NATIONAL ASSOCIATION OF Community Health Centers

April 11, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services (CMS)
Department of Health and Human Services (HHS)
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Proposed Rule (ATTN: CMS-9884-P)

Dear Administrator Oz,

The National Association of Community Health Centers (NACHC) is the leading national membership organization dedicated to promoting Community Health Centers (CHCs) (also known as Federally Qualified Health Centers or health centers) as the Employer, Provider, and Partner of choice in all communities, as well as the foundation of the primary health care system in America.

Community Health Centers are the best, most innovative, and resilient part of our nation's health system. For nearly sixty years, health centers have provided high-quality, comprehensive, affordable primary and preventive care. In addition to medical services, CHCs provide dental, behavioral health, pharmacy, vision, and other essential health services to America's most vulnerable, medically underserved communities in urban, rural, suburban, frontier, and island communities. Today, health centers serve more than 32.5 million people at over 16,000 locations, ensuring patients receive the care they need and pay what they can based on a sliding fee scale.

NACHC maintains its role as the national voice for health centers and believes that high-quality primary health care is essential in creating healthy communities and preventing chronic conditions. The collective mission and mandate of NACHC and the 1,496 health centers nationwide is to close the primary care gap and provide access to high-quality, cost-effective primary and preventative medical care.

Health centers serve a critical role in the success of the Marketplaces in every state. They serve as the medical home for millions of Americans eligible for reduced cost-sharing through Federal and State marketplaces. Twenty percent of health center patients have private insurance, and 50% have Medicaid coverage, some of whom receive coverage through Medicaid expansion.[1]

These individuals are frequently eligible for Marketplace coverage, including Advanced Premium Tax Credits (APTCs) and cost-sharing reductions. Additionally, health centers are a vital source of outreach and enrollment (O&E) assistance nationally. With support from the Health Resources and Services Administration (HRSA), and often from CMS programs, health centers have assisted over 4.5 million individuals seeking coverage in 2023.[2] This assistance includes helping individuals with re-enrollments, renewals, or redeterminations, as well as understanding and utilizing their newly acquired insurance.

[1] 2023 UDS HRSA Health Center Program Data
[2] Ibid.

NACHC welcomes the opportunity to comment on the 2026 Marketplace Integrity and Affordability Proposed Rule. Our comments are broken into three sections: I. Affordability; II. Access and Eligibility; and III. Enrollments.

I. Affordability

Premium Adjustment Percentage

NACHC urges CMS to reevaluate the methodology used at § 156.130(e) to calculate the premium growth measure. NACHC appreciates CMS's intentional focus on comprehensiveness, availability, transparency, and accuracy as a guide for setting PY 2026 premiums. However, we are concerned that the proposed adjustment and updated requirement contribution percentages are too high for many of the patients health centers serve. The resulting annual out-of-pocket costs have increased significantly from PY 2025 and could result in many low-income individuals and households being unable to afford coverage, even with tax credits and cost-sharing reductions.

Health center patients are four times more likely to have an income at or below the Federal Poverty Level (FPL) and twice as likely to have income under 200% of FPL as compared to the U.S. population.[3] More specifically, two out of three health center patients are at or below 100% of the FPL and 90% of health center patients live at or below 200% of the FPL.[4] Premium increases are most impactful for those with the lowest incomes, particularly among enrollees with incomes below the FPL. This policy would quickly impact the majority of patients health centers serve. Additionally, a large body of research shows that premiums can serve as a barrier to obtaining and maintaining healthcare coverage among low-income individuals[5], meaning many patients at health centers may struggle to afford the increasing costs of their insurance or may be unable to sign up for new coverage.

Increasing premiums historically correlates with pressure on safety net providers like CHCs. [6] Several studies show that coverage losses following premium increases lead to higher volumes of uninsured patients being seen by health centers.[7] This is especially burdensome on CHCs, as they are legally mandated to serve every patient that walks through their doors, regardless of their ability to pay. Higher premiums serve as a barrier to obtaining and maintaining coverage for low-income individuals, particularly those with the most limited incomes, and even relatively small levels of cost-sharing reduce the utilization of services. Seeing more insured patients helps health centers pay for those patients in dire need of care who cannot afford coverage. Community health centers are already facing intense financial pressure while operating on razor-thin margins. Already in 2025, several health centers in Virginia were forced to close their doors or suspend vital services over delayed federal funding, highlighting the financial stress CHCs are currently experiencing.[8] A decrease in insured patients would likely force many more CHCs to close doors and could exacerbate health care access in many rural areas. **NACHC urges CMS to reconsider the implementation**

