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April 11, 2025

Center for Medicare and Medicaid Services
Department of Health and Human Services
ATTN: CMS-9884-P
P.O. Box 8016
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Re: Notice of Proposed Rulemaking, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability" (Published in Federal Register Volume 90, Number 52, page 12942 on March 19, 2025)

Dear Secretary Kennedy:

The Massachusetts Health Connector ("Health Connector"), a State-based Exchange ("Marketplace" or "SBM") authorized under the Patient Protection and Affordable Care Act of 2010 ("ACA"), appreciates the opportunity provided by the Department of Health and Human Services (HHS) to comment on the proposed rule, "Marketplace Integrity and Affordability".

Founded in 2006 as part of bipartisan state health reform, the Massachusetts Health Connector is the longest-running SBM in the country. The Health Connector is designed to connect Massachusetts residents and small businesses with high quality, affordable health coverage and to promote universal health coverage in the Commonwealth. Today, the Health Connector serves over 360,480 individuals and over 14,500 small business employees from about 2,400 businesses. The Health Connector's efforts have contributed to the Commonwealth's status as the healthiest state in the nation,[1] with a nation-leading health insurance rate over 98%,[2] and average Marketplace premiums that are among the lowest-cost in the country in 2025.[3]

The Health Connector shares CMS's goals of protecting and advancing program integrity, addressing affordability for all Massachusetts residents, including the unsubsidized population, and maintaining a stable, robust market. However, this comment letter outlines how many of the strategies CMS proposes would negatively impact these shared goals rather than advance them. The Health

[1] See https://wellbeingindex.sharecare.com/interactive-map/?defaultState=MA
[2] Center for Health Information and Analysis (CHIA) 2023 Massachusetts Health Insurance Survey (MHIS), at https://www.chiamass.gov/massachusetts-health-insurance-survey.
[3] Kaiser Family Foundation analysis of data from Healthcare.gov, state rate review websites, and state plan finder tools. Analysis of CMS Public Use Files.`

Connector respectfully offers comments on the proposed rule sections that would have the greatest impact on members, SBMs, and the Massachusetts merged individual and small group insurance market. These comments generally fall into four main categories:

1. **Harm to the Risk Pool and Increases in Premiums:** Concerns that the proposed rule will cause harm to the Massachusetts merged market risk pool and result in premium increases for all market segments, including the unsubsidized population.
2. **Solutions to Problems Not Evidenced in SBM Data:** Identifying the negative, unintended consequences of instituting policies to address issues in the Federally-facilitated Marketplace (FFM) across all SBMs which do not share the same challenges.
3. **Supporting the Data-Driven Role of States, Who Are Closest to the Populations Served:** Supporting the role of SBMs to implement data-driven approaches to meet the unique needs of their local markets to advance shared goals with CMS.
4. **Significant Operational Costs and Unworkable Timeline for Implementation:** Quantifying the operational and administrative challenges, costs, and timeline barriers of implementing key provisions of the proposed rule that do not meaningfully advance program integrity, premium relief for the unsubsidized population, or market stability.

Harm to the Risk Pool and Increases in Premiums

Policies restricting enrollment in the Massachusetts merged market, especially those with the effect of reducing enrollment in the subsidized population, will have a negative impact on market stability and increase premiums for all market segments, including the unsubsidized market and the small group market. Since 2007, Massachusetts has maintained a merged market, a unique market structure that combines the individual and small group markets. In 2019, former Governor Charlie Baker formed the Merged Market Advisory Council (MMAC)[4] to analyze market stability and cost drivers in the merged market for individual and small employer health coverage. The MMAC's final report provided data-driven insights on the health of the Massachusetts merged market.[5] Notably, one of the key findings of that report is that ConnectorCare, the Health Connector's flagship program in which qualifying low- and moderate-income residents up to 300 percent of the federal poverty level (FPL) can access coverage with state and federal subsidies, contributes positively to the risk pool. Specifically, ConnectorCare enrollees were found to be lower risk than unsubsidized, higher-income individual market enrollees, and are cross-subsidizing the non-ConnectorCare individual market (those with incomes above 300 percent of the FPL. ConnectorCare enrollees had the lowest proportion of members with claims over $5,000 (12 percent, compared to 16 percent for small employer groups and 18 percent for other individuals). Additionally, the risk scores for non-ConnectorCare individual market members were over 30 percent higher than the risk scores for ConnectorCare members.

The subsidized population in Massachusetts's ConnectorCare program plays a crucial role in stabilizing the Commonwealth's risk pool and in ensuring unsubsidized individuals have the opportunity to participate in a large, stable market with lower premiums than they otherwise would experience.

