AMERICAN EXPERIMENT

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January 8, 2024

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

The Honorable Lily L. Batchelder
Assistant Secretary (Tax Policy)
Department of the Treasury
1500 Pennsylvania Avenue NW
Washington, D.C. 20220

Submitted Electronically via www.federalregister.gov

RE: [CMS–9895–P] Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO–OP) Program; and Basic Health Program

Dear Secretary Becerra and Assistant Secretary Batchelder:

Thank you for the opportunity to provide comments on the proposals included in the Notice of Benefit and Payment Parameters for 2025 (2025 Payment Notice). As a state-based public policy organization in Minnesota, Center of the American Experiment has a particular interest in how this rule will impact insurance affordability and a state's flexibility to address unique challenges facing its insurance markets under the Patient Protection and Affordable Care Act (ACA). While this rule includes some sensible proposals, the main elements would impose unnecessary restrictions on state-based Exchanges (SBEs) and reduce access to affordable health insurance premiums. The most concerning elements represent what can fairly be described as a federal takeover of state-based Exchanges and a shift from *essential* to *unlimited* health benefits. The following comments highlight these concerns and discuss other aspects of the 2025 Payment Notice that can help and harm consumers.

Proposed restrictions on State-Based Exchanges Undermine Consumer Affordability and Access

Several proposals in the 2025 Payment notice would impose new requirements on SBEs. Section 1321 of the ACA requires HHS to issue regulations on the establishment and operation of the Exchanges. This statutory language gives HHS substantial discretion over the standards that govern Exchanges. Part of this discretion draws from the fact that the functions of the Exchange

outlined in the statute provide only general direction which allows for a broad range of approaches to meet those functions. Despite this regulatory discretion, the statute elevates States as the primary government entity responsible for Exchanges. Section 1311(b) provides that "Each State shall … establish an American Health Benefit Exchange." It's not until the next section of the ACA where the statute acknowledges that the Federal government cannot actually impose such a mandate on States and sets out what to do if a state fails to establish an Exchange. This framework shows that Congress clearly intended for States to be the main entity in charge of running the Exchanges. This "requirement" for States to establish the Exchanges combined with the discretion for HHS to issue regulations on Exchanges creates a clear partnership between States and the federal government over how to establish Exchanges. It also sets a clear expectation that there would be substantial variation in how States establish Exchanges. If Congress intended for Exchanges to be mirror entities, then the ACA would have put the federal government fully in charge of establishing the Exchange.

HHS has generally issued regulations on Exchanges that respect this partnership approach and allow for meaningful variation on how States establish an Exchange. On matters where the statute provides discretion on the establishment of an Exchange, federal rules tend to leave this discretion with States. This approach allows States to mold an Exchange to the unique character of their insurance markets and provides opportunities to experiment with different approaches. Unfortunately, the 2025 Payment Notice proposes several new requirements on SBEs that undermine the partnership the ACA creates with States. By removing so much discretion from States, these proposals would, in large measure, implement a federal takeover of SBEs. In some cases, we believe the proposals illegally go beyond the discretion the statute provides to HHS. We oppose all of the following proposals because they limit States from innovating Exchanges that promote stronger insurance markets and broader access to coverage.

HHS cannot legally require States to first operate an SBE using the Federal platform

HHS proposes to require States seeking to newly operate an SBE to first operate an SBE using the Federal platform (SBE-FP). The SBE-FP currently operates under the framework established by section 1321(c). HHS created the SBE-FP as an option for States that did not want to take full responsibility for establishing an Exchange. This offers a reasonable federal approach to address situations where States fail to establish Exchanges or implement the requirements of the ACA in accord with section 1321(c). The statute acknowledges that states might not establish Exchanges or fully implement the requirements of section 1311 and instructs HHS "take such actions as are necessary to implement such other requirements."

