Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

April 11, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

REF: CMS–9884–P

Re: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability (90 Fed. Reg. 12942)

Dear Administrator Oz:

The Catholic Health Association of the United States (CHA) welcomes the opportunity to submit these comments on the referenced proposed rule. We appreciate and share the desire of CMS to protect consumers and ensure the integrity of ACA marketplaces. However, we are deeply concerned that many of the proposed changes are unnecessary and will have the opposite effect, making it more difficult for eligible individuals to obtain and keep Marketplace plans and resulting in large numbers of people losing access to needed health care.

CHA is the national leadership organization of the Catholic health ministry, representing more than 2,000 Catholic health care sponsors, systems, hospitals, long-term care facilities and related organization across the continuum of care. CHA represents the largest not-for-profit providers of health care services in the nation. All 50 states and the District of Columbia are served by Catholic health care organizations, and more than 700,000 individuals are employed in Catholic hospitals. Every day, more than one in seven patients in the U.S. is cared for in a Catholic hospital.

- **Enrollment Policies**

CMS has proposed several changes that will have the effect of limiting individuals' ability to enroll in and maintain ACA plans. **CHA opposes:**

Annual Enrollment Changes
The annual enrollment period for the federal Marketplace currently runs from November 1 to January 15, with some state-based Marketplaces keeping enrollment open longer. The proposed rule would end open enrollment on December 15 in both the federal and state Marketplaces. Shortening

the period reduces consumer choice and flexibility. Consumers new to the marketplace and those that struggle with health insurance literacy in particular need the extra time to obtain the assistance they need to find the right plan.

Low-income participants who quality for a fully-subsidized plan – they pay no premium – are currently able to automatically re-enroll in their plan with no change in their subsidy. Under the proposed rule, automatic re-enrollment in a zero-dollar premium plan would trigger the imposition of a $5 premium. While the participant can reapply at any time to re-confirm their plan and again be fully subsidized, we are concerned that in practice this will cause low-income individuals and families to suffer coverage lapses or lose coverage. While five dollars may not seem like much, even smaller premium increases, especially when coupled with administrative burdens, have been shown to result in coverage loss.[1]

Special Enrollment Periods (SEPs)

People with incomes no higher than 150% of the federal poverty level are currently able to enroll in or change plans in any month. CMS proposes to eliminate this option, citing concern that people may underestimate their incomes to improperly qualify for the monthly SEP. While we sympathize with the desire to stop people from gaming the system, ending the monthly SEP is not the solution. We are concerned this would harm the low-income people for whom this enrollment flexibility was intended--for example, people who experience income volatility and may churn in and out of Medicaid.

CMS has estimated that the effect of these and other proposed changes could result in 750,000 to 2,000,000 people losing Marketplace coverage and becoming uninsured. The consequences of being uninsured are significant. Because uninsured patients do not receive the right care in the right place, they are up to four times as likely as insured patients to require avoidable hospitalizations and emergency care. **These proposals will create barriers to heath care coverage and access, and CHA urges CMS not to finalize them.**

- **Deferred Action for Childhood Arrivals (DACA) Recipients**

As a Catholic health ministry, our mission and our ethical standards in health care are rooted in and inseparable from the Catholic Church's teachings about the dignity of each and every human person, created in the image of God. Access to health care is essential to promote and protect the inherent and inalienable worth and dignity of every individual. Catholic health care organizations serve immigrants, including refugees and victims of human trafficking, in their clinics, emergency rooms and in their facilities. CHA believes all persons should have equal access to health care, regardless of immigration status.

[1] https://www.fiercehealthcare.com/payers/even-1-premium-discourages-low-income-individuals-coverage-because-hassle-factor-study

Under the Affordable Care Act (ACA), to be eligible to enroll in a Qualified Health Plan through an ACA Exchange or in a Basic Health Program, or to receive premium and cost sharing assistance, an individual must be either a citizen or national of the United States or be "lawfully present" in the United States. The ACA does not define the term "lawfully present." On May 8, 2024, the regulations governing the ACA programs were updated in a final rule to clarify that DACA recipients would be considered lawfully present for purposes of the ACA, as are other individuals granted deferred action under other programs. (89 FR 39392). The CMS decision was based in part on a desire to align its policy with the position taken by the Department of Homeland Security that DACA recipients were "lawfully present" for the purposes of certain Social Security benefits. The agency is now proposing to reverse its decision and exclude DACA recipients from the ACA's definition of "lawfully present."

CHA supported the final rule extending ACA edibility to DACA recipients. While many DACA recipients have access to employer-provided health insurance coverage, prior to the 2024 regulatory change 34% of recipients reported they were uninsured in a 2021 survey. (88 Fed. Reg. 25315-25316). Allowing them to participate in ACA Exchanges and to receive premium and cost sharing assistance helps to ensure they receive preventative and routine health screenings, receive needed medical care promptly and improve their health and well-being. In particular, making sure pregnant DACA recipients can access health care through ACA plans helps to protect their health and safety and that of their newborn children. The rate of maternal mortality in the United State is appalling. Women in the U.S. are more likely to die from complications from pregnancy or childbirth than women in similarly developed nations.[2] **For these reasons, CHA opposes excluding DACA recipients from the definition of "lawfully present" and denying them access to ACA plans and subsidies.**

In closing, thank you for the opportunity to provide comments on the proposed rule. If you have any questions about these comments or need more information, please do not hesitate to contact Kathy Curran, Senior Director, Public Policy or Clay O'Dell, Director, Advocacy at 202-296-3993.

Sincerely,

Lisa A. Smith
Vice President
Public Policy and Advocacy

[2] Munira Z. Gunja, Evan D. Gumas, and Reginald D. Williams II, "The U.S. Maternal Mortality Crisis Continues to Worsen: An International Comparison," To the Point (blog), Commonwealth Fund, Dec. 1, 2022. https://doi.org/10.26099/8vem-fc65int (blog), Commonwealth Fund, Dec. 1, 2022. https://doi.org/10.26099/8vem-fc65