The Honorable Doctor Mehmet Oz
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-9884-P
P.O. Box 8016
Baltimore, MD 21244-8016

4/11/2025

Submitted via regulations.gov

RE: Health and Human Services, Centers for Medicare & Medicaid Services' Patient Protection and Affordable Care Act: Marketplace Integrity and Affordability: Proposed Rule Number CMS-9884-P

Administrator Oz:

Please accept these comments from the Pennsylvania Health Insurance Exchange Authority, known as Pennie, to the Centers for Medicare & Medicaid Services (CMS) regarding the *Marketplace Integrity and Affordability* Proposed Rule.

After a bipartisan, unanimous vote in the Pennsylvania General Assembly in 2019, Pennie was created to establish a health insurance exchange (marketplace) in the Commonwealth of Pennsylvania, directly tied with a reinsurance program. The objectives of the General Assembly were to maintain Pennsylvania's sovereignty over the regulation of health insurance, to ensure a thriving individual market, and to tailor the marketplace to the needs of Pennsylvanians[1].

Pennie operates as an independent state agency, governed by a Board of Directors that includes four of the largest insurers collectively covering 80% of our enrollees, as well as experts in insurance, public health, and enrollment assistance. Our governance structure ensures a thoughtful and balanced approach to marketplace policies that holistically considers implications on individual enrollees as well as the broader market. Having a state-based marketplace allows Pennsylvania to directly address needs and issues that are unique to our state with an approach that is likewise unique, as envisioned by the Affordable Care Act (ACA) and state law. The result is a highly efficient program where we can address problems promptly through tailored and specific solutions, which ensure our control over limiting unnecessary overhead or burden.

The following comments outline our overall concerns along with comments and recommendations on specific provisions.

[1] 40 Pa.C.S. §§ 9102, 9302(b), 9502.

Overall Comments

Pennie shares the commitment to ensuring that only those who are eligible can enroll, to addressing overall market risk and trends, and to avoiding consumers being taken advantage of by brokers who enroll them without their knowledge – areas in which we support proportionate and targeted policies. Where we diverge from CMS is in the approach to solving these issues.

The ACA incentivized the establishment of state-based marketplaces out of a recognition that states are better positioned to implement effective and tailored programs compared to a federal one-size-fits-all approach. One constant over the past fifteen years has been the deference afforded to states consistent with the law's intent. Pennie agrees with Director Peter Nelson's stance[2] that states are in the best position to run the marketplaces. We also understand the federal government's stake in federal spending. However, the proposed rule's own data demonstrates that, generally, state-based marketplaces that have been afforded flexibility have done a *better* job of supporting enrollment without creating the program integrity issues facing the federal marketplace, and thus have avoided improper federal costs.

Consider the following regarding the three repeated aims of the proposed rule: 1) reduce improper enrollments; 2) reduce unauthorized enrollments, and 3) reduce adverse selection:

1. **Pennie's enrollment trends are as expected.** PA has expanded Medicaid. The data outlined in the rule demonstrates an appropriate and expected increase in lower income enrollment in the state given the 90,000 new marketplace enrollees during the Medicaid unwinding, whose verified income confirmed they made just above the Medicaid income threshold.
2. **Pennie's system already deters unauthorized enrollments by brokers**. Pennie requires a significant amount of detailed information, only acquirable directly from the individual, and active consumer consent to enroll.
3. **Pennsylvania's insurance market is robust.** Due to holistic market oversight by the PA Insurance Department, and with Pennie's funding of the reinsurance program, PA has a strong and highly competitive individual market, and with rate increases consistently at or below the national average. Please refer to the PA Insurance Department comment letter.