The ACA does not give HHS the discretion to force States to use the SBE-FP approach because the SBE-FP approach only exists as an alternative when States fail to establish an Exchange. HHS cannot now force states to use something created under the authority of section 1321(c) in cases where a state failed to meet the requirements of section 1311 to now become an establishment requirement under section 1311. Section 1321(c) only operates when a state is not an "electing state." Therefore, once a State decides to become an "electing State," the discretion for HHS to establish an SBE-FP under section 1321(c) disappears.

The requirement for states to first operate an SBE-FP is also unnecessarily burdensome and can undermine state efforts to establish an Exchange. State activities are always subject to changing leadership in both the legislature and the governor's office. The SBE-FP requirement effectively adds a one-year delay into the Exchange establishment process. This can present implementation problems because it forces a governor to establish an Exchange later in their term when they will not have as much time to guide the full establishment process. This makes it more likely that an Exchange launches closer to times when there is a disruption in leadership. This puts a successful launch of an Exchange at risk. It may also discourage States from establishing an Exchange in the first place.

To date, every new Exchange has used the SBE-FP under their own discretion which demonstrates most States will voluntarily meet the proposed requirement already. Any State that opts to not use an SBE-FP to transition to an SBE will almost certainly have a very good reason to avoid the standard approach. Thus, the proposal appears to be addressing a non-existent problem with a requirement that could put the success of a future launch at risk if a State does have a good reason to immediately establish an SBE.

New supporting documentation requirements for State Exchange Blueprint requirements are unnecessary

HHS proposed to require states to provide supporting documentation demonstrating progress toward meeting State Exchange Blueprint requirements. This would allow HHS to keep asking states for additional detailed plans throughout the Exchange establishment process on top of requirements on States to provide live demonstrations of Exchange functionality and/or supporting documentation for progress in meeting the Blueprint. The preamble suggests a level of detail in these plans that HHS already fails to meet in administering the FFE. The preamble specifically calls out information on outreach plans, but HHS fails to demonstrate the effectiveness of their own direct-to-consumer outreach. HHS stopped reporting data on the number of enrollments through navigators versus agents and brokers. Elsewhere in the preamble, HHS admits that direct enrollment is responsible for a "steadily increasing number" of enrollments on the FFE and the SBE-FPs.[1] Yet, there has been no data documenting this since the Biden administration took office.

Every state to date has successfully met the functional requirements of the ACA under the current regulations. Therefore, the current process already provides HHS the oversight it needs to ensure a successful launch. The requirement to provide additional detailed plans will only add unnecessary burdens to this process. Moreover, because HHS will have the discretion to demand more details at any time, this will undermine the certainty of the process. States benefit from clear expectations and this new discretion in the middle of the process will undermine the clarity of the process. To support this added burden, HHS claims their experience shows more information is "imperative to a successful establishment of a State Exchange" and yet every state to date has successfully launched without it. We therefore recommend not finalizing this proposal because adding the discretion to demand additional detailed plans will be unnecessarily burdensome and undermine the clarity of the process.

[1] 88 FR 82510, at 82563.

Additional minimum standards for call center fails to offer enough information to make an informed comment

The ACA requires Exchanges to "provide for the operation of a toll-free telephone hotline to respond to requests for assistance." In applying this provision, HHS proposes to require additional minimum standards to SBE call center operations. This proposal would require the FFE and SBEs to provide consumers with access to a live call center representative during an Exchange's published hours of operation and require call center representatives to be able to help consumers select QHPs and submit enrollment applications. The additional standards should not be finalized because they limit State's ability to tailor call centers to their Exchanges.

HHS admits that all SBEs and the FFE "already meet the minimum standards being proposed" which begs the question: Why is this proposal necessary? The concern appears to be that new SBEs might follow different models that rely on other private enrollment pathways which could lead to a different type of call center. If an SBE relies on a more decentralized enrollment approach, then the call center may not have the operational capacity to directly help consumers select plans and submit enrollment applications. Unfortunately, this is pure supposition because HHS failed to explain what spurred these new requirements when every SBE already meets them. This supposition is based on the rule's proposal to require SBEs to operate a centralized eligibility and enrollment platform which directly follows this call center proposal. Without explaining what spurred this recommendation, the proposed rule does not offer enough information to make an informed comment.

