Federation of American Hospitals®

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President and CEO

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**Via electronic submission at** *https://www.regulations.gov*

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

**RE: CMS-9884-P; Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability: Proposed Rule (Vol. 90, No. 52), March 19, 2025**

Dear Dr. Oz:

The FAH is the national representative of nearly 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC, and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. The FAH appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding the above-referenced Proposed Rule on Marketplace Integrity and Affordability published in the Federal Register (90 Fed. Reg. 12,942) on March 19, 2025.

The FAH shares CMS' goal of ensuring proper program integrity measures are in place in the Exchanges to ensure they function effectively and efficiently, while avoiding unnecessary costs and offering robust health insurance options to individuals, families, and small businesses. We also believe it is critical to strike a proper balance when implementing these measures to ensure that those who otherwise would qualify for coverage are not deterred or even inadvertently precluded from obtaining health care coverage. Our comments below are aimed at adopting policies that achieve this proper balance.

We also highlight the importance of access to health care offered through the Exchanges, which is supported by the availability of premium tax credits. We are deeply concerned that such access will severely diminished if the enhanced premium tax credits (EPTCs), which are set to expire at the end of this year, are not extended. The Making America Healthy Again movement begins with access to health care coverage, from preventive care to specialized services need to treat

those with chronic disease and EPTCs will amplify this movement by ensuring millions of Americans' access to care. In fact, the EPTCs have saved individual Americans an average of $700 annually. On average, premiums will increase 93% if the EPTCs expire, and an estimated 5 million Americans will lose health coverage entirely, including nearly two million people with chronic conditions. Without intervention, many families would face significant financial burdens and potential loss of coverage. We urge CMS and the Administration to support extending the EPTCs to maintain health care access and affordability across the country.

**Standards for Termination of an Agent's, Broker's, or Web-Broker's Exchange Agreements for Cause (Part III.B.2, § 155.220(g)(2))**

The FAH enthusiastically supports decisive action with respect to agents, brokers, and web-brokers that improperly enroll consumers in subsidized coverage, and appreciates HHS' commitment to holding noncompliant agents, brokers, and web-brokers accountable to protect Exchanges and consumers. Noncompliant agents, brokers, and web-brokers earn commissions through improper and fraudulent enrollments at the cost of surprise tax liabilities for consumers and inflated federal health care spending. The FAH believes that robust enforcement of program integrity rules and requirements with respect to agents, brokers, and web-brokers is the single most important measure that HHS can take to address its concerns with respect to improper enrollments and fraud without unwittingly creating barriers to proper enrollments that are critical to maintaining the stability of the Marketplace risk pool.

To this end, the FAH supports the adoption of the proposed preponderance of the evidence standard when terminating noncompliant agents, brokers, or web-brokers Exchange agreements for cause. The FAH also strongly urges CMS to use its authority to impose civil monetary penalties on non-compliant agents and brokers under 45 C.F.R. §§ 155.220(k)(1)(i) and 155.285, in addition to taking appropriate action to suspend and terminate non-compliant brokers and agents. Robust enforcement includes not just preventing further abuses through suspension or termination, but also civil monetary penalties that hold noncompliant agents and brokers accountable for past acts.

In addition, the FAH supports the adoption of further program integrity measures focused on agents, brokers, and web-brokers. For example, the FAH would support limiting the number of authorized agents or brokers, and imposing rigorous vetting requirements for those agents or brokers authorized to handle QHP enrollments. In addition, the misuse of special enrollment periods by agents, brokers, and web-brokers discussed in Part III.B.9 of the Proposed Rule could be more efficiently addressed with targeted program integrity measures focused on the use (and misuse) of special enrollment periods by agents, brokers, and web-brokers. Substituting agent, broker, and web-broker standards and enforcement measures for broad, Exchange-wide verification requirements would address the true driver of improper enrollments without the administrative costs, access barriers, and adverse risk pool impacts that come with Exchange-wide measures. Overall, the FAH supports a broad reevaluation of the program integrity proposals set forth in the Proposed Rule to identify whether and where more robust program integrity measures and enforcement with respect to agents, brokers, and web-brokers can more efficiently and appropriately address the root cause of the improper enrollments identified. Once there has been a period of appropriate enforcement with respect to agent or broker noncompliance, the need for additional, broader program integrity measures can be evaluated to determine whether and where issues exist beyond noncompliant agents and brokers such that the costs, administrative burden, and risk pool impacts of the proposed, Exchange-wide program integrity measures are justified.

