Congress of the United States
Washington, DC 20515

April 11, 2025

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Re: CMS Marketplace Integrity and Affordability Proposed Rule, CMS-9884-P

Dear Secretary Kennedy and Administrator Oz:

We write to express our alarm regarding the detrimental impact the harmful policies included in the 2025 Marketplace Integrity and Affordability Proposed Rule (the Proposed Rule), released on March 10, 2025, will have on millions of hard-working Americans.[1] The Trump Administration is proposing policies that, by its own estimates, will raise premiums by almost $3 billion over the next four years and result in two million Americans losing coverage through the Marketplaces in 2026; even that may be an underestimate, given the $364 million in administrative burden consumers will face.[2] As these policies threaten access to health care services for millions of Americans, we call on you to withdraw the Proposed Rule immediately and cease all other efforts to sabotage the *Affordable Care Act* (ACA). This Proposed Rule is detrimental to all Americans who purchase health coverage on their own by 1) threatening access to coverage, 2) making it harder for people to enroll, and 3) increasing consumer costs.

The Proposed Rule takes away insurance from working Americans

Policies in the Proposed Rule will result in two million Americans who purchase insurance on their own losing coverage through the Marketplaces in 2026—on top of the nearly four million Americans who will lose coverage if Republicans in Congress fail to extend the

[1] Department of Health and Human Services, Center for Medicare and Medicaid Services, *Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability,* 90 Fed. Reg. 12942 (Mar. 19, 2025) (proposed rule).

[2] *Id.* at 13018; *Id.* at 13002; *Id.* at 13003; *Id.* at 12945.

enhanced tax credits available until the end of this year under the Inflation Reduction Act.[3] In fact, as noted in the Proposed Rule, "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."[4] Such coverage losses are expected to particularly hit nine states—Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Utah—resulting from:

1. New restrictions on the lowest income individuals purchasing coverage on their own (largely in states that did not expand Medicaid);

2. New bureaucratic red tape; and

3. Increased out-of-pocket costs resulting from policies that reduce financial help, raise premiums, and harm the risk pool.

These changes are self-imposed policy choices the Administration is making in the name of "fraud" and are both wrong and harmful to millions of people.

The Proposed Rule makes it harder for individuals and families purchasing coverage on their own to access coverage

The Proposed Rule adds red tape to enrolling in coverage—more than *six million* hours of paperwork.[5] New income verification rules and restrictions on enrollment mean that lower income individuals will no longer be able to access coverage in states that did not expand Medicaid. Specifically, we oppose the following policies.

Shortening the open enrollment period

The proposal to shorten the annual open enrollment period by one month will undermine enrollment and destabilize the individual market that millions of Americans rely on. Longer open enrollment periods increase access to quality health coverage by ensuring individuals have the opportunity to assess their needs and enroll in the right plan.[6] The proposal to shorten the open-enrollment period fits within a pattern of Administration efforts to depress enrollment and

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[3] Letter from Phillip L. Swagel, Director, Congressional Budget Office, to Sen. Ron Wyden, Chairman, Senate Committee on Finance; Rep. Richard Neal, Ranking Member, House Committee on Ways and Means; Sen. Jeanne Shaheen; Rep. Lauren Underwood (Dec. 5, 2024).

[4] Department of Health and Human Services, Center for Medicare and Medicaid Services, *Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability,* 90 Fed. Reg. 12942 at 13025 (Mar. 19, 2025) (proposed rule).

[5] *Id.* at 13003.

[6] 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).

sabotage the ACA. Just two months ago, the Administration announced its decision to cut funding for the ACA Navigator program by approximately 90 percent.[7] The ACA's Navigator program provides funding to nonprofits and health care organizations to promote awareness and provide in-person assistance to consumers with Marketplace enrollment. Shortening the open enrollment period coupled with drastic reduction in Navigator funding will depress Marketplace enrollment and raise premiums for millions of consumers.[8]

Eliminating special enrollment periods that help low-income families

The proposal to eliminate the Biden Administration policy establishing a monthly special enrollment period (SEP) for individuals at or below 150 percent of the federal poverty level (FPL) will harm people who experience job changes or income fluctuations. This policy expanded enrollment and reduced the potential for adverse selection, increasing access to coverage for low-income individuals, particularly consumers transitioning from Medicaid or the Children's Health Insurance Program (CHIP) into Marketplace coverage.[9] Eliminating the monthly SEP will make it harder for the lowest income families to enroll in coverage.