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[3] https://www.nachc.org/wp-content/uploads/2024/07/2024-2022-UDS-DATA-Community-Health-Center-Chartbook.pdf
[4] Ibid.
[5] https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/#:~:text=As%20such%2C%20increases%20in%20premiums,increased%20financial%20burdens%20for%20families.
[6] https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/#:~:text=As%20such%2C%20increases%20in%20premiums,increased%20financial%20burdens%20for%20families.
[7] Stephen Zuckerman, Dawn M Miller, and Emily Shelton Page, "Missouri's 2005 Medicaid Cuts: How Did they Affect Enrollees and Providers?," Health Affairs 28, 2, (2009):w335-w345; Mark Gardner and Janet Varon, Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations, (Washington, DC: Kaiser Family Foundation, May 2004); Pamela Hines, et. al., Assessing the Early Impacts of OHP2: A Pilot Study of Federally Qualified Health Centers Impact in Multnomah and Washington Counties, Prepared for Office for Oregon Health Policy & Research, (Salem, OR: Office for Oregon Health Policy & Research, December 2003).
[8] https://www.vpm.org/news/2025-02-04/virginia-community-health-centers-close-federal-funding-grant-access

of the revised methodology and weigh the possibility that fewer low-income consumers would be able to afford their out-of-pocket costs, even with tax credit and cost-sharing reductions, as a result.

Failure to File Taxes and Reconcile the APTC Process

NACHC asks CMS to reconsider amending § 155.305(f)(4) to deny APTCs to tax filers who have failed to file and reconcile their APTCs for a single year. The current policy gives the enrollees a chance to properly document their APTCs on their taxes, so they remain eligible for APTCs the following year if applicable. Furthermore, recent laws have extended APTCs (2021-2022 and 2023-2025)[9] to new populations who may be unfamiliar with the reconciliation process on their taxes at the end of the year. In 2022, many people waited until the last minute to file their taxes, with 21% of respondents stating "general confusion" around all the different tax credits.[10] Additionally, a 2024 survey of over 2,000 people aged 18 or above found that more than half of respondents lack basic tax knowledge, with only 2% possessing "proficient" tax knowledge.[11] With the median household income reported at $80,610 for 2023, having access to APTCs can be crucial to affording comprehensive coverage.[12]

We also know that failing to file APTCs properly is not always the consumer's fault. The proposed rule acknowledges that delays and errors in the Internal Revenue Service (IRS) processing tax returns and issues with sharing tax return information with the Exchanges can cause the IRS to incorrectly note an enrollee with a Failure to File and Reconcile (FTR) status. We understand and appreciate the Administration's intention to maintain program integrity but ask that the Administration craft policies to leverage Marketplace communications to help prevent enrollees from losing financial assistance due to misunderstandings or miscommunications and allow the current policy of only denying APTC after a tax filer failed to file and reconcile their APTC for two consecutive years.

NACHC understands the conforming change to notice requirements at § 155.305(f)(4)(i) and the removal of notice requirement at § 155.305(f)(4)(ii) and urges the agency to leverage data from CHCs when sending direct notices about FTR status. We are concerned about our transient and lower-technological literate patients receiving these direct and indirect notices about their FTR status. Health centers have established relationships with their more transient patients, and we encourage HHS and the Exchanges to use CHCs as a resource. We understand there are privacy concerns related to notification of FTR status. Still, NACHC recommends that HHS utilize health centers if a person's address is not up to date after doing their due diligence in attempting to contact them. We want to ensure these direct notices, sent via the U.S. Postal Service (USPS) to the address of record for tax filers, will arrive at the health center patient, especially if they do not realize their FTR status with an indirect notice. We also recommend States partner with homeless services providers (including the assigned health care providers) to help to ensure addresses are up to date.

NACHC is also concerned about the quick anticipated timeline of the FTR proposal § 155.305(f)(4) and recommends delaying the effective date to Open Enrollment Year 2027 if finalized as proposed.

Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL

NACHC recommends CMS reconsider their proposal at § 155.320(c)(3)(iii) to require all Exchanges to generate annual household income inconsistencies in certain circumstances when applicants report a household income that is *greater than* the income amount represented by income data from trusted sources. We anticipate that this proposal will have negative ramifications for some of the lowest-income

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[9] https://www.cms.gov/marketplace/technical-assistance-resources/aptc-csr-basics.pdf

[10] https://www.cbsnews.com/newyork/news/expert-confusion-reigns-supreme-as-americans-wait-until-the-last-minute-to-file-their-tax-returns/

[11] https://taxfoundation.org/research/all/federal/us-tax-literacy-poll-knowledge-perceptions/

[12] https://www.census.gov/library/publications/2024/demo/p60-282.html

enrollees, many of whom are served by health centers, and believe this will impact Exchange operations as well. The law directs using both the applicant's projection of their income for the coming year and recent tax return data provided by the IRS to see if they qualify for APTCs. If projected income is inconsistent with what's shown in tax data, the Exchange generates a "data matching issue," or DMI. The consumer must then provide additional information to substantiate their projection; if they do not, APTC eligibility is determined based on tax data.