**Coverage Denials for Failure to Pay Premiums for Prior Coverage (Part III.A.2, 45 C.F.R. § 147.104(i))**

The FAH urges caution with respect to the proposed policy change permitting issuers to deny new health coverage to individuals with past-due premiums. This proposed policy would expand on the 2017 Market Stabilization Rule,[1] allowing issuers to condition new coverage on the payment of past-due premiums consistent with state law. As a policy matter, we are concerned about the lack of clarity and confusion that could occur for enrollees and providers under the proposal. At a minimum, we believe that the baseline parameters that accompanied the policy in the 2017 Market Stabilization Rule—defining the controlled group, limiting past-due premiums impacted to those incurred within the prior 12 months, and requiring appropriate issuer notices of such policies—continue to be necessary and appropriate and should not be left wholly to the states.

Moreover, the FAH is concerned that the proposed policy is contrary to the plain language of the ACA because it applies statutory provisions for the renewal of coverage to cases where the applicant is not renewing his or her coverage. Where coverage has been terminated, the guaranteed availability of coverage requirements under section 2702 of the Public Health Services Act apply and section 2703 is inapplicable. For individuals that are within a grace period (*i.e.*, their coverage is at risk of termination due to non-payment of premiums but remains in place at the time the binder payment for the renewal is due), in contrast, section 2703 applies rather than section 2702, and current policy properly permits an issuer to collect past-due premiums such that continuous coverage is maintained.

If CMS chooses to finalize this policy, the FAH supports the adoption of baseline Federal parameters instead of exclusively deferring to state law. The parameters adopted in the 2017 Market Stabilization Rule continue to be both necessary and appropriate. Even if the purchase of new coverage by an individual that had been terminated could be considered a renewal subject to the requirements of section 2703, this would not be true for coverage that was terminated more than 12 months prior or from an issuer that is not a member of the same controlled group. In addition, the FAH believes that transparency is critical for patients and providers. We would urge CMS to require clear, precise, and user-friendly notice to enrollees regarding the issuer's policy with respect to and its applicability to the particular enrollee prior to them purchasing coverage from the issuer. This information is vital to ensuring enrollees can make the most optimal and well-informed choices for their health care needs to maximize meaningful health care coverage. Finally, we would urge CMS to actively monitor compliance with the policy, should it choose to finalize it, to protect both patients and providers.

As noted above, the proposed policy would make no change with respect to situations in which an enrollee's grace period for non-payment of premiums spans two plan years and the enrollee seeks to renew their prior coverage. In those cases, the issuer may attribute the enrollee's premium payments to the oldest outstanding debt in the existing grace period, thereby ensuring continuous coverage. Doing so avoids the retroactive termination of coverage that would otherwise occur for non-payment of premiums in November or December under CMS' current grace period policy. If issuers instead applied premium payments to the renewal of coverage before addressing the past-due premiums, providers would bear the risk of any gaming of the grace period under the current grace period regulations which require termination retroactive to the end of the first month

[1] Market Stabilization, 82 Fed. Reg. 18,346, 18,349-53(Apr. 18, 2017)

of the grace period. Under this grace period policy, providers are inappropriately burdened with bad debt for medically necessary care that was covered at the time of delivery but becomes non-covered due to the retroactive impact of the terminations.

The FAH, however, urges HHS to re-evaluate its grace period regulations and amend them to eliminate retroactive termination provisions consistent with the ACA's statutory language. The ACA provides for a "3-month grace period for non-payment of premiums before discontinuing coverage" for individuals receiving advance payment of the premium tax credits. ACA § 1412(c)(2)(B)(iv)(II) (42 U.S.C. § 18082(c)(2)(B)(iv)(II)). The ACA also broadly prohibits rescissions, permitting cancellation for non-payment only with prior notice to the enrollee. Public Health Services Act § 2712 (42 U.S.C. § 300gg-12). When adopting grace period regulations, HHS initially proposed that Exchange issuers would pay all appropriate claims during the grace period, consistent with the plain text of the statute. But the final regulation instead adopted a policy where claims can be pended for the second and third month of the grace period and then coverage terminated retroactive to the first day of the second month of the grace period. 77 Fed. Reg. 18,310, 18,426-29 (Mar. 27, 2012); *see* 42 C.F.R. §§ 155.430(d)(4), 156.270(g). This policy places providers that furnish services to QHP enrollees that receive advance payment of the premium tax credit at risk and also fails to provide the grace period coverage mandated by the ACA. In the aftermath of the Supreme Court decision in *Loper Bright Enterprises v. Raimondo*, 144 S. Ct. 2244 (2024), HHS' interpretation of the ACA's grace period requirements is not entitled to deference under *Chevron*, and the FAH urges HHS to return to the statutory grace period language that protects both consumers and the providers that care for them during the entirety of the 3-month grace period.