Requiring centralized eligibility and enrollment platform limits opportunities for an SBE to expand enrollment pathways

As HHS admits, "there is no explicit regulatory or statutory requirement that Exchanges operate a centralized eligibility and enrollment platform on their website for performing all eligibility determinations for QHPs and insurance affordability programs."[2] Nonetheless, HHS proposes to require SBEs to operate a centralized eligibility and enrollment platform on the SBEs website. In addition, the rule proposes to require SBEs to be only entity responsible for making determinations for eligibility for QHPs and insurance affordability programs. This would prohibit an SBE from relying solely on web brokers and other non-Exchange entities from making eligibility determinations on behalf of the SBE. Moreover, the proposal would specifically prohibit Exchanges from delegating the responsibility to conduct eligibility determinations to any non-Exchange entities except for entities the Exchanges contract with to operate the centralized eligibility determination.

We oppose requiring a centralized eligibility and enrollment platform because it would limit opportunities for SBEs to expand enrollment pathways. This proposal conflicts with current regulations that allow web brokers to enroll people in QHPs "in a manner that *constitutes* enrollment through the Exchange."[3] By using the word constitutes, this regulation allows SBEs to establish enrollment pathways that qualify as enrollment through the Exchange, but do not actually enroll people through the Exchange. This allows a more decentralized approach to

[2] 88 FR 82510, at 82555.
[3] 45 CFR 155.220(a)(2) (emphasis added).

enrollment that can expand enrollment pathways to boost enrollment and expand access to health coverage.

While admitting the current regulations do not explicitly require a centralized approach, the preamble misrepresents current rules and strains to argue a centralized approach aligns with current rules. The rule states that section 1413(c)(1) of the ACA "requires that Exchanges develop a secure electronic interface that allows consumers to apply for health insurance coverage online … and that Exchanges conduct verifications of eligibility through electronic data interfaces."[4] This statement is made to tie the statute to the proposed requirement on Exchange. However, this section clearly applies to States, not Exchanges. The statute clearly states: "Each State shall develop … a secure, electronic interface …." This refers to the general requirement on States to cooperate with the federal government on establishing a procedure to determine eligibility for all State health subsidy programs through a single application that may be submitted online or through other means. As such, this is related to requirements on States and is not relevant to how SBEs must operate.

HHS claims that the lack of clear statement in the regulations that the Exchange must make all determinations regarding eligibility QHP coverage and other State subsidy programs was an "oversight." This is a bold and unsupported statement. For support, the preamble can only reference other sections of the regulations which "allude to a requirement or expectation that an Exchange operates in this way already" or would be difficult to comply with under a decentralized approach. To justify this statement, HHS simply references two examples which themselves fail to support their position. They claim the requirement for web-brokers to allow consumers to withdraw from the enrollment process and go back to the Exchange website presumes a consumer would then be able to complete an application on the Exchange website. But the regulation does not discuss completing an application on the Exchange website. As such, there is no reason to think this regulation posits that a consumer should always be able to go back to the Exchange for general assistance.

The other example refers to the regulations on how an applicant can directly enroll in a QHP through an issuer. Yet, this section clearly allows direct enrollment through an issuer without applying through the Exchange. In fact, it outlines how an application could be processed through an "Exchange-approved Web service." This strongly suggests SBEs have the flexibility to create decentralized enrollment pathways where the SBE approves Web-services to complete eligibility applications.

HHS also argues consumers may be harmed by a decentralized approach because they might receive incorrect or inconsistent eligibility determinations because eligibility rules may not be updated as frequently. But there is no reason to think that SBEs could not disperse these updates quickly and possibly in real-time as the state and federal government update the rules.

