April 11, 2025

Dr. Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
Department of Health & Human Services

Submitted via regulations.gov.

RE: "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability"

Dear Administrator Oz,

United States of Care (USofCare) is pleased to submit comments in response to the "Marketplace Integrity and Affordability Proposed Rule" issued by the Centers for Medicare & Medicaid Services (CMS). USofCare is a nonpartisan, nonprofit organization working to ensure that everyone has access to quality, affordable health care regardless of health status, social need, or income. Importantly, we are committed to improving the health of everyday people and are eager to engage in solutions that do just that. We advocate for new solutions to tackle our shared health care challenges — solutions that people of every demographic tell us will bring them peace of mind and make a positive impact on their lives. Through our work in the states and listening to people's experiences with the health care system, we are able to identify unique insights from patients on the ground to amplify for uptake at the federal level.

We know that affordability and dependability are top of mind when people think about their needs to achieve optimal health, and thus appreciate that the goals of the proposed rule are to lower premiums and increase access to care. However, we are concerned that these changes, if finalized, would result in inefficiencies and increased costs across the system, largely driven by policies that could jeopardize people's access to care and drive up uncompensated care in the process. We share the goal of people being as healthy as they can and recognize that access to health care and coverage is a key part of achieving that aim. With this in mind, USofCare focuses our comments around the three following themes:

I. The Proposed Changes Erect Barriers to Affordable Coverage, Jeopardizing Overall Health
II. The Proposed Changes Introduce Market Instability and Risk Dependable Coverage for Consumers
III. The Proposed Changes Restrict State Innovation Under Essential Health Benefits

The Proposed Changes Erect Barriers to Affordable Coverage, Jeopardizing Overall Health

We know from our listening work that people's number one concern with health care is affordability. In 2023, 28% of U.S. adults reported that they skipped or delayed care due to cost, with uninsured adults, Black and Hispanic adults, and adults in worse health especially more likely to do so. Skipping and delaying coverage not only leads to worsened health outcomes, but adds tremendous financial strain onto the health care system at large, estimated to be upwards of $150 billion annually. Because of this, USofCare urges CMS to reconsider the provisions of the proposed rule that will make coverage more expensive for people and families. **USofCare urges CMS to:**

- **Uphold the current de minimis requirements instead of making the proposed updates to widen them.** If CMS finalizes widening de minimis standards, it will lead to lower-value plans and increase out-of-pocket spending for consumers, ultimately hampering CMS's goal of affordable coverage. Expanding the de minimis ranges blurs the lines around metal levels, diminishing the purpose of having a metal level tiering system to simplify consumer choice when we know that consumers want coverage they can easily understand.
- **Maintain premium threshold updates in current policy, set forth in the 2026 Notice of Benefit and Payment Parameters.** If CMS finalizes proposals that seek to eliminate gross premium percentage-based and fixed-dollar premium payment thresholds, it will threaten consumers' ability to remain enrolled in coverage, thus adding to the uninsured rate and driving increased costs through uncompensated care. Recent history reveals what harmful impact this can have on affordable coverage for people.
- **Abandon its proposed $5 re-enrollment penalty.** If CMS finalizes a proposal to penalize consumers who are automatically re-enrolled without updating their eligibility information with a $5 monthly premium until it is updated, this will trigger an administratively burdensome and expensive process to manage. Further, research indicates that any form of cost-sharing, even as little as a dollar or two, encourages consumers to delay or skip care altogether, which can add costs to the system in the long run as chronic conditions and diseases are left unaddressed and to worsen over time.

The Proposed Changes Introduce Market Instability and Risk Dependable Coverage for Consumers

In addition to wanting care that they can afford and understand, we know that people strongly desire the security and freedom that dependable health coverage provides through life's changes. Because of this, USofCare is concerned that several provisions in this proposed rule could make health care coverage less reliable and add cost burdens on states. Specifically, USofCare urges CMS to:

- **Discard its proposal to require pre-enrollment verification for special enrollment period (SEP) eligibility for the federal Marketplace and its requirement on state-based marketplaces (SBMs) to verify eligibility for at least 75% of new enrollments through SEPs.** This policy adds unnecessary complexity and administrative burden that erects barriers to coverage for consumers, making care less dependable. This proposed policy undermines the risk pool, too, as studies show that healthier individuals are less likely to follow through with completing eligibility check processes. If finalized, it will warp the risk pool, making the Marketplace more susceptible to steep premium increases and market instability.
- **Maintain the duration of the current Open Enrollment Period (OEP).** Shortening the window by more for OEP will increase implementation costs for state-based exchanges — CMS estimates that it will take SBMs an average of 4,000 hours to implement the OEP change, with an aggregate cost across all SBMs of $7,786,000. A shorter enrollment period could also lead to adverse selection, as younger, healthier individuals tend to enroll later than those most in need, who enroll earlier, leading to higher risk pools.
- **Reconsider its current proposal to eliminate the SEP for individuals at or below 150% FPL.** USofCare supported the provisions in the 2025 NBPP that maintained the monthly SEP, allowing eligible enrollees at or below 150% of the FPL to

receive coverage the first day of the following month, regardless of when in the previous month they enrolled. Rescinding this SEP would increase coverage gaps, leading to consumer confusion about coverage options and likely driving more individuals to become uninsured. Further, CMS asserts within the proposed that no SBMs offer the low-income SEP, even though all SBMs – with the exception of Idaho and Nebraska – offer it to consumers. If affordable coverage is a stated aim of the proposed rule, this policy will undermine consumers' need for dependable coverage and create administrative burden on states.

The Proposed Changes Restrict State Innovation Under Essential Health Benefits

USofCare has long recognized the unique role states play in proposing and enacting creative and innovative policies to address many of our nation's most pressing health policy challenges. Since its founding, USofCare has provided technical support to states and supported state-level policymakers and advocates in advancing durable policy change that often acts as a template for the federal government to implement. As a result, USofCare urges CMS to:

- **Maintain flexibility for states to expand access to comprehensive health benefits under the Essential Health Benefits (EHBs), not restrict them.** States have used this opportunity to adapt the EHB requirements to fit their own needs, such as to cover autism therapies in South Dakota or in opioid misuse in Michigan, which were both approved by this administration during its first term. Instead of allowing states to use the EHB benchmark process to expand access to comprehensive health benefits, this proposed rule would, for the first time ever, restrict a state's ability to set its own standards and limit the opportunity to structure a benchmark that best meets the needs of its residents. What's more, this proposal could raise costs and establish barriers to care for people who require specialized care in a state's population. We urge the administration to withdraw this proposal to ensure that states have the flexibility to best address the needs of their citizens.

Conclusion

Thank you for the opportunity to respond to the proposed rule. Please reach out to Orla Levens, Federal Policy & Advocacy Coordinator, at olevens@usofcare.org with any questions.

Sincerely,

Lisa Hunter
Senior Director for Federal Policy & Advocacy
United States of Care