National Rural Health Association

April 8, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, Maryland 21244

RE: CMS-9884-P; Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability.

Submitted electronically via regulations.gov.

Dear Administrator Oz,

The National Rural Health Association (NRHA) is pleased to offer comments on the proposed Marketplace Integrity and Affordability rule. We appreciate the Centers for Medicare and Medicaid Services' (CMS) continued commitment to the needs of the more than 60 million Americans that reside in rural areas, and we look forward to our continued collaboration to improve health care access throughout rural America.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

NRHA is concerned about the potential for the proposed changes to reduce coverage among rural populations. When fewer patients are insured, rural providers struggle financially due to increases in uncompensated care. Rural hospital financing is a fragile puzzle of various funding streams – reimbursement from Medicare, Medicaid, and the Marketplaces; 340B savings; federal and state grants; tax revenue; and other assistance such as loans and grants. Changes to one source of revenue creates a rift that the other sources must cover, or the rural hospital will see a loss of revenue. Nationally, upwards of 45% of rural hospitals are operating with negative margins and cannot afford additional loses.[1] Rural residents losing health insurance coverage is one such shift.

Rural hospitals on average see about 70% of their revenue come from public payers. Rural areas have a large aging population, meaning higher Medicare enrollment. Non-elderly rural adults rely upon public coverage more than their urban counterparts, mainly due to lower

[1] Michael Topchik, et al., *2025 rural health state of the state,* CHARTIS CENTER FOR RURAL HEALTH (Feb. 11, 2025) https://www.chartis.com/sites/default/files/documents/CCRH%20WP%20-%202025%20Rural%20health%20state%20of%20the%20state_021125.pdf.

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rural household incomes, fewer employment options, more small employers that are less likely to offer employer-sponsored health insurance, and more low-wage workers.[2] Many rural residents remain uninsured and at rates higher than in urban areas even after implementation of the Affordable Care Act (ACA).[3]

Rural residents are more likely to have publicly subsidized Marketplace plans,[4] and thus are more likely to be adversely impacted by the proposed changes. In many states, the vast majority of individuals enrolled in Marketplace plans are rural. For example, half of Iowans and three quarters of Montanans that are covered by Marketplace plans live in rural areas.[5]

Income verification policies.

CMS proposes several changes to the income verification procedures for enrollees to apply through the Marketplaces in order to combat fraud. These include removing an exception that allows Marketplaces to rely on an individual's self-attestation of projected income if the IRS does not have tax return data to verify household size and income; requiring individuals to prove income for the upcoming year is between 100% and 400% of the federal poverty line (FPL); and eliminating an automatic 60-day extension when documentation is needed to verify household income when other sources of proof show income inconsistencies.

NRHA understands the importance of protecting subsidized health coverage from fraud and abuse. However, we are concerned that these proposals will not achieve the goal of reducing fraud but instead burden rural enrollees with documentation requirements of which they have been relieved of for several years. We are concerned that rural individuals will forgo coverage as a result of stricter income verification requirements. This will particularly be an issue for low-wage or hourly workers, including direct care workers who provide essential healthcare services, living in rural areas who may overestimate their annual income for eligibility verification but then see a lower income on their tax return.

Changes to special enrollment periods (SEPs).

CMS proposes to shorten the open enrollment period by one month – from November 1st to January 15th to November 1st to December 15th. NRHA does not support this proposal and asserts that CMS did not adequately justify how this change will prevent fraud. We are concerned that this will only serve to limit enrollment, especially without aggressive

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[2] *See* Timothy McBride, et al., *An Insurance Profile of Rural America: Chartbook,* RURAL POLICY RESEARCH INSTITUTE, UNIVERSITY OF IOWA, 27 (2022) (Uninsured rates were higher in non-metropolitan areas [13.3%] than in metropolitan areas [10.8%] in 2019, consistent with historical patterns of uninsurance) https://digirepo.nlm.nih.gov/master/borndig/9918716488106676/9918716488106676.pdf.

[3] *Id.* at 4.

[4] *Id.*

[5] Katherine Hempstead, *Marketplace Pulse: Health Insurance Coverage in Farm Country,* ROBERT WOOD JOHNSON FOUNDATION, May 1, 2024, at figure 1, https://www.rwjf.org/en/insights/our-research/2024/05/marketplace-pulse-health-insurance-coverage-in-farm-country.html.

communications and outreach to ensure that eligible individuals are aware of the new timeline.
CMS also proposes to change certain SEPs. While most enrollees should find or change coverage during the open enrollment period, SEPs exist for individuals in extenuating circumstances who need to find coverage. One such change is the proposal to remove the low-income SEP, which currently allows individuals whose projected household income is at or below 150% of the FPL enroll or change plans monthly. NRHA believes the majority of individuals who benefit from the low-income SEP meet the intent of the policy and urges CMS to consider a more tailored approach to combat adverse selection rather than end this option altogether.

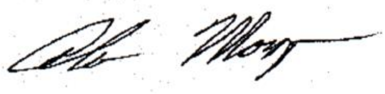
Automatic re-enrollment changes.
CMS proposes to prevent enrollees from being automatically re-enrolled in coverage with monthly premiums fully subsidized by advanced premium tax credits (APTCs) without taking action to confirm eligibility information. Instead, if an enrollee does not submit an application for an updated eligibility determination, the enrollee would be required to pay a $5 monthly premium until the application is received. NRHA is concerned about the impact of unexpected costs for enrollees who are not aware that they now must take affirmative action to retain their APTC. If CMS finalizes this change, we urge the agency to implement the proposed $5 premium and avoid more expensive and burdensome charges.

In sum, the proposed NPRM changes have the potential to create upheaval in the Marketplaces and upend coverage for many rural residents. Looking at the broader context of Marketplace coverage, NRHA notes that enhanced premium tax credits (ePTCs) are set to expire on December 31, 2025, without congressional action to extend them. In rural areas, ePTCs are saving rural enrollees an average of $890 per year, which is about 28% more than their urban counterparts. Rural residents also benefit the most from ePTCs, with benchmark premiums in rural areas being about 10% higher than in urban areas.[6] This presents yet another catastrophic loss of health coverage for rural residents, coupled with CMS' proposals. Affordable, accessible health insurance is key to improving rural health outcomes and making America healthy again, a core component of this Administration's work. Coverage losses only serve to reduce the number of individuals seeking primary and preventive care, increase expensive emergency department utilization, and worsen population health. This is especially true in rural areas where health indicators lag behind those in urban areas.

NRHA thanks CMS for its work on behalf of rural Americans. If you have any questions or would like any further information, please contact NRHA's Government Affairs and Policy Director, Alexa McKinley Abel at amckinley@ruralhealth.us.

[6] Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, *Access to Health Care in Rural America: Current Trends and Key Challenges*, 11 (Oct 31, 2024) https://nrha-prod-eastus-be.azure.silvertech.net/NationalRuralHealth/media/Documents/Advocacy/2025/rural-health-rr-30-Oct-24.pdf.

Sincerely,



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