**Failure to File Taxes and Reconcile APTC Process (Part III.B.3.a, 45 C.F.R. § 155.305(f)(4))**

CMS proposes to terminate eligibility for advance payment of premium tax credits (APTC) after the failure to file taxes and reconcile for one year rather than two years. The proposal describes a complex set of indirect and direct notices that will go out to alert tax filers and enrollees of the pending termination of APTC's for the enrollee. All of this assumes timely notice and that the enrollee, and their tax filer receive these Failure to File and Reconcile (FTR) notices and can timely provide the information requested. The FAH recommends that enrollees and tax filers be given some appeal and extension rights if there is a failure to notify or a mistake in FTR process.

Additionally, the proposal cites that 70% of households took appropriate action to file a tax return and reconcile the APTC after receiving notice regarding their FTR when a one-year look back was previously in place. The FAH encourages continuing review of the 30% of households (or the applicable percentage in future years) that do not act on the FTR notice. Many of these households' failure to take appropriate action may not be due to ineligibility or inability to report income. They may still be eligible for APTCs, leading to enrollment in an Exchange plan, potential contribution to the risk pool, and avoiding the unnecessary costs they and their providers would incur resulting from their uninsured status.

**60-Day Extension to Resolve Income Inconsistency (Part III.B.3.b, § 155.315(f)(7))**

CMS proposes to remove the provision for an automatic extension of 60 days in addition to the 90 days provided under Section 155.315(f)(2)(ii), while retaining the long-standing, efficient, and pragmatic process under section 155.315(f)(3) for granting extensions to applicants that

demonstrate a good faith effort to obtain documentation. In comparing the good faith effort extensions under subsection (f)(3) with the automatic extensions under subsection (f)(7), CMS expresses concern that the automatic extension maintains coverage for 120-days in cases where there has not been a demonstrated good faith effort. We agree with CMS that the ACA provides the statutory authority to permit good faith effort extensions, and that section 155.315(c)(3) represents an appropriate use of CMS' authority. Enrollees have relied on the good faith effort extension under subsection (f)(3) since the first Exchange enrollments, and this extension should continue to be given to all consumers that encounter barriers in accessing necessary documents. The FAH believes that subsection (f)(3) represents a pragmatic flexibility that promotes and maintains the stability of the risk pool by accommodating those younger, healthier contributors to the risk pool that need additional time to gather appropriate documentation.

**Income Verification When Tax Data is Unavailable (Part III.B.3.d, § 155.320(c)(5)**

The FAH urges CMS to reconsider its strict interpretation of the ACA with respect to not allowing enrollee attestation when no tax data is available. Section 1412 of the ACA provides many avenues for the resolution of PTC and APTC qualifications when there is no tax return information. As stated in the proposal "… Section 1412(b)(2) of the ACA puts HHS in charge of establishing the procedures for determining APTC when there is a change in circumstances or no tax return information." The provisions of 1411 through 1412 of the ACA when read together, provide the flexibility for HHS to accommodate other information sources, including the attestations of enrollees, when addressing the verification process. HHS may not choose to exercise this flexibility as it has prior to this rulemaking, but Congress has provided that flexibility.

**Automatic Re-Enrollment Process (Part III.B.4, 45 C.F.R. § 155.335)**

The FAH is very concerned about CMS' proposal to impose a $5 premium payment obligation on enrollees who are automatically re-enrolled in a plan for which APTCs would otherwise fully cover their premium obligation unless the enrollee takes action to reconfirm eligibility. This proposed policy would apply to individuals where the eligibility for APTCs is confirmed through normal Exchange income verification processes, but the individual has not actively re-attested to his or her eligibility. There is very little data on what factors motivate consumers to take an active role in re-enrollment as opposed to relying upon automatic re-enrollment and whether those choices have led to more eligibility errors, tax credit miscalculations, and unrecoverable federal spending. We urge CMS not to finalize the proposal. Rather, the FAH strongly urges CMS to conduct additional analysis before finalizing a policy that would discourage or limit automatic re-enrollment on the Exchanges.

