AAFP

AMERICAN ACADEMY of FAMILY PHYSICIANS

April 8, 2025

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

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 2020

Submitted electronically via regulations.gov

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

Dear Dr. Oz,

On behalf of the American Academy of Family Physicians (AAFP), which represents 128,300 family physicians and medical students across the country, we appreciate the opportunity to comment on the proposed rule published in the Federal Register on March 19, 2025, regarding policy changes to the Affordable Care Act (ACA) Marketplaces. The AAFP has long supported affordable, comprehensive coverage. Family physicians see firsthand, how a lack of comprehensive coverage and high out-of-pocket costs adversely impact patients and can cause patients to delay necessary care out of fear of being unable to afford or access it.

The AAFP supports CMS's mission to protect consumers from waste, fraud, and abuse while ensuring premium relief for Americans. We urge CMS to prioritize safeguarding eligible consumers, holding insurers and brokers accountable, and placing responsibility on them to uphold their commitment to protecting patients. By doing so, CMS can sustain critical coverage, maintain balanced risk pools, reduce downstream health care costs, and deliver lasting relief for taxpayers—all while reinforcing trust in the health care system.

To prevent coverage disruptions and reinstate Marketplace integrity, the AAFP strongly recommend CMS:

- Extend the Marketplace Open Enrollment Period (OEP) to January 15 and preserve state authority to adjust Special Enrollment Periods (SEPs).
- Ensure DACA recipients remain eligible for federal health programs.
- Finalize §155.220(g)(2)), 'Standards for Termination of an Agent's, Broker's, or Web-Broker's Exchange Agreements for Cause' as proposed.

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- Strengthen oversight of insurers' enrollment practices and discrepancies to protect eligible consumers from undue penalties.

Family physicians are the foundation of the health care system, especially in rural and underserved communities, where they often serve as the initial point of access for patients facing significant barriers to affordable care. They simplify the complexities of health insurance, provide guidance on coverage issues, and help ensure they have consistent access to essential preventive and chronic care services throughout their lives. Stable and affordable health care coverage is not just essential for improving individual health outcomes; it is also a cornerstone of advancing population health and managing long-term health care costs for the nation.

Since the ACA was enacted, the uninsured rate has dropped from 15.5% in 2010 to below 8% in 2023.[i] Family physicians have seen firsthand the profound impacts of these coverage gains. More consistent access to care allows family physicians to manage chronic conditions, prevent unnecessary emergency room visits, and provide early interventions that save lives and reduce long-term health care costs for all Americans. The AAFP believes in a primary care–based U.S. health care system in which all people have appropriate and affordable coverage. This system is particularly vital to the more than 52 million Americans who have pre-existing conditions such as cancer, asthma, diabetes, high blood pressure and other serious or life-threatening chronic diseases; a population that has inarguably benefitted from the Patient Protection and Affordable Care Act. Accordingly, while we fully support the administration's efforts to protect taxpayer resources and prevent fraud, waste and abuse, we urge the agency to finalize policies that prioritize access, as they will ultimately deliver the greatest savings both in terms of real dollars and American's health.

Part 147. Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

CMS intends to shorten the annual Open Enrollment Period (OEP) for individual market coverage to run from November 1 to December 15 before the coverage year, instead of extending to January 15. Since 2022, CMS had previously extended the annual OEP to January 15, which resulted in 24.2 million consumers selected plan year 2025 coverage through the Marketplaces, 3.9 million of whom were new consumers.[ii] This change would apply to on- and off-Marketplace coverage, including state-based marketplaces (SBMs) which traditionally exercise their own flexibility in setting later enrollment dates using Special Enrollment Periods (SEPs). This provision aims to reduce consumer confusion, streamline enrollment, align with employer-based plan dates, encourage continuous coverage, and minimize adverse selection risks.

CMS also proposes to eliminate fixed-dollar and gross percentage-based premium thresholds, requiring issuers to rely solely on a net percentage-based threshold. CMS states that the fixed-dollar and gross percentage thresholds increase the risk of undetected improper enrollments, as enrollees might be less likely to receive enrollment invoices or

notices and therefore remain enrolled without their knowledge. Previously, in the 2026 Notice of Benefit and Payment Parameters, CMS established thresholds that allowed enrollees to be considered current if they paid a fixed-dollar amount (capped at $10) or 98% of the gross premium to safeguard coverage for lower-income Marketplace enrollees. Under this change, enrollees would need to pay at least 95% of their premium responsibility to maintain coverage.

