American Lung Association.

April 11, 2025

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

The Honorable Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244

**Re: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability (CMS-9884-P)**

Dear Secretary Kennedy, Jr. and Administrator Oz:

Thank you for the opportunity to submit comments on the proposed rule on Marketplace Integrity and Affordability.

The American Lung Association is the oldest voluntary public health association in the United States, representing the more than 35 million individuals living with chronic lung disease. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The Affordable Care Act (ACA) marketplaces provide quality, affordable healthcare to millions of individuals across the United States. Over 23 million people selected coverage through the ACA marketplaces for 2025, a record high.[1] Marketplace enrollment has increased, in part due to enhanced advance premium tax credits (APTCs), which have made coverage much more affordable for patients and families. This coverage is essential to help people with lung disease access preventive services like lung cancer screening and tobacco cessation treatment, prescription medications, pulmonary rehabilitation, and many more important treatments and services at an affordable cost.

People with lung disease have seen lifesaving benefits from marketplace coverage. For example, here is Daniel's story:

*Daniel lost his job due to his COPD, just nine days before his appointment to discuss getting a lung transplant. This meant losing his insurance coverage too. He tried to find new employment and worked part-time jobs to help pay for his care, but having a chronic condition made it difficult to get hired. It took two years to get on Medicare due to his disability, and in the meantime, he was told he didn't qualify for Medicaid. That's when he learned about a lifesaving option: the marketplace.*

[1] "Nearly 24 Million Consumers Have Selected Affordable Health Coverage in ACA Marketplace, With Time Left to Enroll." *Centers for Medicare and Medicaid Services*, 8 Jan. 2025, https://www.cms.gov/newsroom/press-releases/nearly-24-million-consumers-have-selected-affordable-health-coverage-aca-marketplace-time-left.

*He found a great plan, with subsidies that covered 90% of his premium costs. That meant his plan was affordable, at $120 per month. The coverage was excellent. He had no copayments for doctors' visits, and his medication costs went down to $15 a month. Without coverage for his medication, he isn't sure he would have had money to eat or if he would have survived.*

Many of the policies in the proposed rule, however, will reduce access to quality, affordable healthcare for the individuals and families with lung disease. They would eliminate coverage for two million people. In addition to the robust comments that we submitted with other patient advocacy organizations, the Lung Association offers the following comments and recommendations addressing specific provisions of the proposed rule:

**Reducing the Annual Open Enrollment Period**

The Department of Health and Human Services (HHS) previously established a minimum period for marketplace open enrollment, running from November 1 through January 15. An open enrollment period that extends into January gives individuals a better chance to learn about their options and select a plan suited to their needs, facilitates higher enrollment, provides the opportunity to switch to more affordable coverage, and increases the likelihood that Navigators and other assisters would be able to fully assist all individuals who seek their help.[2]

The Lung Association opposes policies in the proposed rule to shorten the open enrollment period to November 1 through December 15 in both the federal and state-based marketplaces, starting with the open enrollment period for 2026. Neither states with open enrollment periods from November 1 to January 15 nor HHS saw evidence of adverse selection into the marketplace as a result of the longer open enrollment period. On the contrary, those states found that individuals who enroll later tend to be younger and healthier than those who enroll early.

Limiting the federal annual open enrollment period to November 1 through December 15 – and requiring state-based marketplaces to do this – would decrease access to quality, affordable healthcare coverage for individuals with lung disease. The Lung Association strongly urges HHS not to finalize this policy.

**Eliminating the Monthly Special Enrollment Period**

The Lung Association opposes the proposal to eliminate the monthly special enrollment period (SEP) for individuals with incomes up to 150% of the federal poverty level, which would reduce access to affordable healthcare and disproportionately burden individuals with low incomes.

HHS established a SEP for individuals with low incomes due to 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 SEP was designed to provide marketplace- and premium tax credit-eligible individuals with projected incomes at or below 150% of the federal poverty level with additional opportunities to enroll in low-cost coverage. This has helped many individuals with low incomes secure affordable coverage.

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[2] 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

Nearly all states — those that use the federal marketplace as well as those that operate their own enrollment platforms — have implemented this special enrollment period.[3, 4] HHS claims, however, that the special enrollment period is responsible for a large number of "improper" enrollments and therefore must be eliminated immediately. The Lung Association has been deeply concerned about certain agents and brokers enrolling consumers or switching their enrollment without their consent. Last year, HHS took numerous steps to fix systems vulnerabilities with the enhanced direct enrollment marketplace interface, tighten verification procedures, and increase oversight and enforcement, including by suspending hundreds of brokers. These actions appear to have significantly reduced both the incidence and risk of agent and broker misconduct. Continued oversight and enforcement over bad-actor agents and brokers is the best way to address improper enrollments, not taking away a pathway to coverage that helps low-income people access affordable healthcare. The Lung Association urges HHS not to finalize this policy.

