AMERICA'S PHYSICIAN GROUPS

April 11, 2025

Mehmet Oz, MD
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted via https://www.regulations.gov/commenton/CMS-2025-0020-0011

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

Dear Administrator Oz:

America's Physician Groups (APG) appreciates the opportunity to respond to the Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Proposed Rule. APG welcomes your agency's openness to stakeholder input and your ongoing commitment to improving health care for all Americans.

Below, APG will first provide (I) a brief description of our organization, followed by (II) a summary of CMS's proposals, (III) a summary of APG's recommendations, (IV) our fuller comments and recommendations, and (V) our conclusion. Together they reflect the voice of APG's membership and the commitment to working with the agency to ensure that all Americans have consistently accessible, high-quality, equitable, person-centered health care.

I. About America's Physician Groups

APG is a national association representing more than 360 physician groups that are committed to the transition to value, and that engage in the full spectrum of alternative payment models and Medicare Advantage (MA). APG members collectively employ or contract with approximately 195,000 physicians (as well as many nurse practitioners, physician assistants, and other clinicians), and care for approximately 90 million patients, including roughly 30 percent of all Medicare beneficiaries who are enrolled in MA.

APG's motto, "Taking Responsibility for America's Health," underscores our physician groups' preference for being in risk-based, accountable, and responsible relationships with all payers, including MA health plans, rather than being paid by plans on a fee-for-service basis. Delegation of risk from payers to providers creates the optimal incentives for our groups to provide integrated, coordinated care; make investments in innovations in care delivery; advance health equity; and manage our populations of patients in more constructive ways than if our members were merely compensated for the units of service that they provide.

II. Summary of CMS's Proposed Rule

CMS's Proposed Rule sets forth the agency's proposed policies for 2025 and subsequent years concerning standards for health insurance marketplaces that provide coverage to Americans under the Affordable Care Act (ACA) and provides an estimate of how these policies will affect enrollment and marketplace stability, including a projected reduced annual enrollment between 750,000 and 2,000,000 individuals.

The policy proposals included in the Proposed Rule that are most germane to APG members include the following:

- **Overdue Premiums:** CMS would repeal current policy that bans insurers from requiring payment of past-due premiums before those insured under the ACA's qualified health plans can receive new coverage and would permit insurers to add owed past-due premiums to the initial premiums enrollees must pay to start coverage.
- **Annual Eligibility Redeterminations & Special Election Periods:** CMS proposes to institute a $5 monthly premium for individuals automatically enrolled in the Advanced Premium Tax Credit (APTC) that will remain in effect until income eligibility is verified. The proposed rule also modifies the automatic reenrollment hierarchy to remove the ability for marketplaces to automatically enroll individuals from bronze to silver plans under certain conditions.
- **Sex Trait Modification Ban:** CMS proposes prohibiting insurers from providing sex trait modification as an essential health benefit (EHB) under the ACA.

III. Summary of APG's Recommendations

- **APG recommends that CMS to modify or forgo proposed policies that would reduce insurance coverage to avoid disrupting people's ongoing care.**

A. Recommendations Related to Overdue Premiums

- **APG recommends that in the final rule CMS provide clarity around the mechanism for application of past-due premiums when enrollees switch to a plan offered by a different insurer.**

B. Recommendations Related to Annual Eligibility Redeterminations & Special Election Periods

- **APG requests clarification of the extent to which the proposed federal policy would supersede and State Exchange policies.**

- **APG recommends that if CMS finalizes the proposed policy, that the agency include a modification that would actively alert affected consumers about the availability of a silver product that might meet their needs as well as or better than the bronze product that they are currently enrolled in.**

C. Recommendations Related to Sex Trait Modification Ban

- **APG recommends that "sex trait modification" services, also known as gender-affirming care, continue as essential health benefits for all ACA marketplace and state exchange plans.**
- **APG recommends that CMS either remove the term "sex trait modification" from the final rule or to define it narrowly and with specificity, consistent with accepted medical usage, to ensure that coverage for unrelated and medically necessary treatments is not inadvertently restricted.**

IV. APG's Detailed Comments and Recommendations

APG appreciates CMS's efforts to ensure that the ACA enrollment, and the ACA's qualified health plan (QHP) markets and marketplaces remain stable, affordable, and accessible for all enrollees. APG also recognizes that the agency is seeking solutions to address challenges that have arisen while pursuing this goal. However, APG is concerned by CMS's projection that – if the policies included in the Proposed Rule are finalized – 750,000 to 2,000,000 people could lose their current ACA coverage.

