601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004

T 202.778.3200
F 202.331.7487
ahip.org

April 11, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9911-P
Baltimore, MD 21244-8016

Submitted electronically via www.regulations.gov

RE: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Proposed Rule – AHIP Comments

Dear Administrator Oz:

AHIP appreciates the opportunity to provide comments on the "Marketplace Integrity and Affordability Proposed Rule" (Proposed Rule) published by the Centers for Medicare & Medicaid Services (CMS) on March 19, 2025, in the *Federal Register*. AHIP is the national trade association representing the health insurance industry. AHIP's members provide health care coverage, services, and solutions to more than 200 million Americans, including millions who enroll in coverage through the individual market through the Health Insurance Marketplaces (Marketplaces). AHIP and our member health plans are committed to ensuring Americans who buy their own health insurance coverage continue to have access to quality, affordable coverage that meets patients' needs and advances their health and wellbeing.

We are committed to ensuring the integrity of the Marketplaces by reducing health care costs, minimizing fraud, and increasing the number of Americans with affordable health coverage options. The Proposed Rule includes reforms that help ensure consumers and taxpayers are protected from fraud and abuse. Over the past few years, health insurance plans have partnered with CMS to protect consumers from unauthorized enrollments and fraud in the Marketplaces – including conducting investigations into agents and brokers suspected of fraudulent activity and terminating contracts with bad actors, piloting alternative approaches to discourage fraudulent activity, such as limiting agent of record switches, and working with regulatory and law enforcement agencies to share data and coordinate enforcement efforts. AHIP will continue to work with CMS to implement innovative solutions that strengthen marketplace program integrity and protect enrollees.

AHIP appreciates the intent of the Proposed Rule to strengthen program integrity and supports proposals that will reduce fraud, abuse, and improper enrollments, while maintaining pathways for eligible Americans to enroll in and maintain coverage. Several proposals included in the rule will improve the Marketplaces when implemented in 2026; we believe others would strongly benefit from modifications or different implementation timelines. We firmly believe the Proposed Rule, with appropriate modifications, will advance our shared goal of addressing fraud and improper enrollments, and strengthening program integrity, without leading to unnecessary coverage losses.

Throughout our comments, we provide information we believe will assist CMS in creating a final rule that advances these important goals by highlighting areas in which the Proposed Rule could create operational challenges and roadblocks, as well as potential unintended consequences for consumers.

Reforms such as ending the monthly SEP for lower-income households will likely improve program integrity upon taking effect early next year, and we ask that CMS allow such reforms to take effect before implementing additional changes. Many of the goals CMS aims to achieve may not be realized if the implementation timeline and process laid out in the Proposed Rule are not modified. By delaying several effective dates and adjusting proposals to account for the operational needs of health plans and State Exchanges, our shared overarching goals are more likely to be achieved in the long term.

In our detailed comments, AHIP addresses specific provisions of the Proposed Rule along several themes, including:

- **Strengthening Program Integrity.** Enhancing guardrails to protect consumers from fraud and abuse while ensuring continued access to affordable, comprehensive coverage is a top priority for AHIP. The distressing increase in improper enrollments over the past few years has severely harmed consumers and issuers and led to significant negative consequences for the marketplace. Removing the monthly SEP for qualified individuals eligible for Advanced Premium Tax Credits (APTC) with a projected household income at or below 150% of the Federal Poverty Level (FPL) ("150% FPL SEP"). Removing this SEP will encourage continuous enrollment and minimize adverse selection, both of which are key to ensuring a strong and stable marketplace. We encourage CMS to adopt proposals that mitigate fraud and abuse in a manner that minimizes administrative burden and to consider a more gradual approach to implementation for aspects of the proposal that could adversely impact consumers and cause excessive operational challenges for issuers, Exchanges, and stakeholders.

- **Establishing Practical Effective Dates.** The Proposed Rule seeks to curb unauthorized enrollments and improper Federal APTC payments. While AHIP supports many of these changes, several of the proposed effective dates are not feasible for plan year 2026 implementation and should be delayed. Issuers are now submitting their QHP applications and rate filings to federal and state regulators. Product filings across QHP markets range from April 1 to May 15, and several months of preparation are needed to meet those filing deadlines. Issuers spend 18-24 months designing benefit structures and pricing their products based on several factors, including the current regulatory environment, and as proposed, this rule would significantly affect issuer QHP applications and rate filings.

  In addition, issuers, Exchanges, and partners need adequate lead time to develop and test the administrative and technical changes that are required to implement the various policies in the Proposed Rule. Without additional time to develop and test these policies, consumers may experience delayed enrollment or improper terminations, as well as other unintended negative consequences. And even if a final rule were issued shortly after the conclusion of this comment period, it would not be enough time for issuers to implement these significant changes for the upcoming plan year.

- **Preserving State Exchange Flexibility.** The Proposed Rule seeks to apply several provisions to State Exchanges as well as the Federally-Facilitated Marketplace (FFM). While AHIP appreciates a consistent regulatory approach, State Exchanges did not experience the same rate of improper enrollments as the FFM and therefore do not require the same policy solutions as the FFM. Applying policy solutions to State Exchanges without appropriate cause will unnecessarily burden State Exchanges and consumers and other stakeholders operating in those states. We

encourage CMS to continue allowing State Exchanges to establish their own Open Enrollment Periods, decide their own essential health benefits (EHB) structures, and adopt verification requirements at their discretion.

