

April 11, 2025

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Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9884-P  
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As organizations dedicated to promoting the health of our nation's children, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability." We believe that insurance coverage for children must ensure access to timely, affordable, high-quality and age-appropriate health that meets their unique needs. While we share the CMS goal of promoting program integrity and efficiency in the Marketplace, we believe that the rule must be revised to ensure that children and their families – particularly children with chronic, complex or serious health conditions– continue to have access to affordable and appropriate health care.

More than 2 million children were enrolled in Qualified Health Plans in 2024, making Marketplace coverage an increasingly important component of children's coverage overall, and helping to bring the rate of uninsured children to historic lows and improve health outcomes. Our comments focus on changes we believe are needed to the rule to strengthen – and avoid harming – children's coverage. We urge you to:

- Revise proposals that limit access to eligibility, enrollment, and coverage for families with dependent children to ensure that children do not lose appropriate coverage.
- Target oversight on agents and brokers to prevent improper enrollments, rather than implementing broad policy changes—such as eliminating special enrollment periods (SEPs) for low-income families, shortening the open enrollment period (OEP), and requiring enrollees to pay premiums on certain fully subsidized plans—that could lead to inappropriate coverage loss for individuals and their dependents.
- Prioritize education, outreach, and guidance to ensure families are fully informed about changes to the enrollment processes or requirements.

#### **Failure To File Taxes and Reconcile APTC Process (§ 155.305(f)(4))**

We urge CMS to retain current policy and focus its efforts on consumer education and the streamlining of the advanced premium tax credit (APTC) reconciliation process to address concerns about improper enrollment. Consumer education and outreach with clearer guidance on tax filing requirements will help prevent unnecessary coverage loss for enrollees and their dependents.

Alternatively, should CMS move forward with this proposal to require Marketplaces to determine that an individual is ineligible for APTC after one year of failing to file a federal tax return, we urge a delay in the effective date. A delay would provide State-Based Marketplaces (SBMs) and the Internal Revenue Service (IRS) adequate opportunity to implement the necessary changes and educate consumers to limit eligibility and coverage disruptions for individuals and their dependents.

The current two-year threshold was implemented to account for the administrative burden involved in the reconciliation process, delays from the IRS, and the complex nature of failure-to-file-and-reconcile process. Furthermore, the IRS has existing enforcement mechanisms in place for individuals who fail to file their tax returns, making the additional penalty of immediate APTC loss both duplicative and disproportionately harmful to children of lower-income individuals. The proposed change would only increase confusion and the likelihood of families with children losing coverage due to administrative hurdles rather than intentional non-compliance.

### **Annual Eligibility Redetermination (§ 155.335)**

We urge CMS to prioritize enhanced outreach and reminder mechanisms to encourage consumers to update their eligibility information. We share CMS's concerns regarding program integrity but believe that eliminating the auto-enrollment process would impose financial and administrative barriers that increase the risk of coverage loss. This policy change could have a particular impact on families and children, specifically following the end of the COVID-19 Public Health Emergency's continuous eligibility requirement when more families moved from Medicaid to the Marketplace. Automatic re-enrollment has served as a key mechanism to promote continuous coverage,<sup>1</sup> and this policy change, if finalized, could lead to eligible children losing needed access to care.<sup>2</sup> Many consumers face challenges navigating the complexities of insurance coverage, including language barriers and confusion related to the enrollment process. Furthermore, given recent cuts to education and outreach, consumers have fewer resources to navigate these barriers, which may result in unintended disenrollment, leaving children and families without coverage despite continued eligibility.

### **Annual Eligibility Redetermination (§ 155.335(j)(4))**

We urge CMS to retain the current policy that allows consumers eligible for cost-sharing reductions (CSRs) to be automatically enrolled in a more generous silver plan if available. Children with complex health needs require specialized care, which may only be available through certain pediatric specialists. Silver plans with CSRs lower out-of-pocket costs, making essential treatments, medications, and specialist care more accessible. Eliminating the current policy could leave families in bronze plans with higher deductibles, creating financial and logistical barriers to timely care that could lead to poor health outcomes.

### **Premium Payment Threshold (§ 155.400)**

We urge CMS to retain the current premium payment thresholds that protect enrollees from losing coverage when they miss a premium payment. We also encourage CMS to maintain the existing guardrails, such as consistency in which payment thresholds are offered, and implement new measures, such as requiring insurers to notify enrollees of any outstanding balance before terminating coverage or setting a reasonable cap on fixed-dollar thresholds.

Premium payment thresholds grant insurers crucial flexibility to avoid termination of coverage due to de minimis non-payments, which disproportionately affect enrollees with low-dollar premium obligations. Research has found that families faced with this additional financial burden may delay needed care, which can increase inappropriate utilization of emergency room care and affect a child's long-term health outcomes and future productivity.

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<sup>1</sup> <https://www.commonwealthfund.org/publications/fund-reports/2024/mar/automatic-enrollment-health-insurance-pathway-increased-coverage>.

<sup>2</sup> McIntyre A, Shepard M. "Automatic Insurance Policies - Important Tools for Preventing Coverage Loss," *N Engl J Med*. 2022;386(5):408-411. doi:10.1056/NEJMp2114189.