Throughout this comment letter, the Health Connector details how specific provisions in the proposed rule would worsen the risk pool by creating barriers to coverage for a large portion of the individual market, disproportionately impacting younger individuals and those who have lower-than-average

[4] The Council was comprised of 13 members, chaired by Commissioner of Insurance, and included leaders, experts and stakeholders with experience in and knowledge of the health insurance industry, including carriers, brokers, actuaries, and individual purchaser representatives, as well as persons representing the business community, including representatives of employers and small businesses.
[5] https://www.mass.gov/merged-market-advisory-council

medical expenses. If lower cost enrollees lose coverage, thereby leaving the risk pool, it will increase premiums for everyone, including the unsubsidized population. These pressures will erode the Commonwealth's lowest-in-the-nation uninsured rate and raise costs for Massachusetts families.

Solutions to Problems Not Evidenced in SBM Data

The Health Connector engages in robust program integrity activities to prevent improper enrollment and to ensure people meet eligibility requirements for the coverage in which they enroll. The Health Connector does not experience those challenges that CMS describes as occurring within the FFM. Instead, many of CMS's proposals to address improper enrollments and fraud in the FFM would have the opposite of the intended impact here in Massachusetts. The Health Connector prioritizes program integrity to ensure that member data is secure and that health insurance eligibility and associated premium tax credits are awarded correctly. In particular, the Health Connector does not use brokers or web-brokers for individual coverage or allow enhanced direct enrollment websites to enroll residents. The Health Connector carefully considered and assessed how direct enrollment and enhanced direct enrollment would impact the market and chose not to pursue these options due to concerns about negative impacts to program integrity. Massachusetts residents looking to enroll in Health Connector coverage must apply directly through the Health Connector's portal and may access help from certified Assisters and Health Connector call center agents. Assisters and call center agents undergo robust and continuous training to assist individuals and only act with explicit individual consent. To date, out of the more than 1,266,000 people that have enrolled in Health Connector coverage since 2014, the Health Connector has received zero complaints about fraudulent or unauthorized activity by Assisters, or that members were unaware of their coverage and suspected fraudulent enrollment.

The Health Connector's careful attention to program integrity has resulted in several years of no findings on financial audits, programmatic audits, and compliance reviews conducted by CMS and the IRS. Like other SBMs, the Health Connector regularly undergoes intense and comprehensive reviews, audits, and evaluations by different state and federal agencies and offices. In addition, robust outreach to members through education, notices, and public webinars ensures that members and applicants understand the responsibilities associated with enrolling in Marketplace coverage, including keeping information up to date and reconciling tax credits received as part of their annual tax filing.

Supporting the Data-Driven Role of States Who Are Closest to the Population Served

SBMs must be able to implement data-driven approaches to meet the unique needs of their markets in order to advance program integrity, ensure affordability for all market segments, provide market stability, and enable successful implementation of the ACA in combination with intersecting state policies. States are best suited to understand the unique aspects of their local markets and avoid the unintended consequences of policies that may be a good fit for the FFM but not necessarily for SBMs. In the proposed rule, CMS describes challenges and proposes strategies for improving the FFM, highlighting data from healthcare.gov. The Health Connector does not experience the challenges that CMS describes happening within the FFM. In fact, the Health Connector's approach to program integrity has affirmatively prevented those challenges from emerging in the first place. The solutions described in the proposed rule are tailored to FFM issues and the unique policy choices adopted by the FFM. If such solutions are universally applied to SBMs in a one-size-fits-all fashion, it would worsen the Health Connector's ability to reach the shared goals of providing premium relief to all, including the unsubsidized population; advancing program integrity; and protecting the stability of our merged market risk pool.

The Health Connector has many examples of successfully implementing federal rules within the unique Massachusetts context to advance intended outcomes for members and the stability of the merged market. Making tailored, data-driven decisions to respond to local market needs has allowed Massachusetts to continuously lead the nation in health status and to maintain the lowest rate of uninsured residents. For example, in the 2020 Final Notice of Benefit and Payment Parameters, CMS finalized increased flexibilities for private web-based brokers and direct enrollment entities. Use of web-brokers and direct enrollment was left as an option for SBMs – not prescribed as a one-size-fits-all mandate. The Health Connector carefully considered and assessed how such actors and entities would impact its market and program integrity and decided not to pursue this option, acting to preserve program integrity and by ensuring consumers would only be assisted by rigorously trained Assisters and call center Agents known to the Health Connector. This is just one example of how allowing SBMs, like the Health Connector, the option to make data-driven decisions about their unique markets promotes program integrity and our collective ability to maintain near universal coverage.

As the longest-running SBM in the country, Massachusetts's unique policy context only amplifies the need for tailored, data-driven approaches to ensure shared goals and positive outcomes are achieved. For example, Massachusetts enacted an individual mandate in 2006 when a state health reform statute was signed into law. The state's individual mandate remains an integral part of the state's strong risk pool and long-standing commitment to universal coverage. The Health Connector administers the individual mandate and takes seriously the obligation to ensure the risk pool is composed of a balanced mix of risk, thereby helping to manage premium affordability for the residents of the Commonwealth. The Health Connector has a responsibility to carefully craft policies and operational processes that do not create excessive or unnecessary administrative burdens for individuals and families trying to access health coverage. Upholding and successfully administering the individual mandate has extensively-documented positive impacts for health outcomes and our health care economy.[6] The ability to tailor policy design and operations to the market has enabled the Health Connector to live up to our shared high standards regarding program integrity, affordability, and market stability.