This proposal will impact very low-income consumers; over 45% of health center patients are 100% below the FPL – meaning they make a little over $15,000 per year as a single person.[13] It will create a substantial administrative burden on these enrollees who would be required to respond to the DMIs through submitting pay stubs or additional information, which could be difficult to gather to prove their income projection, or risk losing tax credits. The proposed rule estimates 81,000 people annually would be denied tax credits, reducing APTC payments by $189 million, and will create 550,000 DMIs a year.[14] We also are concerned that this will divert time and money at the Exchanges away from other pertinent enrollment and eligibility issues; the proposed rule states the increased DMIs will cost $32 million per year to Exchanges.[15]

Income Verification When Tax Data is Unavailable

NACHC recommends CMS revisit modifying § 155.320(c)(5) and continue accepting enrollee self-attestation of income due to the anticipated negative impact a change could have on health center patients. We understand and sympathize with the Administration's desire to maintain program integrity within the Exchanges. This proposal appears to treat Exchanges having incomplete information as a DMI, where the onus falls on the enrollee to help alleviate the burden. This proposal also does not consider that there are reasons why a person's tax data is unavailable, not due to a DMI. For instance, low-income taxpayers do not have to pay taxes or file a tax return if their income falls below the standard deduction amount for their filing status. For tax year 2025, for a single tax filer it is $15,000, and for a married couple, $30,000.[16]

We appreciate the clarification that people who have legitimate reasons for not having tax data available, like marriage, the birth of a child, name changes, and other demographic updates, would have the opportunity to be verified through other trusted data sources. However, we believe this verification through other trusted data sources should be applied to all enrollees, not just people with cases that fall under the reasons above. Lastly, we believe it could take an enrollee longer than 1 hour to submit documentation related to this income verification requirement. In the instance the enrollee is experiencing homelessness or has been under the income threshold, it would be difficult to gather adequate documentation showcasing their situation. They may need to work with case workers, their healthcare team, and others to gather enough evidence to demonstrate their potential income.

II. Access & Eligibility

Premium Payment Threshold

NACHC encourages CMS to reconsider modifying the premium payment options allowed at § 155.400, which were established under the 2026 Payment Notice, that have proven crucial for low-income enrollees who struggle to pay the full premium amount. Health center patients are disproportionately financially strained compared to other patients; as mentioned previously, 61% are low-income (below 200% of the FPL). This proposal will negatively impact health centers' low-income patient

[13] 2023 UDS HRSA Data

[14] https://www.federalregister.gov/d/2025-04083/p-674

[15] https://www.healthaffairs.org/content/forefront/hhs-proposes-restrict-marketplace-eligibility-enrollment-affordability-part-two

[16] https://www.irs.gov/newsroom/irs-releases-tax-inflation-adjustments-for-tax-year-2025

population. We believe the payment options that are proposed to be eliminated enhance coverage continuity for our patients and allow issuers flexibility to receive payments from enrollees. As such, we request CMS to allow insurers to continue utilizing these provisions. Most recent data show that nearly a quarter of Americans live paycheck to paycheck.[17] Insurance issuers should be granted the flexibility to meet enrollees where they are, regardless of the payment the enrollee is attempting to pay for their health insurance. The additional thresholds allow issuers to focus on collecting most of the premium rather than pursuing small outstanding amounts that might lead to coverage loss. We encourage CMS to explore other options to improve program integrity that do not increase the risk of terminating enrollees from coverage they have made payments on.

Coverage Denials for Failure to Pay Premiums for Prior Coverage

NACHC is concerned about decreased access to coverage if the interpretation of guaranteed availability at § 147.104(i) does not include coverage denials for failure to pay past premiums as a violation. As mentioned, health centers primarily serve low-income populations who may face financial barriers to paying premiums on time. According to a KFF survey, nearly half of insured adults surveyed in 2024 worried about being able to afford their monthly premium.[18] This worry is particularly felt by low-income health center patients. While NACHC appreciates CMS's concerns about creating perverse incentives for individuals not to pay past debt and only enroll in coverage when sick, the guardrails in place, such as short grace periods and requirements to retroactively pay medical expenses, limit the perverse incentives to consumers and impact to issuers. We encourage CMS to look at other guardrails that could be put in place that would not act as a barrier to enrollment. With these guardrails, NACHC concurs with CMS's previous position that the benefits of having someone insured outweigh the potential risks of abuse.