- **Providing Transparent Consumer Communications.** If finalized, the Proposed Rule would adopt many new or revised requirements for consumers seeking to enroll in or maintain coverage through the Marketplaces. Requirements should be communicated clearly and in a timely manner so that consumers understand changes in timelines, additional steps they need to take to enroll in or maintain coverage, documentation they need to provide, and changes in billing or payment practices. Effective communication is key to limiting unnecessary coverage losses among eligible individuals. Marketplaces should develop a communication plan and share with health plans to facilitate coordinated messaging and ensure both Marketplaces and health plans are prepared to provide appropriate customer service support.

We appreciate the opportunity to provide comments on the Proposed Rule and provide more detailed comments on the proposals in the attachment. AHIP looks forward to continued partnership with CMS to achieve our shared goal of access to affordable, quality health insurance coverage for all Americans.

Sincerely,

Jeanette Thornton
Executive Vice President, Policy & Strategy

AHIP Detailed Comments on 2025 Marketplace Integrity & Affordability Proposed Rule

I. Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Projected Household Income at or Below 150 Percent of the Federal Poverty Level (§ 155.420)

AHIP supports the proposal to remove the 150% Federal poverty level (FPL) special enrollment period (SEP). This SEP was established in anticipation of individuals losing Medicaid eligibility when the COVID-19 public health emergency (PHE) ended in May 2023. However, the permanent extension of this SEP undermined program integrity by allowing consumers to change plans monthly, increasing risk for adverse selection and creating a window of opportunity for unscrupulous agents, brokers, and lead generation companies to take advantage of unsuspecting consumers. Removing this SEP will substantially reduce improper enrollments and finalizing this change to apply on the effective date of the final rule should reduce the likelihood that some additional Exchange regulatory changes will be necessary to address improper enrollments.

While well-intentioned, the reality is this expansive SEP was easily abused. Consumers were enrolled into and switched between Exchange issuers without their knowledge or consent, which resulted in coverage disruption—including being unable to fill vital prescriptions or see their regular, in-network provider—and additional financial liability. Issuers immediately responded by raising concerns with CMS, scaling resources, increasing consumer outreach, conducting investigations into agents and brokers suspected of fraudulent activity, and partnering with various federal and state agencies to coordinate enforcement efforts. We appreciate the swift action of this Administration to remove this SEP, curb improper enrollments, and promote coverage continuity.

AHIP Recommendation:

- **Remove the 150% FPL SEP with the proposed effective date.**

II. Operational Considerations – Effective Dates; State Discretion; Issuer Flexibility; and Consumer Communication

AHIP recommends the implementation date of several proposed provisions we support are adjusted to account for operational considerations. These include changes to the proposed effective dates, permitting discretion by State Exchanges, allowing provisions to be optional for issuers, and accounting for how to communicate changes to consumers. CMS proposes a range of policies with the goal of increasing program integrity and reducing the risk of adverse selection. AHIP shares these overarching goals and agrees that several of these policies will add appropriate program integrity guardrails and increase market stability. However, some of the effective dates proposed in the rule are not workable, as there would be insufficient time to implement changes. We ask CMS to carefully consider the unintended consequences rushed implementation would have on issuers, consumers, and the Exchanges. For example, proposed

policies that would take effect on the effective date of a final rule or for Plan Year 2026, including 2026 Open Enrollment, provide limited lead time for implementing and testing changes to exchange eligibility systems, issuer enrollment systems, and related processes like consumer notices. Ensuring compliance with these policies will require extensive time and administrative resources from issuers, Exchanges, and other partners. More time is required to complete these tasks than the Proposed Rule would allow. Without adequate time for implementation and testing, these policies may result in delayed enrollment, unnecessary coverage terminations, and adverse impacts on consumers.

The proposed effective dates for several of the provisions in the Proposed Rule are not compatible with existing processes and timelines. Issuers are currently finalizing Plan Year 2026 rates and preparing to submit proposed rates and QHP applications to state and federal regulators. Rate filing deadlines vary by state, beginning May 1, and qualified health plan (QHP) applications in Federally-facilitated Marketplaces are due May 15, 2025. Before a plan year begins, issuers spend 18-24 months designing benefit structures and pricing products based on several factors, including current regulatory requirements. Certain regulatory policy changes that would impact rates and plan design, like the premium adjustment percentage methodology, cannot be implemented for Plan Year 2026. Therefore, while AHIP supports such changes, we note they can only be implemented for Plan Year 2027. If CMS adopts any new processes and/or compliance requirements, we recommend CMS finalize these policies well in advance of state and federal filing deadlines, otherwise delay them until the following Plan Year.

We strongly encourage CMS to consider how major policy changes will be communicated to consumers. Several of the proposed changes will directly impact enrollees, who are likely unfamiliar with processes for verifying their eligibility. To ensure that policy changes are accessible and understandable to all consumers, including those with limited health literacy, we recommend CMS develop and implement a comprehensive communication and public education strategy. In line with Exchange issuers' longstanding collaboration with CMS, agency officials should share this strategy with issuers and stakeholders to coordinate messaging and customer support.