We strongly agree with Director Peter Nelson that it is important to retain for states the authority to oversee rules and requirements because they are "closer to the ground" and better-positioned to assess situations and implement appropriate solutions, which ultimately promotes a stable market like that in Massachusetts.[7] In addition, as Director Nelson has stated, we have also found that well-regulated state markets, like Massachusetts, thrive when state regulators have authority to address the unique challenges of their market—local dynamics that states more deeply understand.

We strongly agree with Director Nelson's statement that "state regulators live next door to the consumers they serve. They know the communities, the hospital systems, the provider shortage (and surplus) areas, the local economies, insurer footprints, and enrollee experiences better and more intimately than the federal government ever can. States have more incentive to keep a watchful eye on insurers and address policy problems without delay. Citizens can more easily hold states accountable when they don't."[8]

Significant Operational Costs and Unworkable Timeline for Implementation

[6] KFF (2024). Key Facts about the Uninsured Population. Retrieved from, https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

[7] American Experiment (2021). Q&A: No Place Like Home. Retrieved from, https://www.americanexperiment.org/magazine/article/qa-no-place-like-home

[8] American Experiment (2024). The band-aid isn't working. Retrieved from, https://www.americanexperiment.org/magazine/article/the-band-aid-isnt-working

Many of CMS's proposals would generate significant operational and administrative costs and trigger impractical timelines for implementation, threatening program integrity and raising costs for consumers. The Massachusetts Health Connector shares an integrated eligibility system with MassHealth, the state's Medicaid program. Any system changes require a planned technical release to be added to the schedule of system changes that is coordinated between both agencies. It generally takes about a year for a high priority item to be carefully planned and implemented into the integrated eligibility system, ensuring proper testing to avoid adverse outcomes. Changes for Open Enrollment 2026 are already under development to be deployed in a July 2025 system release, as the redetermination process here begins in mid-August. New and high priority changes constantly compete for space in the release schedule. CMS's proposed rule would require a significant volume of system changes that would be expensive and impractical to implement within the proposed timeframe without impairing program integrity. It is possible that the scope of changes proposed in this rule would require scheduling an additional technical release to satisfy the proposed effective dates – this could cost the Commonwealth upwards of $1 million.

The Health Connector takes very seriously member experience, program integrity, and system accuracy. Since the problems that CMS seeks to address through the proposed rule are issues on the FFM (as outlined in the data CMS presents), many of the proposed changes would create significant system implementation costs and burdens for SBMs like the Health Connector for no added benefit. Filling our technical release schedule with changes that do not improve our merged market risk pool or advance our program integrity will use up valuable time, resources, and limited funds.

The Health Connector respectfully offers the following comments on specific provisions of CMS's proposed rule that would have the most significant impact on members, SBMs, and the state's insurance market:

The Health Connector strongly opposes shortening the Annual Open Enrollment Period because it would weaken the merged market risk pool and increase premiums for all segments of the merged market, including the unsubsidized population; give people less time to provide accurate and up to date information; increase the uninsured population which will deter people from getting needed care as well as negatively impact hospitals and health systems; and be a major deviation from what Massachusetts residents expect and how the Commonwealth has historically assessed and updated its open enrollment policies to serve its unique market (§155.410).

The Health Connector's Open Enrollment data show that higher risk individuals are more likely to enroll on or before December 15, and lower risk individuals are more likely to enroll after December 15. During Open Enrollment 2025, the average Total Medical Expenses (TME) per member per month (PMPM) for people who shopped on or before December 15 is more than 10 percent higher compared to people who shopped after December 15.

A longer Open Enrollment enables younger individuals to enroll in coverage and improves the overall risk pool. For Open Enrollment 2025, individuals who shopped during Open Enrollment before December 15 were older than individuals who shopped for coverage after December 15. Individuals between the ages of 18 and 44 are least likely to act early in Open Enrollment. Specifically, individuals between the ages of 18 and 25 were the most likely group to enroll after December 15 (59 percent) and the least likely group to enroll on or before December 15 (41 percent). People aged 65 and over were the group most likely to enroll early, on or before December 15 (54 percent), and the least likely to enroll after December 15 (46 percent). Moreover, people between 55 and 64 years old had the second highest rate of enrollment before December 15 (50 percent).

The Health Connector also found that during Open Enrollment 2025, people who have to pay more for their coverage, including individuals with unsubsidized coverage, were more likely to enroll earlier in Open Enrollment, suggesting they have greater needs for coverage. Contrary to CMS's assertion, shortening Open Enrollment will concentrate enrollment among the highest risk individuals, leaving less time for younger, lower risk individuals to enroll, negatively impacting the risk pool and increasing premiums for all market segments in the merged market – individuals and small businesses alike – over time.