Additionally, health centers serve every patient who walks through the door, regardless of whether they have public, private, or no insurance. Health center patients often experience insurance churn with job loss or access to new coverage. This churn can confuse what plans, coverage, and support are available to them.[19] Patients may not realize they need to terminate coverage, especially if they are not using the insurance. Even if the debt for past due premiums is small, the patients would face barriers to seeking insurance coverage if this proposal were enacted. When patients face barriers to obtaining insurance, health centers, already on razor-thin financial margins, still serve the patient regardless of insurance status. While we appreciate that CMS notes that the impact would be minimal, we believe that CHC patients would face added barriers to access due to this policy.

Annual Eligibility Redeterminations

NACHC supports regulatory efforts to prevent agents, brokers, and web brokers from abusing the system and causing confusion for enrollees. However, we are concerned that the proposal at § 155.335 will negatively impact consumers. We are also concerned that adding an amendment at § 155.335(a)(3) and (n) to prevent enrollees from being automatically re-enrolled in coverage with an APTC that fully covers their premium without taking action to confirm their eligibility information could deter low-income, but eligible consumers from enrolling, as the process can already be confusing and burdensome for patients. We agree that agents and brokers should not abuse the system for commission and should be held accountable for enrolling consumers in inappropriate plans. However, this policy would only impact the consumer, who, as established in this proposal's preamble, may not be aware they are enrolled in the fully subsidized plan. NACHC is especially concerned that this policy would negatively impact self-employed consumers who typically file taxes later in the year. The shortened timeline and the proposed policy to remove self-attestation could prevent many eligible consumers from enrolling in essential coverage.

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[17] https://www.cbsnews.com/news/paycheck-to-paycheck-definition/

[18] https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/

[19] Churning, Confusion And Disruption — The Dark Side Of Marketplace Coverage - KFF Health News

NACHC is worried about the lack of additional communication with enrollees about this policy. Health centers serve some of the poorest, low-income communities. While $5 may not seem substantial for many Americans, it can quickly add up. Without additional communication requirements from insurers regarding this eligibility check, we are concerned rural, unhoused, and/or special populations could incur large fees that they are unaware of until they can no longer afford to pay their premiums. We encourage the agency to revisit the proposed requirement, given its potential to penalize low-income enrollees.

We would also note that this policy would lead to higher rates of uninsured individuals. While the underlying statute envisioned active consumer engagement, many factors, such as time limitations, indifference about their plan, insufficient information about open enrollment, or the complexity of shopping, can prevent consumers from actively shopping. Consumers may also be satisfied with their current plan despite changes that may have been made to the availability of new alternatives. Additionally, communities who have had trouble accessing health care in the past may face higher barriers to active re-enrollment, such as complex enrollment processes, transportation and geographical barriers, financial constraints, language barriers, and distrust of the health care system.[20] Health centers are the key providers for these communities, and we anticipate this policy would negatively affect many of the patients that CHCs serve.

NACHC suggests that CMS reevaluate the policy to focus the penalties on bad actors, such as the agents and brokers performing these improper enrollments, rather than the enrollee to mitigate unnecessary financial penalties and higher rates of uninsured patients in vulnerable communities. We support increased oversight to hold agents of insurance agencies accountable for non-compliance or misconduct when enrolling individuals on Federal and State Exchanges. NACHC recommends that the agency consider requiring insurance agents and brokers to undergo similar training that Navigators must complete[21] before assisting enrollees to reduce the number of improper enrollments and better track malpractice. We also urge CMS to investigate marketing ploys by broker agencies and prohibit certain marketing tactics used to bolster deceptive enrollments. We welcome the opportunity to work with CMS on appropriate and effective policies aimed at reducing and eliminating improper enrollments without penalizing the consumer. NACHC has heard from multiple health centers and Primary Care Associations (PCAs) that there is continued interest to have open discussions with the Administration on sharing best practices to reduce improper enrollments, such as a notification system for the original broker if there is a change in broker that does not allow change in plans or brokers if not acknowledged.