The proposed rule is an unnecessary departure from the historical position of deference given to states, undermining the ability of states to tailor solutions to their unique markets, while imposing onerous operational requirements, unnecessary administrative burdens, and costly changes. The proposed rule itself is compelling on this point, as it states "…**we note that coverage losses are expected to be concentrated in nine States where erroneous and improper enrollment is most noticeable… although we also expect minor coverage losses across all States as the administrative burdens associated with this rule would be applied uniformly across the country**.[3]" This statement acknowledges that the proposed rule is imposing administrative burdens and costs on Pennsylvania for essentially no policy benefit, as we are not one of the nine concerning states. As we state above and throughout our comments on the proposed rule, we do not face the same serious issues seen on the federal marketplace.

[2] https://www.americanexperiment.org/magazine/article/qa-no-place-like-home; https://www.americanexperiment.org/magazine/article/the-band-aid-isnt-working

[3] Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, 90 Fed. Reg. 13025 (proposed rule March 19, 2025).

Of further concern, the proposed rule highlights the expected loss of coverage to be between 750,000 and 2,000,000 individuals and characterizes as a success the corresponding federal cost reductions. However, the narrow focus on federal premium tax credit spending overlooks the broader impacts to the health care system and the overall economy that comes with more people going uninsured[4]. Investments in the population's health result in lower system costs through more effective disease management, better personal economic conditions by preventing medical debt and bankruptcy, and more stability and access for providers by decreasing uncompensated care – overall leading to increased economic productivity. These effects are even more prominent in rural areas, which account for 75% of Pennsylvania's geography, where relatively small changes in the insured rate have potentially significant impacts on the ability of rural hospitals to remain open to provide access to emergency care, cancer treatments, and safe places to give birth.

Simply put, the proposed rule fails to take into consideration that the issues it seeks to address affect mostly federal marketplace states. There is no data or evidence that state-based marketplaces face these issues but if enacted as proposed, Pennie will be forced to implement unnecessary, burdensome, and costly changes. And in doing so, these policies would remove long-standing state-based marketplace flexibility, a key tenet of the ACA.

Instead of addressing these issues in a targeted manner through effective broker oversight and system changes at the Federal Exchange, the proposed rule represents an overreach in mandating policies to all states – even those without these issues – in an unprecedented usurpation of state governance and at a significant operational cost. Meanwhile, the logical conclusion from the data laid out in the proposed rule argues that states should be given more flexibility, not less, given the responsible state approaches. Pennie and other state-based marketplaces have managed more stable programs with better outcomes that have largely avoided the concerning issues seen in the federal marketplace. In short, Pennsylvanians should not be penalized for issues in other states that do not apply in the Commonwealth.

Specific Policies of Concern

More specifically, Pennie opposes several of the proposals related to the administration of Open Enrollment Periods (OEP), changes to the autorenewal process, and arbitrary Special Enrollment Period (SEP) verification requirements to state-based marketplaces. Pennie also opposes proposed changes to the premium adjustment percentage and to the Actuarial Value (AV) de minimis ranges.

Open Enrollment Period (OEP)(§155.410)

Pennie opposes the proposal to limit the Open Enrollment Period (OEP) to run from November 1 to December 15 for state-based marketplaces. States operating their own marketplaces have always had the flexibility to determine the duration of their OEP, even in years when the federal marketplace limited its OEP to 45 days. Unlike the federal marketplace, Pennie has maintained consistent dates that our residents and stakeholders have come to know and expect, providing market stability.

[4] https://www.commonwealthfund.org/publications/issue-briefs/2025/mar/cost-eliminating-enhanced-premium-tax-credits

CMS asserts that limiting OEP will address adverse selection concerns, but the OE dates are not raising this as an issue in Pennsylvania. For the five Open Enrollment Periods in which Pennie has operated, the dates have been consistently November 1 to January 15 after unanimous approval by Pennie's Board of Directors, including all Board-participating insurers. Neither when it established these OEP dates, nor in the subsequent years, has Pennie's Board or its insurers raised concerns about adverse selection.