Ending Open Enrollment on December 15 would be extremely disruptive to enrollment and the market because most people in Massachusetts complete their enrollment after this date. Of the 177,067 Massachusetts residents who shopped for coverage during the 2025 Open Enrollment Period, the majority (55 percent) completed their plan selections after December 15. Providing a longer Open Enrollment Period is even more important for new enrollees joining the Health Connector. During Open Enrollment 2025, only 34 percent of new enrollees enrolled on or before December 15 while 66 percent enrolled after December 15. The Health Connector takes seriously the ability for individuals and families to be able to make personal decisions about the type of health coverage that is best for them and their families and unnecessarily rushing that decision process will negatively impact access to care.

Under both Democratic and Republican administrations, CMS has deferred to SBMs in tailoring Open Enrollment periods to their local market needs. As CCIIO Director Peter Nelson himself noted about his time in the first Trump administration, "A lot of [my work in the Exchange space] was giving states the power and flexibility to oversee rules and requirements because states are in a better position to assess the situation."[9] The Health Connector agrees with Director Nelson and has historically offered a longer Open Enrollment that aligns with its premium payment due date, reducing confusion for applicants and ensuring that families have the time they need to find the plan that is right for them.

The longer Open Enrollment also allows for lower and more predictable call center daily volume and overall cost. Halving the Open Enrollment period is likely to lead to challenges in providing robust call center and Navigator access. During Open Enrollment 2025, there were more than 265,000 calls answered by the Health Connector customer service center. Fifty-two percent of those calls occurred on or before December 15, while the remaining 48 percent, or 128,000 calls, occurred after December 15. Expecting the call center to manage nearly double the volume of calls due to a compressed timeline is untenable and costly and will lead to members and applicants losing coverage. This enhanced call volume will be further exacerbated by the uncertainty surrounding enhanced premium tax credits as plan year 2026 approaches and potentially significant increases in premium costs for current and new enrollees.

At a system level, the administrative burdens created by shortening Open Enrollment will increase the uninsured rate in Massachusetts and negatively impact the financial solvency of hospitals. Uninsured adults are more likely to forgo needed care compared to their insured counterparts. In 2023, nearly half (47 percent) of uninsured adults ages 18 to 64 reported not seeing a doctor or health care professional in the past year compared to about 15 percent with health insurance.[10] Studies repeatedly demonstrate that uninsured individuals are less likely than those with coverage to receive preventive care and services for major health conditions and chronic diseases. These individuals are more likely to use the emergency department for their care, be hospitalized for avoidable health problems, and to experience declines in their overall health. Uncompensated care that results from

[9] American Experiment (2021). Q&A: No Place Like Home. Retrieved from, https://www.americanexperiment.org/magazine/article/qa-no-place-like-home

[10] KFF (2024). Key Facts about the Uninsured Population. Retrieved from, https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population

increased uninsured rates exacerbates hospital financial challenges and increases the likelihood of hospital closures.[11]

In addition, Massachusetts has historically assessed and updated open enrollment policies to ensure the Health Connector is meeting the needs of Massachusetts residents and the unique, changing circumstances in the merged market. Implementing an Open Enrollment Period in Massachusetts that does not account for local insights based on data would work against the goals of the Proposed Rule. Since 2011, Massachusetts has thoughtfully assessed and updated the Open Enrollment Period based on unique state needs. For example, the Massachusetts Legislature instituted an annual Open Enrollment Period for individual health coverage beginning in 2011 at which time the Health Connector maintained two Open Enrollment Periods. Beginning in 2012, this was reduced to one Open Enrollment Period and paired with an Office of Patient Protection option, tasked with considering requests for enrollment outside of this window to ensure flexibility for state residents while preserving the integrity of the risk pool. Each Open Enrollment between 2013 and 2017 responded to unique needs in the Massachusetts market as the state transitioned to Affordable Care Act implementation. The current Open Enrollment period of November 1 to January 23 has remained in place since Open Enrollment 2018. The proposed shortening of Open Enrollment would be a significant departure from what Health Connector enrollees and residents of the Commonwealth have come to expect over the last eight years.

The Health Connector strongly opposes any policy that would limit or disallow auto-renewal or auto-enrollment because it would increase administrative costs, unnecessarily add to call center volume, and potentially lead to drops in enrollment and a worsened risk pool if people face increased barriers getting into coverage (§ 155.335). Auto-enrollment and auto-renewal have played a major role in the state's universal coverage strategies and have not resulted in fraud or unexpected enrollments. The majority of individuals who were enrolled in coverage as of November 1, 2024, auto-renewed their coverage for January 2025 after having received multiple notices outlining their eligibility and plan information for the upcoming year. Fifty-eight percent of the nearly 300,000 individuals who maintained their coverage from November 1, 2024, to January 2025 auto-renewed for Plan Year 2025. Requiring nearly 200,000 people to take new and unnecessary actions to continue their coverage will result in a significant increase in call center inquiries and administrative costs for no added benefit to members or our market. During Open Enrollment 2025, the Health Connector customer service center answered more than 265,000 calls. On average, every call to the Health Connector customer service center costs $15. These extra calls would be coming from a population that should be able to easily maintain their coverage and tie up critical call center staff time when other residents may require much more complex assistance. In addition, the Health Connector would have to make notice changes that would unnecessarily cost the state money without any added benefit.

