify for a cost-sharing reduction program that raises plan actuarial value to 94 percent with minimal deductibles and cost-sharing requirements. The Biden administration has also pursued administrative actions which have made this coverage more accessible for lower-income households and loosened eligibility reviews.

This paper describes the incentives for people to misestimate income to qualify for larger subsidies. By state, this paper shows the number of people claiming income between 100 percent to 150 percent FPL who sign-up for coverage with the likely number of people who are eligible for this coverage within that income grouping. Then, this paper discusses the problematic incentives facing brokers and insurers for improper enrollment. The paper concludes with a set of recommendations to minimize improper and fraudulent enrollment and spending.

## What We Found & Why It Matters

Nearly half of exchange sign-ups during the 2024 open enrollment period reported income between 100 percent and 150 percent FPL, qualifying for fully-subsidized, 94 percent actuarial value plans. The percentage of people signing up who report income in this range has increased substantially since the enhanced subsidies took effect.

In nine states (Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Utah), the number of sign-ups reporting income between 100 percent and 150 percent FPL exceed the number of potential enrollees. The problem is particularly acute in Florida, where we estimate there are four times as many enrollees reporting income in that range as meet legal requirements.

The problem of fraudulent exchange enrollment is much more severe in states that have not adopted the ACA's Medicaid expansion as well as in states that use the federal exchange (HealthCare.gov). In states that use HealthCare.gov, 8.7 million sign-ups reported enrollment between 100 percent and 150 percent FPL compared to only 5.1 million people likely eligible for such coverage, or 1.7 sign-ups for every eligible person.

Overall, fraudulent exchange enrollment appears to be a significant problem in nearly half of states. We estimate that fraudulent enrollment at 100 percent to 150 percent FPL is likely upwards of four to five million people in 2024. We estimate, conservatively, that this cost will likely be upwards of $15 to $20 billion this year.

In all states, there is an incentive for people who have income between 200 and 400 percent of the FPL to report income between 100 and 150 percent of the FPL. They qualify for a larger advanced subsidy and a plan with much lower cost-sharing, and the Internal Revenue Service only recaptures a portion of the excess subsidy when they file their taxes.

In non-Medicaid-expansion states, there is a large incentive for people, particularly older people, to overestimate their income. These individuals do not need to repay any of the subsidy to which they were not entitled.

Controlling for Medicaid expansion demonstrates the problems with HealthCare.gov as the percent of people who report income between 100 percent to 150 percent of FPL as those who are potentially eligible is more than twice as high in states using HealthCare.gov as using a state-based exchange. Evidence suggests that part of the issue is that state-based exchanges have done a more thorough job of re-evaluating people for exchange coverage who were no longer eligible for Medicaid after the public health emergency unwinding than states that use HealthCare.gov.

Unscrupulous brokers are certainly contributing to fraudulent enrollment and the enhanced direct enrollment feature of HealthCare.gov appears to be a problem. Brokers just need a person's name, date of birth, and address to enroll them in coverage, and reports indicate that many people have been recently removed from their plan and enrolled in another plan by brokers who earn commissions by doing so.

Health insurers are a primary beneficiary of the surge in improper enrollment from people misestimating income. The larger subsidies mean that consumers are less sensitive to prices of plans and are more likely to enroll, and it's much easier for insurers to collect subsidies from the U.S. Treasury than customers.

## What We Recommend

We recommend six steps to reduce fraudulent exchange enrollment:

1. Congress should permit the enhanced subsidies to expire after 2025;
2. Congress should raise subsidy recapture limits to reduce incentives for people to misestimate their income;
3. Congress or the next administration should limit automatic re-enrollment into exchange plans and end it for people moving from or into fully-taxpayer subsidized plans;
4. Congress should appropriate cost-sharing reduction payments and prohibit silver-loading;
5. Congress should conduct aggressive oversight of the Biden administration's management of HealthCare.gov, enhanced direct enrollment, and insurer and broker actions to take advantage of misestimating income;
6. Congress or the next administration should reverse policies of the Biden administration that enabled such widespread fraudulent enrollment, particularly the continuous open-enrollment period for people who report they have income below 150 percent FPL.

# BACKGROUND

An analysis of Affordable Care Act (ACA) enrollment data, Census data, and U.S. Treasury data shows a widespread problem of people misestimating their income to maximize subsidies for exchange plans. We estimate upwards of four to five million fraudulently enrolled exchange sign-ups who will cost taxpayers north of $15 to $20 billion this year. We find that the issue is more severe in states that did not adopt the ACA's Medicaid expansion (as there is a large incentive to overestimate income in those states) and states that are using the federal exchange platform for enrollment, HealthCare.gov.

Enrollment in the exchanges has grown substantially over the past few years, driven by increased subsidies. The subsidies, structured as premium tax credits (PTCs), reduce the percentage and amount of income that a person must pay for a benchmark plan — the second-lowest-cost silver plan[1] available to them.

President Biden signed the American Rescue Plan Act of 2021 (ARPA) in March 2021 and the Inflation Reduction Act of 2022 (IRA) in August 2022, which increased the subsidies through 2025.[2] As a result, people who claim that their income is between 100 percent and 150 percent[3] of the federal poverty level (FPL) now pay $0 for benchmark plans, meaning that their coverage is fully paid by taxpayers. The ACA limited the PTCs to enrollees in households with income below 400 percent FPL, but the legislation signed by President Biden lifted that cap, extending the subsidies to households in the top two quintiles. Figure 1 shows the percentage of income that households at a given percentage of the FPL had to pay for benchmark plans under the original ACA and from 2021 to 2025 under the increased subsidies.

The ACA subsidies are generally payments directly from the U.S. Treasury to health insurers on behalf of enrollees who select plans in the exchanges. In official terminology, the subsidies are advance PTCs (APTCs), as they are credited to individuals based on their estimated household income and then sent to insurers. The PTCs are refundable[4] and larger for lower-income enrollees, as they phase down as enrollee income increases. People with income below 200 percent FPL also qualify for a cost-sharing reduction (CSR) program that

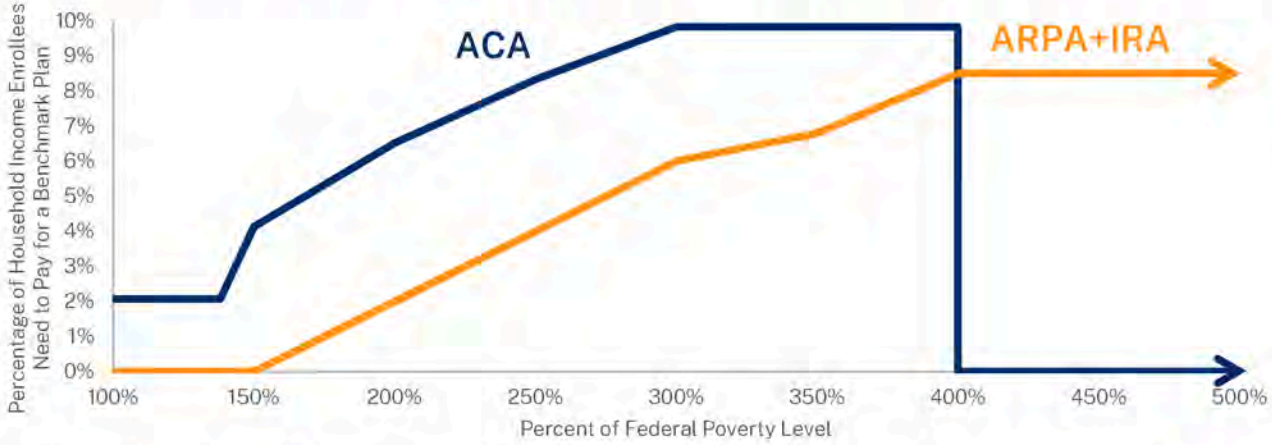
1 A silver plan has an actuarial value of 70 percent, which means that the plan pays for about 70 percent of the typical enrollee's medical expenses covered by the plan.

2 ARPA enhanced subsidies applied for 2021 and 2022, while IRA enhanced subsidies applied for 2023-2025. American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4 (2021). Inflation Reduction Act of 2022, Pub. L. No. 117-169, 136 Stat. 1818 (2022).

3 In 2024, 100 percent FPL for a single person is $15,050. For a household of two, this amount is $20,440. For a four-person household, 100 percent FPL is $31,200.

4 Refundable means that they not only reduce tax liability but are direct payments to qualifying individuals. Most people who claim PTCs do not owe income taxes and receive money back from the federal government through the income tax code after the PTC.

**Figure 1: Legislation Signed by President Biden Significantly Increased ACA Subsidies by Lowering Enrollee Premium Share**




SOURCES: CMS, *Plan Year 2023 Qualified Health Plan Choice and Premiums in HealthCare.gov Marketplaces*, October 26, 2022, https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2023QHPPremiumsChoiceReport.pdf.

NOTE: ARPA is the American Rescue Plan Act and IRA is Inflation Reduction Act.

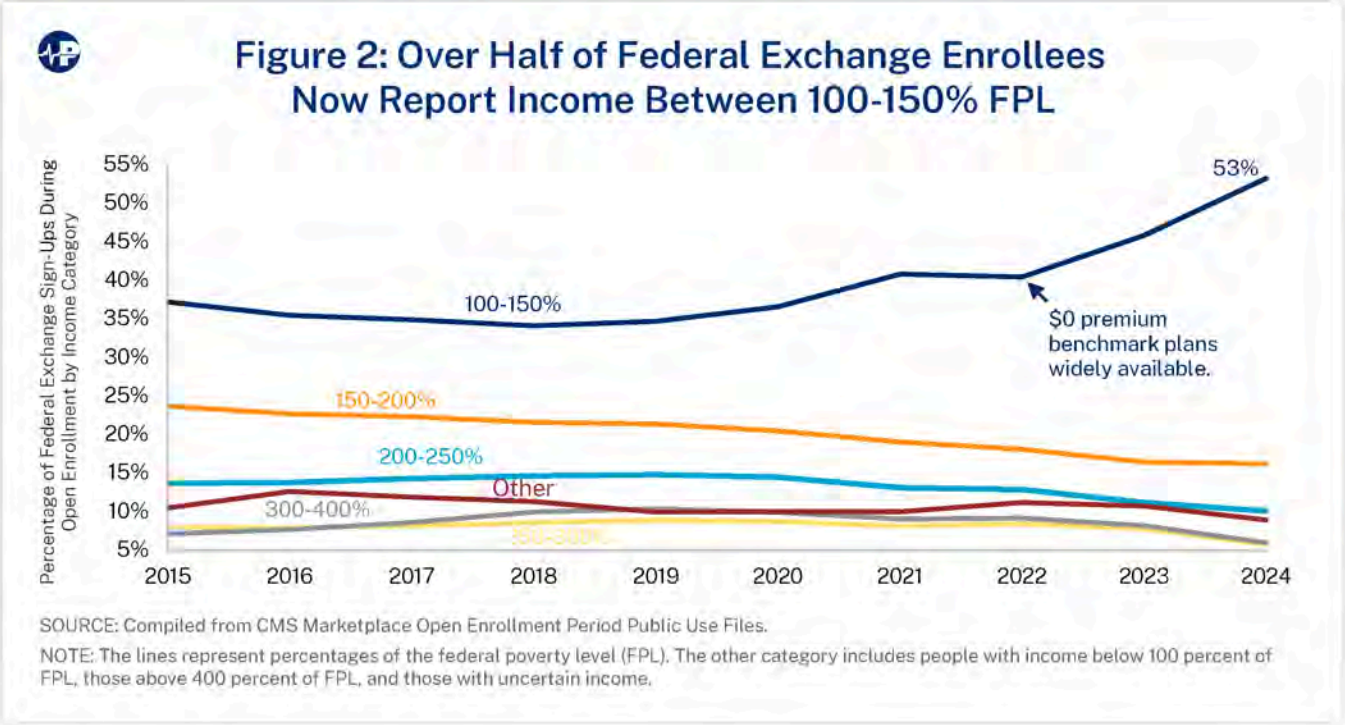
significantly reduces deductibles, cost-sharing amounts, and out-of-pocket limits.[5] For someone with income between 100 percent and 150 percent FPL who selects a silver plan, the CSR program raises plan actuarial value — the average percentage of expenses paid by the plan — to 94 percent. For silver plan enrollees with income between 150 percent and 200 percent FPL, the CSR program raises the actuarial value to 87 percent.

