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April 9, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Proposed Rule

Dear Administrator Oz:

The Association of American Medical Colleges (AAMC or the Association) welcomes this opportunity to comment on the "**Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Proposed Rule**," (March 19, 2025), issued by the Centers for Medicare & Medicaid Services (CMS or the agency).

The AAMC (Association of American Medical Colleges) is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, biomedical research, and community collaborations. Its members are all 160 U.S. medical schools accredited by the Liaison Committee on Medical Education; 12 accredited Canadian medical schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe.

The proposed rule seeks to enhance program integrity in qualified health plans (QHPs) offered through federally facilitated Exchanges (FFEs) and state-based Exchanges on the federal platform (SBE-FPs). These exchanges, also referred to as the Affordable Care Act (ACA) marketplaces, are established under the ACA and enable individuals who qualify to purchase health insurance coverage in QHPs.[1] The agency is proposing policies to establish standards to maintain plan integrity and prevent improper enrollment and changes in enrollee health care coverage. These proposed changes, if finalized, would be implemented alongside other policy

[1] P.L. 111-148

revisions related to the ACA marketplace, including the expiration of ACA enhanced subsidies at the end of 2025. The availability of the marketplace and ACA enhanced subsidies have allowed uninsured rates to reach record lows due to enrollment in QHPs. In 2024, marketplace enrollment hit a record high of 21.4 million individuals, which is largely attributed to the availability of enhanced subsidies that assist enrollees with premium costs.[2]

This shift in enrollee coverage has had a profoundly positive impact across the healthcare ecosystem. In 2024, one in six nonelderly people had health coverage through the ACA.[3] This has resulted in increased access to regular care, decreased financial stress, and improved health outcomes for patients.[4] For providers, increases in healthcare coverage improve payer mix, reduce uncompensated care costs, and ensure the ability to continue offering care to their communities. If finalized, these proposed policies would restrict marketplace eligibility, enrollment, and affordability. Up to two million people could lose their coverage in 2026 alone and decreases in beneficiary coverage would place additional financial strain on providers. Without coverage, these additional costs force providers to find ways to stretch already limited dollars and resources to cover increasing rates of uncompensated care. AAMC-member teaching health-systems and hospitals account for a disproportionate share of uncompensated care costs as member teaching hospitals provide median uncompensated care costs of $33.2 million – more than 16 times nonteaching hospitals.[5] Without adequate coverage for patients, access to care may become strained due to financial constraints. We encourage the administration to bear in mind these cascading effects when weighing the implementation of these proposals and urge the agency not to finalize policies that restrict access to the marketplace or insurance affordability programs. Without coverage, patients may experience additional hurdles in accessing care resulting in worse health outcomes and higher costs.

Ensure Access and Affordability for Insurance Plans in the Marketplace Without Limiting Coverage

As part of CMS' effort to ensure integrity and affordability for plans in the marketplace, the agency is proposing to shorten the annual individual market exchange open enrollment period (OEP) for enrolling or changing coverage in a QHP. Specifically, beginning with benefit years starting January 1, 2026, the agency is proposing to shorten the OEP from November 1 through

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[2] KFF, A Look at ACA Coverage through the Marketplaces and Medicaid Expansion Ahead of Potential Policy Changes (January 2025) https://www.kff.org/affordable-care-act/issue-brief/a-look-at-aca-coverage-through-the-marketplaces-and-medicaid-expansion-ahead-of-potential-policy-changes/

3 KFF, A Look at ACA Coverage through the Marketplaces and Medicaid Expansion Ahead of Potential Policy Changes (January 2025) https://www.kff.org/affordable-care-act/issue-brief/a-look-at-aca-coverage-through-the-marketplaces-and-medicaid-expansion-ahead-of-potential-policy-changes/

[4] https://www.kff.org/affordable-care-act/issue-brief/a-look-at-aca-coverage-through-the-marketplaces-and-medicaid-expansion-ahead-of-potential-policy-changes/

5 Notes: Data reflect short-term, general, nonfederal hospitals. Data for AAMC-member teaching hospitals reflect integrated and independent AAMC members. Charity care is defined as care provided without the expectation of payment. Excludes hospital's bad debt and is measured in terms of costs, not charges.
Source: AAMC analysis of a special tabulation using FY2023 American Hospital Association (AHA) data. AAMC membership data, December 2024.

January 15 to November 1 to December 15, reducing the enrollment timeframe from 76 days to 45 days. In addition, the agency included other proposals that add hurdles for enrollees to prove their qualifications to enroll in a QHP or an insurance affordability program. These proposed changes include imposing pre-verification procedures before an individual can enroll during special enrollment periods, requiring additional income verification checks for premium tax credits, and limitations to re-enrollment. (P. 12943).

