UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, COMMONWEALTH OF MASSACHUSETTS, STATE OF NEW JERSEY, STATE OF ARIZONA, STATE OF COLORADO, STATE OF CONNECTICUT, STATE OF DELAWARE, STATE OF ILLINOIS, STATE OF MAINE, STATE OF MARYLAND, STATE OF MICHIGAN, STATE OF MINNESOTA, STATE OF NEW MEXICO, STATE OF NEVADA, STATE OF NEW YORK, STATE OF OREGON, JOSH SHAPIRO, *in his official capacity as Governor of the Commonwealth of Pennsylvania,* STATE OF RHODE ISLAND, STATE OF VERMONT, STATE OF WASHINGTON, STATE OF WISCONSIN;

Plaintiffs,

v.

ROBERT F. KENNEDY, in his official capacity as Secretary of Health and Human Services, MEHMET OZ, in his official capacity as Administrator for the Centers for Medicare and Medicaid Services, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, U.S. CENTERS FOR MEDICARE AND MEDICAID SERVICES,

Defendants.

Civil Action No.: 25-12019

COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

1. Congress enacted the Patient Protection and Affordable Care Act (ACA) in 2010 to increase the number of Americans with health insurance and decrease the cost of healthcare. Fifteen years later, the Act continues to meet its twin goals, with annual enrollment on the ACA marketplace doubling over the past five years, resulting in over 24 million people signing up for

health insurance coverage for plan year 2025 on the ACA exchanges, the vast majority of whom receive subsidies to make coverage affordable, including approximately seven million people in Plaintiff States.[1]

2. Now, with less than four months until open enrollment for plan year 2026 begins, Defendants, the U.S. Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS), issued a regulation (Final Rule) that will abruptly reverse that trend, erecting a series of new barriers to enrollment that will deprive up to 1.8 million people of health insurance (by the agency's own estimates), and significantly drive up the costs incurred by Plaintiff States in providing healthcare, including increasing state expenditures on Medicaid, uncompensated emergency care, and funding other services provided to newly uninsured residents.

3. The Final Rule effects a range of changes that violate the APA.

4. *First*, it effects substantively invalid changes to the ACA marketplace. The Final Rule truncates and eliminates enrollment periods, makes enrollment more difficult, adds eligibility verification requirements, and erects unreasonable barriers to coverage—making sweeping changes that reach far beyond and bear little relation to the primary harm HHS asserted as its justification: fraudulent enrollment by insurance brokers and agents. The Final Rule makes a number of changes in contravention of substantial record evidence and without adequately considering reasonable alternatives or significant downsides, including the profound impact on the millions who will lose coverage. And it unlawfully allows for denial of coverage in violation of the ACA's "guaranteed issue" requirement, and changes how premiums are calculated in spite of a statutorily required method set by the ACA.

[1] *See* Health Insurance Exchanges 2025 Open Enrollment Report at 5.

5. *Second*, the Final Rule unlawfully prohibits coverage of any "sex-trait modification procedure"[2] as an essential health benefit (EHB), an unwieldy and novel term which could conceivably capture services in multiple EHB categories. The Final Rule's sole basis for treating these items and services as non-essential health benefits is HHS's conclusion that such care is not typically covered by employer plans. In excluding this wide, ambiguous range of benefits, HHS departed from its longstanding policy of prioritizing state flexibility in each State's regulation of healthcare. This conclusion is further belied by unrefuted evidence that was put before the agency yet disregarded without explanation.

6. These categories of changes will cause tremendous harm if they take effect. Plaintiff States that operate their own ACA exchanges will incur unrecoverable compliance costs. Plaintiff States will also lose tax revenue derived from insurance premiums, and incur increased expenses providing healthcare to individuals whom the Final Rule renders uninsured. Worse still, the Final Rule will undermine Plaintiff States' health insurance markets and harm the public health,

[2] "Sex-trait modification" is a term that does not exist in medicine or law; it is a political creation that emerged in or around 2023 in work by the Manhattan Institute. *See, e.g.,* Leor Sapir, "All Appearance, No Substance," CITY JOURNAL (Sept. 11, 2023), https://www.city-journal.org/article/does-sex-trait-modification-improve-mental-health. It cannot be found in a health insurance brochure, nor is it referenced in any State's benchmark plan.

In its Proposed Rule, HHS acknowledged that "sex trait modification," adopts the definition of "chemical and surgical mutilation" in E.O. 14187, in order to refer to "gender-affirming care." 90 F.R. 12,942, at 12,986. While some treatments that might typically be considered gender-affirming care are encompassed by "specified sex trait modification procedures" as defined in the Final Rule, the terms do not map perfectly on each other. For example, and as the Final Rule acknowledges, mental health treatment may be gender-affirming care and is not excluded as an EHB. Rule at 27,159. Gender-affirming care is an umbrella term that does not describe a discrete category of services; rather it describes care that falls within multiple EHB categories, including primary care visits, specialty care, outpatient mental health services, prescription drug benefits, and surgical services.

In this Complaint, Plaintiff States adopt the term "sex-trait modification" to refer to the ambiguous and arbitrary set of services HHS attempts to exclude as EHB. Where appropriate, Plaintiff States may employ different terminology that best reflects the context, including "gender-affirming care," "treatment for gender dysphoria," and "medically necessary care for gender and sexual minorities."

including increasing the risk of disease outbreaks. And Plaintiff States' newly uninsured residents will suffer firsthand the profound harms of lacking access to necessary, affordable healthcare.

7. Because the Final Rule's changes are contrary to law, arbitrary and capricious, and profoundly harmful to Plaintiff States, the States bring this suit to have this unlawful and unjustified HHS regulation preliminarily enjoined and ultimately vacated—protecting access to affordable health care for millions of our residents.

JURISDICTION AND VENUE

8. The Court has jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1346. The Court has further authority under the Declaratory Judgment Act, 28 U.S.C. §§ 2201(a) and 2202.

9. Venue is proper in this district pursuant to 28 U.S.C. §§ 1391(b)(2) and 1391(e)(1). Defendants are U.S. agencies or officers sued in their official capacities. The Commonwealth of Massachusetts is a resident of this judicial district and a substantial part of the events or omissions giving rise to this Complaint occurred within the District of Massachusetts.

PARTIES

I. Plaintiffs

10. Plaintiff the State of California is a sovereign state of the United States of America. It is represented by Attorney General Rob Bonta, the chief law officer of California.

11. Plaintiff the Commonwealth of Massachusetts is a sovereign state of the United States of America. Massachusetts is represented by Attorney General Andrea Joy Campbell, the Commonwealth's chief legal officer.

12. Plaintiff the State of New Jersey, represented by and through its Attorney General, Matthew J. Platkin, is a sovereign State of the United States of America. As the State's chief legal officer, the Attorney General is authorized to act on behalf of the State in this matter.

13. Plaintiff the State of Arizona is a sovereign state of the United States of America. Arizona is represented by Attorney General Kris Mayes, who is the chief law enforcement officer of Arizona and is authorized to act in federal court on behalf of the State.

14. The State of Colorado is a sovereign state in the United States of America. Colorado is represented by Phil Weiser, the Attorney General of Colorado. The Attorney General acts as the chief legal representative of the state and is authorized by Colo Rev. Stat. § 24-31-101 to pursue this action.

15. Plaintiff the State of Connecticut is a sovereign state of the United States of America. It is represented by Attorney General William Tong, the chief law officer of Connecticut.

16. Plaintiff State of Delaware is a sovereign state of the United States of America. This action is brought on behalf of the State of Delaware by Attorney General Kathleen Jennings, the "chief law officer of the State." Darling Apartment Co. v. Springer, 22 A.2d 397, 403 (Del. 1941). Attorney General Jennings also brings this action on behalf of the State of Delaware pursuant to her statutory authority. Del. Code Ann. tit. 29, § 2504.

17. Plaintiff the State of Illinois is a sovereign state in the United States of America. Illinois is represented by Kwame Raoul, the Attorney General of Illinois, who is the chief law enforcement officer of Illinois and authorized to sue on the State's behalf. Under Illinois law, the Attorney General is authorized to represent the State's interests by the Illinois Constitution, article V, section 15. See Ill. Comp. Stat. 205/4.

18. The State of Maine is a sovereign state of the United States of America. Maine is represented by Aaron M. Frey, the Attorney General of Maine. The Attorney General is authorized to pursue this action pursuant to 5 Me. Rev. Stat. Ann. § 191.

19. The State of Maryland is a sovereign state of the United States of America. Maryland is represented by Attorney General Anthony G. Brown who is the chief legal officer of Maryland.

20. The People of the State of Michigan are represented by Attorney General Dana Nessel. The Attorney General is Michigan's chief law enforcement officer and is authorized to bring this action on behalf of the People of the State of Michigan pursuant to Mich. Comp. Laws § 14.28.

21. The State of Minnesota is a sovereign state of the United States. Minnesota is represented by and through its chief legal officer, Minnesota Attorney General Keith Ellison, who has common law and statutory authority to sue on Minnesota's behalf.

22. Plaintiff State of New Mexico, represented by and through its Attorney General, is a sovereign state of the United States of America. Attorney General Raúl Torrez is the chief legal officer of the State of New Mexico. He is authorized to prosecute all actions and proceedings on behalf of New Mexico when, in his judgment, the interest of the State requires such action. N.M. Stat. Ann. § 8-5-2(B). Likewise, he shall appear before federal courts to represent New Mexico when, in his judgment, the public interest of the state requires such action. N.M. Stat. Ann. § 8-5-2(J). This challenge is brought pursuant to Attorney General Torrez's statutory authority.

23. Plaintiff State of Nevada, represented by and through Attorney General Aaron D. Ford, is a sovereign State within the United States of America. The Attorney General is the chief law enforcement of the State of Nevada and is authorized to pursue this action under Nev. Rev. Stat. 228.110 and Nev. Rev. Stat. 228.170.

24. Plaintiff the State of New York is a sovereign state in the United States of America. New York is represented by Attorney General Letitia James, who is the chief law enforcement officer of New York.

25. The State of Oregon is a sovereign state of the United States. Oregon is represented by Attorney General Dan Rayfield. The Attorney General is the chief legal officer of Oregon and is authorized to institute this action.

26. Plaintiff Josh Shapiro brings this suit in his official capacity as Governor of the Commonwealth of Pennsylvania. The Pennsylvania Constitution vests "[t]he supreme executive power" in the Governor, who "shall take care that the laws be faithfully executed." Pa. Const. art. IV, § 2. The Governor oversees all executive agencies in Pennsylvania and is authorized to bring suit on their behalf. 71 P.S. §§ 732-204(c), 732-301(6), 732-303.

27. The State of Rhode Island is a sovereign state in the United States of America. Rhode Island is represented by Attorney General Peter F. Neronha, who is the chief law enforcement officer of Rhode Island.

28. Plaintiff the State of Vermont is a sovereign state of the United States of America. Vermont is represented by Attorney General Charity Clark. Attorney General Clark is authorized to initiate litigation on Vermont's behalf.

29. Plaintiff State of Washington, represented by and through Attorney General Nicholas W. Brown, is a sovereign state of the United States of America. The Attorney General is Washington's chief law enforcement officer and is authorized under Wash. Rev. Code § 43.10.030 to pursue this action.

30. The State of Wisconsin is a sovereign state in the United States of America. Wisconsin is represented by Joshua L. Kaul, the Attorney General of Wisconsin. Attorney General

Kaul is authorized under Wis. Stat. § 165.25(1m) to pursue this action on behalf of the State of Wisconsin.

II. Defendants

31. Defendant U.S. Department of Health and Human Services is a Department of the U.S. Executive Branch. HHS is an agency within the meaning of 5 U.S.C. § 551(1).

32. Defendant Robert F. Kennedy, Jr. is the HHS Secretary. He is responsible for overseeing and administering all HHS programs through the Office of the Secretary and HHS's operating divisions. He is sued in his official capacity.

33. Defendant Centers for Medicare and Medicaid Services is an agency within HHS. CMS is an agency within the meaning of 5 U.S.C. § 551(1).

34. Defendant Mehmet Oz is the CMS Administrator. He is responsible for overseeing and administering all CMS programs through the Office of the Administrator and CMS's centers and offices. He is sued in his official capacity.

BACKGROUND

I. The Affordable Care Act.

35. The ACA is a landmark law that made affordable health coverage available to more than 44 million Americans this year alone, and the ACA works each year to sharply reduce the number of Americans without health insurance by both making private insurance more affordable and expanding access to Medicaid. The ACA was designed to reform state-based markets to create affordable insurance choices for consumers, in order to "increase the number of Americans covered by health insurance and decrease the cost of health care." *NFIB v. Sebelius*, 567 U.S. 519, 538 (2012). The ACA adopted a "series of interlocking reforms" to achieve these goals. *King v. Burwell*, 576 U.S. 473, 478 (2015). The closely intertwined reforms implemented by the ACA include both a statutory requirement that insurers must accept every person seeking coverage and

that they cannot charge them higher premiums based on their health (i.e., that they cannot discriminate based on "pre-existing conditions"), and the provision of federal subsidies designed to make insurance coverage more affordable. *Id*.

36. To achieve these goals, the ACA created Exchanges, both state-run and federally-run, that allow people to compare and purchase insurance plans. Exchanges may be established either by a State, or, if a State does not establish an Exchange, by the federal government.

37. Since plan year 2014, consumers and small businesses in every State have been able to obtain health coverage via exchanges operated by the States (State-based Exchanges, or SBEs), or pursuant to the exchange operated by the federal government (the Federally-facilitated Exchange, or FFE), or through a state's small group off-exchange market. There are currently 20 SBEs, as well as 3 SBEs on the federal platform (SBE-FPs).[3] 28 States lack SBEs, and are "FFE States" instead.

38. Consumers and small businesses seeking health coverage typically sign up during the open enrollment period (OEP). For Plan Year (PY) 2025, the OEP on the federal exchange ran from November 1, 2024 through January 15, 2025. Open enrollment on SBEs began on November 1, 2024 and typically ended between mid-January and early February 2025. Exchanges calibrate the length of the OEP to balance the risk of adverse selection (a term that describes when enrollees seek coverage only after getting sick) against the need to ensure health coverage is accessible to as many people as possible. In addition to the OEP, there are special enrollment periods (SEPs), during which consumers who experience certain life events (like a change in their family status or financial circumstances) may enroll in health coverage at other times of the year.

[3] SBE-FPs rely on HHS to perform certain exchange functions (typically eligibility and enrollment), and consumers enroll in coverage through healthcare.gov. SBE-FP states retain responsibility for all other marketplace functions.

39. For PY 2025, more than 24 million Americans signed up for health coverage through the ACA's state-based and federally-facilitated marketplaces.

40. Healthcare expenses (for those with health insurance) generally fall into two categories. First, health insurance companies typically charge monthly premiums for the coverage that they provide. Second, insurance plans usually require insured individuals and families to make out-of-pocket payments to healthcare providers in the form of copayments for medical visits and prescription drugs, coinsurance, and deductibles (known as "cost-sharing" requirements).

41. One critical component of the ACA is that it permanently appropriated billions of dollars in federal subsidies to make healthcare more affordable for eligible low- and moderate-income Americans. The ACA provides advance premium tax credits (APTCs) that reduce monthly insurance premiums for eligible individuals. 26 U.S.C. § 36B. Qualified individuals are those with household incomes between 100% and 400% of the federal poverty level (FPL).[4] Such individuals may purchase insurance with the APTCs—which the Treasury Secretary pays in advance directly to the individual's health insurer. APTCs are among the Act's key reforms, involving billions of dollars in spending each year and affecting the price of health insurance for millions of people. 92% of the 24 million Americans who signed up for health coverage through the exchanges in 2025 qualified for APTC and received at least partially subsidized coverage.[5]

42. APTC awards are based on projections of future income. Some enrollees are entitled to APTC awards sufficient to reduce their out-of-pocket premium cost to $0. After filing

[4] The American Rescue Plan temporarily extended eligibility for APTCs beyond 400% of the federal poverty level, but those enhanced subsidies are scheduled to expire on December 31, 2025.

[5] *See* CMS.Gov, *Health Insurance Exchanges 2025 Open Enrollment Report* at 16, https://www.cms.gov/files/document/health-insurance-exchanges-2025-open-enrollment-report.pdf (Last Accessed July 16, 2025).

taxes, which are retrospective, individuals must reconcile their claimed APTC amount against their actual eligibility as shown in their tax filings. If the enrollee earned more than projected and thus collected more APTC than they should have, they owe the difference back to the government in the form of a tax liability, though such liability may be capped depending on income.

43. Under existing law, an enrollee who fails to file taxes and reconcile their claimed APTC award against their actual eligibility—known as failure to file and reconcile, or FTR—for two consecutive years loses their eligibility for any future APTCs and must repay the amount of the overpayment in the amount of a tax liability. The amount of that repayment liability is currently capped at a certain level determined by household income and adjusted each year for inflation, but Congress recently eliminated those caps beginning with the 2026 tax year. *See* 26 U.S.C. § 36B(f)(2)(A), (B) (setting excess APTC repayment levels).

44. The ACA also requires insurers to insure all eligible applicants, regardless of health status or other factors (known as the "guaranteed issue" requirement). *See* 42 U.S.C. § 300gg-1 (stating that health insurance issuers "must accept every employer and individual in the State that applies for such coverage"). Insurance plans can be terminated for failure to pay a premium after a grace period, but a new enrollee who pays the first-month premium must be issued coverage, even if they owe a past-due premium from their prior coverage. Insurers, like any other entity, can pursue ordinary collection methods and other remedies in the event of nonpayment of past premiums owed.

45. The ACA was enacted to improve access to comprehensive health insurance coverage and remedy disparities in access to healthcare, especially for more vulnerable populations

such as individuals with preexisting conditions.[6] In service of this mission, the ACA imposes minimum coverage requirements known as "essential health benefits" (EHB). By mandating coverage for EHBs, the ACA has drastically improved access to healthcare for those who need it most.[7]

46. Before passage of the ACA, insurance plans could exclude a range of life-saving services from coverage, leaving many Americans without access to basic care, such as maternity care, substance use treatment, mental health treatment, or even prescription drugs.[8]

47. To ensure that all Americans are able to access insurance for these basic needs, the ACA requires certain individual and small group health plans to provide an EHB package providing coverage for items and services falling within ten benefit categories. Classification of a benefit as an EHB matters: EHBs are "protected by cost-sharing limits and count towards a plan's actuarial value."[9] The EHBs are minimum standards for these plans, but States are free to add "additional benefits." 42 U.S.C. § 18031(d)(3)(B).

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[6] *See Bank v. United States Dep't of Health and Human Services*, 413 F.Supp.3d 165, 167 (E.D.N.Y. 2019); *Fact Sheet: The Six Month Anniversary of the Affordable Care Act*, The White House: Office of the Press Secretary (Sept. 22, 2010), https://obamawhitehouse.archives.gov/the-press-office/2010/09/22/fact-sheet-six-month-anniversary-affordable-care-act (lauding passage of "Patient's Bill of Rights").

[7] Wei Ye & Javier M. Rodriguez, *Highly vulnerable communities and the Affordable Care Act: Health insurance coverage effects, 2010-2018,* 270 Soc. Sci. & Med. (Jan. 12, 2021); Thomas Buchmueller & Rebecca L. Haffajee, *Reducing Disparities in Health Care Coverage and Access Under the ACA*, HealthAffairs (Jun. 7, 2024), https://www.healthaffairs.org/content/forefront/reducing-disparities-health-care-coverage-and-access.

[8] Sarah Lueck, *If "Essential Health Benefits" Standards Are Repealed, Health Plans Would Cover Little*, Center on Budget &Policy Priorities (Mar. 23, 2017), https://tinyurl.com/44b8e9z2.

[9] Kaiser Family Found., New Rule Proposes Changes to ACA Coverage of Gender-Affirming Care, Potentially Increasing Costs for Consumers (Mar. 24, 2025), https://tinyurl.com/2637fye3.

48. The ACA requires the HHS Secretary to "define" EHBs and to ensure that the scope of EHBs "is equal to the scope of benefits provided under a typical employer plan." 42 U.S.C. § 18022(b)(2)(A). That requires that the Secretary periodically review and further define EHBs to reflect changes in science and medicine or to address any gaps in access faced by enrollees. 42 U.S.C. § 18022(b)(4). The Secretary must also ensure that EHBs are provided in a nondiscriminatory manner and that they "take into account the health care needs of diverse segments of the population." 42 U.S.C. § 18022(b)(4)(C).

49. Tied to HHS's statutory obligations, States must submit "benchmark" plans to HHS for review and approval. While the ACA requires that state plan provide coverage for EHBs (the federal EHB mandate), States also have authority to offer "additional health benefits, like vision, dental, and medical management programs (for example, for weight loss)."[10] States may submit a customized plan or adopt "model" plans provided by HHS.[11]

50. State benchmark plans are maintained on file with the Department, so that private insurers can compare plans to ensure compliance with the standards set forth therein. Even if a State has not updated its benchmark plan to match updated federal requirements, private insurers must also review plans for compliance with federal EHB mandates.[12]

51. To date, the Department has only explicitly prohibited EHB status for a very limited number of services: abortion, non-pediatric dental or eye exam services, long-term nursing care, and non-medically necessary orthodontia. These limited services have long been served by existing

[10] Jared Ortaliza & Cynthia Cox, *The Affordable Care Act 101*, Kaiser Family Found. (May 28, 2024), https://tinyurl.com/yz5utdrn.

[11] Centers for Medicare and Medicaid Servs., Information on Essential Health Benefits (EHB) Benchmark Plans, https://tinyurl.com/3jbebvzc (last updated Jan. 14, 2025).

[12] *Id.*

separate plans. However, even for those limited services, a state EHB plan may cover them should a State so choose.

52. For the States with anti-discrimination mandates prohibiting discrimination in insurance coverage on the basis of gender identity (that, in effect, require coverage of medically necessary treatment for gender dysphoria), and where those services fall within the ambit of an EHB—such as hospitalization or the provision of medication—those States could receive the benefit of the services being treated as an EHB even if not explicitly called out in their EHB benchmark plans.

53. In many of these states, each plan listed on that State's marketplace must cover medically necessary treatment for gender dysphoria. Absent an express prohibition, certain services that are part of this treatment, like medication, mental health care, surgeries, and lab services, are treated as EHBs for purposes of cost-sharing and premium tax credits.

54. However, if gender-affirming care is explicitly barred from inclusion as an EHB, then States requiring coverage of gender-affirming care services would themselves be responsible for defraying the increased cost to cover those services and comply with state mandates.

55. By way of illustration, each plan must provide to the State the breakdown of its services so that the State may understand what percent of the premium is subject to tax credits. So if a plan has a premium that costs $100 and $96 of that premium is to cover the costs associated with the coverage of EHBs, then $96 is subject to premium tax credits. The exclusion of medically necessary treatment for gender dysphoria from EHBs means that each plan must now segregate these costs out of that eligible premium amount. So what was once $96 may be lowered to $95 in premiums eligible for tax credits.

56. In States that mandate or guarantee gender-affirming care, the State is responsible for defraying the extra cost of premiums covering state-mandated services that are not EHBs, which gender-affirming care is now considered under the Final Rule.

II. The Final Rule

57. HHS and CMS published a proposed rule on March 19, 2025, entitled *Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability*, 90 Fed. Reg. 12,942 (March 19, 2025) (Proposed Rule), for the stated purpose of combating fraud.

58. The Proposed Rule set forth a series of sweeping regulatory changes to eligibility and enrollment systems under the ACA. It admitted these changes would cause "750,000 to 2,000,000 individuals to lose coverage." Proposed Rule at 13,025.

59. The Proposed Rule offered a mere twenty-three days for public comment, notwithstanding that HHS and the Office of Management and Budget received subsequent objections asking for at least 30, and ideally 60, days for public comment.

60. CMS received 26,396 public comments in response to the Proposed Rule in the twenty-three-day period after publication during which HHS allowed public comment.

61. Many of Plaintiff States submitted a comment in opposition to the Proposed Rule. *Letter from California, Massachusetts, New Jersey, and 19 Other States, Comment Letter on Proposed Rule*, (April 11, 2025), available at https://www.regulations.gov/comment/CMS-2025-0020-23836.

62. Plaintiff States' comment objected to a wide variety of changes made to the ACA marketplace exchanges, including (1) a series of changes to eligibility criteria and enrollment procedures that would make it more difficult to access insurance via ACA exchanges, and (2) removal of medically necessary treatments for transgender individuals from the definition of an Essential Health Benefit.

63. Many other commenters opposed the Proposed Rule, including professional health care organizations and health care providers—including the American Medical Association, the American College of Physicians, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the Society of Adolescent Health and Medicine, the Robert Wood Johnson Foundation, and more.

64. These and many other comments explained that the Proposed Rule would decrease enrollment on ACA exchanges and health-insurance coverage, and as a result, would inexorably increase overall health care costs, limit availability of health care to vulnerable populations, and impose negative public health outcomes.

65. But Defendants brushed these comments, and over 26,000 others, aside.

66. Just over three months later, on June 25, 2025, HHS published its Final Rule. *See Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability*, 90 Fed. Reg. 27,074 (June 25, 2025) (hereafter the "Final Rule").

67. Despite the ACA's goal of increasing access to healthcare while lowering cost, *King v. Burwell*, 576 U.S. 473, 491 (2015) ("Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them"), the Final Rule makes enrollment and reenrollment *more* burdensome and difficult rather than less: it shortens the OEP, imposes significant new paperwork verification requirements, doubles the frequency with which consumers must prove their eligibility for previously awarded premium tax credits, newly allows insurers to deny coverage for past-due premiums on earlier coverage, makes annual automatic reenrollment much more difficult every year, and even imposes an unlawful $5 monthly charge on automatic reenrollees who by law are entitled to pay $0 premiums.

68. Not only does the Final Rule enact these sweeping changes, for the first time, HHS removes States' substantial autonomy to set their own policies on their SBEs with respect to several of these policies. For instance, rather than merely setting new regulations for the federal government's own platform, HealthCare.gov, HHS mandates that *States* impose some of these burdens upon their own enrollees—consumers who never touch the FFE.

69. Supposedly in keeping with the President's directive that all Federal agencies must take pains to "increase the prosperity of the American worker," HHS claims that these changes are "aimed at strengthening the integrity of the [ACA] eligibility and enrollment systems to reduce waste, fraud, and abuse." Proposed Rule at 12,942. Specifically, HHS asserts that unscrupulous brokers and agents are wrongfully enrolling consumers in coverage they either do not want or are not eligible for, using tax credits they are not entitled to, costing the Federal government billions of dollars and imposing burdensome tax liabilities upon consumers when those improper credits must be repaid. Proposed Rule at 12,942-43. In addition, HHS claims that "several regulatory policies recently put in place to make it easier to enroll in subsidized coverage severely weakened program integrity and put consumers at risk from improper enrollment." *Id.* Therefore, the Final Rule's changes are aimed at reducing fraud, unauthorized enrollments, and improper payment of tax credits, while simultaneously strengthening program integrity and bringing costs down for consumers.

70. If, as HHS acknowledges, the Final Rule will throw millions of people off the health insurance exchanges while imposing substantial new administrative barriers and increasing costs to States, Defendants must have robust evidence showing that these changes will accomplish their goals, justifying the burden on ordinary Americans. But they do not.

71. Take the problem of fraudulent enrollments by brokers and agents. Reports of fraud spiked in early 2024, with "federal regulators receiv[ing] roughly 275,000 complaints about unauthorized enrollments or plan changes," which were "concentrated in states that use the federal marketplace, HealthCare.gov. There has been *no indication to date of similar problems in states that operate their own marketplaces.*"[13] Imposing these changes on States where no appreciable enrollment fraud exists, in the name of combatting enrollment fraud, is nonsensical.

72. During the comment period, States and industry groups pointed out HHS's flawed logic and strongly urged Defendants to reconsider. In their comment letter, Plaintiff States noted that even California, with the largest SBE, "simply does not have a large-scale issue with fraudulent enrollments" due to simple security measures like multi-factor authentication and affirmative access monitoring, while Pennsylvania "similarly allows only agents designated by the consumer to access the user's account," and urged Defendants to adopt other, more targeted anti-fraud reforms instead of the Rule's sweeping changes.[14] The District of Columbia's Health Benefit Exchange Authority (DC HBEA), D.C.'s SBE, informed Defendants that fraud on its platform is "rare."[15] Covered California wrote that it "does not have any indication of widespread fraud and abuse occurring in our market," and decried Defendants' "one-size-fits-all solution to a problem

[13] Justin Giovannelli & Stacey Pogue, *Policymakers Can Protect Against Fraud in the ACA Marketplaces Without Hiking Premiums*, The Commonwealth Fund (March 5, 2025), https://tinyurl.com/rw5wxjze.

[14] Letter from California, Massachusetts, New Jersey, and 19 Other States, Comment Letter on Proposed Rule, (April 11, 2025), at 16, available at https://www.regulations.gov/comment/CMS-2025-0020-23836.

[15] Letter from Mila Kofman, Executive Director, DC Health Benefit Exchange Authority, Comment Letter on Proposed Rule (April 11, 2025), at 1, available at https://www.regulations.gov/comment/CMS-2025-0020-23984.

that does not exist in California."[16] As Covered California commented to HHS before the rule was finalized, "a robust review of consumer complaints and enrollment partner activity in recent years did not reveal a single identified case of a consumer being enrolled in Covered California without their knowledge." Altman Letter (Exhibit A) at 2. Washington, too, is simply not experiencing fraudulent enrollments on any serious scale, and told Defendants so during the comment period.[17]

73. And the Blue Cross Blue Shield Association (BCBSA), an insurer, pointed out that the federal marketplace, not the State marketplaces, had the biggest issue with fraudulent enrollments; therefore, in BCBSA's view, "there is insufficient justification" to impose several of the Proposed Rule's requirements on "the State Exchanges." BCBSA Letter at 9. America's Health Insurance Plans, a trade group, agreed, writing, "State Exchanges did not experience the same rate of improper enrollments as the [Federally-Facilitated Marketplace] and therefore do not require the same policy solutions as the FFM."[18]

74. But Defendants' goal was not to reduce fraud. If it was, Defendants would have considered the data and views submitted by states, exchanges, and industry experts during the comment period. In fact, only one of the Proposed Rule's changes—making it easier to remove brokers for cause—would have effectively addressed the fraud issue. Plaintiff States had supported that proposal.[19] If preventing fraud was Defendants' true concern, they would have finalized the

[16] Letter from Jessica Altman, Executive Director, Covered California, Comment Letter on Proposed Rule (April 11, 2025), at 2, available at https://www.regulations.gov/comment/CMS-2025-0020-25629 (EXHIBIT A).

[17] Letter from Washington State's Health Benefit Exchange, Comment Letter on Proposed Rule (April 11, 2025), at 3, available at https://www.regulations.gov/comment/CMS-2025-0020-24557.

[18] Letter from America's Health Insurance Plans, Comment Letter on Proposed Rule(April 11, 2025), at 2, available at https://www.regulations.gov/comment/CMS-2025-0020-24078.

[19] California et al. Comment Letter, *supra* note 13, at 15.

broker-removal provisions, implemented two-factor authentication, adopted several other changes Plaintiff States proposed—and stopped there.

75. As for the issues of cost and marketplace integrity, several commenters with particular expertise—the State-Based Exchanges themselves—repeatedly pointed out that the very consumers who would likely be barred from, or drop out of, the Marketplaces as a result of the Proposed Rule's changes tended to be, on average, healthier, younger, and less costly to insure, with lower aggregate risk scores, than enrollees likelier to remain—meaning the Final Rule's ultimate changes in fact *harm* risk pools and will likely cause premiums to increase, not the reverse.

76. As Covered California explained during rulemaking, "[E]ven small obstacles to enrollment significantly influence enrollment choices."[20] Every additional barrier that Defendants impose on enrollees will likely lower enrollment—and even without this Rule, significant barriers await in 2026. Washington Health Benefit Exchange in its comment letter stressed that the looming expiration of enhanced premium tax credits "will cause 80,000 [qualified health plan] enrollees in Washington to lose their coverage," and will "be a major disruption to customers' ability to afford their existing coverage," and urged Defendants "not to take action to make health coverage even less affordable and further destabilize the individual market."[21]

77. The Final Rule, broadly speaking, adopts all of the categories of regulatory action that Plaintiff States opposed in their comment letter. Via the Final Rule, HHS and CMS (1) make a series of changes to eligibility criteria and enrollment procedures for the ACA's health insurance marketplace exchanges, that will truncate and eliminate enrollment periods for millions of consumers, limit access to benefits, and otherwise make it more difficult to participate on both

[20] Exhibit A at 6.
[21] Letter from Washington State's Health Benefit Exchange, *supra* note 16, at 3, 6, 14.

federal and state-run ACA exchanges, and (2) eliminate a broad swath of services as EHB, many of which are considered medically necessary treatments for transgender individuals, even though those services fall within multiple EHB categories. Many of these changes will begin to become effective on August 25, 2025. Notably, likely in recognizance of the injurious nature of many of the changes, the Final Rule sunsets the effective date of many of the first category of changes to expire after Plan Year 2026.

ALLEGATIONS

I. HHS's 23 Day Period for Notice and Comment Was Legally Insufficient.

78. HHS published the Proposed Rule in the Federal Register on March 19, 2025, with comments accepted through April 11, 2025.

79. The Proposed Rule was a complicated, multifaceted rule spanning 90 pages in the Federal Register.

80. HHS provided only 23 days to review the Proposed Rule.

81. Plaintiff States submitted a comment letter objecting to the abbreviated comment period and requesting at least 30, and ideally 60 days, for public comment.[22] As Plaintiff States explained to HHS, the shortened comment period prejudiced their ability to address certain highly technical matters; for example, SBEs could not perform a complete analysis of the expected enrollment losses, premium impacts, and risk pool changes associated with this rule because of the truncated comment period.[23]

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[22] California et al. Comment Letter, *supra* note 13, at 2.

[23] California Department of Managed Health Care, Comment Letter on Proposed Rule (Apr. 11, 2025), at 1-2, available at https://www.regulations.gov/comment/CMS-2025-0020-23127 (attachments); Washington Health Benefit Exchange, Comment Letter on Proposed Rule (Apr. 11, 2025), at 3, available at https://www.regulations.gov/comment/CMS-2025-0020-24557 (attachments) (Washington HBE Comment Letter).

82. A 30-day comment period is generally the shortest period sufficient for interested persons to meaningfully review and provide informed comment. *See Prometheus Radio Project v. FCC*, 652 F.3d 431, 453 (3d Cir. 2011) (holding 28-day comment period insufficient); *Azar v. Allina Health Servs*., 139 S.Ct. 1804, 1809 (2019) (referring to the "APA minimum of 30 days").

83. Even a 30-day period is atypical, and highly disfavored, for such substantial changes. *See Petry v. Block*, 737 F.2d 1193, 1202 (D.C. Cir. 1984) (observing that 30 days for comment "cut[s] the comment period to the bone" and 60 days is "a more reasonable *minimum* time for comment" for complex rules (quotation omitted)); *Nat'l Lifeline Ass'n v. FCC*, 921 F.3d 1102, 1117-18 (D.C. Cir. 2019) ("When substantial rule changes are proposed, a 30-day comment period is generally the shortest time period sufficient for interested persons to meaningfully review a proposed rule and provide informed comment.").

84. 5 U.S.C. § 553(b)(B) requires an agency to find "good cause" for justifying a truncated comment period. A rule that has a comment period of less than 30 days is "generally characterized by the presence of exigent circumstances in which agency action was required in a mere matter of days." *N.C. Growers' Ass'n, Inc.*, 702 F.3d 755, 770 (4th Cir. 2012).

85. Here, the Final Rule includes no such finding of "good cause," and its mere 23-day comment period is legally deficient, not only because it is less than the bare legal minimum of 30 days, but also because a rule of such complexity and magnitude, involving various technical issues under the ACA, requires a significantly longer comment period to ensure technical comments and allow for full consideration of reliance interests.

86. Indeed, multiple recent prior rulemaking under the ACA typically afforded a comment period well over 30 days. *See, e.g.*, *Extension of Comment Period for Rule Regarding ACA Interoperability*, 84 Fed. Reg. 16,834 (Apr. 23, 2019) (extending existing comment period

from 60 days to 90 days in response to public feedback); *Patient Protection and Affordable Care Act; Increasing Consumer Choice Through the Sale of Individual Health Insurance Coverage Across State Lines Through Health Care Choice Compacts*, 84 Fed. Reg. 8,657 (Mar. 11, 2019) (56-day comment period).

87. As such, the Final Rule is procedurally invalid—a sufficient basis for the Final Rule to be stayed and/or preliminarily enjoined (and ultimately vacated).

II. The Final Rule's Marketplace Integrity Changes Are Unlawful.

A. Mandating a $5 Minimum Premium for Auto-Reenrollments Is Unlawful and Arbitrary[24]

88. Ever since Exchange coverage became available under the ACA, enrollees who maintained eligibility for coverage from year to year were automatically re-enrolled in the same plan unless they opted to disenroll or selected a different one. For those who receive sufficient APTC to fully cover their premium—leaving $0 in out-of-pocket costs—the Final Rule now directs Exchanges to reduce the APTC award by $5 per month for auto-re-enrollees, until those enrollees can confirm their continued eligibility for no-cost coverage.

89. But APTC awards are set by statute, not by regulation, and cannot be reduced arbitrarily by executive fiat. This Final Rule orders Exchanges to calculate the amount of APTC required by law and then ignore the result, imposing an illegal charge on consumers who are by law entitled to $0 premiums.

90. Section 36B of the Internal Revenue Code, which was added by the ACA, sets forth the calculations for determining an individual's PTC eligibility. Section 1412(c) of the Affordable Care Act specifies that APTC amounts "shall" be made in accordance with Section

[24] This provision of the Final Rule applies to States utilizing the Federal Exchange; among Plaintiff States, those states are Arizona, Delaware, Michigan, Oregon, and Wisconsin.

36B. Therefore, Section 36B is the only source of statutory authority for calculating PTC amounts. This calculation is not optional. The ACA explicitly specifies that APTC amounts "shall" be paid as directed by Section 36B. 42 U.S.C. § 18082(c)(2)(A).

91. Section 1412 of the ACA does not allow the Secretary or CMS to pay, or an issuer to receive, an amount less than the amount calculated under Section 36B, and Defendants do not have the authority under the text of the statute to require the Exchanges to fail to make the full payment as calculated in accordance with Section 36B.

92. In addition to being necessarily contrary to law, this provision of the Final Rule is arbitrary and capricious. Several commenters raised this concern; Defendants brush it aside with perfunctory statements of what they "believe." Responding to the objections that "section 1411(f)(1)(B) of the ACA does not give HHS the authority to withhold APTC," and that Exchanges lack authority "to reduce the amount of APTC used toward an enrollee's coverage," Defendants provide just two sentences. First, Defendants make the bald assertion that they "believe" the ACA "directs the Secretary to establish procedures by which it 'redetermines eligibility on a periodic basis in appropriate circumstances.'" Final Rule at 27,109. Second, Defendants assert that the "recent history of improper enrollments" is "an appropriate circumstance" for imposing an arbitrary $5 premium on consumers who are entitled by law to pay $0. *Id.* They cite no authority.

93. Moreover, if a consumer fails to pay this $5 charge, they risk loss of coverage for the rest of the year—because loss of minimum essential coverage due to failure to pay a premium is *not* a triggering event allowing access to an SEP. This provision of the Final Rule, in other words, cruelly imposes a charge in January on consumers who are accustomed to $0 premiums and thus not expecting it, and then yanks their access to health care for the entire remainder of the year if they fail to notice and pay it.

94. By requiring that all fully subsidized enrollees take "an affirmative action" to confirm their continued eligibility for APTC, the Final Rule imposes another barrier to coverage for the lowest-income consumers, who, by definition, are the ones entitled to $0 premiums. Even small barriers matter. As commenters pointed out during rulemaking, "one study found that premiums less than $10 led to a 14 percent decrease in enrollment." Levitis et al., Letter (Exhibit B) at 18. Even small premiums—as low as $1—are known to contribute to a decline in enrollment.[25] Additionally, "young and healthy consumers are at the greatest risk of failing to notice the junk premium charge and losing coverage as a result, while those with significant health care needs will likely resolve the issue more quickly." Exhibit B at 18. Therefore, this provision of the Final Rule poses a significant risk of weakening the risk pool.

95. Defendants did not acknowledge or respond to those concerns.

B. Shortening the Open Enrollment Period Is Unlawful and Arbitrary

96. Historically, Defendants have allowed SBEs wide latitude to determine the length of their open enrollment periods. In California, for instance, the length of the OEP set by its SBE, Covered California, has been 91 days in length (from November 1 to January 31) for over ten years.[26] But the Final Rule limits the OEP to just nine weeks, beginning no later than November 1 and ending no later than December 31, on the federal exchange and the SBEs. The Final Rule specifically forbids any Exchange from extending the OEP into January. This change cuts the OEP by more than thirty percent in California. While this is a less drastic cut than initially proposed, it is still likely to be significantly detrimental. Covered California told Defendants during rulemaking that "[c]utting the OEP in half would unnecessarily put significant strain on our enrollment partner

[25] Adrianna McIntyre, Mark Shephard, & Timothy J. Layton, *Small Marketplace Premiums Pose Financial and Administrative Burdens: Evidence From Massachusetts, 2016-17*, Health Affairs (January 2024), https://doi.org/10.1377/hlthaff.2023.00649/.

[26] Altman Letter, Exhibit A at 2.

workforce and potentially hinder their ability to reach and enroll. Further, our data and experience show that the longer OEP strengthens our risk pool and enhances overall market stability."[27]

97. For many consumers, the ability to change plans in January is valuable. *See* Rule at 27,140 ("One commenter noted that Exchange enrollees who are automatically re-enrolled into a plan may not learn of cost increases until after they receive their first bill in January."). During rulemaking, Defendants acknowledged that an OEP lasting through at least January 15 allows consumers who had been automatically re-enrolled into a plan that they may no longer want "the opportunity to change plans after receiving updated plan cost information from their issuer and to select a new plan that is more affordable to them." HHS previously took that position too. But HHS dismissed that concern without explaining why it was departing from its prior position. In the Final Rule, HHS inadequately addressed this concern by asserting merely that Defendants "provide notice in advance of the OEP to consumers about the importance of updating information for the future plan year and actively comparing plan options and prices." *Id.* That is not meaningfully responsive.

98. HHS claims that this change will reduce consumer confusion by aligning the OEP with common employer OEPs outside of the Exchanges.

99. Plaintiff States know firsthand that longer OEPs allow hundreds of thousands of additional consumers to enroll, strengthening the risk pool. Longer OEPs also afford consumers more time to comparison-shop between available Exchange plans and select the one that is right for them. And later enrollees tend to be younger and healthier than earlier enrollees, meaning that shortening the OEP is likely to weaken the risk pool.[28]

[27] Altman Letter, Exhibit A at 3.
[28] *Id*.

100. In addition, the longer enrollment period gives States more time to process enrollments. Even with the current 90-day period, brokers are inundated with calls, working long hours to meet demand for enrollment assistance. States will be harmed by the mandatory shortened enrollment window. Agents and brokers who assist consumers with both the Medicare and the Exchange marketplaces will have fewer days to process applications after the close of the Medicare window.

101. Despite Defendants' claims, there is no data showing that the risk of adverse selection or consumer confusion are worsened by a longer OEP, or that shortening the OEP is likely to have a material impact on adverse selection risk for insurers. On the contrary, in previous rulemaking, Defendants acknowledged that a "shortened enrollment period could lead to a reduction in enrollees, primarily younger and healthier enrollees who usually enroll late in the enrollment period."[29] Defendants also acknowledged that several Marketplace experts, including "Navigators, certified application counselors (CACs), agents, and brokers," were concerned about "a lack of time to fully assist all interested Exchange applicants with comparing their different plan choices," suggesting that the longer OEP is both necessary and justified. Rule at 27,136-37. Defendants have not explained why these concerns are no longer valid.

102. In fact, shortening the OEP by thirty percent in some states, like California, would impose new, significant barriers to enrollment by substantially increasing the burden on those agents, brokers, and Navigators.

103. By contrast, longer OEPs are correlated with higher enrollment and a healthier risk pool. The Department has previously found that a shorter OEP "could lead to a reduction in

[29] *Patient Protection and Affordable Care Act; Market Stabilization*, 82 Fed. Reg. 18,346, 18,377 (Apr. 18, 2017) (Final Rule).

enrollees, primarily younger and healthier enrollees who usually enroll late in the enrollment period."[30] The people most likely to drop out of coverage because of the shortened OEP are younger, healthier enrollees who contribute to the overall health of the risk pool. The shortened OEP will weaken the risk pool across all States.

104. By decreasing the number of individuals insured, increasing the number of uninsured, and making it more difficult to access health insurance, this provision runs directly contrary to the purposes of the ACA by squarely undermining Congress' twin goals of expanding access to healthcare and making it more affordable. *See Sebelius*, 567 U.S. at 538 (Congress enacted the ACA to "increase the number of Americans covered by health insurance and decrease the cost of health care."). HHS has acted contrary to the ACA, and may not cast aside Congressional intent and replace statutory objectives with different policy goals. *See Indep. U.S. Tanker Owners Comm. v. Dole*, 809 F.2d 847, 854 (D.C. Cir. 1987).

C. Requiring 75% Verification for Triggering-Event SEPs Is Arbitrary[31]

105. Consumers and small businesses seeking health coverage typically sign up during annual OEPs.

106. But SEPs allow for enrollment in coverage outside of the OEP upon the occurrence of a triggering event, such as the loss of minimum essential coverage, a move to a new geographic region, or the birth of a child. To ensure that people in such circumstances are not locked out of accessing the healthcare system for several months, the ACA allows them to enroll in coverage outside of the OEP.

[30] *Id.*

[31] This provision of the Final Rule applies to States utilizing the Federal Exchange; among Plaintiff States, those states are Arizona, Delaware, Michigan, Oregon, and Wisconsin.

107. The Final Rule also imposes new pre-enrollment verification requirements pertaining to individuals utilizing these triggering-event SEPs. Specifically, all Exchanges on the federal platform must now verify eligibility for at least 75% of new enrollees utilizing an SEP enrollment pathway before coverage can take effect, and this pre-enrollment verification requirement will apply to all *types* of SEPs—not just the loss of minimum essential coverage, as the prior policy required. Final Rule at 27,079.

108. The Final Rule sunsets this provision after one year—meaning the verification requirements will revert to status quo for Plan Year 2027. Final Rule at 27,151.

109. HHS claims that its analysis shows that the pre-enrollment verification process, which currently applies only to those claiming eligibility due to the loss of minimum essential coverage (MEC), presents no "substantial enrollment barrier." Final Rule at 27,149. HHS reasons that the supposed lack of impact for pre-verification of MEC loss will also extend to consumers claiming eligibility for every other pathway to SEP enrollment. *Id.*

110. There are at least two problems with this line of reasoning. First, HHS has presented insufficient evidence showing that SEP enrollees are harming risk pools through adverse selection or fraudulent enrollments. Second, HHS has inadequately addressed the harm that will befall consumers who are deterred, or wrongly barred, from obtaining health coverage as a result of this rule.

111. As to the first problem, this verification requirement might itself contribute to adverse selection. This is because more motivated individuals—i.e., sicker individuals—are more likely than less motivated individuals to overcome enrollment barriers. As a result, the verification process itself might *worsen* the adverse-selection problem. HHS acknowledges that "verification . . . may deter healthier, less motivated individuals from enrolling." Final Rule at 27,148. However,

Defendants simultaneously assert that they "believe the positive impact of verification on the risk pool far exceeds the potential negative impact on the risk pool." *Id.* Therefore, HHS claims that this change will in fact cause premiums to go *down* because the new verification requirements will prevent ineligible consumers from enrolling.

112. There is a crucial piece missing from this logic: not only has HHS not demonstrated that improper enrollments are in fact occurring, CMS has failed to show that these phantom ineligible enrollees *are in fact more expensive to insure* than eligible consumers. Therefore, HHS has not demonstrated that blocking these improper enrollees—if they even exist—would lower premiums and improve the health of the insurance marketplaces' risk pools.

113. During the comment period, many industry participants submitted evidence showing that SEP and non-SEP enrollees tend to have the same or similar risk scores, meaning they cost roughly the same amount of money to insure. If that is the case, then increasing barriers to enrollment for SEP consumers would harm, not improve, the risk pool. For example, Covered California informed Defendants that "the prospective risk scores for consumers enrolling during SEPs have been consistently equal to or lower than those during the OEP, even during years of flexible SEP policies and the implementation of enhanced federal premium tax credits (PTC)." [CC letter at 4]. As for Washington, "[t]here is no evidence of the type of fraud this proposal is attempting to address."[32] . As for the federal exchange, HHS analyzed this question in the 2023 Payment Notice, 87 Fed. Reg. 27,278, and "scaled back pre-enrollment verification for every SEP type, with the exception of . . . minimum essential coverage," due to recognition that "the extra step required by verification can deter eligible consumers from enrolling in coverage through an SEP, which in turn, can negatively impact the risk pool because younger, often healthier,

[32] Letter from Washington, *supra*, n. 16 at 9.

consumers submit acceptable documentation to verify their SEP eligibility at much lower rates than older consumers." Final Rule at 27,149.