The PTC structure, particularly after the enhancement, creates numerous problems, which we have explored in other papers.[6] The focus of this piece, however, is to present data on how the PTC structure — particularly after President Biden signed legislation increasing the subsidies and making fully subsidized plans with very limited cost-sharing available to enrollees with income between 100 percent and 150 percent FPL — has led to far more people enrolling in the lowest income category than are eligible.

Figure 2 demonstrates the shift in overall enrollment to the lowest-income category in the states that use HealthCare.gov. In 2022, the fully subsidized plans were first readily available during that year's open enrollment period. In 2024, 53 percent of people who signed up for coverage during open enrollment reported that their income was between 100 percent and

5 People with income between 200 percent and 250 percent FPL also qualify for the CSR program, but for them the effect is much more limited as the actuarial value of the plan increases to only 73 percent, just a 3 percentage point increase from the standard silver plan without CSR subsidies.

6 Brian Blase, "Fourteen Reasons to Let the Expanded Obamacare Subsidies Expire," *Forbes*, May 26, 2022, https://www.forbes.com/sites/theapothecary/2022/05/26/fourteen-reasons-to-let-the-expanded-obamacare-subsidies-expire/?sh=32c98a3b6cba; Brian Blase, "Expanded ACA Subsidies: Exacerbating Health Inflation and Income Inequality," Galen Institute, June 2021, https://galen.org/assets/Expanded-ACA-Subsidies-Exacerbating-Health-Inflation-and-Income-Inequality.pdf.




150 percent FPL. This figure shows only the federal exchange sign-ups, because not all states with state-based exchanges reported sign-ups by income grouping prior to 2022.

Overall, when including states with their own exchanges, 47 percent of people who selected plans during open enrollment reported income between 100 percent and 150 percent FPL in 2024. The reason for the decline when including states that established their own exchanges is that all those states expanded Medicaid under the ACA. In those states, the ACA requires that people with income between 100 percent and 138 percent FPL enroll in Medicaid and not in exchange-based plans.

## *A Massive Incentive to Misestimate Income*

During open enrollment (typically in November and December preceding the coverage year), enrollees sign up for exchange plans. During this period, they, likely with the assistance of brokers or navigators working with them on their applications, estimate their household income for the following year.

The APTC is a function of this estimated income, so people generally qualify for larger subsidies if they underestimate their income, although there is an incentive for some people in states that have not expanded Medicaid to overestimate income (see discussion below). When a person files his or her subsequent tax return (generally in April of the year after the coverage), the APTC amount gets reconciled with the amount of the PTC that person was entitled because of actual income. People who received excessive subsidies would owe the

excess back when they file their taxes, subject to limits discussed below. Those who received subsidies that were too small would receive additional credit against their taxes when they file.

In Medicaid expansion states, able-bodied, working-age adults with income below 138 percent FPL are eligible for Medicaid. Therefore, in expansion states, only enrollees who estimate their income between 138 percent and 150 percent FPL are eligible for fully subsidized benchmark plans.

In states that have not expanded their Medicaid programs, enrollees with income between 100 percent and 150 percent FPL are eligible for fully subsidized benchmark plans, as able-bodied, working-age enrollees are generally not eligible for Medicaid in those states. If their income is below 100 percent FPL, they also are ineligible for PTCs. This creates an incentive for able-bodied adults with income below the poverty line to overestimate their earnings. By estimating that their earnings are between 100 percent and 150 percent FPL, such an individual can claim a PTC that now covers the entire premium for a benchmark plan that would also have a very low deductible, cost-sharing amounts, and out-of-pocket limit because of the CSR program. By misstating their income, these individuals get generous coverage at zero cost to them—instead of being ineligible for any subsidies at all.

The incentives to misstate income are magnified because the law limits the amount that people need to repay when they file their taxes. For 2024, the amount that single filers must pay back to the Internal Revenue Service (IRS) is capped at $375 for individuals between 100 percent and 200 percent FPL, $950 for those between 200 percent and 300 percent FPL, and $1,575 for those between 300 percent and 400 percent FPL.[7] People with income above 400 percent FPL would need to fully reconcile the APTC amounts with the PTC amounts to which they were entitled.

Because of these relatively low recapture limits, many enrollees have an incentive to underestimate their income. For example, for a 40-year-old enrollee at 290 percent FPL, the incentive for estimating income at just under 150 percent FPL is $1,438 on average in the United States. He would receive an APTC of $5,723 to cover the full premium of insurance coverage with an actuarial value of 94 percent. At 290 percent FPL, he was eligible for a PTC of $3,355—receiving $2,368 of excessive subsidy for much less generous coverage (70 percent actuarial value). He would need to repay $950, which would leave him better off by $1,418 in premium subsidies due to underestimating his income and the added benefit of having coverage with much less cost-sharing.

7 IRS, Revenue Procedure 2023-34, https://www.irs.gov/pub/irs-drop/rp-23-34.pdf. These amounts are indexed to inflation. The amounts are also double for married persons filing jointly.

The incentives to overestimate income in non-expansion states are much larger for older enrollees, as the PTC structure limits premium payment to a certain percentage of household income, regardless of the premium amount. Because premiums are three times more for enrollees near 65 than for enrollees in their 20s, the subsidies are also much larger. Nationally, the average PTC for a 21-year-old is $4,478 and the average PTC for a 64-year old is $13,434.[8] Older enrollees demand more medical services all else equal, and some may be looking to retire before the age of 65. These factors contribute to a larger incentive for them to overestimate income to earn a PTC.

Given how the subsidy structure works, there is not much differential incentive for older people to underestimate their income to gain a higher subsidy. In fact, the only differential occurs because the value of the cost-sharing reduction subsidy, which we explain below, is greater for older enrollees than younger enrollees.

Figure 3 demonstrates the age dynamic. The incentive to underestimate income is minimal for enrollees with income below 200 percent FPL, so the figure starts showing the benefit of underestimating income at 200 percent FPL. The benefit gradually increases as household income increases until the benefit ceases at 400 percent FPL. Figure 3 includes an estimate of the taxpayer cost for enrollees who underestimate their income to qualify for the CSR program and a 94 percent actuarial value plan.[9]

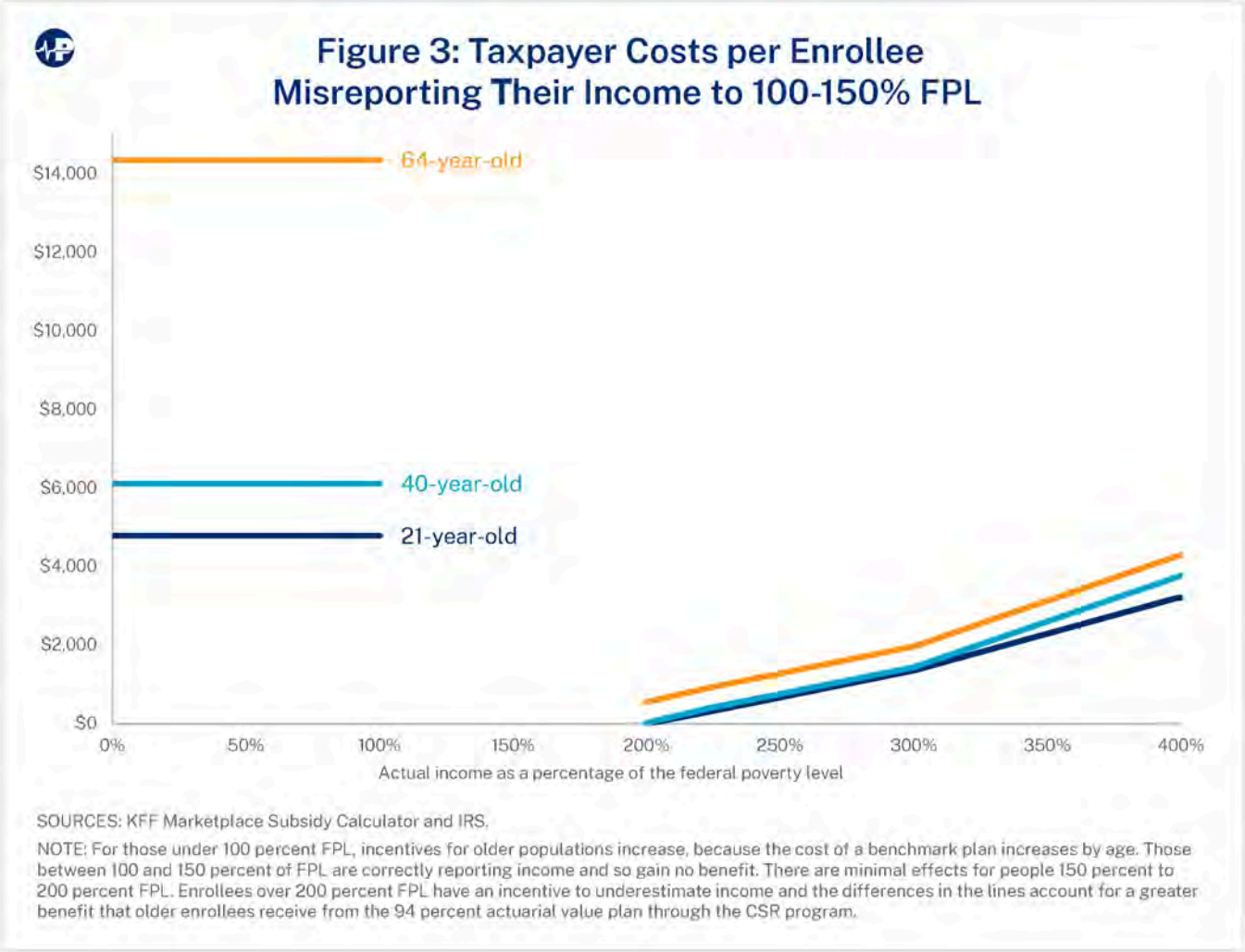
People who estimate their income to be at least 100 percent FPL at the time of enrollment but end up earning less than 100 percent FPL do not have to pay any of the APTC back. In that circumstance, the IRS considers the person to be qualified for the PTC so long as the income estimate was not made "with intentional or reckless disregard for the facts."[10] Therefore, people with income below 100 percent FPL in non-Medicaid expansion states have an even more significant incentive to overestimate their income to qualify for a large PTC, as they would not need to pay any of it back. Such enrollees who overestimate their income to an amount greater than 100 percent FPL receive a full subsidy. In other words, they pay zero premium for plans with actuarial values of 94 percent.

In 2024, a 40-year-old enrollee reporting income between 100 percent to 150 percent FPL would receive an average subsidy of $5,869 in Florida, $5,556 in Georgia, and $5,700 in

8 KFF, "Health Insurance Marketplace Calculator," https://www.kff.org/interactive/subsidy-calculator/.

9 Since most silver plan enrollees report income that qualifies them for the CSR program, the average actuarial value for a silver plan is 88 percent. In order to approximate the added marginal benefit of the CSR program for enrollees who report income between 100 to 150 percent FPL, we multiplied the benchmark premium by 94/88.