Overall, HHS has failed to marshal any substantive reason to require a centralized eligibility and enrollment platform. Therefore, we recommend that HHS not finalize this proposal and instead work in good faith with states that may want to pursue a decentralized approach. This approach holds the potential to increase coverage by expanding enrollment pathways.

[4] 88 FR 82510, at 82555.

HHS should set current HHS standards on web-brokers applicable in the FFEs and SBE-FPs as the default standard for SBEs, but allow states to apply for exceptions

HHS proposes to require SBEs to apply the existing federal web-broker standards that apply to the FFEs and the SBE-FPs. These standards do provide important consumer protections. As such, they represent a reasonable starting point for SBEs to follow. However, states should still have the flexibility to enforce their own standards. Therefore, we recommend that HHS set the current web-broker standards for FFEs and the SBE-FPs as the default standard for SBEs. If state wishes to adopt different standards, HHS should establish an approval process to allow SBEs to amend the federal default.

HHS should continue giving SBEs discretion over enrollment periods

HHS proposes to require SBEs to adopt an open enrollment period (OEP) that runs from November 1 to January 15 to align with the federal Exchange OEP. Similarly, HHS proposes to require SBEs to align with the effective dates of special enrollment periods to the federal Exchange. There is no evidence showing that a longer OEP encourages broader enrollment in QHPs from people who are eligible for coverage. When HHS previously reduced the OEP to end on December 15, enrollment did not suffer. Moreover, Medicare and employer markets all employ OEPs of a similar length. This speaks to how the federal Exchange should reduce the current OEP.

The ACA requires SEPs and an OEP to protect the risk pool and expanding it too far will harm the risk pool and raise premiums. States are in a far better position to assess how enrollment period policies impact their risk pool and should therefore retain discretion over enrollment periods.

HHS should not impose federal Exchange network adequacy standards on SBEs

HHS imposed new quantitative time and distance QHP network adequacy standards on federal Exchanges in the 2023 Payment Notice. HHS proposes to require SBEs to meet these same network adequacy standards. We opposed the adoption of these network adequacy standards on the federal Exchange and even more strongly oppose applying these standards to SBEs. Applying the standards to SBEs undermines the value of operating an SBE, especially in regard to how operating an SBE gives SBEs useful information and experience about state insurance markets that put it in a better position to assess network adequacy.

We offered the following argument against network adequacy standards in our comments to the 2023 Payment Notice which apply equally to the proposals in the 2025 Payment Notice:

> While we support the goal of ensuring adequate networks for consumers, the proposed modification of the network adequacy requirements are unlikely to achieve this goal and will in fact increase administrative burdens and costs for consumers.
>
> First, as HHS recognizes in the preamble discussion, there is wide variation between states in network adequacy standards. But rather than reflecting some kind of inequity or

vacuum that needs to be filled by Federal regulation, these differences reflect very real and legitimate differences in geography, population density, rural versus urban mix, provider concentration, and other factors. In addition, HHS has recognized the ongoing national shortage of healthcare providers, a problem that has been even further exacerbated by the pandemic. Doctors, nurses, and other health care providers are leaving the profession at an alarming rate, creating acute local staffing shortages that impact patient care. These problems are even worse in rural areas, where it is often difficult for patients to get an appointment with any provider at all, much less a specialist. Imposing a one-size-fits all national standard as HHS proposes will do nothing to alter these realities.

Time and distance reviews for QHPs were administered for the 2015 to 2017 plan years. However, the experience with these early reviews indicate that the process served only to add an unneeded layer of administrative burden and cost. The Federal time and distance reviews conducted from plan years 2015 to 2017 had little or no impact on increasing network breadth. The reviews merely caused issuers to generate myriads of written justifications for why a particular provider or specialty was unavailable. In the end, HHS still mainly deferred to states, and, as multiple studies have shown, the reviews still resulted in narrow networks in QHPs.

