United States Department of Health and Human Services
Centers for Medicare and Medicaid Services
Re: CMS-9884-P

April 7, 2025

Gentlepersons;

The American Public Health Association (APHA) and individual health law and policy scholars appreciate the opportunity to submit these comments on the above-captioned regulations.

On behalf of its more than 23,000 members, APHA advocates for the power of public health policy to make communities safer and is committed to improving health equity in the United States. The individual signers are distinguished scholars and researchers whose expertise spans a variety of public health disciplines and who possess extensive expertise in connection with the issues raised by these proposed rules. In particular, they possess deep knowledge about the Affordable Care Act and the potential impact of the proposed policy changes on coverage, access, health outcomes, and population health.

We consider these rules highly problematic from both a law and policy perspective. In its Impact Statement, CMS estimates that the cumulative effect of the changes it puts forth will be to disinsure between 750,000 and 2 million people.[1] CMS claims that widespread disinsurance is the proper response to two distinct problems: consumer complaints regarding improper enrollments; and the need to "provide relief from rising health care costs".[2] We are unaware of any authority that would support the proposition that disinsuring up to 2 million people represents a reasonable response to either high health care costs or concern over improper enrollments. Indeed, CMS notes in its analysis that eliminating coverage for millions will likely shift costs onto those who remain insured and who will experience higher health care prices as a result. Furthermore, experts have identified numerous steps that can be taken to protect consumers from improper industry behavior. [3]

Ultimately CMS reveals the true purposes of its proposed rule: to "provide premium relief to families who do not qualify for federal premium subsidies and reduce the burden of the ACA premium subsidy expenditures to the Federal taxpayer."[4] In other words, the agency considers poor consumers bad health risks and costly to taxpayers and proposes to address the problem by

[1] 90 Fed. Reg. 13025 (March 19, 2025)
[2] 90 Fed. Reg. 12942
[3] Justin Giovannelli and Stacey Pogue, *Policymakers Can Protect Against Fraud in the ACA Marketplaces Without Hiking Premiums* (Commonwealth Fund, 2024) https://www.commonwealthfund.org/blog/2025/policymakers-can-protect-against-fraud-aca-marketplaces-without-hiking-premiums (Accessed April 2, 2025)

[4] Id.

depriving them of the premium tax credits and enrollment opportunities to which they are entitled under law. The agency's concern over health costs makes its proposal to exclude DACA recipients especially ironic, given CMS's own admission that the population is relatively young and healthy and likely has an overall positive impact on premium costs.

Beyond CMS's effort to disenroll low-income consumers is its proposal to adopt a policy to exclude coverage of medically necessary gender-affirming care as an essential health benefit (EHB). CMS lacks the legal authority under the ACA to carve otherwise covered medically necessary treatments out of the EHB definition because agency officials disfavor a particular, medically-recognized diagnosis or condition. Furthermore, Section 1557 of the ACA,[5] the landmark civil rights statute that governs all federally assisted health care programs, prohibits CMS from effectively ordering federally-assisted health care entities to discriminate on the basis of sex by withholding otherwise covered services based on a diagnosis of gender dysphoria.

The health insurance marketplace is a vital source of affordable health insurance coverage for millions of people

According to CMS,[6] as of January 17, 2025, 24.2 million consumers had selected a Marketplace plan for 2025. The great majority (20.2 million) had active coverage in 2024 and had either selected a 2025 plan or were automatically re-enrolled. As CMS points out, since the Exchanges became operational and premium tax credits became available, the Marketplace has grown in size and importance, with notable growth in the wake of legislative reforms enacted by Congress under the Biden administration to increase the generosity of the premium tax credit.[7] The substantial premium savings afforded by premium tax credits have made it possible for millions of people to gain insurance for themselves and their families.[8]

Given the high cost of job-based health insurance,[9] it is not surprising that employment-based insurance covers only 53.7% of the working-age population – a slight downturn from the

[5] 42 U.S.C. § 18116

[6] CMS, Marketplace 2025 Open Enrollment Period Report: National Snapshot, https://www.cms.gov/newsroom/fact-sheets/marketplace-2025-open-enrollment-period-report-national-snapshot-2 (accessed March 28, 2025)

[7] American Rescue Plan Act (Pub. L. 117-2, 2021); Inflation Reduction Act (Pub. L. 117-69, 2022). See, Cong. Research Service, *Health Insurance Premium Tax Credits and Cost Sharing Reductions* (Feb. 2025), available at file:///C:/Users/sarar/Downloads/R44425.28.pdf (Accessed March 28, 2025)