114. As to the second problem, this change will cause harm to consumers. The expansion of the pre-enrollment verification requirements for the remaining SEPs will cause an additional 293,073 SEP verification issues that the consumer will need to rectify before enrolling in coverage, per HHS's estimate. Final Rule at 27,186.

115. The impact on consumers was brushed aside at the rulemaking phase. Defendants claimed during rulemaking, without justification, that a pre-enrollment verification process poses no "substantial enrollment barrier" to people seeking coverage via a triggering-event SEP, despite simultaneously acknowledging that more than one in four SEP enrollees (27%) were unable even to submit documents verifying their eligibility within fourteen days of an SEP verification issue (SVI) being generated. *See* Proposed Rule at 12,983 (73% of SEP enrollees who received an SVI were able to submit documents within fourteen days of the SVI). And only 63 percent were able to fully resolve their SVI within that time, and even after 30 days, 14 percent remained unable to verify. Proposed Rule at 12,983. Overall, more than 75 thousand individuals were blocked from obtaining coverage due to their inability to resolve an SVI in Plan Year 2019. Proposed Rule at 12,983. Still, in Defendants' view, this did not rise to the level of a "substantial" barrier to essential health insurance coverage.

116. Requiring consumers to navigate complex documentation processes, often during times of significant and sudden changes in their personal circumstances, will undoubtedly discourage eligible individuals, including younger and healthier people, from obtaining coverage. This will in turn harm the risk pool, a downside Defendants readily acknowledge. Final Rule at 27,149.

117. This rule change, by Defendants' own admission, could cause over 293,000 would-be enrollees to be blocked from coverage, at an increased cost of over $7 million in 2026. Rule at 27,186-27,187. HHS has provided no estimate of how many of those coverage denials would be in error, and HHS has moreover provided insufficient justification for this severe restriction on marketplace eligibility. Defendants' only justification is that SEP enrollees *might* be abusing the system to obtain coverage, but Defendants failed to show that is in fact happening, cannot estimate its likely prevalence, and cannot even show that the SEP enrollees are more expensive to cover than non-SEP enrollees.

118. Defendants are not even persuaded by their own argument. They are sunsetting this requirement—supposedly essential to prevent fraud—after one year. Plaintiff States could not even comment on this requirement sunsetting after just one year because that was not included in the Proposed Rule. This rule change is arbitrary and capricious and contrary to the purposes of the ACA.

119. Moreover, this change is arbitrary to the extent that it is intended to address fraud because Defendants failed to adequately consider adopting the several changes Plaintiff States proposed during the comment period calibrated to reduce fraud, such as multi-factor authentication.[33] Defendants' only response is that they "are continuing to explore additional operational solutions to further curb improper enrollments, including two-factor verification." Final Rule at 27,147. Nowhere do Defendants acknowledge these myriad solutions that would have effectively blocked improper enrollments without burdening innocent consumers. The Final Rule is arbitrary and capricious due to its failure to consider these reasonable alternatives.

[33] States of California, Massachusetts, New Jersey, et al. Comment Letter (Apr. 11, 2025), at 16, https://www.regulations.gov/comment/CMS-2025-0020-23836 (accessible as download).

D. Ending Acceptance of Self-Attested Projected Household Income for Low-Income Enrollees is Arbitrary

120. Similar to the requirement that Exchanges verify enrollees who claim SEP eligibility, the Final Rule also imposes burdensome verification requirements on the lowest-income enrollees. In both cases, HHS claims that ineligible enrollees are obtaining coverage and APTC for which they are not eligible. In the former case, HHS at least limits the policy change to the Federal platform, where, Defendants concede, the lion's share of improper enrollment occurs. But here, HHS imposes these new verification requirements on all Exchanges—even though, as described below, all of the SBE Plaintiff States are Medicaid-expansion states where the incentive underlying this purported fraud does not exist. Defendants impose an extraordinarily burdensome verification regime upon States that will produce little, or no, benefit, because fraud is not occurring.

121. Prior to the Final Rule, Exchange plans accepted the self-attestation of an enrollee who claimed eligibility by projecting annual household income at or above 100% of the federal poverty level (FPL). This previous self-attestation policy was designed to ensure that the lowest-income enrollees, who are often younger and healthier, are not discouraged from entering the risk pool due to paperwork burdens. The prior policy also recognized the challenges that low-income individuals face in accurately estimating their annual income. Many low-income individuals experience significant fluctuations in their earnings over the course of the year, and it can be especially challenging for such individuals to accurately predict how much they will earn.

122. The Final Rule changes this policy in two ways. First, whenever Internal Revenue Service (IRS) data or other trusted data sources show that a consumer has income below 100% of the FPL (in contrast to what the consumer projected), a "data matching issue" (DMI), described below, will be automatically generated. Second, if the consumer projects income at or above the

FPL, and there is no IRS data available to confirm that, the Exchange must then verify household income using other trusted data sources; if those do not agree with the consumer's projection, then the Exchange must generate a DMI.

123. When a DMI is generated, consumers will have 90 days to track down and submit the necessary paperwork to verify their projected income, with extensions granted on a case-by-case basis. Final Rule at 27,124-25. In the meantime, they can access APTCs and enroll in provisional coverage; after 90 days, if they have not completed the verification process, they may lose APTCs and be disenrolled from coverage. *Id.*

124. These changes will impose enormous paperwork and financial burdens on low-income consumers. Together, these changes will generate an estimated 2.7 million new DMIs—"requiring 2.7 million people, many of whom live just above the FPL, to track down and submit paperwork in order to buy health insurance every year." Exhibit B at 20. Moreover, the vast majority of these DMIs—2.1 million—will be generated because of missing IRS data, which may be due to no fault of the consumer. *Id*.

125. DMIs also create costly and burdensome administrative requirements for SBEs, which are required to receive, process, and determine whether the newly submitted paperwork adequately addresses the issue. The Final Rule estimates that the first type of DMI (with contradictory IRS data) will cost SBEs $12.4 million to receive, review, and verify submitted verification documents and to conduct outreach and determine DMI outcomes for consumers, as well as $14.7 million in one-time costs to update their eligibility systems and perform other technical updates for this change. Final Rule at 27,199. And because this provision, too, is sunsetting at the end of PY2026, Exchanges must incur $14.7 million in costs *again* to undo the

changes required by this Rule. *Id.* ("Exchanges would incur the same one-time costs at the time of sunsetting this policy at the end of 2026").

126. For the second type of DMI (a lack of IRS data), the Final Rule estimates an increase in annual burden costs of approximately $62.8 million for SBEs to receive, review, and verify submitted verification documents as well as: conduct outreach and determine DMI outcomes for consumers; approximate one-time costs of $16.6 million to update their eligibility systems; perform other technical updates for this change, and; another $16.6 million when this provision sunsets. Final Rule at 27,200. Low-income consumers will spend *nearly $67 million* trying to obtain and submit the proper documents in 2026 alone, and 407,000 could lose APTCs entirely based on this DMI (155,000 on SBEs and 252,000 on FFEs and SBE-FPs Federal platform). *Id.*

127. All told, by HHS's estimates, these new paperwork burdens relating to both forms of DMIs will cost consumers and exchanges hundreds of millions of dollars to implement and will result in close to half a million people—"most of whom are likely eligible" for APTCs—losing health coverage because they are unable to submit all the necessary documentation. Exhibit B at 20.

128. In response to several SBEs who voiced concerns about implementation costs, Defendants say only that they "believe that the program integrity gains outweigh the potential costs to State Exchanges," and do not respond at all to one State's concern that they would be entirely unable to implement this provision "due to their State's limits on how they can use Federal tax information." Final Rule at 27,126.

129. Imposing costly and burdensome administrative hurdles will cause younger and healthier consumers to drop out of the marketplace. That inevitable result, in turn, will worsen the

risk pool, cause adverse selection, and ultimately increase premiums for unsubsidized consumers. The Final Rule "acknowledge[s] that income verification can be more challenging for lower-income tax filers due to less consistent employment," but nevertheless asserts that "the [income verification] process does not impose a substantial burden." Final Rule at 27,200. But that evidence-free conclusion "runs counter to the evidence before the agency." *See Motor Vehicle Mfrs. Ass'n of U.S.,* 463 U.S. at 43. It also contradicts HHS's own conclusion that consumers and exchanges will spend hundreds of millions of dollars and hundreds of thousands of hours trying to meet these new requirements, and that almost half a million people will fail to do so. Final Rule at 27,199.

130. The Final Rule claims that enough consumers "are intentionally inflating their incomes" to justify these new requirements. Final Rule at 27,121. The Final Rule points to a Government Accountability Office (GAO) recommendation that CMS verify household incomes "when attested income amounts significantly exceed income amounts reported by IRS or other third-party sources." *Id.* As a preliminary matter, that recommendation would at most justify only the first DMI—based on an actual *contradiction* between self-reported income and IRS-reported income. It would not justify the second DMI (based on the mere absence of data), which would generate more than 75% of new DMIs under this policy change.

131. To support its claim that low-income individuals are improperly inflating their expected income, the Final Rule cites a recent analysis of 2024 open enrollment data. Final Rule at 27,122. Even setting aside the fact that the analysis was produced by a partisan think tank, on its own terms, that analysis pointed to income inflation that purportedly occurred in a handful of non-Medicaid expansion FFE states. *Id*.

132. Only 10 states have declined to expand Medicaid. None of them are plaintiffs in this lawsuit except Wisconsin. Yet this burdensome rule change—aimed at addressing a problem that exists almost nowhere outside of those non-plaintiff States—is being forced upon all states.

133. In states that have accepted the ACA's Medicaid expansion, there is no incentive to inflate incomes for APTC purposes because adults with incomes up to 138% of the FPL are generally eligible for Medicaid. In addition, many Medicaid-expansion states have mechanisms to ensure that Medicaid-eligible clients do not receive APTC. For example, the State of Washington has an integrated eligibility portal, so that those who opt out of Medicaid are barred from APTC eligibility until they provide updated documentation showing they once again qualify for APTC due to a change in income.[34] In fact, the very same think-tank study that CMS cited as justifying this Rule examined Washington enrollment data and "found that Washington Exchange enrollees reporting income between 100% and 150% of the [FPL] represented only 17% of enrollees, well below the 50% benchmark the authors suggest as an indicator of potential fraudulent enrollments for Medicaid expansion states."[35]

134. And as discussed previously, purported fraud in a small subset of States on the federal exchange is no basis to impose new, burdensome requirements on SBEs where there is no allegation that such fraud is widespread. Defendants could have ended self-attestation of projected household income for low-income enrollees in FFE states, just like they imposed the 75% SEP verification requirement only on the FFE states. Or they could have imposed the Final Rule only on States that have not expanded Medicaid. But the Final Rule failed to consider these obvious alternatives that would have narrowly targeted the problematic conduct. At a minimum, the Final

[34] Washington State Health Benefit Exchange, Comment Letter on Proposed Rule (April 11, 2025), at 4, available at https://www.regulations.gov/comment/CMS-2025-0020-24557.

[35] *Id*. at 3.

Rule does not rationally connect the data cited with its sweeping imposition of these new DMI requirements on all exchanges (including SBEs), making it arbitrary and capricious on that basis as well.

135. Moreover, this change is arbitrary to the extent that it is intended to address fraud because Defendants failed to adequately consider adopting the several changes Plaintiff States proposed during the comment period calibrated to reduce fraud, such as multi-factor authentication,[36] or ending self-attestation of projected household income for low-income enrollees in states that have not expanded Medicaid, as commenters urged.[37] Defendants' only response is that they "are continuing to explore additional operational solutions to further curb improper enrollments, including two-factor verification." Final Rule at 27,147. Nowhere do Defendants acknowledge these myriad solutions that would have effectively blocked improper enrollments (committed primarily by unscrupulous brokers) without burdening innocent consumers. The Final Rule is arbitrary and capricious due to its failure to consider these reasonable alternatives.

E. Transitioning to a One-Year FTR Eligibility Window is Arbitrary

136. The ACA awards APTCs to enrollees based on their projected future income. 26 U.S.C. § 36B; 42 U.S.C. § 18082. When the enrollee files income taxes with the IRS the following year, the amount of the APTC award that was claimed is reconciled against eligibility as shown by the tax data. Importantly, HHS does not have access to such data—only the IRS does. *See* Rule at 27,116 ("privacy concerns" prevent HHS from knowing individual FTR status). Under existing law, an enrollee who fails to file taxes and reconcile their claimed award against their actual eligibility—known as failure to file and reconcile, or FTR—for two consecutive years loses

[36] California et al. Comment Letter, *supra* note 13, at 16.
[37] *E.g.*, Washington HBE Comment Letter, *supra* note 23, at 9-10.

eligibility for future APTCs. The Final Rule temporarily ends this policy, imposing a one-year FTR window.[38]

137. Reverting to a one-year FTR grace period rather than a two-year grace period is unlikely to accomplish HHS' stated goal of reducing fraud on the Exchanges, as demonstrated by the fact that many more people receive one-year FTR codes than two-year FTR codes.[39] HHS acknowledges that the availability of enhanced APTCs (eAPTCs) drove fraudulent enrollment in the first place, and further acknowledges that the eAPTCs are expiring at the end of *2025*—yet imposes this change for 2026 anyway, before reverting back to a two-year window once again for 2027. Rule at 27,075.

138. Not only is this change ineffective, it is also harmful. A one-year FTR window risks eligible individuals losing access to APTCs due to administrative errors or paperwork delays. HHS acknowledged during rulemaking that the FTR eligibility check needed to be suspended during the Covid-19 emergency "due to concerns that consumers who had filed and reconciled would lose APTC due to IRS processing delays resulting from IRS processing facility closures and a corresponding processing backlog of paper filings." 90 Fed. Reg. 12,958 (March 19, 2025). Far from theoretical, HHS acknowledged that the IRS backlog during the pandemic "severely impacted the IRS's ability to process tax returns for the 2019, 2020, and 2021 tax years." Rule at 27,114. That concern is especially relevant today, when the Administration may be planning to cut

[38] Underscoring the absurdity, the recently enacted budget reconciliation bill then *re-imposes* this sunsetted FTR provision for plan years 2028 and beyond. *See* Pub. L. 119-21 §§ 71303(a)-(c), 139 Stat. 72, 324 (July 4, 2025) (implementing this provision of the Final Rule with an effective date of January 1, 2028). Thus, over the next few years, Exchanges must change to a one-year FTR window for 2026 (due to the Final Rule), revert to a two-year window for 2027 (due to the Final Rule's sunset provision), and then change *again* to a one-year window for 2028 (due to the legislation).

[39] California et al. Comment Letter, *supra* note 13, at 9.

the IRS in half.[40] Plaintiff States pointed this out during rulemaking,[41] and HHS did not specifically respond to the concern regarding the looming cuts to IRS staffing.

139. Moreover, the compliance costs of this change are significant. HHS estimates one-time costs of $19.4 million borne by the SBEs to update their systems, and then another $19.4 million to revert to the two-year window that will once again be in effect for 2027. Rule at 27,189. Additionally, some states, such as Washington, will struggle severely to create a new one-year FTR window from scratch in a matter of months. But HHS is unmoved. Remarkably, HHS seems not to care that the "majority of State Exchanges expressed in comments that they *could not make the technological changes* to revert back to a 1-year FTR policy in time for OEP 2026," requiring "all exchanges" to "impose a 1-year FTR requirement beginning for PY 2026" regardless of the Exchanges' warnings that compliance on this timeline is impossible. *See* Rule at 27,199 (emphasis added).

F. Allowing Plans to Deny Coverage for Those Who Owe Past-Due Premiums from Previous Policies is Unlawful and Arbitrary

140. The Final Rule allows—but does not require—insurance plans to decline to issue coverage to eligible applicants who owe a past-due premium of any amount, from any previous coverage year, even if the applicant pays the first-month premium for the coverage period for which they are eligible. Rule at 27,077. If an insurance plan intends to deny an applicant on this basis, inexplicably, the Final Rule does not require the plan to tell applicants about this policy and that they may be denied new coverage if they cannot also pay past-due premiums for old coverage.

141. The ACA requires "each health insurance issuer that offers health insurance coverage in the individual or group market in a State" to "accept every employer and individual in

[40] Fatima Hussein, *The IRS is drafting plans to cut as much as half of its 90,000-person workforce, AP sources say*, Associated Press (March 4, 2025), https://tinyurl.com/m58czdjb.

[41] California et al. Comment Letter, *supra* note 13, at 9.

the State that applies for such coverage," subject to certain exceptions. 42 U.S.C. § 300gg-1. This is known as the "guaranteed issue" provision. No exception allows an insurer to deny new coverage to an otherwise eligible individual who owes a past-due premium from a prior period of coverage.

142. Insurers, just like any other vendor of goods and services, can pursue collections in the event of nonpayment, and can terminate coverage after a grace period for failure to pay a premium. But the text of the ACA does not allow an insurer to deny coverage to otherwise eligible new enrollees who pay their first-month premium, and insurers are forbidden from attributing payment of a new premium to a past-due premium for prior coverage; in other words, insurers cannot deny coverage to new enrollees who owe past-due premiums from prior coverage, so long as the enrollee pays the new premium. *See* 42 U.S.C. § 300gg-1.

143. This Final Rule change is likely to cause confusion among consumers. Consider an individual who can no longer afford premiums and stops paying, understanding and fully accepting that this means his coverage will terminate. What he may not understand is that, even after he stops paying, he falls into a "grace period" during which his insurer must still cover him if he pays his premium. *See* Rule at 27,085. If he does not pay his premium, that grace period *still counts* as a period for which a premium is outstanding—even if he did not utilize any healthcare during the grace period and may not even realize he is still covered. Later, when his finances recover and he attempts to re-enroll, he will be barred from doing so unless he is able to pay his new premium and the grace period premium. And moreover, under the Final Rule, he may never understand why he owes so much for new coverage because the insurer will not even be required to tell him about this new policy. Had he known, he could have tried to enroll with a different insurance plan. Instead, he might go without coverage.

144. The Final Rule is likely to harm the risk pool, because the people most likely to be denied coverage as a result of this Rule are younger, healthier, and less wealthy enrollees. As explained above, several commenters pointed out, and Defendants acknowledge, that "less healthy individuals would be most likely" to overcome barriers to enrollment—meaning that each additional barrier risks contributing to adverse selection, harming the risk pool. *See* Rule at 27,090.

145. This provision is contrary to the ACA, and is therefore unlawful.

146. It is also arbitrary and capricious insofar as the Department has not provided any evidence for its assertion that any discouragement from enrolling as a result of this change "would be minimal." Rule at 27,087.

G. HHS's Changes to the Premium Adjustment Percentage Methodology are Arbitrary

147. Section 1302(c)(4) of the ACA directs the Secretary to determine an annual premium adjustment percentage, a measure of premium growth that is used to set the rate of increase for three parameters: (1) the maximum annual limitation on cost sharing (section 1302(c)(1) of the ACA); (2) the required contribution percentage used to determine whether an individual can afford minimum essential coverage (MEC) (section 5000A of the Internal Revenue Code of 1986 (the Code), as enacted by section 1501 of the ACA); and (3) the employer shared responsibility payment amounts (section 4980H of the Code, as enacted by section 1513 of the ACA). 42 U.S.C. § 18022(c). Cost-sharing includes copays, coinsurance, and deductibles due from the enrollee over the plan year. *Id*.

148. Each of these values are adjusted in reference to a measure of premium inflation called the annual premium adjustment percentage, which is set by the HHS Secretary each year. *Id*. In addition, the IRS uses the premium adjustment percentage when determining individuals' expected contributions and thus the amount of APTC the enrollee will receive. Accordingly, even

small changes in the way the premium adjustment percentage is calculated can have large effects on both out-of-pocket costs and the amount of APTC an enrollee is entitled to receive.

149. For many years, HHS policy recognized that the premium adjustment methodology needed to be price-stable to reduce volatility and keep premiums from spiking. Under that prior policy, the adjustment methodology looked to a biannual measure of premium inflation that is based on the employer-sponsored insurance (ESI) market. The Final Rule changes the premium adjustment methodology to include consideration of premium changes in the individual market, in addition to premium changes in the ESI market. Rule at 27,166-73. Under the Final Rule, CMS would consider individual market premiums going back to 2013, before the ACA was in effect. *Id*. at 27,167.

150. The premium adjustment percentage is intended to measure underlying trends in health insurance premiums. Including the more price-volatile individual market premiums in the measure of inflation will harm consumers by significantly increasing premium contributions for those who qualify for premium tax credits for Exchange coverage and allowing higher out-of-pocket costs (including for the 160 million Americans with employer-based insurance).[42]

151. First, this change will cause the amount that consumers pay towards premiums to rise. By including consideration of inflation in the individual market, the premium adjustment percentage in 2026 will be about 4.5 percent higher than under the previous methodology. That means that the consumer's share of premiums for the APTC benchmark silver plan in 2026 will be about 4.5 percent higher than under the prior methodology on account of this change. That is

[42] *See* The Origins and Growth of Employer-Provided Insurance | U.S. Chamber of Commerce.

substantial. For a family of four making $85,000 a year, this change will result in an annual premium increase of $313.[43]

152. Second, this change will directly cause out-of-pocket costs to rise significantly. According to the Final Rule, applying this new premium adjustment percentage in 2026 will cause "approximately a 15.2 percent increase [in the annual limitation on cost-sharing] from the [Plan Year] PY 2025 parameters of $9,200 for self-only coverage and $18,400 for other than self-only coverage." Rule at 12,993. That is an increase of $1400 for self-only coverage and $2800 for all other coverage. *Id*. Many commenters explained to HHS that this would threaten the affordability of healthcare coverage for many consumers. "[T]his change would expose a typical family to an additional $900 in cost-sharing and $313 in premiums annually." Exhibit B at 3. "[T]he proposed escalation of out-of-pocket costs directly threatens the affordability of essential health coverage, particularly for individuals already struggling to manage healthcare expenses." Exhibit A at 9.

153. HHS openly acknowledges these detrimental effects. HHS stated during rulemaking that this change will "result in a higher maximum annual limitation on cost sharing, higher reduced annual limitations on cost sharing, a higher required contribution percentage, and higher employer shared responsibility payment amounts than if the current premium adjustment percentage premium measure (ESI only) were used for PY 2026." Proposed Rule at 12,992. HHS further acknowledged that this change will "increase the portion of the premium the consumer is responsible for paying and therefore would decrease the amount of APTC for which consumers qualify." *Id*. at 12,993. But the Final Rule does not address how this change is consistent with Congress's goal of expanding coverage and affordability. *See Nat'l Fed'n of Indep. Bus. v.*

[43] *See* Proposed ACA Marketplace Rule Would Raise Health Care Costs for Millions of Families | Center on Budget and Policy Priorities at Table 2.

Sebelius, 567 U.S. 519, 538 (2012) (Congress enacted the ACA to "increase the number of Americans covered by health insurance and decrease the cost of health care.").

154. Other commenters pointed out that, "because the premium adjustment percentage is a cumulative measure," the high price volatility of the individual market in the early post-ACA years will skew the growth measure if incorporated into the calculation. Rule at 27,173. Defendants acknowledge this but assert that the effect of the skew diminishes over time as the skewed years become a smaller proportion of the total number of elapsed years since 2013. *Id*. However, Defendants provide no data or analysis quantifying this effect on premium growth.

155. Although the ACA requires using 2013 as the comparator year when calculating the premium adjustment percentage, *see* 42 U.S.C. § 18022(c)(4), HHS is not required to consider the more price-volatile individual market, and has historically only considered the employer-sponsored insurance market because it is more price-stable. Indeed, in rulemaking, HHS acknowledged that "between 2015 and 2018, private individual health insurance market per enrollee premiums offered on-Exchange grew faster than [employer-sponsored insurance] premiums, most notably in PY 2017 and PY 2018." Proposed Rule at 12,992. For this reason, commenters during rulemaking informed HHS of their concern that "looking at individual market premiums back to 2013 artificially inflates premium growth over time." Exhibit B at 3. Factoring in those non-representative premiums into the premium adjustment percentage is not "reasonable and reasonably explained." *Fed. Commc'ns Comm'n v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021).

156. Moreover, the changes to the premium adjustment percentage methodology squarely undermines Congress' twin goals of expanding access to healthcare and making it more affordable. *See Sebelius*, 567 U.S. at 538 (Congress enacted the ACA to "increase the number of

Americans covered by health insurance and decrease the cost of health care."). Although this change knowingly reduces enrollment and sharply increases premiums and cost-sharing, HHS claims that "making coverage more accessible and affordable" is an improper "policy objective[]." Proposed Rule at 12,990. HHS, by its own admission, has acted contrary to the ACA, and may not cast aside Congressional intent and replace statutory objectives with different policy goals. *See Indep. U.S. Tanker Owners Comm. v. Dole*, 809 F.2d 847, 854 (D.C. Cir. 1987).

157. Finally, tens of millions of healthcare consumers have also relied on HHS to keep healthcare premiums and out-of-pocket costs from rising too quickly, and this change completely disregards those reliance interests by imposing a 15.2% increase in the annual cost-sharing limit. *See Dep't of Homeland Sec. v. Regents of the Univ. of California*, 591 U.S. 236, 259 (2020) (When an agency changes course, it must "be cognizant that longstanding policies may have engendered serious reliance interests that must be taken into account.) (internal citations omitted).

158. These revisions are contrary to the purposes of the ACA, and are arbitrary and capricious.

H. Expanding the Acceptable Actuarial Value Ranges for Health Plans is Arbitrary

159. Plans sold on the exchanges fall into bronze, silver, gold, and platinum tiers based on their actuarial value (AV), or the percentage of an average consumer's expected health care expenses will be paid by the plan. Section 1302(d)(1) of the ACA requires an AV of: 60 percent for bronze plans, 70 percent for silver plans, 80 percent for gold plans, and 90 percent for platinum plans. 42 U.S.C. § 18022(d)(1). Higher-tier plans typically have higher premiums and lower out-of-pocket costs, whereas lower-tier plans have lower premiums and higher out-of-pocket costs.

160. The ACA also directs CMS to define a range of accepted *de minimis* variation "to account for differences in actuarial value estimates." 42 U.S.C. § 18022(d)(3). Initially, the *de*

minimis AV range for all plans was small, requiring most plans to fall within +2/-2 or +2/-0 percentage points. *See* 78 Fed. Reg. 12,834, 12,851 (Feb. 25, 2013). The narrow range ensured that "consumers can easily compare plans of similar generosity," while providing issuers with flexibility to set "simple and competitive" cost-sharing rates. *Id.*

161. In the 2018 Payment Notice, CMS expanded the range to +5/-2 percentage points specifically for expanded bronze plans, which are bronze plans that cover at least one major service, other than preventive services, before the deductible is met with reasonable cost-sharing rates or qualify as a high deductible health plan. 2018 Payment Notice, 81 Fed. Reg. 94,058, 94,142 (Dec. 22, 2016). The change promoted flexibility and specifically ensured that bronze plans "remain[ed] as generous as catastrophic plans." *Id.*

162. From 2018 to 2022, CMS expanded the *de minimis* actuarial value ranges to +2/-4 percentage points for standard bronze, silver, gold, and platinum plans and +5/-4 percentage points for expanded bronze plans, 82 Fed. Reg. 18,346, 18,368-18,369 (Apr. 18, 2017), before reverting back to the narrower ranges in the 2023 Payment Notice. In the 2023 Payment Notice, CMS concluded that the wider ranges undermined consumers' ability to meaningfully compare plans. 87 Fed. Reg. 27,307, 27,310 (May 6, 2022). In particular, CMS was concerned about consumers' ability "to distinguish the level of coverage between bronze plans and silver plans" under the wider ranges, given "significantly different cost sharing" offered by each tier. *Id*. at 27,306 (noting "generally a 10-percentage point difference in median coinsurance . . . between expanded bronze and base silver plans offered on Heathcare.gov.").

163. The *de minimis* AV range for individual silver market plans also influences the generosity of APTC because the APTC benchmark plan is the second lowest cost silver plan in the market. *See* 81 Fed. Reg. 94,058, 94,144; 87 Fed. Reg. 27,208, 27,276 (May 6, 2022). Beginning

in plan year 2023, CMS set the *de minimis* AV range for individual market silver plans at +2/-0 percentage points "to achieve the compelling policy interest of addressing the rising cost of health insurance premiums by influencing the generosity of the [second lowest cost silver plan]." 87 Fed. Reg. 27,208, 27,309.

164. Now the Final Rule reverses course, significantly expanding the *de minimis* AV range for expanded bronze plans to +5/-4 percentage points and +2/-4 percentage points for standard bronze, silver, gold, and platinum.

165. Allowing plans to undershoot AV requirements by four percentage points decreases the level of coverage offered by these plans, which increases consumers' out-of-pocket costs. By allowing less generous plans within each metal tier, the Final Rule's expanded AV ranges undermine consumer choice, by decreasing the differences between metal tiers, and reduce affordability, by increasing out-of-pocket costs and premiums. As a result, these expanded *de minimis* ranges will lead to higher costs for most individuals enrolled on exchanges.

166. The Final Rule recognizes that wider AV ranges will decrease APTCs by $1.22 billion in 2026 (and more in each subsequent year) because the APTC benchmark plan, the second lowest cost silver plan in the market, can now undershoot the 70% AV requirement by an additional 4 percentage points. Rule at 27,208.

167. The Final Rule will damage risk pools by increasing costs for subsidized enrollees. Decreased APTCs increase costs for subsidized enrollees because they must either purchase less generous coverage and incur higher out-of-pocket expenses or pay higher net premiums for comparable coverage. Subsidized enrollees make up the majority of the risk pool, and healthier individuals are more likely to drop the health insurance due to an increase in premiums.

168. As a result, less healthy risk pools will increase gross premiums for unsubsidized enrollees as well because healthier subsidized enrollees drop their coverage due to increased premiums.

169. The Final Rule claims that the prior ranges "substantially reduce[d] issuer flexibility" and that issuers "voiced concern about their ability to continue to participate in the market generally." Rule at 27,175. But the Final Rule offers no empirical support for these assertions, and the record shows issuer participation in the ACA marketplaces increased under the prior policy, starting at an average of 9.2 issuers in 2022 under the wider ranges and then increasing to an average of 9.4 issuers in 2023 and 9.6 issuers in 2024 under the narrower AV ranges. *See* Jason Levitis et al., Comment Letter on Proposed Rule (Apr. 11, 2025), at 5, available at https://www.regulations.gov/comment/CMS-2025-0020-25047 (attachments) (Levitis et al. Comment Letter). Commenters also noted that existing issuers also expanded their service areas under the narrower ranges. *See id.* Because the explanation for broadening the AV range "runs counter to the evidence before the agency," the Final Rule's decision to change the *de minimis* AV range is arbitrary and capricious. *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

170. The Final Rule also asserts that the wider *de minimis* AV ranges will improve the risk pool by attracting unsubsidized enrollee participation with lowered premiums. Rule at 27,175. Yet commenters emphasized that any decrease in premiums comes at the expense of more generous coverage. *See* Levitis et al. Comment Letter 13. The Final Rule does not meaningfully explain why less generous plans with lower premiums will attract unsubsidized consumers, given that lower metal tier plans already offer these options.

171. The Final Rule also fails to consider whether wider AV ranges will have the opposite effect of increasing gross premiums for unsubsidized enrollees, eliminating any purported benefit on risk pools. HHS accepted commenters' prediction of "some initial weakening of the risk pool," caused by healthier subsidized enrollees "drop[ping] coverage when net premiums rise," Rule at 27,177, and the likely effect of weakened risk pools is increased gross premiums for unsubsidized enrollees. See Levitis et al. Comment Letter 5 (explaining how increased net premiums caused by decreased APTCs will "lead to a smaller, sicker Marketplace risk pool"). By making coverage less affordable for both subsidized and unsubsidized enrollees, the wider AV ranges will further deter unsubsidized enrollees participation, undermining the Final Rule's stated aims.

III. The Final Rule's Elimination of "Sex-Trait Modification Procedures" as an Essential Health Benefit Is Unlawful.

A. The Final Rule Excludes Medically Necessary Treatment of Gender Dysphoria from EHBs

172. The Final Rule provides that "[f]or plan years beginning on any day in calendar year 2026" a plan issuer "may not include . . . specified sex-trait modification procedures (as defined at § 156.400) as EHB." Rule at 27,223.

173. The Final Rule defines "sex-trait modification procedure" as:

> any pharmaceutical or surgical intervention that is provided for the purpose of attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex either by:
>
> (1) Intentionally disrupting or suppressing the normal development of natural biological functions, including primary or secondary sex-based traits; or
>
> (2) Intentionally altering an individual's physical appearance or body, including amputating, minimizing or destroying primary or secondary sex-based traits such as the sexual and reproductive organs.
>
> (3) This term does not include procedures undertaken:

> (i) To treat a person with a medically verifiable disorder of sexual development; or
>
> (ii) For purposes other than attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex.

Rule at 27,223.

174. The novel definition adopted by the Final Rule requires providers to look to the "purpose" for which a service is sought in order to determine whether a service is or is not an EHB. This is contrary to the statutory method of establishing EHB as a set of categorically defined benefits, such as emergency services, hospitalization, or prescription drugs. 42 U.S.C. § 18022(b)(1). Under the Final Rule, instead of covering "generic prescription drugs," a provider would have to parse whether that service is intended "to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex."

175. Notably, the only individuals who might seek services with the express purpose of aligning their gender identity and their body, and their gender identity differs from their sex, are transgender individuals.

176. The Final Rule claims that the reason for the exclusion of any "sex-trait modification procedure" from EHBs is that "such benefits are not covered under typical employer plans." Rule at 27,158.

177. The Final Rule notes that Section 1302(b)(2)(A) of the ACA directs that the scope of the EHB "be equal in scope to the benefits provided under a typical employer plan and that they include at least the 10 general categories outlined in the statute and the items and services covered within those categories." Rule at 27,152.

178. In doing so, the Final Rule adds "sex-trait modification procedures" to the very limited number of services that have been specifically excluded from EHBs noted within the Final

Rule itself: non-pediatric dental or eye exam services, long-term/custodial nursing care, and non-medically necessary orthodontia. Rule at 27,223.[44]

179. But, unlike the other listed services, the Final Rule prohibits insurers from covering certain treatments as EHBs only if those services are "provided to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex." Rule at 27,223.

180. The Final Rule does not prohibit the same treatment if it is offered (i) to treat a person with a medically verifiable disorder of sexual development, or (ii) for purposes other than attempting to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex. Rule at 27,223-24.

181. For example, puberty-delaying medication is commonly used to treat precocious puberty, the premature initiation of puberty by the central nervous system. If left untreated, precocious puberty may lead to negative impacts, including psychosocial issues[45] and impairment of final adult height.[46] The Final Rule allows plan issuers to cover as an EHB the use of hormone agonist medication for the treatment of precocious puberty or cancer, *see* Rule at 27,159, but prohibits EHB coverage of the same treatment when prescribed as medically necessary to treat gender dysphoria, *see* Rule at 27,223-24.

B. The Exclusion of "Sex-Trait Modification Procedures" from EHBs Is Unlawful

a. The Final Rule is Contrary to Law

[44] For plan years beginning on or after January 1, 2027, an issuer of a plan offering EHB may not include routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as EHB.

[45] Kirsten Weir, *The risks of earlier puberty*, American Psychological Association: Monitor on Psychology (Mar. 2016), https://www.apa.org/monitor/2016/03/puberty.

[46] Jean-Claude Carel, *Precocious puberty and structural growth*, National Institute of Health (Mar. 2004), https://pubmed.ncbi.nlm.nih.gov/15073143/.

182. The ACA requires that the HHS Secretary ensure that the scope of EHBs "is equal to the scope of benefits provided under a typical employer plan." 42 U.S.C. § 18022(b)(2)(A).

183. To determine typicality, the ACA requires Labor Secretary to conduct a survey of employer-sponsored coverage "to determine the benefits typically covered by employers" so as to "inform" the HHS Secretary's determination of what is "typical." 42 U.S.C. § 18022(b)(2)(A).

184. In December 2011, in anticipation of the ACA's EHB provisions becoming effective, HHS determined for the first time what benefits are typically covered by employers. In doing so, it considered a Department of Labor survey,[47] recommendations from the Institute of Medicine (IOM), and public input. Based on that information, HHS issued agency guidance. *See* CMS, Ctr. for Consumer Information & Oversight, "Essential Health Benefits Bulletin" (Dec. 16, 2011) (2011 CMS Bulletin).

185. HHS failed to conduct such a study before drafting the Final Rule that changed the scope of EHBs, violating its statutory mandate.

186. Moreover, the ACA mandates that in "revising [EHB] the Secretary shall submit a report to the appropriate committees of Congress," presumably premised on renewed reports by DOL based on "a survey of employer-sponsored coverage." 42 U.S.C. § 18022(a)(2). HHS did not conduct or consider a new DOL report in excluding treatment for gender dysphoria from EHB.

b. HHS's Exclusion of "Sex Trait Modification Procedures" is Arbitrary and Capricious

[47] The Department of Labor (DOL) released that survey of employer-sponsored plans, which included those of large and small employers, on April 15, 2011. *See* "Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services" (Apr. 15, 2011), https://www.bls.gov/ebs/additional-resources/selected-medical-benefits-a-report-from-dol-to-hhs.pdf. The survey used 2008 and 2009 National Compensation Survey data. Essential Health Benefits Bulletin (p. 2). This 2011 DOL survey was the first and last completed in accordance with 42 U.S.C. §18022(b)(2).

187. The Final Rule unlawfully and unreasonably eliminates any "sex-trait modification procedure" from EHBs, which includes many forms of medically necessary treatment for gender dysphoria.

188. HHS claims that its approach is a reasonable way to comply with its statutory mandate to ensure that the scope of EHBs "is equal to the scope of benefits provided under a typical employer plan," *see* 42 U.S.C. § 18022(b)(2)(A), but this claim does not withstand even the slightest scrutiny.

189. *First*, HHS diverges without good reason, *see FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009), from its settled policy of determining on a state-by-state basis (*not* on a uniform national basis) what benefits may be included in a state's benchmark plan, based on the benefits provided under a "typical" employer plan in each state. And HHS does so without even considering and addressing the significant reliance interests of states. *See Regents of the Univ. of Cal.*, 591 U.S. at 33.

190. *Second*, even taken on its own terms, HHS's explanation of what benefits are covered under a "typical" employer plan inexplicably "runs counter to the evidence before the agency." *State Farm*, 463 U.S. at 43.

191. *Third*, HHS failed to take statutorily required steps in redefining EHBs that would have provided additional evidence that coverage of medically necessary treatments for transgender individuals is more common than shown by the limited data set used by HHS in drafting the Final Rule.

192. The Final Rule arbitrarily diverges from the longstanding approach of determining a "typical" employer plan on a state-by-state basis.

193. In its 2011 guidance setting out the contents of EHBs, HHS announced its commitment to "State flexibility" and clarified that assessing the contents of a "typical employer plan" is a state-specific inquiry. *See* 2011 CMS Bulletin at 9.

194. Consequently, the process by which each state fills in the details of the ten statutory EHB categories has always been in the form of a benchmark plan "reflecting both the scope of services and any limits offered by a 'typical employer plan' *in that state* as required by Section 1302(b)(2)(A) of the [ACA]." *Id.* at 8 (emphasis added).

195. HHS confirmed in its 2013 rule on EHBs that "typical employer plans differ by state" and that the EHB benchmark system allows "states [to] continue to maintain their traditional role in defining the scope of insurance benefits and may exercise that authority by selecting a plan that reflects the benefit priorities *of that state*." *ACA; Standards Related to EHBs, Actuarial Value, and Accreditation*, 78 Fed. Reg. 12,834, 12,843 (Feb. 25, 2013) (emphasis added).

196. HHS has consistently updated marketplace rules to enhance state flexibility. *See, e.g.,* 83 F.R. 16,930, 16,931 (adopting rule to "provide[] States with additional flexibility in applying the definition of EHBs to their markets" allowing "States to modify EHBs to increase affordability of health insurance in the individual and small group markets"). In the Plaintiff States that expressly *prohibit* insurers from excluding or denying coverage and claims based on a consumer's gender identity, every fully insured employer plan, regardless of employer size, *must cover* medically necessary care for the treatment of gender dysphoria.[48]

[48] *See* Movement Advancement Project, Healthcare Laws and Policies: Private Insurance Nondiscrimination Laws, Bans on Exclusions of Transgender Health Care, and Related Policies (Apr. 26, 2024), https://tinyurl.com/39h489an. The Final Rule relies on EDGE data to assess whether gender-affirming care is covered by the typical employer plan. Rule at 27,155 ("[W]e believe these data reflect the coverage experiences of consumers receiving coverage through the small business health options program (SHOP), which we believe to be more reflective of the

197. Considering the established state-by-state approach to EHBs and state prohibitions on excluding or denying this coverage, it is beyond dispute that the "typical" employer plan in each Plaintiff State provides coverage for medically necessary treatments of gender dysphoria, services that likely fall within the definition of "sex-trait modification." As such, CMS's decision to exclude this care in Plaintiff States—purportedly to match "the scope of benefits provided under a typical employer plan," Final Rule at 27,163—is inconsistent and wholly capricious.

198. Although the Final Rule acknowledges that in defining typicality HHS "relied on and represented [insurance coverage data from the Movement Advancement Project (MAP)] and that [said data] represent a sound statistical basis to inform [the Final Rule]," Rule at 27,155. HHS did not consider the most salient aspect of this MAP data:[49] that is, twenty-four (24) states—including Plaintiff States—explicitly *cover* gender-affirming care as part of their state employee health insurance package.

199. Therefore, the Final Rule not only "entirely fail[s] to consider an important aspect of the problem," *State Farm*, 463 U.S. at 43, it also squarely conflicts with HHS's longstanding and settled policy of State flexibility, providing no good reason for that drastic change, *Fox*, 556 U.S. at 515.

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coverage typically provided by the majority of employers, which are significantly smaller than those employers surveyed by, for example, the Corporate Equity Index or KFF."). SHOP plans are fully insured, which means that SHOP plans in each Plaintiff State cover gender-affirming care. Notably, the Final Rule does not even evaluate SHOP plans; rather, it uses enrollment and claims data from a variety of plans to make an assertion about SHOP plans specifically.

[49] MAP provides tables describing the prevalence of state antidiscrimination laws and the "state laws or administrative policies which explicitly include, explicitly exclude, or have no clear policy covering transition-related or gender-affirming care for transgender people who are state employees as part of their state employee health benefits." https://www.lgbtmap.org/equality-maps/healthcare_laws_and_policies.

200. The Final Rule effects this drastic change while failing to consider or address the significant reliance interests of SBEs. *See Regents of the Univ. of Cal.*, 591 U.S. at 33.

201. States have selected their EHB benchmark plans to best reflect the coverage and benefits typical to each state's insurance market, including coverage that complies with state-based legal requirements, including nondiscrimination protections, and state-specific conditions. HHS's abrupt decision to exclude services from EHBs nationwide *on the very basis of gender identity* is highly disruptive, interferes with the States' ability to regulate healthcare, and will force states to re-evaluate their benchmark plans.

202. Five states explicitly include certain gender-affirming care in their benchmark plans. *See* Rule at 27,154 n.196 ("The EHB-benchmark plans for California, Colorado, New Mexico, Vermont, and Washington specifically include coverage of some sex-trait modification.").

203. For those states that do not explicitly include gender-affirming care in their benchmark plans, but that otherwise require coverage of this care through state anti-discrimination mandates, they will be subject to defrayal costs pursuant to §155.170, and will separately be forced to analyze and exclude care that would have previously been eligible for treatment as an EHB, such as surgery or medication, from that category. The Final Rule acknowledges as much: "if any State separately mandates coverage for sex-trait modification outside of its EHB-benchmark plan, the State would be required to defray the cost of that State mandated benefit as it would be considered in addition to EHB." Rule at 27,154.

204. States could not have reasonably anticipated such a nationwide restriction in part because gender-affirming care is not a stand-alone category of health care and rather spans nearly every mandatory category of EHBs, including emergency services, hospitalization, mental health

and substance use disorders services, prescription drugs, laboratory services, preventive and wellness services, and pediatric services. Further, HHS previously affirmed that this coverage is consistent with the "typical" employer plan in a state. Rule at 27,154 (EHB benchmark plans for five states include medically necessary treatment for gender dysphoria).

205. Because the Final Rule applies the exclusion to PY 2026, states must finalize these changes in under two months, though many states have already adopted benchmark plans under prior HHS guidelines.

206. Rather than continue to allow the scope of EHBs to be determined on a state-by-state basis as contemplated by the ACA and HHS's regulations, the Final Rule tries to dictate nationwide what has since its inception been, and been understood as, a state-by-state process. *See* 78 Fed. Reg. at 12,841 ("The benchmark plan options for each state reflect the scope of benefits and services typically offered in the employer market *in that state*. This approach meets the statutory requirement that EHB reflect a typical employer plan as well as the recommendation provided by the IOM on the approach to defining EHB." (emphasis added)).

207. HHS was required to at least consider the states' significant reliance interests when imposing such a profound change in approach, and HHS's failure to do so is arbitrary and capricious. *Regents of the Univ. of Cal.*, 591 U.S. at 33 (where agency is "'not writing on a blank slate,' it [i]s required to assess whether there were reliance interests, determine whether they were significant, and weigh any such interests against competing policy concerns" (citation omitted)).

208. Even on its own terms, HHS's purported finding that a typical employer plan does not cover gender-affirming care is contradicted by the very evidence before the agency, rendering the Final Rule arbitrary. *State Farm*, 463 U.S. at 43.

209. As detailed above, HHS relied on MAP data, which shows that 24 states explicitly require coverage of gender-affirming care by state employee health benefit plans, as compared to 14 states that exclude coverage.

210. When compared to other services HHS has determined qualify as EHB, the level of coverage for gender-affirming care is sufficiently "typical" even on a nationwide basis. By way of comparison, HHS's 2011 determination of EHBs was informed by the Department of Labor's dataset, which revealed that only 27 percent of plans surveyed offered coverage for infertility treatments.[50] Yet HHS did not exclude coverage for infertility treatment services on the basis that they were not part of a typical employer plan under 42 U.S.C. § 18022(b)(2)(A).

211. The Final Rule fails to explain why it is holding gender-affirming care to a different and higher standard than it held infertility treatments, though both are medically necessary, leading to the logical conclusion that the exclusion of gender-affirming care from EHBs is arbitrary and capricious.

212. Further evidencing its untenable rationale, HHS's Final Rule cherry-picks from nationwide data, disregarding without meaningful explanation the evidence that undercuts the premise for its regulatory action.

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[50] "Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services" (Apr. 15, 2011), https://www.bls.gov/ebs/additional-resources/selected-medical-benefits-a-report-from-dol-to-hhs.pdf. In order to assess employer-sponsored coverage for the report, DOL drew on data from the Bureau of Labor Statistics (BLS). *Id.* DOL not only reviewed the BLS National Compensation Survey, which captured data from approximately 36,000 employers, but also a BLS analysis of 3,900 private sector plans to assess "detailed provisions of employment-based health care benefits." *Id.* BLS analyzed plan documents requested from those 3,900 private sector plans to evaluate existing coverage for treatments for conditions like infertility; BLS found that, of all of the private sector plans, only 27 percent covered infertility treatments (meaning, covered diagnosis *and* treatment). Overall, 47 percent of assessed plan documents mentioned infertility treatments, and 60 percent of those that mentioned infertility treatments covered more than a diagnosis. *Id.*

213. Employer plans are the predominant source of healthcare coverage in the United States, and a substantial number of them offer gender-affirming care coverage. A significant proportion of American workers with employer healthcare plans have coverage for gender transition services, and this number has grown over time. According to the Human Rights Campaign's Corporate Equality Index 2025 Report, 72 percent of Fortune 500 companies offer "transgender-inclusive healthcare benefits," which includes hormone therapies, surgeries, and mental health care, up from 0 percent in 2002. [51]

214. A 2024 survey run by the Kaiser Family Foundation (KFF) found that 50 percent of companies with 5,000 or more workers certified that they specifically cover gender-affirming hormone therapy. A little less than half of all workers covered by employer plans in the United States (43 percent) work for companies with 5,000 or more workers. Even after broadening to all large employers (companies with 200 or more workers that offer health benefits), which employ over 72 percent of American workers with job-based coverage, around one fourth (24 percent) stated that they explicitly cover gender-affirming hormone therapy.[52]

215. The analogous KFF survey from 2023 reported similar findings regarding employer coverage for gender-affirming surgery. Over 60 percent of companies with 5,000 or more workers stated that they provide coverage for gender-affirming surgery; 12 percent were unsure about whether they provide the same coverage. As was the case with employer coverage for gender-affirming hormone therapies, a little less than one fourth (23 percent) of all large employers, with

[51] Human Rights Campaign Foundation, Corporate Equality Index 2025: Rating Workplaces on Lesbian, Gay Bisexual, Transgender and Queer Equality (Jan. 2025), https://tinyurl.com/53dwc7mb.

[52] Kaiser Family Foundation, 2024 Employer Health Benefits Survey (Oct. 9, 2024), https://tinyurl.com/46t4msuh.