Part 147 of this proposed rule also repeals the current provision that prevents insurers from requiring enrollees to pay past-due premium amounts to obtain coverage under a new policy or contract term. Instead, CMS proposes to reinstate the 2017 policy permitting insurers to combine an enrollee's past-due premiums with the initial premium required for coverage under a new policy or contract term. Under this proposal, insurers can deny coverage if the combined amount of past-due premiums and the initial premium is not paid in full.

AAFP Comments on Part 147. Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

While the AAFP commends CMS for its efforts to stabilize the ACA Marketplace and safeguard consumers and taxpayer dollars, we are concerned that reducing enrollment may not effectively achieve these goals. The AAFP has consistently emphasized the importance of affordable and accessible health coverage for all, as reflected in our previous comments on the 2026 Notice of Benefit and Payment Parameters. Ensuring broad access to coverage is essential not only for consumers but also for the overall stability of health systems.

CMS justifies these proposals as measures to prevent fraudulent enrollments while promoting consistent payment and conserving resources. However, such limitations on enrollment risk excluding millions of eligible Americans from coverage, particularly low-income consumers.

Low-income individuals and those with limited health literacy already face significant enrollment barriers, compounded by underfunded assistance programs. In 2023, nearly one in five uninsured low-income individuals cited confusion around enrollment deadlines and subsidy eligibility as key obstacles to obtaining coverage.[iii] Shortening the OEP risks increasing confusion and interrupting coverage, disproportionately impacting eligible consumers most in need of insurance. States will also be impacted, as limiting SBM flexibility to extend OEPs with SEPs is estimated to require states 4,000 hours and cost $7.8 million. Implementing this provision would place undue administrative and financial burdens on state resources while limiting access to coverage for state beneficiaries. Further, in 2022, 73% of enrollees had incomes between 100–250% of the Federal Poverty Level (FPL), leaving them highly sensitive to costs.[iv] Requiring repayment of premiums could discourage these consumers from re-enrolling, shrinking risk pools, and driving up premiums for all, ultimately compromising market stability. Moreover, costs do not vanish when consumers lose coverage. Uninsured Americans often incur medical costs that shift to hospitals, taxpayers, or the patient themselves. The proposed provisions aiming to boost accountability and continuous coverage actually risk worsening financial strain on already vulnerable health systems and communities, burdening them with greater uncompensated care.

Rather than restricting open enrollment and penalizing eligible consumers through blanket coverage denials, we urge CMS to optimize the impact of its limited resources by targeting specific sources of fraudulent enrollment, such as broker noncompliance or high-risk SEP enrollees, as we discus later in this letter. A targeted, strategic approach will curb waste while protecting legitimate and essential coverage for vulnerable Americans. CMS has demonstrated success in protecting Marketplace integrity through robust oversight of agents and brokers on the Federal Facilitated Marketplace (FFM). For instance, these efforts reduced the number of plan changes associated with agents and brokers by nearly 70% in 2024, showing that fraud intervention at the agent and broker levels is highly effective.[v] This proven approach to addressing fraud safeguards consumers and the stability of the Marketplace.

Additionally, the AAFP agrees with CMS on the critical need for transparency and accountability in premium payments. However, penalizing consumers for improper enrollments they may unknowingly face shifts responsibility away from the real stewards of these principles: insurers. Insurers play a pivotal role in the enrollment process, and misleading marketing practices or improper enrollments on their part can undermine Marketplace integrity as much, if not more, than consumer errors. Insurer steerage exemplifies this issue, often pushing consumers toward inappropriate coverage that results in care gaps and unexpected financial burdens. To address these concerns, **the AAFP supports granting issuers flexibility to waive or disregard minor premium discrepancies when evaluating coverage retention. However, this flexibility must come with the expectation that insurers will leverage their scale, resources, and data to actively prevent improper enrollments.** Stricter CMS oversight of insurers' practices is essential to ensure transparency and accountability throughout the system. Accountability must also rest with those managing enrollment, and not just the patients relying on it.