Like many other commenters, the FAH expressed significant concern with CMS' similar proposal in the 2021 Payment Notice, which CMS ultimately did not finalize.[2] For benefit year 2025, approximately 2.68 million enrollees were automatically re-enrolled in a plan with no premium obligation due to APTCs. These consumers have come to expect that they will be automatically re-enrolled each plan year without any further action or administrative burdens.

[2] FAH, Comment Letter on Proposed Rule on Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021(March 2, 2020), https://assets.fah.org/uploads/2020/07/Exchange_Benefit_and_Payment_Parameters_Proposed_Rule_Comments_3220_-_FINAL-2.pdf.

Automatic re-enrollment stabilizes the marketplace because healthier individuals may be more likely to rely on automatic re-enrollment processes as compared to individuals that expect to rely on their coverage for significant care in the coming plan year.

Furthermore, the imposition of a premium or withholding of APTC of fully subsidized enrollees is inconsistent with section 1412 of the ACA, which governs the procedures for determining APTC eligibility. The ACA does not permit the Exchanges to consider information unrelated to APTC eligibility in making APTC determinations or to partially withhold APTCs from enrollees. Thus, CMS cannot require that Exchanges reduce APTCs, such as by imposing a $5 premium, or eliminate them based on whether an individual is undergoing automatic re-enrollment.

Even if APTCs could be partially withheld, leaving a $5 premium payment obligation for automatically re-enrolled individuals, such a policy risks instability on the marketplace and loss of coverage because some enrollees will fail to make the initial binder payment or keep current on their premium payment obligations. Where an enrollee makes the initial $5 payment under this policy, they have undoubtedly confirmed that the coverage is both authorized and desired, but the failure to make later payments may trigger a grace period, risking termination of coverage. During the grace period, an enrollee may still seek and receive health services from a hospital or other provider. Under current CMS regulations, issuers can pend claims for services furnished to these policyholders during the second and third months of the 90-day grace period. If the policyholder does not pay his/her outstanding premiums by the end of the three-month grace period, the issuer may deny all pending claims for services rendered during the second and third months.[3] Hospitals and other health care providers, therefore, are responsible for collecting payment for services furnished during this time period. The reality is that it is extremely difficult to collect payment for care from low-income patients who already are having trouble paying their premiums. Therefore, any policy that imposes or increases the share of premiums owed by individuals receiving APTCs subjects enrollees to significant personal liability for health care services and risks hospitals and other health care providers being unable to collect payment for services furnished to these enrollees.

We believe more analysis should be considered before imposing new requirements on automatic re-enrollment for enrollees who qualify for fully subsidized plan. Available data do not demonstrate whether and when automatic re-enrollment is a conscious choice by consumers after considering their own circumstances or a choice made with little consideration of changed circumstances. To the extent that this proposal is focused on addressing the automatic renewal of improper enrollments by agents, brokers, or web-brokers, the FAH strongly supports robust enforcement with respect to noncompliant agents, brokers, or web-brokers along with targeted program integrity measures focused on agent, broker, and web-broker conduct. The FAH recommends further inquiry into whether limitations on automatic re-enrollment would lead to tangible improvements in federal spending or benefits to consumers on the Exchange.

**Annual Eligibility Redetermination (Part III.B.5, 45 C.F.R. § 155.335(j))**

The FAH is concerned about CMS' proposal to revoke authority for Exchanges to apply re-enrollment hierarchies that appropriately prioritize access to income-based cost-sharing reductions

[3] As discussed in connection with comments on Part III.A.2 of the Proposed Rule, above, the FAH urges a reevaluation of grace period rules. The ACA does not permit the retroactive termination of coverage during the grace period, and termination should only take effect after proper notice and exhaustion of the entire grace period.

(CSRs) for eligible consumers. The FAH believes that having these silver-level plans higher up on the re-enrollment hierarchy promotes the transition of CSR-eligible consumers to affordable plans with cost sharing benefits that better support their access to needed care.