### **Annual Open Enrollment Period (§ 155.410)**

We urge CMS to reconsider shortening the annual Open Enrollment Period (OEP) from Jan. 15 to Dec. 15, and instead, to retain the current timespan. Reducing the OEP window could lead to coverage gaps that impact children's access to necessary services, particularly children with serious, chronic or complex medical needs. Additionally, we recommend preserving SBM flexibility in setting their own enrollment periods based on state-specific needs.

The longer enrollment period with a Jan. 15 deadline gives enrollees with dependents additional time to assess their coverage options and find a plan that meets their unique needs. This is especially important for families with a child with a serious, chronic, or complex health condition who may need specialized care and providers and will need to comparison shop across plans.

Moreover, the proposed rule's assertion that a shorter OEP would reduce burden on consumer assisters must be considered in the context of recent cuts to the Navigator program.<sup>3</sup> While we recognize the need for efficient use of resources, limiting the OEP, combined with the recent reduction in funding for enrollment assistance, may make it more difficult for families with eligible children to find appropriate coverage, particularly those in families who need additional support navigating the process.

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

We appreciate CMS's concerns about fraudulent activity by agents and brokers (including web brokers) that is leading to higher numbers of improper enrollment in this monthly special enrollment period (SEP). Rather than eliminate this coverage pathway, we encourage CMS to establish an oversight policy focused on enrollment practices by agents and brokers (including web brokers) with a history of fraudulent activity to address program integrity concerns. This oversight should be combined with robust outreach and education efforts to eligible consumers to ensure individuals and their dependents who qualify can access and receive coverage.

The monthly SEP for those who are APTC-eligible with a projected household income at or below 150% of the federal poverty level has played a critical role in ensuring that children in those eligible families have continuous access to health coverage. Many low-income families experience fluctuations in income that may not align with the annual open enrollment period and without the low-income SEP, may find themselves without the opportunity to secure affordable health insurance.

We urge CMS to ensure that families understand any policy changes and their implications on insurance coverage. Maintaining continuous coverage is essential for children's health and overall well-being; gaps in coverage can lead to missed preventative services, interruptions in treatment for chronic conditions, and reliance on more costly emergency care.

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

We understand CMS's intent of ensuring the integrity of the Marketplace, but are concerned that reinstating pre-enrollment verification for SEPs could create unnecessary barriers to coverage for eligible families and their children. Rather than implement broad pre-enrollment verification for SEPs, CMS should focus program integrity efforts on the monitoring and oversight of enrollment through brokers and agents flagged for fraud and other high-risk program integrity categories.

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<sup>3</sup> <https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding>

As CMS acknowledges, a pre-enrollment verification process could discourage some consumers from enrolling. Requiring pre-enrollment verification for SEPs could also result in unintentional delays that interrupt access to necessary care for families that are eligible. SEPs are essential for ensuring that individuals and their dependents who experience qualifying life events can maintain continuous access to health care coverage. Children, particularly those with chronic conditions or ongoing health needs, depend on consistent access to health care and delays in enrollment can lead to disruptions in their treatment and care continuity that can result in poorer health outcomes.

In the event that this policy is finalized as proposed, we recommend CMS provide guidance or provisional coverage to enrollees while eligibility is confirmed to balance the policy with the need for access to timely and continuous coverage for children and families.

### **Definition of “Lawfully Present” and Exclusion of DACA Recipients (§ 155.20)**

We ask that CMS reconsider the proposal to narrow the definition of “lawfully present” to exclude Deferred Action for Childhood Arrivals (DACA) recipients. Across the United States, 300,000 U.S.-born children have at least one parent with DACA<sup>4</sup>, and approximately 1% of DACA recipients are children and youth.<sup>5</sup> Barring access to coverage for DACA recipients will have immediate and long-term negative impacts on health care access for recipients themselves, as well as for their U.S. citizen children. We know that when parents and caregivers gain access to health coverage, their children also gain access to coverage and are more likely to access routine and preventive health care that will help them thrive.

### **Prohibition on Coverage of “Sex-Trait Modification” as an EHB (§ 156.115(d))**

We ask CMS to retract the proposal to prohibit issuers from offering “sex-trait modification” as an EHB, starting in plan year 2026. This proposal disrupts the balance established between safeguarding access to a minimum level of services across the country and state flexibility to address the health care needs of their populations. Since HHS delineated the EHB benchmarking process in federal regulations, the agency has never utilized the EHB framework to force states to categorically exclude benefits that target specific populations with a particular condition. This proposed rule would set a precedent of creating coverage barriers for treatments.

In conclusion, the undersigned organizations appreciate this opportunity to share our views regarding the proposed rule. We look forward to working with you to ensure that the Marketplaces meet the unique health care needs of children and their families who rely on this coverage.

Sincerely,

American Academy of Pediatrics  
Children’s Hospital Association  
First Focus on Children  
Georgetown Center for Children and Families  
March of Dimes  
National Association of Pediatric Nurse Practitioners

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<sup>4</sup> <https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition/>

<sup>5</sup> [https://www.uscis.gov/sites/default/files/document/data/Active\\_DACA\\_Recipients\\_March\\_FY23\\_qtr2.pdf](https://www.uscis.gov/sites/default/files/document/data/Active_DACA_Recipients_March_FY23_qtr2.pdf)