Additionally, NACHC supports reducing consumer confusion but requests the agency reconsider removing 155.335(j)(4). The automatic re-enrollment hierarchy standards policy, finalized in the 2026 Payment Notice, was created to improve an enrollee's quality of care without increasing costs. When seeking health insurance coverage, it can be confusing and overwhelming for individuals to understand and choose from all the different plan options presented on the Exchange. For instance, from 2019 to 2023, the number of plans shown to the average marketplace consumer has grown from 25.9 to 113.6.[22] Some studies have shown that too many plan choices—such as over 30—can lead to poor enrollment decisions because they confuse and overwhelm the enrollee.[23] Still, elements such as benefits, provider networks, and/or formularies can help enrollees better discern key differences between plans, helping them better compare and understand their options. Health centers continue to support patients eligible for cost-sharing reduction subsidies, and we anticipate this policy will improve health coverage for our patients even after APTCs

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[20] https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01466

[21] https://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf: Conflict-of-Interest Standards for Navigators (§155.215(a)(1)) and for Non- Navigator Assistance Personnel Carrying Out Consumer Assistance Functions Under §155.205(d) and (e) (§155.215(a)(2)); List of required training module content standards is set forth in §155.215(b)(2).

[22] https://www.shvs.org/the-proposed-2024-notice-of-benefit-payment-parameters-implications-for-states/

[23] Rose Chu et.al., "Facilitating Consumer Choice: Standardized Plans in Health Insurance Marketplaces, ASPE Office of Health Policy Issue Brief, December 28, 2021.

have expired. Instead of removing the policy altogether, we support added notices and communications regarding the crosswalking of policies to better inform enrollees of the availability of a similar quality plan for the same price. **We urge CMS to continue streamlining and simplifying the selection process for enrollees.**

III. Enrollment

Annual Open Enrollment Period

NACHC supports efforts at § 155.410(e) to decrease consumer confusion but urges CMS to delay implementation of the 45-day open enrollment period and consider keeping the 76-day enrollment period. The proposed rule asserts this shortened open-enrollment timeline would alleviate the administrative and financial burdens on enrollment staff. However, a shorter enrollment period will likely have significant impacts on CHCs. Under federal law, health centers are mandated to provide care to every patient who comes to them regardless of their ability to pay. In 2023, health centers cared for 5.6 million uninsured individuals, with the total cost of the care gap exceeding $3.16 billion.[24] In comparison, health centers cared for one million fewer uninsured patients in 2019, but the cost of that care gap has increased by $1 billion. In 2023, Federal Section 330 grant funding, which supports health centers' role as safety net providers, only made up 11% of health center revenue.[25] Health centers relied heavily on reimbursements from their insured populations to ensure they could pay for the care they provide to their uninsured patients. This rise in costs for health centers will only be exacerbated by a decrease in health insurance enrollments.

Health center enrollment teams are sometimes booked out weeks in advance of an open enrollment period and continue to see consumers coming in at the last minute to enroll. Several outreach and enrollment staff also note they typically experience a large wave of enrollment and re-enrollments right before the January 15 deadline. One health center in Pennsylvania highlighted that they see a greater number of enrollments between December 15 – January 15 for consumers who are self-employed or independent contractors because they file their taxes later in the year. Health centers assist these individuals in ensuring they have the coverage needed to stay healthy, and a shortened timeline will impact their ability to find quality, affordable healthcare coverage.

We are also concerned about the compound impact on enrollments given the recent decrease in funding available for the Navigator program.[26] Past reductions to Navigator funding have been associated with decreases in unsubsidized enrollment. This decrease will ultimately add to the burden on the safety net and generally lead to poorer public health, as being uninsured is associated with decreased access to health services and poorer health monitoring.[27, 28, 29]

Health centers continue playing a crucial role in helping uninsured patients receive critical care, but inadequate funding for enrollment efforts will lead to less revenue for health centers to operate, ultimately leading to physician burnout and a reduction in services health centers are able to provide. **We urge the agency to consider delaying the implementation of the proposed 45-day timeline to PY 2027 to ensure**

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[24] HRSA UDS Data, 2023.
[25] https://www.kff.org/medicaid/issue-brief/community-health-center-patients-financing-and-services/
[26] https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding
[27] McWilliams, J. M., Zaslavsky, A. M., Meara, E., & Ayanian, J. Z. (2003). Impact of Medicare coverage on basic clinical services for previously uninsured adults. JAMA, 290(6), 757–764.
[28] Baicker, K., Taubman, S. L., Allen, H. L., Bernstein, M., Gruber, J. H., Newhouse, J. P., ... & Finkelstein, A. N. (2013). The Oregon experiment — effects of Medicaid on clinical outcomes. New England Journal of Medicine, 368(18), 1713–1722.
[29] Buchmueller, T. C., Grumbach, K., Kronick, R., & Kahn, J. G. (2005). Book review: The effect of health insurance on medical care utilization and implications for insurance expansion: A review of the literature. Medical Care Research and Review, 62(1), 3–30.

health center staff and navigators have sufficient time to plan and perform significant outreach to their communities to ensure their patients are insured.