Not only is imposing a Federal network adequacy standard unhelpful, but it could actually harm consumers by imposing significant new administrative burdens on issuers that increase costs and drive up premiums. Now, rather than only having to receive approval of their networks from the state regulator, issuers will have to gain the approval of two separate regulators, each with different and potentially conflicting standards. This will inevitably add time, burden, and cost to the process of building and receiving approval for provider networks, which will ultimately negatively impact consumers.

Due to the wide variation in access to providers that exists state-to-state, state regulators remain in the best position to address network adequacy determinations. State regulators better understand the unique needs of the consumers in their markets and are in the best position to oversee issuer provider networks in order to protect their citizens. Instead of pursuing a one-size-fits all Federal standard, HHS should continue to defer to states for network adequacy determinations.

Proposed EHB changes risk making ACA benefit requirements even less affordable

The ACA requires health insurance issuers on the individual and small group markets to include a set of essential health benefits (EHB).[5] HHS must ensure that EHBs cover "at least" ten categories of items and services.[6] This sets a minimum requirement on what benefits must be offered. HHS must also ensure that the scope of benefits provided by EHBs is equal to the scope of benefits provided under a typical employer plan.[7] This sets a maximum requirement on what EHBs can be covered and gives meaning to the term "essential." The 2025 Payment Notice

[5] 42 USC 300gg-6.
[6] Patient Protection and Affordable Care Act, Section 1302(b)(1).
[7] Patient Protection and Affordable Care Act, Section 1302(b)(2).

proposes several changes that would allow EHBs to expand beyond what is essential and instead allow states to shift from essential to unlimited health benefits. We oppose these proposals.

Not requiring defrayal when states newly require benefits already provided in the benchmark plan allows for backdoor expansion of EHB

Federal regulations allow states to pick an EHB from the EHBs covered by a set of benchmark plans and assigns a default in cases where States do not choose a benchmark. Federal regulations also require states to defray the cost of any State benefit requirement enacted after December 31, 2011. This effectively grandfathers in state benefit mandates that existed prior to the ACA. This framework allows for a situation where a state might enact a benefit requirement after December 31, 2011 that is also included in the State's benchmark EHB. Current rules require States to still defray the cost of this benefit despite the fact that it is included in the benchmark EHB.

On its face, the requirement to defray the cost of a benefit that is actually included in a State's EHB might seem illogical. Defrayal exists largely to ensure federal premium tax credits don't automatically increase to fund additional state benefit mandates. If the new benefit requirement is already included in EHB before the state requires it, then there is no increase in PTCs. So long as states must defray if the EHB later changes to not include the new state requirement as the proposal would require, then the federal budget will not be impacted. However, this ignores how the EHB benchmark framework HHS uses can inadvertently or strategically be used to inflate the scope of EHBs if states are allowed to enforce new state benefit requirements without defrayal.

The HHS decision to allow EHB benchmarks versus establishing a single benchmark for the nation was largely due to the political difficulty HHS would have had in picking and choosing a specific set of EHBs. Every special interest from the health care sector and disease or condition group would have lobbied hard to prove that they were "essential." Setting EHBs using benchmarks offered a creative (and possibly illegal) approach to avoid this political difficulty. However, this benchmark approach allows flexibility to change the benchmark. Due to the ability to change benchmarks, a state can enact a benefit requirement that is covered by the current EHB which applies to other EHB benchmark options. If a state is not required to defray in this case, then the state will be free to choose a new EHB benchmark in the future which will have been subject to the state benefit requirement too. In this way, the state benefit requirement will carry forward to the new benchmark without the need for defrayal and carry forward to all future EHB benchmarks that were subject to the state benefit requirement. This would allow for strategic or just inadvertent switching among EHB benchmarks from year to year to add in new state benefit requirements without the need for defrayal.

States should not be allowed to expand the scope of EHBs in this way. Because it would likely increase premiums and therefore federal spending on premium tax credits, this proposal likely constitutes an illegal approach to administering EHBs.