The proposed rule claims that very few people enroll after December 15th and, without supporting data, that shortening OEP will reduce costs for state-based marketplaces. That is not Pennie's experience. For OEP 2025, Pennie had roughly 36,000 new enrollments between December 16 and January 15 – 40% of our total new enrollments for OEP. Our research shows that it takes several touches to reach uninsured populations, and the last month is a crucial time period for outreach efforts throughout OEP to result in individual action. It is worth noting that the post-December 15 enrollees were younger on average than those who enrolled before December15. Further, based on the structure of our contracts, the ability of assisters to help more individuals over more time, and the steady enrollment we see over the last month, Pennie does not incur net costs for a longer open enrollment as there are offsets from the user fees associated with the new enrollments. However, Pennie and our insurer, broker and assister stakeholders *would* incur costs to update systems, notices, and processes to reflect an earlier OEP deadline, if this policy is finalized.

It is also important that state-based marketplaces maintain the ability to extend deadlines if unforeseen events inhibit enrollment, for example in the case of technical issues on deadline days.

Not only would this proposal add an unprecedented restriction on state-based marketplaces but if finalized, this restriction will make it more difficult for both current and prospective enrollees to make informed insurance choices, therefore increasing the number of non-active shoppers and undermining many of CMS' arguments supporting the rule. This issue exemplifies how a one-size-fits-all federal approach based on incorrect assumptions undermines policies that are working at the state level.

Auto Renewals (§ 155.335)

Pennie opposes the proposal to require a $5 premium payment for those current enrollees who are reenrolled in a plan with a $0 net premium, and whose continued eligibility for that $0 net premium has been verified, if they fail to take additional action on their own.

A plain reading of the ACA does not give marketplaces the authority to reduce the amount of advance premium tax credits that a qualified individual can use simply because the affected individual is enrolled (or reenrolled) in a new policy at the start of a new plan year. Before providing further explanation, we will address the policy itself in terms of the issues it is seeking to address.

If the concern is one of eligibility based on income, regulations already require marketplaces to re-verify income and other key eligibility criteria every year at the time of auto renewals. Rather than rely on trusted data sources, mandating a $5 premium to individuals who are accurately redetermined as eligible for a fully subsidized plan absent *action* by them is onerous, duplicative of the eligibility verification that

already exists, and has no basis under the ACA as a verification approach. Furthermore, if this proposed rule is enacted, it risks being potentially discriminatory in operation since it only affects a subset of the population.

If the concern is one of improper enrollments where the consumer was enrolled without their knowledge by a broker, we fully support taking meaningful approaches to address this issue. However, the proposed $5 premium approach will not solve this problem. The same brokers that had no qualms about enrolling someone without their knowledge to begin with will assuredly have no hesitations about updating the application on behalf of the consumer to maintain the $0 coverage, presumably also without their knowledge. The result is that this policy will not address the unauthorized broker enrollments.

Our broader concern is that the proposed policy is, at best, duplicative and ineffective, and at worst, impermissible under law. Marketplaces are directed to verify information to determine eligibility for a premium tax credit, the amount of which is strictly dictated by the Internal Revenue Service (IRS)[5]. Once determined eligible based on the procedures outlined in the statute, the marketplace is directed to allow the qualified individual to claim "any" of their tax credit in advance[6]. Then, the Treasury is directed to make the advance payment to the qualified issuer based on the enrollment[7]. Thus, the statutory role of the marketplace is only to be a facilitator of the premium tax credit such that premiums are directly reduced. The marketplace itself has no independent statutory authority to adjust the amount of premium tax credit that an individual can use once that individual is determined eligible based on the statutory criteria, none of which include additional marketplace-driven conditions.

The proposed policy creates a new construct whereby a marketplace, instead of being a facilitator of an IRS tax credit, becomes a policy-driven intermediary with an unprecedented ability to alter and place conditions on how much of the tax credit an eligible individual can access based on current policy preferences, instead of based on eligibility criteria laid out in the statute. The ACA does not provide any construct for the marketplace to take independent action to adjust the tax credit based on new marketplace-specific policy initiatives. The concern is that with such a new precedent, marketplaces could go beyond this policy to interfere with access to the full amount of advance premium tax credit by imposing new and arbitrary policy conditions as an intermediary, when the statutory intent was for the marketplace to serve as a passthrough of the premium tax credit for qualified individuals.