[8] Carson Richards and Sara R. Collins, *Enhanced Premium Tax Credits for ACA Health Plans: Who They Help, and Who Gets Hurt If They're Not Extended* (Commonwealth Fund, 2025) https://www.commonwealthfund.org/publications/explainer/2025/feb/enhanced-premium-tax-credits-aca-health-plans (Accessed April 2, 2025)

[9] Kristen Kolb et al., *How Affordable is Job-Based Health Coverage for Workers?* (Commonwealth Fund, 2025) https://www.commonwealthfund.org/blog/2025/how-affordable-job-based-health-coverage-workers (Accessed April 2, 2025)

preceding year.[10] For this reason, affordable health plans purchased through Exchanges have become a staple of the U.S. approach to insuring the population, in this case for individuals and families without access to affordable employer coverage and ineligible for Medicare or Medicaid. Exchange plans play an especially prominent role for low-income individuals and families because the ACA's premium tax credits have placed comprehensive health insurance within reach of a population historically without access to coverage, either because their employers offer none, or because they cannot afford the plans available to them. As of 2024, 93% of all Marketplace policyholders received advance premium tax credits, and 50% received additional assistance through cost-sharing reductions.[11]

The coverage made available through the qualified health plans sold through Exchange-operated Marketplaces is comprehensive. Qualified health plans must offer essential health benefits (EHBs) [12] covering a full range of health services, along with cost-sharing reduction assistance for eligible people. The scope of the EHB package ranges from population-wide no-cost preventive screening and treatment procedures to comprehensive medical care and additional oral and vision care for children.[13] In defining the scope of EHBs, the Secretary must take into account "the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups".[14] The EHB package is defined in relation to a "typical employer plan," and states have broad discretion to select the employer plan benchmark against which the EHB package is to be measured.

Outside of ensuring adherence to the essential health benefit coverage parameters and preventing discrimination against groups of enrolled people, the Secretary has no authority to impose condition-based exclusions on health plans, providers, or enrollees. Furthermore, CMS must administer the ACA in accordance with the protections afforded by U.S. civil rights laws, most notably in this instance, Section 1557 of the ACA, which bars discrimination by federally assisted health care entities on the basis of race, color, national origin, age, disability, and sex.

[10] Katherine Keisler-Starkey and Lisa N. Bunch, Health Insurance Coverage in the United States: 2023 (United States Census Bureau, Current Population Reports), available at https://www2.census.gov/library/publications/2024/demo/p60-284.pdf (Accessed March 28, 2025)
[11] KFF, Effectuated Marketplace Effectuated Enrollment and Financial Assistance (2024), available at https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (Accessed March 28, 2025)
[12] 42 U.S.C. § 18022
[13] CMS, Information on Essential Health Benefits Benchmark Plans, available at https://www.cms.gov/marketplace/resources/data/essential-health-benefits (Accessed March 28, 2025)
[14] 42 U.S.C. § 18022 (b)(4).

Expanded insurance coverage under the ACA is associated with significant improvements in access to the most effective forms of health care

Access to affordable coverage provides people with extraordinarily important benefits. At its core, insurance provides greater financial security in the event of serious illness or injury.[15] Beyond this, the health insurance reforms made by the ACA have had a demonstrably significant impact on access to highly effective health care services shown to reduce mortality and morbidity.[16] ACA plans guarantee policyholders hundreds of free-of-charge, evidence-based preventive services across the full lifespan,[17] ranging from newborn screening and health services that promote childhood and adolescent growth and development to comprehensive family planning, ACIP-recommended immunizations, hypertension management, diabetes and cancer screening, and preventive therapies for people living with HIV. The essential health benefits included in the subsidized qualified health plans made available through the Marketplace ensure that for a full range of health conditions, medically necessary treatments through a participating provider network will be insured.