Part 155. Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

Definitions; Deferred Action for Childhood Arrivals (§155.20)

The proposed rule seeks to remove Deferred Action for Childhood Arrivals (DACA) recipients from the definition of "lawfully present" for ACA Marketplace, premium tax credits, cost-sharing reductions, and Basic Health Program (BHP) eligibility. This change would be made upon the effective date of the final rule, requiring issuers to terminate coverage in the middle of the year for DACA recipients. This marks a reversal of the 2023 decision to include DACA recipients in ACA coverage, a move that expanded access for an estimated 580,000 individuals, with CMS projecting that 100,000 previously uninsured DACA recipients could gain coverage with financial assistance.

AAFP comments on Definitions; Deferred Action for Childhood Arrivals (§155.20)

The AAFP strongly supports ensuring DACA recipients remain eligible for federal health programs. As the AAFP has emphasized in its Joint Comments to CMS on DACA Eligibility for Medicaid and CHIP, we strongly believe that the inclusion of DACA recipients in the definition of "lawfully present" is essential not only for their well-being, but also for advancing public health and reducing health care costs system-wide. Ensuring access to federal health programs for this population is a necessary step toward creating a healthier America and more cost-effective health care system for all.

Historically, DACA recipients, primarily low-income young adults, have faced uninsured rates three times higher than the general U.S. population.[vi] Since its inception in 2012, the DACA program has provided critical protections for more than 800,000 immigrants who entered the United States as children. DACA recipients contribute significantly to the workforce, with approximately 343,000 employed as essential workers, nearly 20,000 of whom are educators, 100,000 supporting the food supply chain, and 45,000 working in health care settings, even during the height of the pandemic.[vii] Despite their essential contributions, many DACA recipients face barriers to accessing health care. Younger recipients who cannot work may lack coverage if their parents are uninsured, and those with employer-sponsored insurance are often left without options if they lose their jobs or have reduced hours. The instability of coverage was starkly highlighted during the COVID-19 pandemic, when nearly 18% of surveyed DACA recipients lost employer-provided insurance.[viii]

If excluded from ACA coverage, thousands of DACA recipients will not only lose coverage but also shift health care costs to state and community programs, safety-net providers, and emergency rooms. This exclusion could lead to delays in preventive care and reliance on costly acute interventions. Such outcomes would harm the health of DACA recipients while driving up overall costs for the health care system. Additionally, CMS estimates that the implementation of this provision would cost each SBM at least 1,000 hours, with an additional 1,000 hours to terminate coverage for current DACA enrollees. CMS notes that this estimate does not account for the consumer outreach and education necessary to notify beneficiaries of this change. This significant administrative burden would waste critical CMS resources, while also disproportionately increasing health care costs for communities with DACA residents. Further, per 2023 USCIS data and this proposed rule, DACA recipients are relatively younger and healthier than the general population.[ix] Their inclusion in risk pools can actually improve insurance rates and provide a source of Market stabilization that CMS aims to achieve in this proposed rule.

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

CMS proposes adopting a "preponderance of the evidence" standard to evaluate whether agents, brokers, or web-brokers should face Marketplace Agreement terminations for noncompliance. The proposed rule outlines several grounds for termination including failure to comply with CMS guidelines, misrepresentation of plan details, unauthorized enrollment or data breaches, failure to provide accurate plan options, and engagement in fraudulent practices. To enhance transparency and protect consumers, the rule would require brokers to document consumer consent for enrollments and plan changes, grant CMS expanded

authority to impose monetary penalties for violations, and mandate written notifications to consumers if a broker's agreement is terminated, along with guidance on alternative enrollment options.

AAFP comments on Standards for Termination of an Agent's, Broker's, or Web-Broker's Exchange Agreements for Cause (§155.220(g)(2))

The AAFP applauds CMS for its efforts to strengthen consumer protections against misleading broker practices and enhance the integrity of the Marketplace. Safeguarding consumers from unauthorized or misleading enrollments is critical to maintaining public confidence in the health care system. The AAFP identifies this as a key area where CMS can effectively reduce waste and fraud without penalizing eligible consumers. Notably, in 2024, CMS reported that a "substantial increase in consumer complaints from people who were unaware that they had been enrolled by an agent, broker, or web-broker in Exchange coverage suggests many of these improper enrollments are due to fraud". And as we have mentioned earlier in this letter, CMS compliance enforcement actions have reduced the number of plan changes associated with agents and brokers, demonstrating that targeted fraud intervention at the agent, issuer, and broker levels yield effective results, but more can be done.