AHIP Recommendations:

- **Delay the effective dates for certain proposals to ensure adequate time to reflect new policies in rates, plan designs, and operations processes.**
- **Implement a comprehensive communication and public education strategy to ensure consumers understand any new policy changes that may affect their coverage.**

III. Health Insurance Reform Requirements (Part 147)

Coverage Denials for Failure to Pay Premiums for Prior Coverage (§ 147.104(i))

AHIP supports CMS' proposal to provide issuers the option to require enrollees to pay past-due premiums before new coverage can start, with a request for clarification. This proposal will reduce adverse selection by discouraging enrollees from dropping coverage at the end of the year and reenrolling in January coverage. AHIP supports policies that promote continuous, year-round coverage, which is essential to maintaining a stable individual market.

Because every issuer does not have the necessary data or technology to operationalize this change, we stress the importance of keeping this provision optional for issuers, as proposed. We encourage CMS to provide issuers and State Exchanges flexibility in how they implement this policy and for CMS to continue deferring to issuers on payment and business decisions. Furthermore, due to the nominal amount

many enrollees owe in past-due premiums, for many issuers the implementation costs may outweigh revenue from potential collections of past-due premiums.

AHIP Recommendations:

- **Finalize proposal to allow issuers the option to require payment of past-due premiums before new coverage can start.**
- **If finalized, expressly state this policy is optional for issuers.**
- **Continue to provide issuers and State Exchanges flexibility in how they implement payment policies.**

IV. Exchange Standards (Part 155)

Definitions: Deferred Action for Childhood Arrivals (§ 155.20)
Should this proposed definition be finalized, CMS should clarify how Exchanges will terminate DACA enrollees, including whether this policy will apply to current DACA recipients enrolled in Exchange coverage, DACA recipients who do not currently have Exchange coverage and are attempting to enroll, or both. If this policy applies to current enrollees, CMS should clarify the timeline for Exchanges to identify impacted enrollees, notify enrollees, and communicate terminations to issuers. Exchanges are responsible for eligibility determinations and issuers do not have information on enrollees DACA status, nor are issuers able to make eligibility determinations.

In addition, more time is needed to operationalize coverage terminations resulting from this policy. The proposed effective date would create significant challenges for Exchanges to accurately identify an enrollee or prospective enrollee's DACA status and send termination transactions to issuers for impacted enrollees. Insufficient lead time could result in delayed or incorrect terminations, potentially disenrolling members who should remain covered. If this provision is finalized, we recommend CMS delay the effective date to the last day of the month following the effective date of the final rule to provide sufficient time for issuers to receive and process termination transactions.

AHIP Recommendation:

- **If finalized, delay the effective date to last day of the month following the effective date of the final rule so issuers and Exchanges have sufficient lead time to operationalize terminations.**

Standards for Termination of an Agent's, Broker's, or Web-Broker's Exchange Agreements for Cause (§ 155.220(g)(2))
AHIP supports CMS' efforts to increase transparency around agent, broker, and web-broker compliance measures by adding a "preponderance of the evidence" standard of proof to assess potential noncompliance and terminate for cause. Unscrupulous agents, brokers, and web-brokers should be held accountable for fraudulent and abusive activity, especially related to improper enrollments. A reasonable standard of proof will provide additional clarity around current compliance measures and ensure stakeholders are held to a fair, universal standard.

We appreciate that CMS has adopted several of our recommendations in response to unauthorized enrollment and unauthorized plan switches by brokers. Additional improvements to strengthen consumer protections include:

- **Provide opportunities for additional consent verification – such as two-factor authentication – for consumers.** Two-factor authentication is an internet best practice to protect consumer information and is used successfully by several State Exchanges to add an agent or broker to an application or allow an agent or broker to update an enrollment. For example, Covered California sends a one-time password to the consumer, who then gives it to the agent before any changes can be made. D.C. Health Link requires consumers to list their preferred agent or broker on their Exchange application. Only those agents or brokers listed on their application may access their application. In SBMs that use Get Insured for their enrollment and shopping platform, an agent or broker can only act on enrollments to which they've been assigned, and both the broker and enrolling consumer must consent to have the broker assigned to an enrollment. We encourage CMS to coordinate with State Exchanges regarding two-factor authentication and other best practices that will strengthen consumer protections. We also encourage CMS to provide consumers with the option to employ consent verification so that it would provide additional protection for those who want it and not affect those who choose not to adopt it or who do not have the technical capabilities to employ it.
- **Require agents and brokers to follow specific consumer consent documentation requirements when an enrollee seeks to make an Exchange enrollment or plan change**. CMS should provide agents and brokers with a standardized consumer consent form and a centralized hub to upload documentation. We also recommend CMS confirm receipt of any consent documentation using the centralized hub.
- **Share additional information with issuers on SEP enrollment trends**, including by SEP type, duration of SEP enrollments, and the number of SEP enrollments assisted by agents or brokers, and other relevant information. Sharing this information will allow stakeholders to work together to address any gaps caused by SEP fraud and abuse and identify potential policy solutions.