Monthly Special Enrollment Period for Low-Consumers

NACHC is concerned about the proposal at § 155.420 to eliminate the monthly special enrollment period (SEP) for APTC-eligible individuals with incomes at or below 150% of the FPL due to a potential decrease in enrollment. The goal of this SEP was to ensure that uninsured people who qualify but are not enrolled in coverage can access free or nearly-free platinum-equivalent Marketplace coverage,[30] but additional provisions were included to elevate the SEP as an additional safety net, especially for consumers transitioning from Medicaid or CHIP into other coverage, and a lower-than-anticipated risk of adverse selection. The 150% FPL SEP was also used to mitigate the impact of individuals disenrolled from Medicaid. According to states with available data, the majority (69%) of those who were disenrolled lost their health insurance coverage.[31] For health centers, nearly one in four patients lost coverage during the unwinding, with only about 25% of disenrolled patients able to successfully re-enroll in Medicaid coverage.[32] The implementation of the 150% SEP was a critical safety net for low-income families and those affected by the unwinding to maintain access to coverage and continuous health care.

The policy was made permanent in the 2026 Payment Notice to create flexibility for eligible consumers whose annual income is no more than 150% of the FPL ($22,590 for a single person, $38,730 for a family of 3).[33] Many of the consumers using this opportunity were eligible for silver plans with small or no premiums, sometimes with cost-sharing subsidies that dramatically reduced their deductibles and copays. Reflecting the mission of health centers to serve anyone regardless of ability to pay, nine in ten patients served at health centers had incomes that were at or below 200% of the FPL, and two-thirds of patients (67%) had incomes at or below the poverty level in 2023.[34] Additionally, the share of low-income patients served at health centers is three times that of the U.S. population. The removal of this enrollment period could impact a substantial number of health center patients, many of whom are eligible for the 150% SEP, thus reducing the time consumers have to apply for insurance and drastically reducing enrollments.

Additionally, NACHC appreciates CMS's focus and commitment to maintaining program integrity, particularly as group and individual health insurance markets are interlocked with Exchanges. While CHCs serve all patients regardless of insurance status, at least one in five CHC patients had private insurance in 2022.[35] Much of the strength and sustainability of community health centers can be attributed to the mixed payor pool. **While we agree with the spirit of reducing premiums and improving adverse selection, NACHC is concerned about the negative impact on enrollment if the SEPs for those at or below 150% of the FPL were eliminated for the group and individual Health Insurance Marketplaces in addition to the elimination for the Exchange, as proposed in § 147.104(b)(2).**

In response to CMS's concerns that Navigators and Certified Application Counselors (CACs) could be encouraging low-income enrollees to underreport their income to qualify for the special enrollment period, we want to assure the agency that CHCs and Navigators do not engage in this way. Navigators provide enrollees with unbiased information about the Exchanges and available health plans.[36] They also help

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[30] https://www.commonwealthfund.org/blog/2021/new-special-enrollment-period-low-income-people-could-boost-coverage
[31] https://www.benefitspro.com/2024/07/04/new-special-enrollment-period-offers-lifeline-to-affordable-health-insurance/?slreturn=20250402112458
[32] https://publichealth.gwu.edu/community-health-centers-report-impact-medicaid-unwinding-year-later
[33] https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/i-hear-there-is-a-new-special-enrollment-opportunity-in-2022-for-people-with-very-low-income-how-does-that-work/
[34] 2023 HRSA UDS Data
[35] https://www.nachc.org/wp-content/uploads/2024/07/2024-2022-UDS-DATA-Community-Health-Center-Chartbook.pdf
[36] https://www.healthinsurance.org/glossary/navigator/#:~:text=In%20the%20guidelines%20for%202020,FFEs%20to%20help%20more%20consumers.%22

enrollees determine whether they qualify for subsidies or Medicaid and assist with enrollment. Most Navigators assist with Medicaid enrollments, while most brokers do not, as there is no commission for Medicaid enrollments.[37] As of 2018, Navigators also provided targeted assistance for underserved and uninsured populations[38], which as we have stated throughout this letter, are a major patient population for health centers. There are strict integrity guardrails for Navigators, including training and certification, conflict of interest attestations, and meaningful access standards.[39] These are not required for insurance brokers. Navigators are also assigned ID numbers that must be recorded on the enrollments they assist with, meaning any malpractice can easily be tracked. Experienced health center enrollment staff and Navigators assist consumers in ensuring they meet all the requirements to qualify for the SEP. We have heard from many health center O&E staff that, if anything, they encourage consumers to overestimate their income and receive a lower APTC to avoid having to pay back their tax credits. Consumers are not trying to game the system to qualify for greater subsidies but simply trying to enroll in a health plan they can afford.