ACA coverage has achieved more than coverage. Marketplace health plans have made evidence-based preventive services free-of-charge coverage and care, not only reducing the percentage of uninsured Americans but improving access to care itself. As HHS itself has reported:

> The ACA coverage expansions . . . have fueled a dramatic growth of studies that have contributed to our understanding of the effects of health insurance on both health outcomes and other outcomes related to individual and societal well-being. This research finds effects of health insurance coverage on improved access to care, increased utilization of preventive care, better health outcomes, financial benefits, and reduced income inequality. Measures of access and affordability, such as having a routine checkup and fewer problems accessing care, improved for adults at all income levels and regardless of state expansion status, though some impacts, such as reductions in problems paying family medical bills, unmet needs for care because of cost, and not having a usual source of care, were more pronounced for lower income groups. As disparities in health insurance coverage related to race and ethnicity decreased, so too did disparities in access to care.[18]

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[15] American Hospital Association, *The Importance of Health Coverage* https://www.aha.org/guidesreports/report-importance-health-coverage (Accessed online March 29, 2025); National Academy of Science, *Coverage Matters* (National Academy Press, 2003); Andrew Friedson, *health Insurance is Financial Protection* (Milken Institute, 2024) https://milkeninstitute.org/article/health-insurance-financial-protection (Accessed online March 29, 2025)

[16] Thomas Buchmueller et al., Improving Access to Affordable and Equitable Health Coverage: A Review from 2010 to 2024 (HHS ASPE, 2024), https://aspe.hhs.gov/sites/default/files/documents/9376755db2480ad7288aaa5ec38f3d8c/improving-access-to-coverage.pdf (Accessed online March 29, 2025)

[17] Healthcare.gov, *Preventive Health Services* https://www.healthcare.gov/coverage/preventive-care-benefits/ (Accessed online March 29, 2025)

[18] Id.

In sum, the ACA's achievement in insuring millions through affordable Marketplace plans in turn has improved access to timely, effective health care and reduced the financial and medical burden of illness. For this reason, it is incumbent on CMS to approach any policy reforms that implicate access to affordable coverage with the utmost care. Of special concern, in light of HHS's own conclusion regarding the heightened role of health insurance for lower income populations, are changes that could lead to the disinsurance of low-income Marketplace consumers; in Medicaid nonexpansion states, where eligibility for ACA subsidies drops to 100% of the federal poverty level, these numbers swell still further. [19]

Rather than addressing improper industry practices, CMS proposes to disinsure millions of people.

To address improper enrollment and renewal practices by the insurance industry, one would expect CMS, as the lead federal regulatory agency, to adopt heightened enforcement policies and to expand its work with state departments of insurance to curb improper conduct that harms low-income Marketplace consumers. Indeed, these approaches have been under consideration within CMS for some time. [20]

Instead, CMS has elected a radically different approach aimed at barring up to two million consumers, by the agency's own estimates, from having access to affordable insurance through a streamlined enrollment and renewal process. Rather than addressing fraud, the rules act as a systematic block to affordable coverage. Several proposals are deeply concerning and are totally nonresponsive to the problem of improper enrollment. One proposal (euphemistically titled "additional consumer protections") would terminate automatic renewal for consumers entitled to full advance premium tax credits (APTCs). Instead, they would be required to reapply for assistance; if they do not, they would be charged a $5.00 monthly premium until they reapply. Not only does this appear to be a direct violation of their premium entitlement, but CMS appears to be deliberately pursuing a policy known to be deeply unworkable in the case of low-income consumers who, as federal regulators have documented, experience extensive unbanking.[21]

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[19] Jennifer Tolbert et al., *A Look at ACA Coverage through the Marketplaces and Medicaid Expansion Ahead of Potential Policy Changes* (KFF, 2025) https://www.kff.org/affordable-care-act/issue-brief/a-look-at-aca-coverage-through-the-marketplaces-and-medicaid-expansion-ahead-of-potential-policy-changes/ (Accessed online March 29, 2025)

[20] NPR, How the government is trying to stop rogue brokers from plaguing ACA enrollees (May 7, 2024), https://www.npr.org/sections/health-shots/2024/05/07/1249417648/aca-health-insurance-brokers-obamacare-stop-fraud (Accessed March 29, 2025)

[21] Federal Deposit Insurance Corporation, 2023 FDIC National Survey of Unbanked and Underbanked Households, https://www.fdic.gov/household-survey (Accessed March 29, 2025)

Another policy proposal would terminate the monthly special enrollment period (SEP) for the lowest income consumers, a critical reform aimed at easing access for a population whose monthly income fluctuations may require more frequent shifts between Medicaid and Marketplace subsidies. Still other proposals would add verification requirements to consumers who seek to enroll during a special enrollment period (SEP). DACA recipients, whose presence in the Marketplace is considered beneficial to the risk pool by CMS because of their age and health status, would be barred from enrolling.

