April 11, 2025

The Honorable Robert Kennedy
Secretary
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

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

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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[1] Connect for Health Colorado, Board Meeting Minutes. February 10, 2025. Available at: https://c4-media.s3.amazonaws.com/wp-content/uploads/2025/03/10021103/20250210_Board_Minutes.pdf ;

[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

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

[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

[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

[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