200 or more workers, were certain that they explicitly cover gender-affirming surgery. Forty percent did not know whether offered health benefits included such surgery.[53]

216. The Final Rule rejects data proving that the vast majority of Fortune 500 companies and that a substantial number of companies of all sizes cover medically necessary treatments for transgender individuals on the basis that the typicality analysis should focus solely on small employers, not large employer plans, even though the latter plans cover more Americans.[54] *See* Rule at 27,154-55. Once again, this approach is a sharp divergence from how HHS has approached these issues until now.

217. HHS's 2011 analysis of DOL survey data, for example, examined benefits offered by plans of all sizes,[55] and the CMS's December 2011 Essential Health Benefits Bulletin explained that, in trying to define "typical," HHS "gathered benefit information on large employer plans (which account for the majority of employer plan enrollees)" as well as "small employer products (which account for the majority of employer plans), and plans offered to public employees." 2011

[53] Kaiser Family Foundation, 2023 Employer Health Benefits Survey (Oct. 18, 2023), https://tinyurl.com/2mshf4hz.

[54] HHS tries to dismiss this data by suggesting, without evidence, that "very large employers also receive more pressure from advocacy organizations to cover sex-trait modification procedures and, therefore, likely do not represent the typical employer to the degree a portion respond to this pressure." 90 F.R. 27074 at 27155. HHS suggests that the "voluntary participation" of employers in that survey "suggests these employers do not represent the typical employer and, instead, align with the advocacy organization's views." *Id*. However, HHS misunderstands that survey data on employer benefits is typically based on voluntary participation. *See, e.g.*, Kaiser Family Foundation, *2024 Employer Health Benefits Survey*, (Oct. 9, 2024), https://www.kff.org/health-costs/report/2024-employer-health-benefits-survey/. If HHS wanted to commission its own survey or analysis—as it did through an extensive process before issuing guidance in 2011—it could have. But the agency cannot use its own failure to thoroughly investigate this issue to dismiss evidence submitted by commenters that its policies are capricious.

[55] *See* "Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services" (Apr. 15, 2011), https://www.bls.gov/ebs/additional-resources/selected-medical-benefits-a-report-from-dol-to-hhs.pdf. As stated above, this was the first and last DOL report on the contents of typical employer plans.

CMS Bulletin at 3-4. While the Bulletin expressed that HHS's "intended approach to EHB incorporates plans typically offered by small employers," it clarified that the approach also "incorporates . . . benefits that are covered *across the current employer marketplace*" – those covered by plans of all sizes. 2011 CMS Bulletin at 8 (emphasis added). This underscores the importance of the state-by-state approach—disregarded here by HHS—which provides the most accurate picture of the benefits covered in the employer marketplace in each state.

218. Further, in asserting that small employer plans somehow provide a better model of the "typical employer plan," the Final Rule capriciously relies on and misinterprets a "limited data set" collected by HHS to assist researchers, the External Data Gathering Environment (EDGE data).[56] Rule at 27,155.

219. EDGE data describes levels of enrollment in certain plans and the frequency of types of claims submitted. The Final Rule does not provide a substantive analysis of that data nor does it describe the method by which it determined what types of services it considered as "claims." Rather, the Final Rule makes the conclusory statement that the number of claims for "sex trait modification procedures" is low, then leaps to the conclusion that this care is infrequently utilized and therefore not typically covered by small business plans. Rule at 27,155-56. But there is a marked difference between a lack of coverage and infrequent utilization of that coverage. Public and commercial insurance regularly covers healthcare services that are infrequently used. For instance, there were 3,456 patients waiting for heart transplants and 898 patients waiting for lung transplants in the United States in 2024. [57] Although these transplants are exceptionally rare,

[56] The data set covers "masked enrollee-level data submitted to EDGE servers by issuers of risk adjustment covered plans in the individual and small group (including merged) markets."

[57] Detailed Description of Data, Health Res. and Servs. Admin., https://tinyurl.com/m3nvrvzd (Last Accessed July. 16, 2025).

the vast majority of public and private insurance plans cover them, and transplants themselves are not excluded from EHBs. Similarly, most healthcare plans cover treatment for multiple sclerosis, which affects almost 1 million people in the United States, and major insurance providers also cover treatment for scleroderma, which impacts only around 300,000 Americans.[58]

220. Furthermore, HHS has never before cited utilization as grounds for exclusion from EHB coverage, *see* 78 Fed. Reg. at 12,844-45 (excluding as EHBs limited category of services "because they are not typically included in medical plans offered by a typical employer"), *See* 89 Fed. Reg. 26,218, 26,342-26,349 (Apr. 15, 2024) (lifting exclusion of non-pediatric dental benefits from EHBs because services typically covered in employer plans, action would promote State flexibility and promote health outcomes and equity). This is for good reason. Medical care should not be denied simply because a need is not overly common. Indeed, even within the Final Rule itself, low utilization is not consistently grounds for exclusion from EHB coverage.

221. The Final Rule itself also does not consistently apply utilization as a ground for exclusion of care. The Final Rule explicitly excepts hormone therapy for the treatment of precocious puberty, which affects a smaller percentage of the population than individuals who seek hormone therapy for the treatment of gender dysphoria as a ground for exclusion of care.[59]

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[58] Natl. Scleroderma Found., *Who Gets Scleroderma?*, https://tinyurl.com/3ap44hk9 (Last Accessed July 16, 2025.

[59] Precocious puberty affects between 0.0001 and 0.0002 percent (1 in 5-10,000) of adolescents in the U.S. population, predominantly girls, whereas 1.4 percent of adolescents identify as transgender. Eunice Kennedy Shriver National Institute of Child Health and Human Development, *How Many Children are Affected by/at risk of Precocious Puberty?*, https://www.nichd.nih.gov/health/topics/puberty/conditioninfo/risk (Last Accessed July 16, 2025); *see also*, Ahmed Alghamdi, *Precocious Puberty Types, Pathogenesis and Updated Management*, Cureus (Oct. 22, 2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC10663169/ (Last Accessed July 16, 2025).; UCLA School of Law Williams Institute, *How Many Adults and Youth Identify as Transgender in the United States?* (June 2022), https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/ (Last Accessed July 16, 2025).

222. The fact that a condition only impacts a subset of the general population is not, in and of itself, a sufficient reason to exclude it from inclusion in EHBs.[60] Thus, even if gender-affirming care coverage were infrequently utilized, the usage rate alone would not be a reason to exclude the care from EHBs.

223. A low number of claims in EDGE data is also not surprising given that transgender people make up a small proportion of the population. Indeed, only an estimated 0.6% of U.S. residents, or over 2 million Americans, experience gender dysphoria.[61] Of those who experience gender dysphoria, treatment is individualized, and not all items or services may be medically necessary, prescribed, or otherwise recommended for a given individual based on standards of care.

224. Ultimately, because HHS failed to consider evidence and incorrectly dismissed gender-affirming care as not being covered by "typical" employer plans, the decision to exclude gender-affirming care from EHBs is arbitrary and capricious.

C. Gender-Affirming Care to Treat Gender Dysphoria Is Medically Necessary

225. Gender-affirming care is critical healthcare that people rely on.

226. Gender identity refers to a person's internal sense of belonging to a particular gender.

227. An individual's gender identity often aligns with their sex assigned at birth.

228. Transgender people have a gender identity that varies from their sex assigned at birth. For some transgender people, the incongruence between their gender identity and sex assigned at birth can cause clinically significant distress, recognized by the American Psychiatric

[60] Gender dysphoria, for instance, does not even meet the requirements of a "rare" condition, which would typically require that it impact fewer than 200,000 Americans.

[61] Danyon Anderson et al., *Gender Dysphoria and Its Non-Surgical and Surgical Treatments*, 10 Health Psychology Res. (Sept. 2022), https://tinyurl.com/tvnvukzw.

Association's *Diagnostic & Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* ("DSM-5-TR") as "gender dysphoria."[62]

229. Gender dysphoria is a serious medical condition. Treatment for gender dysphoria is medically necessary and aims to resolve the distress associated with the incongruence between a transgender person's assigned sex at birth and their gender identity. [63]

230. Left untreated, gender dysphoria can cause clinically significant distress and may result in "symptoms of depression and anxiety, substance use disorders, a negative sense of well-being and poor self-esteem, and an increased risk of self-harm and suicidality."[64]

231. Around 300,000 minors between the ages of 13 and 17 and 1.3 million adults identify as transgender and approximately 1.2 million people in the U.S. identify as nonbinary.[65] Though there are overlapping populations within these gender diverse groups, it is clear that millions of Americans need access to gender-affirming care. Gender dysphoria can be treated with social and medical interventions. Medical interventions include surgery, prescription medications such as puberty-delaying medication and hormone treatment, and other forms of treatment—typically referred to collectively as "gender-affirming care." [66]

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[62] Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 513-14 (5th ed., text rev. 2022).

[63] *Id.*

[64] *Id.*

[65] Press Release, UCLA Williams Inst., New Estimates Show 300,000 Youth Ages 13-17 Identify as Transgender in the U.S. (June 10, 2022), https://tinyurl.com/4h3wdp77p Press Release, UCLA Williams Inst., 1.2 Million LGBTQ Adults in the U.S. Identify as Nonbinary (June 22, 2021), https://tinyurl.com/vbwr387f.

295 Rebecca Boone & Jeff McMillan, How Many Transgender and Intersex People Live in the U.S.? Anti-LGBTQ+ Laws Will Impact Millions, Associated Press (July 27, 2023), https://tinyurl.com/mvbe6xk8.

[66] Patrick Boyle, *What is gender-affirming care? Your questions answered*, Am. Ass'n Med. Coll. (Apr. 12, 2022), https://www.aamc.org/news/what-gender-affirming-care-your-questions-

232. Major medical associations—including the American Medical Association, American Psychiatric Association, American College of Physicians, American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, and the American College of Obstetricians and Gynecologists—recognize that "[g]ender-affirming care has consistently been shown to improve quality of life, improve health outcomes, and reduce rates of SI and SAs."[67]

233. There is overwhelming medical evidence that gender-affirming care improves the symptoms of gender dysphoria, and that denying such care can have tragic consequences for transgender individuals' physical and mental well-being.

234. Medically necessary treatment for gender dysphoria is essential healthcare, and prohibitions on this medical care are a "dangerous intrusion into the practice of medicine" and violate the "sanctity of the patient-physician relationship."[68]

THE FINAL RULE HARMS THE STATES

235. Nearly every marketplace change implemented by the Final Rule will be harmful to individual consumers and state and local governments. And the cumulative effects of these changes—coupled with the expiring enhanced APTCs—will be catastrophic. The Final Rule

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answered#:~:text=Gender%2Daffirming%20care%2C%20as%20defined,they%20were%20assigned%20at%20birth (Last Accessed July 16, 2025).

[67] Nita Bhatt, Jesse Cannella, & Julie P. Gentile, *Gender-affirming Care for Transgender Patients*, 19 Innovations Clinical Neuroscience 23, 23 – 31 (2022) https://pubmed.ncbi.nlm.nih.gov/35958971/; *see also* Medical Association Statements in Support of Health Care for Transgender People and Youth, GLAAD (June 26, 2024), https://tinyurl.com/2thfbh4m; Moira Szilagyi, *Why We Stand Up for Transgender Children and Teens*, Am. Acad. of Pediatrics Voices Blog (Aug. 10, 2022), https://tinyurl.com/4v7m9b72(Last Accessed July 16, 2025).

[68] Press Release, Am. Med. Ass'n, *AMA To States: Stop Interfering in Health Care of Transgender Children* (Apr. 26, 2021), https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children (Last Accessed July 16, 2025).

imposes burdensome and costly paperwork requirements, limits the opportunities to sign up for health coverage, diminishes the actuarial value of coverage for those who still manage to procure coverage, substantially increases cost-sharing limits, and forces exchanges and consumers to spend hundreds of millions of dollars to prove eligibility for coverage and subsidies. These changes will result in direct and immediate costs to States as well as harms tied to decreased enrollment.

236. *First*, the Final Rule correctly acknowledges that it will "result in costs to State Exchanges and the Federal Government to update eligibility systems in accordance with this policy." Rule at 27,193. As open enrollment for benefit year 2026 begins in less than four months, Plaintiff States that operate their own ACA exchange are *already* incurring and will continue to incur compliance costs. The changes made by the Final Rule require such States to implement changes to technology platforms, retrain their staff, update websites and publications, conduct advertising and outreach, and send notices to affected individuals. For example, in California there will be over $1.5 million in compliance costs that will be incurred as a result of the Final Rule. The Final Rule's exclusion of treatment for gender dysphoria from essential health benefits further requires SBEs to work with carriers to review revised health plans and develop cost-defrayal mechanisms on an expedited basis. Even if the Final Rule is later enjoined after it has become effective, Plaintiff States will not be able to recover these costs, and indeed would incur additional costs to revert to the pre-Final Rule status quo.

237. *Second*, the Final Rule will also reduce the specific revenue streams from the assessments levied on the payment of insurance premiums by many Plaintiff States. As the Final Rule acknowledges, once it becomes effective, up to 1.8 million people, many of whom reside in Plaintiff States, will immediately lose access to health insurance coverage. Rule at 27,213. Plaintiff States with SBEs and State exchanges based on the federal platform have assessed millions of

dollars in fees tied directly to insurance premiums paid by individuals who were allowed to access insurance through ACA exchanges. As one example, California's state-run exchange, Covered California, generates revenue because insurance carriers pay a 2.25% fee on the total monthly premium collected for each health benefits plan sold through the individual exchange and a 5.2% fee for each plan sold through California's small business exchange. Altman Decl. ¶ 8. The Final Rule will deprive the States of the revenues generated by these premiums. Moreover, this population of newly-uninsured individuals now has only six months to secure alternative coverage, assuming any affordable coverage remains available. Any individuals who cannot secure coverage will be foreclosed from enrolling in exchange plans for all of plan year 2026, and a subsequent ruling will not be able to reinstate it or restore the associated lost revenue.

238. *Third*, the Final Rule imposes on Plaintiff States increased expenses for providing medical care to individuals who lose insurance due to these changes. State Medicaid expenditures will only balloon as people who lose subsidized marketplace coverage turn to publicly funded healthcare as a backstop. And for those individuals who become uninsured, Plaintiff States will incur substantial costs for their care, including millions annually in unreimbursed costs for the care of uninsured residents at public hospitals and hundreds of millions in annual subsidies to defray the cost of health care services that are provided to uninsured residents. The Final Rule expressly acknowledges these harms. *See, e.g.,* Rule at 27,213 ("An individual who loses coverage may be required to incur additional expense to obtain coverage or may go uninsured. An increase in the rate of uninsurance may impose greater burdens on the health care system through strain on emergency departments, additional costs to the Federal Government and to States to provide limited Medicaid coverage for the treatment of an emergency medical condition").

239. These costs include subsidies for preventive or emergency care services for uninsured residents. One example is New Jersey's Uncompensated Care Fund, which subsidizes preventive health services for uninsured residents by paying a flat rate from State funds per visit ($114 per visit for primary and dental care, and $74 per visit for mental health services). For this program, and similar programs across Plaintiff States, the greater the number of uninsured residents, the more the State spends on health care for uninsured individuals. Moreover, because these state-operated programs do not defray all costs of uncompensated care, state-owned hospitals also incur significant costs in providing services to uninsured patients.

240. *Fourth*, Plaintiff States face increased costs resulting from the adverse health outcomes that predictably follow from newly-uninsured individuals foregoing preventive or emergency health care absent affordable insurance. Just a year ago, HHS acknowledged that "[i]ndividuals without health insurance are less likely to receive preventive or routine health screenings and may delay necessary medical care, incurring high costs and debts," and that such "[d]elays in care can lead to negative health outcomes including longer hospital stays and increased mortality." 89 Fed. Reg. at 39,396. Loss of insurance can also result in increased medical debt, reduced spending power, lost work productivity, and absenteeism—as uninsured individuals, less likely to seek preventive care, are more likely to get sick and miss work. *See* 89 Fed. Reg. at 39,396. Moreover, individuals who have recently initiated a time-sensitive course of treatment they were previously delaying, such as chemotherapy, will now have to decide whether to continue such treatment and pay out-of-pocket, or to interrupt treatment and risk significant adverse health consequences.

241. *Fifth*, the Final Rule acknowledges some of its changes "may deter enrollments among younger people at higher rates, which could worsen the risk pool and increase premiums."

Rule at 27,203. The changes that HHS acknowledges will deteriorate risk pools include shortening the Open Enrollment Period by thirty percent or more in some States, imposing an unlawful $5 charge on all automatic re-enrollees, the barriers to coverage that will be imposed by the new SEP verification requirements on the Federal Exchange, ending self-attestation for low-income consumers, allowing insurers to deny coverage for those who owe past-due premiums, and expanding the acceptable actuarial value ranges for health plans. Rule at 27,201-16; 27,145-48.

242. And *sixth*, the Final Rule causing up to 1.8 million people to lose insurance coverage will increase the risk and magnitude of disease outbreaks and thus place a greater strain on hospitals due to the nature of communicable diseases. *See e.g.*, Travis Campbell et al., Exacerbation of COVID-19 mortality by the fragmented United States healthcare system, *The Lancet Regional Health* (May 12, 2022), https://tinyurl.com/mr26zt3r (finding that "insurance gaps exacerbated local COVID-19 outbreaks and resulted in more cases, hospitalization, and death than experienced by jurisdictions with better coverage"). And because uninsured individuals are less likely to have access to regular outpatient care—leading to greater rates of hospitalization for longer periods, *see* 89 Fed. Reg. at 39,396—smaller communities with fewer resources to address higher hospitalization rates will feel the strain most acutely. *See* Jennifer Tolbert et al., Key Facts about the Uninsured Population, Kaiser Family Foundation (Dec. 18, 2023), https://tinyurl.com/2s3jmmbm ("[h]igh uninsured rates contribute to rural hospital closures and greater financial challenges for rural hospitals, leaving individuals living in rural areas at an even greater disadvantage to accessing care").

243. The result of the implementation of the Final Rule's provisions is that millions of Americans will lose health coverage. Those who maintain coverage will pay higher premiums for diminished coverage and will spend more on out-of-pocket costs to use that coverage (in the form

of co-pays and deductibles). And when these newly uninsured individuals need healthcare—as everyone eventually will—the States will bear the cost. State and local governments will pay for the dramatic increase in uncompensated care costs for individuals who become uninsured as a result of the Final Rule. State Medicaid expenditures will balloon as people who lose their subsidized marketplace coverage will turn to publicly funded healthcare as a backstop. And States will lose tax revenue derived from insurance premiums no longer paid by those who have dropped or lost coverage as a result of these changes.

244. The Final Rule's exclusion of treatment for gender dysphoria as an EHB will result in additional harms to Plaintiff States.

245. As detailed above, whether gender-affirming care is included as an EHB has long been for individual states to decide. Indeed, states historically have enjoyed the authority to refine EHB requirements within statutory parameters since the Affordable Care Act was passed.

246. Prior to the issuance of this Final Rule, HHS has not interfered with a state's power by imposing a nationwide ban on EHB coverage for treatment for transgender people.

247. To the contrary, in 2021, HHS affirmatively approved a change to Colorado's state benchmark plan to explicitly standardize and clarify the coverage of gender-affirming care as an EHB. As a result, many states have administered their marketplaces and benchmark plans with the expectation that employer healthcare plans would cover gender-affirming care as an EHB, and employers followed suit.

248. A variety of states, including many Plaintiff States prohibit insurers from excluding or denying coverage and claims based on a consumer's gender identity through non-discrimination laws. If treatments for transgender people are reclassified under the Final Rule, these consumers would lose ACA protections such as annual out-of-pocket maximum limits and prohibitions on

lifetime or annual coverage caps, thereby creating substantial financial barriers for transgender individuals seeking medically necessary care.

249. Transgender and gender non-conforming individuals face significant barriers to accessing healthcare and the Final Rule will only exacerbate accessibility and affordability concerns expressed by these populations in Plaintiff States, despite efforts to protect such care.[69]

250. In sum, the Final Rule, if allowed to stand, will work direct and substantial injuries to Plaintiff States and their residents.

FIRST CAUSE OF ACTION

Administrative Procedure Act – 5 U.S.C. § 706(2)(D)
Agency Action Without Observance of Procedure Required by Law

251. Plaintiff States reallege and incorporate by reference the allegations set forth in each of the preceding paragraphs.

252. The APA requires agencies to provide public notice and an opportunity to be heard before promulgating a regulation. 5 U.S.C. § 553(c). The APA provides that a court "shall . . . hold unlawful and set aside agency action" that is "without observance of procedure required by law." 5 U.S.C. § 706(2)(D).

253. Defendants violated the APA by providing the public with less than 30 days to comment on the proposed rule. The Final Rule's 30-day comment period was inadequate to give interested persons a meaningful opportunity to participate in light of the number of changes

[69] https://publichealth.jhu.edu/2024/study-reveals-significant-barriers-for-tgnc-adults-accessing-healthcare-in-the-us

proposed by the Proposed Rule, a complicated, multifaceted rule spanning 90 pages in the Federal Register.

254. Notice and comment is particularly important in legally and factually complex circumstances like those presented here. Notice and comment allows affected parties—including states—to explain the practical effects of a rule before it is implemented, and ensures that the agency proceeds in a fully informed manner, exploring alternative, less harmful approaches.

255. Defendants have not and cannot demonstrate good cause for providing an inadequate notice and comment period. The Final Rule is therefore procedurally invalid and should be set aside under the APA.

256. The Final Rule will cause harm to Plaintiff States and their residents.

SECOND CAUSE OF ACTION

Administrative Procedure Act – 5 U.S.C. § 706(2)(A)
Arbitrary and Capricious Agency Action–Marketplace Integrity

257. Plaintiff States reallege and incorporate by reference the allegations set forth in each of the preceding paragraphs.

258. The Final Rule is a "final agency action for which there is no other adequate remedy in a court" and is subject to judicial review. 5 U.S.C. § 704.

259. The APA requires a court to "hold unlawful and set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A).

260. As discussed above, Defendants failed to provide adequate reasons for numerous changes that they imposed, nor did they meaningfully respond to comments about those proposed changes. The following changes were not "reasonable and reasonably explained" and should be vacated as arbitrary and capricious under section 706(2)(A):

a. The $5 premium penalty on automatic re-enrollees in the Final Rule's addition of 45 C.F.R. § 155.335(a)(3) and (n);

b. The shortening of the open enrollment period in the Final Rule's amendments to 45 C.F.R. § 155.410(e) and (f);

c. The Final Rule's requirement that states utilizing the federal exchange conduct pre-enrollment eligibility verification for at least 75% of Special Enrollment Periods triggered by a major live event, pursuant to 45 C.F.R. § 155.420(g);

d. The Final Rule's requirement that a data-matching issue be generated if either existing federal tax data shows a lower income than an enrollee's projected annual household income at or above 100% of the federal poverty level, or if there is no federal tax available, effective as of August 25, 2025, pursuant to 45 C.F.R. § 155.320(c)(3)(iii), (5);

e. The failure to reconcile (FTR) policy in 45 C.F.R. § 155.305(f), including the Final Rule's amendments to 45 C.F.R. § 155.305(f)(4);

f. The Final Rule's revocation of guaranteed insurance coverage for individuals with past-due premiums, effective August 25, 2025, pursuant to 45 C.F.R. § 147.104(i);

g. The Final Rule's change to the premium adjustment percentage methodology, effective as of plan year 2026, pursuant to 45 C.F.R. § 156.130(e); and

h. The Final Rule's revisions to the de minimis ranges for actuarial value calculations in the Final Rule's amendments to 45 C.F.R. §§ 156.140(c), 156.200(b)(3), and 156.400.

261. Defendants' issuance of the Final Rule is therefore arbitrary or capricious. Pursuant to 5 U.S.C. § 706(2)(A), Plaintiff States are entitled to an order vacating the Final Rule and declaratory and injunctive relief against Defendants taking any action to implement the Final Rule.

262. The Final Rule will cause harm to Plaintiff States and their residents.

THIRD CAUSE OF ACTION

Administrative Procedure Act – 5 U.S.C. § 706(2)(A)
Arbitrary and Capricious Agency Action–Exclusion of Treatment for Gender Dysphoria

263. Plaintiff States reallege and incorporate by reference the allegations set forth in each of the preceding paragraphs.

264. The APA requires a court to "hold unlawful and set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A).

265. To date, Defendants explicitly prohibited EHB coverage for only a limited number of services: abortion, non-pediatric dental or eye exam services, long-term nursing care, and non-medically necessary orthodontia. However, even for those services, an EHB plan may cover them should a state so choose. For example, non-pediatric dental care, which cannot be required to be covered as an EHB, is permitted to be covered as part of an EHB benchmark plan should a state choose to do so.

266. The Defendants have not sufficiently justified why what they refer to as "sex-trait modification procedures" should be treated similarly to those other services explicitly excluded, as opposed to the litany of services that are covered as EHBs under law, and none of the purported justifications provided meet the appropriate standard.

267. Defendants' exclusion of medically necessary treatment for gender dysphoria from EHBs is arbitrary and capricious because this care is often covered by employer-sponsored health

plans. As described above, Defendants failed to fully consider national and state-specific data which demonstrates that coverage for treatment for gender dysphoria is "typical" as is required under the statute.

268. Further, Defendants' decision is arbitrary and capricious for the additional reason that the rate of utilization of a particular healthcare benefit is not an appropriate standard for exclusion from EHBs and has not previously been used to deny EHB inclusion.

269. Defendants' decision is arbitrary and capricious for the additional reason that it does not accommodate or acknowledge important reliance interests around coverage for the health needs of transgender people due to the preexisting federal regulatory environment.

270. The Defendants are "not writing on a blank slate" here. See *Regents*, 591 U.S. at 33 (where agency was "not writing on a blank slate, it was required to assess whether there were reliance interests, determine whether they were significant, and weigh any such interests against competing policy concerns") (cleaned up). States have enjoyed the authority to refine EHB requirements within statutory parameters since the ACA was passed; and the Defendants have never before sought to interfere with that authority by imposing a nation-wide ban on EHB coverage for treatment for gender dysphoria. Far from it, in 2021, the Defendants affirmatively approved a state benchmark plan that explicitly identified that care as an EHB.

271. As a result, many States have administered their marketplaces and benchmark plans with the expectation that healthcare plans would cover gender-affirming care as an EHB; and insurers followed suit.

272. States that continue to mandate coverage for the medically necessary treatment of gender dysphoria—through their State non-discrimination laws or otherwise—are suddenly required to absorb the associated defrayal costs under the Proposed Rule at 12,987.

273. The Final Rule will cause harm to Plaintiff States and their residents.

FOURTH CAUSE OF ACTION

Administrative Procedure Act – 5 U.S.C. § 706(2)(C)
Agency Action That Is In Excess Of Statutory Authority–Marketplace Integrity

274. Plaintiff States reallege and incorporate by reference the allegations set forth in each of the preceding paragraphs.

275. The APA requires a court to "hold unlawful and set aside agency action, findings, and conclusions found to be . . . in excess of statutory jurisdiction, authority, or limitations, or short of statutory right." 5 U.S.C. § 706(2)(C).

276. The Final Rule is a "final agency action for which there is no other adequate remedy in a court" and is "subject to judicial review." 5 U.S.C. § 704.

277. Several of the Final Rule's provisions violate the ACA and other federal statutes and regulations and therefore are "in excess of statutory jurisdiction" or "otherwise not in accordance with law." 5 U.S.C. § 706(2)(A), (C). These include:

a. The $5 premium penalty on automatic re-enrollees in the Final Rule's addition of 45 C.F.R. § 155.335(a)(3) and (n) is contrary to 42 U.S.C. §§ 18081 and 18082, as the statutes provide no authority for the Secretary to set APTC amounts, withhold APTCs, or require consumers to pay an arbitrary amount in pre-APTC premiums;

b. The revocation of guaranteed insurance coverage for individuals with past due premiums in the 2025 Rule's amendment to 45 C.F.R. § 147.104(i) is contrary to the requirement in 42 U.S.C. § 300gg-1 that "each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the state that applies for such coverage,"

subject to exceptions not applicable here, 42 U.S.C. § 300gg-1(a), and the guaranteed renewability requirement in 42 U.S.C. § 300gg-2(a).

278. The Final Rule will cause harm to Plaintiff States and their residents.

FIFTH CAUSE OF ACTION

Administrative Procedure Act – 5 U.S.C. § 706(2)(C)
Agency Action That Is In Excess Of Statutory Authority–Exclusion of Treatment for Gender Dysphoria

279. Plaintiff States reallege and incorporate by reference the allegations set forth in each of the preceding paragraphs.

280. The APA provides that a court "shall . . . hold unlawful and set aside agency action" that is "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right." 5 U.S.C. § 706(2)(C).

281. The HHS Secretary must ensure that the scope of EHBs "is equal to the scope of benefits provided under a typical employer plan." 42 U.S.C. § 18022(b)(2)(A). To determine typicality, the ACA requires the Labor Secretary to conduct a survey of employer-sponsored coverage "to determine the benefits typically covered by employers." 42 U.S.C. § 18022(b)(2)(A).

282. Defendants violated the APA by failing to conduct a survey of employer-sponsored coverage to "determine the benefits typically covered by employers." 42 U.S.C. § 18022(b)(2)(A).

283. Further, the ACA mandates that in "revising [EHB] the Secretary shall submit a report to the appropriate committees of Congress." based on "a survey of employer-sponsored coverage." 42 U.S.C. § 18022(a)(2).

284. Defendants violated the APA by failing to submit such a report to Congress during its revisions of EHB coverage nationwide. The Final Rule contains no mention of such a report.

285. The Final Rule will cause harm to Plaintiff States and their residents.

SIXTH CAUSE OF ACTION

Ultra Vires Agency Action Not Authorized by Congress

286. Plaintiff States reallege and incorporate by reference the allegations set forth in each of the preceding paragraphs.

287. An executive agency "has no power to act . . . unless and until Congress confers power upon it." *La. Pub. Serv. Comm'n v. FCC*, 476 U.S. 355, 374 (1986).

288. Defendants may exercise only that authority which is conferred by statute. *See City of Arlington v. FCC*, 569 U.S. 290, 297 (2013) (federal agencies' "power to act and how they are to act is authoritatively prescribed by Congress, so that when they act improperly, no less than when they act beyond their jurisdiction, what they do is ultra vires").

289. Federal courts possess the power in equity to grant injunctive relief "with respect to violations of federal law by federal officials." *Armstrong v. Exceptional Child Ctr., Inc.*, 575 U.S. 320, 326-27 (2015). Indeed, the Supreme Court has repeatedly allowed equitable relief against federal officials who act "beyond th[e] limitations" imposed by federal statute. *Larson v. Domestic & Foreign Com. Corp.*, 337 U.S. 682, 689 (1949).

290. Defendants lack the statutory authority to impose the following measures in the Final Rule: (1) The $5 premium penalty on automatic re-enrollees in the Final Rule's addition of 45 C.F.R. § 155.335(a)(3) and (n) which is contrary to 42 U.S.C. §§ 18081 and 18082; (2) the revocation of guaranteed insurance coverage for individuals with past due premiums in the Final Rule's amendment to 45 C.F.R. § 147.104(i) which is contrary to the requirement in 42 U.S.C. § 300gg-1; (3) excluding "sex-trait modification" as an EHB without conducting a survey of employer-sponsored coverage to "determine the benefits typically covered by employers," 42 U.S.C. § 18022(b)(2)(A) and submitting a report to the appropriate committees of Congress based on that "survey of employer-sponsored coverage." 42 U.S.C. § 18022(a)(2).

291. No provision of the ACA or any other statute authorizes the agency to impose these measures. Indeed, the plain text of the ACA precludes their imposition.

292. In imposing these measures through the Final Rule, Defendants exceeded the statutory authority granted to HHS and CMS by Congress. These measures are therefore ultra vires executive agency actions.

293. The Final Rule will cause harm to Plaintiff States and their residents.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff States pray that the Court:

a. Postpone the effective date of the challenged provisions of Final Rule, as to Plaintiff States, pending judicial review;

b. Declare that the Final Rule violates the laws of the United States;

c. Declare that the Final Rule violates the Administrative Procedure Act;

d. Preliminarily and permanently enjoin Defendants from implementing or enforcing the challenged provisions of the Final Rule as to Plaintiff States;

e. Vacate the Final Rule; and

f. Award such additional relief as the interests of justice may require.

July 17, 2025

Respectfully submitted,

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**Application for pro hac vice admission forthcoming*

JS 44 (Rev. 10/20)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

State of California, et al. (see attached)

(b) County of Residence of First Listed Plaintiff n/a
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*

(see attached)

DEFENDANTS

Robert F. Kennedy, Jr., et al.

County of Residence of First Listed Defendant n/a
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

United States Department of Justice, 950 Pennsylvania Avenue NW, Washington D.C., 20530 (202-514-2000)

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☐ 3 Federal Question *(U.S. Government Not a Party)*
- ☒ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☒ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

- ☒ 1 Original Proceeding
- ☐ 2 Removed from State Court
- ☐ 3 Remanded from Appellate Court
- ☐ 4 Reinstated or Reopened
- ☐ 5 Transferred from Another District *(specify)*
- ☐ 6 Multidistrict Litigation - Transfer
- ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
Administrative Procedure Act, 5 U.S.C. § 706

Brief description of cause:
APA challenge to promulgation Final Rule, 90 F.R. 27,074

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:

JURY DEMAND: ☐ Yes ☒ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE _____ DOCKET NUMBER _____

DATE
July 17, 2025

SIGNATURE OF ATTORNEY OF RECORD
/s/ Allyson Slater

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

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State of Arizona
State of Colorado
State of Connecticut
State of Delaware
State of Illinois
State of Maine
State of Maryland
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Robert F. Kennedy, Jr., in his official capacity as Secretary of Health and Human Services
Mehmet Oz, in his official capacity as Administrator for the Centers for Medicare and Medicaid Services
United States Department of Health and Human Services
United States Centers for Medicare and Medicaid Services

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

1. **Title of case (name of first party on each side only)** STATE OF CALIFORNIA, et al., v. ROBERT F. KENNEDY, JR., et al.

2. **Category in which the case belongs based upon the numbered nature of suit code listed on the civil cover sheet. (See local rule 40.1(a)(1)).**

☐ **I.** **160, 400, 410, 441, 535, 830*, 835*, 850, 880, 891, 893, R.23, REGARDLESS OF NATURE OF SUIT.**

☑ **II.** **110, 130, 190, 196, 370, 375, 376, 440, 442, 443, 445, 446, 448, 470, 751, 820*, 840*, 895, 896, 899.**

☐ **III.** **120, 140, 150, 151, 152, 153, 195, 210, 220, 230, 240, 245, 290, 310, 315, 320, 330, 340, 345, 350, 355, 360, 362, 365, 367, 368, 371, 380, 385, 422, 423, 430, 450, 460, 462, 463, 465, 480, 485, 490, 510, 530, 540, 550, 555, 560, 625, 690, 710, 720, 740, 790, 791, 861-865, 870, 871, 890, 950.**

***Also complete AO 120 or AO 121. for patent, trademark or copyright cases.**

3. **Title and number, if any, of related cases. (See local rule 40.1(g)). If more than one prior related case has been filed in this district please indicate the title and number of the first filed case in this court.**

NONE

4. **Has a prior action between the same parties and based on the same claim ever been filed in this court?**

YES ☐ **NO** ☑

5. **Does the complaint in this case question the constitutionality of an act of congress affecting the public interest? (See 28 USC §2403)**

YES ☐ **NO** ☑

If so, is the U.S.A. or an officer, agent or employee of the U.S. a party?

YES ☐ **NO** ☐

6. **Is this case required to be heard and determined by a district court of three judges pursuant to title 28 USC §2284?**

YES ☐ **NO** ☑

7. **Do all of the parties in this action, excluding governmental agencies of the United States and the Commonwealth of Massachusetts ("governmental agencies"), residing in Massachusetts reside in the same division? - (See Local Rule 40.1(d)).**

YES ☐ **NO** ☐

A. **If yes, in which division do all of the non-governmental parties reside?**

Eastern Division ☐ **Central Division** ☐ **Western Division** ☐

B. **If no, in which division do the majority of the plaintiffs or the only parties, excluding governmental agencies, residing in Massachusetts reside?**

Eastern Division ☐ **Central Division** ☐ **Western Division** ☐

8. **If filing a Notice of Removal - are there any motions pending in the state court requiring the attention of this Court? (If yes, submit a separate sheet identifying the motions)**

YES ☐ **NO** ☐

(PLEASE TYPE OR PRINT)
ATTORNEY'S NAME Allyson Slater
ADDRESS One Ashburton Place, Boston, Massachusetts 02108
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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

STATE OF CALIFORNIA, et al.
***Plaintiffs*,**
v.
ROBERT F. KENNEDY, JR., et al.,
Defendants.

Civil Action No.: _____

DECLARATION OF ALLYSON SLATER

I, Allyson Slater, an attorney admitted to practice before this Court, do hereby state the following under penalty of perjury, pursuant to 28 U.S.C. § 1746:

1. I am the Director of the Reproductive Justice Unit in the Office of the Attorney General for the Commonwealth of Massachusetts, and I appear on behalf of the Commonwealth of Massachusetts in this action.

2. I submit this declaration in support of Plaintiff States' Complaint for Declaratory and Injunctive Relief.

3. The facts set forth herein are based upon my personal knowledge or a review of the files in my possession.

4. Attached hereto as Exhibit A is a true and correct copy of the April 11, 2025 Comment Letter to Administrator Mehmet Oz submitted by Jessica Altman of Covered California.

5. Attached hereto as Exhibit B is a true and correct copy of the April 11, 2025 Comment Letter to Secretary Robert F. Kennedy, Jr. and Administrator Oz submitted by Jason

Levitis of the Urban Institute, Christen Linke Young of the Brookings Institution, and Sabrina Corlette of Georgetown University.

6. Attached hereto as Exhibit C is a true and correct copy of the April 11, 2025 Comment Letter on Proposed Rule: Patient Protection and Affordable Care Act: Marketplace Integrity an Affordability submitted by the Attorneys General of California, Massachusetts, New Jersey, Arizona, Colorado, Connecticut, the District of Columbia, Delaware, Hawai‘i, Illinois, Maine, Maryland, Michigan, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Vermont, Washington, and Wisconsin.

Dated: July 17, 2025
Boston, MA

/s/ Allyson Slater
Allyson Slater
Director, Reproductive Justice Unit
Office of the Attorney General

CERTIFICATE OF SERVICE

I, Allyson Slater, certify that counsel for or on behalf of plaintiffs have submitted the foregoing document with the clerk of court for the District of Massachusetts, using the electronic case filing system of the Court. Counsel for Plaintiffs hereby certify that they have served all parties electronically or by another manner authorized by Fed. R. Civ. P. 5(b)(2).

/s/ *Allyson Slater*
Allyson Slater
Director, Reproductive Justice Unit
Office of the Attorney General

COVERED CALIFORNIA

April 11, 2025

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9884–P
P.O. Box 8016
Baltimore, MD 21244-8016

Subject: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability (RIN 0938-AV61)

Dear Administrator Oz,

Covered California welcomes the opportunity to offer the following insights in response to the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) proposed rule regarding marketplace integrity and affordability under the Patient Protection and Affordable Care Act (ACA).

Since Covered California launched in 2014, more than 6.3 million Californians, or about one in six, have had health insurance through the marketplace at one point in their lives. Additionally, the state's uninsured rate has fallen from 17.2 percent in 2014 to 6.4 percent in 2023, the largest percentage-point drop for any state in the nation during the ACA era.[1] With record-breaking enrollment of nearly 2 million Californians this past open enrollment, Covered California offers a competitive market, a robust risk pool, and high-quality health plan options as we proudly continue to deliver on the promise of the ACA to make sure all individuals have access to quality, affordable health coverage.

As we have made healthcare a reality for more Californians than ever before, our success is, in large part, due to our ability to implement innovative strategies that work best for California's unique needs. Through state flexibility and a deep understanding of our market, we have pioneered groundbreaking policies to make it easier for consumers to enroll in more generous plans at lower or no additional cost, expand financial assistance available with enhanced premium subsidies and cost-sharing reductions (CSRs), and implement robust fraud oversight and enforcement standards to effectively

[1] Covered California. (2025, March 25). With Record High Enrollment Covered California Celebrates the 15th Anniversary of the Historic Affordable Care Act. https://www.coveredca.com/newsroom/news-releases/2025/03/24/with-record-high-enrollment-covered-california-celebrates-the-15th-anniversary-of-the-historic-affordable-care-act/.

safeguard consumers from improper enrollments and hold agents and brokers accountable. This has enabled us to experience incredibly low instances of fraud, maintain one of the healthiest risk mixes in the country, and reduce administrative and financial barriers to coverage for those who need it most. It has also allowed us to uphold California's core values as a state to safeguard the rights of all communities, empowering individuals to lead healthier, happier lives.

This proposed rule is a marked departure from the traditional relationship between CMS and state-based marketplaces, now requiring state-based marketplaces to follow the same policies as the federal marketplace without robust explanation as to why such uniformity is necessary or beneficial. Covered California is deeply committed to program integrity and lauds CMS's efforts to identify and eliminate fraudulent activity on the federally facilitated marketplace. Covered California has continually invested in the integrity of our systems, and takes swift action if and when any improper activity is identified. As a result, Covered California does not have any indication of widespread fraud and abuse occurring in our market. In fact, a robust review of consumer complaints and enrollment partner activity in recent years did not reveal a single identified case of a consumer being enrolled in Covered California without their knowledge. These outcomes are largely because we have implemented tailored approaches that make sense for California's market and Covered California's systems, ensuring the over 14,000 enrollment partners we work with abide by the highest standards with comprehensive support and oversight. **With a one-size-fits-all solution to a problem that does not exist in California, we are concerned that the proposed changes would make it more difficult for eligible consumers to enroll in and pay for needed care while unnecessarily undermining the efficiency and stability of our marketplace operations.**

Drawing on our experience and shared commitment to upholding program integrity and strong consumer protections to best provide quality, affordable health coverage to all, we offer these recommendations on specific policies in the proposed rule related to eligibility criteria and enrollment opportunities, affordability and coverage, and compliance standards for agents, brokers, and web-based brokers.

Eligibility Criteria and Enrollment Opportunities

Shortened Open Enrollment Period (OEP)

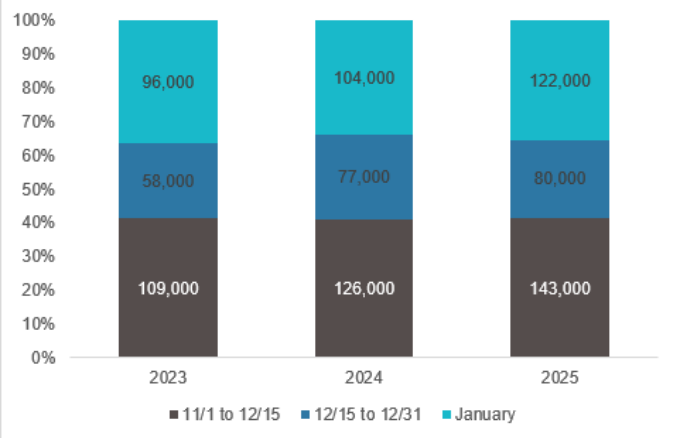
Covered California strongly encourages CMS to maintain state flexibility in determining what OEP length works in our markets and meets the needs of our communities. In the absence of this flexibility, we urge CMS to allow states capable of initiating the OEP before November 1 to do so and extend the OEP through December 31 for coverage effective January 1. For over ten years, Covered California has held its Open Enrollment Period (OEP) from November 1 through

January 31. Though CMS cites operational difficulties, consumer confusion, and increased risks of adverse selection as the need for a uniform, shortened OEP, our experience tells us that those would actually be the impacts of shortening the OEP in California.

Through close collaboration with our participating qualified health plan (QHP) issuers, enrollment partners, and community organizations, our consumers have grown very familiar with the January 31 deadline. Our enrollment partners already experience overwhelming demand during the OEP as they work around the clock to renew their existing customers and enroll new ones. Cutting the OEP in half would unnecessarily put significant strain on our enrollment partner workforce and potentially hinder their ability to reach and enroll. Further, our data and experience show that the longer OEP strengthens our risk pool and enhances overall market stability.

Specifically, as illustrated in Figure 1 below, our data shows that a significant portion of our enrollees opt into coverage after the proposed standardized cutoff date of December 15. In the past three OEP cycles, we have seen an average of 24 percent of our total enrollees make their health plan selections between December 15 and December 31. Moreover, the month of January has historically been a critical period for enrollment, with an average of 35 percent of enrollees securing their coverage during this time. In some years, the data indicates that nearly half of new enrollees chose their plans after December 15. Our data also indicates that enrollees who sign up later in the period tend to be healthier and younger, contributing positively to our risk pool and overall market health.[2]

Figure 1: Distribution of Open Enrollment Plan Selections by Sign-Up Date



[2] See slide 2. Covered California. (2025, Apr. 3). Data Snapshot: Covered California Open and Special Enrollment Periods. Covered California's 2024 Member Survey. https://hbex.coveredca.com/data-research/library/CoveredCA_OE_SEP_Data_Snapshot_20250403.pdf.

Covered California's traditional OEP has proven effective and straightforward for our consumers, allowing them sufficient time to choose a plan that is right for them. Further, it has worked for our market, supporting both additional and healthier individuals to enroll, and has helped enhance the stability of our marketplace. Given the long-term stability of our OEP timeline, any change, and certainly one as significant as shortening the time period in half, risks mass consumer confusion and resulting instability in our marketplace.

Should CMS forego state flexibility with respect to continuing their OEP into January, we suggest that state-based marketplaces have other flexibilities as their infrastructure supports. Specifically, while the federally-facilitated marketplace and some state-based marketplaces can only support an enrollment deadline of December 15 for coverage effective January 1, Covered California and other state-based marketplaces that are able to enroll individuals through December 31 for coverage effective January 1 should be allowed to do so. Additionally, states should have the option to begin their OEP earlier than November 1.

Pre-enrollment Verification for Special Enrollment Periods (SEPs)

Covered California recommends CMS maintain states' ability to customize SEP strategies that meet their specific needs, promoting healthy risk pools and reducing—not increasing—coverage barriers. At a minimum, we ask for sufficient time for states to implement these changes, considering the substantial costs and resources involved. Supporting the ACA's broader goal of increasing and maintaining the insured population, SEPs serve the critical purpose of ensuring individuals and families who experience significant life changes are not left without coverage as they find themselves in new and often difficult circumstances. As SEPs promote continuous coverage and access to services, our data shows that these enrollments help maintain the stability and health of our marketplace.

Specifically, in California, the prospective risk scores for consumers enrolling during SEPs have been consistently equal to or lower than those during the OEP, even during years of flexible SEP policies and the implementation of enhanced federal premium tax credits (PTC). For example, in 2024, the prospective risk scores for both OEP and SEP enrollment were the same, at 0.96. In previous years, the trend of SEP enrollees presenting a lower or equal risk compared to their OEP counterparts has been consistent.[3]

Moreover, the demographic profile of SEP enrollees, particularly since 2019, skews younger than those enrolling during the OEP, contributing to a healthier risk pool

[3] See slide 4. Covered California. (2025, Apr. 3). Data Snapshot: Covered California Open and Special Enrollment Periods. Covered California's 2024 Member Survey. https://hbex.coveredca.com/data-research/library/CoveredCA_OE_SEP_Data_Snapshot_20250403.pdf.

overall.[4] Since 2019, the average age of consumers enrolling through special enrollment was 36.3 years, compared to 38.2 years for those enrolling during the OEP, and significantly lower than the combined average age of 42.1 years for the OEP and renewal populations.

Given the success of SEPs and lack of identified issues, the proposed requirement that consumers identify and submit documentation proving that they have experienced a qualifying life event would impose an unnecessary and substantial burden on consumers genuinely in need of coverage during major personal life changes. As CMS knows, with very limited real-time verification data sources, these additional SEP verifications will require largely manual processes. With CMS data showing that 27 percent of people are unable to meet the SEP documentation deadline, it is clear that these verification hurdles are significant. They particularly discourage younger, healthier people from enrolling, who are less likely to navigate complex paperwork during life changes. This could lead to fewer healthy individuals in the insurance pool, undermining its stability and driving up costs for everyone.

Beyond placing an undue burden on consumers without benefit to the risk pool, this proposal would impose a significant administrative and financial burden on marketplaces to implement, especially given the anticipated rapid timeline. The requirement to operationalize and finance the proposed thorough document verification processes, many needing manual intervention, would lead to unforeseen expenses, stretch pre-assigned budgets and planned system updates, and necessitate extra staffing—all within a very tight timeframe. We urge CMS to preserve the autonomy of states to tailor SEP enrollment strategies that best suit their needs, ensuring the sustainability of healthy risk pools and minimizing coverage obstacles, rather than creating new ones. At minimum, we request CMS to give states a reasonable amount of time to implement these changes given the significant cost and resources required to do so.