Interruptions in insurance coverage can too easily lead to disruptions in care. As physicians who take responsibility for the quality and total cost of patients' care through value-based care arrangements, APG members caution that it is impossible to structure such arrangements – which are inherently linked to health insurance – for populations that are uninsured. In addition, APG fundamentally opposes policies that would separate patients unnecessarily from their insurance coverage, disrupt continuity and coordination of care, result in greater morbidity and mortality, and add to avoidable costs in health care.

The evidence shows that persons without insurance coverage are likely to forgo necessary care,[1] making them less healthy and contravening the objectives of the current administration to "make Americans healthy again." When acute illness strikes, or untreated chronic conditions are exacerbated, persons without insurance often seek care in hospital emergency departments. Given EMTALA requirements, hospitals and emergency department physicians must treat all patients, regardless of insurance coverage and ability to pay. A surge in uninsured patients seeking care in these situations will also place further financial strain on health systems and physicians that could be avoided if broader insurance coverage is maintained. To avoid disrupting people's ongoing care, APG urges CMS to modify or forgo proposed policies that would reduce insurance coverage.

[1] McWilliams JM, Health Consequences of Uninsurance among Adults in the United States: Recent Evidence and Implications. The Milbank Quarterly, June 4, 2009. https://doi.org/10.1111/j.1468-0009.2009.00564.x

In summary:

- **APG recommends that CMS to modify or forgo proposed policies that would reduce insurance coverage to avoid disrupting people's ongoing care.**

A. Overdue Premiums

Current regulations ban insurers from requiring payment of past-due premiums for a previous year for individuals to obtain new coverage for a new year. The proposed rule would repeal this ban and permit insurers to include owed past-due premiums in the initial premiums enrollees must pay to start coverage for the new year. CMS would require insurers to apply the policy equally across all employers or individuals in similar circumstances in the applicable market regardless of health status, and consistent with applicable nondiscrimination requirements. CMS argues that the proposed rule will eliminate the "perverse incentives" that exist under current regulations that, in its view, effectively encourages non-payment of past due premiums.

APG questions how past-due premiums would be applied when enrollees switch to plans offered by a different insurer year-to-year. APG requests that in the final rule CMS provide clarity around the mechanism for application of past-due premiums when enrollees switch to a plan offered by a different insurer.

In summary:

- **APG recommends that in the final rule CMS provide clarity around the mechanism for application of past-due premiums when enrollees switch to a plan offered by a different insurer.**

B. Annual Eligibility Redeterminations & Special Election Periods

CMS proposes multiple modifications to existing regulations, as described further below.

CMS proposes to modify the annual eligibility redetermination process by requiring marketplaces to ensure that consumers who are automatically re-enrolled without affirming or updating their eligibility information, and who would have been automatically re-enrolled in a QHP with a fully subsidized premium after the application of APTC, to instead be automatically re-enrolled with a $5 monthly premium. Once consumers confirm their eligibility, the $5 monthly bill could be eliminated. Any premium paid would potentially be rebated to affected enrollees when they file and reconcile their APTC on their taxes if they remain eligible for a fully subsidized premium.

CMS also proposes to require that the $5 monthly premium to be instituted by benefit year 2026 for the federal marketplace exchanges and by benefit year 2027 for state exchanges. CMS says that this proposed policy would potentially reduce improper enrollments and surprise tax liabilities and also benefit consumers by increasing awareness and engagement in their health coverage decisions and ensuring that their coverage aligns with their current needs and eligibility. CMS notes that the change would "lead to increased price sensitivity to premiums and premium changes among enrollees with fully

subsidized premiums."

CMS additionally proposes to amend the automatic reenrollment hierarchy to remove the ability for marketplaces to automatically enroll individuals from bronze to silver plans under certain conditions. Under current policy, Bronze to Silver plan reenrollment occurs when cost-sharing reductions (CSR-) eligible enrollees who have signed up for a Bronze plan are automatically moved by the marketplace to a Silver plan if the latter plan is essentially the same product, has the same provider network, and has a lower or equivalent net premium as the bronze plan into which the enrollee would otherwise have been re-enrolled. The rationale for such a move is that consumers can only take advantage of the extra savings available through CSR reductions by enrolling in a Silver plan. CMS notes that in effect, this current policy allows marketplaces and exchanges to terminate an enrollee's coverage through a Bronze plan and reenroll in a Silver plan without the enrollee's active participation. CMS also argues that a lack of consumer awareness of various plan options, and the conditions of eligibility for cost-sharing subsidies, that spurred the current policy in 2017 is much less of an issue today.

APG appreciates CMS's efforts to ensure that automatic reenrollment policies balance the rights of enrollees to remain in the plan that they have actively selected with the goal of aligning enrollees with the plan that best meets their needs. APG members note that their patients have benefitted from being automatically enrolled in Silver plans, especially through the Covered California exchange. APG requests clarification of the extent to which the proposed federal policy would supersede California's and other states' exchange policies. In addition, APG requests that if CMS finalizes the proposed policy, that the agency includes a modification that would actively alert affected consumers about the availability of a Silver plan that might meet their needs as well as or better than the Bronze plan that they are currently enrolled in.