AHIP Recommendations:

- **Adopt the "preponderance of the evidence" standard as proposed.**
- **Strengthen consumer protections through opportunities for additional consent verification, such as two-factor authentication.**
- **Require agents and brokers to use a standardized consumer consent form and a centralized hub to upload documentation.**
- **Share additional information with issuers on SEP enrollment trends.**

<u>Verification Process Related to Income Eligibility for Insurance Affordability Programs (§§ 155.305, 155.315, and 155.320)</u>

Failure to File Taxes and Reconcile APTC Process (§ 155.305(f)(4))
AHIP supports the proposal to amend the current failure to file and reconcile (FTR) process by requiring Exchanges to determine consumers ineligible for APTC if they have an FTR status of one year, rather than two consecutive years. Shortening the FTR requirement to one year will bolster Exchange program integrity and ensure consumers avoid increased tax liabilities. Exchanges should clearly communicate this change to enrollees and provide timely information on filing requirements and timelines to encourage consumers to file a federal income tax return to reconcile APTC. We recommend CMS publish the amended standard notices as soon as possible.

Timely data sharing with the Internal Revenue Service (IRS) is critical to successfully implementing this proposal. To avoid unnecessary disruptions in coverage, we encourage CMS to confirm that IRS has

adequate resources to support the updated standard and is prepared to verify eligibility and communicate impacted taxpayers to Exchanges in a timely manner.

AHIP Recommendations:

- **Reinstate the requirement for Exchanges to terminate APTC eligibility for consumers who have an FTR status for one year.**
- **Publish the amended draft standard notices for review as soon as possible.**
- **Coordinate with IRS to prepare for the updated FTR threshold to ensure timely eligibility checks, information sharing with Exchanges, and notification to impacted taxpayers.**

60-Day Extension to Resolve Income Inconsistency (§ 155.315)
AHIP supports the proposal to eliminate the 60-day extension to resolve income inconsistencies. Eliminating this automatic extension will align with the statutorily required time to resolve data matching inconsistencies (DMI) and ensure improper payments are addressed as quickly as possible in situations where there is an unauthorized enrollment.

Given the various new verification requirements in this rule, we recommend Exchanges be permitted to extend the 90-day period if they experience delays or backlogs in their verification processes. We are concerned that the potential influx of verifications will result in delays and require additional time for case resolution and consumer outreach, potentially resulting in inappropriate coverage terminations for eligible enrollees. In addition, in the Proposed Rule, CMS stated it previously found one-third of consumers who resolve income DMIs used an extension between 2018 and 2021. We recommend the federal Exchange provide extensions if administrative backlogs to avoid unnecessary terminations for eligible enrollees. Extensions could be handled on a rolling basis, pausing the clock after an enrollee submits documentation to allow Exchanges time to review and respond.

We recommend CMS ensure enrollee notifications clearly communicate the DMI reasons, documentation to resolve an inconsistency, and timelines to resolve income inconsistencies. If finalized as proposed, enrollees will be faced with several new, unfamiliar verification standards. CMS, issuers, and partners will need to conduct coordinated education and outreach to ensure consumers are aware of these requirements.

AHIP Recommendations:

- **Eliminate the 60-day extension to resolve income inconsistencies.**
- **Ensure Exchanges and verification vendors have resources in place to conduct timely verifications of DMI cases.**
- **Automatically provide extensions if cases are delayed for administrative reasons so that eligible enrollees do not lose coverage due to lack of adequate response time.**
- **Ensure Exchanges communicate terminations with issuers in a timely manner so that issuers can coordinate outreach and call center support.**
- **Ensure notices and consumer outreach are timely and clearly communicate inconsistencies, timelines, and applicable resolution processes.**

Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii))
AHIP supports verifications to reduce instances of improper APTC payments and increase program integrity. However, requiring enrollees with incomes below 100% FPL to verify income will create

excessive administrative burden for enrollees, operational challenges for Exchanges, and will be detrimental to the risk pool. In 2025, an individual with annual income at 100% FPL is earning just $15,650; for a single parent with two children, that amount is $26,650. We recommend CMS delay finalizing this proposal until after it evaluates whether other program integrity proposals are sufficient to address concerns about improper enrollments.

We are concerned that new verification requirements for this population will add administrative complexity during a time when Exchanges, issuers, and stakeholders are working to implement various verification requirements. Estimating future income poses several distinct challenges that can lead to enrollees submitting inaccurate estimates that are not a result of intentional fraud. Future income is inherently uncertain, especially for individuals who may be self-employed, work uncertain hours, multiple jobs, seasonal jobs, or depend on tips for a substantial part of their income. In addition, certain data sources may not accurately represent actual income for low-income families, as not all individuals are required to file tax returns. Verifying income for individuals with attested income below 100% FPL would be extremely challenging and poses excessive administrative burden on Exchanges and consumers.

This policy would adversely affect eligible low-income enrollees. Research shows that administrative burdens, such as income verification requirements, represent a greater barrier for those with fewer resources and thus disproportionately hurt lower income populations.[1] For example, an analysis of the Pennsylvania Medicaid program found that the largest singular reason that individuals—regardless of enrollment type—are terminated from Medicaid is failure to furnish required information.[2] This could include delays in furnishing verification documents or an income discrepancy with electronic data sources that cannot be resolved before disenrollment occurs. Approximately 33% of children, 27% of the expansion population, and about 22% of beneficiaries with disabilities cited this reason as cause for disenrollment.

