Center on Health Policy at BROOKINGS

April 11, 2025

Secretary Robert F. Kennedy, Jr.
Department of Health and Human Services (HHS)

Administrator Mehmet Oz
Centers for Medicare and Medicaid Services

Re: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability [CMS-9884-P]

Dear Secretary Kennedy and Administrator Oz:

Thank you for the opportunity to comment on HHS' Marketplace Integrity and Affordability proposed rule.[1] This letter makes three points about the analysis that supports the proposed rule:

1. Abundant evidence shows that, contrary to HHS' assumptions, administrative burdens created by HHS' changes to the Marketplace enrollment process would deter eligible people from enrolling, reducing insurance coverage and increasing insurance premiums.

2. HHS does not meaningfully justify its claim that its proposed changes to special enrollment period (SEP) policies would sharply reduce premiums, and HHS is ignoring evidence that could allow it to make a more evidence-based assessment of these policies.

3. HHS' methods for estimating the extent of improper enrollment have serious flaws. Some other approaches that lack these flaws do suggest that there are a relatively large number of Marketplace enrollees with incomes just above 100% of the federal poverty level (FPL) in Medicaid non-expansion states. However, it is not clear how much such enrollment there is or how much of that enrollment is improper. Moreover, even to the extent that some is improper, it points to a narrower and more specific problem than the one HHS suggests exists.

The remainder of this letter examines these points in greater detail.

Larger administrative burdens will deter eligible enrollees, increasing premiums

HHS' analysis of the proposed rule assumes that greater administrative burdens due to changes in Marketplace enrollment processes will have no effect on enrollment among eligible enrollees.[2] This approach is at odds with a wealth of evidence from health insurance markets and beyond.

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[1] The views expressed in this letter are my own and do not necessarily reflect the views of the Brookings Institution or anyone affiliated with the Brookings Institution other than myself. I thank Christen Linke Young and Richard Frank for helpful comments on a draft of this letter, as well as Paris Rich Bingham and Rasa Siniakovas for excellent research and editorial assistance, respectively.

[2] In discussing the potential limitations of the regulatory impact analysis, HHS explains that it has not assessed these impacts: "Likewise, 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."

Notably, multiple high-quality studies have shown that adding steps to the health insurance enrollment process, as many of HHS' proposals would do, substantially reduces enrollment.[3] Similarly, many studies have found that imposing small premium obligations, as some of HHS' other proposals would do, also generates large reductions in enrollment.[4] This is most likely not because those small premium payments pose a substantial financial burden, but instead because they add another step to the enrollment process: remitting the small premium payment. Importantly, this evidence is drawn from settings where there is little reason to believe that HHS' present concerns about inappropriate enrollments were relevant, so the findings of these studies almost surely reflect reductions in enrollment among *eligible* individuals.

It is also worth noting that evidence from many contexts beyond health insurance also shows that making processes more administratively burdensome can have large effects on benefit enrollment decisions. Notably, this has been clearly demonstrated for employer retirement programs, student aid programs, and food assistance programs.[5] In short, the evidence that even seemingly modest administrative burdens can have large enrollment effects is robust and pervasive.

Eligible enrollees deterred by increased administrative burdens very likely use less health care, on average, than those who continue to enroll. Economic theory implies that health insurance is most valuable to those with greater health care needs and, in turn, that enrollees with lesser health care needs are most likely to leave the market when the financial or non-financial cost of enrolling rises. And, indeed, this is borne out empirically. Some of the studies of increased administrative burdens

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[3] Mark Shepard and Myles Wagner, "Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollment," *American Economic Review* 115, no. 3 (March 2025): 772–822, https://doi.org/10.1257/aer.20231133; Keith Marzilli Ericson et al., "Reducing Administrative Barriers Increases Take-Up of Subsidized Health Insurance Coverage: Evidence from a Field Experiment," *The Review of Economics and Statistics*, March 5, 2025, 1–32, https://doi.org/10.1162/rest_a_01573.

[4] Laura Dague, "The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach," *Journal of Health Economics* 37 (September 2014): 1–12, https://doi.org/10.1016/j.jhealeco.2014.05.001; Adrianna McIntyre, Mark Shepard, and Myles Wagner, "Can Automatic Retention Improve Health Insurance Market Outcomes?," *AEA Papers and Proceedings* 111 (May 2021): 560–66, https://doi.org/10.1257/pandp.20211083; Adrianna McIntyre, Mark Shepard, and Timothy J. Layton, "Small Marketplace Premiums Pose Financial And Administrative Burdens: Evidence From Massachusetts, 2016–17," *Health Affairs* 43, no. 1 (January 2024): 80–90, https://doi.org/10.1377/hlthaff.2023.00649; Coleman Drake et al., "Financial Transaction Costs Reduce Benefit Take-up Evidence from Zero-Premium Health Insurance Plans in Colorado," *Journal of Health Economics* 89 (May 1, 2023): 102752, https://doi.org/10.1016/j.jhealeco.2023.102752.