10 IRS, 2023 Instructions for Form 8962, https://www.irs.gov/pub/irs-pdf/i8962.pdf.




Texas.[11] For a 60-year-old enrollee, the amounts in these states would be $12,464, $11,799, and $12,104.[12] And their cost-sharing would be far more generous than what all but a few Americans get through their employer-sponsored insurance. These estimates of the benefit of misestimating their income are conservative, because they do not factor in the additional value of the CSR program that benefits them. However, Figure 3 accounts for the extra benefits of the CSR program and the 94 percent actuarial value plan to which enrollees who report income between 100 percent and 150 percent FPL are entitled.

## *Analysis Confirms People Are Misestimating Income*

New research shows that people have been misestimating their income — with a particularly high concentration in Florida — since the ACA's key provisions took effect. In a 2024 piece using 2015-2017 federal exchange data, three authors — all of whom are past or present

11 KFF, "Marketplace Average Benchmark Premiums: 2024," https://www.kff.org/affordable-care-act/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

12 KFF, "Marketplace Average Benchmark Premiums: 2024." We apply age rating tables from CMS. "State Specific Age Curve Variations" https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/downloads/statespecagecrv053117.pdf

Congressional Budget Office experts — find "evidence suggesting that many people in the coverage gap in non-expansion states obtain subsidies by reporting income just above the Federal Poverty Line at the time of enrollment, especially in Florida."[13] The "coverage gap" refers to people in non-expansion states with incomes below 100 percent FPL.

The authors continued, "The precise incomes reported by marketplace enrollees suggests that they were aware of the cutoff for PTC eligibility at the FPL. Consider single-person households in non-expansion states in 2015, for whom the lower bound for eligibility for the PTCs was $11,670.... [S]o many enrollees reported income between $11,670 and $12,500 to Healthcare.gov that actual marketplace enrollment was 136% of estimated potential enrollment in that range. Furthermore, many of these enrollees reported [modified adjusted gross income] precisely equal to $11,670, $11,700, or $12,000, suggesting that they were aware of the cutoff for PTC eligibility and reported just enough income to exceed it. Other spikes correspond to round values, like $15,000, or inflation-adjusted round values from 2014." Such precision on a widespread scale suggests significant counseling of income manipulation by outside entities aware of the program rules.

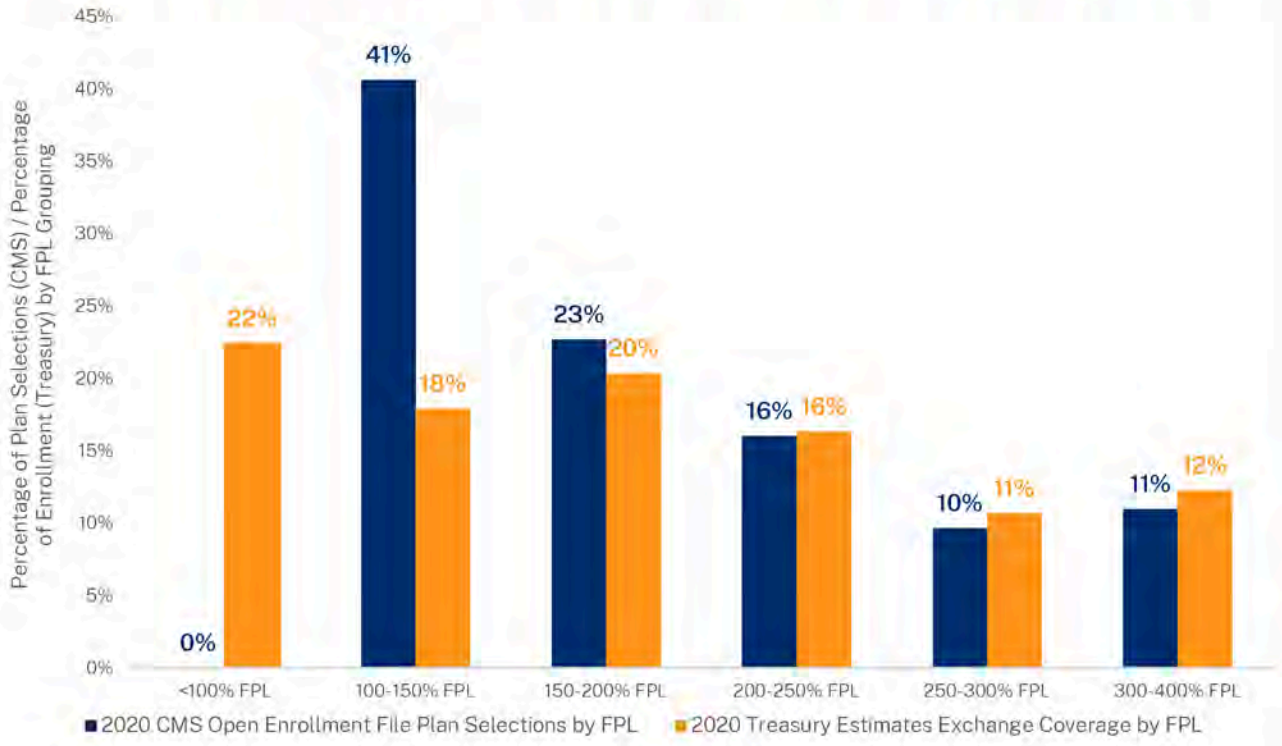
The authors conclude: "Taken together, these facts suggest that many people who eventually earned less than 100% FPL reported that they expected to earn more than this amount when enrolling in marketplace insurance and were able to receive PTCs. This implies that many people who earned less than the FPL (or, in the ACS [American Community Survey], reported earning less) were effectively eligible for PTCs."

In 2019 (the most recent year Treasury published this analysis), the Treasury Department estimated that over one-fourth of all PTCs — an amount equal to $11.32 billion — would be paid to insurers on behalf of households with income below 100 percent FPL in 2020.[14] Treasury estimates that roughly 1.70 million tax filers receiving PTCs would have income under 100 percent FPL, and 1.38 million who would receive PTCs would have income between 100 percent and 150 percent FPL. This data shows that the reported income data that the Centers for Medicare and Medicaid Services (CMS) uses has major problems, as CMS enrollment data did not include any enrollment for people with income below 100 percent FPL. Figure 4 highlights the discrepancy between Treasury estimates and CMS plan selection data. This data shows that misestimating income for people with income below 100 percent FPL was a problem before the enhanced subsidies. That problem was made worse given the access to

13 Ben Hopkins, Jessica Banthin, and Alexandra Minicozzi, "How Did Take-Up of Marketplace Plans Vary with Price, Income, and Gender?," *American Journal of Health Economics* 10, no. 2 (Spring 2024), https://www.journals.uchicago.edu/doi/epdf/10.1086/727785.

14 U.S. Department of the Treasury, "Treasury's Baseline Estimates of Health Coverage, FY 2020." September 11, 2019. https://home.treasury.gov/system/files/131/Treasurys-Baseline-Estimates-of-Health-Coverage-FY-2020.pdf. Total subsidies were $43.89 billion according to Treasury in 2020.

**Figure 4: More than One-Fifth of Exchange Enrollees Had Income Below 100% FPL in 2020, Despite None Being Reported by CMS**




SOURCES: 2020 CMS Open Enrollment Public Use File and 2020 Treasury Department Baseline Estimates of Health Coverage.

fully subsidized plans, while the problem with people above 150 percent FPL underestimating income was made more severe.

It is worth noting that people also have incentives to report lower income in order to enroll in Medicaid in expansion states. Medicaid has extremely low (if any) cost-sharing, and the plans are similar to exchange plans in terms of providers accepting the coverage. Our analysis, which focuses on exchange enrollment, excludes this dynamic and thus makes expansion states look better than non-expansion states on these fraudulent enrollment statistics.

## *The Data and Methodology*

We contrast sign-ups during open enrollment by state for people claiming income across FPL categories with estimates of the number of people who would be eligible for exchange plans and PTCs in each FPL category. The first set of tables is for the lowest-income category: 100-150 percent FPL. We show the number of 100-150 percent FPL sign-ups and the number of state residents between 19 and 64 years of age who report income between 100 percent and 150 percent FPL and who also do not report having Medicare or Medicaid. We exclude those ages 19-64 in this income category who reported coverage in Medicaid or Medicare,

because they are likely on federal disability programs with that coverage (and thus precluded from eligibility for PTCs in the exchange) or live in expansion states and are on Medicaid.[15] We exclude children age 18 and under because they are eligible for Medicaid or the Children's Health Insurance Program (CHIP) if their incomes are in this range and are thus precluded from exchange coverage and PTC eligibility.[16] We exclude seniors, because they are almost certainly enrolled in Medicare and are precluded from exchange coverage. People who have either Medicare or Medicaid are also precluded from exchange coverage.[17]

The data set we use is the 2022 ACS 1-Year Public Use Microdata Sample file. This survey is a nationally representative survey from the U.S. Census Bureau that produces information about the U.S. population, including demographic and economic data. For our analysis, we use this data to estimate the number of people by state who would potentially enroll in exchange coverage within income groupings. We adjust this data by population growth trends by state from 2020 to 2023 in order to approximate the number of people in income groupings in 2024.[18] We compare this estimate to the number of plan selections on the exchanges in 2024 by FPL from the CMS Marketplace Open Enrollment Public Use File. We exclude New York and Minnesota from the analysis due to their Basic Health Programs (BHP), which provide coverage for this lower-income exchange population. We exclude the District of Columbia, as most of its reporting in the open enrollment file does not report income.

For our analysis, we have attempted to be overly inclusive of the population with income between 100 percent and 150 percent FPL eligible for exchange coverage with APTCs. We do not exclude individuals who report employer coverage. Excluding these people would further reduce the number of people potentially eligible for exchange coverage. ACS data generally undercounts people in lower income brackets,[19] but we make other assumptions that include people as potential enrollees between 100 percent and 150 percent FPL who would not be eligible for an exchange plan with a PTC. Much of our analysis is on the fraudulent enrollment comparisons across states, which means that our findings of differences across states should

15 To be eligible for PTCs, individuals must not be eligible for public coverage including Medicaid, CHIP, Medicare, or military coverage (TRICARE). Section 5000A(f) of the ACA refers to these types of insurance as "Minimum Essential Coverage." Affordable Health Care Act Pub. L. No. 111-148, 124 Stat. 119 (2010), https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

16 IRS, Publication 974 (2023), https://www.irs.gov/publications/p974.

17 Our approach is simpler than Hopkins et al. Regarding potential exchange enrollment, Hopkins et al. classify this population as those between the ages of 20 and 64, excluding Medicare, Medicaid, CHIP, and TRICARE enrollees. Additionally, they exclude individuals who would be eligible for Medicaid or CHIP based on age and imputed income, as well as through pregnancy pathways. They also use different income assumptions for potential eligibility between expansion and non-expansion states. For expansion states, they apply a lower bound reflective of current law: 100 percent FPL. In non-expansion states, they apply a lower bound of 80 percent FPL, because their "analysis strongly suggests that many people with income below 100 percent FPL in non-expansion states obtain advanced PTCs." Our work is illustrative of this specific finding in Hopkins et al.'s research for individuals below 100 percent FPL using CMS exchange data but using publicly available data. Hopkins et al. focuses on federal exchanges while this piece looks at all exchanges.

18 United States Census Bureau. "State Population Totals and Components of Change: 2020-2023" Vintage 2023. https://www.census.gov/data/tables/time-series/demo/popest/2020s-state-total.html#v2023. We apply the three-year trend to fully estimate state populations in 2024. This approach will not capture distributional changes that might be present.

