April 11, 2025

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

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-9884-P– Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Proposed Rule
90 Fed. Reg. 12942 (March 19, 2025)

Dear Secretary Kennedy and Administrator Oz:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the Marketplace Integrity and Affordability proposed rule. ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change, as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is more determined than ever to end cancer as we know it, for everyone.

More than 2 million Americans will be diagnosed with cancer this year and more than 18 million Americans living today have a history of cancer.[1] ACS CAN supports the administration's goal of improving market integrity and we are committed to policies that effectively address any waste, fraud, and abuse that exists in public health care programs. However, we are concerned the overall impact of this proposed rule will actually impede access to comprehensive health insurance coverage and create more gaps in coverage rather than address any potential waste in the program.

Having comprehensive and affordable health insurance coverage is a key determinant for surviving cancer. Research from the American Cancer Society shows that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.[2] Studies show that uninsured patients had substantially higher risks of presenting with late-stage cancers at diagnosis, especially for screen-detectable cancers and cancers with early signs and symptoms, for which access to care is critical for early diagnosis.[3]

By CMS' own estimates between 750,000 to 2 million fewer individuals would enroll in qualified health plan (QHP) coverage in 2026 if this proposal was finalized.[4] These estimates do not account for other recent agency actions such as the significant cuts to navigator grant funding[5] and the reduction of CMS personnel which are

[1] American Cancer Society. *Cancer Facts & Figures 2025.* Atlanta: American Cancer Society; 2025.
[2] Zhao, J., Han, X., Nogueira, L., Fedewa, S.A., Jemal, A., Halpern, M.T. and Yabroff, K.R. (2022), Health insurance status and cancer stage at diagnosis and survival in the United States. CA A Cancer J Clin. https://doi.org/10.3322/caac.21732.
[3] Timothy P. Hanna et al., (Nov. 2020), Mortality Due to Cancer Treatment Delay: Systematic Review and Meta-analysis. 371 BMJ m4087 at 5, https://www.bmj.com/content/371/bmj.m4087.
[4] 90 Fed. Reg. at 13024.
[5] Centers for Medicare & Medicaid Services. CMS Announcement on Federal Navigator Program Funding. Feb. 14, 2025. Available from https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding.

likely to result in decreased enrollment. Nor do CMS estimates account for the potential expiration of the enhanced Affordable Care Act (ACA) tax credits which have contributed to the record-breaking enrollment in Marketplace plans since they were enacted by Congress in 2021. ACS CAN is concerned that these cumulative policies will result in fewer individuals having access to affordable, comprehensive coverage.

III. Provisions of the Individual Health Insurance Market and Exchange Program Integrity Proposed Rule

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

1. Limited Open Enrollment Periods (§ 147.104(b)(2))

HHS proposes to remove the monthly special enrollment period (SEP) for individuals who are eligible for the advanced premium tax credits (APTCs) and who have an estimated household income up to 150% of the federal poverty level (FPL), which is only $23,475 for an individual or $31,725 for a family of 4.

ACS CAN opposes this proposal to remove the SEP. We note that individuals who have a household income of up to 150% FPL may be particularly vulnerable to income fluctuations from month-to-month. We believe eliminating this SEP is particularly ill timed given the recent announcement that CMS is planning significant cuts to its navigator program, which will hamper education and enrollment activities, making it harder for individuals who qualify for tax credits and subsidies to be aware of their existence and to enroll in Marketplace coverage.

2. Coverage denials for failure to pay premiums for prior coverage (§ 147.104(i))

HHS proposes to allow issuers to include past-due premium amounts that are owed in the initial premium the enrollee must pay in order to effectuate new coverage.

ACS CAN urges HHS to retain the current policy. The proposed policy would hinder an individual's ability to obtain comprehensive coverage, particularly for low- and moderate-income individuals who experience a sudden or unexpected financial burden associated with a serious illness like cancer. Under this policy, an individual who fails to pay past-due premium amounts (even de minimis past due amounts) could be prohibited from enrolling in Marketplace coverage. Of particular concern is the fact that the proposed rule also seeks to eliminate SEPs and limit the annual election period, thus giving consumers who owe past-due premiums very little time in which to reconcile accounts before they would be permitted to enroll in Marketplace coverage. We urge HHS to consider allowing individuals with past-due premiums to pay those premiums in installments over the plan year and to allow plans the ability to forgive past-due premiums of a de-minimis amount.