CMS suggests that enrollees may be unaware of their coverage unless forced to re-shop for a plan. The Health Connector's experience indicates that is not the case. The Health Connector identified zero calls among the 1.19 million calls to its customer service center in 2024 where a caller indicated they were unaware of their enrollment or that they were fraudulently enrolled in Health Connector coverage.

Maintaining the ability to auto-renew and auto-enroll individuals is critical to supporting a strong merged market risk pool and to preventing premium increases for everyone in the market. Analyses of total medical expenses of more than two million member months of 2024 claims data suggest that

[11] KFF (2024). Key Facts about the Uninsured Population. Retrieved from, https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

individuals who auto-renewed for Health Connector coverage and never subsequently shopped were lower cost than those who shopped for coverage during Open Enrollment 2025. Without tools like auto-enrollment and auto-renewal, continuous coverage will decline, the risk pool will erode, and more people will fall out of coverage due to administrative burdens. An increased uninsured rate will lead to worse health outcomes and financial instability within the health care system.

A change to auto-renewal or auto-enrollment would require significant time and resources to implement and would not be possible for Open Enrollment 2026. Preparations for Open Enrollment are already well underway, including updates to the Health Connector's technical systems and contracting with its call center vendor.

The Health Connector opposes CMS's proposal to verify income when data sources indicate household income is less than 100% FPL because this policy would not help the Health Connector advance program integrity and would only create unnecessary and costly operational and administrative burdens. CMS presents data within the proposed rule to support this proposal by highlighting FFM states and states that did not expand Medicaid. In Medicaid expansion states and states with SBMs, like Massachusetts, people do not have the incentives CMS describes to inflate their income (§155.320(c)(3)(iii)). Further, Massachusetts has an integrated Marketplace-Medicaid eligibility system, which more accurately helps residents qualify for the correct coverage. In addition, Massachusetts does not have agents, brokers, and web-brokers enrolling people in individual Marketplace coverage, and therefore does not experience the same issues that the FFM experiences related to these entities. As a result, applying this one-size-fits-all proposal to SBMs like Massachusetts—a Medicaid expansion state with an integrated eligibility system and without agents, brokers, or web-brokers involved in the Marketplace—would only create costly and unnecessary administrative and operational burdens without any added benefit.

The Health Connector opposes CMS's proposal to eliminate flexibility for Marketplaces to accept income attestation when the IRS cannot verify household income because this is an issue with IRS data and individuals and families should not have to face extra administrative burdens as a result (§155.320(c)(5)). Individuals and families should not have to experience burdensome, unnecessary, and costly consequences to correct for IRS data challenges. The Health Connector experienced a 40 percent reduction in income inconsistencies after implementing changes to consider income verified in the event of a non-income response from the IRS. CMS's proposal to reverse the ability to accept attestation of income when no IRS data is available would result in significantly more individuals receiving unnecessary income Data Matching Inconsistencies (called Requests for Information in Massachusetts), significantly increasing administrative burdens for applicants and members, and leading to coverage erosion. Such coverage erosion would adversely impact the merged market risk pool and increase premiums for all in the market, as adult applicants under age 45 are slightly more likely to receive a non-income response from the IRS, at 41.5 percent compared to 38.5 percent of applicants over 45.

The Health Connector often receives a response from the federal data services hub indicating that no tax return information was available to verify an applicant's attested income and has found that the receipt of a null income response from the IRS is not correlated with a particular income group or with a particular tax status. It is unclear to the Health Connector why the IRS is unable to provide return information for these cases, but the Health Connector does not support making it more difficult for individuals to get health insurance coverage as a result.

Maintaining continuous coverage is critical to a healthy risk pool. The Health Connector saw a significant decrease of about 33 percent in unnecessary subsidy loss due to unverified income during

Open Enrollment 2025 as a direct result of accepting an individual's attestation of income when null income is received from the IRS. Enabling individuals to maintain their same level of coverage from one year to the next makes it more likely that people stay enrolled and supports a balanced, strong, and stable risk pool.