19 This is partially due to eligibility for health coverage being defined differently than the FPL variables in ACS capture. These "tax unit" or "health insurance unit" designations tend to increase the number of people below 150 percent FPL.

be largely unaffected by the ACS undercount — assuming that there is not large variation in the undercount across states.[20]

We are unable to exclude unauthorized immigrants, people who receive veterans' health care, and anyone who might have an offer of affordable coverage from an employer. Additionally, this analysis does not account for individuals who are unaware that they have Medicaid coverage, which represented nearly 30 percent of Medicaid enrollees in 2022.[21] Accounting for these limitations would result in an even smaller number of exchange-eligible people, which are additional reasons why our estimates are overly inclusive.

## LARGE-SCALE EXCHANGE ENROLLMENT FRAUD

Table 1 compares the number of people ages 19-64 who sign up for exchange plans and report income between 100 percent and 150 percent FPL with the projected maximum number of people who would be eligible for such coverage.

In nine states, more people signed up for coverage than would be eligible, meaning that the number of people who enrolled in a plan with zero premium and very low cost-sharing plans exceeded the number of eligible adults in that income range. Seven of these nine states did not expand their Medicaid programs — an indication that a large part of the issue is people in non-Medicaid expansion states overestimating their income in order to qualify for fully subsidized, low cost-sharing plans. This outcome is expected considering people with incomes between 100 percent and 138 percent FPL in the 100 percent to 150 percent FPL range do not legally qualify for APTCs in expansion states. Florida is a clear outlier, enrolling more than four times as many people in this income category as we estimate are eligible. Georgia, Mississippi, and South Carolina enrolled more than twice as many people in this income category as estimated eligible. Texas enrolled nearly twice as many people in this income category as estimated eligible.

20 For more discussion see Giovann Alarcon et al., "Defining Family for Studies of Health Insurance Coverage," State Health Access Data Assistance Center (SHADAC), August 2021, https://www.shadac.org/sites/default/files/publications/2021%20HIU%20Defining%20families%20brief.pdf; and Ithai Lurie and James Pierce, "The Effects of ACA on Income Eligibility for Medicaid and Subsidized Private Insurance Coverage: Income Definitions and Thresholds Across CPS and Administrative Data," U.S. Department of Treasury, Office of Tax Analysis. In SHADAC's methodology, this undercount is substantial, but the majority of the adjustment occurs below 100 percent FPL. In some states, fewer people are estimated in the 100 percent to 150 percent FPL category. Using Tresury's estimates suggests that 50 percent additional people could be between 100 percent and 150 percent of poverty ages 0-64. Treasury estimates 31.9 million versus 21 million in the ACS. Treasury estimates there are 9.3 million people aged 0-64 who have income between 100 percent to 150 percent FPL after excluding those with government and employer coverage. Our primary estimate of potential enrollees, which excludes children, seniors and people with Medicaid or Medicare, totals 7.0 million without New York, Minnesota, and the District of Columbia. Our expansive estimate, which includes those in this income range who report Medicare or Medicaid is 12.0 million.

21 Dong Ding, Benjamin D. Sommers, and Sherry A. Glied, "Unwinding and the Medicaid Undercount: Millions Enrolled in Medicaid During the Pandemic Thought They Were Uninsured," *Health Affairs* 43, no. 5 (May 2024), https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.01069.

# Table 1: Exchange Sign-Ups Reporting Income 100-150% FPL Compared to Total Potential Enrollees

| State | Platform | Expansion Status | Exchange Sign-Ups (1) | Total Potential Enrollees (2) | Percentage (1)/(2) |
|---|---|---|---|---|---|
| Alabama | HC.gov | Not Adopted | 228,883 | 160,429 | 142.7% |
| Alaska | HC.gov | Adopted | 2,317 | 11,671 | 19.9% |
| Arizona | HC.gov | Adopted | 114,197 | 175,174 | 65.2% |
| Arkansas | HC.gov | Adopted | 56,640 | 79,825 | 71.0% |
| California | SBE | Adopted | 278,204 | 676,577 | 41.1% |
| Colorado | SBE | Adopted | 14,786 | 105,073 | 14.1% |
| Connecticut | SBE | Adopted | 12,991 | 45,615 | 28.5% |
| Delaware | HC.gov | Adopted | 8,374 | 16,292 | 51.4% |
| Florida | HC.gov | Not Adopted | 2,718,501 | 676,297 | 402.0% |
| Georgia | HC.gov | Not Adopted | 834,058 | 338,044 | 246.7% |
| Hawaii | HC.gov | Adopted | 3,006 | 27,349 | 11.0% |
| Idaho | SBE | Adopted | 8,193 | 55,863 | 14.7% |
| Illinois | HC.gov | Adopted | 111,131 | 232,030 | 47.9% |
| Indiana | HC.gov | Adopted | 112,127 | 140,930 | 79.6% |
| Iowa | HC.gov | Adopted | 23,908 | 54,344 | 44.0% |
| Kansas | HC.gov | Not Adopted | 82,256 | 83,391 | 98.6% |
| Kentucky | SBE | Adopted | 8,534 | 82,820 | 10.3% |
| Louisiana | HC.gov | Adopted | 93,833 | 107,669 | 87.1% |
| Maine | SBE | Adopted | 4,581 | 19,696 | 23.3% |
| Maryland | SBE | Adopted | 21,599 | 92,608 | 23.3% |
| Massachusetts | SBE | Adopted | 30,595 | 78,527 | 39.0% |
| Michigan | HC.gov | Adopted | 122,597 | 179,256 | 68.4% |
| Mississippi | HC.gov | Not Adopted | 210,749 | 104,613 | 201.5% |
| Missouri | HC.gov | Adopted | 154,459 | 170,544 | 90.6% |
| Montana | HC.gov | Adopted | 8,522 | 25,591 | 33.3% |
| Nebraska | HC.gov | Adopted | 25,158 | 53,877 | 46.7% |
| Nevada | SBE | Adopted | 22,471 | 85,772 | 26.2% |
| New Hampshire | HC.gov | Adopted | 8,484 | 15,449 | 54.9% |
| New Jersey | SBE | Adopted | 69,867 | 134,985 | 51.8% |
| New Mexico | SBE | Adopted | 6,747 | 44,995 | 15.0% |
| North Carolina | HC.gov | Adopted | 507,098 | 304,295 | 166.6% |
| North Dakota | HC.gov | Adopted | 3,770 | 16,468 | 22.9% |
| Ohio | HC.gov | Adopted | 166,814 | 209,037 | 79.8% |
| Oklahoma | HC.gov | Adopted | 120,013 | 130,807 | 91.7% |
| Oregon | HC.gov | Adopted | 11,190 | 81,209 | 13.8% |
| Pennsylvania | SBE | Adopted | 81,714 | 206,033 | 39.7% |
| Rhode Island | SBE | Adopted | 6,117 | 14,238 | 43.0% |
| South Carolina | HC.gov | Not Adopted | 301,553 | 147,569 | 204.3% |
| South Dakota | HC.gov | Adopted | 8,821 | 23,677 | 37.3% |
| Tennessee | HC.gov | Not Adopted | 310,781 | 207,288 | 149.9% |
| Texas | HC.gov | Not Adopted | 2,133,460 | 1,097,793 | 194.3% |
| Utah | HC.gov | Adopted | 133,065 | 79,712 | 166.9% |
| Vermont | SBE | Adopted | 2,227 | 6,979 | 31.9% |
| Virginia | SBE | Adopted | 110,912 | 152,173 | 72.9% |
| Washington | SBE | Adopted | 21,588 | 126,253 | 17.1% |
| West Virginia | HC.gov | Adopted | 17,243 | 38,859 | 44.4% |
| Wisconsin | HC.gov | Not Adopted | 64,398 | 112,084 | 57.5% |
| Wyoming | HC.gov | Not Adopted | 8,054 | 15,952 | 50.5% |
| TOTAL | | | 9,406,586 | 7,045,733 | 133.5% |

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File.

NOTES: Total potential enrollees are ages 19-64 and do not report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

## *Conservative Estimates of Enrollment Fraud: Upwards of 4-5 Million People and $15-$20 Billion in 2024*

We estimate four to five million people improperly enrolled for subsidized health coverage on the exchanges in 2024 and that the cost of improper enrollment is likely upward of $15-$20 billion this year.

We estimate improper enrollment separately for Medicaid expansion and non-Medicaid expansion states. In non-Medicaid expansion states, we count improper enrollment as any enrollment above the total potential enrollees (i.e., the number of 19-64-year-olds with income in that category as reported by the ACS). In expansion states, we count improper enrollment as any enrollment above half the number of potential enrollees. As a reminder, only those with income between 138 percent to 150 percent FPL would be eligible for exchange coverage in this income category. We believe both estimates are conservative.

This method yields 4.84 million fraudulently enrolled people at 100 percent to 150 percent FPL, but only in 21 states as the other states, which include New York and Minnesota that rely on the BHP for coverage for this population, do not meet the above criteria. Since there is some degree of improper enrollment in every state, and our methodology is designed to yield a conservative estimate, the number of improperly enrolled people at 100 to 150 percent FPL is likely higher than this four to five million people range.

Taking a conservative estimate of five million people improperly enrolled in fully subsidized plans, we estimate that 60 percent of enrollees have income below 100 percent of the FPL and are receiving $6,000 worth of subsidy to which they are not entitled. Of the remaining 40 percent of enrollees who have underestimated their income, we estimate they have received an excess subsidy of $1,000.[22] Putting these together yields about $20 billion of improper PTCs for 2024.

The main reason these estimates are conservative is because we use a $6,000 average subsidy, which is the subsidy for a 40-year-old. The average age of an exchange enrollee is older than 40 and, as Figure 3 shows, the PTC is much larger for older enrollees. If the average PTC for improperly enrolled people is $8,000 (which may be more realistic), then the estimated cost of improper enrollment would be $26 billion in 2024.

An additional reason the $20 billion is a conservative estimate is that the number of people who have overestimated their income in non-expansion states who are receiving fully

22 The $1,000 is a rough average of the improper benefit for people with income between 150 percent and 400 percent FPL who underestimate their income to between 100 percent and 150 percent FPL.

subsidized PTCs to which they are not entitled (by far the biggest contributor to improper spending) almost certainly exceeds 3.0 million people. In seven non-expansion states, there are 4.0 million more 100 percent to 150 percent sign-ups than ACS data indicate are eligible in that income category. Our back-of-the-envelope estimate does not consider any improper enrollment in the other three non-expansion states — Kansas (sign-ups are 98.7 percent of potential enrollees), Wisconsin, and Wyoming.

Using a similar methodology for the more expansive set of potential enrollees for the 100 percent to 150 percent FPL group, consistent with Table 3 below, produces estimates of roughly 4 million improper enrollees in this category at a cost of about $15 billion in 2024. We believe that this estimate is a lower bound of total fraudulent enrollment in the 100 percent to 150 percent group and the associated cost.

## Fraudulent Enrollment in North Carolina

North Carolina expanded Medicaid on December 1, 2023, and was the only state to adopt the ACA's expansion of the program during the 2024 ACA open enrollment period, which started on November 1, 2023.

As of May 5, 2024, 451,194 people enrolled under North Carolina's Medicaid expansion.[23] While enrollment in Medicaid expansion has been substantial, at the same time significantly more North Carolinians reporting income between 100 percent and 150 percent FPL enrolled in exchange plans in the 2024 open enrollment period (507,098) than selected plans in 2023 (347,551).