Automatic reenrollment of eligible consumers from a bronze to a silver plan

Covered California recommends that CMS continue to allow states to implement innovative reenrollment policies that enhance affordability and value for consumers, simplifying the process in a clear and transparent way that still accommodates consumer choice. Proudly leading the nation with our bronze-to-silver Affordability Crosswalk, which has been in place since 2022, Covered California transitions eligible enrollees to the Silver CSR variant of their current plan at renewal, specifically targeting individuals with incomes below 250 percent of the federal poverty

[4] See slide 5. Covered California. (2025, Apr. 3). Data Snapshot: Covered California Open and Special Enrollment Periods. Covered California's 2024 Member Survey. https://hbex.coveredca.com/data-research/library/CoveredCA_OE_SEP_Data_Snapshot_20250403.pdf.

level (FPL), allowing them access to the same benefits and providers with equal or better value at the same or lower premium. Importantly, we inform consumers of the plan change and provide ample time for them to opt out of their "crosswalked" plan should they choose. We note that, for these consumers, there is no advantage to remaining in their current plan, as it provides the same network and providers with only higher costs. These Crosswalks have proven to be the most effective tool to maximize consumer value and do not in any way inhibit consumer choice.

Building on this success, Covered California expanded the policy to include transitions from Gold and Platinum to Silver 87 and 94 plans, respectively, as well as from Bronze plans to $0 Silver 73 and Silver 87 plans. This strategic expansion resulted in more than 34,000 consumers receiving a higher value plan at a lower cost for the 2024 plan year. Notably, over 60 percent of these consumers were moved from either Gold or Platinum plans, saving them money each month on their premium and fewer out-of-pocket expenses given crosswalked to richer benefits while likely improving their long-term health. We also note that the Platinum and Gold crosswalks can lead to federal savings on the premium tax credit when the crosswalked plan happens to be the lowest cost Silver plan.

The 2024 Covered California Member Survey[5] reflects strong approval for the Affordability Crosswalk initiative, with 90 percent of members who were notified about their plan change finding the crosswalk useful. This indicates broad endorsement of the policy and, crucially, has not led to consumer confusion or grievances.

We strongly recommend that CMS continue to allow states the freedom to adopt these innovative policies that make it easier for consumers to obtain the best coverage, value, and affordability for them.

Minimum premium payment to renew fully subsidized coverage

Covered California urges CMS to preserve state flexibility in enacting automatic reenrollment policies that effectively maximize affordability, ease the renewal process, and reduce barriers to coverage—particularly for economically vulnerable groups. Our experience with the Affordability Crosswalk also informs our views on annually reenrolling consumers with $0 premiums. We have observed that even small obstacles to enrollment significantly influence enrollment choices. Imposing a $5 charge on those seeking to continue their fully subsidized coverage, even temporarily, unfairly impacts the most economically vulnerable groups.

[5] NORC at the University of Chicago and Covered California. (2024, Nov. 21). Covered California's 2024 Member Survey. https://hbex.coveredca.com/data-research/library/Member_Survey_2024_Public_Report.pdf.

Furthermore, without evidence of confusion or complaints about the annual re-enrollment process, introducing a $5 premium complicates a previously clear procedure, risking lower enrollment, market destabilization, decreased long-term affordability and added administrative hurdles. On the contrary, Covered California enrollee survey feedback demonstrates strong support for automatic reenrollment, highlighting its positive impact on accessibility and satisfaction with the renewal process. This feedback aligns with the widespread use of automatic reenrollment across the larger healthcare system, a norm in employer-sponsored insurance, Medicare, and Medicaid alike. Imposing a more cumbersome reenrollment process exclusively on marketplace consumers is both unjustified and illogical. Ironically, implementing a $5 charge that may later be eliminated is more likely to lead to consumer confusion, and ultimately, loss of coverage. Again, we urge CMS to continue to allow states the ability to continue policies that have proven effective for their marketplaces.

SEP for low-income consumers

Covered California recommends CMS provide states the flexibility to continue with this SEP, particularly if they are not experiencing associated adverse selection or improper enrollments. While we recognize CMS's concern that this policy encourages consumers to wait until they become sick instead of promoting continuous enrollment, Covered California's low enrollment in this SEP due to the expansion of our Medicaid program, together with our strong risk mix, suggests that the problems of improper enrollments and adverse selection are just not prevalent in our marketplace. Here, especially, recognizing the unique dynamics of each individual state is paramount in determining whether these proposed solutions are necessary. In California, the state has an integrated eligibility and enrollment system that verifies applicants for both Medicaid and marketplace coverage, limiting any fraudulent enrollment through this SEP.

Affordability and Coverage

DACA recipient eligibility for coverage and financial assistance

With a mutual commitment to the well-being of all communities, Covered California advocates for CMS to keep DACA recipients within the lawful presence definition, preserving their access to marketplace coverage and financial assistance. If this proposal is implemented, we urge CMS to allow states enough time to effectively communicate and implement these changes. Covered California is deeply committed to ensuring that all individuals and communities have access to comprehensive, equitable healthcare, reflecting our state's core values of equity and accessibility. By embracing the diversity of our state and recognizing healthcare as a fundamental right, we work towards a healthier California. Including DACA recipients in marketplace coverage reduces uninsured rates, brings younger enrollees into the

market, and connects Californians to coverage they need and deserve. We strongly oppose removing DACA recipients from the definition of lawful presence.

However, should this proposal be finalized, we urge CMS to provide states sufficient time to effectively communicate changes, manage the notice and disenrollment process, and ensure that individuals are not inadvertently receiving financial assistance for which they are no longer eligible. For example, delaying implementation until the end of the plan year would allow for smoother transitions and minimize impact to consumers. The thoughtful and accurate execution of these changes is especially critical for this population, as they have consistently experienced significant instability and rapid policy shifts with very tangible consequences.

Sex trait modification as an Essential Health Benefit (EHB)

Covered California recommends CMS preserve state flexibility in defining their EHBs, allowing states to uphold both their commitments to equitable healthcare for diverse needs and the ACA's requirement to align with typical employer coverage standards. CMS's proposal to exclude sex trait modification, or gender-affirming care, as an EHB is problematic in several ways. First, similar to CMS's proposal to bar DACA recipients from marketplace coverage, this suggested exclusion challenges California's broader commitment to equitable and accessible healthcare for all. Second, it contradicts the ACA's requirement that the scope of EHB represent those offered under a typical employer plan. Further, it marks a sharp departure from CMS's approach of increasing state flexibility in defining the scope of EHB to keep pace with the diverse healthcare needs of Americans and variation across states.

The ACA and its implementing regulations require EHB to be equal in scope to the benefits provided under a typical employer plan and give states flexibility to define EHB through selecting a benchmark plan.[6] While federal law requires CMS to ensure that the scope of EHB reflect a typical employer plan through data-driven analysis,[7] CMS has not provided a coverage survey, report, or study to support its claim that "sex-trait modification" is not covered within a typical employer plan.

In California, longstanding nondiscrimination requirements prohibit coverage exclusions based on an enrollee's sex, including gender identity.[8] Such requirements apply to all state-regulated employer-sponsored coverage in California, and applied to California's selected EHB benchmark plan at the time of adoption. CMS's proposal to prohibit "sex-trait modification" within EHB would be nonrepresentative of a typical employer plan within California. Additionally, available evidence suggests gender-affirming care is

[6] 42 U.S.C. § 18022(b); 45 C.F.R. § 156.100.
[7] 42 U.S.C. § 18022(b).
[8] See Cal. Health & Safety Code, § 1365.5; Cal. Ins. Code, § 10140.

widely covered by employer-sponsored coverage across the country, especially among large employers.[9]

The ACA provides States the authority to define the scope of EHB to account for the specific needs of a state's population, with narrow limitations.[10] Existing regulations include a small number of benefits that may not be considered EHB, including those such as routine non-pediatric eye exams and long-term/custodial nursing home care benefits.[11] CMS determined these benefits are not representative of a typical employer plan because they are generally offered by employers as excepted benefits. However, recognizing the importance of state flexibility and differences in employer-sponsored coverage offerings across the country, CMS recently removed the exclusion for non-pediatric dental services from this section beginning with Plan Year 2027. CMS is now reversing course by proposing to add "sex-trait modification" to the list of EHB exclusions. CMS's proposal, for the first time, would exclude benefits that are traditionally embedded within a health plan. This proposal is contrary to CMS's use of this restriction only for excepted benefits and would now inappropriately limit the state's ability to determine benefits within their own state benchmark plan.

Rather than implementing a blanket prohibition on coverage of "sex-trait modification" as an EHB, CMS should honor state flexibility in EHB definition, ensuring packages are comprehensive, evidence-based, and match employer coverage standards, in line with the ACA's purpose.

Premium growth methodology

Covered California urges CMS to reevaluate the proposed premium growth methodology adjustments, as they would lead to higher costs for consumers. Covered California expresses concern over CMS's proposal to revise the premium adjustment calculation for Plan Year 2026, which would substantially raise the Maximum Annual Limitation on Cost Sharing. While these adjustments aim to reflect market fluctuations in both the individual and employer sponsored insurance markets, we believe that they will have a detrimental impact on consumers. Specifically, the proposed escalation of out-of-pocket costs directly threatens the affordability of essential healthcare coverage, particularly for individuals already struggling to manage healthcare expenses. This proposed increase in cost-sharing limits will

[9] Dawson, Lindsey, et al. "New Rule Proposes Changes to ACA Coverage of Gender-Affirming Care, Potentially Increasing Costs for Consumers." KFF, 24 Mar. 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/.
[10] 45 C.F.R. §§ 156.100, 156.111.
[11] 45 C.F.R. § 156.115(d)

disproportionately affect consumers, potentially leading to decreased access to necessary medical care.

Compliance Standards for Agents, Brokers, and Web-Brokers

Covered California fully supports CMS's proposal to enhance oversight of agents, brokers, and web-based brokers operating within the federally-facilitated marketplace. We share CMS's commitment to safeguarding our enrollees from improper enrollments and holding these entities, collectively referred to as agents, accountable for unauthorized activity. To this end, Covered California has proactively instituted stringent requirements, tools, and oversight mechanisms to ensure that agents have consent prior to making any coverage changes.

For example, to act on behalf of a consumer, agents must either be specifically added by the consumer through the consumer portal or verify consent through three-way calls with a consumer and a Covered California representative. Consumers can use this same portal to edit and remove permissions. Alternatively, agents may verify the consumer's personal information they have and, if the details match, a one-time passcode is sent directly to the consumer for the agent to access the case. Additionally, agency delegation transfers may only be done by those Covered California authorizes. These practices have been so successful in California that CMS adopted several of them in 2024 when it sought to address growing complaints of improper enrollments on the federally-facilitated marketplace.

As a result, reports of unauthorized enrollments within Covered California remain very low. For the few instances reported, we have taken decisive corrective measures, including comprehensive investigations, monitoring agents, and if necessary, issuing warnings, suspensions, or even decertifying and terminating agreements with agents. Additionally, Covered California collaborates closely with state regulators and law enforcement to ensure these matters are properly addressed. We recommend CMS adopt similar program integrity standards as the means of addressing improper enrollments and not put unnecessary burdens on consumers in state-based marketplaces as the proposed rule does in other areas.

Future of Federal Subsidies and Impact on Marketplace Stability

As a final note, the proposed implementation of these policies coincides with a moment already marked by significant uncertainty and potential disruption for marketplaces due to the upcoming expiration of the enhanced federal PTCs. **If CMS chooses to move forward on these proposals, Covered California urges CMS to consider delaying these proposals until there is greater certainty on the future of the enhanced PTCs and to provide flexibility on implementation timelines for new eligibility rules. This would allow marketplaces more time to mitigate impacts to pricing,**

enrollee risk profiles, and other dynamics that will affect the coverage millions of Californians rely upon. This is the most important step CMS can take to support stable markets and risk pools in light of the significant uncertainty already facing marketplaces and the consumers we serve.

Expiration of the enhanced PTCs would drastically increase consumer costs and reduce enrollment in marketplaces across the country. Even without additional broad changes to marketplace rules, if enhanced PTCs expire, the upcoming open enrollment will be stressful and confusing for consumers facing difficult coverage choices, overwhelming for enrollment partners and health plans supporting consumers through those choices, challenging for marketplaces to adjust systems and other operations to accommodate last minute federal decisions, and disruptive of market stability due to decreased enrollment and associated risk pool degradation.

This proposed rule contains many provisions that, if finalized, would exacerbate these same challenges by giving less time, increasing consumer confusion and barriers to coverage, and imposing unnecessary uncertainties and last-minute operational burdens on marketplaces and our partners. In particular, the proposed rule would require several significant changes to our eligibility system within a very rapid period, some of which are not even possible to complete by the proposed implementation date. Operationalizing others in such a short window would disrupt additional system changes planned well in advance and strain pre-established budgets. Moreover, these changes would heavily impact our communication and outreach efforts, as well as service center staffing, potentially necessitating an expansion of our resources. To provide marketplaces with the necessary time to adapt, stabilize, and minimize impact to consumers, we recommend postponing implementation of any finalized proposals.

We appreciate your consideration of Covered California's comments and look forward to our ongoing partnership to ensure that the ACA continues to work effectively and build on its foundation to ensure that all Americans have access to high-quality, affordable health care.

If you have any questions or would like more information, please feel free to contact me.

Sincerely,

Jessica Altman
Executive Director

April 11, 2025

Submitted via https://www.regulations.gov/

The Honorable Robert F. Kennedy, Jr.
Secretary
Department of Health and Human Services

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services

Attention: CMS-9884-P, P.O. Box 8016
7500 Security Boulevard
Baltimore, MD 21244-8016

RE: RIN 0938-AV61, CMS-9884-P Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability

Dear Mr. Kennedy and Dr. Oz:

Thank you for the opportunity to comment on the Marketplace Integrity and Affordability rule.

This proposed rule represents a sharp reversal of previous policy without sufficient new evidence, without a reasonable connection to the justifications provided, and without considering key reliance interests.

Virtually every provision individually is harmful to consumers and/or inconsistent with the best reading of the statute. In addition, the proposals are justified with flawed analysis with respect to the major goals cited: reducing improper enrollment and improving the risk pool. And even to the extent that real problems exist under current policy (including evidence of fraud by brokers), the proposals bear no reasonable relationship to solutions that would address these problems. There are ways to address concerns about fraud by agents and brokers, but the rule omits such measures.

The rule also undermines state autonomy, imposes needless costs on states, and requires states to make changes on infeasible timelines, often in ways that would reverse policies on which they have relied for years.

Finally, the rule fails to provide a meaningful opportunity to comment, due to both the short comment period and the Centers for Medicare and Medicaid Services' ("CMS") failure to make publicly available key data that the agency has access to.

We urge CMS to go back to square one on this rule. It should perform credible analysis, reconsider its proposals in light of this analysis, release such analysis, and provide a meaningful comment period to consider or challenge it, and delay any effective dates to allow for this process and a workable implementation timeline.

This comment is organized into three sections.

- The first provides comments on specific proposals of the rule.
- The second provides comments on the rule's regulatory impact analysis and analytical claims generally.
- The third raises additional concerns about procedural issues in promulgating the rule.

Comments On Specific Proposals

The rule generally includes three categories of proposals, which we consider in turn:

- Proposals that reduce affordability and benefits
- Proposals that impose administrative burdens and reduce opportunities to enroll
- Proposals that narrow eligibility for coverage

Proposals that Reduce Affordability and Benefits

Changing the Premium Adjustment Percentage to Increase Consumers' Premium Contributions and Out-of-Pocket Costs (Section 156.130(e))

CMS proposes to change the rules for calculating the "premium adjustment percentage," a measure of premium growth that is used to make annual updates to several Affordable Care Act ("ACA") coverage parameters. The change would result in higher out-of-pocket costs for individuals with commercial health insurance (including the 160 million people with employer-based insurance), lower premium tax credits ("PTC") for Marketplace enrollees, and larger payments under the ACA's employer shared responsibility provision.

Under the ACA, the premium adjustment percentage is used to update the maximum annual limit on out-of-pocket cost-sharing ("MOOP") under employer-sponsored and individual market health plans. The Internal Revenue Service ("IRS") uses the premium adjustment percentage to update individual contributions for Marketplace enrollees receiving the PTC. It is also used to update other ACA parameters, like the employer shared responsibility payment.

Under current regulations, the premium adjustment percentage measures premium growth by looking at changes in the cost of employer-sponsored coverage. CMS proposes to change the calculation to also include coverage in the individual market. Either way, the calculation looks at changes to premiums dating back to 2013, before most of the ACA had taken effect.

Under the proposed new methodology, the premium adjustment percentage for 2026 would be about 4.5% higher than under the current methodology. This would mean a similar increase in the MOOP and employer payments for 2026, resulting in an overall increase of about 15% over 2025's levels. In addition, if the IRS adopts CMS's premium adjustment percentage methodology, as is required under current IRS regulations, consumers receiving Marketplace subsidies could expect to pay 4.5% higher premiums for a benchmark silver plan than under the current methodology. Together with the actuarial value change discussed below, this change would expose a typical family to an additional $900 in cost-sharing and $313 in premiums annually. CMS estimates that this would reduce federal PTC spending by $1.27 billion and enrollment by 80,000 individuals in 2026. The MOOP change would permit insurance companies to impose higher deductibles and other cost-sharing on not only Marketplace enrollees but also the 160 million people with employer-sponsored coverage.

The proposal is contrary to Congress's intent for the premium adjustment percentage to account for underlying trends in the cost of health coverage.

The premium adjustment percentage is intended to measure underlying trends in health insurance premiums, not the effect of the policy changes made in the ACA itself. Individual market premiums experienced a discrete period of volatility when the Marketplaces came online and due to subsequent policy changes, including changes in the PTC itself. Indeed, the existence of a temporary reinsurance program guaranteed premium increases as the program phased out–premium changes that are unrelated to any trends in health spending. As a result, looking at individual market premiums back to 2013 artificially inflates premium growth over time. Group market premiums are insulated from ACA policy changes and have been far more stable, making them the only accurate premium metric of actual trends in health care spending.

The proposal is contrary to the ACA purpose of expanding coverage and affordability.

In enacting the ACA, Congress's stated purpose was to expand access to affordable coverage options. By making premiums and cost-sharing less affordable, this proposal would undermine that goal and thus is inconsistent with the intent of Congress.

The proposal will worsen the risk pool and increase premiums for unsubsidized enrollees.

Increasing premiums for subsidized enrollees and worsening the value of coverage is expected to deter enrollment of healthier enrollees, as described in more detail below. This will worsen the average risk pool and increase premiums, contrary to CMS's purported goal of increasing affordability in promulgating this regulation.

For the foregoing reasons, we urge CMS not to finalize this proposal.

Reduced Plan Generosity and Premium Tax Credits (Sections 156.140, 156.200, 156.400)

CMS proposes to change the de minimis ranges for health plans' actuarial values ("AV") in the individual and small-group markets. Under the ACA, insurers in the individual and small group markets are required to offer plans with specified levels of generosity (called "actuarial value"), labeled bronze (covering 60% of an average enrollee's costs), silver (70%), gold (80%), and platinum (90%). However, insurers have some flexibility in meeting these actuarial value levels. In the proposed rule, CMS would change the de minimis ranges to permit lower-value plans at each metal level:

Figure 1. Proposed Changes to De Minimis Ranges for AV.

Plan Level or Type	Current range	Proposed range
Bronze	+2/-2	+2/-4
Expanded Bronze*	+5/-2	+5/-4
Silver	+2/-2	+2/-4
Cost-sharing reduced Silver variations	+1/0	+1/-1
On-Marketplace Silver	+2/0	+2/-4
Gold	+2/-2	+2/-4
Platinum	+2/-2	+2/-4

CMS argues that giving issuers greater flexibility to increase cost-sharing for consumers will reduce premiums, improve the risk pool, and reduce the risk that issuers will exit the market. CMS estimates that gross premiums would decrease by 1%, on average, as a result of this change. CMS acknowledges that widening the de minimis range for on-Marketplace silver plans will reduce Advanced Premium Tax Credits ("APTC") for consumers and thus increase net premiums. This is because APTCs are based on the premiums for the second lowest-cost silver plan in the market, and plans with lower actuarial values generally have lower premiums.

As a result, the proposed change will result in higher costs for the vast majority of Marketplace enrollees. That is, due to smaller APTCs, recipients will have the choice of either purchasing less comprehensive coverage or paying more in premiums for comparable coverage. CMS's own analysis acknowledges that the expanded de minimis ranges will effectively transfer costs from the government to consumers, by reducing APTCs in 2026 by $1.22 billion, reaching $1.4 billion in plan year 2029.

Moreover, any resulting reduction in premiums for unsubsidized enrollees will be due to less-generous coverage, which exposes enrollees to higher deductibles and other cost sharing. This sort of shrinkflation does not help consumers. Indeed, under the current de minimis ranges, most consumers, subsidized and unsubsidized alike, who wish to pay lower premiums and risk higher cost-sharing can already do so by purchasing a plan at a lower metal level.

CMS also argues, without providing evidence, that increasing the de minimis range will improve the Marketplace risk pool. In fact, the opposite is likely to occur. That's because it will *increase* premiums for comparable coverage for subsidized enrollees, who represent most of the risk pool. Reducing APTCs by an estimated $1.2 billion in plan year 2026 will make coverage less affordable for most enrollees. The evidence is clear that those most likely to drop their insurance due to an increase in premiums are healthy individuals; sicker individuals are more willing to tolerate higher premiums because they need the coverage. This proposed change would thus lead to a smaller, sicker Marketplace risk pool. Accounting for that effect, the rule will ultimately raise gross premiums for unsubsidized individuals as well.

An additional rationale that CMS provides for the proposed changes to de minimis ranges is that issuers have threatened to leave the Marketplace if they are not accorded greater flexibility. Even if such threats have occurred, there is no evidence that issuers will actually withdraw from the Marketplaces. Since the Biden administration tightened the de minimis ranges in the 2023 Notice of Benefit and Payment Parameters, issuer participation has only increased. In 2022, an average of 9.2 issuers participated in the ACA Marketplaces. That number grew to 9.4 in 2023 and 9.6 in 2025. The Marketplaces have not only benefited from new issuers entering the market, but many existing issuers have also expanded their service areas since the tighter de minimis ranges were implemented. Thus, there is no evidence that the narrower de minimis ranges are reducing participation.

For the foregoing reasons, we urge CMS not to finalize the proposal to widen de minimis ranges.

Prohibiting Coverage for Treatment of Gender Dysphoria (Section 156.115(d))

CMS proposes to prohibit issuers in the individual and small-group markets from covering what it refers to as "sex trait modification" as part of essential health benefits ("EHB"), beginning in plan year 2026. CMS asserts, without evidence, that the items and services associated with the treatment of gender dysphoria are not typically covered in employer-sponsored health plans. However, as described below, available evidence indicates that the majority of employer-sponsored health plans do in fact offer such coverage. Section 1302(b) of the ACA requires the Secretary of Health and Human Services to ensure that the scope of EHB be "equal to the scope of benefits provided under a typical employer plan." In doing so, the Secretary is prohibited from making coverage decisions or designing benefits in ways that discriminate against individuals because of a disability and must account for the health care needs of diverse segments of the population.

We urge CMS not to finalize this proposal because it is discriminatory. The proposal will also raise consumer costs, impose new administrative burdens on plans and issuers, and reduce access to medically necessary items and services that have been recommended by virtually all major U.S. medical associations. Barring plans from covering treatment for gender dysphoria as EHB will expose policyholders who need these services to higher out-of-pocket costs. Transgender individuals, on average, have lower incomes than cisgender individuals, making higher costs a greater barrier to getting the care they need.

CMS's stated rationale for removing gender-affirming care from EHB is grounded in a false premise: that employer-based insurance does not generally cover such services. In fact, the opposite is true. KFF, the publisher of the preeminent annual survey of employer health plans, finds that "[c]overage of gender affirming care services in employer plans is fairly common." In the 2025 Corporate Equality Index, the Human Rights Campaign Foundation found that 72% of Fortune 500 businesses (and 91% of businesses listed on the Corporate Equality Index) offer coverage of treatment for gender dysphoria. Similarly, coverage for gender dysphoria is widespread among state employee plans (24 states and Washington, DC), and 14 states and DC prohibit exclusions of coverage for gender dysphoria in state-regulated plans.

The proposed rule notes that current federal rules prohibit issuers from including as part of EHB non-pediatric eye exam services, long-term/custodial nursing home care, or non-medically necessary orthodontia.[1] Such services are generally not covered in the commercial market, major medical health plans. Unlike these other services listed in 45 C.F.R. § 156.115(d), the medications and services used to treat gender dysphoria are commonly covered in major medical health plans, including by 55% of insurers that offered 2025 Marketplace plans. Indeed, this proposal would be the first time that CMS prohibited states from including in EHB benchmark services that clearly fall within the 10 statutory EHB categories–a substantial imposition on state autonomy.

CMS acknowledges that individual and small-group market plans cover treatment for gender dysphoria, noting that 0.11% of enrollees in non-grandfathered individual and small group market plans used this type of care in 2022 and 2023. CMS interprets this utilization level to indicate that treatment for gender dysphoria is not covered by these plans. But in fact, the relatively low utilization rate is explained by the small size of the transgender population and the fact that individual medical needs vary. Data from a UCLA School of Law Williams Institute report show that only 0.6% of people over the age of 13 are transgender, and, under expert standards of care, treatment for gender dysphoria is highly individualized. There are many other services, such as heart transplants, that are infrequently used by the population at large but are commonly covered by employer-based, major medical health insurance.

The proposed rule would also be difficult for issuers to implement because many of the items and services used to treat gender dysphoria cut across multiple EHB categories and are also

[1] For plan years 2026 and prior, federal rules also prohibited issuers from including routine non-pediatric dental services in EHB. CMS lifted that prohibition in the 2025 Notice of Benefit & Payment Parameters, effective for plan year 2027.

used to treat other medical conditions. If this proposed rule is finalized, issuers would need to determine when and how to cover a range of widely covered, medically necessary services—including mental and behavioral health care, prescription drugs, and surgical care (e.g., a hysterectomy)—based on diagnosis, significantly complicating claims and utilization management processes.

These challenges in differentiating whether common treatments are aimed at a specific diagnosis could delay or interfere with a wide range of patients receiving these treatments—compounding the already deep frustration that patients and their providers have with insurers' utilization management practices and diminishing the value of enrollees' coverage.

Furthermore, preventing plans and issuers from covering treatment for people with gender dysphoria as an EHB is contrary to the requirement that EHBs be defined in a way that protects individuals from discriminatory benefit design. It is also inconsistent with existing laws and policies, including Section 1557 of the ACA, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act—laws that courts have interpreted to prohibit discrimination against people with gender dysphoria.[2]

Increased Administrative Burdens and Reduced Opportunities for Enrollment

Shortening the Opportunity to Enroll (Section 155.410)

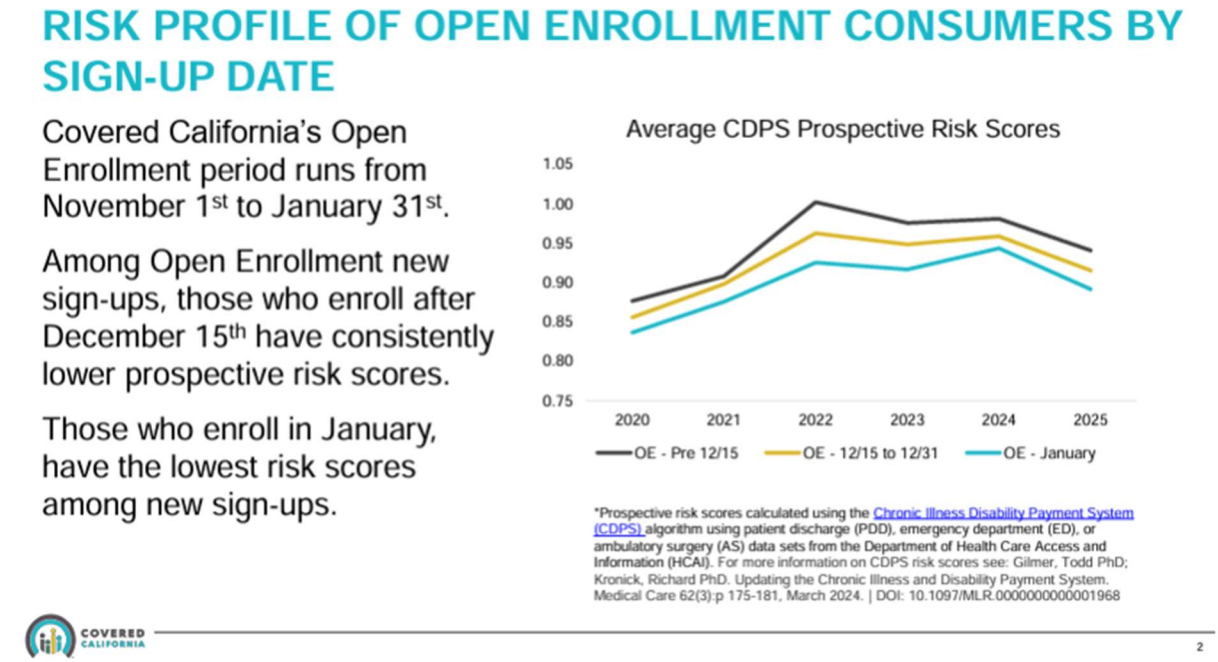
CMS proposes to shorten the annual open enrollment period ("OEP") for the federally facilitated exchange ("FFE") from 76 to 45 days. Further, in a break from historic deference to state flexibility, the proposed rule would prohibit the state-based exchanges ("SBE") from having a longer OEP. If finalized, all Marketplace OEPs would be required to run from November 1-December 15. CMS supports this proposed change by suggesting, contrary to available evidence, that extending the OEP past December 15 contributes to adverse selection. CMS also asserts that a longer OEP does not help boost enrollment and contributes to "consumer confusion." However, the agency provides no evidence to support these claims.

Available data contradict CMS's claims.

In fact, the experience of SBEs suggests that longer OEP durations encourage greater enrollment among younger, healthier individuals, thereby strengthening the Marketplace risk pool. For example, average risk scores for individuals enrolling early in Covered California's OEP (before December 15) have consistently been higher than those enrolling after January 1. The trend is striking and consistent across all years and time periods: the later in the OEP consumers enroll, the healthier they are. See Fig. 2.

[2] Bostock v. Clayton County, 590 U.S. 644 (2020) (holding that discrimination based on gender identity constitutes sex discrimination).

Figure 2. Risk Scores for Covered California Enrollees During OEP, Plan Years 2020-2025.



Source: https://hbex.coveredca.com/data-research/library/CoveredCA_OE_SEP_Data_Snapshot_20250403.pdf

Covered California's longer OEP (which runs until January 31) has in fact resulted in a healthier risk pool over time. *See also* Figure 2.

Similarly, in the final month of New York State of Health's ("NYSOH") 2017 OEP, which ended January 31, more than 135,000 individuals enrolled in Marketplace health plans. Using age as a proxy for risk status, New York found that younger enrollees made up a higher share of total enrollment in January than they did earlier in the OEP. Enrollees ages 55-64 comprise a larger proportion of Marketplace enrollees before January as opposed to after. NYSOH has also found that a greater share of consumers enroll in Platinum and Gold plans earlier during OEP versus the final month of enrollment, when Bronze and Silver enrollment is predominant. This suggests that those enrolling in January are healthier than those who enroll early in the OEP.

Although CMS presumably has data about the relative risk profile of January enrollees for the FFE, it fails to provide this data to support its assertions about adverse selection. This may be because, as in the SBEs, sicker individuals or those expecting significant health expenditures are more motivated to sign up for coverage early in the OEP. Those who are healthy are less motivated to enroll, and more likely to be deterred by financial and time constraints during the busy holiday period.

The proposed policy change will impose major costs on SBEs.

If finalized, this proposed change in OEP dates will impose significant new costs on the FFE and SBEs alike. By CMS's own estimates, it would take each SBE 4,000 hours to develop and code changes to their IT systems, at a cost of almost $7.8 million. This cost estimate does not take into account the expenditures for SBEs and issuers associated with the required outreach to consumers and training of consumer assisters. The proposed rule provides no justification for extending the FFE OEP deadline to SBEs and constraining state autonomy.

The SBEs are in a better position than the federal government to assess their market and the needs of their consumers. As noted above, many maintain a longer OEP than the FFE because they have found that it boosts enrollment among young, healthy individuals. *See* Figure 2. Indeed, as the current director of the Center for Consumer Information and Insurance Oversight ("CCIIO") has previously noted: "states are in a better position [than the federal government] to assess the situation. This promotes a stable marketplace."

Other important policy considerations weigh against finalizing the proposed policy change.

There is also evidence that the holiday period that runs from Thanksgiving to New Year's Eve is a time of financial constraint, particularly for the low- and moderate-income families that enroll in the ACA Marketplaces. Giving these families until January 15 to enroll avoids imposing additional stress during this time. SBE enrollees may face additional confusion since many SBEs have maintained the same OEP duration for many years. For example, NYSOH's OEP has extended to January 31 since 2016.

Furthermore, CMS acknowledges that many current Marketplace enrollees could face significant premium increases for plan year 2026–both as a result of other provisions of this proposed rule and if Congress fails to extend the enhanced premium tax credits originally provided in the American Rescue Plan Act of 2021 and extended through 2025 in the Inflation Reduction Act of 2022. Many of these enrollees may not learn of those premium changes until they receive their first bill for 2026, which may be well after December 15. Ending OEP on December 15 would leave them without the necessary time to make plan changes.

At the same time, CMS has slashed Navigator grants by 90%, leaving these critical consumer assisters without the resources to educate consumers about changing Marketplace policies and with limited capacity to help during the shortened enrollment window. Indeed, CMS acknowledges that it has received concerns from Navigators, agents and brokers, and other consumer assisters that a 45-day OEP is insufficient time for them to fully assist Marketplace applicants with comparing their plan choices. Thus, rather than reducing burdens on these consumer assisters, the proposed shortened OEP will only make it harder for them to provide quality support for their clients. Similarly, shortening the OEP by half will place considerable strain on Marketplace call centers, resulting in longer wait times and a degraded customer experience.

We therefore urge CMS not to finalize this proposal, to maintain the current OEP duration of November 1-January 15, and to continue to provide SBEs with flexibility to determine their own OEP dates. Finalizing this proposal will result in reduced enrollment, a less-healthy risk pool, and higher premiums for Marketplace enrollees. At a minimum, the proposed change to the OEP dates should be delayed until 2027, to mitigate the harms and confusion consumers will face if Congress does not extend the enhanced APTCs.

Eliminating a Critical Enrollment Opportunity for Low-Income Individuals (Section 155.420)

CMS proposes to repeal the special enrollment period ("SEP") made available to individuals at or below 150 percent of the federal poverty level ("FPL") (or an annual income of $23,475 for an individual, $48,225 for a family of four). In its 2025 Proposed Notice of Benefit and Payment Parameters, CMS found that the availability of this SEP has helped low-income consumers access affordable health insurance coverage and maintain access to care. However, CMS suggests that this SEP (referred to here as the "low-income SEP") has contributed to improper enrollments, driven largely by unscrupulous brokers and web-brokers seeking commissions. CMS also suggests, without evidence, that this SEP has increased adverse selection, leading to a less-healthy risk pool. The agency further posits that the low-income SEP lacks a statutory basis.

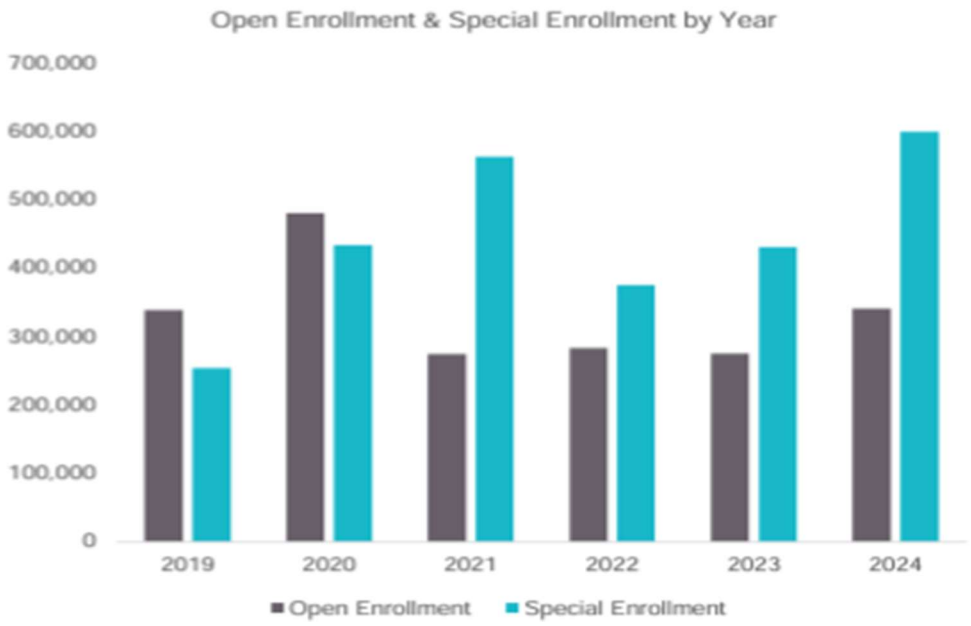
We urge CMS not to finalize this proposal. The low-income SEP has helped over one million individuals overcome challenges enrolling in health coverage. These challenges are particularly acute for lower-income individuals who may lack access to necessary information, face greater employment and household volatility, or reside in areas without sufficient enrollment assistance. These obstacles to health coverage will only be exacerbated if CMS finalizes its proposal to shorten the OEP by almost half, from 76 to 45 days.

There is no evidence that the existence of the low-income SEP has caused the increase in fraudulent enrollments experienced by the FFE in 2024. In fact, CMS traced the cause of enrollments and plan switches made without consumer consent to brokers and agents in the FFE taking advantage of system vulnerabilities that are unique to the FFE. CMS's proposed policy solutions seem poorly targeted to address the true problem of broker and agent fraud. Attempting to deter fraudulent enrollments by making it harder for people to obtain insurance coverage is like "trying to prevent car theft by making it more difficult for people to own cars."

By CMS's own estimates, fraud associated with unauthorized enrollments and plan switches for people under 150% FPL is concentrated in states that use the FFE and that have chosen not to expand Medicaid under the ACA. There is no evidence of any meaningful fraud in the SBE states, all but one of whom have expanded Medicaid and all but two have implemented the low-income SEP and have had it available to consumers for multiple years. None of these SBEs have reported problems with fraud. Indeed, Covered California reports that SEPs have become a critical source of enrollment, with more consumers signing up via SEP than during the annual OEP. See Figure 3. Yet there is no evidence of any meaningful fraud, due to Covered

California's comprehensive safeguards to ensure that brokers obtain consumer consent before completing an enrollment. Similarly, the Massachusetts Connector, which has long had a year-round SEP for low- and moderate-income individuals, has identified "zero consumer reports among the 1.2 million calls to its customer service center in 2024" of unauthorized enrollments.

Figure 3. Covered California OEP and SEP Enrollment, Plan Years 2019-2024.



Source: https://hbex.coveredca.com/data-research/library/CoveredCA_OE_SEP_Data_Snapshot_20250403.pdf

There is also no evidence that the low-income SEP has contributed to adverse selection. Although CMS has access to data that would indicate the risk status of people who enroll through SEPs compared to the OEP, data supporting that contention are notably absent from this proposed rule.

More strikingly, the experience of SBEs suggests that the people enrolling through low-income SEPs are, in fact, younger and lower-cost on average than those who enroll via OEP. For example, Massachusetts has long offered year-round enrollment to people who qualify for ConnectorCare, the state's Marketplace program for low- and moderate-income individuals. Massachusetts Health Connector officials report that they have "not experienced adverse selection within the program," and their "risk scores have been healthier than for insurers off-Marketplace."

Data included in a comment submitted by the Vermont Marketplace show that per-member-per-month costs associated with SEP enrollees are 8% lower than non-SEP enrollments, and that costs are lower-than-average among enrollees in an equivalent position to those who qualify for the FFE's under-150 SEP.

Covered California has found that the prospective risk scores of consumers enrolling through SEPs was equal to or lower than those enrolling through the OEP each year from 2020 to 2024. See Figure 4.

Figure 4. Covered California Average Risk Scores for OEP and SEP Enrollees, Plan Years 2020-2025.

	Open Enrollment	Special Enrollment
2020	0.86	0.85
2021	0.89	0.87
2022	0.96	0.93
2023	0.95	0.94
2024	0.96	0.96
2025*	0.92	

Source: https://hbex.coveredca.com/data-research/library/CoveredCA_OE_SEP_Data_Snapshot_20250403.pdf

DC Health Link, in reviewing 2019-2021 enrollment, found that the age of the SEP population remained consistent with the population that enrolled during open enrollment, and in some cases was even younger. See Fig. 5.

Figure 5. Ages of SEP and OEP Enrollees in DC Health Link, Plan Years 2019-2021

Age	2019 Open Enrollment %	2019 SEP %	2020 Open Enrollment %	2020 SEP %	2021 Open Enrollment %	2021 SEP %
< 18	10%	10%	10%	10%	9%	10%
18-25	5%	7%	10%	9%	10%	9%
26-34	34%	40%	39%	44%	42%	44%
35-44	22%	22%	20%	18%	19%	19%
45-54	15%	12%	11%	10%	11%	9%
55-64	13%	9%	9%	8%	8%	8%
65+	1%	1%	1%	1%	1%	1%
TOTAL	100%	100%	100%	100%	100%	100%

*Source: https://hbx.dc.gov/sites/default/files/dc/sites/hbx/page_content/attachments/DC%20HBX%202023%20NBPP%20Comments%20Final%201-27-22.pdf

Similarly, Massachusetts Connector officials have found that the average age of people enrolling through a SEP is 38—younger than the average age of enrollees overall, which is 41.

Even if Congress does not extend the enhanced APTCs this year, households with income at or below 150% FPL are still likely to find Marketplace plans with $0 premiums, further mitigating the risk of adverse selection. CMS's own data show that in 2020, before the enhanced APTCs were provided, 900,000 people were enrolled in fully subsidized bronze plans where the net premium was $0. About 77% of people at or below 150% FPL had access to a $0 premium bronze plan and 16 percent had access to a $0 premium silver plan. The availability of such plans to low-income consumers significantly mitigates the risk of adverse selection (because there is nothing to be gained by delaying enrollment), a fact CMS fails to take into account in its current rulemaking.

CMS does not provide an estimate of the cost to SBEs of implementing this proposed change, incorrectly stating that no SBE has implemented the low-income SEP. In fact, 18 SBEs—all but Idaho and Nevada—have implemented this SEP. The agency further proposes to require the removal of this SEP from SBEs immediately upon the effective date of the final rule. Requiring SBEs to remove this SEP from their eligibility and enrollment systems would result in significant costs, not only in terms of the necessary IT system changes but also to change current consumer communications, outreach, and training programs for consumer assisters. Furthermore, the requirement to implement this change in 60 days would be extremely challenging if not impossible.

As CCIIO's Director has observed, states are in a better position than the federal government to understand their markets and customer needs. Given that SBEs have reported neither fraud nor adverse selection arising from the low-income SEP, there is simply no rational basis to require the SBEs to eliminate this SEP.

CMS also posits that it lacks statutory authority to establish the low-income SEP, citing to the list of SEPs enumerated in sections 1311(c)(6)(C) and (D) of the ACA. However, section 1311(c)(6)(C) provides ample authority for this SEP. Specifically, it provides that "the Secretary *shall require* an Exchange to provide for…other special enrollment periods under circumstances similar to such periods under" Medicare Part D. Section 1860D-1(b)(3)(C) of the Social Security Act provides the Secretary with authority to establish SEPs for Medicare Part D enrollment, including the explicit authority to establish SEPs for "extraordinary circumstances," a broad term that the statute does not define. This alone creates the necessary authority.

CMS argues that the low-income SEP is dissimilar to Part D SEPs in statute. But in fact, Medicare Part D has a similar low-income SEP, which allows people with low incomes to change plans once per month or to drop Medicare Advantage and join traditional Medicare with a Part D drug plan. The Medicare Part D statute, similar to the ACA, lists certain specific SEPs that the Secretary must set up as a minimum; not all Medicare Part D SEPs are specified in statute. Thus, the low-income Marketplace SEP is indeed similar to a SEP in Medicare Part D.

More generally, Congress enacted the ACA with the goal of expanding access to health insurance. To effectuate this goal, section 1321(a) of the ACA provides the Secretary with broad authority to set standards for the offering of health plans through the Marketplaces, including standards relating to enrollment.

The authority in Section 1311(c)(6)(C) has been used dozens of times by CMS and by SBEs for all sorts of circumstances, including many that provide an enrollment opportunity for designated groups of applicants, such as during Medicaid unwinding and after certain natural disasters. Creating the low-income SEP is fully consistent with these precedents and the underlying authority. Asserting otherwise would represent a stark reversal from years of widespread practices.

Added Paperwork for Consumers Using a Special Enrollment Period (Section 155.420(g))

CMS proposes to impose additional documentation requirements on consumers seeking to enroll in Marketplace coverage through a SEP. Additionally, although CMS has traditionally given SBEs deference in the establishment and verification of SEPs, the proposed rule would require all Marketplaces, including SBEs, to conduct pre-enrollment eligibility verification for at least 75% of new enrollments through SEPs.

In proposing this change, CMS argues that requiring consumers to submit documents proving that they have experienced a SEP-triggering event will prevent people from enrolling only after they become sick or need health care services. Without providing evidence, CMS asserts that new documentation burdens will improve, not worsen, the Marketplace risk pools. In fact, CMS's own analysis in this proposed rule found that "younger, often healthier, consumers submit acceptable documentation to verify their SEP eligibility at much lower rates than older consumers."

CMS appears to assume, without any basis, that providing pre-enrollment documentation is easy for consumers, and that all consumers have "ready access" to the necessary official documents. In fact, a considerable body of research has found that paperwork and other administrative hurdles to enrollment in coverage programs serve as a strong deterrent to enrollment among people who are otherwise eligible for the coverage. Younger, healthier individuals are more likely to be deterred from enrolling, leading to a less-healthy risk pool. For example, a study published by the American Economic Association found that adding one single additional step to the enrollment process prompted a 33 percent decline in enrollment, predominantly among young, healthy, and economically disadvantaged people. Removing paperwork burdens, on the other hand, has been found to significantly increase enrollment and continuity of coverage among healthy, younger individuals.

CMS also argues that imposing new documentation requirements on consumers will help curtail SEP enrollments made without consumer consent. However, there is no evidence that adding bureaucratic headaches to the lives of consumers will serve as an impediment to the brokers

and web-brokers set on committing fraud. Many SBEs use an applicant's self-attestation as the primary mechanism for verifying SEP eligibility, yet no SBE has reported any meaningful fraud in their markets. SBEs are also in close communication with their participating issuers and are in a better position than the federal government to identify and address any concerns about how the SEP verification process is being used. Currently, many SBEs require consumers seeking to enroll via many SEPs to attest, upon penalty of perjury, that they qualify for the SEP in question. CMS has provided no evidence of any abuse of this process.

CMS's proposal would extend the new paperwork requirements across all Marketplaces, not just the FFE. Such a requirement would pose a significant, unfunded mandate on the SBEs. CMS estimates that the proposed changes would result in an annual new cost of $1,736,615 per SBE, not including costs associated with consumer communications, outreach, and assister training. Although CMS proposes allowing SBEs to submit a request for an alternative verification process, submitting such requests to CMS also poses significant, unnecessary burdens on SBE staff. Because CMS provides no evidence to support either the use of SEPs to commit fraud in the SBEs, nor evidence of adverse selection, there is no rational basis to take away SBEs' traditional flexibility to determine the SEP verification processes that work for their issuers and markets.

We urge CMS not to finalize this proposal.

Denying APTC for Failure to Reconcile (Section 155.305(f)(4))

CMS's proposal would change a recently instituted policy, under which consumers are only denied future APTC after IRS reports that they have not filed and reconciled past APTC for two years—referred to as failure to file and reconcile ("FTR"). If finalized, CMS's proposal would deny a consumer APTC if the IRS reports that they had not reconciled APTC for a single year, instead of the two years under the current policy.

Under the ACA, consumers receive APTC based on their projected income and then must file a tax return to reconcile APTC against the PTC they are ultimately due. An individual who fails to reconcile is subject to all of the IRS's normal enforcement tools for failing to properly file a return. FTR rules—created in CMS regulations—provided an additional penalty: individuals who failed to reconcile would also be denied APTC. But this FTR penalty appears nowhere in the statute.

FTR rules have long raised concerns about administrative burdens and fairness. IRS privacy rules generally prohibit Exchanges from providing applicants with information about their FTR status, even when denying them APTC on that basis—a recipe for consumer confusion and frustration. Consumers can also be incorrectly targeted for FTR denial due to delays or errors in processing tax returns. This is especially likely for individuals who file paper returns, which may disproportionately affect filers who are older and lower-income, and those who amend their returns. Delays and errors are also possible in the process the IRS must perform to share FTR information with Exchanges through the federal data services Hub. When these errors occur,

resolving them is complicated by the Exchanges' inability to discuss the reason for the denial. More generally, completing the forms to properly reconcile APTC is a complex process that may frustrate even those taxpayers attempting to comply.