Removing the 150% SEP would mostly affect low-income consumers and inadvertently impact health centers, which will no longer be able to enroll their uninsured patients who would be eligible for the 150% FPL SEP. As previously noted, NACHC is also concerned about how this new policy would compound with the reduction in Navigator funding.

NACHC echoes our concerns with the proposal at § 155.420(g) to include pre-enrollment verification of eligibility for applicants in all categories of individual market SEPs. We are concerned about the amendment requiring all Exchanges to conduct pre-enrollment verification of eligibility for at least 75% of new SEP enrollments. The proposed rule highlights that pre-enrollment verification and the process of locating and submitting documents or other proof pose a barrier to enrollment and would deter consumers. As previously mentioned, we echo these concerns, especially for individuals who do not make enough annually to report their income to the IRS.

We are also concerned about the administrative burden being placed on state-based exchanges (SBEs) to perform. For pre-enrollment verification, applicants must submit additional documentation to verify the SEP. Consumers can pick a plan before submitting proof, but their enrollment is "pended" until SEP eligibility is verified. Once verified, the person must pay the first month's premium, and coverage will be effective based on when the person selects their plan. Although SBEs could ask to use alternative SEP verification methods, this change could also be costly for SBEs: most SBEs would incur one-time costs of about $12 million, while five SBEs would incur one-time costs of about $60 million.[40] This is in addition to ongoing annual costs to implement and operationalize SEP verification requirements. **We are concerned that the implementation timeline for this proposal and the cost could delay approvals, thus delaying the start of the enrollee's coverage. As we have highlighted throughout our response, this could lead to decreased patient access and increased costs for health centers and states. As such, we urge the agency to reconsider this proposal.**

Standards for Termination of an Agent's, Broker's, or Web-broker's Exchange Agreements for Cause NACHC supports CMS' proposal at § 155.220(g)(2) for HHS to apply a "preponderance of evidence" standard of proof to assess potential non-compliance with agents, web brokers, and brokers. We appreciate the Administration's focus on rooting out unscrupulous enrollment practices by brokers, given the high number of enrollment issues health centers have helped their patients overcome. We appreciate

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[37] "A 90% Cut to the ACA Navigator Program" KFF.org. Feb. 14, 2025.
[38] 45 CFR 155.210(e)(9)
[39] https://www.gpo.gov/fdsys/pkg/FR-2013-07-17/pdf/2013-17125.pdf; Conflict-of-Interest Standards for Navigators (§155.215(a)(1)) and for Non- Navigator Assistance Personnel Carrying Out Consumer Assistance Functions Under §155.205(d) and (e) (§155.215(a)(2)) ; List of required training module content standards is set forth in §155.215(b)(2).
[40] https://www.healthaffairs.org/content/forefront/hhs-proposes-restrict-marketplace-eligibility-enrollment-and-affordability-first-major

CMS's system changes last year to prevent unauthorized activity on enrollees' Marketplace accounts[41] and believe this proposal further builds upon that. These proposals will help ensure the entire entity is held accountable in the case of patterns of non-compliant behavior and support enrollees' ability to work with honest agencies.

Many health center patients possess characteristics that correlate to lower health literacy; for instance, patients with lower incomes, chronic conditions, and those who are non-native English speakers are associated with lower health literacy.[42] Even when the patient is already enrolled in one plan, they oftentimes get a call from another broker urging them to enroll in another plan. If a patient with an existing Marketplace plan gets swayed to move to another plan constantly, this could negatively impact their care continuity because their regular doctors are suddenly outside their network. Health center patients can be unfairly taken advantage of by these commission-based agents. A pattern of unethical business practices can wreak havoc on patients' access to quality, affordable health coverage, and these businesses need to be held accountable. The "preponderance of guilt" standard will help create more uniform standards when trying to consider what violates an Exchange agreement.

NACHC appreciates the intense oversight and enforcement actions CMS will have to hold brokers and lead agencies to the highest standards. We seek to ensure that all eligible patients receive non-biased, comprehensive enrollment assistance, and it's essential that CMS holds all brokers and lead agencies accountable. Here are two key instances that illustrate the importance of tackling this issue:

1) A Community Health Center and certified Primary Care Medical Home in Ohio has noticed an alarming number of fraudulent enrollment cases among its patients for the past year. This health center served more than 14,400 patients with 73,330 visits in 2022, and since Marketplace Open Enrollment in 2023, it has identified more than 200 patients who have been impacted by being enrolled in unauthorized plans despite already having Medicaid coverage.