The AAMC appreciates the agency's efforts to ensure integrity and affordability for plans in the marketplace. However, we are concerned that these proposals would limit enrollment and access to coverage through the exchanges. In recent years, Americans have benefited from the opportunity to purchase affordable health insurance coverage through the marketplace. If finalized as proposed, these changes could result in approximately 750,000 to 2,000,000 individuals losing coverage, eliminating advancements in lowering the uninsured rate in the United States. **Rather than creating additional barriers to coverage, CMS should focus on policies that incentivize healthy individuals to select and maintain coverage to prevent adverse selection.**

Further, CMS should ensure that beneficiaries are notified of any changes in updated plan cost information or financial assistance for the upcoming plan year prior to closing the OEP. This ensures that enrollees can select plans most affordable for them and their health needs. In seeking comment on whether to delay the OEP changes until plan year (PY) 2027 due to the expiration of enhanced subsides at the end of 2025, the agency discusses the uncertainty of plan costs enrollees may experience. (P. 12978). Such variation year to year in policies and qualifications used to determine an enrollee's eligibility in an insurance affordability program highlight the need for a longer OEP to provide enrollees with complete cost information prior to selecting a plan. Additionally, we are concerned policy changes that add hurdles for enrollees to establish whether they qualify for such programs may limit the ability to meet the shortened deadlines for open enrollment.

Maintain Access to Care for DACA Recipients

In addition to changes in enrollment timeframes, the agency is proposing to reverse its 2024 interpretation of "lawfully present" for the purposes of determining eligibility to enroll in a QHP or insurance affordability programs. (P.12953). Such programs include the premium tax credit, advanced premium tax credit, cost-sharing reductions, and enrollment in a basic health plan (BHP) for states offering BHPs. Under the ACA, individuals who are not "lawfully present" are excluded from eligibility in these programs. Under the agency's proposal, noncitizens in the United States under the Deferred Action for Childhood Arrivals (DACA) policy would no longer be considered "lawfully present" for the purposes of determining eligibility in a QHP or insurance affordability program. (P. 12953). This proposal reverses the DACA Final Rule,[6] where the agency concluded that because the Department of Homeland Security determined DACA recipients were 'lawfully present' for the purposes of certain Social Security benefits

[6] 89 FR 39395

such as work authorization then the agencies should align their positions, making DACA recipients eligible for a QHP or insurance affordability program. The reversal of this final rule has the potential to jeopardize coverage and access to care for the nearly 600,000 individuals who are DACA recipients.

The AAMC urges the agency not to finalize its proposal to alter its interpretation of "lawfully present" for the purposes of determining eligibility in a QHP or insurance affordability programs to exclude DACA recipients. DACA recipients often experience high rates of uninsurance, which can be linked to limited eligibility in coverage due to policies such as that proposed.[7] Lack of coverage may cause individuals to forgo healthcare treatments and services. The KFF has reported that six in ten uninsured adults report they went without needed care due to cost.[8] When left without access to regular health care, individuals put off seeking treatment until there is a medical emergency or crisis. Consequently, the complexity and costs of treatment increase for that individual and society as a whole. Lack of coverage for this population may also drive a reliance on emergency departments and community health centers for routine health care, rather than receiving more effective and efficient care in other settings.[9]

Further, DACA recipients serve a vital role in supporting our society and healthcare system. Currently, 34,000 DACA recipients – physicians, nurses, dentists, and many others - provide health care to patients in communities across the nation.[10] Meanwhile, the Health Resources and Services Administration (HRSA) estimates that 77 million Americans live in primary care Health Professional Shortage Areas (HPSAs), 60 million live in dental health HPSAs, and 122 million live in mental health HPSAs. To put it in perspective, at least 13,300 primary care practitioners, 10,100 dental health practitioners, and 6,200 mental health practitioners would be needed to serve these areas to eliminate their shortage designation.[11] These individuals in the United States under the DACA policy contribute significantly by aiding in filling some of these provider gaps. Ensuring DACA recipients have similar access to coverage and care as the patients they serve is essential to ensuring their health, quality of life, and ability to continue mitigating shortages and serving others through the healthcare workforce.

CONCLUSION

Thank you for the opportunity to comment on this proposed rule. We urge the agency to be mindful of potential negative, downstream effects from proposals that limit access to the

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[7] KFF, Overview and Implications of the ACA Marketplace Expansion to DACA Recipients (October 2024) https://www.kff.org/racial-equity-and-health-policy/issue-brief/overview-and-implications-of-the-aca-marketplace-expansion-to-daca-recipients/

[8] KFF, Americans' Challenges with Health Care Costs (March 2024) https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/#:~:text=The%20cost%20of%20health%20care,year%20because%20of%20the%20cost.

[9] Park, J. K., Yale-Loehr, S., & Kaur, G. (2023). DACA, public health, and immigrant restrictions on healthcare in the United States. *Lancet regional health. Americas*, *21*, 100493. https://doi.org/10.1016/j.lana.2023.100493

[10] "New CAP Data Confirm DACA Is a Positive Force For Recipients and Their Families" Center for American Progress, November 2021

[11] Health Workforce Shortage Areas, Health Resources and Services Administration, March 2025

marketplace and urge CMS to explore options to maintain the integrity of the marketplace without jeopardizing enrollee coverage and access. We would be happy to work with CMS on any of the issues discussed or other topics that involve the academic community. If you have questions regarding our comments, please feel free to contact Katie Gaynor at kgaynor@aamc.org.

Sincerely,

Jonathan Jaffery, M.D., M.S., M.M.M., F.A.C.P.
Chief Health Care Officer

cc: David Skorton, M.D., AAMC President and Chief Executive Officer