Prior experience has shown that additional verifications adversely affect risk pools. Implementing this policy in combination with the other proposed verification requirements could result in unnecessary coverage terminations for younger and healthier consumers who remain eligible but find the administrative burden for enrolling too high. Research shows that bureaucracy, paperwork, and administrative burden are major drivers of low uptake and a source of frustration for consumers.[3] CMS proposes several policies that should strengthen Exchange program integrity, including eliminating the 150% FPL SEP, reinstating pre-enrollment verification for SEPs, revising FTR requirements, eliminating the 60-day DMI extension, and requiring verification as to when tax data is unavailable, that should mitigate fraudulent or improper enrollments. We recommend CMS finalize these policy changes and determine their effectiveness before implementing additional income verification policies for individuals with attested income less than 100% FPL.

AHIP Recommendations:

- **Due to the operational complexity of this proposal, significant burden on enrollees, and potential adverse effects for risk pool stability, CMS should delay implementation until the effectiveness of other policies is evaluated.**

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[1] https://academic.oup.com/healthaffairsscholar/article/1/1/qxad001/7203712
[2] https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/docs/publications/documents/highlighted-reports/PA%20DHS%20Medicaid%20Churn.FINAL.pdf
[3] https://www.nber.org/system/files/working_papers/w30781/w30781.pdf

- **If finalized, this policy should be optional for State Exchanges, which have not experienced the same degree of improper enrollments that this policy seeks to address.**

Income Verification When Tax Data is Unavailable (§ 155.320(c)(5))
AHIP supports removing the requirement that Exchanges accept an applicant's or enrollee's self-attestation of projected annual household income when the Exchange requests tax return data, but the IRS confirms there is no such tax return data available. This proposal will minimize the risk of adverse selection and further protect the individual market from income fraud.

AHIP recommends CMS adopt exceptions for situations in which tax data may not be available through no fault of the applicant, including that they were not required to file a tax return in the prior year, or the presence of IRS privacy rules precluding sharing data if the family unit applying for coverage differs from the prior year due to marriage, divorce, birth, death, or other reasons, as well as in situations in which an enrollee was unable to verify eligibility during enrollment but would have been eligible based on their reported income and tax return data.

We encourage CMS to ensure Exchanges are adequately prepared to complete any required verifications so that consumers are not adversely affected by this proposal. Requiring Exchanges to verify household income with other sources when tax data is unavailable could result in unnecessary and harmful delays because Exchanges, including the Federal Exchanges, generally do not have the resources or staff to verify this information.

AHIP Recommendations:
- **Support the elimination of self-attestation of income.**
- **Provide exceptions for certain situations in which income tax data may not be available.**
- **Provide exceptions for situations in which an enrollee was unable verify eligibility during enrollment but would have been eligible based on their reported income and tax return data.**
- **Provide State Exchanges the option to adopt this proposal.**
- **Ensure State and Federal Exchanges are adequately prepared to implement this proposal without undue harm to consumers.**

<u>Annual Eligibility Redetermination (§ 155.335)</u>
AHIP supports policies that will reduce improper, fraudulent, and ghost enrollments while maintaining pathways for eligible consumers to enroll in and maintain coverage. However, given the sizable operational burden of the proposed verification requirements and potential for unnecessary consumer confusion and abrasion, we recommend CMS not finalize the proposed $5 premium passive re-enrollment requirement for fully subsidized individuals until CMS can assess the impact and efficacy of other verification requirements proposed in this rule.

First, there are substantive operational details that need to be addressed before issuers and Exchanges could implement the proposed policy. Exchanges and issuers would need to make significant changes to their billing processes and timelines, batch auto-renewal coding changes, and enrollment reconciliation processes. For example, some Exchanges provide reenrollment data to issuers in October or November. Issuers then use this data to produce January billing statements, which are usually sent to enrollees in early December. Because the December 15 deadline to actively reenroll is after the timeline for mailing January billing statements, Exchanges would need to clarify how and when they will send accurate

information about tax credit eligibility to issuers to ensure consumers receive timely notices about their January premium.

Exchanges and issuers require time to conduct thorough testing to ensure premium tax credit information is communicated accurately between Exchanges, issuers, and consumers. Specifically, Exchanges would need to produce new consumer notices, update customer service training instructions, and coordinate across stakeholders to ensure consumers are informed about this policy change. If implemented, CMS should clarify the process and timing to reinstate full tax credit eligibility. We recommend income updates are effective on the first of the following month—following timing for most SEP enrollments—to limit financial liability for eligible consumers. CMS should clarify the impact for other related policies, such as whether impacted enrollees would continue to be eligible for the 3-month grace period.

This proposal would mark a significant change in current automatic reenrollment processes, adding extensive cost and resource burdens, especially if other income verification requirements are implemented for plan year 2026. AHIP recommends CMS first evaluate the effectiveness of other policies and verification requirements proposed in this rule to address program integrity concerns before deciding to finalize the $5 premium passive re-enrollment requirement for fully subsidized individuals.