Combining 2024 exchange plan selections in open enrollment with the number of Medicaid expansion enrollees totals 958,292 individuals. This is 28.2 percent higher than the 2023 ACS estimate for the number of people in North Carolina under 150 percent FPL ages 19-64 who did not report having Medicaid or Medicare — which is an upper bound on the number of individuals potentially eligible for the exchanges or Medicaid expansion.[24]

23 North Carolina Office of the Governor, "NC Medicaid Expansion Hits 450,000 Enrollees in Just Five Months," press release, May 9, 2024, https://governor.nc.gov/news/press-releases/2024/05/09/nc-medicaid-expansion-hits-450000-enrollees-just-five-months.

24 CMS, 2024 Open Enrollment Public Use File, https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files. Note: Even adjusting the population under 100 percent FPL according to SHADAC methodology still implies that the entire population under 150 percent FPL has health coverage. We attempt to provide this estimate for the project expansion population by excluding enrollment in traditional Medicaid.

The data indicates that many North Carolinians were (and likely still are) simultaneously enrolled in Medicaid and the exchanges. Because North Carolina transitioned its Medicaid program to managed care in 2021,[25] this suggests that insurers are potentially reaping windfall profits from dual enrollment. It also suggests that enrollees in North Carolina are at substantial risk of financial penalties, as the state put out the following guidance: "If you qualify for full Medicaid, you will not be able to get financial help with the cost of your Marketplace plan. Therefore, you probably will not want to keep your Marketplace coverage because it will cost more than coverage through NC Medicaid."[26]

25 NC Medicaid, "Fact Sheet NC Medicaid Managed Care," April 2021, https://medicaid.ncdhhs.gov/ncmt-fact-sheet-managedcarepopulations-04292021/download?attachment.

26 NC Medicaid Division of Health Benefits, "Questions and Answers about Medicaid Expansion," April 11, 2024, https://medicaid.ncdhhs.gov/questions-and-answers-about-medicaid-expansion.

### Table 2: North Carolina Medicaid Expansion Enrollment and 100-150% FPL Exchange Enrollment Exceeds Eligible Population

| | |
|---|---|
| Plan Selections 2024 | 507,098 |
| Medicaid Expansion Enrollment | 451,194 |
| Current Total | 958,292 |
| Population Ages 19-64, Under 150 percent of FPL, Excluding Medicaid and Medicare | 747,554 |

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 and 2023 Open Enrollment File and North Carolina Office of the Governor, "NC Medicaid Expansion Hits 450,000 Enrollees in Just Five Months," press release, May 9, 2024, https://governor.nc.gov/news/press-releases/2024/05/09/nc-medicaid-expansion-hits-450000-enrollees-just-five-months.

Table 3 shows the same results as Table 1, except it compares the number of people who signed up for coverage during open enrollment reporting income between 100 percent and 150 percent FPL with all potential enrollees who are residents ages 19-64 by state. The difference with Table 1 is that we include people who report either Medicaid or Medicare in this income category as potential exchange enrollees with PTCs. We do this because it is possible that people are confusing exchange plans with Medicaid plans.[27] In many states, exchange plans are very similar to Medicaid plans, and many of these enrollees use little if any

27 Research shows that there are more false positives for Medicaid—people with private coverage reporting Medicaid—in the ACS than in other surveys. "Among those for whom public coverage was reported, over-reporting in the ACS was higher than in the CPS—8.6% and 2.1%, respectively." See Joanne Pascale, Angela Fertig, and Kathleen Call, "Validation of Two Federal Health Insurance Survey Modules After Affordable Care Act Implementation," *Journal of Official Statistics* 35, no. 2 (June 2019), https://sciendo.com/article/10.2478/jos-2019-0019.

## Table 3: Exchange Sign-Ups Reporting Income 100-150% FPL Compared to Total Potential Enrollees (Expansive Assumptions)

| State | Platform | Expansion Status | Exchange Sign-Ups (1) | Total Potential Enrollees (Expansive Assumptions (2) | Percentage (1)/(2) |
|---|---|---|---|---|---|
| Alabama | HC.gov | Not Adopted | 228,883 | 241,825 | 94.6% |
| Alaska | HC.gov | Adopted | 2,317 | 24,709 | 9.4% |
| Arizona | HC.gov | Adopted | 114,197 | 294,562 | 38.8% |
| Arkansas | HC.gov | Adopted | 56,640 | 154,595 | 36.6% |
| California | SBE | Adopted | 278,204 | 1,501,964 | 18.5% |
| Colorado | SBE | Adopted | 14,786 | 183,259 | 8.1% |
| Connecticut | SBE | Adopted | 12,991 | 111,731 | 11.6% |
| Delaware | HC.gov | Adopted | 8,374 | 28,953 | 28.9% |
| Florida | HC.gov | Not Adopted | 2,718,501 | 952,666 | 285.4% |
| Georgia | HC.gov | Not Adopted | 834,058 | 453,044 | 184.1% |
| Hawaii | HC.gov | Adopted | 3,006 | 47,574 | 6.3% |
| Idaho | SBE | Adopted | 8,193 | 89,492 | 9.2% |
| Illinois | HC.gov | Adopted | 111,131 | 447,001 | 24.9% |
| Indiana | HC.gov | Adopted | 112,127 | 261,413 | 42.9% |
| Iowa | HC.gov | Adopted | 23,908 | 115,741 | 20.7% |
| Kansas | HC.gov | Not Adopted | 82,256 | 109,945 | 74.8% |
| Kentucky | SBE | Adopted | 8,534 | 200,601 | 4.3% |
| Louisiana | HC.gov | Adopted | 93,833 | 246,452 | 38.1% |
| Maine | SBE | Adopted | 4,581 | 46,939 | 9.8% |
| Maryland | SBE | Adopted | 21,599 | 170,883 | 12.6% |
| Massachusetts | SBE | Adopted | 30,595 | 203,664 | 15.0% |
| Michigan | HC.gov | Adopted | 122,597 | 393,876 | 31.1% |
| Mississippi | HC.gov | Not Adopted | 210,749 | 150,673 | 139.9% |
| Missouri | HC.gov | Adopted | 154,459 | 251,022 | 61.5% |
| Montana | HC.gov | Adopted | 8,522 | 46,007 | 18.5% |
| Nebraska | HC.gov | Adopted | 25,158 | 82,415 | 30.5% |
| Nevada | SBE | Adopted | 22,471 | 138,250 | 16.3% |
| New Hampshire | HC.gov | Adopted | 8,484 | 32,356 | 26.2% |
| New Jersey | SBE | Adopted | 69,867 | 250,657 | 27.9% |
| New Mexico | SBE | Adopted | 6,747 | 106,051 | 6.4% |
| North Carolina | HC.gov | Adopted | 507,098 | 444,838 | 114.0% |
| North Dakota | HC.gov | Adopted | 3,770 | 25,512 | 14.8% |
| Ohio | HC.gov | Adopted | 166,814 | 446,496 | 37.4% |
| Oklahoma | HC.gov | Adopted | 120,013 | 199,569 | 60.1% |
| Oregon | HC.gov | Adopted | 11,190 | 169,456 | 6.6% |
| Pennsylvania | SBE | Adopted | 81,714 | 439,826 | 18.6% |
| Rhode Island | SBE | Adopted | 6,117 | 32,294 | 18.9% |
| South Carolina | HC.gov | Not Adopted | 301,553 | 217,740 | 138.5% |
| South Dakota | HC.gov | Adopted | 8,821 | 31,161 | 28.3% |
| Tennessee | HC.gov | Not Adopted | 310,781 | 313,721 | 99.1% |
| Texas | HC.gov | Not Adopted | 2,133,460 | 1,371,752 | 155.5% |
| Utah | HC.gov | Adopted | 133,065 | 106,353 | 125.1% |
| Vermont | SBE | Adopted | 2,227 | 18,527 | 12.0% |
| Virginia | SBE | Adopted | 110,912 | 270,980 | 40.9% |
| Washington | SBE | Adopted | 21,588 | 237,173 | 9.1% |
| West Virginia | HC.gov | Adopted | 17,243 | 89,695 | 19.2% |
| Wisconsin | HC.gov | Not Adopted | 64,398 | 204,105 | 31.6% |
| Wyoming | HC.gov | Not Adopted | 8,054 | 20,769 | 38.8% |
| TOTAL | | | 9,406,586 | 11,978,289 | 78.5% |

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File.

NOTES: Total potential enrollees are ages 19-64, including those who report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

health care and are not highly engaged or knowledgeable about their coverage.[28] So Table 3 provides conservative estimates on the extent of the fraudulent enrollment problem and likely represents a lower bound on the degree of improper enrollment in the income category of 100 percent to 150 percent FPL.

Table 3 illustrates that fraudulent enrollment is so acute in several states that there are more people signing up for exchange plans than could possibly be eligible, even under expansive assumptions that raise the number of potential enrollees. These states include Florida, Georgia, Texas, South Carolina, Mississippi, Utah, and North Carolina, but fraudulent enrollment is certainly occurring to a significant degree in many other states as well. The states with the most severe problems are all states that use HealthCare.gov, and most are states that did not expand Medicaid. Of the 20 states that have fewer than 20 percent of the 19-64 year old, 100 percent to 150 percent of the FPL population enrolling in exchange plans during open enrollment (from Table 3's calculation), 14 are states with state-based exchanges. For context, there are only 16 state-based exchange states in our analysis, as we have excluded Minnesota, New York, and the District of Columbia.[29]

### *Fraudulent Enrollment Much Greater in Non-Expansion States and HealthCare.gov States*

Table 4 shows the enrollment estimates broken down by expansion states and non-expansion states and states using the federal exchange (HealthCare.gov) and those states that established their own exchanges. The data clearly indicates that fraudulent enrollment is much more severe in states that did not expand Medicaid as well as in states that use the HealthCare.gov platform. As expected, the number of people misestimating their income is much greater in non-expansion states, as there is both an incentive for people above 200 percent FPL to report lower income and an incentive for people with income below 100 percent FPL to report higher income.

More surprising is that fraud is much greater in HealthCare.gov states. In states that used HealthCare.gov, 8.7 million sign-ups reported enrollment between 100 percent and 150 percent FPL compared to only 5.1 million people likely eligible for such coverage, or 1.7 sign-ups for every eligible person.

Unique deficiencies with HealthCare.gov are shown when controlling for whether states expanded Medicaid. All states with state-based exchanges did expand Medicaid, but many expansion states also used HealthCare.gov. Isolating the analysis to expansion states

28 Daniel Cruz and Greg Fann, "The Shortcomings of the ACA Exchanges: Far Less Enrollment at a Much Higher Cost," Paragon Health Institute, September 2023, https://paragoninstitute.org/wp-content/uploads/2023/11/Shortcomings-of-the-ACA-Cruz-Fann.pdf.

29 New Jersey and Virginia are the two state-based exchange states that do not satisfy this criteria.

## Table 4: Fraudulent Exchange Enrollment More Severe in Non-Medicaid-Expansion States and States Using HealthCare.gov

| State | Exchange Sign-Ups (1) | Total Potential Enrollees (2) | Percentage (1)/(2) | Total Potential Enrollees (Expansive Assumptions) (3) | Percentage (1)/(3) |
|---|---|---|---|---|---|
| HC.gov | 8,705,460 | 5,117,524 | 170.1% | 7,975,997 | 109.1% |
| Expansion and HC.gov | 1,812,767 | 2,174,064 | 83.4% | 3,939,756 | 46.0% |
| Non-expansion and HC.gov | 6,892,693 | 2,943,461 | 234.2% | 4,036,240 | 170.8% |
| SBE | 701,126 | 1,928,208 | 36.4% | 4,002,293 | 17.5% |
| Medicaid Expansion | 2,513,893 | 4,102,272 | 61.3% | 7,942,049 | 31.7% |
| Expansion and SBE | 701,126 | 1,928,208 | 36.4% | 4,002,293 | 17.5% |
| Expansion and HC.gov | 1,812,767 | 2,174,064 | 83.4% | 3,939,756 | 46.0% |

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File.