The Health Connector opposes CMS's proposal to deny APTCs after one year of failing to file and reconcile (FTR) instead of two years because Massachusetts does not have the same issues with agent, broker, and web-broker improper enrollments as described in the rule, and this change would cause unnecessary consumer confusion and enrollment declines (§155.305(f)(4)). CMS argues that one of the reasons to deny APTCs after one year instead of two is because agents, brokers, and web-brokers are improperly enrolling people in coverage with APTC without their knowledge. The Health Connector does not permit the use of agents, brokers, web-brokers, or private external entities, such as direct-enrollment entities, to enroll individuals and families in the individual market. Instead, the Health Connector relies on a network of qualified Assisters who receive robust training. Assisters, including both Navigators and Certified Application Counselors (CACs) are highly trained in the rules around reconciliation. These professionals regularly work with applicants and members to make them aware of the expectations around reconciliation and help members fill out their applications accurately to reduce concerns about tax liabilities at the end of the year.

A recent focus group with Navigator partners across Massachusetts highlighted how seriously Navigators take the program integrity aspect of their role in helping individuals report accurate income information. They recognize that many individuals enrolled in coverage through the Health Connector are self-employed and/or have seasonal income and thus are likely to have fluctuations in income throughout the year. This makes projected annual income difficult to predict and often means that last year's tax returns are not always the best predictor of current income. Most individuals who rely on Health Connector coverage are aware of the requirements to reconcile their tax credits at tax time and take the time to report income as accurately as possible to avoid having to pay back significant amounts of money. Navigators work closely with these individuals to report accurate income information and to assist individuals with reporting changes to income throughout the year.

Additionally, the Health Connector has reason to believe that most people are completing the necessary steps with the IRS. One percent of Health Connector enrollees for 2025 failed to file a tax return based on data collected from the IRS at renewal. Further, the IRS has in place processes to identify and outreach tax filers who complete a return but do not include Form 8962 to reconcile their tax credits, providing Marketplace enrollees with direct feedback on their reconciliation that, given strict rules around the privacy of federal tax information, is best suited to come from the IRS. Further, there is no clear correlation between income and FTR codes among enrollees in Health Connector coverage. This suggests that individuals enrolling in free coverage are not more likely than other groups to fail to reconcile.

Since the Health Connector does not experience the same issues that CMS describes within the FFM, this policy change would not solve any existing problem for the Health Connector and would only cause unnecessary consumer confusion which may lead to drops in enrollment without any added benefit for the shared goal of program integrity.

The Health Connector requests that CMS continue to provide SBMs with flexibility to manage special enrollment period (SEP) processes that promote active management of markets and robust SEP verification process (§ 155.420(g)). Requiring SBMs to conform to FFM policies or revise and seek approval for their Blueprint under 45 CFR 155.315(h) would add unnecessary costs, operational challenges, and administrative burdens in addition to undermining states' abilities to manage their

markets. While the majority of SEP verifications are verified pre-enrollment for Health Connector coverage, due to verifiable information available through the Commonwealth's integrated eligibility system, the Health Connector appreciates the flexibility to maintain its current approach to verifications for people who must submit proof of their SEP eligibility. The Health Connector set up a robust SEP verification process in 2015 which served as a model in how to administer SEP verifications for other states as well as the FFM. The majority of qualifying life events are verified prior to enrollment because they are based on eligibility changes administered through the Health Connector's application. The Health Connector appreciates the flexibility under the rule to continue its approach of allowing individuals to attest to their SEP status and submit verifications of the qualifying event after enrollment, terminating prospectively if the verification process is not completed. This mirrors the eligibility verification process, enables individuals to access coverage without a gap, and has proven to be successful for residents of the Commonwealth. For Plan Year 2024, the average age of individuals who enrolled through a SEP at the Health Connector was three years younger than the average age of 41 for all enrollees. This suggests that creating additional barriers to timely enrollment via a SEP may increase the average age in the market, and lead to harm to the risk pool, and higher premiums.

The Health Connector opposes CMS's proposal to prohibit inclusion of gender-affirming care as an Essential Health Benefit (EHB) because it is discriminatory, would limit access to necessary health care services, cause financial hardship, and lead to coverage loss (§156.115(d)). Targeting a specific group and limiting their access to health care services is not permitted under the ACA's nondiscrimination law. Section 1557 of the ACA protects against sex discrimination in health care and these protections extend to sexual orientation and gender identity.

In *Bostock v. Clayton County*, the Supreme Court found that Title VII's prohibition on discrimination in employment considerations "on the basis of sex" was violated when the employer's discriminatory reason was grounded in the sexual orientation or gender identity characteristics of the impacted individual because that reason is predicated on taking into consideration the "sex" of the impacted individual as the basis for the discriminatory act.[12]

Title IX uses the same phrase, "on the basis of sex" ("No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving Federal financial assistance.[13]"). Therefore, Section 1557's incorporation of Title IX's language necessarily requires the same understanding that entities covered by Section 1557 may not deny coverage of otherwise available services to individuals based on their sexual orientation or gender identity, since this impermissibly discriminates on the basis of such individuals' sex.