CMS acknowledges that these shifts in policy will take a high toll on coverage of the lowest-income consumers. At the same time, the agency essentially fails to present detailed evidence weighing the gains achieved by excluding people from coverage against the individual and population-wide impact of disinsuring millions.

CMS lacks either the legal authority or the evidence to exclude gender-affirming care as an essential health benefit

CMS proposes to exclude gender affirming care for transgender people as an essential health benefit. The agency begins by justifying its action on several grounds: Executive Order (EO) 14168, Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, Executive Order 14187, Protecting Children from Chemical and Surgical Mutilation", and the Secretary's authority under the ACA to implement the essential health benefit statute, 42 U.S.C. §18022. CMS then recognizes that two federal courts have enjoined agency actions based on both EOs as unlawful[22] and instead relies exclusively on its ACA essential health benefit authority. CMS simply bypasses the fact that Section 1557 of the ACA bars the agency from administering federal health care laws in a manner that would require federally assisted health care entities, including insurers, plan administrators, and health care providers, from discriminating against individuals on the basis of sex.

Furthermore, despite the fact that essential health benefits must, by statute, reflect the range of benefits and services covered under a typical employer plan,[23] CMS offers no evidence that coverage of medically necessary gender-affirming treatment is not typical of today's employer plans. Instead the agency simply asserts that limited data show that such care (which the agency improperly refers to as "sex trait modification") is rare. This is obviously the case for countless types of advanced health care for rare conditions, a fact that does not justify excluding any form of medically accepted, clinically appropriate treatment for rare conditions. Indeed, in the case of gender-affirming care, half of all states (including the District of Columbia) mandate treatment for gender dysphoria as a state employee health plan benefit,[24] and evidence further shows that nearly three-quarters of Fortune 500 companies cover such services.[25] As one expert analysis

[22] 90 Fed. Reg. 12986
[23] 42 U.S.C. § 18022(b)(2)(A)
[24] MAP, *Health Care Laws and Policies* https://www.mapresearch.org/equality-maps/healthcare_laws_and_policies (Accessed March 30, 2025)
[25] Human Rights Campaign, *Corporate Equality Index* (2025), https://reports.hrc.org/corporate-equality-index-2025 (Accessed March 30, 2025)

points out, CMS's assumption that not all states mandate such coverage as a health insurance benefit lacks any meaning, since half of all states have interpreted their state health laws to bar discrimination against people with gender dysphoria.[26]

In *Bostock v Clayton County* (590 U.S. 644, (2020)), the United States Supreme Court held that discrimination against people who are transgender constituted discrimination on the basis of sex. Thus, Section 1557 properly bars coverage exclusions that discriminate by withholding effective treatment for gender dysphoria. CMS has no legal authority to order federally assisted health care entities to engage in prohibited discrimination.

CMS fails to account for the harms caused by its policy of disinsuring an estimated two million people

The United States Supreme Court has made clear that in order to avoid being considered arbitrary and capricious and therefore a violation of the Administrative Procedure Act, an agency must demonstrate that it has considered the important aspects of the problem before the agency.[27] In the case of the policies under consideration in this proposed rule, this means that the agency must carefully weigh the health, health care, and population health impact of disinsuring up to two million people against other remedies for addressing improper industry marketing and enrollment practices or health care costs. By failing to do so, the proposed rule fails this basic test of lawfulness.

The range of policy reforms with a major coverage access impact that CMS proposes is breathtaking: exclusion of DACA recipients from the Marketplace; allowing insurers to charge for past-due premiums before commencing new coverage; denial of coverage for failure to reconcile prior year credits; shortening the open enrollment period; imposing new pre-enrollment verification burdens; effectively depriving consumers entitled to full premium tax credits of their ability to auto-renew their coverage without a financial penalty; adding verification burdens to the use of SEPs; and ending the monthly open enrollment period for the lowest-income consumers. CMS readily acknowledges that the cumulative effects of these reforms will be widespread loss of coverage and ongoing ineligibility for coverage that previously would have been available.