In our comments on the 2026 Notice of Benefit and Payment Parameters, we wrote in support of CMS's policy to review and enforce compliance against lead agents for insurance agencies. **The AAFP supports CMS in its continued efforts to protect enrollees from agents and brokers who fail to comply with regulations designed to safeguard consumers and urges CMS to finalize this provision of this proposed rule.** Coverage decisions must prioritize the best interests of enrollees. However, commissions earned by agents and brokers create a conflict of interest. Whenever financial incentives have the potential to influence coverage decisions, CMS must rigorously enforce regulations to prevent misconduct and protect consumers. Unlike brokers and agents who operate on a commission basis, Navigators are required to provide unbiased assistance and cannot steer consumers toward specific plans for financial gain. Navigators are particularly critical in educating and supporting low-income, minority, and non-English-speaking Americans, who often face significant barriers to enrollment. However, their value was recently stymied by a funding reduction for Navigator programs in February—from $100 million annually to just $10 million.[x] With such limited resources, assisting vulnerable populations becomes increasingly challenging, raising the risk of lower enrollment rates and more uninsured individuals.

To prevent gaps in enrollment assistance following rightful broker terminations, the AAFP urges CMS to distinguish regulation between Navigators and brokers/agents. **CMS should continue regulating brokers and agents while reinvesting in the Navigator program to expand their capacity, particularly in areas where broker terminations could create coverage gaps.** Strengthening Navigator support will ensure eligible consumers maintain access to unbiased enrollment assistance, even as broker availability declines.

Proposals related to income eligibility and verification

CMS outlines several changes to the eligibility and enrollment verification process for the Marketplace, Advance Premium Tax Credits (APTC), and Cost-Sharing Reductions (CSR). These provisions aim to prevent fraud, reduce abuse, and improve the accuracy of subsidy payments by implementing the following measures:

- **Eliminate the automatic 60-day extension for consumers** to resolve income discrepancies, resulting in terminated APTCs and CSRs. *(§155.315(f)(7))*
- **Tighten the allowable income verification threshold** to allow for less income variability before triggering an income inconsistency notice and requiring documentation from consumers. *(§155.320(c)(5))*
- **Remove self-attestation of income** as an acceptable source of income verification if IRS data is unavailable. *(§155.320(c)(5))*
- **Terminate APTC eligibility after one year of Failure-to-Reconcile (FTR)** the previous year's APTCs through tax filing. *(§155.305(f)(4))*
- **Expand pre-enrollment verification for all types of Special Enrollment Periods (SEPs)** and require pre-enrollment verification for at least 75% new SEP enrollments. *(§155.420)*
- **Eliminate monthly SEPs for individuals with household incomes at or below 150% of the FPL,** which currently allows eligible low-income consumers to enroll in Marketplace plans at any time throughout the year. *(§155.420(d)*
- **Charge consumers $5 premiums upon automatic re-enrollment** in zero-premium plans until they update their income information to retain their plan. *(§155.335)*
- **Eliminate automatic re-enrollment from a bronze to a silver Qualified Health Plan** when the silver plan is within the same product, has the same provider network, and offers an equal or lower net premium compared to the bronze plan. (§155.335(j)(4))

AAFP Comments on Proposals related to income eligibility and verification

While these changes intend to bolster program integrity, they pose significant risks to low-income populations and rural communities, groups that already face substantial barriers to coverage. Stricter verification requirements and additional administrative hurdles can result in higher uninsured rates, increased reliance on acute emergency care, and worsening health outcomes that affect the entire health care system.

The proposed expansion of SEP verification requirements is particularly concerning for rural and underserved areas, where limited health literacy and limited access to documentation and enrollment support makes navigating the process even more challenging. Delayed coverage or denial due to verification issues can also exacerbate poor health outcomes and increase financial and operational pressures on rural health systems. Similarly, the FTR rule threatens to disproportionately impact consumers with limited financial literacy or inconsistent income, potentially leaving many without affordable coverage. Also, the monthly SEPs for individuals with household incomes at or below 150% of the FPL, introduced during the COVID-19 Public Health Emergency, had been crucial in providing coverage for low-

income Americans who often face income volatility, employment changes, and other barriers to timely enrollment. Removing this monthly SEP would restrict enrollment opportunities for those who miss the annual OEP which is also being shortened under this proposed rule. By introducing these measures, the proposed rule risks undermining CMS's goal of expanding access to affordable health care, as these policies can create coverage losses among vulnerable populations.