**Increasing Paperwork Requirements**

The proposed rule would require individuals to submit additional paperwork to enroll in coverage during a SEP. It would also deny a premium tax credit to certain individuals with low incomes whose projected annual household income cannot be immediately verified. Extensive research on the impact of administrative burden and application complexities demonstrate that this approach will reduce enrollment.[5, 6, 7]

The Lung Association opposes this proposal and urges HHS not to increase paperwork requirements. This rule would make it harder for individuals with lung disease to enroll in coverage and may deter them from enrolling.

**Charging New Premiums**

This rule would require individuals with low incomes who are eligible for a large advance premium tax credit to pay a $5 premium until they actively re-enroll in marketplace coverage. The Lung Association urges HHS not to adopt this proposal, as this would also decrease coverage affordability.

The federal government cannot create a premium obligation by reducing the amount of advanced premium tax credits an individual is eligible for, nor by refusing to pay out this allowed

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

[4] Rachel Swindle et al., "ACA State Marketplace Models and Key Policy Decisions," interactive maps, Commonwealth Fund, last updated Mar. 14, 2025. https://doi.org/10.26099/xg67-4051

[5] Ericson, Keith. "REDUCING ADMINISTRATIVE BARRIERS INCREASES TAKE-UP OF SUBSIDIZED HEALTH INSURANCE COVERAGE: EVIDENCE FROM A FIELD EXPERIMENT." *National Bureau of Economic Research*, https://www.nber.org/system/files/working_papers/w30885/w30885.pdf. Accessed 4 Apr. 2025.

[6] Tolbert, Jennifer, et al. "Key Facts about the Uninsured Population." *Kaiser Family Foundation*, 18 Dec. 2024, https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

[7] McIntyre, Adrianna, et al. "Small Marketplace Premiums Pose Financial And Administrative Burdens: Evidence From Massachusetts, 2016–17." *Health Affairs*, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2023.00649?journalCode=hlthaff. Accessed 4 Apr. 2025.

amount. HHS does not have the legal authority to charge individuals with low incomes a premium they do not actually owe.[8]

Additionally, doing this would undermine marketplace coverage affordability. Data shows that even nominal premiums of less than $10 in marketplace plans decrease enrollment, compared to plans with no premium cost.[9] The associated administrative burdens may be an obstacle for plan enrollees – particularly if the premiums are new and enrollees previously did not have to make regular payments.[10] Research shows that even small premium depress enrollment, particularly by healthy enrollees. As a result, this would reduce coverage and make coverage more expensive for those enrolled in a marketplace plan.[11]

**Removing Flexibility for Premium Payments**

HHS recently finalized rules that give issuers greater flexibility to effectuate an enrollee' coverage, or allow an enrollee to remain in coverage, if their premium payment meets or exceeds a predetermined threshold. Individuals may fall behind on owed health insurance premiums, due to other financial pressures or simple error. Issuers should not be required to deny or terminate coverage in these cases. HHS's recent rule changes, which would take effect in 2026, provided additional commonsense flexibility to issuers to enable them to avoid such outcomes.

This rule proposes to reverse course 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 have been abused. The Lung Association urges HHS to 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 Issue**

The Lung Association opposes allowing health insurers to deny coverage to individuals who may not have paid past-due premiums. This proposed rule would apply not just to past-due premiums in the last 12 months but extend to any time period before that.

The guaranteed availability provision codified in the Public Health Service Act clearly requires insurers to make coverage available to all individuals who apply. This is a fundamental protection for individuals with lung disease, who cannot afford a gap in care while trying to pay off previous premium debt. Permitting insurers to condition enrollment on payment of premiums for a prior period of coverage would grant significant authority to insurers at the expense of individuals enrolling in coverage. It would violate the guaranteed availability of coverage

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[8] 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.

[9] McIntyre, Adrianna, et al. "Small Marketplace Premiums Pose Financial And Administrative Burdens: Evidence From Massachusetts, 2016–17." *Health Affairs*, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2023.00649?journalCode=hlthaff. Accessed 1 Apr. 2025.

[10] Ibid

[11] McIntyre, Adrianna, Mark Shepard, and Myles Wagner. 2021. "Can Automatic Retention Improve Health Insurance Market Outcomes?" *AEA Papers and Proceedings* 111: 560–66.

requirement and decrease access to healthcare coverage for individuals with lung disease. The Lung Association urges HHS not to finalize this policy.

**Ending Coverage for DACA Recipients**
Existing law and regulations permit young individuals who are granted deferred action under the Deferred Action for Childhood Arrivals (DACA) policy to enroll in marketplace coverage if they are otherwise eligible. This rule proposes to revoke eligibility for these individuals, insisting that HHS is not required to treat everyone with deferred action the same.