[5] Brigitte C. Madrian and Dennis F. Shea, "The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior," *The Quarterly Journal of Economics* 116, no. 4 (November 1, 2001): 1149–87, https://doi.org/10.1162/003355301753265543; Raj Chetty et al., "Active vs. Passive Decisions and Crowd-Out in Retirement Savings Accounts: Evidence from Denmark," *The Quarterly Journal of Economics* 129, no. 3 (August 1, 2014): 1141–1219, https://doi.org/10.1093/qje/qju013; Eric P. Bettinger et al., "The Role of Application Assistance and Information in College Decisions: Results from the H&R Block Fafsa Experiment," *The Quarterly Journal of Economics* 127, no. 3 (August 1, 2012): 1205–42, https://doi.org/10.1093/qje/qjs017; Amy Finkelstein and Matthew J Notowidigdo, "Take-Up and Targeting: Experimental Evidence from SNAP," *The Quarterly Journal of Economics* 134, no. 3 (August 1, 2019): 1505–56, https://doi.org/10.1093/qje/qjz013; Eric Giannella et al., "Administrative Burden and Procedural Denials: Experimental Evidence from SNAP," *American Economic Journal: Economic Policy* 16, no. 4 (November 2024): 316–40, https://doi.org/10.1257/pol.20220701.

described above directly estimate the health care use of people deterred by greater burdens; they find that the deterred enrollees do indeed use less care, potentially markedly less.[6] Similarly, increasing the financial cost of enrollment also disproportionately deters enrollees who use less care.[7] This implies that the loss of eligible enrollees in response to increased administrative burdens would worsen the individual market risk pool and, thus, increase premiums.

The discussion above makes clear that it is not possible to credibly estimate the proposed rule's effects on Marketplace enrollment and premiums without considering the effects of increased administrative burdens. Moreover, the evidence reviewed above provides the information needed to account for these types of effects, so it would be feasible for HHS to remedy this flaw.

HHS' estimates for SEP policy changes have little clear basis and ignore useful evidence

HHS' claim that the proposed rule would reduce premiums is (depending on the scenario) either mostly or entirely accounted for by its assumptions that changes to SEP policies would reduce premiums. In particular, HHS assumes that removing the current monthly SEP for people with incomes below 150% of the FPL would reduce premiums by 3.4%, and it assumes that the proposed rule's SEP verification provisions would reduce premiums by an additional 0.5%.[8]

The basis for HHS' estimates is opaque, at best. In the main text of the proposed rule, HHS references a prior estimate that the monthly SEP policy would increase premiums by "3 to 4 percent" in the absence of the IRA subsidies, but then provides a revised range of "0.5 to 3.6 percent."[9] In the regulatory impact analysis, however, HHS reverts to its discarded "3 to 4 percent" estimate,[10] before adopting 3.4% as its point estimate. At no point does HHS explain the methods or assumptions underlying any of these estimates. Similarly, the methods or assumptions underlying the proposed rule's estimate that the proposed rule's SEP verification provisions would reduce premiums by 0.5% do not appear to be explained anywhere in the proposed rule.

It is clearly possible that the proposed rule's SEP provisions would reduce premiums by preventing some people with relatively high health care needs from enrolling in coverage.[11] However, this is

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[6] Shepard and Wagner, "Do Ordeals Work for Selection Markets?"; McIntyre, Shepard, and Wagner, "Can Automatic Retention Improve Health Insurance Market Outcomes?"

[7] Martin B. Hackmann, Jonathan T. Kolstad, and Amanda E. Kowalski, "Adverse Selection and an Individual Mandate: When Theory Meets Practice," *American Economic Review* 105, no. 3 (March 2015): 1030–66, https://doi.org/10.1257/aer.20130758; Amy Finkelstein, Nathaniel Hendren, and Mark Shepard, "Subsidizing Health Insurance for Low-Income Adults: Evidence from Massachusetts," *American Economic Review* 109, no. 4 (April 2019): 1530–67, https://doi.org/10.1257/aer.20171455.

[8] 90 FR 13024

[9] 90 FR 12982

[10] 90 FR 13009

[11] Indeed, prior to implementation of the monthly SEP, I conducted an analysis that concluded this policy would increase premiums. See Matthew Fiedler, "Comments on a CMS Proposal to Allow Year-Round Marketplace Enrollment for Low-Income People" (Brookings Institution, August 2, 2021), https://www.brookings.edu/opinions/comments-on-a-cms-proposal-to-allow-year-round-marketplace-enrollment-for-low-income-people/.

far from guaranteed. If the monthly SEP is allowing people who are relatively inattentive to their health insurance—a group that is plausibly relatively healthy—to enroll even if they miss open enrollment, then eliminating it could *increase* premiums rather than reduce them. Similarly, like other policies that increase administrative burden, requiring SEP enrollees to submit additional documentation would deter some eligible enrollees who use relatively little health care from enrolling, which could partially or fully offset any effects from removing ineligible enrollees.