While we share the goal of wanting to ensure individuals are eligible and know they have coverage, the proposed approach will not address the issues it is attempting to fix while simultaneously setting a potentially illegal precedent with no discernable statutory basis.

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[5] The IRS (26 U.S. Code § 36B), not the ACA, dictates the refundable credit under a QHP.

[6] Under 42 U.S.C. § 18031(d)(4)(G), the Exchange must"[…] establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of **any premium tax credit under section 36B [of the Internal Revenue Code]** and any cost-sharing reduction under section 1402[.]" (*emphasis added*).

[7] Under 42 U.S.C. § 18082(c)(2)(A),"[t]he Secretary of the Treasury shall make the advance payment under this section of **any premium tax credit allowed under section 36B** of [the Internal Revenue Code] to the issuer of a qualified health plan on a monthly basis (or such other periodic basis as the Secretary may provide).(*emphasis added*)

Premium Adjustment Percentage (§ 156.130(e)) and Levels of Coverage (Actuarial Value) (§§ 156.140, 156.200, 156.400)

Pennie opposes the proposed amended premium adjustment percentage methodology and the *de minimis* range for plans subject to actuarial value (AV) requirements. Together, these proposals would significantly raise costs for Pennsylvanians to both purchase and use their coverage.

CMS acknowledges that these proposals, if finalized, would increase premiums by an estimated 4.5% for second-lowest cost silver plans and cost-sharing limits by 15% above 2025 parameters, while simultaneously being likely to reduce the premium tax credits a household is eligible for by allowing lower level, and therefore, lower premium second-lowest cost silver plans. When taken with the other changes potentially coming for Plan Year 2026, such as the average 82% increase in premiums if the enhanced premium tax credits are not extended, further reductions in purchasing power could compound affordability challenges and result in many eligible individuals who rely on their coverage for needed medical care to be priced out of the market.

In addition to decreasing the value of coverage, the changes also make plan selection more difficult. Such changes would not only reduce the value of plans but would make plans in each metal level virtually indistinguishable, making it more difficult for consumers to make an informed decision when shopping for a plan. Pennie is committed to making it easier for consumers to understand their plan options. If finalized, these provisions would only make what can already be a daunting process more difficult.

Pennie recommends maintaining the prior premium adjustment percentage methodology and *de minimis* AV ranges, and we further propose that no adjustments are made for plan year 2026 given the significant market disruption we will see if the enhanced premium tax credits are not extended.

Pre-enrollment verifications for Special Enrollment Periods (SEP) (§155.420(g))

Pennie opposes the proposal to require state-based marketplaces to conduct pre-enrollment verification of eligibility for at least 75% of new enrollments through SEPs. Pennie's Board of Directors, which again includes four of the Commonwealth's largest insurers, voted unanimously to approve several SEPs for which Pennie requires pre-enrollment verification. The Board balanced several factors unique to the Pennsylvania marketplace. CMS asserts that for general adverse selection concerns, it must impose what appears to be arbitrary SEP verification requirements on all marketplaces, including state-based marketplaces despite sharing no evidence of adverse selection in Pennsylvania. Pennie requests that states remain able to determine which SEPs require pre-enrollment verification based on factors unique to the Pennsylvania market, as we understand more about the attributes of our market to appropriately weigh the trade-offs between verification of SEPs versus the risk of misuse.