DACA recipients are significantly more likely to be uninsured and many report delaying medical care due to cost.[12] The Lung Association urges HHS not to finalize this proposal, which would make marketplace coverage inaccessible for DACA recipients who have lung disease and continue to exacerbate barriers to care for this population.

**Changing the Premium Adjustment Percentage, Increasing Enrollee Costs**
This proposed rule would change how the "premium adjustment percentage" is calculated, a measure intended to reflect health care cost growth that is used to determine what enrollees 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. — HHS 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.

The result is that the premium adjustment percentage will be about 4.5% higher than under the current methodology. Under this approach, premium tax credits will be reduced, and marketplace enrollees 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.[13]

In addition, the limit on out-of-pocket costs will be 4.5% higher, or $900 more for a family plan and $450 more for an individual plan. This increase will also impact the more than 150 million individuals with employer-sponsored coverage. The increased costs will disproportionately impact individuals who use more healthcare 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 may have to forgo necessary care, leading to costly and dangerous complications. For example, one in six people with COPD forego taking their medication due to cost, and that number goes up to one in four for those under age 65.[14] If a person with COPD skips their medication, they could end up in the emergency room struggling to breathe, costly both to the healthcare system and their own health.

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[12] National Immigration Law Center, DACA Recipients' Access to Health Care: 2023 Report. https://www.nilc.org/wp-content/uploads/2023/05/NILC_DACA-Report_2023.pdf. Published May 2023.
[13] Lukens, Gideon, and Elizabeth Zhang. "Proposed ACA Marketplace Rule Would Raise Health Care Costs for Millions of Families." *Center for Budget and Policy Priorities*, 1 Apr. 2024, https://www.cbpp.org/research/health/proposed-aca-marketplace-rule-would-raise-health-care-costs-for-millions-of.
[14] Wen X, Qiu H, Yu B, et al. Cost-related medication nonadherence in adults with COPD in the United States 2013-2020. *BMC Public Health*. 2024;24(1):864. doi:10.1186/s12889-024-18333-z

Reducing healthcare costs, not increasing them, is important to improve outcomes for people with lung disease. The Lung Association strongly opposes this proposed change which would decrease affordability as well as access to care and urges HHS not to finalize it.

**Preventing Automatic Reenrollment in Lower-Cost Coverage**
HHS 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 premium is not more expensive after accounting for premium tax credits, is from the same issuer, and has the same provider network).

This proposed rule would end that policy. As a result, 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 incomes up to twice the federal 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 out-of-pocket limit.

Data shows public awareness that marketplace financial assistance exists remains low — much less awareness of the nuances of metal levels and other policy changes.[15] Further, HHS recently cut 90% of funding for Navigators, though they provide individuals with plan, cost-sharing and benefit information needed to understand plan choices.[16] As a result, enrollees may unnecessarily pay significantly more to obtain care.

The Lung Association strongly opposes this proposed change which would reduce affordability of marketplace health plans and urges HHS not to finalize it.

**Reducing Plan Generosity**
To help individuals choose a marketplace plan and promote the affordability and adequacy of coverage, non-grandfathered individual and small group marketplace plans must be offered only at specified levels of value. Plans at a particular value tier – gold, bronze, or silver – must adhere to the actuarial value requirements specified for the tier by law. Those plans may not vary from the prescribed actuarial value except by a negligible amount.

HHS policies in 2023 revised the allowable “de minimis variation” in actuarial value of each tier to protect enrollees and to ensure that those who were eligible could receive the full value of marketplace subsidies.

The proposed rule would again change the definition of allowable de minimis variation in actuarial value; however, this time making it more difficult for individuals to compare their options and make informed decisions. The proposed de minimis ranges in this rule 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 premium tax credits and in turn, result in a smaller premium tax credit. Individuals will therefore have to buy a less generous plan with their reduced premium tax credit and pay

[15] “Survivor Views on Enhanced Premium Tax Credits.” *American Cancer Society Cancer Action Network*, 28 Jan. 2025, https://www.fightcancer.org/policy-resources/survivor-views-enhanced-premium-tax-credits.
[16] “CMS Announcement on Federal Navigator Program Funding.” *Centers for Medicare and Medicaid Services*, 14 Feb. 2025, https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding.

more to obtain care, or pay higher premiums to have a silver plan with an actuarial value comparable to their plan under the new de minimis standard.

This proposal would decrease affordability and access to care for individuals with lung disease. The Lung Association opposes this proposed change and urges HHS not to finalize it.

**Conclusion**
The Lung Association urges HHS not to finalize this proposed rule, which would decrease access to affordable, quality healthcare coverage and negatively impact individuals with lung disease and their families.

Thank you for the opportunity to provide these comments.

Sincerely,

Harold P. Wimmer
President and CEO