An individual in active treatment for cancer usually incurs significant out-of-pocket costs for required deductibles, copayments and coinsurance, as well as costs for services not covered by insurance. These additional costs may make it even more difficult for a cancer patient to pay their insurance premiums. Nearly 37% of American adults report being unable to cover an emergency expense costing $400 without having to borrow or sell something to do so.[6] Individuals often need additional time in order to try to obtain funds to cover these unexpected medical costs. We urge HHS to recognize that life circumstances for individuals with serious illness could negatively impact patients' ability to pay their monthly premium and to protect these enrollees' access to coverage when they need it the most.

[6] Report on the Economic Well-Being of U.S. Households in 2023-May 2024. Accessed March 19, 2025. https://www.federalreserve.gov/publications/2024-economic-well-being-of-us-households-in-2023-executive-summary.htm.

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

1. Definitions: Deferred Action for Childhood Arrivals (§ 155.20)

HHS is proposing to amend the definition of "lawfully present" to exclude from the definition Deferred Action for Childhood Arrivals (DACA) recipients. As a result, DACA recipients would not be eligible for tax credits for Marketplace plans.

Access to care for those who have comprehensive health insurance not only ensures that serious diseases like cancer can be detected and treated earlier but also often means better patient outcomes and less costs to the individual and the larger health care system. Unfortunately, despite the coverage gains after the enactment of the ACA, data shows that noncitizens are more likely to be uninsured.[7] As of 2023, 18% of lawfully present individuals had health insurance while only 8% of U.S. citizens were uninsured.[8] DACA recipients are almost 5 times as likely to be uninsured (47%) than the general U.S. population (10%).[9]

A majority of DACA recipients are 35 years or younger and 64% report their health as excellent or very good, while an additional 28% report their health as being good.[10] Including DACA recipients under the definition of those "lawfully present" will help attract younger, healthier individuals to Marketplace risk pools, thus helping to lower premiums for all enrollees. The high quality, affordable health insurance the ACA facilitates promotes economic activity and growth on a broader level, too. As CMS observed in the 2023 Final Rule, high quality health coverage not only improves health outcomes but also allows covered individuals to "be even more productive and better economic contributors to their communities and society at large with improved access to health care."[11]

3. Verification Process Related to Income Eligibility for Insurance Affordability Programs (§§ 155.305, 155.315, and 155.320)

a. Failure to file taxes and reconcile APTC Process (§ 155.305(f)(4))

HHS proposes to reinstate the former policy that an Exchange may not determine a tax filer or their enrollee eligible if: (1) HHS notifies the Exchange that APTCs were paid on behalf of the tax filer or their spouse (if married), for a year for which tax data would be utilized for verification of household and family size, and (2) the tax filer did not comply with the requirement to file a Federal income tax return and reconcile their APTC for that year.

This proposal will result in some individuals being dropped from coverage and no longer having access to care while they address their problems with tax filing. ACS CAN supports erring on the side of giving continued access to health care while such problems are resolved, especially when many of them do get resolved with the

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[7] KFF. Key facts on health coverage of immigrants. Jan. 15, 2025. Available at https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/#:~:text=Noncitizen%20immigrants%20are%20more%20likely,likely%20to%20provide%20health%20benefits.

[8] Id.

[9] KFF. Key facts on Deferred Action for Childhood Arrivals (DACA). Feb 11, 2025. Available at https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/#:~:text=of%20DACA%20Recipients-,As%20of%20September%2030%2C%202024%2C%20there%20were%20roughly%20538%2C000%20active,the%20country%20(Figure%201).

[10] Id.

[11] 89 Fed. Reg. at 39,396.

individual's eligibility for APTCs remaining intact.

b. 60-day extension to resolve income inconsistency (§ 155.315)

HHS is proposing to remove the requirement that Exchanges provide an automatic 60-day extension to allow applicants sufficient time to provide documentation to verify household income.

This policy will negatively impact continued access to care for individuals who are legitimately eligible for APTCs and enrollment through Exchanges but have difficulty obtaining the necessary paperwork or meeting other reporting requirements. Providing a limited time period allotted to this process is often insufficient for many applicants to provide this documentation, since it can require multiple documents from various household members along with an explanation of seasonal employment or self-employment, including multiple jobs. We urge HHS to retain the automatic 60-day extension to help prevent individuals from being wrongfully dropped from coverage and lacking access to health care.