Creating unnecessary enrollment verification requirements

The Proposed Rule also includes several policies related to enrollment verification, which the rule admits will establish enrollment barriers and deter Marketplace enrollment. The proposal to require pre-enrollment verification of eligibility for SEPs across all Marketplaces, and the proposal to require that Marketplaces, including state Marketplaces, verify eligibility for at least 75 percent of new enrollments through SEPs, would create barriers to coverage and increase consumer burden. Pre-enrollment SEP verification contributes to a higher uninsured rate and disproportionately has a negative impact on Black American consumers who submit verification documentations at much lower rates than White consumers.[10]

Eliminating DACA eligibility

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[7] Centers for Medicare & Medicaid Services, *CMS Announcement on Federal Navigator Program Funding* (Feb. 14, 2025) (https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding).

[8] *Id.:* in February 2025, CMS announced an approximately 90 percent reduction in funding for the ACA Navigator program, which provides funding to nonprofits and health care organizations to promote awareness and provide in-person assistance to consumers with Marketplace enrollment. Navigators serve a crucial role in reducing the uninsured rate because their efforts target individuals who may need extra assistance with the enrollment process.

[9] Centers for Medicare and Medicaid Services, *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* (CMS-9895-F).

[10] Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023*, 87 Fed. Reg. 584 (Jan. 5, 2022) (proposed rule).

We strongly oppose the Administration's decision to eliminate Marketplace eligibility for 11,000 Deferred Action for Childhood Arrivals (DACA) recipients. Under the ACA, individuals qualify for Marketplace coverage if they are a "citizen or national of the United States or . . . lawfully present in the United States."[11] As the Department of Health and Human Services (HHS) previously outlined, including DACA recipients in the definition of "lawfully present" supports the goal of the ACA by making health insurance available to more people and aligns with the longstanding definition that the Department of Homeland Security (DHS) has used for purposes of applying for Social Security benefits.[12] The cruel decision to eliminate coverage for these individuals will raise premiums across the board—DACA recipients tend to be younger and healthier—and particularly harm states with the greatest number of DACA recipients enrolled: California (28 percent), Texas (17 percent), Illinois (5 percent), and Florida and New York (4 percent each).[13]

The Proposed Rule needlessly increases health care costs for individuals and saddles states with administrative costs

Multiple policies in the Proposed Rule will raise costs for consumers, including increasing premiums and cost-sharing, reducing the tax credit that helps make coverage affordable, and increasing the amount of time it takes people to get enrolled in coverage.

Imposing nuisance fees and higher deductibles for automatically re-enrolled individuals

The Proposed Rule includes a policy that would require millions of people who are automatically reenrolled in zero-dollar premium plans to pay a nuisance fee—a $5 monthly premium—until they confirm or update information. Both auto-enrollment and zero-premium plans are meant to support lower income workers and their families. Even a nominal fee applied to this population could be enough to make it impossible to continue to afford health coverage. Based on the Administration's own estimates, this policy would have affected nearly 2.7 million enrollees if it was in effect in 2025.[14]

The Proposed Rule would also end a policy that lowers out-of-pocket costs and improves coverage for automatically re-enrolled individuals. Right now, an individual who would automatically be re-enrolled in a bronze plan can be moved to a higher quality silver plan if the premium is the same or lower, while retaining their insurer and network. Eliminating this policy

[11] 42 U.S.C. § 18081(a)(1).

[12] Centers for Medicare & Medicaid Services, *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*, 89 Fed. Reg. 39392 (May 8, 2024) (final rule).

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

[14] *See* note 1.

under the guise of "consumer choice" would only harm consumers by preventing them from accessing better coverage at a lower cost.