Allowing routine adult dental service to be included in EHB removes a key limit and undermines consumer cost controls

HHS proposes to remove the regulatory prohibition against including routine non-pediatric dental services as an EHB. Considering the ten EHBs outlined in the ACA specifically include "Pediatric services, including oral and vision care," this strongly suggests that Congress did not view adult oral and vision care as an EHB at the time the ACA passed. Admittedly, these ten EHB categories set the floor and adult dental could in theory be added on top of this minimum set of EHBs. However, the EHB typicality standard requires the scope of EHBs to be equal to the scope of a typical employer plan.

HHS argues that, according to the KFF Employer Health Benefits Survey, "among firms offering health benefits in 2019 included in the report, 59 percent of small firms (3–199 workers) and 92 percent of large firms (200 or more workers) offered a dental insurance program to their workers separate from the health plan(s)." However, HHS acknowledges these were separate plans. Moreover the KFF report clearly explains how these are voluntary benefits where employers only sometime contribute, "while other times employees pay the entire cost."[8] Therefore, the KFF report clearly shows employers do not include dental benefits as part of their traditional health plan. Because these benefits are not in the traditional health plan, they should not be included in the scope of benefits used to establish the scope of the typical employer plan.

Moreover, these KFF numbers are not substantially higher than the portion of employers that offered separate dental coverage from KFF's 2010 survey at the ACA passed. At that time 45 percent of small firms and 87 percent of large firms offered separate dental benefits.[9] Thus, the KFF report overall suggests Congress did not consider adult dental benefits to be an EHB in 2010 and this hasn't changed.

The main purpose of insurance is to fund high-cost, unforeseen events. When insurance funds routine health care services, it removes the natural incentives to control the cost of care when they directly pay for the services. Here HHS proposes to allow states to expand the amount of routine services covered under a health insurance plan. This will inevitably lead to less pressure to control cost and, as a result, lead to higher premiums and higher health care costs overall. Therefore, we encourage HHS to not finalize this proposal.

EHB proposals expose the benchmark approach to new legal scrutiny

The effort to shift essential to unlimited health benefits puts the current EHB benchmark approach at legal risk. When this approach was proposed in 2012, we offered comments that cautioned HHS about several legal issues with the EHB benchmark approach.[10] We noted how the benchmark approach created a lack of uniformity in the application of the EHB across states because state benefit mandates that applied to the benchmarks varied widely. We then made the following observations:

[8] KFF, Employer Health Benefits: *2019 Annual Survey*, available at https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/.
[9] KFF, *Employer Health Benefits: 2010 Annual Survey*, available at https://www.kff.org/wp-content/uploads/2013/04/8085.pdf.
[10] Comments, "RE: Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Proposed Rule," Center of the American Experiment (December 26, 2012).

- "First, it's unclear how something can be labeled 'essential' in Rhode Island, yet not 'essential' in Idaho. An individual's essential medical needs do not vary by state."
- "Second, varying what is deemed essential from state to state varies the benefits that will be available to people who qualify for tax credits. It is one thing for insurance market variations to create this inequity; it's quite another for federal law to create this inequity."
- "Third, some states will be locked in with higher and more expensive benefit mandates and be unable to eliminate those mandates for the time being."
- "Fourth, variation across states will make it more difficult for the U.S. Office of Personnel and Management to contract with insurance companies to provide multi-state insurance plans through exchanges."
- "Finally, we believe the rule as applied to many states may violate state sovereignty protected by the Tenth Amendment by forcing states to cooperate with the administration of the rule."

All of these observations suggest legal issues with the benchmark plan approach. Any effort to take further advantage of this benchmark approach to expand the scope of EHBs risks inviting litigation on the original rulemaking by further exposing these legal issues.