4. Annual Eligibility Redetermination (§155.335)

HHS proposes to amend the annual eligibility redetermination regulation to prevent enrollees from being automatically re-enrolled in coverage with an APTC that fully covers their premium without taking an action to confirm their eligibility information. HHS would require that if an enrollee who qualifies for a $0 premium plan fails to update their eligibility information, the Exchange would decrease the amount of the APTC such that the enrollee owes $5 per month until the enrollee updates their information. HHS proposes that state-based marketplaces (SBMs) and federally-facilitated marketplaces (FFMs) must institute this policy beginning with the 2026 plan year.

ACS CAN strongly opposes this policy. We share HHS' goal of ensuring that all Marketplace enrollees properly receive tax credits and subsidies to which they are legally entitled. However, we do not believe that instituting a policy to penalize individuals who have not confirmed their eligibility information is a policy that is tailored to address any potentially fraudulent behavior.

Under this proposal HHS would be requiring an individual who is eligible for a fully subsidized premium (e.g., under the statute the individual is entitled to a $0 monthly premium) to pay a $5 monthly fee for failing to update their eligibility information. We are concerned this new policy would be confusing to an individual who maintains enrollment in their $0 premium plan. Many individuals are unaware of the requirement to annually update their eligibility information. Moreover, the significant cuts to the navigator program reduces the likelihood that individuals will be made aware of or understand this new policy.

It is also unclear from the proposed rule, whether an individual could be disenrolled for non-payment of premiums and whether an individual who complies with this requirement mid-year would be prohibited from reenrolling in their same plan until this penalty were satisfied.

7. Annual Open Enrollment Period (155.410)

HHS proposes to amend the annual Open Enrollment Period (OEP) beginning January 1, 2026. Under the proposal the OEP would run from November 1st through December 15th of the calendar year preceding the benefit year. This requirement would apply to all Exchanges including SBMs.

ACS CAN opposes this requirement. The American Cancer Society's National Cancer Information Center regularly fields calls from cancer patients who are looking for options to enroll in or switch their health insurance coverage, and these callers have many more viable options when they call during open enrollment. Through these calls we know that consumers often need time to digest their health coverage options. This is particularly true for consumers with complex medical needs like cancer, who need additional time to determine treatment

plans, research plan options to determine whether their providers are in-network and whether a given plan covers their prescription drugs. We urge HHS to retain a longer open enrollment period and allow SBMs flexibility to refine their OEP to align with the needs of their constituents. A longer open enrollment period is particularly needed given CMS' announcement earlier this year that it is significantly cutting navigator funding, which will harm the ability to conduct outreach and enrollment efforts to individuals who are currently uninsured but may be hard to reach with advertising and other methods.

8. Monthly SEP for APTC-Eligible Individuals with Incomes at or Below 150 Percent FPL (§ 155.420)

HHS proposes to repeal the monthly SEP for APTC-eligible qualified individuals with a projected annual household income at or below 150 % FPL (referred to as the "150% FPL SEP").

ACS CAN opposes this policy because we fear it will result in some individuals experiencing a gap in coverage. For a patient in active cancer treatment, even a gap of a few weeks or months can be significantly disruptive to treatment, and even life-threatening. Gaps in insurance coverage have been shown to cause delays or inability to obtain prescription drugs[12] – which are an important part of most cancer treatment plans. Evidence-based protocols for chemotherapy and other cancer treatments often require treatment delivery on a prescribed timeline. Interruptions to this timeline because of coverage gaps can be detrimental. A gap in coverage can also cause a fatal delay in initiation of a treatment protocol. For example, research shows that delays in the initiation of chemotherapy for breast cancer patients result in adverse health outcomes.[13]

Individuals with limited incomes are more likely to be uninsured, and people facing cancer and survivors with limited incomes experience higher health care costs and significantly more financial hardship compared to individuals who have not been diagnosed with cancer.[14] Because of their limited incomes, these individuals are also less able to afford any health insurance options available outside of the Marketplace and may fall prey to promotion of non-comprehensive junk insurance products. We urge HHS to rescind this policy and to give this population access to comprehensive Marketplace plans year-round through an SEP.

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

HHS proposes to reinstate a previous requirement that Exchanges on the federal platform must conduct pre-enrollment verification of applicant eligibility for certain categories of individual market SEPs. HHS proposes to require all Exchanges to conduct pre-enrollment verification of eligibility for at least 75% of new enrollments through SEPs.