To address these concerns, CMS adopted a new policy, effective for coverage year 2025, under which the Exchange denies APTC only when the IRS reports that a consumer has failed to reconcile for two consecutive years. This approach mitigates concerns about delayed or missing IRS data, consumer confusion, and administrative burden. In adopting this rule, CMS noted that this middle ground would "properly balance consumer protections and program integrity concerns, and therefore support that we should continue to improve the FTR process rather than repeal it entirely."

In addition, the IRS recently made an administrative change that minimizes the risk that consumers could fail to reconcile in the first place. If a consumer received APTC and then attempts to e-file a return without reconciling, the IRS will now bounce back that return. This policy increases the likelihood that any appearance of an FTR flag is due to IRS delay or error. CMS does not mention this recent change and does not appear to have considered it. This measure is in addition to the IRS's long-standing enforcement mechanisms for individuals who fail to properly file a return or pay taxes that are due, which can include the withholding of tax refunds and liens and levies.

CMS estimates that its proposal would deny APTC to between 265,000 and 424,000 consumers and reduce APTC spending by between $1.16 billion and $1.86 billion in 2026. Of course, CMS justifies this change by claiming that "new analysis of the enrollment and tax filing status suggests a large number of people with FTR status are ineligible for APTC and that pausing removal of APTC due to an FTR status allows ineligible enrollees to accumulate tax liabilities." But the agency offers no data to support this claim. Its claim about "further analysis of enrollment data" is cited generally to the CMS webpage listing public use files—no specific statistics are cited. Similarly, CMS asserts that "[a]fter reviewing the tax filing data, we remain concerned that enrollees are accumulating tax liabilities due to misestimating their income." But no tax statistics are provided. CMS also asserts that those with FTR status account for a substantial number of those improperly enrolled. But it similarly provides no data to support this assertion.

CMS does not address the premium impact of this change. But given that sicker individuals are more motivated to overcome administrative burdens to enroll in coverage than healthier ones, it would likely worsen the risk pool and increase premiums.

This proposal would be implemented in fall 2025, beginning with the 2026 open enrollment period. Eligibility would be tied to filing a 2024 federal tax return and reconciling APTC in order to remain eligible for APTC in 2026. This implementation timeline may be infeasible for some SBEs and for the IRS, both of which have historically required years to implement new FTR rules.

We urge CMS not to finalize this proposal.

Junk Charges for Automatic Re-Enrollment (Section 155.335)

CMS proposes an unlawful approach to calculating APTC for certain consumers at automatic re-enrollment. Specifically, the agency proposes that Marketplaces will first make an eligibility determination for APTC following the terms of the statute, and then if APTC is sufficiently large, arbitrarily reduce the amount of APTC made available so that the consumer owes $5 in premium until the consumer returns to the Marketplace for an active enrollment. The ACA prohibits the imposition of this junk charge, which has no basis in statute.

The ACA specifies how APTC must be calculated.

Automatic re-enrollment is the process by which a consumer from the prior year who has not actively submitted an application and enrolled in coverage for the upcoming benefit year is re-enrolled. In determining eligibility for APTC during the re-enrollment process, agency action is governed by several sections of the ACA.

Section 36B of the Internal Revenue Code (as added by the ACA) specifies a series of criteria and calculations used in determining premium tax credit amounts. ACA section 1411 directs the Secretary of the U.S. Department of Health and Human Services ("HHS") to "establish a program… for determining… in the case of an individual claiming a premium tax credit or reduced cost-sharing under Section 36B of such Code or section 1402 whether the individual meets the income and coverage requirements of such sections." Section 1412(a) directs the Secretary to "establish a program under which… advanced determinations are made under section 1411." And section 1412(c) directs that the federal government "shall make the advanced payment under this section of any premium tax credit allowed under section 36B."

In other words, section 36B is the sole statutory instruction in how to calculate a premium tax credit amount. The program established under section 1411 must determine eligibility under section 36B. And once an individual has been determined eligible under section 1411, the federal government "shall make" payments in the amount "allowed under section 36B," as required under section 1412. In other words, the statute makes payment of the full amount mandatory.

There is no statutory authority to alter an eligibility determination.

CMS has expressed a policy concern about consumers for whom APTC fully covers their premium, such that they owe nothing out-of-pocket each month. The agency thus proposes that when a Marketplace has conducted an eligibility determination that results in that outcome, the Marketplace must arbitrarily reduce APTC so that the consumer owes a premium of $5. Section 1412 clearly forecloses this outcome. Section 1412(c) requires payment of the amount "allowed under section 36B," not some other amount determined arbitrarily by CMS. It is true that ACA section 1411(f)(1)(B) provides general authority for the agency to "establish procedures" for eligibility redeterminations, as CMS notes. But nothing in that section confers authority to make

the advance determination of eligibility but then pay less than the amount dictated by the eligibility determination; rather the Marketplace "shall" pay the amount of APTC established pursuant to the eligibility determination process. Whatever policy concerns the agency may have, the text of the statute is clear and provides no discretion for a Marketplace to impose a $5 junk charge that is squarely contrary to the express provisions of the law.

These same prohibitions apply to an alternative proposal that CMS discusses, under which APTC would be removed in its entirety. A decision to apply no APTC at all for consumers determined eligible under section 1411 transparently violates the requirement that the federal government "shall make the advanced payment." If an individual has been determined eligible, APTC must be paid.[3] Similarly, these same concerns would apply if CMS attempted to direct Marketplaces not to re-enroll all consumers who qualify for APTC. If a Marketplace conducts an eligibility determination, section 1411 specifies that it must evaluate eligibility for APTC. And once an eligibility determination has occurred, the Marketplace is bound by the results—CMS has no statutory authority to direct the Marketplace to do anything different.

CMS fails to address important policy considerations.

Beyond the fact that the proposal violates the statute, CMS's analysis of the issue ignores a number of important policy considerations. These changes will require significant action on the part of state-based Marketplaces—requiring them to expend technical resources and damage their brand by charging consumers money they should not owe—despite no evidence of a problem. Further, in this rule, CMS proposes shortening the Marketplace OEP to end on December 15, which makes it impossible for consumers who notice the junk charge only as they are about to lose coverage to avoid paying it while keeping coverage for the rest of the year.

Finally, CMS does not quantify or grapple with the risk pool impacts of this proposal. Enrollment will fall as a result of this barrier: one study found that premiums less than $10 led to a 14 percent decrease in enrollment. As discussed extensively below, young and healthy consumers are at the greatest risk of failing to notice the junk premium charge and losing coverage as a result, while those with significant health care needs will likely resolve the issue more quickly. Indeed, real-world evidence underscores that supporting automatic re-enrollment rather than imposing small premium burdens is associated with retention of healthier consumers. CMS's proposal will worsen the risk pool and drive up premiums for unsubsidized consumers.

[3] We note that this circumstance is completely different from other cases where a consumer may lose APTC at automatic enrollment. In those cases, the Marketplace is making a determination *pursuant to section 1411* that the individual does not "meet[] the income and coverage requirements" of section 36B. Here, CMS is proposing the Marketplace would make a determination under section 1411 that a person is eligible and calculate an amount under section 36B, and then reject or alter that determination and apply a different amount of APTC or no APTC at all. It may not do so. Section 1412 requires the payment of APTC in the amount for which the consumer has been determined eligible.

Imposing Higher Deductibles at Re-Enrollment (Section 155.335)

CMS proposes to end a policy that lowers deductibles and cost-sharing for enrollees at automatic re-enrollment. Under current policy, if an individual who is being automatically enrolled into a bronze plan can be moved into a silver plan (with lower deductibles and other cost-sharing), with the same network and from the same issuer, and with the same or lower premium, then they will be automatically re-enrolled into the silver plan. This maximizes consumer value and promotes consumer retention in coverage. The arguments CMS advances for changing the policy are not supported by evidence.

CMS's primary justification is that consumer awareness of APTC generosity has increased and therefore support to help enroll consumers in plans with lower deductibles is not necessary. Yet the agency offers no empirical evidence of such an improvement in understanding. Instead, polling data show that public awareness of the existence of APTC at all—much less the nuances of metal levels and recent changes—remains quite low. The agency also points to alleged harms from consumer confusion but offers no plausible reason why a consumer would be "confused" by being enrolled into a plan that is identical to her prior coverage, except for the fact that it has lower deductibles and cost-sharing. Indeed, the agency has provided no plausible justification for making this change and should not finalize the policy.

More "Data Matching Issues" and More Paperwork Burden (Section 155.320)

CMS proposes two policies that will generate more paperwork related to income verification, especially for low-income people: generating a "data matching issue" ("DMI") when IRS data show income below 100% FPL, and generating a DMI in the absence of IRS data. These changes will have the effect of making it more burdensome and less efficient for low-income people and those with variable incomes or family circumstances (like small business owners and the self-employed) to receive benefits to which they are entitled. For this reason, the policy changes will deter enrollment of healthy people. The proposed changes are also expected to meaningfully worsen the Marketplace risk pool and increase premiums for unsubsidized enrollees. Indeed, a 2019 version of one of these policies was struck down under the APA. The court found that CMS's decision to "prioritize a hypothetical risk of fraud over the substantiated risk that its decision [would] result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic."[4] While CMS claims that "new" data show that the package of policies is justified, it offers no data supporting this view. In fact, the available data *undermine* the policy rationale for the proposals. Further, CMS's claims that the statute requires these changes are specious.

[4] City of Columbus v. Cochran, 523 F. Supp. 3d 731, 763 (2021).

The proposed changes will cause a significant increase in administrative burden that will worsen the risk pool and increase premiums.

The CMS proposal to generate DMIs when IRS data is absent or shows income below 100% FPL will place substantial new administrative burdens on people and on state and federal Marketplaces. Together, the proposals will generate an estimated 2.7 million new income DMIs (550,000 for tax data below 100% FPL and 2.1 million for missing tax data)—requiring 2.7 million people, many of whom live just above the FPL, to track down and submit paperwork in order to buy health insurance. Every year, CMS expects that people will spend $66 million dealing with the paperwork requests, and state and federal Marketplaces will spend $155 million in reviewing these documents. An estimated 480,000 people, most of whom are likely eligible, will lose health insurance because they fail to successfully navigate the process.

As discussed above, this is exactly the kind of administrative burden that deters enrollment of younger and healthier enrollees and causes problematic adverse selection. An enrollee with heart disease who is taking multiple expensive medications is *far* more motivated to track down a stack of documents to prove their income than a healthy 30-year-old enrolling in coverage for the financial security it provides. CMS has long underscored that coverage losses associated with DMIs are concentrated among the young, a pattern that CMS acknowledges continues to this day. Recent data from Massachusetts document the same pattern. Deterring these younger and healthier people from enrolling worsens the risk pool and increases premiums—further deterring enrollment of healthy unsubsidized enrollees. This "spiral" is exactly the kind of practice that CMS purports to be trying to avoid in this rule.

CMS briefly acknowledges these impacts but asserts that it is moving forward regardless because of concerns about fraud and improper enrollments. Yet CMS provides no analysis quantifying the scale of the premium increases associated with this large new administrative burden and attendant losses of coverage. Without acknowledging and assessing the adverse impacts on the risk pool and on premiums, CMS has not provided sufficient justification for the proposed additional paperwork burdens being placed on Marketplace consumers. Thus, the agency cannot make such a tradeoff in any non-arbitrary way. This is doubly true because, as discussed below, CMS's purported evidence of large-scale fraud in fact shows nothing of the kind.

CMS's policy is based on faulty analysis that could justify the opposite conclusion as the one reached by the agency.

CMS asserts that it needs to impose these major burdens on people because the status quo—under which CMS has focused on ways to simplify enrollment—has facilitated fraud and improper enrollment. CMS provides analysis that the agency claims demonstrates these problems at a meaningful scale. However, the analysis does not support that conclusion.

Marketplace financial assistance is based on *projected* annual income for the year. This is not a knowable number that is measured in any surveys or on one's tax return; it is a subjective projection based on the household's expectations. As described in more detail below, CMS

fundamentally misunderstands this distinction in its analysis of Marketplace enrollment patterns. In focusing on enrollment of individuals who end up having an annual income below 100% FPL, CMS claims that such an enrollment is "improper." This is simply untrue; if an enrollee had a reasonable basis for expecting that her future income would be above 100% FPL, then her enrollment is wholly legitimate, even if their income turns out to be below 100% FPL at the end of the year. CMS's claim that enrollment near the poverty level is "136 percent higher than the total population of potential enrollments" is false: the accurate denominator in such a calculation is the number of people who have reason to believe they will have income above 100% FPL, not the smaller number based on the post hoc results that are used in the calculation on which CMS relies.

Indeed, challenges in estimating annual income are especially acute for the low-income people targeted by CMS's policies, a fact which the agency entirely fails to address. One detailed analysis of earnings variability among low-income workers found that more than half experienced significant variability in income, a proportion that is greater than higher income workers. Moreover, the actual magnitude of this income variability is quite striking, with workers in the lowest quintile having more than double the magnitude of variability than all other income groups. (For low-income workers, the standard deviation of monthly income was 85% of the mean—so that someone who earned an average of $1000 per month had so much variation month-to-month that a month where their income was anything from $150 to $1850 would be within a single standard deviation.) Multiple other analyses find this same basic pattern. Against this factual backdrop, it is clear that projected income and actual annual income are fundamentally distinct concepts, especially for low-income people. The agency's acknowledgement that variability exists does not mitigate the fact that the agency's assertions regarding improper enrollment are based on that faulty premise.

Moreover, the agency's data on changes in certain enrollment patterns over time show the exact opposite of what it claims. CMS presents a table that examines the rate at which people at different income levels end the year with more APTC than the PTC calculated based on their actual end of year income. It finds that after CMS made changes to prevent unnecessary income DMIs (changes that this proposed rule would undo), the rate at which low-income people received more APTC than PTC did increase. But CMS ignores that the rate for low-income people remained *less than half* of the rate for higher income people. While there are certain structural differences between PTC calculations for high-income and low-income people, this analysis undercuts their claims that improper enrollments are concentrated among low-income people. This is especially true because income variability is so much greater for this population. Instead, to the extent that these data are a useful metric, they suggest just the opposite: that the agency was right to be concerned that aspects of their 2019-era enrollment policies were "punitive," and that changes to decrease administrative burdens were justified. Far from these data showing that the agency has more basis for acting than they did in 2019, the analysis shows that it has even less justification than it thought.

Claims that the ACA requires change are wrong.

Finally, CMS claims that it is required to make one or both of these changes because its current policy violates the ACA. In fact, the law clearly authorizes the status quo.

To advance its argument to the contrary, CMS claims that statutory language that provides "flexibility" for the agency to "modify the program" "for the exchange and verification of information" somehow does not actually provide flexibility to modify verification. This rests on two assertions: (1) that the statute only authorizes modifications if those modifications affect *both* "exchange" and "verification" of information, and (2) that the status quo is too significant a departure to be understood as agency action to "modify" these rules. Both claims are inconsistent with the ACA's statutory language.

To start, section 1411 of the ACA establishes a process for obtaining information related to eligibility and using that information to verify eligibility. Under a subsection labeled "Actions Relating to Verification," section 1411 establishes the DMI process that is at issue in this section of the proposed rule. In a separate subsection, the statute provides the flexibility noted above to "modify the methods used under the program established by this section for the Exchange and verification of information." This clearly authorizes modifications related to "verification." Yet CMS argues that what Congress really meant was that modifications were only allowed if they were directly related to rules for how information is *both* exchanged and verified. If Congress had meant this, they would have said so. They did not.

Similarly, CMS's claims that modifications under current policy are not actually modifications are baseless. The current rule modifies the circumstances under which a DMI is triggered and considers information adequately verified without paperwork in more circumstances. This is squarely a "modification" of the general rule and is precisely the sort of modification to reduce administrative burdens that was envisioned by the statute.

Thus, CMS cannot justify the proposals in the rule to generate new DMIs with claims that they are required by the statute to adopt these changes.

Making Data Matching Issues Harder to Resolve (Section 155.315)

CMS also proposes to make DMIs harder to resolve by requiring a manual request for additional time to resolve a DMI rather than automatically extending the clock by 60 days. CMS justifies this primarily by arguing that the statutory language noted above that provides "flexibility" related to "verification" does not provide statutory authority for current policy. That argument fails for all the reasons noted above: the time period for resolving a DMI is clearly an aspect of verification, and so modifying it is clearly authorized under the statute.

CMS also fails to grapple with a number of critical aspects of this policy. First and foremost, the changes described above will result in a substantial increase in the number of income DMIs generated and a major additional burden in reviewing documents. As the agency sheds critical staff who, among other things, monitor contractor performance in reviewing DMIs documents

timely and make adjustments as needed, it is not at all clear whether the agency has a plan to ensure that consumers are not harmed by contractor back-ups caused by agency actions. Without automatic clock extensions, this inefficiency could cause consumers to lose coverage through no fault of their own. CMS also fails to address the additional information collection burden associated with requesting 60-day extensions.

Limiting Eligibility for Coverage

Terminating Coverage for Thousands of DACA Recipients (Section 155.20)

CMS proposes to reverse its policy relating to Deferred Action for Childhood Arrivals ("DACA") recipients by re-defining the term "lawfully present" to exclude DACA recipients for the purposes of enrollment in Marketplace and Basic Health Program ("BHP") coverage, premium tax credits, and cost-sharing reductions. This proposed change in definition would go into effect upon the effective date of the final rule, prompting DACA recipients currently enrolled in Marketplace or BHP coverage to lose eligibility mid-year. This change will cause significant disruptions in the form of interrupted and canceled health care services, increased exposure to catastrophic medical bills for this financially vulnerable population, and greater uncompensated care costs for providers. Some current Marketplace or BHP enrollees could lose coverage while in the middle of a course of treatment.

We urge CMS not to finalize this proposal and to retain its current definition of "lawfully present" to include DACA recipients. HHS has generally interpreted "lawfully present" to include those granted deferred action by the Department of Homeland Security ("DHS"). Although HHS excluded DACA recipients from the definition of lawfully present in 2012—after DHS first announced its DACA policy earlier that year—since then DHS issued regulations formalizing its DACA policy. Among other policies, DHS's DACA final rule reiterated the agency's view that a non-citizen who has been granted deferred action is deemed "lawfully present" for purposes of Social Security benefits.

CMS reconsidered its Marketplace and BHP policies in light of the DHS 2022 rule, and in 2024 the agency finalized a rule that would no longer treat DACA recipients differently than other people granted deferred action. Not only does this ensure equitable treatment across this population, the 2024 final rule better aligns with the goals of the ACA to reduce the numbers of uninsured and improve access to affordable health coverage.

In several sections of the preamble to this proposed rule, CMS expresses concerns about adverse selection in the ACA Marketplaces. Yet the proposal to end coverage for DACA recipients would remove from the risk pool a population that is healthier, on average, than the general population. A 2024 analysis of federal survey data found that the majority of immigrants likely eligible for DACA are working and have self-reported excellent or very good health.

CMS estimates that 10,000 DACA recipients will lose their Marketplace coverage and 1,000 will lose BHP coverage if this proposed rule is finalized. However, this may be an underestimate of the harm. In the final 2024 rule that includes DACA recipients in the definition of lawfully present, CMS estimated that about 100,000 people with DACA would benefit from access to Marketplace coverage and subsidies. Although only a small proportion of those may be enrolled in Marketplace or BHP coverage for plan year 2025, this is likely because the policy is new, and many DACA recipients may not have known about their new coverage options in time to enroll. Additionally, litigation over the DHS and HHS DACA rules has likely contributed to confusion among DACA recipients about their right to enroll in Marketplace or BHP coverage.

Furthermore, CMS's proposed change will place considerable burdens on SBEs and the two BHP states, requiring them to reverse current processes and change their systems, mid-year, to terminate coverage for existing enrollees and halt future enrollment for DACA recipients. Additionally, CMS's estimates of the time and cost burden for SBEs and the BHP states do not appear to take into account expenditures related to customer outreach and education, changing call center scripts and website copy, and training for call center workers and consumer assisters.

Reducing State and Insurer Flexibility on Premium Payment Thresholds (Section 155.400(g))

CMS proposes to revoke the recently finalized policy to give insurers additional options to avoid terminating coverage when enrollees underpay premiums by a de minimis amount. Specifically, CMS would eliminate the options, finalized in the plan year 2026 payment notice, to provide fixed-dollar thresholds and gross premium percentage thresholds. This change has not yet taken effect.

Long-standing regulations permit insurers to set a minimum percentage of the consumer's premium share (a "net premium percentage threshold") that they will accept for purposes effectuating enrollment (referred to as a "binder payment") or avoiding triggering a three-month grace period or termination. For example, if a consumer's full premium is $400, of which APTC covers $300, and the issuer permits a net premium threshold of 95%, the consumer satisfies the threshold so long as they pay at least $95 (95 percent of the $100 net premium).

This threshold provides relief where a consumer makes a nearly complete payment. But it does not help if the consumer owes only a minimal amount and pays a smaller share. For example, if the full premium was $400, APTC was $398, and the consumer paid none (or even $1.50) of their $2 share, a net premium threshold of 95% would not protect the consumer, since they would not have paid 95% of their $2 net premium.

To address such situations, the 2026 payment notice created two additional threshold options. First, insurers could set a threshold of no less than 98 percent for the combined premium paid by APTC and the consumer (a "gross premium percentage threshold"). Second, insurers could set a dollar value for permissible non-payment (a "fixed-dollar threshold"), which had to be no

more than $10. The rule also clarified that, for the existing option (the net premium percentage threshold), a threshold of at least 95 percent of the net premium would be considered reasonable.

Current rules include some significant constraints on the new options. Both apply for purposes of triggering grace periods and coverage loss, but not for binder payments. As a result, an enrollee with even a very small or nominal premium must make a payment to effectuate coverage. Second, insurers may offer only one of the percentage-based thresholds. Finally, all of the options are based on the accumulated non-payment. For example, if the insurer has a dollar-value threshold of $5 and a consumer underpays by $3 for two consecutive months, the accumulated shortfall of $6 is considered as exceeding the $5 threshold.

Offering such thresholds is generally optional for insurers, and states may also limit them using insurance regulatory authority.

CMS now proposes to eliminate both new threshold options before they take effect, preemptively reducing the flexibility afforded to states and insurers. Insurers' flexibility would be limited to offering only net premium percentage thresholds. As a result, de minimis non-payments would continue to result in coverage loss. CMS estimates that this change would reduce APTC payments by about $820 million in 2026.

The agency justifies this proposal based on continued reports of enrollment fraud tied to brokers, which they say indicate that anti-fraud measures to date have been insufficient. CMS notes that it received 7,134 consumer complaints of improper enrollments in December 2024, an increase from 5,032 in December 2023, and that complaints in 2024 overall were up from 2023.

This explanation does not reasonably support the proposal for several reasons. First, CMS's measures to reduce broker fraud were phased in over the course of 2024, so the annual figures shed little light on their impact. Indeed, CMS released data in October finding "a dramatic and sustained drop across several key metrics that indicate that Marketplace system changes that were implemented in July 2024 are having the desired effect of successfully preventing consumers from being switched to different plans or enrolled in coverage without their informed consent." Moreover, CMS provides no evidence that this fraud—which has been tied to brokers—is related to premium payment thresholds. Such a connection seems especially unlikely given that the options CMS proposes to abolish have not yet taken effect, so they clearly have played no role in fraud to date.

Allowing Coverage Denials for Past-Due Premiums (Section 147.104(i))

CMS proposes to allow issuers to condition new coverage on the repayment of outstanding premium debt for prior coverage. This policy is confusing for consumers, violates the statute, and will worsen Marketplace risk pools.

Under current policy, issuers are permitted to pursue traditional payment collection activities to collect on past-due premiums that an enrollee failed to pay; however, when a consumer makes a payment to the issuer for a *new* enrollment, the issuer must accept their new enrollment and cannot treat that payment as if it were payment for an *old* debt. To allow otherwise would be confusing for consumers. Marketplace consumers are generally engaging in an e-commerce-like transaction in which they have gone to a website, selected an item for purchase, and then visited another website and provided payment information in order to complete the purchase. CMS proposes to allow the issuer to accept the consumer's payment—but *not* actually sell them the item and instead keep the payment for an unrelated debt. Consumers in this situation could feel tricked into payment, and CMS is proposing to permit this once again.

Indeed, CMS has historically—and correctly—interpreted the statute to prohibit this behavior. Section 2702 of the PHS Act specifies that the issuer "must accept every… individual in the state that applies." The statute notes one limited exception to this requirement, relating to the time of year in which the enrollment occurs. No exceptions are available related to past due premium collections. Thus, an issuer that takes a consumer's payment but refuses the enrollment on the grounds that the funds have been applied to an old debt has violated the guaranteed availability requirements of section 2702. CMS was historically correct to articulate that the statute prohibits this behavior, and the statutory language clearly forecloses the atextual exception that is proposed.

Moreover, allowing these coverage denials will worsen Marketplace risk pools and raise premiums for all consumers, including the unsubsidized. These effects are the exact opposite of CMS's articulated goals in this proposed rule. A large body of literature demonstrates that young and healthier enrollees are far more price sensitive than older and sicker enrollees. These young and healthy individuals are more likely to decline to enroll if they make a payment—which they expect is their full premium payment—and yet are told they need to make an even greater payment to enroll. Moreover, these young and healthy enrollees are far more likely to have fallen out of coverage in the first place for past nonpayment of premiums. Deterring this group from returning to the Marketplace will only worsen the overall risk pool. In the proposed rule preamble, CMS notes that the proportion of enrollees terminated for nonpayment of premiums fell in a prior time period in which a version of this policy was in place. That analysis, however, ignores the fact that overall Marketplace enrollment also fell during this time period and premiums rose significantly—suggesting that a combination of policies led to fewer healthy enrollees retaining coverage and Marketplace coverage remaining only for those more at risk of health events, who are more likely to pay premiums throughout. CMS fails to account for these negative effects on this risk pool in their analysis of the proposed rule.

Holding Agents, Brokers, and Web-Brokers Accountable for Unauthorized Enrollments (Section 155.220(g)(2))

CMS proposes to clarify the standards under which it would pursue a termination of an agent, broker, or web-broker's (collectively, "broker") Marketplace agreement. Specifically, CMS would

use a "preponderance of the evidence" standard of proof in order to assess whether a broker is in compliance with relevant laws, regulatory requirements, and agreement terms and conditions.

We support CMS's efforts to clarify the standard of proof it uses to assess brokers' conduct and pursue cases of suspected fraud or misconduct. We also appreciate CMS's recent efforts to mitigate the risk of unauthorized enrollments or plan switching, including the July 2024 action requiring a 3-way call with the Marketplace before a new broker can change an enrollee's existing plan. Following this action, broker-initiated plan changes dropped nearly 70%, and the redirection of commissions from a consumer's original broker to a new one (an indicator of potential misconduct) fell almost 90%. We further applaud the rule finalized in January 2025 clarifying CMS's authority to pursue actions against fraud or misconduct directed or facilitated by broker agencies.

However, we are concerned that CMS, without notifying the public, has reinstated the certifications of brokers that it previously suspended. This places consumers at continued risk of being victims of fraudulent enrollments or plan switching and sends a signal to the broker community that they will not be held accountable for misconduct. We are also extremely concerned about the past and possible future reductions in the CCIIO workforce and their impact on efforts to identify improper enrollments and conduct enforcement actions against brokers who have failed to properly gain consumer consent for an enrollment or plan change.

CMS seeks comment on further actions it should take to mitigate the harms associated with unauthorized enrollments and plan switching. We offer the following recommendations:

- CMS should provide an exceptional circumstances SEP, beginning when a consumer learns that he or she has been improperly switched to a new plan, to enroll in the plan of their choice.
- CMS should ensure that consumers are held harmless for any APTCs paid towards a plan for which their consent to enroll cannot be documented.
- CMS should work with participating issuers to stop payment of broker commissions on enrollments where consumer consent cannot be adequately documented.
- CMS should share information about troubling patterns of broker behavior with state insurance regulators prior to the final adjudication of a case. While we recognize that the details of an investigation cannot be made public, state insurance regulators are responsible for the licensure of brokers within their states. Therefore, regulators can and should be important partners with CMS in protecting consumers from broker misconduct.
- CMS should conduct consumer testing on its model consent form and scripts. Once tested, CMS should require the use of these forms and scripts by brokers for documenting consumers' review and confirmation of consent.

Comments on the Regulatory Impact Analysis

The proposed rule includes a regulatory impact analysis that is central to its justification for the package overall and specific proposals. CMS requests comments on all aspects of the analysis. This section responds to those requests. It addresses two central elements of the analysis: claims about improper enrollment and claims about the rule's impact on the individual market risk pool.

The analysis is lengthy but frequently unclear about its specific methods and the data it relies on. It is also poorly connected to the proposals in the rule and thus does not provide a reasonable basis for finalizing the rule.

Analysis of Improper Enrollment

The rule says that its primary purpose is to address the large number of improper enrollments that CMS claims exist. This is reflected in the reference to "integrity" in the rule's title and the numerous places in which CMS justifies its proposals on that basis.

CMS estimates that there were 4 to 5 million "improper" enrollments overall in 2024. It arrives at this figure by comparing actual enrollment in each state based on 2024 administrative enrollment data to estimates of the eligible population in each state based on 2023 survey data from the Census Bureau, trended forward to 2024. CMS finds that enrollment exceeds estimated eligibility in nine states, and the excesses in these states add up to 4.4 million. This methodology follows a Paragon paper, "The Great Obamacare Fraud." CMS also cites extensively documented data on consumer complaints about broker fraud.

CMS next estimates improper enrollments in 2026 by reducing the 2024 figure to account for the expiration of the PTC enhancements. CMS claims that the expiration of the enhancements will eliminate more than half of improper enrollments. CMS then appears to claim that the proposals in this rule will eliminate all remaining improper enrollments—reducing enrollment by between 750,000 and 2 million people. CMS further claims that the reduction in enrollment would only affect those improperly enrolled; in other words, the proposals will have no effect on legitimate enrollment. This final claim is addressed in the next section of this comment, focusing on risk pool effects of the proposals.

CMS's state-by-state estimates find that excess enrollment is highly concentrated in FFE states, especially non-expansion states. Indeed, 8 of the 9 states that were found to have take-up over 100% were non-expansion FFE states at the time of the data. None was an SBE state.

CMS's analysis of improper enrollment suffers from numerous flaws that undermine its credibility as a reasonable basis for rulemaking.

The recent well-documented fraud by brokers is a legitimate and serious program integrity problem. CMS must have the resources and authority to investigate and take action against

fraudulent actions that compromise the integrity of marketplace programs. Indeed, it has already taken multiple steps to do so, as discussed below.

That said, CMS's analysis of "improper enrollments" contains numerous flaws that undermine its credibility and call into question the justifications for the rule's proposals. CMS concedes numerous shortcomings with its methodology, including that it does not account for recent CMS actions to improve program integrity, enrollees' uncertainty around their expected income, the tendency of survey respondents to understate income, and "the imprecision inherent in the use of survey data." CMS seeks comment on ways to improve its estimate, and on its proposals.

We respectfully submit the following suggestion to improve the analysis:

- **CMS should revise its analysis to avoid inaccurately describing individuals who enroll consistent with statutory rules as ineligible.** As we discuss in the section on denying APTC for FTR, CMS's analysis mis-applies eligibility rules in a way that leads it to overstate improper enrollment. Under the ACA, Marketplace financial assistance is based on *projected* annual income for the year. A consumer can receive APTC if they reasonably project that their income for the coverage year will be within the eligible range–for example, because they currently have a job in which they expect to earn 150% of FPL for the year, or they own a small business that is expected to produce that much profit. Because the reasonable projection standard is built into the rules, the consumer does not become "improperly enrolled" if they unexpectedly lose their job or realize a smaller-than-expected profit. Thus CMS's calculations of the "take-up rate" use the wrong denominator: it uses the number of people reporting eligible income for the year, but it should use the number of people who reasonably expected that they would have eligible income. (Measuring this correct figure is challenging, but that doesn't justify grounding policy changes in inaccurate figures.) Given that FPL is quite low—just over $15,000 for a single person for 2025 coverage—it is not unreasonable for people to think that their income could reach that level.

  It's also important to note that challenges in estimating annual income are especially acute for the low-income people targeted by CMS's policies, which means that the difference between the *correct* measure of the potentially eligible population and the number CMS uses will be especially wide. One detailed analysis of earnings variability among low-income workers found that more than half experienced significant variability in income, greater than higher income workers. The actual magnitude of this income variability is quite striking, with workers in the lowest quintile having more than double the magnitude of variability than all other income groups. (For low-income workers, the standard deviation of monthly income was 85% of the mean—so that someone who earned an average of $1,000 per month had so much variation month-to-month that a month where their income was anything from $150 to $1,850 would be within a single standard deviation.) Multiple other analyses find this same basic pattern.

This uncertainty point is reinforced by a paper by former and current Congressional Budget Office authors cited by CMS in the rule. The paper notes that "[g]iven the high income-volatility among low-income families, these results do not necessarily prove that ineligible people are signing up for marketplace coverage. Eligibility for advanced PTCs is based on an enrollee's expected annual household income for the coming year rather than on point-in-time income at the time of enrollment. This amount is hard to estimate, especially for households whose members may work part-time or seasonally, expect to change jobs, or are self-employed." CMS's analysis omits this qualification of the paper's findings.

- **The analysis should not calculate improper enrollment by comparing actual enrollment data to survey-based estimates of the eligible population.** CMS's estimate of improper enrollment relies on the conceptually incorrect method of comparing the actual enrollment data to estimates of the eligible population based on survey data. This approach creates several methodological problems, some of which CMS recognizes in the rule.
    - As CMS notes, the survey asks about income for the prior year, not the individual's reasonable expectation as to their income for the upcoming one. As noted above, the latter is what is relevant to eligibility.
    - Survey data generally understate incomes, as CMS notes in the rule. This inflates the number of people reporting income below the APTC eligibility range.
    - The survey data come from 2023. At this time the Medicaid continuous coverage requirement was in effect, which increased Medicaid enrollment by millions of people—many of whom would otherwise have qualified for subsidized Marketplace coverage. This reduces CMS's estimates of the number "eligible" for subsidized Marketplace coverage and thus exaggerates the number of improper enrollments.
    - The survey data used in the analysis that CMS cites uses a different family unit than is used for APTC eligibility.

  Given these flaws, any efforts to estimate improper enrollments should use a different method. For example, research could be undertaken based on a sampling of actual enrollees. This is the method commonly employed by oversight agencies like GAO.

- **CMS's analysis should not ignore the effects of recent policy changes to address fraud.** Over the course of 2024 and into early 2025, CMS instituted numerous changes to protect consumers from unauthorized enrollments and plan switching in the FFE. The effects of these changes are not reflected in the enrollment counts used for CMS's analysis, since they are based on data from the OEP for 2024. These measures include the following:

    - Adding a documentation requirement for agents and brokers to show that individuals have consented to enroll.

- Imposing a requirement that prevented new brokers from changing existing coverage through enhanced direct enrollment ("EDE") channels until the Marketplace documented consumer consent through a 3-way call.
- Re-allocating staff to review and address consumer complaints as quickly as possible.
- Adding a requirement for agent and brokers to provide an SSN for applicants.
- Updating Marketplace IT systems to detect suspicious activity and prevent fraud
- Arming consumers with resources and information to better identify and protect themselves from unauthorized enrollments.
- Providing brokers with model consent notices and scripts to ensure their consumer clients are fully informed and that consent is adequately documented.
- Finalizing (in January 2025) rules clarifying CMS's authority to suspend brokers from facilitating enrollments and extending CMS's enforcement authority to broker agencies that direct or facilitate improper behavior by brokers, agents, or web-brokers.
- Several technical safeguard changes across enrollment platforms to protect against misuse of broker credentials.

There is evidence that these measures are working. After implementing the 3-way-call rule, broker-initiated plan changes dropped nearly 70% and changes that redirected a commission from a consumer's original broker to a new one—an indicator of potential misconduct—fell almost 90%. As CMS noted in October, "Marketplace system changes that were implemented in July 2024 are having the desired effect of successfully preventing consumers from being switched to different plans or enrolled in coverage without their informed consent." The current CCIIO director also recently noted that these measures are working.

- **CMS should wait until it can release more reliable results before proposing policy changes based on them.** CMS admits that its estimates of improper enrollment are deeply flawed and yet proceeds to propose policy changes justified by those estimates. This order of operations indicates a rulemaking process that is not grounded in careful analysis. CMS repeatedly asserts that changes are worth doing despite their downsides because there are so many improper enrollments.[5] Flaws in the improper enrollment figures undermine this central justification for the rule. These flaws also deny the public a meaningful opportunity to comment, since they lack information about the true scope and nature of the problem.

[5] For example, regarding the DMI policy when tax data are unavailable, CMS notes: "Considering the amount of improper enrollments under the current policy, we believe this administrative burden of requiring people with an income DMI due to unavailable IRS data to provide documentation to verify income are more than offset by the program integrity benefits." Regarding shortening the period to resolve a DMI, CMS notes: "However, we must weigh this potential positive impact on the risk pool against the substantial increase in APTC expenditures that we identified from ineligible people who stay enrolled and receive APTC for an additional 60 days. We believe the cost to taxpayers and decline in program integrity outweigh any possible benefit to the risk pool."

Even if CMS's estimates of improper enrollment were credible, they would not provide a reasonable basis for many of the proposals in the rule.

- **CMS should not require nationwide changes because it finds no evidence of improper enrollment in the vast majority of states.** CMS's analysis claims that there is excess enrollment in just 9 states, all of which use the FFE and all but one of which hadn't expanded Medicaid at the time the analysis was conducted. As such, the primary basis for the proposals in the rule is absent in 41 states. CMS finds excess enrollment in none of the 16 SBE states included in the analysis. Indeed, CMS finds an average take-up in the SBE states of just 32%—nowhere near the over 100% take up found in those 9 FFE states.

  This geographic trend is consistent with previously reported information about key FFE shortcomings involving brokers, EDE, and lead generators. It's also consistent with SBEs' experience on the ground, as noted in several comment letters and in comments at a recent NAIC meeting by Idaho insurance commissioner Dean Cameron. These comments confirm that SBEs are not seeing widespread complaints about fraud. And this dog-that-didn't-bark is meaningful—as CMS's experience shows, when this fraud exists, people complain, because it often leads to them losing other coverage, such as Medicaid.

  Despite this lack of evidence of improper enrollment in over four-fifths of states, the rule would force numerous changes nationwide. As discussed in comments by SBEs, this is a substantial imposition on state resources and autonomy that is not justified by CMS's data.

- **CMS should afford states flexibility and deference to manage their insurance markets.** The importance of state flexibility has been articulated by CCIIO Director Peter Nelson when, in 2024, he wrote, "States deserve more trust to protect consumers than the feds. Critics of state authority over health insurance take the untenable position that the federal government knows best and cares more. But 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."

- **Since CMS finds that improper enrollments are concentrated in FFE states, it should focus solutions on what FFE states are doing differently.** CMS's analysis finds that "take-up" rates in 2024 are high in FFE states, averaging 106% due to exceptionally high values in a few large states. Take-up rates are especially high in states that have not expanded Medicaid, averaging 179%. Again, this is consistent with

previously reported information about key FFE shortcomings involving brokers, EDE, and lead generators.

Given that the problem appears confined to a small group of states, it makes sense to consider what these states are doing differently and address those discrepancies. For example, while most SBEs maintain and operate their own agent and broker portals for assisted enrollments, the FFE allows enhanced direct enrollment entities to provide an enrollment platform for agents and brokers. In 2024, only FFE states used enhanced direct enrollment, which is known to be a key source of the problem. The FFE sees clear evidence of problems with agent and broker behavior in their use of enhanced direct enrollment platforms

Yet CMS does not include proposals that would address the known FFE issues, such as strengthening the FFE actions already taken, bringing FFE practices in line with SBEs practices, ensuring adequate regulation and enforcement of regulations governing EDE entities, regulating lead generators, and other options that target the actual problem rather than imposing new burdens on consumers. Instead, they force Marketplaces to make changes that lack a clear connection to the known problems.

In short, the proposals bear no reasonable connection to their stated justification and should be considered only if a suitable justification is provided.

Analysis Relating to Risk Pool Effects of the Rule

CMS's second main justification for the proposed rule is that it would reduce premiums overall. CMS notes that this would encourage unsubsidized enrollment and help such enrollees, which CMS claims is especially important to the strength of the market.

Specifically, CMS claims that the proposed rule would improve the risk pool and thus reduce premiums by between 0.9% and 5.4%, depending on how much it reduces enrollment. The methodology for calculating the enrollment change is not entirely clear, but it appears to be based primarily on the assumption that the proposals would eliminate all improper enrollment while leaving all other enrollment unaffected—both extremely aggressive assumptions.

CMS estimates a range of potential enrollment reduction equal to its estimated range of improper enrollments in 2026, which—as discussed above—is three-quarters of a million to 2 million. CMS concedes that "this range may underestimate the actual number of individuals impacted, as eligible enrollees may lose coverage as a result of the administrative burdens imposed by the provisions of this rule." But it proceeds with its calculations as though no such coverage loss would occur.

CMS projects that this attrition of three quarters of a million to two million improperly enrolled people would likely hurt the risk pool, in part because individuals improperly enrolled by brokers may be unaware that they were enrolled and thus make little use of the coverage. Relying on

this projection, it estimates that eliminating improper enrollment would change premiums by between -0.5% and +4%. CMS then combines this range with several risk pool improvements that it claims will result from measures in the proposed rule. Specifically, CMS estimates that eliminating the under-150 SEP would reduce premiums by 3.4%, that expanding SEP verification would reduce premiums by 0.5%, and that the AV de minimis change will reduce premiums by 1%. Summing those figures arrives at the projected range of improvement—from 0.9% to 5.4%. CMS then assumes that the imposition of new administrative burdens will not cause eligible individuals to lose coverage, and thus that the range of a 0.9% to 5.4% improvement is the total impact.

CMS requests comments on this analysis and on the proposals it supports.

CMS's analysis of the risk pool effect of the rule suffers from numerous flaws that undermine its credibility as a reasonable basis for rulemaking.

CMS's method for calculating the risk pool effects (and coverage effects) of its proposals is flawed in crucial ways that undermine the calculation's accuracy. The method makes unsupported assumptions, ignores key effects, fails to provide available data, and relies heavily on its flawed calculations about improper enrollment, as discussed above. The analysis could be improved in the following ways:

- **The risk analysis should not rely on the rule's deeply flawed estimate of improper enrollments, as discussed above.** Instead, CMS should improve that analysis, as discussed above, and then use better estimates of improper enrollment as the basis for its projections about coverage and the risk pool.

- **The analysis should not assume that the proposed rule would be 100% successful in eliminating improper enrollment.** CMS begins its methodological discussion by noting that "[o]ne approach to estimate the possible reduction in erroneous and improper enrollments under the proposed changes in this rule is to [use its estimate of total improper enrollments]." It then proceeds to follow this approach without explaining why it makes sense. The key assumption at work here—that the proposed rule would eliminate all improper enrollment—is implausible for several reasons. First, achieving a 100% success rate in eliminating improper payments is unheard of in any context—CMS provides no examples of it being achieved. Second, CMS offers no basis for such a bold assumption in this case. It provides no microsimulation analysis modeling the proposals, nor any scenario analysis for how its proposals would stop brokers in various situations. Third, as discussed above, CMS's proposals do not address many of the problems that are known to be leading to improper enrollments in the FFE. To produce a more accurate estimate, CMS should drop this assumption of perfection and engage in analysis of how its specific proposals would affect consumers.

- **The analysis should not make the implausible assumption that increasing administrative burdens will have no effect on enrollment and thus coverage**

losses will be limited to people who weren't eligible to begin with. CMS should further recognize that the eligible people deterred from enrolling by these administrative burdens will be disproportionately healthy, and thus that these new administrative burdens will hurt the risk pool. The rule asserts repeatedly that only improperly enrolled people will lose coverage. This appears to be based on two errors. First, CMS's estimates assume that increasing administrative burdens would lead to no coverage loss (and thus no risk pool impact) among eligible people. The proposed rule includes a wide array of proposals that increase administrative burdens on eligible people seeking to enroll, including new paperwork requirements under the DMI and SEP verification proposals, less margin of error for complying with administrative requirements under the FTR and premium payment threshold proposal, and narrower enrollment opportunities. A substantial body of evidence (including those listed below) indicates that administrative burdens reduce take-up among eligible people. In addition, this attrition disproportionately affects lower-risk individuals, since sicker people are more likely to fight through the burdens to stay covered.

- A Mcintyre, Shepard, & Layton study finds that states that implemented nominal monthly premiums saw enrollment fall by 14%.
- A 2025 study in the American Economic Review finds that imposing administrative burdens to enrollment "differentially exclud[es] young, healthy, and economically disadvantaged people."
- An American Economic Association study on auto-retention finds "that automatic retention has a sizable impact,...differentially retaining healthy, low-cost individuals."
- Commonwealth Fund report (Policy Innovations in the Affordable Care Act Marketplaces)
- A KFF brief (Key Facts about the Uninsured Population) describes how almost 20 percent of uninsured nonelderly adults cite the difficulty or complexity of signing up as a reason for their lack of health insurance coverage
- National Bureau of Economic Research report (Reducing Administrative Barriers Increases Take-up of Subsidized Health Insurance Coverage)
- 2016 Urban Institute research report (Helping Special Enrollment Periods Work under the Affordable Care Act)

There is also evidence to this effect from SBEs, as discussed below.
CMS makes no effort to address or refute this overwhelming evidence. It simply assumes that administrative burdens will not reduce enrollment.

This claim also appears to be predicated on the high estimates for improper enrollment, discussed above. Given that improper enrollments are likely much smaller than CMS estimates, it's implausible that all coverage losses would fall in this group.

- **CMS should tabulate and release the data it clearly possesses on the coverage and risk effects of its proposals.** The proposed rule repeatedly asserts impacts from its proposals without providing directly relevant data that it clearly has access to. For

example, the central basis for the claim of risk pool improvement is the estimate that eliminating the under-150 SEP would improve the risk pool by 3.4%. To support this estimate, CMS cites the estimate it made at the time it issued the regulation that created the SEP; at that time, CMS thought it would hurt the risk pool. However, CMS should have access to data obtained from the actual experience with implementing and utilizing the SEP, which could readily be used to calculate the risk profile of enrollees using it. But CMS does not provide such data. CMS explains this omission by arguing that releasing such information would not cleanly capture the risk impact of eliminating the SEP, since some people could switch to a different SEP. Still, it could provide an extremely relevant data point. Similarly, CMS could readily calculate the risk profile of individuals enrolling during the open enrollment period after Dec. 15, individuals losing coverage due to DMIs, individuals losing coverage due to FTR, and individuals re-enrolling with a zero premium. That CMS withholds such information likely suggests that available data do not support its case. CMS should release this information to permit a clearer understanding of the impacts of its proposals.

- **CMS's analysis fails to incorporate available evidence from state-based Marketplaces, which undermines its assumptions.** While CMS has not released FFE data directly applicable to its proposals, several SBEs have released such data. Their evidence directly contradicts CMS's assumptions and analysis. For example:
    - Actuarial data from California show that enrollees using SEPs generally have about the same risk profile as OEP enrollees. The California data also show that individuals using the OEP after Dec. 15 have a better risk profile than those enrolling earlier during OEP.
    - Actuarial data from the Massachusetts Connector show that their population with the most SEP eligibility generally has lower risk than other enrollees. Additionally, consumers enrolling through an SEP tend to be slightly younger than those enrolling through an OEP.
    - Enrollment data from the Massachusetts Connector show that younger individuals are slightly more likely to receive a non-income response from the IRS.
    - Enrollment data from New York show younger enrollees were more likely to enroll late in the open enrollment period.
    - DC Health Link found that the age of the SEP population remained consistent with the population that enrolled during open enrollment, and in some cases was even younger. See Fig. 5.

- **CMS should heed its own previous analysis suggesting that its current proposals would harm the risk pool.** For example, in eliminating data matching issues where tax data are missing in the 2024 NBPP, HHS noted that ending such DMIs would "strengthen the risk pool." However, the proposed rule does not acknowledge that reinstituting such DMIs would harm the risk pool. CMS has not even attempted to justify this change in position.

- **The analysis should recognize that adding administrative burdens is especially likely to be harmful amidst substantial cuts to staff that are needed to help resolve them.** Imposing additional administrative hurdles leads to more consumers needing help in meeting requirements to avoid losing coverage. But recent and ongoing funding and workforce reductions will mean less of this help. Recent cuts to Navigators will mean less enrollment support for consumers in resolving all of these issues. CMS staff reductions could mean less capacity to process DMI and SEP-V documentation. IRS staff reductions could mean less support for consumers facing FTR issues and fewer staff to ensure that returns are quickly processed and that Hub data are quickly updated to reflect processed returns. In addition to ignoring the prospect of coverage losses due to administrative burdens, CMS also ignores the fact that these losses could be exacerbated by staffing reductions. CMS's analysis should be revised to consider the impact of these cuts on coverage losses due to administrative burdens.