Changes to public notice and comment procedures for section 1332 waivers appropriately extend state flexibility and suggest further flexibility is warranted

In the application process for a 1332 waiver, the ACA requires public notice and comment at the state level to provide a meaningful level of public input. This requirement provides transparency through the process and ensures states consider all major areas of public concern. HHS proposes to give states flexibility to make public hearings held in a virtual or hybrid format equivalent to in-person hearings. We support this change. States are in the best position to understand what type of public hearing will work best to pull in the most meaningful level of public input. However, we recommend that CMS investigate how in-person meetings might provide a higher level of engagement and dialogue than virtual meetings. In our experience, in-person public testimony during the state legislative process can have more meaningful impact than virtual testimony. While states should retain flexibility, HHS can provide important guidance on best practices by taking advantage of its resources to gather feedback from other states.

The data reported in the proposed rule also suggest that HHS should provide additional flexibilities to states on whether or not to conduct post-award forums. The data on public participation in post-award forum shows the public has virtually no interest in providing input after a waiver application had been approved. For example, Minnesota reported only 4 attendees in 2018, 1 in 2019, 4 in 2020, 9 in 2021, and 4 in 2020. While all input is important, this input could be gathered at a much lower cost by simply encouraging the public to provide annual written comments after a 1332 application is approved. Moreover, there is no statutory requirement for a post-award forum. Section 1332 specifically requires State-level public input only on the application. Moreover, the statute provides only for "the periodic evaluation by the Secretary", not States. Therefore, a State can make a strong argument that HHS and the Department of the Treasury do not even have authority to require State-level input after the application is approved.

One reason why there may be little public participation in these post-award forums is due to the fact that they duplicate other state processes that already provide periodic State-level evaluations. State budgets must be authorized every one to two years, depending on the state. Therefore, a reinsurance waiver and any other 1332 waiver that receives state funding will always receive regular public evaluation at the State level under each state's budget approval process. This evaluation includes opportunities for public testimony in legislative hearings just the same as a post-award forum. In future rulemaking, we recommend that HHS propose removing the requirement for post-award forums due to the lack of statutory authority and the duplication with other state evaluation processes.

People who fail to reconcile APTCs in tax filings need regular updates on their status to avoid tax liabilities

HHS proposes to require all Exchange to send notices for failure to reconcile (FTR) APTCs in tax filings in the first year during which they fail to reconcile. This proposal follows the recent finalization of rule that changes the FTR process that delays an Exchange from determining someone ineligible for APTC due to FTR until they have failed to reconcile for two consecutive years. We filed comments opposing this change. However, now that this change is in place, people who fail to reconcile are at a heightened risk to incur a large tax liability for overpayments of APTC. We support the requirement for annual notices to protect people from incurring these tax liabilities.

Cost-benefit analysis supports accepting attestations of incarceration status, which is all the statute requires

HHS proposes to permit all Exchanges to accept an applicant's attestation of incarceration status for verification of incarceration. Currently, regulations require Exchanges to verify incarceration status with a data source approve by HHS. To support this proposal, HHS provides a thorough cost-benefit analysis that documents how the savings from identifying the small number of incarcerated people who receive APTC overpayments "are dwarfed by the administrative costs …"[11]

Though not being incarcerated is a clear statutory eligibility standard that must plainly be enforced, section 1411(c)(4)(B) also permits HHS to modify verification methods if "such modifications would reduce the administrative costs and burdens on the applicant …." It may be helpful for HHS to cite this for their authority to modify the verification process.

The cost-benefit analysis is all that HHS needs to justify this proposal. Unfortunately, HHS felt compelled by President Biden to introduce a rationale that improperly argues the current rule to verify incarceration status "may have contributed to inequity in the Exchange population, as Black adults were imprisoned at five times the rate for White adults and are more likely to face systemic obstacles hindering their ability to secure employment post incarceration." The ACA provides clear requirements related to incarceration status and the fact that people of one race are incarcerated at different rates than other races cannot justify a deviation from the statutory

[11] 88 FR 82510, at 82573.

requirement. Adding racial equity as a factor in rulemaking therefore increases the risk that this proposal might fall to an arbitrary and capricious challenge under the Administrative Procedures Act. We recommend removing justifications related to racial equity and let President Biden discuss those issues in more appropriate venues.