HHS could provide more compelling estimates by analyzing data it holds on recent years' experience under alternative SEP policy regimes. In particular, HHS could examine how the volume of enrollment during open enrollment versus during SEPs changed after relaxation of SEP verification processes and implementation of the monthly SEP. It could also use risk adjustment data to examine how the average claims risk of these two types of enrollees changed over time. If the SEP policies are assumed not to affect the pace of enrollment during open enrollment, these trends could form the basis for a "difference-in-differences" estimate of the effect of these policies changes on the amount and risk mix of SEP enrollment and, in turn, the effect of these past SEP policy changes on the risk pool. Even if this assumption is rejected, alternative assumptions could be made, and the resulting estimates would likely be far superior to simply ignoring this evidence, as HHS opted to do for the purposes of the analysis presented in the proposed rule.

HHS' methods for estimating the prevalence of improper enrollments are flawed

To support assertions that improper Marketplace enrollments are widespread, HHS repeatedly cites an analysis published by the Paragon Health Institute, which HHS then updates in the rule's regulatory impact analysis.[12] HHS' updated analysis compares administrative tallies of the number of plan selections among people with incomes between 100 and 150% of the FPL to an estimate of the corresponding "eligible population" derived using 2023 American Community Survey (ACS) data. In states where the number of plan selections exceeds its estimate of the eligible population, HHS treats the excess as improper enrollments, yielding an estimate that there were "as many as 4.4 million erroneous or improper enrollments" in 2024.

As HHS itself notes in the proposed rule, this methodology has substantial limitations for measuring improper enrollments since its ACS-based measure of the eligible population has serious shortcomings.[13] Perhaps the most fundamental problem is that eligibility for advance payments of the premium tax credits is based on a Marketplace applicant's *projected* income, not the enrollee's actual income for the year, which is what is measured in the ACS data. Considering the substantial income volatility experienced by low-income enrollees,[14] the distribution of

[12] Brian Blase and Drew Gonshorowski, "The Great Obamacare Enrollment Fraud" (Paragon Health Institute, June 2024), https://paragoninstitute.org/wp-content/uploads/2024/06/The-Great-Obamacare-Enrollment-Fraud_FOR_RELEASE_V2.pdf.

[13] 90 FR 13021

[14] Lauren Bauer, Chloe N. East, and Olivia Howard, "Low-Income Workers Experience the Most Earnings and Work Hours Instability" (The Hamilton Project), accessed April 7, 2025, https://www.hamiltonproject.org/publication/post/low-income-workers-experience-by-far-the-most-earnings-and-work-hours-instability/.

projected income need not neatly align with the distribution of actual income. Other significant problems include that HHS' analysis relies on the wrong measure of income and family size, that survey data like the ACS can be subject to significant measurement error, and that HHS is relying on ACS data that incorporates only part of the effects of Medicaid unwinding. Together with the other limitations of this methodology catalogued in the proposed rule, this implies that this analysis offers an unreliable basis for HHS' conclusion that improper enrollments are widespread.

Other research using methods that avoid the many problems of the Paragon methodology does suggest that there are a relatively large number of Marketplace enrollees with attested incomes just above 100% of the FPL in Medicaid non-expansion states, the income threshold at which enrollees become eligible for Marketplace coverage rather than falling in the "coverage gap."[15] In particular, using data for 2015-2017, this analysis found that there were many more enrollees just above 100% of the FPL (e.g., between 100 and 110% of the FPL) than there are slightly farther above this threshold (e.g., between 110 and 120% of the FPL) in these states. This finding suggests the presence of the eligibility threshold at 100% of the FPL is influencing enrollees' income estimates. However, it is not at all clear that applying this methodology to updated data would produce an estimate of "excess" enrollment comparable to HHS' current estimate.

It is also important to note that, while this finding does suggest that enrollees' income estimates are influenced by the 100% of the FPL threshold, it does not necessarily mean that all or even most of these "excess" enrollments are improper. While this pattern could arise if enrollees are purposely misstating their income, it could also arise in other ways. For example, if enrollees submit an initial good-faith estimate and then realize that they have forgotten to report some smaller sources of income only if found ineligible, that could generate precisely this pattern despite all enrollees operating in good faith. Alternatively, if some enrollees adjust their labor supply in response to the eligibility threshold, that could also contribute to such a pattern.

A final note is that even to the extent that these "excess" enrollments are improper, it points to a narrow and specific issue pertaining to how enrollees near the 100% of FPL threshold estimate their income. This could potentially justify some proposals in the proposed rule focused narrowly on verifying enrollee income estimates (although HHS would still need to weigh the intended effect of rooting out ineligible enrollees against the likelihood that new documentation requirements would deter eligible enrollees as well). But it is unlikely it could justify many of the HHS assertions and proposals in the proposed rule that rely on this evidence to support the claim that there is a much wider-ranging improper enrollment problem.

Thank you for the opportunity to comment on the proposed rule. I hope that this information is helpful to you. If I can provide any additional information, I would be happy to do so.

[15] Benjamin Hopkins, Jessica Banthin, and Alexandra Minicozzi, "How Did Take-Up of Marketplace Plans Vary with Price, Income, and Gender?," *American Journal of Health Economics* 11, no. 1 (January 2025): 63–90, https://doi.org/10.1086/727785.

Sincerely,

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