The AAFP commends CMS for its commitment to improving program integrity but emphasizes the importance of safeguarding consumer access to coverage and protecting vulnerable populations. To achieve these goals, **the AAFP recommends that CMS:**

- **Focus SEP verification efforts on high-risk categories:** By concentrating verification efforts on the high-risk categories identified by CMS as having the greatest enrollment discrepancies and likelihood of fraud, CMS can conserve federal and state resources. This targeted approach minimizes administrative burdens on states, providers, and consumers, ensures fraud reduction, and avoids discouraging eligible individuals from enrolling.
- **Provide guidance on alternative coverage options or provisional coverage:** For consumers, whose verification is still being processed, CMS should offer clear guidance on alternative coverage options or provide provisional coverage to safeguard access to care during the verification period.
- **Enforce insurer accountability:** The proposed changes disproportionately target consumers while overlooking the role of insurers in mitigating fraudulent enrollments. Insurers possess the consumer data, resources, and scale necessary to improve enrollment practices but have not faced sufficient oversight. CMS can enhance program integrity by strengthening oversight of insurers' marketing practices, subsidy reconciliation processes, and consumer outreach and education. This ensures accountability while protecting consumers from unwarranted penalties.

By prioritizing reasonable documentation, focusing on high-risk verification categories, and holding insurers accountable, CMS can enhance subsidy accuracy and uphold the ACA's mission of expanding affordable health care access without placing undue burdens on consumers and vulnerable populations.

Part 156. Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges

Prohibition on Coverage of Sex-Trait Modification as an Essential Health Benefit (EHB) (§156.115(d))

CMS proposes to prohibit insurers from treating "sex-trait modification" services as EHBs in PY26.
If this provision is finalized, insurers would no longer be required to cover gender-affirming care services that can fall under EHBs. While insurers may still offer coverage for these services voluntarily, these services would be considered non-EHB, therefore dissolving EHB-associated consumer protection standards for gender-affirming care services. Also, CMS

notes states that mandate coverage for gender-affirming care outside their EHB benchmark plan would be required to defray the associated costs.

To guide implementation of this proposed rule, CMS has also invited public comment on whether a formal definition of "sex-trait modification" should be adopted and whether exceptions should be established to allow coverage of items and services as EHBs for medical conditions that may involve treatments associated with this term.

AAFP comments on Prohibition on Coverage of Sex-Trait Modification as an EHB (§156.115(d))

The AAFP supports access to gender-affirming care for gender-diverse patients and supports an informed consent model rather than a diagnostic model as the preferred approach to providing this care. The AAFP believes that gender-affirming health care is part of comprehensive primary care for gender-diverse patients, and may include supportive behavioral health care, voice therapy, gender-affirming hormones, puberty blockade, surgical interventions, permanent hair removal, and other medical procedures. Accordingly, we encourage CMS to maintain EHB status for gender-affirming care services.

CMS justifies this provision by stating that "coverage of sex-trait modification is not typically included in employer-sponsored plans, and EHB must be equal in scope to a typical employer plan." However, data indicates that 72% of Fortune 500 companies currently offer health insurance plans that include gender-affirming care.[xi] This suggests that coverage of gender-affirming care is already a common feature in many employer-sponsored plans.

Thus, the AAFP also recommends that CMS refrain from defining "sex-trait modification" within the proposed rule. Attempting to codify a definition risks oversimplifying the range of medical treatments that could fall under this category. "Sex-trait modification" is not a category explicitly referenced in EHB packages, which vary by state, nor is it widely utilized among employer plans or Marketplace standards. States already manage how gender-affirming care services are categorized within EHBs, demonstrating that a federal definition is unnecessary. The AAFP also believes that all decisions about patient care should be guided by the physician-patient relationship, which is central to ensuring individualized and appropriate care. We encourage CMS to defer to medical expertise and clinical guidelines rather than define terms that are not widely used in the medical community. The AAFP has consistently opposed any policy that might constrain the breadth or content of communication within the physician-patient relationship, as this could compromise the health and well-being of American individuals, families, and communities.

We appreciate the opportunity to provide comments on this proposed rule. For additional questions, please contact Sahana Chakravartti, Regulatory Specialist, at schakravartti@aafp.org

Sincerely,

Steve Furr, M.D., FAAFP

Steven Furr, MD, FAAFP
American Academy of Physicians, Board Chair

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