CMS's proposal would also significantly raise costs for people, potentially driving more people out of coverage and curtailing their access to needed health care. Specifically, this proposal would block consumers from accessing gender-affirming care with the same cost-sharing and benefit design protections as services included in the EHB package. Costs accrued for gender-affirming care would not be required to count towards deductibles or maximum out-of-pocket limits. In addition, these services would also not be protected from lifetime limits. Increases in out-of-pocket costs would deter enrollees from accessing gender-affirming care services, which are medically necessary and

[12] Bostock v. Clayton County, Georgia, 590 U.S. ___, 140 S. Ct. 1731,slip op. at 19 (2020); "We agree that homosexuality and transgender status are distinct concepts from sex. But, as we've seen, discrimination based on homosexuality or transgender status necessarily entails discrimination based on sex; the first cannot happen without the second."
[13] 20 U. S. C. §1681(a)

recommended by nearly all major US medical associations.[14,15] Transgender people are more likely to be living on lower-incomes, making higher cost care especially challenging, likely leading to coverage loss and significant decreases in access to health care.[16]

The Health Connector strongly opposes revising the premium adjustment percentage methodology because the methodology CMS proposes would increase premiums and out-of-pocket costs for Massachusetts residents, increase state costs, lead to coverage loss, and harm our risk pool, further exacerbating premium increases for all (§156.130). Because CMS's proposed methodology change will increase the premium adjustment percentage, the change will lead to higher ACA indexed limits such as the maximum annual limitation on cost sharing and result in lower APTCs for people already struggling with health care costs. Despite near universal health insurance coverage in Massachusetts, 41.3 percent of Massachusetts residents reported that they or their families had health care affordability issues, and 16.5% of residents reported multiple affordability issues in their families.[17] Nationwide, about half of U.S. adults say it is difficult to afford health care costs, and one in four say they or a family member in their household had problems paying for health care in the past 12 months. The cost of health care can also lead some to put off needed care. One in four U.S. adults say that in the past 12 months they have skipped or postponed getting health care they needed because of the cost.[18] Specifically, premiums would rise to about 4.5 percent higher for a benchmark plan compared to current rules.[19] This policy change would also increase state subsidy costs for Massachusetts by approximately $10 million in 2026. Increases in premiums due to this change in methodology will lead to drops in enrollment and deteriorate risk pools, resulting in even greater premium increases for everyone. Moreover, decreasing affordability for people at the same time that enhanced premium tax credits are set to expire will exacerbate premium increases in 2026 for individuals and families across the country who are already struggling to afford health coverage and care. The Health Connector strongly recommends continued use of the National Health Expenditure Accounts (NHEA) ESI (Employer Sponsored Insurance) premium measure that is used today and has historically been used to estimate premium growth. We believe using the NHEA ESI premium measure aligns with the statutory language at section 1302(c)(4) of the ACA, as ESI represents the vast majority of the market.

The Health Connector is opposed to excluding Deferred Action for Childhood Arrivals (DACA) recipients from the definition of lawfully present for the purpose of accessing affordable Marketplace coverage. Blocking DACA recipients from access to affordable health coverage would increase the uninsured rate, erode the merged market risk pool, and negatively impact communities across the Commonwealth, including the many mixed-status immigrant families who reside in the state (§155.20). Although the number of DACA recipients enrolled in Health Connector coverage is small, access to affordable, quality coverage for this population is important to maintain the Commonwealth's high insured rate, prevent merged market erosion that would result in premium increases for all market segments, and protect the health and wellbeing of communities across Massachusetts.

The Health Connector agrees with the arguments HHS made in the May 8, 2024, Federal Register (89 FR 39392) (DACA Rule) when reinterpreting "lawfully present" to include DACA recipients and certain

[14] KFF (2024): https://www.kff.org/health-policy-101-lgbtq-health-policy/?entry=table-of-contents-gender-affirming-care
[15] KFF (2025): https://www.kff.org/private-insurance/issue-brief/new-rule-proposes-changes-to-aca-coverage-of-gender-affirming-care-potentially-increasing-costs-for-consumers/
[16] KFF (2023): https://www.kff.org/other/issue-brief/trans-people-in-the-u-s-identities-demographics-and-wellbeing/
[17] CHIA (2024): https://www.chiamass.gov/assets/docs/r/survey/mhis-2023/MHIS-2023-04-Health-Care-Affordability.pdf
[18] KFF (2024): https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/
[19] Health Affairs (2025): https://www.healthaffairs.org/content/forefront/hhs-proposes-restrict-marketplace-eligibility-enrollment-and-affordability-first-major

other noncitizens for the purposes of determining eligibility to enroll in a QHP through an Exchange. Specifically, the Health Connector agrees that including DACA recipients in the definition of lawfully present would significantly expand affordable coverage across the U.S. and provide DACA recipients with access to affordable and high-quality health coverage and care. As HHS noted in 2024, this increase in insurance coverage reduces delays in care, improves the ACA's risk pool, and makes DACA recipients more productive members of society. A substantial body of research has established the positive impacts of health coverage on improved access to and use of healthcare services (e.g., receipt of recommended screenings and care), which leads to better health outcomes. The Health Connector also strongly agrees with HHS's argument in 2024 that including DACA recipients in the definition of lawfully present aligns with the goals of the ACA—specifically, to lower the number of people who are uninsured in the U.S. and make affordable health insurance available to more people. In the 2023 proposed rule, HHS noted that DACA recipients represent a pool of relatively young, healthy adults; at an average age of 30, per U.S. Citizenship and Immigration Services (USCIS) data, they are younger than the general Marketplace population and may therefore have a positive effect on risk pools.