NOTES: Total potential enrollees are ages 19-64, including those who report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

excludes the states where fraudulent enrollment is severe. The percentage of open enrollment sign-ups reporting income between 100 percent and 150 percent FPL relative to all those ages 19-64 eligible for such coverage is more than twice as high in expansion states with HealthCare.gov than in expansion states with state-based exchanges.

Some state-based exchanges verify income using alternative data sources, such as state tax data.[30] In 2017, the Government Accountability Office reviewed processes in three states — Idaho, Maryland, and Rhode Island — to verify eligibility for APTCs and found "few indications of potentially improper enrollments."[31] States using alternative data or state-specific data to verify eligibility could contribute to observed differences in fraudulent enrollment between the federal and state-based exchanges.

Some of the differences appear to be in how states have handled the removal of Medicaid enrollees (the "unwinding" process) who were no longer eligible for that program after the conclusion of the public health emergency. For the duration of the public health emergency,

30 Tara Straw, "Final 2024 Payment Rule, Part 3: Exchange Operational Standards And APTC Policies," *Health Affairs Forefront*, April 21, 2023, https://www.healthaffairs.org/content/forefront/final-2024-payment-rule-part-3-exchange-operational-standards-and-aptc-policies.

31 U.S. Government Accountability Office, *State Health-Insurance Marketplaces: Three States Used Varied Data Sources for Eligibility and Had Few Indications of Potentially Improper Enrollments*, GAO-17-694, September 2017, https://www.gao.gov/assets/gao-17-694.pdf.

## Table 5: Ex-Medicaid Enrollees Far More Likely to Move to Exchange Plans in HealthCare.gov states (as of January 2024)

| Category | Federal Exchange | % of Removed from Medicaid/CHIP | State-Based Exchange | % of Removed from Medicaid/CHIP |
|---|---|---|---|---|
| All States | | | | |
| Removed from Medicaid/CHIP | 4,788,553 | | 2,936,872 | |
| Determined exchange eligible | 4,236,031 | 88% | 2,192,908 | 75% |
| Determined eligible for APTC | 3,759,747 | 79% | 1,282,878 | 44% |
| Consumers with a plan selection | 3,341,758 | 70% | 482,231 | 16% |
| Expansion States | | | | |
| Removed from Medicaid/CHIP | 2,084,714 | | 2,936,872 | |
| Determined exchange eligible | 1,795,737 | 86% | 2,192,908 | 75% |
| Determined eligible for APTC | 1,577,138 | 76% | 1,282,878 | 44% |
| Consumers with a plan selection | 1,417,478 | 68% | 482,231 | 16% |

SOURCES: CMS Unwinding Monthly Update Files. Most recent data is available for January 2024.

NOTES: Excludes DC, MN, and NY, and VA. VA is excluded because of data issues due to converting to SBE within the year. At the state level, SBE results widely vary, but are particularly driven by CA.

which lasted for more than three years, states did not remove enrollees from Medicaid regardless of whether they gained other coverage or earned income making them ineligible.[32]

As detailed in Table 5, according to CMS, 70 percent of individuals enrolled in Medicaid and CHIP at the start of the unwinding process were enrolled in an exchange plan when removed from Medicaid in HealthCare.gov states. In expansion states, this percentage was 68 percent — demonstrating that there was not a difference in this percentage overall based on whether states adopted Medicaid expansion or not. In contrast, in states with state-based exchanges, only 16 percent of people who lost Medicaid or CHIP during the unwinding were enrolled in an exchange plan. In states with state-based exchanges, a far lower percentage of enrollees was deemed eligible for PTCs and a far lower percentage of enrollees deemed eligible for PTCs enrolled in coverage. This data strongly suggests that HealthCare.gov eased the flow of people from Medicaid to the exchanges, potentially without proper verification, including through more fraudulent claims of income between 100 percent and 150 percent FPL.

32 Drew Gonshorowski, Brian Blase, and Niklas Kleinworth, "The Cost of Good Intentions: The Harm of Delaying the Disenrollment of Medicaid Ineligibles," Paragon Health Institute, July 2023, https://paragoninstitute.org/wp-content/uploads/2023/07/the-cost-of-good-intentions.pdf.

## *Examining the Population Between 138 Percent and 150 Percent FPL*

While the majority of this analysis focuses on incentives that occur for populations under 100 percent FPL, there is an incentive for people in expansion states to report income between 138 percent and 150 percent FPL in order to gain fully subsidized exchange plans. Table 6 presents similar findings to previous tables, focusing on people reporting income between 138 percent and 150 percent FPL. Plan sign-ups are calculated from the 2024 open enrollment files, and this table focuses on working-age adults (19-64) who do not report Medicaid or Medicare enrollment (and so corresponds to Table 1).

Regardless of expansion status, many states have more exchange sign-ups reporting income between 138 percent and 150 percent FPL than potentially eligible individuals in this income range. Utah is an outlier at more than four times as many people reporting income in this category than would be eligible. Twenty-two states have more people signing up who report income between 138 percent and 150 percent FPL than are potentially eligible.

Again, there is a drastic difference between federal exchange states and state-based exchange states in fraudulent enrollment rates — as noted in Table 7. In federal exchange states, sign-ups reporting income between 138 percent and 150 percent FPL are 155 percent of the eligible population. In states with state-based exchanges, sign-ups are 76 percent of the eligible population. In expansion states using HealthCare.gov, sign-ups who report income between 138 percent and 150 percent FPL are 177 percent of the eligible population. This implies that the misreporting of income is also a severe issue in expansion states, with the biggest fraud in those using HealthCare.gov.

## *Big Money for Insurers and Brokers*

The Biden administration has made a political decision to prioritize enrollment in public programs and neglect program integrity issues. For example, the administration extended the COVID public health emergency into the spring of 2023 to delay Medicaid redeterminations and removals.[33] This led to approximately 18 million ineligible Medicaid enrollees in March 2023.[34] The administration has created a continuous open enrollment period for the exchanges for people below 150 percent FPL.[35] As should be apparent from the analysis above, because half of exchange enrollees are claiming income below 150 percent FPL, this

33 President Joe Biden, "Continuation of the National Emergency Concerning the Coronavirus Disease 2019 (COVID-19) Pandemic," 88 Fed. Reg. 9385 (February 10, 2023), https://www.federalregister.gov/d/2023-03218.

34 Matthew Buettgens and Andrew Green, "The Impact of the COVID-19 Public Health Emergency Expiration on All Types of Health Coverage," Urban Institute, December 5, 2022, https://www.urban.org/research/publication/impact-covid-19-public-health-emergency-expiration-all-types-health-coverage.

35 CMS, "HHS Notice of Benefit and Payment Parameters for 2025 Final Rule," April 2, 2024, https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2025-final-rule.

# Table 6: Exchange Sign-Ups Reporting Income 138-150% FPL Compared to Total Potential Enrollees

| State | Platform | Expansion Status | Exchange Sign-Ups (1) | Total Potential Enrollees (2) | Percentage (1)/(2) |
|---|---|---|---|---|---|
| Alabama | HC.gov | Not Adopted | 35,892 | 45,380 | 79.1% |
| Alaska | HC.gov | Adopted | 1,214 | 2,595 | 46.8% |
| Arizona | HC.gov | Adopted | 85,621 | 52,861 | 162.0% |
| Arkansas | HC.gov | Adopted | 40,727 | 25,106 | 162.2% |
| California | SBE | Adopted | 191,029 | 179,304 | 106.5% |
| Colorado | SBE | Adopted | 10,754 | 29,431 | 36.5% |
| Connecticut | SBE | Adopted | 4,196 | 10,691 | 39.2% |
| Delaware | HC.gov | Adopted | 5,465 | 6,160 | 88.7% |
| Florida | HC.gov | Not Adopted | 462,458 | 175,008 | 264.2% |
| Georgia | HC.gov | Not Adopted | 124,074 | 89,563 | 138.5% |
| Hawaii | HC.gov | Adopted | 1,888 | 10,525 | 17.9% |
| Idaho | SBE | Adopted | 5,362 | 16,655 | 32.2% |
| Illinois | HC.gov | Adopted | 75,082 | 63,636 | 118.0% |
| Indiana | HC.gov | Adopted | 79,886 | 40,403 | 197.7% |
| Iowa | HC.gov | Adopted | 18,114 | 15,702 | 115.4% |
| Kansas | HC.gov | Not Adopted | 16,614 | 20,181 | 82.3% |
| Kentucky | SBE | Adopted | 5,710 | 26,170 | 21.8% |
| Louisiana | HC.gov | Adopted | 68,566 | 31,425 | 218.2% |
| Maine | SBE | Adopted | 2,832 | 5,762 | 49.1% |
| Maryland | SBE | Adopted | 11,895 | 25,591 | 46.5% |
| Massachusetts | SBE | Adopted | 14,134 | 21,937 | 64.4% |
| Michigan | HC.gov | Adopted | 90,585 | 43,078 | 210.3% |
| Mississippi | HC.gov | Not Adopted | 28,905 | 25,822 | 111.9% |
| Missouri | HC.gov | Adopted | 106,913 | 49,044 | 218.0% |
| Montana | HC.gov | Adopted | 5,792 | 7,574 | 76.5% |
| Nebraska | HC.gov | Adopted | 17,479 | 20,148 | 86.8% |
| Nevada | SBE | Adopted | 11,732 | 25,180 | 46.6% |
| New Hampshire | HC.gov | Adopted | 5,994 | 4,764 | 125.8% |
| New Jersey | SBE | Adopted | 32,762 | 33,289 | 98.4% |
| New Mexico | SBE | Adopted | 2,807 | 9,422 | 29.8% |
| North Carolina | HC.gov | Adopted | 168,594 | 79,020 | 213.4% |
| North Dakota | HC.gov | Adopted | 2,426 | 3,073 | 78.9% |
| Ohio | HC.gov | Adopted | 117,548 | 55,245 | 212.8% |
| Oklahoma | HC.gov | Adopted | 77,306 | 38,379 | 201.4% |
| Oregon | HC.gov | Adopted | 8,160 | 21,420 | 38.1% |
| Pennsylvania | SBE | Adopted | 37,821 | 65,519 | 57.7% |
| Rhode Island | SBE | Adopted | 2,148 | 3,935 | 54.6% |
| South Carolina | HC.gov | Not Adopted | 48,395 | 41,080 | 117.8% |
| South Dakota | HC.gov | Adopted | 4,313 | 6,071 | 71.0% |
| Tennessee | HC.gov | Not Adopted | 49,375 | 55,420 | 89.1% |
| Texas | HC.gov | Not Adopted | 281,332 | 289,384 | 97.2% |
| Utah | HC.gov | Adopted | 81,644 | 19,748 | 413.4% |
| Vermont | SBE | Adopted | 1,387 | 592 | 234.4% |
| Virginia | SBE | Adopted | 54,018 | 40,812 | 132.4% |
| Washington | SBE | Adopted | 16,396 | 37,046 | 44.3% |
| West Virginia | HC.gov | Adopted | 12,529 | 10,409 | 120.4% |
| Wisconsin | HC.gov | Not Adopted | 17,827 | 32,866 | 54.2% |
| Wyoming | HC.gov | Not Adopted | 1,715 | 4,556 | 37.6% |
| TOTAL | | | 2,547,416 | 1,916,982 | 132.9% |

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File.