- **CMS's estimates regarding the risk pool and improper enrollment should be internally consistent.** Throughout multiple parts of its rule, CMS claims that the real-world impact of terminating 2 million people from coverage will be small, at times suggesting that most of these enrollments are from people who were enrolled without their knowledge. For all the reasons described above, that is certainly not true. CMS's proposals will result in families losing coverage on which they depend and to which they are entitled. But if CMS believes its claim to be true, then it would cause a very large *increase* in premiums that the agency is not accounting for. As a stylized example, if CMS's actions were to result in 2 million such enrollments being eliminated, premiums would increase for remaining enrollees by a staggering 9%. CMS has no basis for any of the claims about premium reductions made in its analysis, but they certainly cannot sustain those claims in the face of a 9% impact pointing the other direction.

- **CMS should recognize that its proposed rule would very likely increase premiums overall and reduce unsubsidized enrollment.** Given the numerous flaws discussed above with CMS's risk pool analysis and overwhelming countervailing evidence, it is almost certain that the proposed rule would in fact hurt the risk pool and increase premiums overall. In addition, several of the new administrative burdens would interfere with not just subsidized enrollment but unsubsidized enrollment as well. As a result, unsubsidized enrollment would be very likely to fall as well.

- **CMS should abandon its claim that the interests of subsidized and unsubsidized enrollees are at odds.** CMS seems to concede that its proposals would harm subsidized enrollees. To justify this, it attempts to make the case that the interests of subsidized and unsubsidized enrollees are somehow in conflict, and that making subsidies smaller and harder to get will somehow help the unsubsidized. This view is in conflict with decades of experience with health policy. Efforts to provide good coverage at a premium that doesn't account for health risk, without a strong financial incentive to enroll—such as strong subsidies—has uniformly led to an adverse selection death spiral. The best thing for unsubsidized people is a good risk pool, which requires strong

> subsidies that are easy to get and thus induce healthier people to enroll. This is the hard-earned lesson that became the basis for health reform in Massachusetts under Governor Mitt Romney and then for the ACA.

Comments on Procedural Issues Under the Rule

The proposed rule suffers from several problems of administrative procedure and law that, individually and together, deny the public a meaningful opportunity to comment. These problems must be addressed before the rule can be finalized.

The rule fails to provide readily available information that is directly relevant to understanding the proposals.

As noted above, the rule fails in numerous places to provide data that are clearly relevant to understanding the proposals and that CMS has access to. For example, CMS certainly has the data needed to calculate the risk profile of individuals who lose coverage under DMI and FTR policies. Yet it does not reveal this information. Instead, it repeatedly claims generally that its proposals are supported by "analysis" without citing specific data, sometimes citing generally to "public use files" or "tax filing data." (Indeed, as noted above publicly available data and data from SBEs often indicate the opposite of what CMS claims.) Withholding this information on which CMS purports to rely denies the public a reasonable opportunity to comment.

The rule and subsequent CMS actions indicate a premeditated intent to finalize the proposals without meaningfully considering comments.

The rule includes the following statement disparaging commenters and the comment process:

> We acknowledge that a higher number of comments can suggest a position we should consider more closely. However, we must also consider that many parties who comment on rulemaking may represent the will of special interests who do not necessarily represent all special interests or the general public interest in the faithful and efficient administration of the statute. It is not uncommon to receive comments that only represent one side and no opposing comments that might represent other special interests or a more general interest in good governance or the equities of the taxpayer. As our constitutional role is to faithfully execute the statute, we are responsible for considering all comments, as well as perspectives that may not be fully represented in comments, within the context of what the statute requires.

We are aware of no precedent for a statement like this. Its disparagement of commenters as "special interests" shows a disrespect for the notice and comment process required by the Administrative Procedure Act ("APA"). Its threat of dismissing prevailing public views suggests a premeditated intent to finalize the rule's proposals regardless of comments.

CMS confirmed this intent when, during the comment period, it released a revised final actual value calculator reflecting the changes in the proposed rule, which commits the agency to finalize certain policies as proposed.

In short, CMS has made clear that it does not intend to meaningfully consider comments, as required by the APA.

In addition, we note that by deciding to finalize certain provisions of the rule before consideration of public comments, CMS has also restricted the administrative record on which the agency can rely in defending their choices regarding those provisions as non-arbitrary. CMS had decided and committed the agency to finalize many of the policies in the rule before the comment period for the proposed rule had closed. Therefore, any analysis that CMS conducts in response to comments—and any explanation that appears in the final rule preamble—is a post hoc justification. Such analysis will have occurred entirely *after* CMS had committed the agency to finalize the policies as proposed and cannot be treated as analysis that the agency considered in the course of reaching a non-arbitrary decision to finalize. CMS will generally be limited to the analysis that it provided in the preamble to the proposed rule, unless the agency can make a specific showing that any additional considerations were weighed internally by the agency before release of the AV calculator. Attempts to cite the final rule preamble for this purpose have been foreclosed by the agency.

The public comment period is too short to provide meaningful comments—especially given the request for detailed comments on analytical claims—and should be extended.

CMS provides an unusually short comment period for the rule, despite its great complexity. The comment period is just 23 days from when the rule was published in the Federal Register (March 19, 2025) to the deadline on April 11.

The short comment period is especially troubling because of CMS's request for comments on the methods and results in the regulatory impact analysis. Such analysis requires detailed modeling work, which is impossible in the timeframe provided. CMS should extend the comment period, providing a minimum of 90 days from the announced extension.

The short comment period is likely connected to speedy effective dates for several provisions. Many of the proposed changes would be impossible for Exchanges to implement in the timespan contemplated. When it announces an extension of the comment period, CMS should also delay these proposed effective dates.

Sincerely,

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STATE OF CALIFORNIA OFFICE OF THE ATTORNEY GENERAL ROB BONTA

COMMONWEALTH OF MASSACHUSETTS OFFICE OF THE ATTORNEY GENERAL ANDREA JOY CAMPBELL

STATE OF NEW JERSEY OFFICE OF THE ATTORNEY GENERAL MATTHEW J. PLATKIN

April 11, 2025

Via Federal eRulemaking Portal at www.regulations.gov
Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Comments on Proposed Rule: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability
Docket No. CMS-2025-0020-0011 (formerly CMS-9884-P), RIN 0938–AV61
90 Fed. Reg. 12,942 (Mar. 19, 2025)

Dear Ms. Carlton:

We, the undersigned Attorneys General of California, Massachusetts, New Jersey, Arizona, Colorado, Connecticut, the District of Columbia, Delaware, Hawai'i, Illinois, Maine, Maryland, Michigan, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Vermont, Washington, and Wisconsin write[1] in response to the proposed rulemaking by the U.S. Department of Health and Human Services and Centers for Medicare & Medicaid Services (collectively, "Department") entitled "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability."[2] The Proposed Rule creates new hurdles that will significantly restrict eligibility, diminish enrollment, and increase consumers' health insurance premiums and out-of-pocket costs. This outcome will undermine the purpose of the Patient Protection and Affordable Care Act (the

[1] The Department should deem all materials cited to in this comment letter as submitted into the administrative record.

[2] 90 Fed. Reg. 12,942 (March 19, 2025) (hereafter the "Proposed Rule").

ACA), which is to increase access to high quality and affordable healthcare. As discussed below, most of the Proposed Rule's changes should be withdrawn.[3]

Congress enacted the ACA to "*increase* the number of Americans covered by health insurance and *decrease* the cost of health care."[4] The goal of covering as many Americans as possible is at the heart of the ACA; Congress elected to model the ACA on the then-existing system in Massachusetts, which combined tax credits, market regulations, and a coverage mandate, resulting in an uninsured rate of "2.6 percent, by far the lowest in the nation."[5]

The Department is tasked with furthering the ACA's twin goals—cover as many people as possible, as affordably as possible—when implementing its provisions, while protecting the financial integrity of the marketplace. The Proposed Rule, however, will have the opposite effect, and will not accomplish its purported goals. Millions of Americans will go uninsured under the Proposed Rule. The Proposed Rule projects that between 750,000 and two *million* individuals will lose their health coverage because of the proposed changes.[6] And when these newly uninsured individuals need healthcare—as everyone eventually will—the States will bear the cost.

The Proposed Rule claims to target fraud but does little to address the actual sources of fraud—most of which occurs at the federal, not state level. Instead, the Proposed Rule introduces measures that will not meaningfully decrease fraud, and instead will throw millions of people out of the healthcare marketplaces. This, in turn, will result in: (1) "potential costs to State governments and private hospitals in the form of charity care for individuals who become uninsured as a result of the proposals in this rule"; (2) increased state Medicaid expenditures from "enrolling more people in Medicaid who would have otherwise enrolled in" subsidized marketplace coverage; and (3) potential increased costs to the States from covering emergency medical treatment for DACA recipients "who would become uninsured if the proposal pertaining to DACA recipients in this Rule is finalized."[7] The Department should not finalize a Proposed

[3] The undersigned States also object to the truncated review period for the Proposed Rule. The Proposed Rule was published in the Federal Register on March 19, 2025, and comments are accepted through April 11, 2025. HHS therefore provided only 23 days to review a complicated, multifaceted rule spanning 90 pages in the Federal Register. At a minimum, rulemaking requires at least thirty full days, and ideally longer, for public comment. *See, e.g., Nat'l Lifeline Ass'n v. Fed. Commc'ns Comm'n*, 921 F.3d 1102, 1117-18 (D.C. Cir. 2019) ("When substantial rule changes are proposed, a 30-day comment period is generally the shortest time period sufficient for interested persons to meaningfully review a proposed rule and provide informed comment.") Nevertheless, a Proposed Rule of this complexity and magnitude warrants a comment period of 60 days, which is standard. That would have allowed for proper analysis of the dozens of significant changes being proposed. The California Attorney General submitted a letter to HHS and the Office of Management and Budget on April 2, 2025, making this objection and asking for at least 30, and ideally 60, days for public comment.

[4] *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 538 (2012) (emphases added); *see King v. Burwell*, 576 U.S. 473, 491(2015) ("Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them.")

[5] *King*, 576 U.S. at 481.

[6] 90 Fed. Reg. at 13,007.

[7] 90 Fed. Reg. at 13,008.

Rule that—by its own admission—will spike the uninsured rate and unfairly shift significant healthcare costs to state and local governments.

Nor is the damage limited to those who will lose their health coverage entirely. Consumers who remain in the marketplaces will face higher premiums and out-of-pocket costs because of the Proposed Rule's changes to the premium adjustment methodology[8] and actuarial value targets.[9] This will also lower the amount of advance premium tax credits (APTCs).

Additionally, the elimination of eligibility for DACA recipients does nothing to further the goals of the ACA, weakens the risk pool, and unfairly targets a vulnerable group of individuals who have lived in this country for at least 17 years (and often more). Because DACA recipients are frequently among the younger and healthier members of the health insurance risk pool, ending their eligibility for coverage is not just cruel and capricious, it squarely contradicts sound healthcare policy. Excluding DACA recipients from the marketplaces does nothing to advance public health.

Similarly, there is no reason to remove medically necessary treatments for transgender individuals from the definition of an Essential Health Benefit (EHB). The Proposed Rule is simply wrong when it asserts that employer-sponsored plans do not cover such care; many, in fact, do, at very little cost. This proposal, too, smacks of discriminatory targeting of a vulnerable group of individuals purely because they are politically disfavored.

Finally, the Proposed Rule infringes on our states' independence and sovereignty by mandating several changes that reduce flexibility in our own marketplaces. Congress established the Federally Facilitated Exchange (FFE) alongside the State-Based Exchanges (SBEs) precisely so that States could experiment with their own approaches to healthcare marketplace provisions if they wished to do so. States, not the federal government, are best positioned to respond to their citizens' unique needs, and allowing SBEs to operate with broad discretion promotes innovation in the marketplace. Tellingly, the Proposed Rule does not suggest that any of the integrity concerns it raises are present in the SBEs. The federal government should encourage, not suppress, the flexibility and experimentation represented in the SBEs.[10]

We appreciate the opportunity to provide these comments and stand ready to collaborate with the Department to ensure a robust, affordable, comprehensive, and secure healthcare marketplace.

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[8] 90 Fed. Reg. at 12,987-95.

[9] 90 Fed. Reg. at 12,995-97.

[10] Randy Pate, former Director of the CMS Center for Consumer Information and Insurance Oversight during the previous Trump Administration, has argued that States should eschew the federal exchange platform and run their own SBEs and utilize the ACA's Section 1332 waivers to "reduce costs, increase state autonomy and oversight, and promote state flexibility," pointing out that the Constitution leaves health and welfare decisions largely to the States. Randy Pate, Statement to the Managed Care (B) Committee, Annual Conf. of the Nat'l Ass'n of Ins. Comm'rs (Summer 2022), https://tinyurl.com/4nc9pnh5.

I. THE MARKETPLACE INTEGRITY CHANGES ARE NOT SUPPORTED BY EVIDENCE, ARE NOT REASONABLY EXPLAINED, AND IGNORE SUBSTANTIAL RELIANCE INTERESTS

A. Several Proposals Will Make Coverage Unnecessarily Difficult to Obtain

Federal agencies may not justify their decisions using explanations that are "incongruent with what the record reveals about the agency's priorities and decisionmaking process."[11] The Department of Health and Human Services exists to promote public health. And while many of the Proposed Rule's changes are justified on the basis that they combat fraud, increase efficiency, or promote marketplace integrity and consumer protection, several of the proposed changes will make it more difficult for enrollees to secure coverage. These proposals contradict HHS's priorities and should be withdrawn.

1. Requiring all exchanges to end open enrollment on December 15 will likely cause hundreds of thousands of people to miss the enrollment window.

To help encourage consumers to maintain coverage year-round, health insurance exchanges generally only accept enrollees for the upcoming calendar year during the open enrollment period (OEP). The length of the OEP should be calibrated to balance the risk of adverse selection—enrollees only seeking coverage when sick—against the need to make coverage accessible to as many people as possible. Sometimes, special circumstances might necessitate allowing enrollees to access coverage outside of the OEP, as discussed in the following section. Here, this Proposed Rule would limit open enrollment to 45 days (November 1 through December 15) on both the FFE and the SBEs.[12] SBEs have always had the flexibility to establish a longer open enrollment period, and most do so. There is no reason to eliminate states' flexibility to have a longer open enrollment period. Data shows that permitting open enrollment through mid-January allows hundreds of thousands of additional consumers to enroll and gives them sufficient time to choose the plan that is right for them.

The Proposed Rule claims that a longer open enrollment period contributes to adverse selection.[13] But the Proposed Rule does not provide any data showing that the risk of adverse selection is worsened by a longer OEP, or that shortening the OEP is likely to have a material impact on adverse selection risk for insurers. On the contrary, in previous rulemaking, the Department acknowledged that a "shortened enrollment period could lead to a reduction in enrollees, primarily younger and healthier enrollees who usually enroll late in the enrollment period."[14] The Proposed Rule also acknowledges that extending the OEP through January 15 allows consumers who had been automatically re-enrolled in a plan they may not want "the opportunity to change plans after receiving updated plan cost information from their issuer and to

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[11] *Dep't of Com. v. New York*, 588 U.S. 752, 785 (2019).
[12] 90 Fed. Reg. at 12,976.
[13] *Id*.
[14] *Patient Protection and Affordable Care Act; Market Stabilization*, 82 Fed. Reg. 18,346, 18,377 (Apr. 18, 2017) (final rule).

select a new plan that is more affordable to them."[15] Further, the Proposed Rule acknowledges that several marketplace experts, including "Navigators, certified application counselors (CACs), agents, and brokers" conveyed during prior rulemaking that they were concerned about "a lack of time to fully assist all interested Exchange applicants with comparing their different plan choices," suggesting that the longer OEP is both necessary and justified.[16] The Department's sudden disregard for those concerns, which remain just as valid today, is not "reasonable and reasonably explained."[17]

As the Department admits, nearly half a million individuals—or approximately three percent of enrollees—for the 2025 plan year elected to end coverage or switch plans between December 15 and January 15.[18] Many of those consumers will likely fail to sign up in time if open enrollment ends on December 15. The shortening of the annual OEP to 45 days disregards the need for consumers to have sufficient time to understand their options and make informed decisions. At a bare minimum, if the Department finalizes the shorter OEP for the FFE, the Department should not take away the flexibility SBMs have had to set OEPs that work in their markets and should delay shortening the open enrollment period until 2027, given the uncertainty over whether the enhanced premium tax credits will expire at the end of 2025.

Our States know firsthand that longer OEPs benefit our residents. New Jersey, for instance, utilizes an OEP that runs from November 1 through January 31. In the most recent OEP, 513,217 New Jerseyans signed up for coverage through Get Covered NJ—a 30% increase year-over-year, and a 108% increase since New Jersey launched its Get Covered NJ initiative.[19] At the same time, New Jersey has no significant problem with fraudulent enrollments on its exchange. And in Massachusetts, over half of enrollees who manually shopped for a plan during the most recent OEP completed their plan selections after December 15, 2024. Those later enrollees also tended to have lower average medical expenses than the earlier enrollees. The story is similar in the District of Columbia, where an average of 46% of new enrollments in the two most recent OEPs occurred after December 15. In Colorado, too, those who enrolled after December 15 tended to be younger and healthier, raising concerns that a shorter OEP would harm the risk pool and cause premiums to increase. In Washington State, 46% of new customers selected a plan after December 15, and 4 in 10 of those new customers are under the age of 35, compared to 3 in 10 under age 35 for those who enrolled before December 15. Finally, in Connecticut, consumers who enrolled before December 15 tended to be older than those who enrolled on December 15 or later, and a higher percentage of the post-December 15 enrollment pool were "new" enrollees rather than returning enrollees. These data demonstrate that the longer enrollment period is key to maintaining robust enrollment and a balanced and healthy risk pool.

The proposal to not only shorten the OEP, but to mandate that independent state exchanges shorten theirs, too, is not in the best interests of consumers and should be withdrawn.

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[15] 90 Fed. Reg. at 12,978.
[16] 90 Fed. Reg. at 12,978.
[17] *Fed. Commc'ns Comm'n v. Prometheus Radio Project*, 592 U.S. 414, 423 (2021).
[18] 90 Fed. Reg. at 12,978.
[19] N.J. Dep't. of Banking and Ins., *Governor Murphy and Commissioner Zimmerman Announce Historic 2025 Get Covered New Jersey Sign-Ups* (Feb. 20, 2025), https://tinyurl.com/379j9f9u.

2. Eliminating the low-income special enrollment period (SEP) for individuals whose projected annual household income is at or below 150 percent of the federal poverty level (FPL) needlessly restricts access to coverage for low-income Americans.

In addition to the standard OEP, there are several different special enrollment periods (SEPs) for individuals facing particular circumstances. One such SEP allows individuals or families whose projected annual household income is at or below 150 percent of the federal poverty level to sign up for coverage at any time of the year. This mirrors Medicaid and the Children's Health Insurance Program (CHIP), both of which allow enrollment for low-income Americans at any time of year. One rationale for creating this SEP was to ensure that those who were transitioning off Medicaid or CHIP would not be stranded without coverage until the next OEP. Such flexibility is especially vital now, with over 25 million people having been disenrolled from Medicaid since the unwinding of the Covid-era continuous enrollment condition.[20] The Proposed Rule eliminates the low-income SEP entirely.[21] This would harm hundreds of thousands of our residents. In Illinois alone, over 146,000 current enrollees have incomes that fall within 100 to 150 percent of the FPL.

The Department has cited no evidence supporting its contention that this SEP is a unique driver of fraudulent enrollment, or that eliminating it is likely to have a material effect on any such abuse. The monthly SEP for those with household incomes at or below 150 percent of the federal poverty level is a critical protection for the lowest-income Americans. Last year, the Department acknowledged that the continued availability of this SEP "may continue to help consumers who lose other [minimum essential] coverage, especially those disenrolling from Medicaid or CHIP coverage to regain health care coverage."[22] The Department additionally found that the risk of adverse selection associated with this SEP was lower than anticipated.[23]

Unable to point to any data showing that its prior evaluation was wrong, the Department now asserts—without citing evidence—that "more experience with this SEP suggests it has substantially increased the level of improper enrollments, as well as increased the risk for adverse selection, as [this] SEP incentivizes consumers to wait until they are sick to enroll in Exchange coverage."[24] Neither assertion is well taken.

With respect to improper enrollments, while it is true that "some agents, brokers, and web-brokers have exploited" certain weaknesses in the Healthcare.gov technology to allow

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[20] *Medicaid Enrollment and Unwinding Tracker*, Kaiser Family Foundation (Mar. 31. 2025), https://tinyurl.com/5eb2rsbj.

[21] 90 Fed. Reg. at 12,979-82.

[22] Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program, 89 Fed. Reg. 26,218, 26,320 (April 15, 2024) (final rule).

[23] *See* 89 Fed. Reg. at 26,321 ("[A]n analysis of the plans available to consumers in 2020, just before implementation of the enhanced subsidies, suggests that the risk of adverse selection we acknowledged may be lower than expected, and therefore, downstream impacts of that risk may be mitigated.")

[24] 90 Fed. Reg. at 12,979.

enrollment—and thus earn commissions—without a consumer's consent,[25] there are other, less burdensome changes—such as requiring two-factor authentication and verbal authorization from the consumer—that would adequately address the problem of fraudulent enrollment without imposing a heavy burden on the poorest Americans. The Department also acknowledges that the number of consumer complaints for unauthorized enrollments dropped from a high of 39,985 in February 2024 to just 7,134 in December 2024—even though the SEP remained available during that entire period.[26] In light of that massive decrease in complaints while the SEP remained in place, eliminating the SEP is not necessary to substantially reduce the problem of fraudulent enrollment by unscrupulous brokers.

The Department also points to a supposed discrepancy between the number of Floridians who claimed estimated annual household income between 100 and 150 percent of the FPL and the number of Floridians who have income within that level according to the U.S. Census American Community Survey.[27] But commentators have called this an "an apples-to-oranges" comparison,[28] and it is not clear why the Department expect households' estimates of income to match Census Bureau data, especially when the respondent populations do not perfectly overlap with one another and when other factors such as immigration status, household size, and geographic location may drive distinctions between the two groups.

Eliminating this SEP would harm the most vulnerable residents of our States and leave the lowest-income participants unable to obtain health coverage when they need it. This proposal should be withdrawn.

3. Requiring that all exchanges verify enrollment eligibility for those who claim SEP eligibility due to a "triggering event" risks barring consumers from coverage due to paperwork errors and imposes tremendous costs on State exchanges.

Another kind of SEP allows for enrollment in a health plan after some triggering event such as the loss of a job, a move to a new geographical area, or the birth of a child. The Proposed Rule reintroduces an earlier rule that exchanges on the federal platform verify all such claims of eligibility, and newly requires that all exchanges—including SBEs—verify eligibility for at least 75% of new enrollees under this SEP prior to commencing coverage.

These changes would impose difficult—and sometimes insurmountable—verification barriers. The paperwork to verify qualifying life events is not always readily available. A small employer that suddenly goes bankrupt may not be able to provide its former employees with the paperwork that would allow access to the healthcare marketplace, or a local government might need over a month to mail a birth certificate to a new parent. In these situations, the enrollee faces

[25] 90 Fed. Reg. at 12,980.
[26] *Id*.
[27] 90 Fed. Reg. at 12,980-81; *see also id.* at n.121 (citing U.S. Census Bureau, U.S. Dep't. of Commerce, *American Community Survey* (2022), https://tinyurl.com/4bw2aajf).
[28] Katie Keith & Jason Levitis, *HHS Proposes to Restrict Marketplace Eligibility, Enrollment, and Affordability In First Major Rule Under Trump Administration (Part 1)*, Health Affairs (March 12, 2025), https://tinyurl.com/bd3289tp (hereafter "Keith & Levitis Part 1").

the prospect of going without coverage due to these paperwork requirements that they are unable to satisfy.

The Department acknowledges that only 73 percent of consumers were able to submit documents within 14 days after an SEP verification issue (SVI) was generated—meaning 27 percent, or more than one in four, enrollees attempting to utilize an SEP may be blocked from doing so for technical reasons unrelated to their eligibility.[29] Therefore, the Department's claim that pre-enrollment verification poses no "substantial enrollment barrier"[30] is simply untrue according to its own data. And any barrier to enrollment is likely to discourage younger, healthier enrollees from completing the sign-up process. Requiring consumers to navigate complex documentation processes, often during times of significant and sudden changes in their personal circumstances, will undoubtedly deter eligible individuals, including younger and healthier people, from obtaining coverage.

By turning away eligible individuals because of inadequate paperwork, this proposed change is also likely to negatively impact the risk pool. In DC, for instance, enrollees utilizing "triggering event" SEPs tend to be younger than enrollees utilizing the Open Enrollment Period. As the Department acknowledges, "younger people submit acceptable documentation to verify their SEP eligibility at lower rates than older consumers, which can negatively impact the risk pool as younger consumers use less health care on average,"[31] meaning that the added verification requirements are likely to result in fewer young enrollees entering the risk pool. Imposing this additional requirement is almost certain to weaken the risk pool, not strengthen it. *See infra* p. 31.

In addition to imposing an unnecessary burden on consumers and weakening the risk pool, this change also imposes substantial burdens on the State-Based Exchanges, which will have to fund extensive document verification operations in the absence of any demonstrated benefit to the States for doing so. With at least sixty days to evaluate this change, *see supra* n.2, California and other undersigned States could have conducted a robust analysis of the fiscal and administrative impact of the 75% verification requirement on their state Exchanges.

Finally, there is no evidence showing that this change is necessary to reduce fraudulent enrollment or adverse selection.

The Department should withdraw the proposal to require exchanges to verify enrollment eligibility for at least 75% of those who claim SEP eligibility due to a "triggering event," or, at a minimum, should allow SBEs to opt out of implementing this change.

[29] 90 Fed. Reg. at 12,983.
[30] 90 Fed. Reg. at 12,984.
[31] *Id*.

4. Eliminating APTC eligibility for individuals who fail to file and reconcile (FTR) their income data against their APTC award for one year rather than two years increases the chance of wrongful terminations due to administrative error, limits consumer choice, and threatens to allow government ineptitude to harm consumers.

The ACA provides tax credits—APTCs—to individuals whose projected household income qualifies them for assistance with paying their healthcare premiums. Because those APTC awards are based on projections, the recipient must later reconcile their APTC award against their actual income, as shown in their tax filings with the Internal Revenue Service (IRS). If the enrollee earned more than projected, the enrollee then owes the difference as a tax liability when they next file taxes. This requirement ensures that patients cannot claim and retain credits to which they are not entitled. When an individual fails to file taxes and reconcile their income data with the APTC award, they lose eligibility for future credits and owe the prior period's credits as a tax liability. This is known as failure to file and reconcile, or FTR. This proposal would eliminate APTC credit eligibility and impose a corresponding tax liability after one FTR year, rather than after two consecutive FTR years.

Reverting to a one-year FTR rule increases the risk of eligible individuals losing access to APTCs due to administrative complexities or processing delays. Many more people receive one-year FTR codes than two-year FTR codes; in Massachusetts, for instance, one percent of enrollees for January 2025 coverage received a one-year FTR code, while just 0.1% received a two-year code. This implies that most people with one-year FTR codes can resolve their FTR status before receiving a two-year code. If this proposed change were to be implemented, all those people would lose coverage. But there are sometimes anodyne explanations for FTR status: the Department acknowledged that FTR needed to be paused during the Covid-19 public health emergency "due to concerns that consumers who had filed and reconciled would lose APTC due to IRS processing delays resulting from IRS processing facility closures and a corresponding processing backlog of paper filings."[32] The Department should formalize this practice via rulemaking, so that future IRS processing delays do not cause an enrollee to lose coverage through the FTR process. APTC beneficiaries are especially vulnerable to IRS processing delays in the future because the IRS is reportedly seeking to cut as much as half of its 90,000-person workforce.[33] The Department has not considered the potential impact of this change on otherwise eligible enrollees who may lose tax credits erroneously. The Department should evaluate the risk of IRS processing delays before implementing this change.

The Department claims this change will help reduce tax liability for consumers, because the maximum accumulated wrongful benefit will be just one year of APTC rather than two.[34] To the extent any consumers do face increased tax liability, the Department should consider whether such a trade-off was a rational choice for the consumer at the time, *i.e.*, the maintenance of health coverage was worth more to the consumer than the increased tax liability at the end of the two-year FTR period. The Department should evaluate whether, for such consumers, the tax liability

[32] 90 Fed. Reg. at 12,958.

[33] Fatima Hussein, *The IRS is drafting plans to cut as much as half of its 90,000-person workforce, AP sources say,* Associated Press (March 4, 2025), https://tinyurl.com/m58czdjb.

[34] 90 Fed. Reg. at 12,959.

is not as burdensome as the loss of coverage would have been. Because the Department claims that respecting consumer choice is a motivating factor behind its proposal to eliminate the crosswalk policy, as discussed *infra*, the Department should also consider the role that consumer choice and rational economic decisionmaking plays in the FTR context.

The Department estimates this change could remove up to $1.86 billion of federal tax credits from the health insurance market.[35] Reducing tax credits, not protecting consumers, appears to be the reason behind this proposed change.

The proposal to move to a one-year FTR period should be withdrawn.

5. Allowing plans to deny coverage for those with prior past-due premiums will block access to healthcare for those whose prior nonpayment may have been unintentional.

Currently, insurance plans may pursue collection for past-due premiums but may not condition the provision of new coverage upon the payment of past-due premiums from prior coverage. Insurers, like any business, have legal options for pursuing collection of amounts owed to them. This proposal, for the first time, would allow insurers to deny coverage to an enrollee who owes past-due premiums from *any* prior period, not just the last twelve months, as an earlier rule provided. This proposed change does not require insurers to notify enrollees if they implement this policy—raising concerns that consumers could be denied coverage without being aware that the denial is due to owing a past-due premium.

This rule change is likely to harm consumers whose earlier nonpayment may not have been intentional. The Department acknowledges that this change would cause those individuals to lose coverage but expects that such losses would be minimal; no evidence is provided for that assertion.[36]

In previous rulemaking, the Department acknowledged that nonpayment could be due to a variety of factors and found that existing balance-collection methods are sufficient to protect insurers.[37] At a minimum, the Department should not mandate this change across the board. States should be free to enact their own policies regarding premium payments.

The proposal to allow insurance plans to deny coverage to consumers who owe a past-due premium from any prior period should be withdrawn.

B. Several Proposals Will Result in Increased Costs and Decreased Coverage for Remaining Enrollees

The previous set of proposals, along with the wholesale deletion of DACA recipients from the risk pool, seem designed to eliminate coverage for as many people as possible. The following

[35] 90 Fed. Reg. at 13,011-12.
[36] 90 Fed. Reg. at 13,009-10.
[37] *Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review*, 78 Fed. Reg. 13,406, 13,416-17 (Feb. 27, 2013).

set of proposals, if adopted, will ensure that those who remain enrolled in an Exchange plan pay higher premiums for lower-quality coverage. The Department has wholly failed to consider the costs that these changes will impose on consumers, and has not explained why, in its view, the purported benefits of these changes outweigh the very significant harms.[38] Because it has not done so, the Department should withdraw these proposals.

1. Changing the premium adjustment calculation methodology and the acceptable actuarial value ranges will increase health insurance plans' costs and lower their quality.

Exchange plans set a maximum annual limit on cost-sharing, such as copays, coinsurance, and out-of-pocket maxima due from the enrollee over the plan year. Those annual limits are adjusted in reference to a measure of premium inflation called the annual premium adjustment percentage, set by the HHS Secretary each year. In addition, the IRS uses the premium adjustment percentage when determining individuals' expected contributions and thus the amount of APTC the enrollee will receive. Accordingly, subtle changes in the way the premium adjustment percentage is calculated can have large effects on both out-of-pocket costs and the amount of APTC an enrollee is entitled to receive.

Present policy recognizes that the premium adjustment methodology needs to be price-stable to reduce volatility and keep premiums from spiking. Presently, the adjustment methodology looks to a biannual measure of premium inflation that is based on the employer-sponsored insurance (ESI) market, rather than the individual market, which is much more price-volatile. Including the more price-volatile market in the measure of inflation is certain to increase out-of-pocket costs to consumers.[39] The Department has not shown that this change will increase efficiency or improve resource allocation.

Because the point of the ACA is to make healthcare more accessible and affordable,[40] it is concerning that HHS now believes that "making coverage more accessible and affordable" is an improper "policy objective" that "can only serve to distort the alignment the ACA requires HHS to maintain between premium growth and the parameters subject to the premium adjustment percentage."[41] This exceedingly narrow reading of HHS' statutory authority is wrong and disregards Supreme Court precedent regarding the law's purpose.[42]

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[38] *See Dep't. of Commerce v. New York*, 588 U.S. at 785 (agencies must provide "reasons that can be scrutinized by courts and the interested public.")

[39] *See* Keith & Levitis Part 1, *supra* note 28 (finding that the 2020 update to premium adjustment methodology, which accounted for individual market premiums, "resulted in a higher premium adjustment percentage *and thus a higher annual limit on out-of-pocket costs* and a higher required contribution from subsidy-eligible consumers") (emphasis added).

[40] *Nat'l. Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. at 539.

[41] 90 Fed. Reg. at 12,990.

[42] *See Nat'l. Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. at 539 (the purpose of the ACA is to "*increase* the number of Americans covered by health insurance and *decrease* the cost of health care") (emphasis added).

The change to premium adjustment methodology will cause out-of-pocket maxima, copays, and annual limits to increase, without justification. This proposal, if adopted, will cause "consumer premiums [to] rise as well to about 4.5 percent higher for a benchmark plan compared to current rules."[43] In 2023, for example, an average on-exchange plan in the individual market cost $590.08 per member per month (PMPM), for an annual premium of $7,080.96 per member.[44] A 4.5 percent increase in that premium is an additional $318.64 annually. For an average annual premium of $25,572 for family coverage, a 4.5% increase is an extra $1,150.74 per year.[45] Any increase in premiums causes enrollment to suffer. [46] States will be fiscally impacted as well. Massachusetts estimates that, because of this change, state subsidy costs will increase by approximately $10 million in 2026.

Aside from the increase to premiums, a change in the premium adjustment percentage would also affect other out-of-pocket costs such as copays and deductibles. "Even relatively small levels of cost sharing in the range of $1 to $5 are associated with reduced use of care, including necessary services."[47] Any increase in out-of-pocket cost for the consumer is statistically certain to result in a decreased utilization rate, meaning more Americans choosing to go without coverage (and then skipping needed medical treatment as a result).

The Department should withdraw this proposed change.

2. Expanding the acceptable actuarial value ranges for health plans will also increase health insurance plans' costs and lower their value.

Plans sold on the exchanges fall into Bronze, Silver, Gold, and Platinum tiers based on how much of an average consumer's expected medical cost will be paid by the plan. Bronze plans must cover 60 percent of the expected cost; Silver plans, 70 percent; Gold plans, 80 percent; and Platinum plans, 90 percent. Higher-tier plans typically have higher premiums and lower out-of-pocket costs. Lower-tier plans have the opposite: lower premiums and higher out-of-pocket costs. Insurers on the exchanges must offer plans that meet these targets within some range of accepted de minimis variation. These ranges are presently small—most plans must fall within +2/-2, or +2/-0, percentage points. The reason for this narrow range is to encourage transparency and diminish consumer confusion in the marketplace, because a plan that claims to be Silver but undershoots its target by five percentage might only offer Bronze-level value and should be priced accordingly. Keeping the bands narrow promotes that policy goal.

The Proposed Rule widens the accepted ranges. For expanded bronze plans, the proposed range is +5/-4 percentage points. For all other plans, the proposed range is +2/-4 percentage points.

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[43] Keith & Levitis Part 1, *supra* note 28.

[44] Cal. Dep't of Managed Health Care, *Individual and Small Group Aggregate Premium Rate Report: Measurement Year 2023* 1, https://tinyurl.com/mwjumsd5.

[45] *2024 Employer Health Benefits Survey*, Kaiser Family Foundation (Oct. 9, 2024), https://tinyurl.com/pd5umckm.

[46] *See* Samantha Artiga et al., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings*, Kaiser Family Foundation (June 1, 2017), https://tinyurl.com/2hmm9pf7 (finding that "[p]remiums serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals.").

[47] *Id.*

By allowing all plans to undershoot their claimed targets by four percentage points, this proposal is certain to decrease the level of coverage provided to consumers, while charging those consumers the same price for their premiums.

The certain result of this change will be that a plan in 2027 will provide up to four percentage points less coverage than the same plan did in 2024. And although this change does not directly affect the premium, other rule changes affecting the premium adjustment methodology and shrinking the risk pool mean that consumers will be paying more for worse coverage. The Department claims that the benefit of this change is that plans need wider AV variability ranges for better plan cost sharing, but the Department did not provide any evidence to support this claim, nor did the Department acknowledge—let alone quantify—the harms to consumers of enrollment in lower-value plans.[48]

The proposed change to actuarial value *de minimis* variation will ultimately reduce affordability by increasing premiums and out-of-pocket costs for consumers. This change appears designed to prioritize insurer flexibility over ensuring affordable and comprehensive coverage for the public. This proposal should be withdrawn.

3. Eliminating the "crosswalk" policy will decrease marketplace efficiency and reduce the value of the ACA's subsidies to consumers.

Under current policy, an enrollee who selects a Bronze-tier plan, where there is a Silver-tier plan available at the same or lesser cost in the same provider network, will be automatically re-enrolled in the better plan. This policy ensures rational economic decisionmaking in the marketplace by automating the objectively superior plan choice when it is available. By automating the selection of the best available deal, this policy also minimizes the need for a consumer to rely on brokers and other third parties. The Proposed Rule eliminates this policy.

This proposed change is not supported by evidence and is counterproductive. The Department asserts that the crosswalk is no longer necessary because consumers are now aware of their options, and automatically enrolling a consumer in a better plan at the same or less cost overrides consumer choice. The Department does not explain how the deliberate selection of a lower-tier plan could ever be a rational choice. The crosswalk policy offers free upgrades to qualifying consumers. No reasonable consumer would decline the option to pay less for identical or better healthcare coverage.

Moreover, the Proposed Rule's reasoning disregards the reality that many enrollees, particularly those with limited resources, may not actively shop for or fully understand the nuances of different health plans.[49]

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[48] *See* 90 Fed. Reg. at 12,996-97 (stating "we believe" seven times but providing no data).

[49] *See* Kaye Pestaina et al., *Signing Up for Marketplace Coverage Remains a Challenge for Many Consumers*, Kaiser Family Foundation (Oct. 30, 2023), https://tinyurl.com/7r8un3ac (finding that 35% of marketplace enrollees "found it somewhat or very difficult to find a plan that meets their needs," and that "[a] large share (41%) of people with Marketplace coverage said

This change prioritizes a narrow interpretation of consumer autonomy over the tangible benefits of automatically connecting eligible individuals with more comprehensive and affordable coverage. It should be withdrawn.

4. Ending acceptance of self-attestation of projected annual household income at or above 100% of FPL will needlessly harm the lowest-income enrollees, who tend to be young and healthy, thus harming the risk pool and increasing premiums for everyone.

Exchange plans currently accept the self-attestation of an enrollee who claims eligibility by projecting annual household income at or above 100% of the federal poverty level. This policy is distinct from the FTR rules, discussed above, which still ensure that an enrollee who over-claims APTC eligibility must repay the overpayment via tax liability or else lose APTC eligibility. This self-attestation policy is designed to ensure that the lowest-income enrollees, who are often younger and healthier, are not discouraged from entering the risk pool due to paperwork burdens.

Aside from a fleeting reference to "internal analysis of historical enrollment and DMI [data-matching issue] data," the Department provides no information on the number of enrollees actually submitting inflated income data to qualify for APTC, and thus offers no actual evidence that impoverished consumers are misusing the self-attestation feature when representing their income.[50] Nor does the Department acknowledge that many consumers might legitimately expect their incomes to be greater than 100% of FPL when they apply for coverage, but later finish the year with incomes below 100% of FPL; individuals in that position have committed no wrongdoing. As discussed *supra*, the existing FTR policy helps to ensure that overpayment of APTC is discouraged and recovered through tax liability imposed on those who over-claim.

With this questionable justification, the Proposed Rule ends this policy, requiring income verification for all such enrollees.

This policy is likely to cause younger, lower-income enrollees to drop out of the risk pool. Additionally, this policy is more likely to impact healthy enrollees than sick ones, because, as commentators have observed, "sicker individuals are typically more motivated to overcome administrative burdens to enroll in coverage."[51] The Department acknowledges this, too, writing

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it was very or somewhat difficult to compare the doctors, hospitals, and other health care providers you could see for each option compared to fewer adults with Employer-sponsored coverage (32%), Medicaid (27%), and Medicare (19%) who said the same").

[50] 90 Fed. Reg. at 13,012. Indeed, in states that have accepted the ACA's Medicaid expansion, there is little to no incentive to inflate incomes for APTC purposes because adults with modified gross incomes up to 138% of the FPL are generally eligible for Medicaid. Many such states have mechanisms to ensure that Medicaid-eligible clients do not receive APTC. For example, Washington State has an integrated eligibility portal, so that those who opt out of Medicaid are barred from APTC eligibility until they provide updated documentation showing they once again qualify for APTC due to a change in income.

[51] Jason Levitis & Katie Keith, *HHS Proposes to Restrict Marketplace Eligibility, Enrollment, and Affordability in First Major Rule Under Trump Administration (Part 2)*, Health

that "verification [of SEP eligibility] can also undermine the risk pool by imposing a barrier to eligible enrollees, which may deter healthier, less motivated individuals from enrolling."[52]

In addition, terminating enrollment eligibility for those without available tax data is especially concerning given the likelihood of staffing cuts at the IRS, which increase the likelihood that tax data for many filers will be delayed or unavailable.[53] This policy change could lead to eligible individuals being wrongly denied crucial financial assistance. The Department estimates that this requirement would deny APTC to 81,000 people annually, reducing these tax credits by $189 million.[54] The Department further estimates that this change would create 550,000 data-matching issues (DMIs) per year, and that it would cost the Exchanges $32 million per year to verify enrollees' income and resolve those DMIs.[55] This policy should be withdrawn.

C. The Proposed Rule Should Implement Broker-Focused Anti-Fraud Provisions

All government programs should strive to obtain the most benefit per taxpayer dollar and minimize waste, fraud, and abuse; the ACA is no exception. However, the changes contemplated by this Proposed Rule discussed above are not necessary "to reduce waste, fraud, and abuse."[56] There are several other, far less burdensome changes that the Department should implement to reduce the problem of fraudulent enrollment or unauthorized plan-switching without placing the burden on Exchange enrollees. The Department considered none of them; here, there is no "rational connection between the facts found and the choice made."[57]

1. Removing brokers for cause by a preponderance of the evidence will help protect consumers from unscrupulous business practices, but the Department should adopt other changes to combat broker fraud.

The Proposed Rule will allow HHS to utilize a preponderance-of-the-evidence standard when terminating brokers for cause, instead of a more stringent standard such as clear and convincing evidence. This change is aimed at penalizing brokers who change enrollees' plans without consent to collect a commission, or other such dishonest practices. The undersigned States share the Department's concern about the increased prevalence of unauthorized plan switching and enrollments. We support the proposed revision to Section 155.220(g)(1) regarding evidentiary standards that the Department will utilize when removing brokers for cause.[58] It is imperative that the Department take robust steps to curb this abusive and fraudulent practice, and to protect consumers from predatory brokers who engage in such tactics. Unauthorized plan changes can

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Affairs (March 13, 2025), https://tinyurl.com/4xkjf7jy.

[52] 90 Fed. Reg. at 12,983.

[53] *See* Hussein, *supra* note 33 and accompanying text.

[54] 90 Fed. Reg. at 13,013.

[55] *90* Fed. Reg. at 13,013.

[56] 90 Fed. Reg. at 12,942.

[57] *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

[58] 90 Fed. Reg. at 12,955.

cause enrollees to lose access to medical care, face higher out-of-pocket costs, and be surprised with unexpected tax bills.

However, as explained above, the Proposed Rule does little to strike at the root of the problem. Broker-driven fraud is the main cause of unauthorized plan switching and enrollments. And this fraud has occurred primarily on the federal government's own healthcare platform, healthcare.gov—not on the exchanges operated by the States.[59] There is no indication that SBEs have experienced similar broker misconduct.[60] In light of that, the Proposed Rule should not limit the ability of SBEs to combat fraud that has not occurred on those platforms.

California, for instance, simply does not have a large-scale issue with fraudulent enrollments, despite having one of the largest state-based exchanges. California sends users a one-time code to share with an agent, while Pennsylvania similarly allows only agents designated by the consumer to access the user's account.[61] Other SBMs use multiple tools to prevent, mitigate, and shut down fraudulent enrollments including logging information recording changes, multi-factor authentication to access accounts, broker certification and all carrier appointments requirements, and rescissions in cases of fraud.

The Proposed Rule also fails to take meaningful steps to combat broker fraud on the federal platform (beyond lowering the evidentiary standard for broker misconduct). The Proposed Rule does not introduce new guidelines or limits on brokers' behavior, make it technically harder to engage in such behavior, or address the financial incentives underlying fraudulent enrollment. Curbing abusive broker practices will require the Department to address these issues. As other commentators have suggested,[62] the Department should consider introducing the following reforms:

- Impose a standard of conduct that obligates brokers to act in the best interest of the consumer and holds liable those who do not.

- Require two-factor authentication (such as a one-time password) or verbal or written consent from an enrollee before any plan change can occur, and require that a broker document, submit, and verify that consent before receiving a commission.

- Require enrollees to create an account on the exchange website and affirmatively select which brokers can access their account, and bar access to all other agents.

- Require third-party marketing entities—significant contributors to fraudulent plan-switching—to register with the marketplace and meet marketing standards.

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[59] Justin Giovannelli & Stacey Pogue, *Policymakers Can Protect Against Fraud in the ACA Marketplaces Without Hiking Premiums*, The Commonwealth Fund (March 5, 2025), https://tinyurl.com/rw5wxjze.

[60] *Id*.

[61] Julie Appleby, *How the Government is Trying to Stop Rogue Brokers from Plaguing ACA Enrollees*, NPR: Health Shots (May 7, 2024), https://tinyurl.com/3bkbcu5d.

[62] Giovannelli & Pogue, *supra* note 59.

The cumulative result of the Proposed Rule's changes is a smaller risk pool and a sicker population that must pay more for lower-quality health coverage, all in the name of preventing fraud that is not occurring at scale in the SBEs.

II. THE PROPOSAL TO BAR DACA RECIPIENTS FROM ACCESS TO STATE AND FEDERAL ACA EXCHANGES IS CONTRARY TO LAW, IS ARBITRARY AND CAPRICIOUS, AND WOULD HARM STATES AND THEIR RESIDENTS.

Less than a year ago, the U.S. Department of Health and Human Services and Centers for Medicare & Medicaid Services completed a thorough rulemaking aimed at increasing patient access to state and federal exchanges under the ACA.[63] The Department's current proposal reverses course, changing the definition of "lawfully present" so it excludes individuals receiving deferred action pursuant to the Deferred Action for Childhood Arrivals policy from the ACA exchanges.[64] That proposal is unlawful and harmful. First, the Proposed Rule will cause significant harm to the States' economies, public health, and welfare by ripping away ACA insurance eligibility from an entire population, thereby increasing the number of uninsured residents in our States. Second, the Proposed Rule is contrary to the text of the ACA, and undermines Congress's aim of increasing access to insurance. Third, the Proposed Rule is arbitrary and capricious for multiple reasons: it fails to consider the myriad of benefits associated with expanding ACA exchange eligibility to DACA recipients, its analysis runs contrary to the text of the ACA, it insufficiently considers the reliance interests of DACA recipients and the States, and it fails to consider reasonable alternatives to complete reversal of DACA recipients' eligibility to participate in ACA exchanges. Fourth, its Regulatory Impact Analysis ("RIA") is flawed and inaccurate, ignoring costs to persons who purchased insurance under the 2024 Rule and costs to States of reversing DACA recipients' ACA exchange eligibility. As state Attorneys General, we urge you to withdraw this proposal.

A. Background

The 2024 Rule authorized DACA recipients to purchase their health insurance on the ACA exchanges, ensuring reliable access to insurance and benefiting DACA recipients, their families, and the States alike. During the rulemaking process for the 2024 Rule, the Department considered the views of businesses, industry groups, workers' organizations, unions, nonprofits, academics, states, state agencies, and private citizens as expressed in 583 comment letters. The Department discussed in detail the ways increasing health insurance access for DACA recipients provides

[63] *See Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients & Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, & a Basic Health Prog.*, 89 Fed. Reg. 39,392 (May 8, 2024) ("2024 Rule").

[64] *See* 90 Fed. Reg. 12,942.

substantial health and financial benefits to recipients and their communities,[65] while assessing the harms associated with a lack of access to such affordable and adequate health insurance.[66]

Prior to the 2024 Rule, many DACA recipients were unable to obtain affordable health insurance through any means other than an employer-sponsored health plan. The federal government has a long history of deferred action, including seventeen different deferred action policies that existed prior to DACA, and none of the recipients of those other programs have been categorically denied access to government health insurance affordability programs. By comparison, prior to the 2024 Rule, the Department had an exception that carved out DACA recipients alone from eligibility, effectively locking recipients out of health insurance programs their tax dollars help fund. In other words, in many cases, unless a DACA recipient's employer provided health insurance benefits for employees, prior to the 2024 Rule, the DACA recipient would have been unable to secure insurance coverage for themselves or, in some instances, their children via ACA exchanges. This barrier to coverage translated to high uninsured rates among the DACA population[67] and resulted in an economic and health precarity felt by recipients' families, communities, and the States. The 2024 Rule extended to DACA recipients the ability to purchase adequate and affordable health insurance.