ACS CAN urges HHS to rescind the proposal. We are supportive of efforts to ensure that ineligible individuals are not enrolling in Exchange plans (either due to error or fraudulent activity). However, we believe this proposal will create an unnecessary, undue burden on consumers and may discourage eligible individuals from enrolling in Marketplace plans. We are particularly concerned about this proposal's impact on the risk pool. Younger individuals are less likely to successfully submit these documents and enroll – resulting in an older risk pool for these plans which would result in higher premiums. Additionally, Black and African American consumers are less likely to complete this process (and therefore get coverage) than white consumers – making this a policy that

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[12] Yabroff KR, Kirby J, Zodet M. Association of Insurance Gains and Losses With Access to Prescription Drugs. JAMA Intern Med. 2017 Oct 1;177(10):1531-1532. doi: 10.1001/jamainternmed.2017.4011. PubMed PMID: 28892527; PubMed Central PMCID: PMC5820691.

[13] Chavez-MacGregor M, Clarke CA, Lichtensztajn DY, Giordano SH. Delayed Initiation of Adjuvant Chemotherapy Among Patients With Breast Cancer. *JAMA Oncol.* 2016;2(3):322-329. doi:10.1001/jamaoncol.2015.3856.

[14] American Cancer Society Cancer Action Network. The Costs of Cancer for People with Limited Incomes. October 19, 2022. https://www.fightcancer.org/sites/default/files/coc_limited_incomes_final2.pdf.

further contributes to health inequities.

For several years our organization has been concerned that pre-enrollment verification requirements caused gaps in insurance coverage because some individuals are unable to satisfy verification requirements, or do not understand the process – and therefore knowingly or unknowingly go without coverage. This is particularly concerning for persons with cancer. ACS CAN urges HHS to rely as much as possible on verification from automatically available data, as it will likely lead to fewer individuals having accidental gaps in coverage.

C. Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges (Part 156)

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

HHS is proposing that issuers of non-grandfathered individual and small group market health insurance coverage (e.g., coverage that is subject to Essential Health Benefit (EHB) requirements) be prohibited from covering sex-trait modification as an EHB beginning in plan year 2026.

HHS fails to define the term "sex trait modification", which could include a number of interventions. Absent a clear definition of "sex trait modification", issuers could impose additional utilization management processes and possibly delay claims for services for covered, medically necessary services. For example, some women with a high risk of developing breast cancer may choose to undergo a prophylactic mastectomy to lower their risk of developing breast cancer. Under the proposed rule, a woman who chooses a prophylactic mastectomy could face additional hurdles and/or a delay in obtaining coverage for her surgery.

We are also concerned that HHS seems to base this proposal on the assertion that "0.11 percent of enrollees in non-grandfathered individual and small group coverage market plans utilized sex-trait modification during PYs 2022 and 2023."[15] We are concerned with HHS' assertion that EHB benchmark plans should not cover a product or service because few people use it. Applying HHS' rationale to other disease states, plans would not have to cover treatment for many cancers, including pediatric cancers, because they affect a small percentage of the population.

Specifically excluding coverage of sex-trait modification from the EHB will mean that even if a plan were to provide coverage, such services would not be subject to the ACA prohibition against lifetime or annual coverage limits and that such services would not count against the maximum annual limitation on cost sharing.

2. Premium Adjustment Percentage (§ 156.130(e))

ACA section 1302(c) directs the Secretary to determine the annual premium adjustment percentage, which is used to calculate the maximum out-of-pocket limit, the employer mandate penalty, and eligibility for certain individual mandate penalty exceptions. HHS is proposing to use average per enrollee private health insurance premiums (excluding Medigap and property and casualty insurance) rather than the current measure which uses employer-sponsored insurance premiums.

ACS CAN is concerned with the potential impact and urges HHS to withdraw its proposal given the negative impact on enrollees, as discussed in more detail below:

Increased premiums and lower enrollment: According to HHS' own regulatory impact analysis, this policy alone would result in net premium increases of $530 million per year for plan year (PY) 2026 through PY 2030, which is approximately a 2% net premium increase.[16] These increases would affect low-income enrollees who are likely

[15] 90 Fed. Reg. at 12,987.
[16] 90 Fed. Reg. at 13,018.

to find larger premium payments very challenging to absorb into their already tight budgets. We are concerned that increased premiums could cause people to forego coverage, or choose an off-Marketplace plan, which may not provide comprehensive benefits. In addition, through HHS' own estimates, approximately 80,000 people a year would disenroll from Marketplace coverage.[17] We are concerned this policy could contribute to a destabilization of the Marketplace and result in fewer Americans choosing comprehensive coverage options. We urge HHS to withdraw this proposed policy.