Second, should the enhanced tax credits be removed from the Internal Revenue Code at the end of 2025, the population impacted by this proposal would decrease substantially. Given the current uncertainty around the enhanced tax credits, this policy should not, at a minimum, be adopted for Plan Year 2026. If enhanced tax credits expire, we recommend this policy not be finalized, as the administrative burden of this proposal would outweigh the potential benefits to program integrity.

Third, if finalized, we recommend this policy be optional for State Exchanges. State Exchanges did not experience the same sharp rise in improper enrollments as the Federal Exchange. In fact, a 2024 study from Paragon Health Institute found that there is a drastic difference in fraudulent enrollment rates between Federal and State Exchange states.[4] Using data from the 2024 OEP, Paragon researchers found that, in Federal Exchange states, sign-ups reporting income between 138-150% FPL were 155% of the eligible population, while sign-ups in State Exchange states were only 76% of the eligible population. As such, the problem this policy seeks to address is not applicable to State Exchanges and should therefore be optional. In addition, implementing this process for State Exchanges would be complex and resource intensive. State Exchanges would need to build new logic for its APTC calculations, create a new system for verifying APTC and reversing that logic, and modify its timelines so that it could provide renewal data to issuers after the Open Enrollment deadline. To avoid unnecessary administrative burden, CMS should allow State Exchanges the option to adopt this proposal.

Fourth, to ensure coverage continuity for eligible individuals, CMS should not adopt a standard greater than $5 so as not to deter enrollment or result in unnecessary coverage cancellations for eligible enrollees. We strongly oppose adopting the alternative proposal to automatically re-enroll fully subsidized enrollees without any APTC if they do not actively re-enroll in coverage during Open Enrollment. This policy, combined with a shortened OEP, would result in a significant decrease in enrollment of eligible individuals.

[4] The-Great-Obamacare-Enrollment-Fraud_FOR_RELEASE_V2.pdf

Lastly, we emphasize AHIP's support for automatic reenrollment. Automatic reenrollment promotes continuity of coverage and removes unnecessary administrative burden for enrollees who are satisfied with their health coverage and is used across lines of business, including employer provided coverage. A National Bureau of Economic Research paper found that eliminating auto-enrollment for health insurance reduced enrollment by 33 percent and differentially excluded young, healthy, and economically disadvantaged people.[5] Similarly, research on Massachusetts' health insurance exchange (prior to ACA implementation) found that individuals who were automatically reenrolled into coverage were typically younger and healthier than other enrollees, with medical costs 44% below average.[6] These findings suggest that automatic reenrollment strengthens the risk pool and ensures eligible enrollees maintain their coverage. Furthermore, automatic reenrollment is a standard practice in the employer market, showing it is a trusted process to ensure consumers maintain coverage.

AHIP Recommendations:

- **Delay implementation until CMS assesses the impact of other verification requirements on fraud and abuse and consumer behavior.**
- **Provide State Exchanges with the option to adopt this proposal.**
- **Do not adopt a standard greater than $5, nor the alternative proposal to automatically re-enroll fully subsidized enrollees without any APTC if they do not actively re-enroll in coverage during Open Enrollment.**
- **Ensure income updates to resolve the $5 premium requirement are effective on the first of the following month, consistent with timing for most SEP changes, to limit financial impact for enrollees.**

Annual Eligibility Redetermination (§ 155.335(j))

AHIP supports CMS' proposal to amend the automatic re-enrollment hierarchy by removing the bronze-to-silver crosswalk policy. Automatically changing a consumer's plan from bronze to silver relies too heavily on the assumption that the Exchange will make a better choice for a consumer than they will for themselves. Many consumers do not actively change their plan selection because they are satisfied with their current plan and expect to be automatically re-enrolled in the next Plan Year. The proposed policy restores consumer choice to the re-enrollment process by allowing consumers to retain their original plan selection.

Consistent with prior recommendations from AHIP, we encourage CMS to consider additional decision support tools to enhance the healthcare.gov experience for consumers eligible for cost-sharing reductions (CSRs). Some consumers may find it difficult to select a plan because they do not understand how cost sharing works and, in some cases, may be misled by plan metal levels. To help consumers make the best decision for their health care needs, CMS could consider additional pop-ups that help explain why a particular metal level (e.g., silver) may be preferable based on the consumer's eligibility for cost-sharing subsidies.

AHIP Recommendations:

- **Remove the bronze-to-silver crosswalk policy, as proposed.**
- **Provide additional support to CSR-eligible enrollees during the plan selection process.**

[5] https://www.nber.org/system/files/working_papers/w30781/w30781.pdf
[6] https://www.nejm.org/doi/full/10.1056/NEJMp2114189

Premium Payment Threshold (§ 155.400)
AHIP recommends CMS allow issuers to maintain existing flexibility in offering enrollees a percentage-based premium payment threshold and/or fixed-dollar premium payment threshold. Issuers have historically managed payment thresholds and are best positioned to implement these thresholds due to their deep understanding of enrollee needs and local market dynamics. We encourage CMS to continue deferring to issuers regarding their billing policies. In addition, this policy promotes coverage continuity by protecting consumers from coverage terminations because of owing de minimis amounts of premium. Promoting continuous coverage contributes to a more stable and balanced risk pool, and in turn reduces premiums.