Low Income SEP (§155.420(d)(16); §147.104(b)(2)(i)(G)

Pennie opposes the proposal requiring all marketplaces to eliminate the SEP for households with projected income at, or below, 150% of the federal poverty level (FPL). In previous rulemaking, CMS

provided state-based marketplaces with the option to implement this SEP within their own markets. Pennie's Board of Directors voted unanimously to adopt this SEP and it has served as a meaningful pathway to coverage for low-income Pennsylvanians, without the drawbacks that CMS claims. During the 2024 plan year, Pennie had approximately 27,000 enrollees who accessed this SEP by virtue of their income being verified as under 150 percent of the FPL. Pennie requests that state-based marketplaces continue to have the option of utilizing this SEP and to be able to determine if this SEP suits the unique aspects of the state's marketplace.

Income discrepancies within 100-400% of the Federal Poverty Limit (FPL)(§155.320(c)(3)(iii))

Pennie opposes requiring state-based marketplaces to generate household income inconsistencies when attested income is between 100% and 400% FPL and data sources indicate that projected income is lower than 100%. In its discussion of this proposal, CMS specifically mentions that non-Medicaid expansion states may be susceptible to improper enrollments because there is an incentive for individuals to inflate their income so they can qualify for APTC through the marketplace due to not qualifying for Medicaid in their states. As Pennsylvania is a Medicaid expansion state, that incentive is not present. Again, this proposal imposes rules and costly burdens to address a problem for a subset of federal marketplace states to *all* marketplaces, incurring unnecessary burdens on both the state and the individuals they serve. Pennie requests that this proposal be optional for state-based marketplaces.

Other Provisions

While the provisions discussed above are of most importance to Pennie, we also seek clarification and make further suggestions and comments on the following policies.

Broker Fraud - Preponderance of Evidence (§155.220(g)(2))

The premise of the proposed rule aims to address instances of brokers improperly enrolling consumers in marketplace coverage. While much of the proposed rule focuses on requiring action by individuals to counteract inappropriate broker behavior, we applaud CMS for including a provision that directly addresses the root of the issue by holding brokers to account. While Pennsylvania has not seen the same unauthorized enrollments as the federal marketplace, strict accountability measures at the federal level can set a helpful tone across the country.

Failure to file and Reconcile (FTR) (§155.305(f)(4))

Pennie requests flexibility on the Failure to Reconcile (FTR) provision. The changes to the original implementation were made due to concerns around backlogs of IRS processing tax returns. In times where there are documented IRS backlogs, we request the ability to work with enrollees to verify that they are in the process to report and reconcile their prior premium tax credits. Given operational changes, we request SBMs have until the 2027 Open Enrollment Period to adjust systems.

Past Due Premiums (§147.104(i))

The proposal is to allow issuers to attribute past due premiums from prior coverage before effectuating coverage under a new plan. At a minimum, Pennie requests that, if finalized, CMS allows states to define appropriate look-back period to address the concern while also ensuring it is realistically time-constrained and feasible to implement.

Income verification timeframe (§155.315(f)(7))

Pennie does not oppose the provision to return to a 90-day income verification period. However, Pennie requests the continued flexibility to provide limited extensions to the income verification reasonable opportunity period when needed to ensure our customers can maintain coverage when exceptional circumstances prevent them from providing verification within 90 days.

Enrollment Hierarchies (§ 155.335(j))

Pennie urges state flexibility on the enrollment hierarchy proposal. Pennie has successfully transitioned consumers into richer plans providing better value as well as maximizing the amount of APTC eligibility on the consumer's behalf. Combined with a potentially shorter annual open enrollment period, individuals may not have sufficient time to engage in understanding the benefits of switching to a silver plan. Allowing SBMs flexibility to continue this policy is a greater benefit than restricting it entirely.

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We appreciate the opportunity for public comment, particularly because many of the key policies cite the same singular and partisan report as evidence, while the public comment process allows for input from the vast range of expertise across the country that can inform a more comprehensive view on these policies. As such, Pennie respectfully submits these comments for your consideration. We look forward to continuing our longstanding partnership with CMS.

Respectfully Submitted,

Devon Trolley
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Pennsylvania Health Insurance Exchange Authority d/b/a Pennie