The 2024 Rule went into effect on November 1, 2024,[68] and thousands of DACA recipients have already enrolled in health plans purchased via ACA exchanges.[69] Given this newfound access to health insurance, DACA recipients have likely started seeking medical care that they previously put off because of insurance concerns.[70] And the States have come to rely on the expectation that

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[65] *See, e.g.*, 89 Fed. Reg. at 39,405 (noting benefits of the 2024 Rule may be especially important "for those DACA recipients who may be victims of child abuse, domestic violence, sexual assault, and human trafficking"); *id*. at 39406 (Rule "could help decrease the amount of uncompensated care that [emergency departments] provide which could lead to better financial sustainability for emergency care safety net providers," and thus "promote a lower cost and more efficient health care system by reducing high-cost emergency care, increasing lower-cost preventive care, and ultimately decreasing the number of DACA recipients and other impacted noncitizens who qualify only for the treatment of an emergency medical condition under Medicaid").

[66] *See, e.g.*, 89 Fed. Reg. at 39,396 ("[i]ndividuals without health insurance are less likely to receive preventive or routine health screenings and may delay necessary medical care, incurring high costs and debts"); *id*. at 39,406 (explaining "that uninsured individuals might delay seeking vital care, which can result in [emergency department] use").

[67] *See* 89 Fed. Reg. at 39,392 (noting effective date); 89 Fed. Reg. at 39,395 (noting "that DACA recipients are still more than three times more likely to be uninsured than the general U.S. population, which had a national uninsured rate of 7.7 percent); Isobel Mohyeddin et al., *DACA Recipients' Access to Health Care: 2023 Report*, National Immigration Law Center (May 2023), https://tinyurl.com/5t2ra26w.

[68] *See* 89 Fed. Reg. at 39,392 (noting effective date).

[69] *Kansas et al. v. United States of America*, No. 1:24-cv-150 (D. N.D. Aug. 8, 2024), ECF 156-7 at ¶ 17 (As of January 2025, California estimates that over 1,868 DACA recipients have enrolled in a plan). Data on record with the New Jersey Department of Banking and Insurance (DOBI) indicates that, in New Jersey, 519 DACA recipients have enrolled in a plan for the 2024-2025 open enrollment period.

[70] *Cf.* 89 Fed. Reg. at 39,396 (noting "[i]ndividuals without health insurance are less likely to receive preventive or routine health screenings and may delay necessary medical care, incurring high costs and debts").

more residents will seek preventive care, less residents will need to seek emergency care, and the States will need to expend less on uncompensated care costs for uninsured individuals. *See infra* at 21-23. Significantly, the States are also now counting on increased taxes stemming from DACA recipients' enrollment in health plans via the ACA exchanges. But the Proposed Rule disregards all these benefits and threatens to throw these reliance interests into disarray.

B. Removal of DACA Recipients from ACA Exchanges Is Harmful and Unlawful

The Department should withdraw the Proposed Rule. The proposal would harm the States and their residents. It would violate the plain language and purpose of the ACA. It is arbitrary and capricious. And it rests on multiple analytical errors.

1. The Proposed Rule would harm the States and their residents.

Eliminating DACA recipients' access to health insurance from the ACA exchanges would leave them, in many cases, without access to affordable quality health insurance. That would harm not only DACA recipients, but would impose significant harms on the States' economies and on public health and welfare within their borders. This Proposed Rule is ill-advised and harmful.

a. The Proposed Rule, if adopted, would impose significant economic harm on the States.

The Proposed Rule, by its own terms, would deprive all DACA recipients of access to affordable health insurance options on ACA exchanges. In many cases, that would leave DACA recipients without access to health insurance entirely; as the Department recently acknowledged in its 2024 Rule, DACA recipients were over three times more likely than the general U.S. population to be uninsured.[71] But DACA recipients, like any other population, will still have health needs, whether or not they have insurance. Indeed, as the Department is well aware, States incur significant costs for the care of their uninsured residents, including millions in annual unreimbursed costs for the care of uninsured residents at public hospitals,[72] and hundreds of millions in annual subsidies to defray the cost of health care services provided to uninsured residents.[73] It is thereby undeniable that removing DACA recipients' access to ACA exchanges will generate significant expenses for preventive and emergency care that States would now have to assume.

New Jersey's health care programs illustrate ways in which States incur costs for health care services provided to uninsured residents, including uninsured DACA recipients. For example, an uninsured resident can visit Federally Qualified Healthcare Centers ("FQHC") to obtain free or

[71] 89 Fed. Reg. at 39,395.

[72] *Kansas*, No. 1:24-cv-00150, ECF 156-4 (New Jersey University Hospital's uninsured costs), ECF 156-5 (New Jersey Charity Care and Uncompensated Care Fund (UCF) costs).

[73] *Id.* at ECF 156-4 (same), ECF 156-5 (same), ECF 156-8 (NJ FamilyCare and related healthcare program costs), ECF 156-9 (Arizona uninsured DACA recipient emergency medical care costs).

low-cost preventive health services. New Jersey's UCF subsidizes these services by paying a flat rate from State funds per visit for an uninsured resident: $114 per visit for primary and dental care and $74 per visit for mental health services.[74] New Jersey funds the UCF, so the greater the number of uninsured residents in New Jersey, the more the State spends on preventive care for those who obtain such services.[75] Similar logic applies to New Jersey's Charity Care program (which offers annual subsidies to support free or low-cost emergency care services for uninsured residents), and its Supplemental Prenatal and Contraceptive Program (which provides prenatal and family-planning services to residents who do not qualify for Medicaid due to immigration status).[76] For each of these programs, the greater the number of uninsured residents, the more the State spends on health care for uninsured individuals.[77]

Other States' programs offer further illustrations of this reality. In FY 2024, Arizona paid $501,411 in state funds through the Federal Emergency Services Program (FESP) to provide emergency medical or behavioral health care services to 519 DACA recipients.[78]

The States would incur these costs for each of the thousands of DACA recipients who are no longer able to purchase insurance plans through an ACA exchange for the 2024-2025 open enrollment period.[79] Because the Department's Proposed Rule does not grandfather[80] in the DACA recipients that have purchased insurance through the exchanges,[81] it would leave most of these individuals without health insurance (even if they are eligible to procure health insurance via an employer in the middle of the year) and concomitantly require the States to incur significant expenses when they seek preventive or emergency health care.

Nor are those the only costs the Proposed Rule would impose on the States. The Proposed Rule would also result in lost revenue streams from the assessments levied on the payment of insurance premiums by many States for each DACA recipient who is no longer able to purchase insurance through the exchanges. States like New Jersey and California have assessed hundreds of thousands of dollars in fees tied directly to insurance premiums paid by DACA recipients who, under the 2024 Rule, can purchase insurance via ACA exchanges.[82] Moreover, the Proposed Rule would also impose direct and entirely unnecessary compliance costs on the States that operate their own state exchanges. If this Proposed Rule reverses DACA eligibility for their exchanges, such

[74] *Id*. at ECF 156-5 at ¶ 24.
[75] *Id.* at ECF 156-5 at ¶¶ 20-24.
[76] *Id.* at ECF 156-5 at ¶¶ 16-20; ECF 156-8 at ¶¶ 10-19.
[77] *Id.*
[78] *Id.* at ECF 156-9 at ¶ 9.
[79] *Id.* at ECF 156-7 at ¶ 17 (California estimates that over 1,868 DACA recipients have enrolled in a plan). Data on record with the New Jersey Department of Banking and Insurance (DOBI) indicates that, in New Jersey, 519 DACA recipients have enrolled in a plan for the 2024-2025 open enrollment period.
[80] *Infra* pp.34-35.
[81] On the contrary, the Proposed Rule estimates that its changes would result in 10,000 fewer QHP and 1,000 fewer BHP enrollments by DACA recipients. 90 Fed. Reg. at 13,010.
[82] *See, e.g.*, *Kansas*, No. 1:24-cv-150 at ECF 156-6 at ¶¶ 19-20 (New Jersey's projected loss of revenue would be $68,584 if the Proposed Rule is effectuated); ECF 156-7 at ¶¶ 29-30 (California's projected loss of revenue would be $409,151 if the Proposed Rule is effectuated).

States would incur compliance costs, including to implement changes to technology platforms, retrain their staff, update websites and publications, conduct advertising and outreach, and send notices to participating DACA recipients.[83]

The Proposed Rule thus imposes significant economic costs on the States—by (1) requiring them to incur costs for unreimbursed preventive and emergency care by newly-uninsured DACA recipients; (2) depriving them of lost revenue streams from insurance premium assessments; and (3) imposing compliance costs directly imposed by its reversal of a policy that required numerous technological and personnel-related changes to implement just last year.

b. In addition to economic harms, the Proposed Rule would impose significant harms to the public health of the States.

Depriving DACA recipients of access to affordable health insurance on the exchanges will undermine short-term and long-term health outcomes across the board.

The Proposed Rule recognizes that the loss of affordable insurance for a large swath of DACA recipients would result in many recipients becoming uninsured.[84] But while the Proposed Rule acknowledges "[t]his may result in costs to the Federal Government and [] States,"[85] it does not analyze the dangers that this poses to health outcomes for DACA recipients. The absence of such consideration is particularly striking given that the Proposed Rule does consider the potential for adverse health outcomes in connection with other provisions unrelated to DACA recipients.[86] And there would no doubt be adverse health outcomes for DACA recipients and other residents in our states. The Department is well aware that "[i]ndividuals without health insurance are less likely to receive preventive or routine health screenings and may delay necessary medical care, incurring high costs and debts."[87] This includes foregoing preventive services for chronic conditions such as cardiovascular disease, cancer, and diabetes.[88] Such "[d]elays in care can lead to negative health outcomes including longer hospital stays and increased mortality."[89]

These negative health outcomes are not just limited to DACA recipients who lose their affordable and adequate health insurance. To take one obvious example, reversing the 2024 Rule will also immediately impact the children of uninsured DACA recipients—who number at least

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[83] *See, e.g.*, *Kansas*, No. 1:24-cv-150 at ECF 156-7 at ¶¶ 21-27 (detailing over $600,000 in compliance costs incurred by California and describing additional costs that would be incurred if the 2024 Rule were invalidated); ECF 156-6 at ¶¶ 23-27 (describing New Jersey's compliance costs).

[84] 90 Fed. Reg. at 13,010 ("However, we anticipate the majority who lose Exchange or BHP coverage would become uninsured.").

[85] *Id.*

[86] *See* 90 Fed Reg. at 13,014 (potential impact of proposed change to annual eligibility redetermination "could lead to adverse health outcomes"), 13,019 (potential impact of premium adjustment percentage index changes "may contribute to negative public health outcomes").

[87] 89 Fed. Reg. at 39,396.

[88] U.S. Dep't of Health and Human Servs., *Access to Health Services*, Healthy People 2030, https://tinyurl.com/5n7s2cu7 (last visited Apr. 7, 2025).

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

250,000, as the Department of Homeland Security has found—who are likely to be uninsured, since children are generally less likely to be uninsured when their parents have health insurance.[90] Medicaid and CHIP do not serve to patch up these insurance holes as DACA recipients are often hesitant to enroll their U.S.-born children in these programs due to fear and uncertainty in their own status and a concern over threats of deportation and family separation.[91]

The Proposed Rule's harms to public health would also redound beyond the households of DACA recipients to the broader communities of DACA recipients' home states by increasing the risk and magnitude of disease outbreaks and placing a greater strain on hospitals. One study found that "wider insurance gaps exacerbated local COVID-19 outbreaks and resulted in more cases, hospitalization, and death than experienced by jurisdictions with better coverage," meaning that "[r]educing the number of [individuals] without health insurance is a crucial and underappreciated component of pandemic preparedness."[92]

Additionally, by decreasing access to health insurance, the Proposed Rule would decrease access to regular outpatient care, leading to greater rates of hospitalization for longer periods of time.[93] This can cause particularly acute problems in smaller communities with fewer resources to address these higher hospitalization rates, where "[h]igh uninsured rates contribute to rural hospital closures and greater financial challenges for rural hospitals, leaving individuals living in rural areas at an even greater disadvantage to accessing care."[94] Simply put, the Proposed Rule increases gaps in insurance coverage[95] and so threatens the public health of the greater community.[96]

In short, the Proposed Rule would undermine public health within our States: of our DACA recipient residents, their families, and the broader communities at large.

c. Beyond threatening public health, the Proposed Rule also endangers public welfare.

As the Department has previously recognized, real-world evidence confirms that a lack of insurance can result in uncompensated care costs, increased medical debt, reduced spending power, lost work productivity, absenteeism, and increased premature mortality—among other

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[90] 89 Fed. Reg. at 39,402.

[91] Samantha Artiga & Anthony Damico, *Nearly 20 Million Children Live in Immigrant Families that Could Be Affected by Evolving Immigration Policies*, Kaiser Family Foundation (Apr. 18, 2018), https://tinyurl.com/37dwfce9. *See also* Samantha Artiga & Petry Ubri, *Living in an Immigrant Family in America: How Fear and Toxic Stress are Affecting Daily Life, Well-Being, & Health*, Kaiser Family Foundation (Dec. 13, 2017), https://tinyurl.com/46m24hur.

[92] Travis Campbell et al., *Exacerbation of COVID-19 mortality by the fragmented United States healthcare system: A retrospective observational study*, The Lancet Regional Health (May 12, 2022), https://tinyurl.com/mr26zt3r.

[93] *See* 89 Fed. Reg. at 39,396.

[94] Jennifer Tolbert et al., *Key Facts about the Uninsured Population*, Kaiser Family Foundation (Dec. 18, 2024), https://tinyurl.com/2s3jmmbm.

[95] 90 Fed. Reg. at 13,010.

[96] *See* Tolbert et al., *supra* note 94.

harms.[97] And, as the Department recognizes, DACA recipients are generally younger and healthier than the overall population who participates in the exchanges.[98] By eliminating them from the ACA insurance pools, the Proposed Rule will likely weaken those pools and increase costs across the board.[99]

Overall, the Proposed Rule threatens significant harms to the States' economies and their public health and welfare. The Department should withdraw this proposal.

2. The Proposed Rule contravenes the text and purpose of the ACA.

a. The Proposed Rule is contrary to the text, history, and structure of the ACA.

Under the ACA, noncitizens may be eligible to purchase insurance through ACA exchanges and to receive certain federal subsidies, provided that they are "lawfully present in the United States." For almost three decades, the Executive Branch has understood this term of art to encompass recipients of deferred action for purposes of certain federal benefits statutes. The 2024 Rule removes the Department's previous exception to this well-established understanding of lawful presence as it relates to DACA recipients, and allows DACA recipients to access affordable and adequate health insurance under the ACA.

The ACA uses a term of art—"lawfully present"—as an eligibility criterion in numerous provisions.[100] In doing so, Congress conveyed a clear policy directive: individuals who are lawfully present, rather than only those who have citizenship or another lawful status, would receive access to the ACA's benefits.[101] Although the ACA does not define "lawfully present," the phrase is also used in 8 U.S.C. § 1611(b)(2), which predates the ACA, as an eligibility criterion for Social Security. That statutory provision grants authority to the Attorney General (now the Secretary of Homeland Security) to define who is lawfully present.[102] Lawful presence has long been understood to encompass an individual "who is (under the law as enacted by Congress) subject to removal, and whose immigration status affords no protection from removal, but whose temporary presence in the United States the Government has chosen to tolerate, including for reasons of resource allocation, administrability, humanitarian concern, agency convenience, and

[97] *See* 89 Fed. Reg. at 39,396 (lack of insurance "can have downstream impacts that further disrupt individuals' health and financial stability, and therefore their ability to work or study. Delays in care can lead to negative health outcomes …whereas being unable to pay medical bill puts individuals at higher risk of food and housing insecurity.").

[98] 90 Fed. Reg. at 13,010.

[99] *See* 89 Fed. Reg. at 39,398; *Kansas*, No. 1:24-cv-150 at ECF 156-7 at ¶¶ 32-33, ECF 156-10 at ¶¶ 24-26, ECF 156-8 at ¶¶ 7, 33.

[100] *See* 42 U.S.C. § 18032(f)(3) (eligibility to enroll in a health plan on the exchange); 26 U.S.C. § 36B(e) (eligibility for refundable premium tax credits); 42 U.S.C. § 18071(e) (eligibility for cost sharing); 42 U.S.C. 18081(c) (process by which lawful presence will be verified); 42 U.S.C. § 18082(d) (advanced payment of credits or cost sharing).

[101] *See id.*

[102] *See* 8 U.S.C. § 1103(a)(1).

other factors."[103] That background understanding was in place before the adoption of the ACA, and thus Congress's use of that term brought with it that old soil.[104]

The Department's contrary statutory analysis—an about-face from its view as recently as a few months ago—is unavailing. The reason the Department provides for reversing course from its 2024 Rule is that it believes its proposal "realign[s] [HHS's] policy with the text of the ACA."[105] Citing only to two recent Executive Orders, the Department explains it is "reconsidering the[] arguments" that it laid out in the 2024 Rule.[106] The Department maintains simply that, even though it previously believed it "should 'align' its position to that of DHS," it now believes that "the separate statutory and policy considerations" that govern HHS and DHS do "not compel HHS to 'align' its position on DACA recipients with the position that DHS took with regard to DACA recipients' eligibility for certain Social Security benefits."[107] But the Department says nothing of how "the broad aims of the ACA"—namely "to increase access to health coverage"— informed its analysis just a year prior.[108] And it does not sufficiently grapple with the reality that the ACA is using a specialized term that already carried with it a specialized meaning. The Department gives no reason why Congress would have wanted to use that term but to abrogate its meaning.

By comparison, as part of the rulemaking for its 2024 Rule, the Department reviewed comments noting its prior exclusion of DACA recipients from the definition of "lawfully present" was "inconsistent with other rules pertaining to public benefits for individuals with deferred action," including DHS regulations for Social Security benefits.[109] The Department also addressed comments opposing the changes the then-proposed 2024 Rule would make, ultimately noting that its inclusion of DACA recipients in the definition of "lawfully present" for purposes of the ACA exchanges is "consistent with the relevant statutory authorities," and consistent with DHS's ability to "recognize[] that even individuals who did not enter the United States legally could become 'lawfully present' under the statutes governing particular benefit programs."[110] In response to comments, the Department explained that the 2024 Rule "aim[ed] to establish criteria only for [the ACA exchanges]" and "d[id] not address or revise immigration policy, including DHS's DACA policy," reiterating "that other recipients of deferred action have long been considered lawfully present under [HHS] regulations and policies" and the Department was simply "removing the exception for DACA Recipients for the purposes of eligibility for [the ACA exchanges]."[111] The Department underscored that it "d[id] not believe that [the 2024 Rule] w[ould] encourage irregular

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[103] 87 Fed. Reg. at 53,209.

[104] *Cf., e.g.*, *Lamar, Archer & Cofrin, LLP v. Appling*, 584 U.S. 709, 721-22 (2018) (noting use of term of art with preexisting meaning indicates Congress intended for the statutory term to carry with it that same meaning).

[105] 90 Fed. Reg. at 12,954.

[106] 90 Fed. Reg. at 12,954.

[107] 90 Fed. Reg. at 12,954.

[108] 89 Fed. Reg. at 39,395 (explaining rationale for 2024 Rule); *see also* 90 Fed. Reg. at 12953-55 (briefly acknowledging the benefits that underpinned the 2024 Rule, but otherwise failing to engage with the Department's own analysis of the ACA in 2024).

[109] *See* 89 Fed. Reg. at 39,398.

[110] 89 Fed. Reg. at 39,399 (explaining how the term "lawfully presence" has been applied historically).

[111] 89 Fed. Reg. at 39,399.

migration, fraud or abuse of government systems, or encourage dependency on Federal programs."[112] In its new proposal, the Department fails to engage with any of its previous reasons for including DACA recipients in the definition of "lawfully present," other than saying excluding DACA recipients "reflect[s] the better view of the appropriate intersection of DACA and the ACA."[113] That is not statutory analysis.

The Department's current reasoning also completely disregards how DHS treats DACA recipients for the purposes of immigration law. Although DACA (and deferred action generally) is not a form of "lawful status," DHS does not consider those subject to a grant of deferred action to be *un*lawfully present in the U.S. as long as the deferred action is in effect.[114] Unlawful presence has serious ramifications: a person who accrues unlawful presence in the U.S. and leaves the country and tries to reenter may be barred and deemed inadmissible for 3 or 10 years, depending on the length of unlawful stay.[115] DACA recipients do not accrue that unlawful presence time so long as the individualized grant of their DACA requests and renewals remains valid.[116] Moreover, DACA recipients and other recipients of deferred action are, due to decades-old DHS regulations, eligible for work authorization.[117] Taken as a whole, for the past decade, current DACA recipients had been eligible to live and work in the U.S. and have been eligible to receive benefits like Social Security, but they still *could not* access crucial aspects of the healthcare system. This is despite the fact that according to one estimate, as of 2021, DACA recipients and their households pay $6.2 billion in annual federal taxes and about $3.3 billion in annual State and local taxes—meaning that DACA recipients were previously paying into the very same benefits from which they are barred.[118] By denying DACA recipients access to the ACA's benefits, the Proposed Rule once again treats these individuals as a *sui generis* subset of deferred action recipients when, in fact, DACA is just one in a historically long line of deferred action programs in the nation's history.[119]

Setting aside the Department's slipshod statutory analysis and its disregard for DHS's treatment of deferred action historically, the Proposed Rule simply misunderstands immigration law. The Department raises a purported concern about "inadvertently expand[ing] the scope of the DACA process"[120] as a basis for its proposal. The Proposed Rule maintains that DACA's "purpose did not include extending ACA access to health insurance Exchanges."[121] But nothing in the

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[112] 89 Fed. Reg. at 39,399.

[113] 90 Fed. Reg. at 12,954.

[114] *See What is Deferred Action for Childhood Arrivals*, U.S. Citizenship and Immigr. Servs., https://tinyurl.com/mr4yn5pe (last updated May 30, 2023).

[115] Immigration and Nationality Act (INA), 8 U.S.C. § 1182(a)(9)(B)(i)(1). *See also Unlawful Presence and Inadmissibility*, U.S. Citizenship and Immigr. Servs., https://tinyurl.com/2eazvc4v (last updated June 24, 2022).

[116] *See What is Deferred Action for Childhood Arrivals?*, *supra* note 114.

[117] 8 C.F.R. §§ 274a.12, 274a.13.

[118] Nicole Prchal Svajlenka & Trinh Q. Truong, *The Demographic and Economic Impacts of DACA Recipients: Fall 2021 Edition*, Center For American Progress (Nov. 24, 2021), https://tinyurl.com/mryjxdkd.

[119] *See* Ben Harrington, Congressional Research Service, *An Overview of Discretionary Reprieves from Removal: Deferred Action, DACA, TPS, and Others* (April 10, 2018), https://tinyurl.com/2f3z4mt9.

[120] 90 Fed. Reg. at 12,955 (cleaned up).

[121] 90 Fed. Reg. at 12,954 (explaining that DACA rests on three principles: the

DACA regulations indicates that *denying* DACA recipients access to health insurance fits deferred action either. In fact, DACA recipients can access health insurance through employer-sponsored health plans. Allowing them to access the ACA exchanges only gives them the ability to *purchase* health insurance on the marketplace when an employer-sponsored plan is unaffordable or inadequate—it does not fold DACA recipients into government-funded benefits programs like Medicaid. Just a year ago, the Department discussed DHS's DACA regulations, noting DHS itself acknowledged that the term "lawfully present" "does not confer lawful status or authorization to remain in the United States, but instead describes noncitizens who are eligible for certain benefits."[122] In that vein, the Department's prior rulemaking aptly understood DHS's goal in promulgating the DACA regulations, noting "it is clear that the DACA policy is intended to provide recipients with a degree of stability and assurance that would allow them to obtain education and lawful employment, including because recipients remain lower priorities for removal," and "[e]xtending eligibility to these individuals is consistent with those [DHS] goals."[123] The Department's current concern that allowing DACA recipients to buy health insurance on the marketplace would disrupt DHS's immigration policy is not supported by law—as giving DACA recipients access to the marketplace does not change anything about their legal immigration status.[124]

Despite its misplaced concerns over immigration law, the Department also asserts that it does not need to operate in lock-step with DHS.[125] As noted, the Proposed Rule avers "there is no requirement that HHS align[] its definition of 'lawfully present' with DHS's" definition, and there is "no requirement that HHS align its treatment of DACA recipients with other recipients of deferred action, particularly given the fundamental differences between DHS's DACA policy and other policies under which DHS may grant deferred action."[126] But the Proposed Rule also points to nothing requiring the Department maintain a separate definition of "lawfully present" that excludes DACA recipients.[127] Simply because the Department is not *required* to harmonize its definition of "lawfully present" with DHS's definition, does not mean it is *prohibited* from doing so. And where the Department previously sought to adopt a definition to effectuate "the broad aims of the ACA to increase access to health coverage,"[128] and cited evidence in support of its regulatory change, this Proposed Rule does precisely the opposite.

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identification of a group of individuals deemed low enforcement priorities, forbearance from removal for these individuals, and work authorization during this period of deferred action).

[122] 89 Fed. Reg. at 39,394 (referencing DHS's discussion of "lawfully present" in its DACA regulations).

[123] 89 Fed. Reg. at 39,395.

[124] *See* 89 Fed. Reg. at 39,400 (making clear the 2024 Rule "in [no] way change[s] existing immigration policy, nor does it confer lawful immigration status").

[125] 90 Fed. Reg. at 12,955.

[126] *Id.*

[127] *Cf.* 89 Fed. Reg. at 39,395 (noting in 2024 Rule that there is "no statutory mandate to distinguish between recipients of deferred action under the DACA policy and other deferred action recipients").

[128] *Id.*

Put simply, the Proposed Rule rests on circular logic.[129] The Department's explanation for changing course amounts to: because DACA recipients were previously excluded from the definition of "lawfully present" they should remain excluded now. This reasoning does nothing to engage with the Department's rationale for changing the definition of "lawfully present" last year, or to justify its change in position now. As discussed, the rulemaking for the 2024 Rule indicates that the inclusion of DACA recipients in the definition of "lawful presence" is supported by the fact that "other recipients of deferred action have long been considered lawfully present under [HHS] regulations and policies."[130] Likewise, nothing in the DACA regulations indicate that DHS intended to deny DACA recipients the ability to purchase affordable and adequate health insurance on the ACA exchanges as part of the agency's deferred action policy.[131] Importantly, the 2024 Rule did not "change existing immigration policy," nor did it "confer lawful immigration status."[132]

The Department has disregarded the statutory arguments that underlaid its prior position, failing to engage with its own reasons for including DACA recipients in the definition of "lawfully present" just a year ago. The Department's Proposed Rule is contrary to law and, in its current formulation, violates the APA.[133]

b. The Proposed Rule is also inconsistent with Congress's purposes in adopting the ACA.

Insufficient insurance coverage is a barrier to improving health outcomes and addressing health disparities across the United States. Inequitable access to healthcare and resulting adverse health outcomes, in turn, impose significant costs on society at large, diminish national and local economic potential, and increase national vulnerability to future disease outbreaks and pandemics. Recognizing these systemic issues, Congress enacted the ACA to increase access to health insurance and improve health and well-being by tackling barriers to accessing affordable, quality insurance coverage. Tens of millions of individuals have since gained insurance coverage through ACA policies focused primarily on helping individuals who do not receive coverage through an employer or government program to purchase affordable insurance directly. ACA coverage can improve health, quality of life, and economic productivity for all State residents, including low-income and vulnerable individuals. In passing the ACA, Congress intended to reduce the number of uninsured individuals in the country and to make health insurance more available. The 2024 Rule sought to align the eligibility for all lawfully present recipients of deferred action with the aims of the ACA, with data demonstrating that the 2024 Rule would address a significant health insurance coverage gap and provide substantial economic and public health benefits for many states.[134] The Proposed Rule does the opposite, while lacking any evidence-based justification.

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[129] *See* 90 Fed. Reg. at 12,954 (maintaining that "the use of the term 'lawfully present' in the ACA is best implemented by excluding DACA recipients for purposes of" ACA exchange eligibility).
[130] 89 Fed. Reg. at 39,399.
[131] See 89 Fed. Reg. at 39,400-01.
[132] 89 Fed. Reg. at 39,400.
[133] *Ball, Ball & Brosamer, Inc. v. Reich*, 24 F.3d 1447, 1450 (2d Cir. 1994).
[134] *See, e.g.*, 89 Fed. Reg. at 39,395-96, 39,403-04.

Further, the ACA may expressly prohibit the type of action the Proposed Rule seeks in removing eligibility for participation in ACA exchanges to DACA recipients. The ACA prohibits HHS from promulgating "any regulation that creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care . . . [or] limits the availability of health care treatment for the full duration of a patient's medical needs."[135] When a Rule, like the Proposed Rule, places a "substantive barrier" on individuals' ability to obtain appropriate care, it runs afoul of the statutory intent of the ACA.[136] This is not an instance where Congress has decided whether or not to fund programs under the ACA, but rather an explicit rulemaking proposal that prevents DACA recipients who accessed ACA marketplaces—and who may have begun care—from continuing to receive appropriate medical care.

High rates of uninsured can result in uncompensated care costs, increased medical debt, reduced spending power, lost work productivity, absenteeism, increased premature mortality, and social and systemic costs-of-illness. *See supra* pp. 22-23. Without recognizing the economic burden associated with coverage gaps, the Proposed Rule overlooks significant social, systemic, and economic benefits that result from the expanded, rather than restricted, access to health insurance.

The Proposed Rule undermines the ACA's aims to increase access and availability to health insurance and will result in significant costs on States' medical and insurance industries. Without access to affordable health insurance, DACA recipients are "less likely to receive preventive or routine health screenings and may delay necessary medical care, incurring high costs and debts."[137] The Proposed Rule acknowledges that prohibiting DACA recipients from purchasing insurance on the ACA exchanges would reduce enrollments by up to 10,000 otherwise eligible individuals.[138] The Proposed Rule discounts the effect of the 2024 Rule, asserting that actual enrollment of DACA recipients in insurance was much lower than anticipated.[139] States who have expanded insurance and Medicaid access to DACA recipients provide ample evidence that increasing access to health insurance yields positive outcomes for residents and public health at large. For example, a May 2024 report by the Kaiser Family Foundation indicated that immigrant adults in States with more expansive health care coverage policies are half as likely to be uninsured or to report delaying or going without medical care due to cost compared to those in less expansive States.[140] Another study found that after New York and California extended eligibility for their States' Medicaid programs to DACA recipients, DACA-eligible immigrants were 4% more likely to report insurance coverage than in other States that did not extend coverage to low-income DACA recipients.[141] In New York alone, more than 13,000 DACA recipients have enrolled in Medicaid,

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[135] 42 U.S.C. § 18114.

[136] *California v. Azar*, 950 F.3d 1067, 1095 (9th Cir. 2020) (articulating a standard for invalidating a regulation under 42 U.S.C. § 18114.

[137] 89 Fed. Reg. at 39,396.

[138] 90 Fed. Reg. at 13,010.

[139] 90 Fed. Reg. at 13,010.

[140] Akash Pillai et al., *State Health Coverage for Immigrants and Implications for Health Coverage and Care*, Kaiser Family Foundation (May 1, 2024), https://tinyurl.com/5cd2jjx6.

[141] *See State Spotlight: California's Landmark Coverage Expansion for Immigrant Populations*, Manatt Health (Nov. 2022), https://tinyurl.com/3b4jcu5f; Osea Giuntella & Jakub Lonsky, *The Effects of DACA on Health Insurance, Access to Care, and Health Outcomes*, IZA

aided by specially trained enrollment assistors in a number of languages,[142] while in Minnesota, 281 DACA recipients have received state-funded Medicaid through MinnesotaCare.[143] And in 2023, New Jersey expanded Medicaid and CHIP to children under 19 whose families meet income and eligibility requirements regardless of immigration status.[144] During the initial six-month period, 17,896 children who satisfied income and other eligibility criteria and who had previously been ineligible due to their immigration status were enrolled. As of the end of August 2024, the total number of enrolled children had reached 41,532.[145]

While the Proposed Rule asserts that the actual number of DACA recipients is lower than the 2024 Rule anticipated, it ignores the consequence of a preliminary injunction issued in the midst of many States' open enrollment periods that halted eligibility for individuals living in States covered by the injunction.[146] Indeed, several States represented in this letter filed an amicus brief in support of the 2024 Rule[147] and, as articulated *supra*, several of these States demonstrate the effectiveness and benefits of extending eligibility for insurance programs to DACA recipients.

3. The Proposed Rule is arbitrary and capricious

Under the APA, agencies must engage in "reasoned decisionmaking."[148] When an agency changes longstanding policies, it must "show that there are good reasons for the new policy" and provide a "detailed justification" for adopting its proposed policy.[149] Agencies must consider "the advantages *and* the disadvantages of agency decisions" before taking action.[150] If an agency fails to meet these requirements, the action can be set aside as arbitrary and capricious.[151] That is so even where a federal agency believes its prior policy was unlawful, and that a new policy is remedying that prior illegality; it must still engage in the broader reasoned decisionmaking that the APA requires.[152] But the Department has failed to engage in reasoned decisionmaking here.

Institute of Labor Economics (April 2018), at 10, https://repec.iza.org/dp11469.pdf.

[142] Information provided by NYSDOH; *see also Fast Facts on Health Insurance for Immigrants*, NSYDOH (Sept. 2015), https://tinyurl.com/ccfd5sd7.

[143] Information provided by the Minnesota Department of Human Services.

[144] *See Governor Highlights Expanded Eligibility for NJ FamilyCare Health Care Coverage as Administration Continues Efforts to Cover All Kids*, N.J. Dep't of Human Servs. (Jan 18, 2023), https://tinyurl.com/24rxdyb5.

[145] *Kansas*, No. 1:24-cv-150 at ECF 156-12 at ¶ 11.

[146] 90 Fed. Reg. at 13,010.

[147] *Kansas*, No. 1:24-cv-150 at ECF 69.

[148] *State Farm*, 463 U.S. at 52.

[149] *FCC v. Fox Television Stations*, 556 U.S. 502, 515 (2009).

[150] *Michigan v. EPA*, 576 U.S. 743, 753 (2015).

[151] *See Fox Television Stations*, 556 U.S. at 537.

[152] *See, e.g.*, *Dep't of Homeland Security v. Regents of the Univ. of Calif.*, 591 U.S. 1, 29-30 (holding that agency's change in course from policy it deemed was illegal still required reasoned decisionmaking, including consideration of reliance interests); *Nat'l Lifeline Ass'n*, 921 F.3d at 1111 (APA's standard of reasoned decisionmaking applies to changes in policy, and agency must show "there are good reasons for the new policy") (cleaned up); *Open Soc'y Inst. v. U.S. Citizenship & Immigr. Servs.*, 573 F. Supp. 3d 294, 321 (D.D.C. 2021) (when reviewing an agency's change in policy, the "touchstone" is that the agency's explanation must "enable" a reviewing court to conclude it was the product of reasoned decisionmaking) (cleaned up).

a. The Department failed to consider myriad benefits of the 2024 Rule

In contrast to the comprehensive and carefully considered 2024 Rule, the Department's current plan to exclude DACA recipients from access to ACA exchanges relies upon an inadequate analysis. Simply put, the Department ignores multiple important benefits that it previously, and recently, found would result from allowing DACA recipients to purchase health insurance plans from the marketplace, all of which formed the basis for the 2024 Rule.[153] Indeed, the Department acknowledges that the proposal "may result in costs to the Federal Government and to States" due to increased emergency medical care for DACA recipients "who become uninsured as a result of this rule."[154] The Department never explains why incurring these costs would be justified, but more fundamentally, the Proposed Rule never accounts for the loss of the many other benefits the Department and commenters identified as flowing from the 2024 Rule.

While an agency "need not always provide a more detailed justification than what would suffice for a new policy created on a blank slate," "[s]ometimes it must," including when "its new policy rests upon factual findings that contradict those which underlay its prior policy."[155] A "reasoned explanation is needed for disregarding facts and circumstances that underlay . . . the prior policy," and it "would be arbitrary and capricious to ignore such matters."[156] In its proposal, the Department simply ignores the fact that increased access to health insurance results in better public health outcomes for the individual and the public generally, increased financial stability and productivity at work and school, and reduced uncompensated care costs for the States—all of which are consistent with the purpose of the ACA.[157] The Department's failure to adequately explain its proposal, and its complete disregard of nearly all the factual findings in the 2024 Rule, renders its proposal arbitrary and capricious in multiple ways, as discussed below.

First, as the Department anticipated just last year, "[i]ndividuals without health insurance are less likely to receive preventive or routine health screenings and may delay necessary medical care, incurring high costs and debts."[158] In support of this finding, the Department pointed to survey data that showed "48 percent of respondents" delaying "medical care due to their immigration status," with "71 percent of respondents unable to pay medical bills or expenses."[159] These types of outcomes "have downstream impacts that further disrupt individuals' health and financial stability," affecting "their ability to work or study."[160] Delays in care not only lead to "negative health outcomes" like "longer hospital stays and increased mortality," but the delays can result in unpaid medical bills, which puts individuals "at higher risk of food and housing

[153] *See* 89 Fed. Reg. at 39,395 (explaining goal of 2024 Rule was to effectuate "the broad aims of the ACA to increase access to health coverage"); *id.* at 39396 (detailing harms associated with lack of health insurance coverage, as well as benefits that stem from DACA recipients' increased access to health insurance).

[154] 90 Fed. Reg. at 13,010.

[155] *Fox Television Stations*, 556 U.S. at 5161.

[156] *Id*. at 515-16.

[157] 89 Fed. Reg. at 39,395-96 (explaining why the 2024 Rule is consistent with the ACA, and detailing the benefits of increased access to health insurance).

[158] 89 Fed. Reg. at 39,396.

[159] *Id*.

[160] *Id*.

insecurity."[161] Given that "over 200,000 DACA recipients served as essential workers during the COVID-19 [public health emergency],"—including "43,500 DACA recipients who worked in health care and social assistance occupations" with "10,300 in hospitals and 2,000 in nursing care facilities"—it is crucial that these individuals have access to affordable and adequate health insurance.[162] The Department fails to grapple with the impact of reducing DACA recipients' access to affordable and adequate health insurance, noting only that it "anticipate[s] the majority who lose" access to the ACA exchanges "would become uninsured," which "may result in costs to the Federal Government and to States to provide limited Medicaid coverage for the treatment of an emergency medical condition to DACA recipients who have a qualifying medical emergency and who become uninsured as a result of this rule."[163] Rather than address the downstream impacts of so many people losing their health insurance in one fell swoop, the Department tries to summarily minimize the harms to DACA recipients, the States, and the Federal Government.[164]

Second, and by comparison, in 2024 the Department found that "increasing access to health insurance would improve the health and well-being of many DACA recipients currently without coverage."[165] Beyond these improved health outcomes, DACA recipients "could be even more productive and better economic contributors to their communities and society at large with improved access to health care."[166] In support of this conclusion, the Department cited to a 2016 study, which found that "a worker with health insurance is estimated to miss 77 percent fewer days than an uninsured worker."[167] Now, the Department fails to address these benefits, even though they formed the basis for the 2024 Rule, and does nothing to engage with the harms that come from DACA recipients' losing access to the ACA exchanges. Short of acknowledging in an unrelated section elsewhere in the proposal that "[a]n increase in the rate of uninsurance may . . . cause an overall reduction to labor productivity,"[168] the Department does nothing to engage with the impacts of its proposal on DACA recipients, their families, and the communities they live in.

Third, in 2024 the Department found that allowing DACA recipients to access affordable, quality health insurance on the ACA exchanges "align[ed] with the goals of the ACA," to "lower the number of people who are uninsured in the United States and make affordable health insurance available to more people."[169] Because "DACA recipients represent a pool of relatively young, healthy adults," who are "younger than the general Exchange population," inclusion of DACA recipients in the marketplace may have "a slight positive effect on the [ACA exchanges'] risk pools."[170] This improvement to risk pools "could result in cost savings for health insurance issuers in the form of lower claims costs and for individuals in the form of lower health insurance

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[161] *Id*.
[162] *Id*. (noting that at "the height of the pandemic, essential workers were disproportionately likely to contract COVID-19").
[163] 90 Fed. Reg. at 13,010.
[164] *Id*.
[165] 89 Fed. Reg. at 39,396; *id*. at 39,403.
[166] 89 Fed. Reg. at 39,396.
[167] *Id*.
[168] 90 Fed. Reg. at 13,025.
[169] 89 Fed. Reg. at 39,396.
[170] *Id*.

premiums."[171] In its current proposal, the Department acknowledges that "[b]ecause DACA recipients are young" and "generally tend to be healthier," excluding them from ACA exchanges "would have a small negative impact on the individual market risk pool," without saying anything more on the subject,[172] failing to explain why it is reasonable to forego this benefit of the 2024 Rule.

Fourth, and as discussed above, the Proposed Rule disregards the harms that it would work on the States. As State Attorneys General, we are particularly concerned with the impact that the Proposed Rule would have on public health in our States and on our States' ability to absorb uncompensated care costs. *See supra* pp.19-23. Because DACA recipients remain ineligible for Medicaid, access to the private market is a crucial way of ensuring that more of our residents can receive affordable and adequate health insurance. States that operate ACA exchanges experience an increase in user fees that help fund the state-run exchanges; the total user fee collected by States operating their own exchanges increases when there are more enrollees.[173] Consistent with the Department's findings in 2024, increased access to health insurance means that our states will see improved public health outcomes, healthier and more productive residents, and lower uncompensated care costs. While the Department acknowledges that "the majority who lose" access to the marketplace "would become uninsured," it tries to minimize the costs to the States and Federal Government, noting this increase in uninsured individuals "may result in costs . . . to provide *limited* Medicaid coverage for the treatment of an emergency medical condition to DACA recipients who have a qualifying medical emergency and who become uninsured as a result of this rule."[174] But this cursory analysis does not account for the fact that uninsured individuals are more likely to put off preventive and routine health screenings, resulting in more serious health outcomes with "longer hospital stays and increased mortality."[175] These more serious and expensive health care costs will either put individuals at a higher risk of food and housing insecurity, or result in the States having to absorb the cost. Those are costs that the Department has yet to seriously grapple with.

In sum, allowing DACA recipients to purchase health insurance from the marketplace allows DACA recipients to seek routine and preventive care, results in less emergency medical care, decreases the spread of contagious diseases, increases worker productivity, brings in tax revenue to our States, improves the risk pool leading to cost savings for consumers, and decreases the need for States to absorb uncompensated care costs for uninsured individuals. *See supra* pp. 19-23. These are all significant and concrete benefits that the Department recognized and discussed in detail in the rulemaking leading up to the 2024 Rule. All of these benefits derive from the Department changing the definition of "lawfully present" to include DACA recipients and, thus, effectuating the goal of the ACA. The Department's current failure to even consider these benefits, or the impact of its proposal depriving the States of these benefits, is arbitrary and capricious and

[171] 89 Fed. Reg. at 39,429.
[172] 90 Fed. Reg. at 13,010.
[173] *Kansas*, ECF 156-6 at ¶¶ 14-16 (noting that, in New Jersey, "the total user fee collected by [the State] correspondingly decreases as the number of enrollees decreases").
[174] 90 Fed. Reg. at 13,010 (emphasis added).
[175] 89 Fed. Reg. at 39,396.

shows a blatant disregard for public health and the goal of increasing access to health services, which the Department is charged with protecting.[176]

b. The Department failed to account for reliance interests.

At no point in the Proposed Rule does the Department acknowledge that DACA recipients and States have reliance interests following the 2024 Rule. Because the Department is "not writing on a blank slate" with its proposal, "it [i]s required to assess whether there were reliance interests, determine whether they were significant, and weigh any such interests against competing policy concerns."[177] The Department's "failure" to "even address[] the options of . . . accommodating particular reliance interests" is "arbitrary and capricious in violation of the APA."[178]

In 2024, the Department cited evidence supporting its findings that "[i]ndividuals without health insurance are less likely to receive preventive or routine health screenings," and "may delay necessary medical care."[179] This makes sense because "[m]any doctors will not even see a patient without first seeing proof of insurance."[180] It is reasonable to assume that DACA recipients who have been able to purchase health insurance on the ACA exchanges have sought treatment they were previously putting off, like chemotherapy or surgery to address chronic pain.[181] Additionally, DACA recipients who already purchased insurance on the ACA exchanges and who need regular bloodwork because of health conditions like heart disease or cancer by now assume those testing costs would be covered by their insurance—and without coverage they will have to resume paying out of pocket, or the State will again have to resume absorbing the cost.[182]

It is not just DACA recipients who have developed reliance interests following the 2024 Rule, but our States and residents. As noted, *supra* pp. 19-21, States incur significant costs for the care of uninsured residents at public hospitals and through annual subsidies intended to defray the cost of healthcare services provided to uninsured individuals. The greater the number of uninsured residents, the more States spend on uncompensated care.[183] It follows, with DACA recipients eligible for health insurance via the ACA exchanges, that our States anticipated a decrease in the

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[176] U.S. Department of Health and Human Services (HHS), https://tinyurl.com/bdwr5knz (last visited April 9, 2025).

[177] *Regents*, 591 U.S. at 33 (citation omitted).

[178] *Id.*

[179] 89 Fed. Reg. at 39,396.

[180] *Hector v. Raymond*, 692 So.2d 1284, 1288 (La. App. 3 Cir. 1997).

[181] *See* Rachel Garfield & Katherine Young, *How Does Gaining Coverage Affect People's Lives? Access, Utilization, and Financial Security among Newly Insured Adults*, Kaiser Family Foundation (June 19, 2015), https://tinyurl.com/323r257j (those who newly gained coverage in 2014 were "more likely to be linked to regular care, less likely to postpone care when they need it, and more likely to use preventive services than those who remained uninsured."); *cf.* JPMorgan Chase & Co. Institute, *Deferred Care: How Tax Refunds Enable Healthcare Spending* (January 2018), https://tinyurl.com/46r7zpsb (finding that "[c]onsumers immediately increased their total out-of-pocket healthcare spending by 60 percent in the week after receiving a tax refund").

[182] *See, e.g.*, *Kansas*, ECF 49-4 at ¶¶ 9-13 (small business owner without access to employer-sponsored insurance requires regular cancer-related bloodwork).

[183] *Id.*, ECF 156-5 at ¶¶ 16-25; ECF 165-8 at ¶¶ 10-25.

number of uninsured individuals and an improvement in public health. *See supra* pp. 19-23. For States that operate their own ACA exchange, an increase in the number of insurance enrollees results in an increase in the user fees that the States use to fund those state-based exchanges.[184] The 2024 Rule already resulted in increased enrollment in health insurance plans,[185] and our States planned for an uptick in user fees for state-based exchanges. If the Proposed Rule were finalized, our States would again have to absorb higher uncompensated care costs for uninsured individuals, risk greater harms to public health, and would experience a decrease in user fees from insurance premiums. Further, States that manage their own ACA exchanges incurred compliance costs, and would now incur *additional* compliance costs as the Department whipsaws to remove this group of otherwise eligible ACA exchange participants after welcoming them in just last year.

The Department does nothing to engage with the possibility that the 2024 Rule has already engendered these reliance interests.[186] It fails to make note that such reliance interests could exist, and does not solicit any comments on the subject. The Department is not required "to consider all policy alternatives" in its rulemaking, but it must, at the very least, consider the reliance interests at stake when it is changing course.[187] The Department's failure to do so makes its proposal arbitrary and capricious.

c. The Department failed to consider reasonable alternatives.

The Department also acted in an arbitrary and capricious manner by failing to meaningfully consider reasonable alternatives that preserve DACA recipients' access to health insurance. Consistent with bedrock principles of administrative law, if there are "significant and viable and obvious alternatives" that address rising health care costs but reduce harm to DACA recipients, the Department needs to explain sufficiently why it did not adopt them.[188] Failure to give these alternatives serious consideration would therefore fall far short of a requisite justification.[189] That is what happened here: the Department failed to explore multiple significant alternatives to their

[184] *Id*., ECF 156-6 at ¶¶ 14-16 (noting that, in New Jersey, "for each individual who ceases to be enrolled in a health benefits plan in New Jersey, including plans sold on [the state-based exchange]" the State "loses user fee revenue").

[185] *See e.g.*, *id*. at ECF 156-7 at ¶ 17 (as of January 2025, California estimates that over 1,868 DACA recipients have enrolled in a plan). Data on record with the New Jersey Department of Banking and Insurance (DOBI) indicates that, in New Jersey, 519 DACA recipients have enrolled in a plan for the 2024-2025 open enrollment period.

[186] *Regents*, 591 U.S. at 31 (noting that regardless of the "strength of any reliance interests," "consideration must be undertaken by the agency in the first instance").

[187] *Id*. at 33 (citation omitted).

[188] *Dist. Hosp. Partners, L.P. v. Burwell*, 786 F.3d 46, 59 (D.C. Cir. 2015) (cleaned up); *see also Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, 591 U.S. 657, 708-08 (2020) (Kagan, J., concurring in the judgment).