NOTES: Total potential enrollees are ages 19-64 and do not report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

## Table 7: Exchange Enrollment Fraud of 138-150% FPL Enrollees More Severe in States Using HealthCare.gov

| State | Exchange Sign-Ups (1) | Total Potential Enrollees (2) | Percentage (1)/(2) |
|---|---|---|---|
| HC.gov | 2,142,433 | 1,385,646 | 154.6% |
| Expansion and HC.gov | 1,075,846 | 606,387 | 177.4% |
| Non-expansion and HC.gov | 1,066,587 | 779,260 | 136.9% |
| SBE | 404,983 | 531,335 | 76.2% |
| Medicaid Expansion | 1,480,829 | 1,137,722 | 130.2% |
| Expansion and SBE | 404,983 | 531,335 | 76.2% |
| Expansion and HC.gov | 1,075,846 | 606,387 | 177.4% |

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File.

NOTES: Total potential enrollees are ages 19-64 and do not report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

open enrollment period is almost certainly subject to widespread abuse. The administration has also been sympathetic to self-attestation rather than verification of information.[36]

In 2021, a federal district court stopped four provisions of the 2019 Notice of Benefit and Payment Parameters (NBPP),[37] which would have required people to submit additional information to verify their income if they reported income above the FPL and administrative data suggests that their income is below that level.[38] In *City of Columbus, et al. v. Norris Cochran*, the cities of Columbus, Baltimore, Cincinnati, Chicago, and Philadelphia (along with two individuals) sued the federal government, alleging that the 2019 NBPP would harm enrollees and that the Trump administration was working to undercut the exchanges.[39] The court sided with the plaintiffs and effectively gutted income verification requirements for low-income exchange enrollees. This court decision — combined with no subsidy recapture for enrollees below 100 percent FPL and incentives facing brokers and insurers — set the stage for substantial improper spending.

36 CMS, "2024 Notice of Benefit and Payment Parameters," https://www.cms.gov/files/document/cms-9899-f-patient-protection-final.pdf; CMS, "Streamlining Medicaid and CHIP, Final Rule, Fact Sheet," September 18, 2023, https://www.cms.gov/newsroom/fact-sheets/streamlining-medicaid-and-chip-final-rule-fact-sheet.

37 The four provisions vacated by the decision in *City of Columbus, et al. v. Norris Cochran* included "Federal Review of Network Adequacy," "Income Verification," "Standardized Options," and "Medical Loss Ratio."

38 CMS, HHS; Monetary Offices, Department of the Treasury, "Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond," 86 FedReg 24,216. https://www.federalregister.gov/documents/2021/09/27/2021-20509/patient-protection-and-affordable-care-act-updating-payment-parameters-section-1332-waiver.

39 City of Columbus, et. al. v. Norris Cochran, in his official capacity as Acting Secretary of the Department of HHS, et al., https://democracyforward.org/wp-content/uploads/2021/03/Columbus-et-al.-v.-Trump.pdf.

A primary beneficiary of the surge in improper enrollment from people misestimating their income are health insurers. The larger subsidies mean that consumers are less sensitive to prices of plans, so more of them enroll. It is also much easier to collect subsidies from the U.S. Treasury than premiums from customers. Because roughly half of enrollees have fully subsidized plans, the cost to enrollees is only the paperwork burden. This means that people have incentives to enroll even if they receive very low benefit from the plan. Worse, given automatic re-enrollment, many people might be enrolled for a second year when they already have other coverage, have moved out of state, or have passed away. For re-enrollees in all states, 32.8 percent were automatically re-enrolled in coverage in 2024.[40] All this leads to large payments to health insurers on behalf of many people who are likely receiving low value or no value from the coverage.

Importantly, the insurers are held harmless when people are enrolled receiving larger subsidies than what they were entitled to. Even though the payment goes directly from the U.S. Treasury to the insurer, the payment is effectively a PTC for the enrollee. So, the liability, which is limited for most enrollees who underestimate income (and nonexistent for enrollees with less than 100 percent FPL), is on the enrollees when they reconcile their taxes (assuming that they file their taxes). Insurers have significant financial upside from improper enrollment aimed at maximizing subsidies.

Some private brokers are likely making the problem of fraudulent enrollment worse. These entities have contracts with insurers, and these contracts require the insurers pay them a commission for each enrollee. Some brokers have come under increased scrutiny the past few months for changing the agent of record to capture other agents' commissions, enrolling people without their knowledge, and canceling exchange enrollee coverage and re-enrolling people in different plans to earn higher commissions.[41]

Unscrupulous broker behavior is also made easier in federal exchange states. Julie Appleby's reporting for KFF on unauthorized plan switching highlighted that brokers need very little information to access individuals' accounts.[42] If the broker is registered on HealthCare.gov, all they need is a name, date of birth, and state of residence to enroll an individual into coverage. Additionally, HealthCare.gov lacks basic consumer protections, such as two-factor authentication, and it does not notify enrollees when changes occur to their accounts. Furthermore, any broker or agent can get access to the account of any enrollee for whom the name, date of birth and state enrolled is available regardless of the enrollment platform used,

40 CMS, "2024 OEP State, Metal Level, and Enrollment Status Public Use File," https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2024-marketplace-open-enrollment-period-public-use-files.

41 Julie Appleby, "Rising Complaints of Unauthorized Obamacare Plan-Switching and Sign-Ups Trigger Concern," *KFF Health News*, April 8, 2024, https://kffhealthnews.org/news/article/aca-unauthorized-obamacare-plan-switching-concern/.

42 Appleby, "Rising Complaints."

including HealthCare.gov and direct enrollment platforms. On direct enrollment platforms, the user is redirected to HealthCare.gov. However, on enhanced direct enrollment platforms, an enrollment entity hosts a version of HealthCare.gov's eligibility application and integrates directly with the back-end suite of federal exchange interfaces.[43] The coupling of these improper safeguards with fully subsidized plans means that enrollees can be signed up or have their coverage switched without their knowledge. Prior to fully subsidized plans, the vast majority of enrollees paid some premium each month and would have had a much greater opportunity to know if they were switched.

On May 20, 2024, the Chairman of the Senate Finance Committee Ron Wyden sent a letter to the CMS Administrator Chiquita Brooks-LaSure expressing his "outrage with reports that agents and brokers are submitting plan changes and enrollments in the Federal marketplace without the consent of the people who rely on these plans."[44] Chairman Wyden criticized enhanced web-broker platforms, alleging that "bad actors with access to a consumer's eligibility information through web-broker platforms can make plan and agent-of-record changes while keeping people and their legitimate brokers in the dark."[45]

An additional example of unscrupulous behavior by brokers and agents includes fraudulently signing up homeless people.[46] Law-abiding brokers are harmed by unscrupulous broker behavior and recently filed a complaint against brokers they allege to be stealing their commissions.[47] The fraudsters are likely a small percentage of brokers, but they could still be having a large impact given the plethora of fully taxpayer-subsidized plans where enrollees have little, if any, incentive to pay attention to coverage changes.

According to a CMS presentation to brokers, agents and brokers assisted over 6.8 million enrollments during the 2023 open enrollment period. Direct enrollment and enhanced direct enrollment accounted for 81 percent of all active agent-and broker-assisted plan selections, or 5.5 million plan selections. CMS highlighted that data matching issues were over twice as likely to occur under agent-and broker-assisted enrollments. In fact, 16 percent of those who worked with agents or brokers submitted exchange applications that did not include Social Security Numbers versus less than one percent of consumers who self-enrolled.[48]

43 CMS, "Direct Enrollment and Enhanced Direct Enrollment," https://www.cms.gov/marketplace/agents-brokers/direct-enrollment-partners.

44 United States Senator Ron Wyden, "Wyden Letter to CMS on Brokers" May 20, 2024, https://www.finance.senate.gov/imo/media/doc/wyden_letter_to_cms_on_brokerspdf.pdf.

45 Ibid.

46 Daniel Chang, "Florida Homeless People Duped Into Affordable Care Act Plans They Can't Afford," *Tampa Bay Times*, June 12, 2023, https://www.tampabay.com/news/florida-politics/2023/06/12/florida-homeless-people-duped-into-affordable-care-act-plans-they-cant-afford/

47 Appleby, "Rising Complaints."

48 CMS, "Welcome to the 2023 Agent and Broker Summit," May 24, 2023, https://www.cms.gov/files/document/ab-summit-2023-welcome-slides.pdf.

Heath care "navigators," who work at nonprofit entities, may also be complicit in encouraging misestimates of income, with some likely seeing it as consistent with their purpose and ideological aims to enroll as many people as possible in coverage, knowing that estimating income to maximize subsidies has little downside for people. In 2013, the House Committee on Oversight and Government Reform issued a scathing report on navigators, including a concerning section related to lax protocols to prevent tax fraud.[49]

## RECOMMENDATIONS

As discussed by Theo Merkel and Brian Blase in *Follow the Money: How Tax Policy Shapes Health Care*, enormous problems result from the widespread availability of fully subsidized plans, and this data analysis provides more evidence for the magnitude of resulting waste, fraud, and abuse.[50] The most important way that Congress can mitigate this problem, protect enrollees from unauthorized plan enrollment and switching, ensure that coverage provides at least a modicum of value to enrollees, and protect taxpayers is to let the enhanced PTCs expire after 2025.

Second, Congress should raise the subsidy recapture limits so that there are not large incentives for people to misestimate their income, and Congress should put a portion of the liability on entities that gain from improper enrollment — insurers and brokers — for repaying ill-gotten PTCs. As Senator Wyden recently recommended, brokers who are knowingly working with people to manipulate information to maximize subsidies should also be held criminally liable. And states should suspend their licenses.

Third, Congress or the next administration should limit automatic re-enrollment into exchange plans from one year to the next and end it for people moving from or into fully taxpayer-subsidized plans.

Fourth, as outlined by Merkel and Blase, Congress should appropriate cost-sharing reduction payments and prohibit silver-loading, which has significantly increased PTC amounts.[51] Doing so would reduce the benchmark plan premium and PTCs, returning to a more sensible structure for the overall ACA subsidy structure.

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49 U.S. Congress, House Committee on Oversight and Government Reform, *Risks of Fraud and Misinformation with ObamaCare Outreach Campaign: How Navigator and Assister Program Mismanagement Endangers Consumers*, majority staff report, December 16, 2013, https://oversight.house.gov/wp-content/uploads/2013/12/Navigator-Report-Number-Two-12-13-13.pdf.

50 Theo Merkel and Brian Blase, "Follow the Money: How Tax Policy Shapes Health Care," Paragon Health Institute, May 2024, https://paragoninstitute.org/private-health/follow-the-money-how-tax-policy-shapes-health-care/.

51 Silver-loading is the practice of loading the cost of CSRs onto the silver plans when the Trump administration complied with a federal court ruling that there was no valid congressional appropriation for the CSR payments.

Fifth, Congress should conduct aggressive oversight of both the Biden administration's management of HealthCare.gov, enhanced direct enrollment, and insurer and broker actions. Congress should ask the Joint Committee on Taxation and Treasury what percentage of people overestimate their income, what percentage of people underestimate their income, and how much PTC is improperly expended by year. Congress should require CMS to provide more information on navigators, particularly with respect to the information navigators are providing related to the large subsidies available for people with income between 100 percent and 150 percent FPL. Congress should also require CMS to provide information on data matching issues by platform.

Sixth, Congress or the next administration should reverse policies of the Biden administration that enabled such widespread fraudulent enrollment, particularly the continuous open-enrollment period for people who report they have income below 150 percent FPL.