Verification of income for premium tax credit eligibility is a federal function, not a State function

HHS proposes to "reinterpret" use of the Verify Current Income (VCI) Hub to verify APTC eligibility as an SBE function and not a federal function. In line with this reinterpretation, HHS proposes to charge SBEs for the use of the VCI Hub. This reinterpretation, however, does not follow how sections 1411 and 1413 establish verifications for premium tax credit eligibility. We, therefore, oppose charging SBEs for the use of the VCI Hub.

Section 1411 establishes procedures for determining eligibility for premium tax credits which includes requirements on HHS to verify the accuracy of the information provided applicants for enrollment in QHP on the individual market. This federal government role is found in section 1411(c) and (d). Under this process, the Exchange role is to submit the information provided by the applicant to HHS for verification. This clearly makes HHS primarily responsible for verification. Section 1411(c) then specifies certain verifications that HHS must submit to other federal entities, which includes the submission of income verification to Treasury. Section 1411(d) allows HHS to delegate responsibility for verification to Exchanges, but only for verification of information that is not outlined in section 1411(c). Because income is one of the items outlined in section 1411(c), HHS cannot delegate this verification to Exchanges.

Putting the federal government in charge of income verification for premium tax credits make perfect sense considering the federal government is fully responsible for paying the premium tax credit. Because States do not fund premium tax credit subsidies, States have less incentive to ensure people are eligible. In fact, States have an agency problem when it comes to verifying income because they benefit from covering more people with premium tax subsidies. Covering more people with premium tax credits will mean fewer people depend on State funded health care programs.

In their proposal, HHS also references section 1413 of the ACA. As noted previously, section 1413 requires States to cooperate with the federal government on establishing a procedure to determine eligibility for all State health subsidy programs by developing a secure, electronic interface to allow the exchange of data to eligibility for all State health subsidy programs to be determined from a single application. This section only refers to the data exchange necessary to transmit application data.

HHS should follow the requirements of the statute and retain responsibility for funding the VCI Hub. HHS should also assess whether its current verification processes align with the statute.

Allowing monthly SEPs for people with incomes at or below 150 percent of FPL is unlawful and harms the risk pool

Currently, HHS allows a monthly SEP that people with incomes at or below 150 percent of the federal poverty level to basically enroll in a subsidized QHP at any time through the year. This SEP is authorized to continue only while premium tax credit expansion available under the American Rescue Plan and extended by the Inflation Reduction Act remain in place. HHS proposes to remove this limitation and allow this SEP to continue indefinitely.

We previously issued comments opposing this monthly SEP and explained why the SEP was both unwise and lawful. HHS previously acknowledged that this SEP will likely increase adverse selection and lead to higher premiums. This has not changed. The small benefits to some do not outweigh the substantial negative impact on the risk pool. Moreover, the ACA sets out a specific list of SEPs and this SEP is not in the list and HHS does not have discretion to add to this list. Therefore, this SEP is currently unlawful. HHS should repeal this SEP, not make it permanent.

The Payment Notice is not the appropriate vehicle to propose unrelated changes to the Medicaid program

HHS proposes to provide states with flexibility in determining Medicaid eligibility. Traditionally, the annual Payment Notice provides the vehicle for HHS to propose changes to the administration of federal programs that support the regulation of the Exchanges and the individual and small group insurance markets. This may be the first time that a standalone Medicaid proposal has been included in the Payment Notice. As such, we are very concerned that some stakeholders with interests in and potential insights on the administration of the Medicaid program may not be aware of the proposal and miss the opportunity to comment. Therefore, we recommend that HHS delay finalization of this proposal and seek further comment in separate rulemaking.

Thank you for the opportunity to comment on the 2025 Payment Notice.

Sincerely,

/s/

Peter J. Nelson
Senior Policy Fellow