In the Proposed Rule, CMS expressed concern that the current policy allows Exchanges to terminate the coverage of enrollees who actively participated in choosing their plan. However, under current policy, an Exchange does not have authority to terminate coverage for the current plan year, rather the policy applies to automatic re-enrollment for a subsequent plan year, resulting in enrollment in a silver plan within the same product, with the same provider network, and with a lower or equivalent net premium after the application of the APTC.

**Annual Open Enrollment Period (Part III.B.7, 45 C.F.R. § 155.410)**

The FAH urges CMS to defer any change to the annual Open Enrollment Period (OEP) until after plan year 2026. Consumers are accustomed to the current open enrollment schedule and any change shortening the open enrollment period risks confusion and a reduction in coverage. This is particularly true for the 2026 OEP, which is expected to be more complicated should Congress fail to extend the EPTCs. Although, as discussed above, the FAH urges extension of the EPTCs, under current law they are set to expire at the end of 2025, such that enrollees (and those that assist and educate them) will need to evaluate options in light of decreased financial assistance. A simultaneous shortening of the OEP may overburden the Exchanges and deprive consumers of an appropriate time period for decisions regarding 2026 coverage. Additionally, a shorter OEP may cause confusion and financial hardship, particularly for those who believe they have until January to choose a new plan and miss the new deadline. Therefore, the FAH supports maintaining the current OEP for 2026 and deferring consideration of any change to the OEP. Any change to the OEP can and should be proposed and considered as part of a future HHS Notice of Benefit and Payment Parameters.

Further, we urge CMS to engage in a robust outreach process for the 2026 OEP, particularly if it finalizes its proposal to reduce it to 45 days. Through direct assistance, consumers are better able to assess their health care needs; plan options, including affordability; and the requirements and timelines for gaining such coverage. We encourage CMS to broaden the outreach and enrollment efforts generally, and if the proposed policy is implemented, to alert potential enrollees of any change to the annual OEP.

**Pre-Enrollment Verification for Special Enrollment Period (§ 155.420(g))**

The FAH recommends deferring any change in the current policy regarding the verification of eligibility for a special enrollment period to assess the impact of more robust enforcement of agent, broker, and web-broker standards on improper use of special enrollment periods. To the extent that agents, brokers, and web-brokers have abused special enrollment periods and shifted to using special enrollment periods that did not require document submission, that behavior should be addressed through targeted enforcement activity so as to avoid unnecessarily deterring eligible consumers from enrolling in coverage through a special enrollment period because of documentation burdens. Barriers and burdens in the enrollment process not only create additional expense for the Exchanges, they risk skewing the risk pool toward the sicker individuals that will expend the additional effort to present supporting documentation.

**Premium Adjustment Percentage (Part III.C.2, § 156.130(e))**

The premium adjustment percentage is used to calculate the maximum annual limitation on cost-sharing, the required contribution percentage for individuals for minimum essential coverage, and the employer mandate. It also impacts the amount of federal PTCs.

By changing the formula for this one number, CMS substantially alters the affordability of Exchange coverage. This proposal will raise the annual limit on beneficiary cost-sharing, will increase consumers' minimum contribution amount, and decrease the value of the premium tax credit.

Because CMS' proposal would result in increasing the number of uninsured and raising costs for many of those in the individual market, the FAH requests that CMS not finalize its proposed change to the premium adjustment percentage. Alternatively, the FAH suggests CMS stair-step or delay this proposal to allow enrollees, issuers, and providers to adjust to this significant change.

**Levels of Coverage (Actuarial Value) (Part III.C.3, §§ 156.140, 156.200, 156.400)**

Overall, the FAH encourages CMS to moderate the proposed narrowing of *de minimus* ranges to encourage more incremental changes in ACA products offered across metal classes. A smaller incremental approach to narrowing *de minimis* thresholds enables CMS to more accurately gauge year-to-year how many healthier, unsubsidized enrollees are added to the risk pool by this adjustment, and how many subsidized enrollees become uninsured due to the higher consumer costs resulting from lower PTC's and APTC's. Additionally, a more incremental approach will provide for less variability in product selection year-to-year for both subsidized and unsubsidized enrollees, which is more likely to improve retention in both classes.

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Thank you for the opportunity to comment on these important issues in the Proposed Rule. If you have any questions, please contact me or a member of my staff at 202-624-1500.

Sincerely,