In summary:

- **APG requests clarification of the extent to which the proposed federal policy would supersede and State Exchange policies.**
- **APG recommends that if CMS finalizes the proposed policy, that the agency include a modification that would actively alert affected consumers about the availability of a silver product that might meet their needs as well as or better than the bronze product that they are currently enrolled in.**

C. Sex Trait Modification Ban

CMS proposes to prohibit insurers from offering "sex-trait modification" as an essential health benefit under the ACA starting with Plan Year 2026. CMS notes that President Trump issued Executive Order 14168, which requires agencies to "take all necessary steps, as permitted by law, to end the Federal funding of gender ideology" and Executive Order 14187, which requires the Secretary of HHS to "take all appropriate actions consistent with applicable law to end the chemical and surgical mutilation of children."

E.O.14187 defines "chemical and surgical mutilation" as the use of puberty blockers, sex hormones, and surgical procedures that attempt to transform an individual's physical appearance to align with an identity that differs from his or her sex or that attempt to alter or remove an individual's sexual organs to minimize or destroy their natural biological functions. E.O. 14187 notes that the phrase is sometimes referred to as "gender affirming care" and CMS refers to it in the proposed rule as "sex-

trait modification."

CMS notes that the ban would not prohibit plans from voluntarily covering sex trait modification services nor does it prohibit states from requiring such services in health plans.

CMS recognizes that there are certain medical conditions, such as precocious puberty, where the use of items and services for sex-trait modification may be appropriate and asks for comment concerning whether the agency should define exceptions to permit coverage as an essential health benefit.

APG recognizes that CMS' proposed rule seeks to align with the policy goals outlined in President Trump's executive orders but seeks further clarity on its applicability and urges the agency to consider certain modifications. APG's members have concerns that the rule will inadvertently create barriers to medically recommended treatments for certain disorders, such as precocious puberty or intersex conditions. APG strongly encourages CMS to include exceptions to permit coverage of these services.

Medical and surgical treatments for gender dysphoria and gender incongruence, determined through shared decision-making between patient and physician, have come to be viewed as medically necessary. These treatments align with generally accepted standards of medical and surgical practice, supporting coverage of essential gender-affirming health care services. In addition, the proposed rule does not align with statute that calls for Essential Health Benefits (EHB) to mirror the scope of benefits provided under a typical employer plan, as determined by the Secretary (https://doi.org/10.17226/13182). APG opposes efforts to restrict these services or their coverage under a health plan.

In addition, the proposed rule introduces the term "sex-trait modification" without providing a precise or operational definition. This term is not recognized in the medical or scientific community, nor is it found in widely accepted clinical guidelines or literature. The absence of a clear definition creates substantial ambiguity and raises significant concerns regarding the rule's potential application beyond its stated intent. Without further clarification, the term may be construed to include a broad range of treatments unrelated to gender-affirming care, thereby jeopardizing access to medically necessary services.

For example, the use of gonadotropin-releasing hormone (GnRH) analogs—commonly referred to as puberty blockers—is a standard treatment for children with central precocious puberty. These interventions are clinically distinct from gender-affirming care and are widely accepted as medically necessary under current pediatric endocrinology standards. A broad interpretation of "sex-trait modification" could lead to inappropriate exclusions of such treatments from coverage.

Similarly, many reproductive health services involve hormonal therapies, including treatment for endometriosis, polycystic ovarian syndrome, and other gynecological conditions. These interventions may involve modifying secondary sex characteristics but are clearly not related to gender transition.

For all these reasons, APG urges CMS either to remove the term "sex trait modification" from the final rule or to define it narrowly and with specificity, consistent with accepted medical usage, to ensure that coverage for unrelated and medically necessary treatments is not inadvertently restricted.

In summary:

- **APG recommends that "sex trait modification" services, also known as gender-affirming care, continue as essential health benefits for all ACA marketplace and state exchange plans.**
- **APG recommends that CMS either remove the term "sex trait modification" from the final rule or to define it narrowly and with specificity, consistent with accepted medical usage, to ensure that coverage for unrelated and medically necessary treatments is not inadvertently restricted.**

V. Conclusion

APG appreciates CMS's efforts to ensure that the ACA enrollment, and the ACA's qualified health plans and marketplaces, remain stable, affordable, and accessible for all enrollees. APG encourages CMS to consider the modifications to the proposed policies described in this letter to further refine the proposed policies and help to avoid unintended consequences.

Sincerely,

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