[189] *See City of Brookings Mun. Tel. Co. v. FCC*, 822 F.2d 1153, 1169 (D.C. Cir. 1987) (agency must provide a "reasoned explanation" for rejecting "reasonable alternatives"); *Perez v. Mortg. Bankers Ass'n*, 575 U.S. 92, 106 (2015) ("APA requires an agency to provide a more substantial justification when … its prior policy has engendered serious reliance interests that must be taken into account.") (cleaned up).

chosen action—including making "more limited" changes to the existing policy—and thus failed to provide any reasoned explanation for rejecting them.[190]

First, the Department should have considered minimizing harm to DACA recipients by "grandfathering" in DACA recipients who have already purchased health insurance plans from an ACA exchange. The Department has done so before by grandfathering certain health insurance plans that existed before the ACA was enacted "to help people keep existing health plans that are working for them;"[191] it should consider doing so again now. The Department's own analysis suggests that this approach would have a positive impact on the individual market risk pool and reduce the number of uninsured.[192] And it would certainly reduce the harm to the significant reliance interests of those who have already purchased plans from the exchanges and potentially made major healthcare decisions based on that insurance.[193] But the Department did not even consider these interests, much less the possibility of preserving access to healthcare of DACA recipients.

Second, the Department could have permitted (or at least could have considered permitting) state ACA exchanges to choose to allow DACA recipients to enroll on their own exchanges, if those States have concluded that doing so will benefit their populations and the ACA exchanges themselves. Such discretion has ample precedent, as a total of 23 States (and Washington, D.C.) have exercised discretion to extend CHIP coverage to pregnant individuals regardless of their immigration status.[194] Similarly, 41 States (and D.C.) have exercised their discretion to expand Medicaid coverage to nearly all adults with incomes up to 138% of the Federal Poverty Level.[195] Nine states also provide eligible residents with premium tax credits or cost-sharing reductions in addition to the incentives provided by the federal government.[196] But the Proposed Rule did not consider any such alternative, or any other alternatives for that matter. It simply reverses the 2024 Rule without making any allowances or exceptions.[197]

Third, although the Department makes brief reference to the Fifth Circuit's 2025 decision in *Texas v. United States*,[198] it failed to consider the clear alternative left available by that decision.

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[190] *See Nat'l Shooting Sports Found., Inc. v. Jones*, 716 F.3d 200, 216 (D.C. Cir. 2013); *see also Regents*, 591 U.S. at 30 ("reasoned analysis" must include consideration of more limited alternatives "within the ambit of the existing policy") (cleaned up).

[191] *Amendment to Regulation on "Grandfathered" Health Plans under the Affordable Care Act*, Centers for Medicare & Medicaid Servs., https://tinyurl.com/4ytbur4e (last updated Sept. 10, 2024).

[192] *See* 90 Fed. Reg. at 13,010.

[193] *See* Garfield & Young, *supra* note 181.

[194] Akash Pillai et al., *State Health Coverage for Immigrants and Implications for Health Coverage and Care*, Kaiser Family Foundation (May 1, 2024), https://tinyurl.com/5m425hzx.

[195] *Status of State Medicaid Expansion Decisions*, Kaiser Family Foundation (Feb. 12, 2025), https://tinyurl.com/4uxa7k7y.

[196] *Which states offer additional financial assistance for Marketplace plans?*, Kaiser Family Foundation, https://tinyurl.com/4x2zexyu (last visited Apr. 7, 2025).

[197] *See* 90 Fed. Reg at 13,010-11.

[198] 90 Fed. Reg. at 12,954 n.37 (citing *Texas v. United States*, 126 F.4th 392, 420-21 (5th Cir. 2025)).

The Department emphasizes that the Fifth Circuit concluded that DHS's 2022 DACA Final Rule[199] substantively violated the Immigration and Nationality Act.[200] (The Department's analysis is quite brief; after quoting from a prior Fifth Circuit decision finding DACA unlawful,[201] the Department says only that "[u]pon further reconsideration, we now believe it was improper for HHS to define 'lawfully present' under the ACA in a way that departed from the longstanding understanding of that term with respect to DACA recipients."[202]). But the Department fails to then grapple with the remainder of the 2025 *Texas* opinion, which made clear that the aspect of DACA that forebears removal for recipients survives ("severing the . . . forbearance provisions from the work authorization provisions") and also that the entirety of DACA—including work authorization and the remaining associated features, like Social Security—would survive in every State other than in Texas alone (choosing to "narrow the scope of the injunction to Texas," finding that the injuries Texas alleged were "redressable by a geographically limited injunction").[203] The Department should therefore have considered an alternative that tracks the geographic scope of DACA as it remains in effect after *Texas*. Where individuals can obtain only forbearance and not obtain work authorization or the other benefits associated with "lawful presence" under federal law, then they might be unable to access ACA exchanges tied to "lawful presence" too. But where individuals in light of *Texas* are unquestionably still able to access work authorization and other benefits that are associated with "lawful presence," it makes eminent sense and supports uniformity across policies to allow those individuals to access ACA exchanges as well. The Department did not even consider this alternative, let alone explain its shortcomings, despite otherwise citing to the *Texas* 2022 decision.

These errors in failing to consider reasonable alternatives are especially egregious in light of the underlying statutory obligation in Section 1554 of the ACA to avoid issuing any rule that "creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care" or "impedes timely access to health care services."[204] Despite its direct regulation of ACA exchanges and ACA provisions, the Department's Proposed Rule fails to even mention Section 1554 in the context of DACA recipients, much less consider DACA recipients' ability to obtain medical care or timely access to health care services.[205] Here, the Department had a statutory obligation to avoid creating "unreasonable barriers" to health care. It did not do so, instead adopting a blanket reversal without at least *considering* reasonable alternatives. That is textbook arbitrary decisionmaking.

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[199] *Deferred Action for Childhood Arrivals*, 87 Fed. Reg. 53,152 (Aug. 30, 2022).
[200] *Texas*, 126 F.4th at 417.
[201] 90 Fed. Reg. at 12,954 (quoting *Texas v. United States*, 50 F.4th 498, 526 (5th Cir. 2022).
[202] 90 Fed. Reg. at 12,954.
[203] *Texas*, 126 F.4th at 419-21.
[204] 42 U.S.C. § 18114(1)-(2).
[205] *See* 90 Fed. Reg. at 13,010-11 (Proposed Rule's analysis of DACA recipients). *Contra* 89 Fed. Reg. at 39,402 (2024 Rule's discussion of unique barriers to health care that DACA recipients experience).

4. The Regulatory Impact Analysis fails to accurately assess the effect of the Proposed Rule in reversing the 2024 Rule.

The Department asserts that the Proposed Rule will ultimately be a cost-saving measure, returning ACA eligibility to the pre-2024 Rule standard. However, even a cursory review of the Department's costs analysis reveals its inadequacies as related to the exclusion of DACA recipients from Marketplace eligibility. The Proposed Rule acknowledges the Department's obligation to "assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select those regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity)."[206] The Proposed Rule falls woefully short of this required calculus. As articulated above, the Proposed Rule's reversal of the 2024 Rule ultimately results in fewer people with health insurance, exacerbating State and Federal expenditures, harming individual and community health, and impeding DACA recipients' ability to access healthcare, contrary to law.

As to benefits, the Proposed Rule suggests that the reduced enrollment resulting from denying DACA recipients access to ACA exchanges results in an annual APTC cost saving of $34 million and an annual BHP cost saving s of $3.2 million, for a total of $37.2 million in savings.[207] As to benefits, the Proposed Rule fails to quantify significant costs. It conspicuously leaves unquantified both the "small negative impact on the individuals market risk pool"[208] and, most notably, as articulated below, the "costs to the Federal Government and States to provide limited Medicaid coverage for the treatment of an emergency medical condition to DACA recipients who have a qualifying medical emergency and who will become uninsured as a result of the rule."[209] And the Proposed Rule recognizes that "the majority" of beneficiaries of the 2024 Rule would lose coverage,[210] thus exacerbating costs to the Federal Government and States.

As a result of the Proposed Rule "the majority [of DACA recipients] who lose. . . coverage would become uninsured."[211] Lapses in insurance coverage can have a negative effect on public health, especially in States with large populations of DACA recipients. In a 2021 survey of over 1,000 DACA recipients, 61% of respondents identified their immigration status as a "significant barrier" to receiving health insurance and health care, 47% reported delaying medical care due to immigration status, and 67% indicated that they or a family member were unable to pay medical bills or expenses.[212] Uninsured adults are less likely to receive preventive services for chronic conditions like cardiovascular disease, cancer, and diabetes.[213] And uninsured DACA recipients are also often hesitant to enroll their U.S.-born children in Medicaid and CHIP, resulting in

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[206] 90 Fed. Reg. 13,005
[207] 90 Fed. Reg. at 13,010.
[208] *Id*.
[209] *Id*.
[210] *Id*.
[211] *Id*.
[212] Nat'l Immigr. Law Center, *Tracking DACA Recipients' Access to Health Care*, at 2 (June 1, 2022), https://tinyurl.com/ypdmtrzw.
[213] U.S. Dep't of Health and Human Servs., *Access to Health Services*, Office of Disease Prevention and Health Promotion, https://tinyurl.com/5n7s2cu7 (last visitedApril 8, 2025).

decreased enrollment relative to those with U.S.-born parents.[214] Lack of insurance also poses a grave threat to public health at the national level. One study found that "wider insurance gaps exacerbated local COVID-19 outbreaks and resulted in more cases, hospitalizations, and death than experienced by jurisdictions with better coverage" such that "[r]educing the number of [individuals within the country] without health insurance is a crucial and underappreciated component of pandemic preparedness."[215] This is especially important because, as the 2024 Rule noted, over 200,000 DACA recipients served as essential workers during the COVID-19 pandemic, including 43,500 DACA recipients who worked in health care and social assistance occupations. Of those working in health care settings, at least 10,300 served in hospitals and 2,000 in nursing care facilities.[216] Moreover, individuals without health insurance are less likely to have access to regular outpatient care, leading to greater rates of hospitalization. These problems redound at the local level, especially in smaller rural communities, where "[h]igh uninsured rates contribute to rural hospital closures and greater financial challenges for rural hospitals, leaving individuals living in rural areas at an even greater disadvantage to accessing care."[217] As such, high rates of uninsured individuals can easily threaten the public health of the greater community.[218]

Beyond compliance costs,[219] States will incur significant costs and burdens to their medical systems as a result of the Proposed Rule. The Proposed Rule is likely to increase States' spending on social services by increasing reliance on emergency and charity-healthcare costs. Indeed, the Proposed Rule anticipates that it would have the effect of excluding young, generally healthier DACA recipients from the individual market, causing a negative impact on the market risk pool. Further, because the Proposed Rule recognizes that DACA recipients will become uninsured, the costs will be passed to "the Federal Government and States to provide treatment."[220] States are obligated to pay certain emergency healthcare costs of undocumented immigrants who otherwise meet Medicaid eligibility criteria.[221] Removing access to health insurance for most DACA recipients, therefore, imposes an increased burden on States.[222] The Proposed Rule ignores thorough research that increases in the number of insured individuals has "decreased uncompensated care costs (UCC) overall and for specific types of hospitals, including those in rural areas."[223]

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[214] Samantha Artiga & Anthony Damico, *Nearly 20 Million Children Live in Immigrant Families that Could Be Affected by Evolving Immigration Policies*, Kaiser Family Foundation (Apr. 18, 2018), https://tinyurl.com/37dwfce9.

[215] Travis Campbell et al., *Exacerbation of COVID-19 mortality by the fragmented United States healthcare system: A retrospective observational study*, The Lancet Regional Health (May 12, 2022), https://tinyurl.com/mr26zt3r.

[216] 89 Fed. Reg. at 39,396.

[217] Jennifer Tolbert et al., *Key Facts about the Uninsured Population*, Kaiser Family Foundation (Dec. 18, 2023), https://tinyurl.com/2s3jmmbm.

[218] *Id*.

[219] *See* 90 Fed. Reg. 13,010-11.

[220] 90 Fed. Reg. 13,010.

[221] *Id*.

[222] *Id*.

[223] *See e.g.,* Guth & Meghana Ammula, Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021, Kaiser Fam. Found. 2 (2021); Benjamin D. Sommers et al., Three-Year Impacts of the Affordable Care Act: Improved Medical

Not only does the Proposed Rule ignore the aforementioned economic costs stemming from a lack of health coverage and the benefits of increased health coverage, it ignores essential socioeconomic facts about the DACA recipient population. DACA recipients attend public and private universities and are employed by companies, nonprofit organizations, and government agencies and institutions, all of which benefit from their skills and productivity. They help grow the economy and contribute an estimated $6.2 billion in federal taxes and $3.3 billion in State and local taxes each year.[224] In fact, a 2022 study indicated that Texas's DACA recipients—one of the largest DACA populations in the nation—have a collective spending power of $3.7 billion, and Texas would stand to lose around $139.7 million in annual State and local taxes if the DACA program ended entirely.[225] Important here, "[e]xtending health coverage to noncitizens, including undocumented immigrants, may not be as costly for States as it would be [for] citizens. Studies have shown that immigrants' medical expenditures are roughly one-half to two-thirds that of citizens," and "have a lower per capita expenditure for public and [private] insurers, providing a low-risk pool."[226]

The minimal savings cited by the Proposed Rule[227] are negligible when compared against the benefit to States with DACA recipients in their insurance pool, the loss of revenue for state-based exchanges, and the increased costs to States for covering the emergency medical costs for the newly uninsured DACA recipients. The Department cannot possibly fulfill its obligation to maximize net benefits when it fails to quantify such significant costs in the RIA. This is evident given the Proposed Rule's consideration of regulatory alternatives[228] plainly fails to consider or engage with any reasonable alternatives that would avoid these significant costs. In short, the analysis and cost savings outlined in the Proposed Rule's RIA is, at best, inaccurate, misleading, and woefully incomplete.

III. GENDER-AFFIRMING CARE SHOULD CONTINUE TO BE PERMITTED AS AN ESSENTIAL HEALTH BENEFIT

The Proposed Rule would unlawfully exclude coverage for gender-affirming care[229] as an EHB and should be withdrawn for three reasons: ***First***, gender-affirming care is essential healthcare and the Proposed Rule represents a dangerous incursion into the practice of medicine;

Care and Health Among Low-Income Adults, 36 Health Affs. 1119, 1124 (2017), https://tinyurl.com/49uvdame.

[224] 89 Fed. Reg. at 39,399.

[225] Skyler Korgel, *Celebrating a Decade of DACA in Texas*, Every Texan (Sept. 29, 2022), https://tinyurl.com/4m8vyh8f.

[226] Matthew Buttegens & Urmi Ramchandani, *The Health Coverage of Noncitizens in the United States, 2024*, Urban Institute (May 2023), https://tinyurl.com/3j5x7csa.

[227] *See* 90 Fed. Reg. at 13,010-11.

[228] 90 Fed. Reg. at 13,026-28.

[229] "Sex-trait modification" as used in the Proposed Rule is defined to mirror the definition of "chemical and surgical mutilation" as included in Executive Order 14187. *See* p. 154. This letter will refer to what the Proposed Rule calls "sex-trait modification" as "gender-affirming care", which is the appropriate term and which the Proposed Rule acknowledges refers to the same categories of healthcare. *See id*.

Second, the exclusion of gender-affirming care from EHB coverage is contrary to law because it violates the Equal Protection Clause and Section 1557 of the ACA; and ***Third***, the Proposed Rule is arbitrary and capricious because it fails to consider important facts, including the widespread coverage of gender-affirming care by employer-based health plans, in its proposal to exclude gender-affirming care from EHB coverage.

A. Background

1. Importance of Essential Health Benefits

The ACA requires certain individual and small group health plans to cover a set of EHBs which must be "equal to the scope of benefits provided under a typical employer plan."[230] These EHBs are "protected by cost-sharing limits and count towards a plan's actuarial value."[231] This means the categories protected as EHBs may not have any annual or lifetime dollar limit under the state plans. Per the Department, the "items and services" covered must come from the following ten benefit categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.[232]

Before the ACA, insurance plans could exclude certain key services from coverage. "For example, in 2011, 62 percent of enrollees had individual-market plans [that] didn't cover maternity care; 34 percent had plans that didn't cover substance use treatment; 18 percent had plans that didn't cover mental health; and 9 percent had plans that didn't cover prescription drugs."[233] By including EHBs as part of the minimum standard that must be provided, the ACA reduced these disparities and improved coverage for those who previously did not have access to these services.[234] Mandating coverage for EHB categories also improves coverage for those individuals

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[230] Kaiser Family Foundation, New Rule Proposes Changes to ACA Coverage of Gender-Affirming Care, Potentially Increasing Costs for Consumers (Mar. 24, 2025), https://tinyurl.com/2637fye3.

[231] *Id*.

[232] Centers for Medicare and Medicaid Servs., Information on Essential Health Benefits (EHB) Benchmark Plans, https://tinyurl.com/3jbebvzc (last updated Jan. 14, 2025).

[233] Center on Budget and Policy Priorities, Essential Health Benefits Under Threat, http://cbpp.org/ehbs (last visited Apr. 9, 2025).

[234] Sarah Lueck, *If "Essential Health Benefits" Standards Are Repealed, Health Plans Would Cover Little*, Ctr. on Budget & Policy Priorities (Mar. 23, 2017), https://tinyurl.com/44b8e9z2 (explaining that the consequences of repealing EHBs would include leaving people with pre-existing conditions without healthcare coverage, women being charged more than men, and lead to many people with health insurance to have prohibitively expensive bills); Lois K. Lee, et al., *Women's Coverage, Utilization, Affordability, And Health After The ACA: A Review Of The Literature*, 39 HEALTH AFFAIRS 387, 390 (2020), https://tinyurl.com/3adau3rm.

with pre-existing conditions, as it prevents insurers from screening these individuals out of critical care.[235]

The ACA and its effectuating regulations permit significant latitude to the states in determining how EHBs are defined.[236] As such, states submit their "benchmark" plans to the Department for approval. As the name suggests, EHBs are a minimum standard, and benchmark plans can choose to offer "additional health benefits, like vision, dental, and medical management programs (for example, for weight loss)."[237] Each state maintains a benchmark plan on file with the Department, against which private insurers must compare plans to ensure compliance with the standards set forth therein. Further, if a state has not updated its benchmark plan to match federal requirements, private insurers must also review plans for compliance with federal EHB mandates.

2. Coverage of Gender-Affirming Care as EHBs

Gender-affirming care is a catch-all term for medical and psychosocial healthcare "'designed to support and affirm an individual's gender identity' [one's internal sense of one's gender], when it conflicts with the gender they were assigned at birth.'"[238] Gender-affirming care may include treatment such as surgery, prescription drugs, and mental health treatment, which fall within statutorily defined EHB categories. As such, states have made different coverage decisions with respect to whether to specifically name gender-affirming care in their EHB benchmark plans.

For example, in 2021, the Department approved the state of Colorado's benchmark plan that explicitly included gender-affirming care as an EHB.[239] The plan, which went into effect in 2023, was the first to formally include gender-affirming care in a state benchmark plan.[240] In response to the inclusion of gender-affirming care as an EHB, HHS Secretary Xavier Becerra stated: "Health care should be in reach for everyone; by guaranteeing transgender individuals can access recommended care, we're one step closer to making this a reality . . . I am proud to stand with Colorado to remove barriers that have historically made it difficult for transgender people to access health coverage and medical care." Echoing these sentiments, then-CMS Administrator Chiquita Brooks-LaSure commented: "Health care should be accessible, affordable and delivered equitably to all…To truly break down barriers to care, we must expand access to the full scope of health care, including gender-affirming surgery and other treatments, for people who rely on coverage

[235] Center for American Progress, *10 Ways the ACA Has Improved Health Care in the Past Decade* (Mar. 23, 2020), https://tinyurl.com/24usu69u.

[236] Center on Budget and Policy Priorities, *supra* note 233.

[237] Jared Ortaliza & Cynthia Cox, *The Affordable Care Act 101*, Kaiser Family Found. (May 28, 2024), https://tinyurl.com/yz5utdrn.

[238] *What is gender-affirming care? Your questions answered*, Am. Assoc. Med. Colleges (Apr. 12, 2022), https://tinyurl.com/yrm9wn6f.

[239] Centers for Medicare & Medicaid Servs., Biden-Harris Administration Greenlights Coverage of LGBTQ+ Care as an Essential Health Benefit in Colorado (Oct. 12, 2021), https://tinyurl.com/4bczc5wj.

[240] Colorado Dept. of Regulatory Agencies, Gender-Affirming Care Coverage Guide, https://tinyurl.com/umw3329c.

through Medicare, Medicaid & CHIP and the Marketplaces….” Twenty-four states also expressly *prohibit* providers from excluding transgender-related healthcare.[241]

For states that require coverage for gender-affirming care, the Proposed Rule would have considerable consequences. Indeed, the Proposed Rule states that “if any State separately mandates coverage for sex-trait modification outside of its EHB-benchmark plan, the State would be required to defray the cost of that State mandated benefit as it would be considered in addition to EHB.”[242] As a result, according to the Department, states with laws that mandate coverage outside of its EHB benchmark plan will suddenly be responsible for defraying the costs of covering those services under certain scenarios.[243]

B. The Department Should Not Exclude Gender-Affirming Care as an EHB.

As an initial matter, gender-affirming care is essential healthcare for transgender individuals. Gender-affirming care has proven benefits for transgender individuals, including greatly improved mental health and overall well-being of gender diverse, transgender, and nonbinary children and adolescents.[244] Further, given the scope of what is currently included in EHBs, there is no principled way to exclude gender-affirming care, which may include prescription drugs, mental health treatment, and surgery, from the scope of EHBs. The only explanation for banning this care from coverage as an EHB is sheer animus toward transgender, nonbinary, and gender diverse individuals who may seek to access this care. Thus, the exclusion of gender-affirming care is contrary to law in violation of the APA. The exclusion of gender-affirming care from EHBs is also arbitrary and capricious, as in the past twenty years, coverage for gender-affirming care has increased significantly and coverage for gender-affirming care in employer-sponsored plans is comparable to many other benefits currently considered EHBs.[245] This expansion of coverage marks a recognition by health plans that this treatment has considerable benefits and can improve overall health outcomes for its recipients. The failure of the Proposed Rule to consider these benefits and to improperly state that gender-affirming care is not typically covered is arbitrary and capricious in violation of the APA. The Proposed Rule should be withdrawn.

1. Gender-Affirming care has important benefits.

Gender-affirming care is essential medical treatment for transgender individuals and those experiencing gender dysphoria, a medical condition characterized by an incongruence between gender identity and sex assigned at birth. Gender dysphoria can cause clinically significant distress

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[241] Movement Advancement Project, Healthcare Laws and Policies: Private Insurance Nondiscrimination Laws, Bans on Exclusions of Transgender Health Care, and Related Policies (Apr. 26, 2024), https://tinyurl.com/39h489an.

[242] 90 Fed. Reg. at 12,987.

[243] Kaiser Family Foundation, New Rule Proposes Changes to ACA Coverage of Gender-Affirming Care, Potentially Increasing Costs for Consumers, *supra* note 230.

[244] *Id*.

[245] Kaiser Family Foundation, 2024 Employer Health Benefits Survey (Oct. 9, 2024), https://tinyurl.com/46t4msuh; Human Rights Campaign Foundation, Corporate Equality Index 2025: Rating Workplaces on Lesbian, Gay Bisexual, Transgender and Queer Equality (Jan. 2025), https://tinyurl.com/53dwc7mb.

and may result in "symptoms of depression and anxiety, substance use disorders, a negative sense of well-being and poor self-esteem, and an increased risk of self-harm and suicidality."[246] Major medical associations—including the American Medical Association, American Psychiatric Association, American College of Physicians, American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, and the American College of Obstetricians and Gynecologists—recognize the overwhelming evidence "that evidence-based, gender-affirming care for transgender children and adolescents is medically necessary and appropriate."[247] Even when transgender individuals are not experiencing gender dysphoria, gender-affirming care may be lifesaving preventative mental health care.[248] Gender-affirming care is essential healthcare, and prohibitions on this medical care are a "dangerous intrusion into the practice of medicine" and violate the "sanctity of the patient-physician relationship."[249]

2. The exclusion of Gender-Affirming Care from EHBs is contrary to law.

The exclusion of gender-affirming care is contrary to law in violation of the APA for the additional reason that it discriminates against the undersigned States' residents in violation of the Equal Protection Clause and Section 1557 of the ACA.

a. The Proposed Rule violates the Equal Protection Clause.

At the outset, the Proposed Rule plainly classifies on the basis of sex and transgender status. It thus triggers heightened scrutiny under the Equal Protection Clause;[250] yet HHS offers no legitimate justification for the Rule.

(1) The Proposed Rule classifies based on sex.

The Proposed Rule would prohibit insurers from covering certain healthcare services as EHBs only if those services "attempt to transform an individual's physical appearance to align

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[246] Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders 513-14 (5th ed., text rev. 2022); Garima Garg et al., *Gender Dysphoria*, StatPearls (July 11, 2023), https://tinyurl.com/yj333bw8.

[247] *Medical Association Statements in Support of Health Care for Transgender People and Youth*, GLAAD (June 26, 2024), https://tinyurl.com/2thfbh4m. Moira Szilagyi, *Why We Stand Up for Transgender Children and Teens*, Am. Acad. of Pediatrics Voices Blog (Aug. 10, 2022), https://tinyurl.com/4v7m9b72.

[248] *Why Gender-Affirming Care Should Be Part of Preventive Mental Health Care for Trans People*, Univ. of Wash. Dept. of Epidemiology (July 14, 2023), https://tinyurl.com/yp4pfnp4.

[249] Press Release, Am. Med. Ass'n, AMA To States: Stop Interfering in Health Care of Transgender Children (Apr. 26, 2021), https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children.

[250] *See, e.g., Hecox v. Little*, 104 F.4th 1061, 1073-1080 (9th Cir. 2024); *Kadel v. Folwell,* 100 F.4th 122, 142-156 (4th Cir. 2024); *Grimm v. Gloucester Cty. Sch. Bd.*, 972 F.3d 586, 607-608 (4th Cir. 2020); *Doe v. Horne*, 115 F.4th 1083, 1102-1107 (9th Cir. 2024); *Karnoski v. Trump*, 926 F.3d 1180, 1200-1202 (9th Cir. 2019); *Massachusetts v. U.S. Dep't of Health & Hum. Servs.*, 682 F.3d 1, 8-9 (1st Cir. 2012).

with an identity that differs from his or her sex" or "attempt to alter or remove an individual's sexual organs to minimize or destroy their natural biological functions"—but not for any other purposes.[251] The Department drives this point home by soliciting comments on whether it should incorporate "*explicit* exceptions" into the final rule to ensure that the targeted healthcare services (e.g., puberty blockers, hormone treatments, and surgeries) remain eligible for EHB-status when used to treat any other medical condition, "such as precocious puberty, or therapy subsequent to traumatic injury."[252]

The Proposed Rule is thus "a line drawn on the basis of sex, plain and simple."[253] This is "textbook sex discrimination."[254] With or without any "explicit exceptions," the description of "sex trait modification" reveals that an insurer must know the sex of the patient to determine whether a particular health care service qualifies as an EHB. As an example, consider the provision of testosterone to a sixteen-year-old who identifies as a male and who wishes to align his appearance to his male identity. The Proposed Rule would prohibit an insurer from covering that care as an EHB if the patient was assigned female at birth because it would "transform [his] physical appearance to align with an identity that differs from his . . . sex." But it would allow an insurer to cover that exact same care if the patient was assigned male at birth. Similarly, it would be impossible to know whether any particular surgery was undertaken to "alter or remove an individual's sexual organs to minimize or destroy their natural biological functions"—and thus banned as an EHB under the Rule—without knowing the patient's assigned sex.

The Proposed Rule further discriminates on the basis of sex by reinforcing sex stereotypes and punishing gender nonconformity.[255] It would allow insurers to include as EHBs medical care that aligns a person's appearance with an identity that corresponds to their sex assigned at birth while forcing them to exclude medical care that aligns a person's appearance with an identity that differs from their sex assigned at birth. The Rule thus presumes there is one set way to live as the male and female sexes and penalizes transgender, nonbinary, and gender diverse people for not comporting with those stereotypes by limiting their coverage options.[256]

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[251] 90 Fed. Reg. at 12,986.

[252] 90 Fed. Reg. at 12,987 (emphasis added).

[253] *Doe v. Ladapo*, 676 F. Supp. 3d. 1205, 1217 (N.D. Fl. 2023).

[254] *Kadel*, 100 F.4th at 153.

[255] "Many courts … have held that various forms of discrimination against transgender individuals constitute sex-based discrimination for purposes of the Equal Protection Clause because such policies punish transgender persons for gender non-conformity, thereby relying on sex stereotypes. In so holding, these courts have recognized a central tenet of equal protection in sex discrimination cases: that states 'must not rely on overbroad generalizations' regarding the sexes." *Grimm*, 972 F.3d at 608-609 (internal citations omitted).

[256] *See Kadel*, 100 F.4th at 154 (holding that "a policy that conditions access to gender-affirming surgery on whether the surgery will better align the patient's gender presentation with their sex assigned at birth is a policy based on gender stereotypes"). An example from *Kadel* illustrates this point: "[W]hile mastectomies are available for both people assigned male at birth and those assigned female at birth, when they are conducted for gender-affirming purposes, they are only available to those assigned male at birth [and would be excluded under the Proposed Rule]. This difference in coverage is rooted in a gender stereotype: the assumption that people who have been assigned female at birth are supposed to have breasts, and that people assigned male at birth are not. No doubt, the majority of those assigned female at birth have breasts, and

The Proposed Rule similarly penalizes another segment of the population—intersex people—without even recognizing that they exist.[257] Intersex people may have variations in chromosomes, external genitalia, hormones, and reproductive organs, among other characteristics, that make them neither "male" nor "female."[258] When an intersex person receives gender-affirming care to align their external appearance or reproductive organs with their gender identity, they are not really transforming their appearance "to align with an identity that differs from [their]…sex" because they have traits that correspond with both "male" and "female." However, the Proposed Rule would limit or grant coverage for an intersex person's gender-affirming care based on what their birth certificate happens to say, or, more practically, what gender identity they are raised to inhabit. If an intersex person has a birth certificate that says "female" (and was raised accordingly) and identifies as male, this Proposed Rule would limit coverage for gender-affirming care, like hormone therapy, that aligns their appearance with a male gender identity. However, if this person's birth certificate happened to be marked as "male" (and they were raised accordingly), the Proposed Rule would not limit coverage for that same hormone therapy. That an intersex individual's insurance coverage for the same care would hinge on whether they adhere to certain sex stereotypes prior to receiving gender-affirming care is clearly discriminatory.

(2) The Proposed Rule makes impermissible classification based on transgender status.

The Proposed Rule triggers heightened scrutiny for the additional reason that it targets transgender people. As explained above, the Rule only excludes medical care that aims to address the incongruity between sex assigned at birth and gender identity. Yet that incongruity lies at "the very heart of transgender status."[259] It is not legally significant that the Rule was written to avoid the word "transgender." The Equal Protection Clause looks beyond creative drafting that ensures a discriminatory law would technically apply to all groups to examine whether it would exclusively or predominantly affect only one.[260] Such is the case here. By targeting medical care that enables a person to live in an identity different than their sex assigned at birth, the Proposed Rule plainly and unlawfully targets transgender, nonbinary, and gender diverse people.

(3) The Proposed Rule cannot survive any level of scrutiny.

To survive heightened scrutiny, "the government must show that the classification serves important governmental objectives and that the discriminatory means employed are substantially

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the majority of those assigned male at birth do not. But we cannot mistake what is for what must be. And because gender stereotypes can be so ingrained, we must be particularly careful in order to keep them out of our Equal Protection jurisprudence." *Id.*

[257] The fact that the Proposed Rule does not even consider the needs of intersex people further shows that it is arbitrary and capricious, in violation of the APA. *See State Farm,* 463 U.S. at 43.

[258] *Improving Health Care for Intersex People*, Fenway Health (Oct. 26, 2020), https://tinyurl.com/mt9jtv3y.

[259] *Kadel*, 100 F.4th at 146; *see Hecox*, 104 F.4th at 1080 ("A 'transgender' individual's gender identity does not correspond to their sex assigned at birth[.]").

[260] *See Kadel*, 100 F.4th at 148 and cases cited.

related to the achievement of those objectives."[261] None of the objectives identified in the Rule survive this demanding standard. Indeed, the Department claims to have issued the Proposed Rule "because sex-trait modification is not typically included in employer health plans and therefore cannot legally be covered as an EHB."[262] Yet the Rule does not provide sufficient evidence or any analysis to support this point; and as described below, it is readily disproven.[263]

The Proposed Rule separately suggests that the Department is "concerned about the scientific integrity of claims made to support [the use of gender-affirming care] in health care settings."[264] Incredibly, the Rule does not cite *any* evidence to support this claim and, in failing to do so, cannot "articulate a satisfactory explanation for its action."[265]And in any event, every major medical organization in American has publicly supported the types of care targeted by the Rule.[266]

The Proposed Rule discriminates against people who do not conform to the Trump Administration's conception of what it means to be "male" and "female." That is not a legitimate state interest, much less an "important" one.[267] The Proposed Rule will not survive any level of scrutiny and must be withdrawn.

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[261] *Id.* at 156 (internal quotation marks and citation omitted).

[262] 90 Fed. Reg. at 12,986.

[263] In the same vein, the Proposed Rule alludes to "some stakeholders [that] do not believe that sex-trait modification services fit into any of the 10 categories of EHB and, therefore, do not fit within the EHB framework even if some employers cover such services." 90 Fed. Reg. 12,987. But it does not identify those alleged stakeholders or provide any more information about their alleged belief, making it impossible for the States to fully respond to this claim. In any event, as multiple States have determined, gender-affirming care fits easily within the EHB categories. *See supra* pp. 41-42; 42 U.S.C. § 18022(b)(1) (defining the 10 EHB categories as ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care).

[264] 90 Fed. Reg. at 12,987.

[265] *See State Farm.*, 463 U.S. at 43 ("the agency must examine the relevant data and articulate a satisfactory explanation for its action, including a rational connection between the facts found and the choice made") (internal quotation omitted).

[266] "Organizations who have formally recognized this include the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American College of Obstetricians and Gynecologists, American College of Physicians, American Medical Association, American Psychiatric Association, and at least a dozen more." *Dekker v. Weida,* 679 F. Supp. 3d 1271, 1285 (N.D. Fla. 2023). To the extent the Department means to refer back to the Trump Administration's apparent disdain for standards set forth by the World Professional Association for Transgender Health ("WPATH"), *see* Exec. Order No. 14,187, Protecting Children from Chemical and Surgical Mutilation, 90 Fed. Reg. 8,771 (Jan. 28, 2025), multiple courts have recognized those standards provide the "generally accepted" protocols for treating gender dysphoria. *Kadel*, 100 F.4th at 136-137; *Edmo v. Corizon, Inc.*, 935 F.3d 757, 769-770 (9th Cir. 2019).

[267] Government action motivated by a "bare . . . desire to harm" a disfavored group cannot survive any level of scrutiny. *Romer v. Evans*, 517 U.S. 620, 634-635 (1996).

b. The Proposed Rule violates Section 1557 of the ACA.

In addition to violating the equal protection rights of States' residents, the Proposed Rule contravenes the non-discrimination mandate of the ACA.[268] As relevant here, Section 1557(a) provides that "an individual shall not, on the ground prohibited under . . . title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.) . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance . . . ." Title IX prohibits discrimination on the basis of sex and, as many courts have recognized, transgender status.[269] The reason for this is simple: "it is impossible to discriminate against a person for being . . . transgender without discriminating against that individual based on sex."[270] Section 1557 imposes those same safeguards on federally funded health care entities.[271] Yet the Proposed Rule tosses those safeguards aside, allowing or prohibiting insurers from covering medical care as an EHB based on whether the care aligns with the person's sex assigned at birth. The law does not countenance such flagrant sex-based classifications and stereotypes.

3. The Exclusion of Gender-Affirming Care from EHBs is arbitrary and capricious.

The "arbitrary-and-capricious standard requires that agency action be reasonable and reasonably explained."[272]An agency action fails to meet this test where, among other things, "the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or [made a decision that] is so implausible that it could not be ascribed to a difference in view or the product of agency expertise."[273] The Proposed Rule violates a number of these APA principles.

To date, the Department has explicitly prohibited EHB coverage for only a limited number of services: abortion, non-pediatric dental or eye exam services, long-term nursing care, and non-medically necessary orthodontia.[274] However, even for those services, an EHB plan may cover them should a state so choose.[275] For example, non-pediatric dental care, which cannot be required to be covered as an EHB, is permitted to be covered as part of an EHB benchmark plan should a

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[268] *See* 42 U.S.C. § 18116 ("Section 1557").

[269] *See A.C. v. Metropolitan Sch. District of Martinsville*, 75 F.4th 760, 768-769 (7th Cir. 2023); *Grimm*, 972 F.3d at 616-617.

[270] *Bostock v. Clayton Cty.*, 590 U.S. 644, 660 (2020). Though *Bostock* interpreted Title VII of the Civil Rights At of 1964, its analysis applies with equal force to Title IX both because Congress modeled Title IX after Title VI and because in either context "the discriminator is necessarily referring to the individual's sex to determine incongruence between sex and gender, making sex a but-for cause for the discriminator's action." *Grimm*, 972 F.3d at 616-617.

[271] *See Kadel*, 100 F.4th at 164.

[272] *Prometheus Radio Project*, 592 U.S. at 423.

[273] *State Farm,* 463 U.S. at 43.

[274]45 C.F.R. § 156.115(d); https://tinyurl.com/mr3f37yh (noting that abortion, non-pediatric dental or eye exam services, long-term nursing care, and non-medically necessary orthodontia are excluded from EHB inclusion).

[275] *Id.*

state choose to do so.[276] The Department has not sufficiently justified why gender-affirming care should be treated similarly to those other services explicitly excluded, as opposed to the litany of services that are covered as EHBs under law, and none of the purported justifications provided meet the appropriate standard.

a. EHB Coverage is not as limited as the Proposed Rule suggests.

As justification for excluding gender-affirming care from EHBs, the Proposed Rule argues that gender-affirming care "is not typically included in employer-sponsored plans," so should be left out of EHB coverage.[277] The Proposed Rule fails to cite data supporting this claim, and unsurprisingly, EHB coverage for gender-affirming care is not as limited as the Proposed Rule maintains. Employer plans are the most dominant source of healthcare coverage in the United States, and a substantial number of them offer gender-affirming care coverage.[278] A 2024 survey run by the Kaiser Family Foundation (KFF) found that 50 percent of companies with 5,000 or more workers were able to certify that they specifically cover gender-affirming hormone therapy.[279] A little less than half of all workers covered by employer plans in the United States (43 percent) work for companies with 5,000 or more workers. Even after broadening to all large employers (companies with 200 or more workers that offer health benefits), which employ over 72 percent of American workers with job-based coverage, around one fourth (24 percent) stated that they cover gender-affirming hormone therapy.[280]

The analogous KFF survey from 2023 reported similar findings regarding employer coverage for gender-affirming surgery.[281] Over 60 percent of companies with 5,000 or more workers stated that they provide coverage for gender-affirming surgery; 12 percent were unsure about whether they provide the same coverage. As was the case with employer coverage for gender-affirming hormone therapies, a little less than one fourth (23 percent) of all large employers, with 200 or more workers, were certain that they provide gender-affirming surgery. 40 percent did not know whether offered health benefits included such surgery.

A significant proportion of American workers with employer healthcare plans have coverage for gender-affirming healthcare services, and this number has grown over time. According to the Human Rights Watch's Corporate Equality Index 2025 Report, 72 percent of Fortune 500 companies offer "transgender-inclusive healthcare benefits," which includes hormone therapies,

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[276] *Id.*

[277] 90 Fed. Reg. at 12,986.

[278] Human Rights Campaign Foundation, Corporate Equality Index 2025: Rating Workplaces on Lesbian, Gay Bisexual, Transgender and Queer Equality (Jan. 2025), https://tinyurl.com/53dwc7mb.

[279] Kaiser Family Foundation, 2024 Employer Health Benefits Survey (Oct. 9, 2024), https://tinyurl.com/46t4msuh. Eighteen percent of companies of this size did not know if they offer such coverage. *Id.*

[280] *Id.* Only 31 percent of these large employers stated that they did not offer coverage for gender-affirming hormone therapy; around 45 percent of responding large employers did not know if they covered these services. *Id.*

[281] Kaiser Family Foundation, 2023 Employer Health Benefits Survey (Oct. 18, 2023), https://tinyurl.com/2mshf4hz.

surgeries, and mental health care, up from 0 percent in 2002.[282] The purported basis for excluding gender-affirming care as an EHB—that they are not typically included in employer plans—is factually inaccurate and fails as a foundation for such exclusion.

b. The fact that health conditions are rare does not warrant exclusion from EHB coverage.

The Proposed Rule theorizes (again without support) that the lack of employer coverage of gender-affirming care stems from the low utilization of such care.[283] It explains that "less than 1 percent of the U.S. population seeks forms of sex-trait modification."[284] Yet, there is a marked difference between a lack of coverage and infrequent utilization of that coverage. Public and commercial insurance regularly covers healthcare services that are infrequently used. For instance, there were 3,456 patients waiting for heart transplants and 898 patients waiting for lung transplants in the United States in 2024.[285] Although these transplants are exceptionally rare, the vast majority of public and private insurance plans cover them, and transplants themselves are not excluded from EHBs.[286] Thus, even if gender-affirming care coverage were infrequently utilized, the usage rate alone would not be a reason to exclude the care from EHBs.

Health care utilization is determined by a number of factors, including geography, sex, race, and spoken language.[287] The need for health care is a "major determinant" of utilization.[288] Conditions that motivate the use of gender-affirming care coverage are not truly rare; gender dysphoria, for instance, does not even meet the requirements of a "rare" condition, which would typically require that it impact fewer than 200,000 Americans.[289] Indeed, an estimated 0.6% of U.S. residents, or over 2 million Americans, experience gender dysphoria.[290] Also, most public

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[282] Human Rights Campaign Foundation, *supra* note 278.

[283] 90 Fed. Reg. at 12,986-87.

[284] 90 Fed. Reg. at 12,987.

[285] *Detailed Description of Data*, Health Res. and Servs. Admin., https://tinyurl.com/m3nvrvzd (last visited Apr. 8, 2025).

[286] *Heart Disease and Heart Transplant*, WebMD (James Beckerman ed., June 30, 2023) https://tinyurl.com/4kk3ydwu ("More than 80% of commercial insurers and 97% of Blue Cross/Blue Shield plans offer coverage for heart transplants."); *Planning to Pay for a Transplant*, Cystic Fibrosis Found., https://tinyurl.com/3u96vpyh (last visited Apr. 8, 2025) ("Most health insurance and government programs, including Medicaid, will pay for a lung transplant…"); Lindsey Dawson, Kaye Pestaina, & Matthew Rae, *New Rule Proposes Changes to ACA Coverage of Gender-Affirming Care, Potentially Increasing Costs for Consumers*, Kaiser Family Found. (Mar. 24, 2025), https://tinyurl.com/2637fye3 ("There are other cases where a small share of the population uses a service that is generally covered by insurance. For example, there were fewer than 5,000 heart transplants in the US in 2023 (equaling one ten thousandth of a percent of the population) but public and commercial insurance typically covers this service.").

[287] National Academies of Sciences, Engineering, and Medicine, *Factors That Affect Health-Care Utilization, in* Health-Care Utilization as a Proxy in Disability Determination (2018), https://tinyurl.com/mtcsjc7f.

[288] *Id.* The other factors that impact healthcare utilization, like geography, race, and sex, have independent impacts on utilization. *Id.*

[289] *Rare and Orphan Diseases*, Cleveland Clinic, https://tinyurl.com/5eyz4e2b (last visited Apr. 8, 2025).

[290] Danyon Anderson et al., *Gender Dysphoria and Its Non-Surgical and Surgical*

and private insurance plans cover treatment for a variety of conditions that, while not rare in the medical sense, impact fewer people than gender dysphoria. For example, most healthcare plans cover treatment for multiple sclerosis, which affects almost 1 million people in the United States,[291] and major insurance providers also cover treatment for scleroderma, which impacts only around 300,000 Americans.[292] The fact that a condition only impacts a subset of the general population is not, in and of itself, a sufficient reason to exclude it from inclusion in EHBs.

Additionally, those experiencing gender dysphoria are not the only people who need access to, or make use of, gender-affirming care. Transgender, nonbinary, and intersex individuals who do not suffer from gender dysphoria may need or want gender-affirming care so that they may live as their authentic selves. Around 300,000 minors between the ages of 13 and 17 and 1.3 million adults identify as transgender,[293] approximately 1.2 million LGBTQ people in the U.S. identify as nonbinary,[294] and around 5.6 million people in the U.S. are born intersex.[295] Though there are overlapping populations within these gender diverse groups, it is clear that millions of Americans need access to gender-affirming care.

c. The Proposed Rule fails to account for reliance interests.

The Proposed Rule is arbitrary and capricious for another, related reason: it does not accommodate or even acknowledge that individuals and States have developed important reliance interests around coverage for gender-affirming care due to the preexisting federal regulatory environment. As in the DACA context, the Department is "not writing on a blank slate" here.[296] States have enjoyed the authority to refine EHB requirements within statutory parameters since the ACA was passed; and the Department has never before sought to interfere with that authority by imposing a nation-wide ban on EHB coverage for gender-affirming care. Far from it, in 2021, the Department affirmatively approved a state benchmark plan that explicitly identified that care as an EHB. As a result, many States have administered their marketplaces and benchmark plans with the expectation that employer healthcare plans would cover gender-affirming care as an EHB; and employers followed suit. If the Proposed Rule takes effect, these States would lose the

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Treatments, 10 Health Psychology Res. (Sept. 2022), https://tinyurl.com/tvnvukzw.

[291] Alexandra Benisek, *Covering the Cost of B-Cell Therapy*, WebMD (Oct. 21, 2024), https://tinyurl.com/3urfssdm ("Insurance covers most MS treatments…"); *How Many People Live With Multiple Sclerosis?*, Natl. Multiple Sclerosis Soc'y, https://tinyurl.com/2k8zrd64 (last visited Apr. 8, 2025).

[292] *Who Gets Scleroderma?*, Natl. Scleroderma Found., https://tinyurl.com/3ap44hk9 (last visited Apr. 8, 2025); *Insurance Coverage for Therapeutic Plasma Exchange in the U.S.*, The Scleroderma Education Project, (last visited Apr. 8, 2025).

[293] Press Release, UCLA Williams Inst., New Estimates Show 300,000 Youth Ages 13-17 Identify as Transgender in the U.S. (June 10, 2022), https://tinyurl.com/4h3wdp77.

[294] Press Release, UCLA Williams Inst., 1.2 Million LGBTQ Adults in the U.S. Identify as Nonbinary (June 22, 2021), https://tinyurl.com/vbwr387f.

[295] Rebecca Boone & Jeff McMillan, *How Many Transgender and Intersex People Live in the U.S.? Anti-LGBTQ+ Laws Will Impact Millions*, Associated Press (July 27, 2023), https://tinyurl.com/mvbe6xk8.

[296] *See Regents*, 591 U.S. at 33 (where agency was "not writing on a blank slate, it was required to assess whether there were reliance interests, determine whether they were significant, and weigh any such interests against competing policy concerns") (cleaned up).

flexibility to tailor EHB coverage to the particular needs of their population; and those States that continue to mandate coverage for gender-affirming care—through their State non-discrimination laws or otherwise—would suddenly be required to absorb the associated defrayal costs under 90 Fed. Reg. 12,987. Individuals who currently access gender-affirming care as an EHB through employer healthcare plans also may experience disruptions and increased costs.

However the Department may view these reliance interests, it was obligated to at least acknowledge their existence and consider them when formulating the Proposed Rule.[297] Its failure to do so renders the Rule arbitrary and capricious.

Respectfully submitted,

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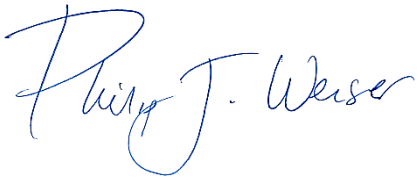

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[297] *Regents*, 591 U.S. at 31.

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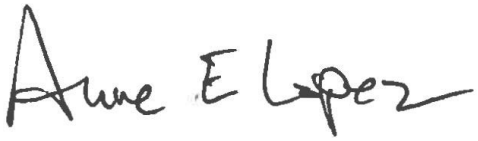

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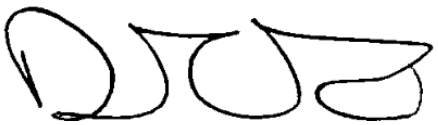

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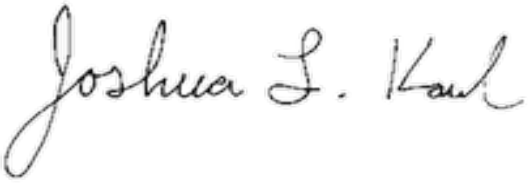

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