   The health center, trying to cancel these fraudulent plans for their patients, has navigated a slow and cumbersome process. To date, they have only successfully canceled approximately 50 to 60 plans. The health center impresses upon the patient the importance of this issue and has the patient file the fraud claim with the Marketplace, the state's insurance commission, and any other agencies tracking fraud and abuse claims. Many of these fraudulent plans have been in place for months, and therefore, when the fraud claim is submitted, it must be reviewed back to when the plan started, often 45 to 60 days. In the meantime, the health center cannot bill Medicaid for any of the patient's visits until the patient's Medicaid coverage is backdated.

   Additionally, if the patient had any healthcare encounters when they had both Medicaid and Marketplace coverage, the health center is not able to bill Medicaid until the Marketplace plan is fully wiped out of the system. This lengthy process is delaying providers, especially safety net providers, from billing timely. Sometimes, when the plans have been canceled, another agent steps in and re-enrolls that patient, and the process begins again.

   Being enrolled in an unauthorized plan places immense stress on patients as well. Not only does it bring unease and stress that they were enrolled in a plan without their knowledge, but canceling their plan is also time-consuming. The patients themselves must be the ones to call the Marketplace

[41] https://www.cms.gov/newsroom/press-releases/cms-statement-system-changes-stop-unauthorized-agent-and-broker-marketplace-activity

[42] https://pmc.ncbi.nlm.nih.gov/articles/PMC6391993/#:~:text=Low%20health%20literacy%20is%20associated,are%20non%2Dnative%20English%20speakers.&text=Approximately%2080%20million%20adults%20in,limited%20or%20low%20health%20literacy.

to cancel their plan.[43] Health center patients are lower-income and may be working multiple jobs to make ends meet, proving difficult to carve out the time to be on hold with the Marketplace call center to cancel their plan.

2) A Community Health Center in Indiana, which serves more than 8,500 patients and provided over 25,000 visits in its service area in 2023, has encountered many instances of brokers potentially taking advantage of patients and providing inaccurate or misleading information to their benefit. They have noticed consumers with a Marketplace plan, but it remains unclear how those patients were enrolled, as they qualified for Indiana's Medicaid program. Many of their patients shared that they received phone calls, and the suspicious agent/broker knew about the patient's insurance situation. In other instances, some CHC patients are unaware that their coverage switched from Medicaid to a Marketplace plan until they arrive at the health center for an appointment. The health center then must allocate additional time and resources to help the patient understand the fraud that has occurred and then help ensure the patient gets enrolled in the appropriate coverage.

   Enrollment in multiple plans puts significant financial stress on the patient and the health center. When a patient comes in for an appointment, it becomes a battle of which insurance will pay for the visit. Often, health centers find it difficult to reconcile, and neither insurance believes they should pay; the Marketplace says the patient has Medicaid coverage, and then Medicaid says the patient has Marketplace coverage. Health centers operate on slim financial margins; more than half of community health centers operate with margins below 5%.[44] Health centers serve anyone regardless of their ability to pay and depend on getting paid on time. Having patients enrolled in multiple insurances, through no fault of their own, puts an unfair financial strain on health centers and needs to be acknowledged.

As mentioned, NACHC also urges HHS to continue looking into marketing ploys broker agencies post on social media. We have heard anecdotally from state PCAs that many patients are finding out about these Marketplace plans via social media such as Facebook or YouTube ads. These Facebook ads or YouTube videos entice consumers by stating they will get money back on their taxes if they enroll in Marketplace plans. We appreciate CMS publishing best practices for Marketplace Advertising and Marketing Guidelines to clearly outline what is and what is not allowed.[45] If CMS could take a stronger stance by prohibiting certain marketing tactics, as it has in a prior Medicare Advantage rule,[46] enrollees and health centers would benefit. CMS could include this in its plan as it continues to investigate agencies engaged in murky enrollment practices; if not, we urge CMS to include marketing within the scope of its investigation.

We greatly appreciate the opportunity to comment on this proposed rule and work with the Administration to balance program integrity with consumer administrative burden. Should you have any questions about our comments, please feel free to contact Elizabeth Linderbaum, Deputy Director of Regulatory Affairs, at elinderbaum@nachc.org.

Sincerely,

[43] https://www.healthcare.gov/how-to-cancel-a-marketplace-plan/
[44] 2023 National Report (hrsa.gov)
[45] https://www.cms.gov/files/document/agent-and-broker-advertising-and-marketing-tip-sheet.pdf
[46] https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

Joe Dunn
Chief Policy Officer