Higher out-of-pocket costs in all private insurance: In addition, this change would result in a higher maximum out-of-pocket limit for all non-grandfathered private insurance plans, including those enrolled in employer-sponsored insurance. The preamble notes the maximum out-of-pocket limit would increase over $1,000 from the PY 2025 parameters of $9,200 for self-only coverage ($18,400 for family coverage) to $10,600 for self-only coverage ($21,200 for family coverage) in PY 2026.[18] This represents a 15.2% increase. We are concerned this increase will result in enrollees not only paying more in premiums but also spending more before hitting their maximum out-of-pocket cap. ACS CAN's *Costs of Cancer* report showed that typical cancer patients in the individual market reach their maximum out-of-pocket limit in the first 1 to 3 months after a positive cancer screening – meaning they must pay multiple thousands of dollars in a very short amount of time.[19] Allowing this maximum limit to increase will mean newly-diagnosed cancer patients – and many survivors – will have to pay more out-of-pocket costs.

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

HHS is proposing to change the actuarial value (AV) of plans. The AV requirement is determined based on the plan's coverage of EHBs for a standard population. The higher the AV, the less enrollee cost sharing will be paid, on average. The statute sets the required AV for each level of coverage but authorizes HHS to develop guidelines to provide for a de minimis variation in the AVs used to determine the level of coverage of a plan. HHS proposes to broaden the de minimis ranges. Beginning in plan year 2026, the de minimis range would be +5/-4 percentage points for expanded bronze plans and +2/-4 percentage points for all other individual and small group market plans subject to the AV requirement.

ACS CAN opposes this policy because it would reduce the generosity of health plan coverage which may result in slightly lower premiums (which HHS estimates to be 1% on average[20]) but will certainly result in higher cost sharing. A lower premium plan with higher cost sharing may not actually save cancer patients money because cancer patients are high utilizers of care. We also are concerned that the confluence of this proposal combined with the premium adjustment percentage proposal could lead to significantly higher out-of-pocket costs for those who need access to care, such as cancer patients.

This policy could exacerbate medical debt that impacts many consumers, including cancer patients. People with cancer often bear significant health care costs because they can have substantial health care needs, are high utilizers of health care services, use many different providers, and sometimes require more expensive treatments. They also must pay many indirect costs, like transportation and lodging as well as lost wages due to unpaid time off or job loss, that add to their already heavy cost burden. According to a 2024 ACS CAN *Survivor Views* survey, 47% of cancer patients and survivors incurred medical debt to pay for their cancer care, including

[17] Id.
[18] 90 Fed. Reg. at 12,993.
[19] American Cancer Society Cancer Action Network. The Costs of Cancer: Addressing Patient Costs. April 2017. Available at www.fightcancer.org/costsofcancer.
[20] 90 Fed. Reg. at 13,019.

98% who had health care coverage at the time they accumulated debt to pay for their care.[21] Those with medical debt are more than 3 times as likely to be behind in their cancer screenings. Delaying or forgoing care because of cost, which is more common among people with medical debt, is associated with increased mortality risk among cancer survivors.[22]

CONCLUSION

Thank you for the opportunity to comment on the Patient Protection and Affordable Care Act, Marketplace Integrity and Affordability proposed rule. If you have any questions, please feel free to contact me or have your staff contact Anna Schwamlein Howard, Policy Principal, Access and Quality of Care at Anna.Howard@cancer.org.

Sincerely,

Lisa A. Lacasse, MBA
President
American Cancer Society Cancer Action Network

[21] American Cancer Society Cancer Action Network. Medical Debt and Cancer. May 9, 2024. Available at https://www.fightcancer.org/policy-resources/medical-debt-and-cancer.
[22] Yabroff KR, Han X, Song W, Zhao J, Nogueira L, Pollack CE, Jemal A, Zheng Z. Association of Medical Financial Hardship and Mortality Among Cancer Survivors in the United States. J Natl Cancer Inst. 2022 Jun 13;114(6):863-870.