The Health Connector supports any efforts to tighten standards for agents, brokers, and web-brokers in the Marketplaces that rely on them to ensure everyone can access high quality and accurate help, though the Health Connector does not have agents, brokers, or web-brokers associated with individual market applications, instead relying on highly trained and qualified Assisters (§155.220(g)(2)). The Health Connector's qualified Assisters, such as Navigators and Certified Application Counselors (CACs), assist individuals and families with applying for and enrolling in coverage. The high standards and extensive training provided to these Assisters have greatly contributed to the strength of our program integrity. State flexibility to establish qualifications for trained assisters and our careful decision to not permit agents, brokers, web-brokers, or direct-enrollment entities to assist individuals with applying, shopping for, and enrolling in health insurance has resulted in robust consumer protection for Health Connector members. Massachusetts has over 140 local Navigators from 24 organizations in 50 locations. In November and December 2024, more than 26,000 residents were helped by Navigators. Members can also receive support from Certified Application Counselors (CACs), who are vetted extensively before signing a contract with the Health Connector and the Massachusetts Executive Office of Health and Human Services (EOHHS). CACs are required to annually certify by going through a wide-ranging curriculum and passing a certification test. Both Navigators and CACs cannot assist an individual unless the individual has signed a designation form indicating they understand the role of the Assister and what they can or cannot do on their behalf. These agreements are tracked systematically to provide transparent and accountable support for consumers looking for high quality help. To date, the Health Connector has not received complaints about any fraudulent or unauthorized activity by Assisters.

This experience in maintaining high standards for Assisters to protect program integrity, leads the Health Connector to support CMS's proposal to strengthen HHS' ability to hold agents, brokers, and web-brokers accountable. This change would improve transparency in the process for holding these entities accountable for compliance with applicable law, regulatory requirements, and their Marketplace Agreements and protect consumers from the impacts of potential noncompliance, including improper enrollments.

The Health Connector opposes requiring members to pay debt for past-due premiums before effectuating new coverage (§147.104(i)). The Health Connector conducts premium billing on behalf of its carriers and has not observed abuse of grace periods and guaranteed issue provisions. Instead, individuals who fail to pay for coverage are often in the midst of household changes that result in higher premiums mid-year. If individuals are excluded from health insurance coverage due to previous

non-payment, rates of uninsurance are likely to rise leading to greater strain on the broader health care system and market. Health care affordability is one of the top concerns of Americans nationwide with 67 percent of people across the U.S. stating that it is one of the biggest problems in the country today.[20] Excluding individuals who are unable to pay past premium debt may have significant impacts on the nongroup insurance market. Impacts include higher and more costly emergency department utilization with worse health outcomes, risk pool instability, and market distortion. Individuals without health insurance are more likely to rely on emergency department care for conditions that could have been managed in a lower-cost setting. As care becomes increasingly unaffordable and inaccessible, fewer healthy individuals are likely to stay enrolled in coverage, adversely affecting the risk pool by increasing the share of sicker, higher-cost enrollees. Those who are unable to effectuate enrollment due to unpaid premiums may end up in high-cost, short-term plans or scam plans outside of the merged market leading to market distortions and further driving up health insurance premiums. In addition, since non-ACA compliant plans do not need to cover essential health benefits required under the ACA, increased reliance on such plans leads to more uncompensated care, putting hospitals and emergency departments at significant risk of financial instability due to unpaid claims.[21]

Thank you again for your careful consideration of our evidence-based perspectives, which are informed by nineteen years of serving as the Massachusetts health insurance marketplace, with the nation's lowest rate of uninsured, the country's healthiest population, and among the lowest Marketplace premiums in the nation.

The Health Connector is committed to protecting and advancing program integrity, addressing affordability for all Massachusetts residents, including the unsubsidized population, and maintaining a stable, robust merged market. Thank you for consideration of these comments in pursuit of the shared goal of a high-functioning Marketplace. Massachusetts has demonstrated the power of state-driven health policy with the Commonwealth's near universal health coverage rate and looks forward to building on its success in partnership with CMS.

Sincerely,

Audrey Morse Gasteier
Executive Director

[20] Pew Research Center (2025). Retrieved from, https://www.pewresearch.org/politics/2025/02/20/americans-continue-to-view-several-economic-issues-as-top-national-problems/
[21] Healthcare Finance (2018). Retrieved from, https://www.healthcarefinancenews.com/news/increase-uncompensated-hospital-care-could-be-one-effect-short-term-coverage-rule