CMS seeks to remove this policy due to the potential risk it poses to program integrity. While we acknowledge CMS' concerns, the various protections included in this Proposed Rule will ensure enrollees who are unknowingly enrolled in Exchange coverage are properly terminated. Furthermore, this policy limits application of the fixed-dollar premium payment threshold and gross premium-payment threshold to payments made after coverage is effectuated, so that it does not apply to the binder payment. This ensures that enrollees must take action to effectuate their coverage and protects Exchanges from improper enrollments.

AHIP Recommendation:

- **Allow issuers to maintain flexibility in offering enrollees a percentage-based premium payment threshold and/or fixed-dollar premium payment threshold.**

Annual Open Enrollment Period (§ 155.410)
AHIP supports CMS' proposal to shorten the Open Enrollment Period to conclude on December 15 for federal Exchanges. A shortened OEP will reduce adverse selection and ensure the stability of the individual market. Consistent open enrollment start-dates and end-dates will promote consistency across the federal Exchanges, making it easier for consumers to remember key dates to enroll in coverage during annual OEPs.

We recommend CMS delay the effective date to Plan Year 2027 to account for the uncertainty around the expiration of the enhanced tax credits at the end of the year. Consumers may not have an accurate estimated premium or subsidy for 2026 until the year's end and may need additional time in the new year to consider alternative plan options that best fit their financial and health needs. An earlier OEP deadline may lock consumers into a plan that is vastly more expensive than they anticipated, causing them to drop coverage entirely.

CMS is proposing complex changes in this rule. Assisters, navigators, agents, brokers, and vendors may need additional time to communicate and implement the various provisions of this rule. Consumers rely on agents and brokers to understand eligibility requirements and enrollment processes. Agents and brokers are a limited resource and will be supporting both Medicare and Marketplace open enrollment at the same time, if this provision is finalized. To limit disruptions, support enrollees, and ensure enrollment partners have enough lead time to communicate potential changes to enrollees, we recommend maintaining the current OEP window for Plan Year 2026 and delaying this proposal to take effect beginning in Plan Year 2027.

We recommend CMS finalize the proposed OEP window only for the federal Exchanges. State Exchanges should maintain the flexibility to establish their own OEPs that meet the unique needs of the

state's residents and market dynamics. We recommend CMS not prohibit State Exchanges from issuing SEPs to extend OEPs. If CMS permits states flexibility to determine the appropriate open enrollment deadlines for their markets, the final rule should ensure other proposed policies reflect variability in enrollment deadlines and coverage start dates.

We recommend CMS update renewal notices to include accurate and timely premium and financial assistance information to ensure a seamless enrollment experience for enrollees. The Guaranteed Renewability of Coverage Requirements (45 CFR § 147.106) require carriers to send notices to members 180 days, 90 days, or 60 days prior to discontinuation or renewal, depending on specific mappings and state standards. Under the current batch auto reenrollment (BAR) and renewal notice timelines, most consumers will receive renewal notices that reflect their subsidy eligibility according to the prior year's subsidy benchmark and federal poverty levels. This often leaves consumers with inaccurate information about their subsidy eligibility and net premium for the coming year and can lead consumers to believe they are responsible for paying a much different amount of premium.

Consumers should have access to the information and tools they need to select the health plan that works best for them. AHIP recommends CMS provide issuers flexibility to modify renewal and discontinuation notices to communicate critical information in a manner that will best meet the needs of their enrollees. For example, issuers could be provided a similar renewal notice flexibility to 2022, which encouraged consumers to check healthcare.gov for the most up-to-date information on net premium, deductibles, and out of pocket costs.[7] Ensuring accurate renewal notices is especially pertinent this year as the enhanced tax credits authorized by the IRA are scheduled to expire at the end of 2025. If issuers are not provided additional flexibility, consumers will be falsely led to assume there are minimal, if any, changes to their tax credit amount and net premium, leading them to forgo updating their healthcare.gov or state exchange application or making an active plan selection. It is critical that Exchange enrollees receive accurate, timely information about the change in their tax credit eligibility and net premium so they can make an informed decision about their 2026 coverage.

AHIP Recommendations:

- **Finalize the proposed Open Enrollment dates for the Federal Exchanges.**
- **Delay the effective date to Plan Year 2027.**
- **Allow State Exchanges discretion to establish their own Open Enrollment deadlines**.
- **Provide issuers renewal notice flexibility to ensure consumers do not receive misleading or inaccurate information about their financial assistance and premium amounts.**

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

AHIP supports CMS' proposal to reinstate pre-enrollment verification for SEP eligibility, with accommodations for additional flexibility. SEP pre-enrollment verification promotes a stable risk pool and reduces opportunities for improper enrollments, fraud, and abuse. To ensure consumers have timely access to care and do not experience delayed enrollments, we encourage CMS to consider efficient, automated verification processes so that SEP enrollments are not unnecessarily delayed. Both Federal and State Exchanges must be well prepared to execute SEP verification processes. When Exchanges are unable to perform timely verification, issuers often receive complaints of consumer confusion and abrasion.