# APPENDIX

Appendix Tables 1 and 2 correspond to Tables 1 and 3 but display the information for sign-ups reporting income between 100 percent and 200 percent FPL. There is not as significant an incentive for people to report income between 150 percent and 200 percent FPL, because those enrollees are not eligible for fully subsidized benchmark plans. However, some people who expect income well above 200 percent FPL and who may not wish to exaggerate their income to such a large degree to report it under 150 percent FPL may be amenable to reporting it under 200 percent FPL to get both large subsidies for the premium and qualify for the CSR program, which significantly reduces deductibles and copayments to hit an 87 percent actuarial value.

Appendix Tables 1 and 2 continue to show severe fraudulent enrollment problems, again concentrated largely in Sunbelt states along with Utah. The fraudulent enrollment problem appears concentrated in states that did not adopt Medicaid expansion as well as states using the HealthCare.gov platform.

# Appendix Table 1: Exchange Sign-Ups Reporting Income 100-200% FPL Compared to Total Potential Enrollees

| State | Platform | Expansion Status | Exchange Sign-Ups (1) | Total Potential Enrollees (2) | Percentage (1)/(2) |
|---|---|---|---|---|---|
| Alabama | HC.gov | Not Adopted | 292,425 | 360,379 | 81.1% |
| Alaska | HC.gov | Adopted | 6,640 | 26,638 | 24.9% |
| Arizona | HC.gov | Adopted | 188,459 | 412,970 | 45.6% |
| Arkansas | HC.gov | Adopted | 94,348 | 188,691 | 50.0% |
| California | SBE | Adopted | 717,031 | 1,625,750 | 44.1% |
| Colorado | SBE | Adopted | 51,200 | 252,280 | 20.3% |
| Connecticut | SBE | Adopted | 34,783 | 109,099 | 31.9% |
| Delaware | HC.gov | Adopted | 17,541 | 37,630 | 46.6% |
| Florida | HC.gov | Not Adopted | 3,322,479 | 1,538,613 | 215.9% |
| Georgia | HC.gov | Not Adopted | 1,029,624 | 775,744 | 132.7% |
| Hawaii | HC.gov | Adopted | 7,501 | 63,185 | 11.9% |
| Idaho | SBE | Adopted | 32,244 | 124,126 | 26.0% |
| Illinois | HC.gov | Adopted | 194,237 | 548,965 | 35.4% |
| Indiana | HC.gov | Adopted | 175,041 | 354,519 | 49.4% |
| Iowa | HC.gov | Adopted | 45,930 | 142,404 | 32.3% |
| Kansas | HC.gov | Not Adopted | 110,544 | 195,669 | 56.5% |
| Kentucky | SBE | Adopted | 27,107 | 212,396 | 12.8% |
| Louisiana | HC.gov | Adopted | 142,313 | 238,496 | 59.7% |
| Maine | SBE | Adopted | 15,358 | 59,355 | 25.9% |
| Maryland | SBE | Adopted | 64,343 | 226,305 | 28.4% |
| Massachusetts | SBE | Adopted | 90,454 | 174,445 | 51.9% |
| Michigan | HC.gov | Adopted | 206,518 | 445,267 | 46.4% |
| Mississippi | HC.gov | Not Adopted | 255,396 | 235,938 | 108.2% |
| Missouri | HC.gov | Adopted | 239,119 | 385,638 | 62.0% |
| Montana | HC.gov | Adopted | 21,240 | 61,983 | 34.3% |
| Nebraska | HC.gov | Adopted | 45,298 | 117,491 | 38.6% |
| Nevada | SBE | Adopted | 44,723 | 199,137 | 22.5% |
| New Hampshire | HC.gov | Adopted | 19,616 | 40,937 | 47.9% |
| New Jersey | SBE | Adopted | 154,391 | 341,533 | 45.2% |
| New Mexico | SBE | Adopted | 17,670 | 105,841 | 16.7% |
| North Carolina | HC.gov | Adopted | 671,971 | 701,467 | 95.8% |
| North Dakota | HC.gov | Adopted | 12,021 | 40,112 | 30.0% |
| Ohio | HC.gov | Adopted | 266,876 | 528,940 | 50.5% |
| Oklahoma | HC.gov | Adopted | 185,990 | 299,447 | 62.1% |
| Oregon | HC.gov | Adopted | 34,211 | 189,439 | 18.1% |
| Pennsylvania | SBE | Adopted | 174,885 | 495,748 | 35.3% |
| Rhode Island | SBE | Adopted | 14,617 | 35,624 | 41.0% |
| South Carolina | HC.gov | Not Adopted | 386,973 | 349,974 | 110.6% |
| South Dakota | HC.gov | Adopted | 18,429 | 57,492 | 32.1% |
| Tennessee | HC.gov | Not Adopted | 397,837 | 481,722 | 82.6% |
| Texas | HC.gov | Not Adopted | 2,620,488 | 2,407,750 | 108.8% |
| Utah | HC.gov | Adopted | 196,804 | 201,827 | 97.5% |
| Vermont | SBE | Adopted | 8,223 | 17,204 | 47.8% |
| Virginia | SBE | Adopted | 187,426 | 370,053 | 50.6% |
| Washington | SBE | Adopted | 77,930 | 292,879 | 26.6% |
| West Virginia | HC.gov | Adopted | 28,835 | 88,182 | 32.7% |
| Wisconsin | HC.gov | Not Adopted | 105,983 | 266,700 | 39.7% |
| Wyoming | HC.gov | Not Adopted | 14,416 | 38,451 | 37.5% |
| TOTAL | | | 13,067,488 | 16,464,434 | 79.4% |

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File

NOTES: Total potential enrollees are ages 19-64 and do not report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

## Appendix Table 2: Exchange Sign-Ups Reporting Income 100-200% FPL Compared to Total Potential Enrollees (Expansive Assumptions)

| State | Platform | Expansion Status | Exchange Sign-Ups (1) | Total Potential Enrollees (Expansive Assumptions) (2) | Percentage (1)/(2) |
|---|---|---|---|---|---|
| Alabama | HC.gov | Not Adopted | 292,425 | 487,293 | 60.0% |
| Alaska | HC.gov | Adopted | 6,640 | 51,644 | 12.9% |
| Arizona | HC.gov | Adopted | 188,459 | 632,395 | 29.8% |
| Arkansas | HC.gov | Adopted | 94,348 | 321,353 | 29.4% |
| California | SBE | Adopted | 717,031 | 3,134,648 | 22.9% |
| Colorado | SBE | Adopted | 51,200 | 402,109 | 12.7% |
| Connecticut | SBE | Adopted | 34,783 | 223,522 | 15.6% |
| Delaware | HC.gov | Adopted | 17,541 | 63,856 | 27.5% |
| Florida | HC.gov | Not Adopted | 3,322,479 | 2,015,717 | 164.8% |
| Georgia | HC.gov | Not Adopted | 1,029,624 | 973,526 | 105.8% |
| Hawaii | HC.gov | Adopted | 7,501 | 97,742 | 7.7% |
| Idaho | SBE | Adopted | 32,244 | 187,283 | 17.2% |
| Illinois | HC.gov | Adopted | 194,237 | 905,757 | 21.4% |
| Indiana | HC.gov | Adopted | 175,041 | 570,590 | 30.7% |
| Iowa | HC.gov | Adopted | 45,930 | 239,033 | 19.2% |
| Kansas | HC.gov | Not Adopted | 110,544 | 236,748 | 46.7% |
| Kentucky | SBE | Adopted | 27,107 | 414,762 | 6.5% |
| Louisiana | HC.gov | Adopted | 142,313 | 467,247 | 30.5% |
| Maine | SBE | Adopted | 15,358 | 105,913 | 14.5% |
| Maryland | SBE | Adopted | 64,343 | 375,718 | 17.1% |
| Massachusetts | SBE | Adopted | 90,454 | 409,553 | 22.1% |
| Michigan | HC.gov | Adopted | 206,518 | 814,776 | 25.3% |
| Mississippi | HC.gov | Not Adopted | 255,396 | 309,883 | 82.4% |
| Missouri | HC.gov | Adopted | 239,119 | 522,761 | 45.7% |
| Montana | HC.gov | Adopted | 21,240 | 104,053 | 20.4% |
| Nebraska | HC.gov | Adopted | 45,298 | 160,605 | 28.2% |
| Nevada | SBE | Adopted | 44,723 | 295,567 | 15.1% |
| New Hampshire | HC.gov | Adopted | 19,616 | 70,630 | 27.8% |
| New Jersey | SBE | Adopted | 154,391 | 555,446 | 27.8% |
| New Mexico | SBE | Adopted | 17,670 | 205,929 | 8.6% |
| North Carolina | HC.gov | Adopted | 671,971 | 946,754 | 71.0% |
| North Dakota | HC.gov | Adopted | 12,021 | 54,807 | 21.9% |
| Ohio | HC.gov | Adopted | 266,876 | 927,552 | 28.8% |
| Oklahoma | HC.gov | Adopted | 185,990 | 411,818 | 45.2% |
| Oregon | HC.gov | Adopted | 34,211 | 343,876 | 9.9% |
| Pennsylvania | SBE | Adopted | 174,885 | 879,693 | 19.9% |
| Rhode Island | SBE | Adopted | 14,617 | 67,232 | 21.7% |
| South Carolina | HC.gov | Not Adopted | 386,973 | 472,516 | 81.9% |
| South Dakota | HC.gov | Adopted | 18,429 | 69,076 | 26.7% |
| Tennessee | HC.gov | Not Adopted | 397,837 | 663,105 | 60.0% |
| Texas | HC.gov | Not Adopted | 2,620,488 | 2,893,779 | 90.6% |
| Utah | HC.gov | Adopted | 196,804 | 251,364 | 78.3% |
| Vermont | SBE | Adopted | 8,223 | 39,829 | 20.6% |
| Virginia | SBE | Adopted | 187,426 | 572,620 | 32.7% |
| Washington | SBE | Adopted | 77,930 | 491,832 | 15.8% |
| West Virginia | HC.gov | Adopted | 28,835 | 171,353 | 16.8% |
| Wisconsin | HC.gov | Not Adopted | 105,983 | 423,367 | 25.0% |
| Wyoming | HC.gov | Not Adopted | 14,416 | 46,997 | 30.7% |
| TOTAL | | | 13,067,488 | 25,083,628 | 52.1% |

SOURCES: American Community Survey 2022 1-year PUMS file and 2024 Open Enrollment File.

NOTES: Total potential enrollees are ages 19-64, including those who report Medicaid or Medicare coverage. NY, MN and DC are excluded from this analysis. NY and MN both have Basic Health Programs and do not provide detailed income information. DC is omitted because the majority share of plan selections in DC do not have income information recorded. The ACS data is adjusted to account for population growth, but this adjustment might not fully account for changes in distribution by FPL by state.

**UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF MARYLAND**

| | |
|---|---|
| CITY OF COLUMBUS, *et al.*,<br><br>Plaintiffs,<br><br>v.<br><br>ROBERT F. KENNEDY, JR., in his official capacity as Secretary of the United States Department of Health and Human Services, *et al.*,<br><br>Defendants. | Civil Action No. 1:25-cv-2114-BAH |

**NOTICE OF APPEAL**

Defendants hereby appeal to the United States Court of Appeals for the Fourth Circuit from the Court's June 12, 2026 Memorandum Opinion (ECF No. 73) and Order (ECF No. 74), as amended on June 16, 2026 (ECF No. 76), granting Plaintiffs' motion for summary judgment in part and vacating provisions of the Patient Protection and Affordable Care Act Marketplace Integrity and Affordability Rule.

Dated: July 16, 2026

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