Creating unnecessary income verification requirements

The Proposed Rule includes multiple policies related to income verification that will increase consumer burden and kick people off coverage for which they are eligible. One policy would halt enrollment when Internal Revenue Service (IRS) tax data shows recent income below 100 percent FPL, while a second policy would halt enrollment when no IRS data are available. These changes would mostly harm individuals with variable or unpredictable incomes—such as lower income individuals, small business owners, and self-employed individuals—by making enrollment less efficient and increasing paperwork burden. Consumers will spend an estimated 15 million hours at a cost of $364 million responding to income verification requests and eligibility determinations, according to the Proposed Rule.[15] As a result of the substantial increase in burden, fewer healthy people would enroll, worsening the risk pool, and raising premiums for everyone.

Reducing the quality of health coverage insurance companies must provide

The Proposed Rule includes a policy that changes the methodology for determining the premium adjustment percentage (PAPI), which is used annually to update the limit on maximum out-of-pocket costs and determine tax credit amounts and payments by employers. The new methodology would increase the PAPI for 2026 by 4.5 percent, resulting in higher out-of-pocket costs for commercially insured Americans—including those with employer-sponsored insurance—and lower tax credits for individuals purchasing coverage on their own. The Centers for Medicare & Medicaid Services (CMS) estimates this change will increase consumer out-of-pocket costs and premiums by 4.5 percent.[16]

The Proposed Rule also includes changes to the allowable variation in actuarial value (AV) that would allow insurance companies to cover fewer health services by allowing for more variation from AV standards for each metal tier of coverage on the Marketplace. These changes will allow insurers to offer weaker coverage that reduces affordability and raises out-of-pocket costs for American families. Under the proposed formula, the new methodology would increase the maximum annual out-of-pocket limit for 2026 to $10,600 for self-only coverage and $21,200 for other coverage, which would be a 15 percent increase compared to 2025 plan year limits.[17] An internal CMS memorandum discussing the policy under the first Trump Administration noted

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[15] *See* note 1 at 13002; *Id.* at 13003.

[16] Department of Health and Human Services, Center for Medicare & Medicaid Services, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020,* 84 Fed. Reg. 17454.

[17] Health Affairs, *HHS Proposes To Restrict Marketplace Eligibility, Enrollment, And Affordability In First Major Rule Under Trump Administration (Part 1)* (Mar. 12, 2025) (https://www.healthaffairs.org/content/forefront/hhs-proposes-restrict-marketplace-eligibility-enrollment-and-affordability-first-major).

that the methodology would cause "coverage losses, further premium increases, and market disruption."[18] This change would allow insurers to offer less comprehensive coverage than contemplated by the statute.

Taken together, these policies would increase costs for families to the tune of $900 more in out-of-pocket costs and $313 more in premiums annually—while kicking 80,000 people off of coverage altogether.[19]

Summary

This Proposed Rule will not only raise administrative costs and worsen coverage for people purchasing coverage on their own, but it will also raise insurance premiums for many Americans. Reducing tax credits, increasing excessive administrative burden by millions of hours, and rolling out new red tape will rip affordable health coverage away from millions of Americans. Therefore, we strongly urge you to immediately withdraw these policies that undermine the ACA, jeopardize access to health care, increase health care costs for American families, and make Americans sicker.

Sincerely,

Frank Pallone, Jr.
Ranking Member
House Committee on Energy and Commerce

Robert C. "Bobby" Scott
Ranking Member
House Committee on Education and Workforce

Richard E. Neal
Ranking Member
Committee on Ways and Means

[18] Memorandum from Seema Verma, Administrator, Centers for Medicare & Medicaid Services, to Secretary Azar, Department of Health and Human Services (Aug. 29, 2018) (Bates PalTX-004092-PalTX-004122).

[19] Center for Budget and Policy Priorities, Proposed ACA Marketplace Rule Would Raise Health Care Costs for Millions of Families (Apr. 1, 2025) (https://www.cbpp.org/research/health/proposed-aca-marketplace-rule-would-raise-health-care-costs-for-millions-of); *See* note 1 at 13019.