[7] https://www.cms.gov/files/document/safe-harbors-related-federal-standard-renewal-and-product-discontinuation-notices.pdf

We recommend CMS work with State Exchanges to consider alternative compliance requirements for states, rather than the 75% threshold. Some State Exchanges are not equipped to meet the proposed 75% threshold and would require massive investments to meet that standard. Rather than implement a quantitative standard, CMS should consider giving Exchanges flexibility to target certain classes of SEPs that may pose increased risk to improper enrollments. This would allow State Exchanges to tailor verification requirements to the specific SEPs that enable the most fraud in their unique market, prioritizing qualitative standards over quantitative standards. For example, the threshold could require additional verification standards for SEPs that include a change of address. For the past few years, issuers have partnered with CMS to combat false residency schemes, which occur when Medicaid enrollees are enrolled in commercial benefits in a state the enrollee doesn't live in. These schemes are suggestive of a marketing/body broker scheme, and coordinated through recruiters who promise enrollees that they will be able to receive substance use disorder treatment paid for by an issuer in another state. If CMS implements the 75% threshold, State Exchanges will likely verify their largest SEPs, rather than those that may enable the greatest amount of fraud.

We also encourage CMS to provide issuers with reason codes for SEP enrollments. Some State Exchanges currently transmit reason codes with SEP enrollments, which helps issuers to proactively coordinate care, avoid disruptions in treatment, and ensure that consumers are connected to appropriate providers and services.

AHIP Recommendations:

- **Reinstate pre-enrollment verification for SEP eligibility.**
- **Consider efficient, automated verification processes to ensure enrollment is not delayed.**
- **Ensure that Federal and State Exchanges are adequately prepared to complete verification processes in a timely manner.**
- **Permit State Exchanges flexibility to establish their own thresholds (for example, based on qualitative standards rather than quantitative standards).**
- **Provide issuers with the reason codes for SEP enrollments.**

V. Issuer Standards (Part 156)

Prohibition on Coverage of Sex-trait Modification as an EHB (§ 156.115(d))

Consistent with longstanding AHIP positioning on Essential Health Benefit (EHB) benchmark plans, we recommend CMS preserve the framework that allows states to adopt an EHB benchmark plans that best fit their unique market dynamics.[8] This framework balances the need for state flexibility within a broad federal guardrail while allowing innovation and flexibility in health plan benefit design that meet consumer needs. Since the ACA was enacted, this framework has been durable in a competitive Marketplace where states have the flexibility to modify benefits over time. Changing course to proscribe or prohibit benefits at a more granular level could restrict the ability of states to respond to local needs, increase the price of coverage, limit plan and provider innovation, and hinder flexibility for issuers to respond to changes in scientific evidence and clinical practice. While we support this overarching framework, we note that recent regulatory changes have made it easier for states to mandate benefits without defraying costs by adding them to the EHB benchmark plan. We encourage CMS to require states

[8] https://www.regulations.gov/comment/CMS-2022-0186-0085

to defray the costs of state mandated benefits in addition to EHB and increase oversight of new benefit mandates to avoid increasing premiums for consumers.

AHIP Recommendation:

- **Preserve statutory EHB framework that allows state benefit flexibility within a broad federal guardrail.**
- **Increase oversight of state mandated benefits in addition to EHB for which states are responsible for defraying costs.**

Premium Adjustment Percentage (§ 156.130(e))

AHIP supports CMS' proposal to update the premium adjustment percentage methodology to calculate cost-sharing proposals and hardship exemptions for catastrophic plans. These changes will more accurately reflect changes in cost trends and improve the calculation of cost-sharing limits for future plan years. However, if finalized, there is not sufficient time for issuers to update their plan designs and rates for Plan Year 2026 to reflect this change. AHIP appreciates the updated AV calculator release issued in late March 2025, but despite this updated guidance, the rate filing and QHP submission timeline does not allow issuers enough time to revise plans in accordance with the updated AV calculator and Proposed Rule provisions.

AHIP Recommendation:

- **Finalize updated premium adjustment percentage methodology beginning with the 2027 Plan Year.**

Levels of Coverage (Actuarial Value) (§§ 156.140, 156.200, 156.400)

AHIP supports CMS' proposal to update the actuarial value de minimis ranges to +2/-4 percentage points for all individual and small group market plans subject to the AV requirements under the EHB package, except for expanded bronze plans, for which it proposes a de minimis range of +5/-4 percentage points, and removing the de minimis range of +2/0 for individual market silver QHPs for QHP certification conditions. The expanded de minimis ranges would allow issuers to design plans that meet the needs of enrollees in the individual and small group markets and maintain uniform standards on- and off-Exchange. Because changes to the AV de minimis ranges impact the AV calculator, which CMS recently updated to account for these proposed changes, we urge CMS to make this provision effective as soon as possible.

CMS should also confirm that any modification made to meet the new AV ranges would meet the uniform modification standards under 45 CFR 147.106(e) to ensure that consumers do not experience coverage disruptions because of this change. This approach would be consistent with previous CMS guidance and policies that modified the AV de minimis ranges and clarified that changes made to maintain the same metal tier level directly related to a federal or state requirement and avoid product discontinuations.

AHIP Recommendations:

- **Finalize updated actuarial value de minimis ranges as soon as possible.**
- **Confirm that any modification made to meet the new de minimis ranges would meet the uniform modification standards.**