But outside of noting in passing that the uninsured rate will rise, the health care system will experience more bad debt, and poor consumers will become more cost conscious and gain "increased price sensitivity to premiums",[28] CMS offers no analysis of the impact of depriving so

[26] Katie Keith and Jason Levitis, HHS Proposes To Restrict Marketplace Eligibility, Enrollment, And Affordability In First Major Rule Under Trump Administration (Part 1), https://www.healthaffairs.org/content/forefront/hhs-proposes-restrict-marketplace-eligibility-enrollment-and-affordability-first-major (Accessed March 30, 2025)

[27] *Department of Homeland Security v Regents of the University of California* (2020). https://www.supremecourt.gov/opinions/19pdf/18-587_5ifl.pdf (Accessed March 30, 2025)

[28] 90 Fed. Reg. 13014

many people of coverage. The agency notes that its provisions "may work in concert with each other and affect many of the same individuals seeking coverage through the individual insurance market."[29] This is an admission, of course, that the agency is seeking, through a broad range of policies, to limit access to subsidized Marketplace plans in furtherance of what CMS states in the Preamble are its fundamental aims: to benefit consumers who pay the full premium price; and to advance taxpayer interests as it defines those interests.

Overwhelming evidence points to the fact that it is most definitely *not* in the interest of either consumers who pay the full premium price or taxpayers to deprive two million people of insurance coverage. Decades of research have documented the negative individual, community-wide, and population health impact of high uninsured rates. Indeed, it was this research that led, in great part, to passage of the Affordable Care Act whose advances, especially for low-income consumers, CMS now proposes to curtail.

Even a cursory review of the evidence points to the severe consequences of being uninsured.

Diminished access to preventive and primary health care

As we have noted, one of the ACA's most important advances is its guarantee of comprehensive preventive care without cost-sharing. People who lose ACA coverage lose these benefits, of course. The evidence shows that a lack of insurance decreases the use of preventive services,[30] and clearly shows a connection between preventive care and decreased morbidity and mortality.[31] [32] [33] Uninsured individuals are more likely to have hospitalizations that could have been avoided with access to preventive care, and, when hospitalized, receive fewer diagnostic and therapeutic services and have higher mortality rates than individuals with insurance.[34] Uninsured adults are more likely to be hospitalized for chronic conditions such as diabetes and

[29] 90 Fed. Reg. 13020

[30] *Healthy People 2030* https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care#:~:text=Lack%20of%20health%20insurance%20decreases,associated%20with%20poor%20health%20outcomes.&text=Individuals%20without%20health%20insurance%20may,such%20as%20diabetes%20or%20hypertension. (Accessed March 30, 2025)

[31] Institute of Medicine (US) Committee on Health Insurance Status and Its Consequences. (2009). *America's Uninsured Crisis: Consequences for Health and Health Care*. National Academies Press. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK214966/. DOI: 10.17226/12511

[32] Healthy People 2030 (n.d.). *Access to Primary Care.* U.S. Department of Health and Human Services: Office of Disease Prevention and Health Promotion. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care

[33] Horstman, C., Baumgartner, J. C., & Shah, A. (2023, January 5). *Millions Could Lose Access to Free Preventive Care Services.* The Commonwealth Fund. https://www.commonwealthfund.org/blog/2023/millions-could-lose-access-free-preventive-care-services#:~:text=Losing%20the%20Preventive%20Service%20Provision%20Could%20Impact,require%20cost%20sharing%20for%20these%20critical%20services.

[34] Tolbert, J., Cervantes, S., Bell, C., & Damico, A. (2024, December 18). *Key Facts about the Uninsured Population.* KFF. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

hypertension that could otherwise be managed by a primary care provider.[35] Uninsured individuals are also less likely to receive recommended screenings including blood pressure checks, cholesterol checks, blood sugar screening, pap smear or mammogram, and colon cancer screening, and have an increased risk of being diagnosed later for certain diseases such as cancer.[36] Similarly, uninsured children are less likely to receive preventive services such as dental care and immunizations.[37] [38] Studies show that having insurance increases children's access to preventive care by up to 15%.[39]

Uninsured adults are four times more likely than insured adults to report not having a usual source of care, the access point to primary and preventive care for many.[40] Going without primary care makes it more difficult for uninsured individuals to navigate the health care system, uncover health conditions early, and manage chronic diseases.[41] [42] It also decreases continuity of care and care coordination, which are important for reducing adverse health outcomes.[43] [44]

Primary and preventive care are important for increasing population health outcomes and also play an essential role in promoting health equity.[45] [46] The proposed rule would have a catastrophic impact on health care access and health outcomes.

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[35] Healthy People 2030 (n.d.). *Access to Primary Care*. U.S. Department of Health and Human Services: Office of Disease Prevention and Health Promotion. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care

[36] Garfield, R., Majerol, M., Damico, A., & Foutz, J. (2016, November). *The Uninsured: A Primer.* The Kaiser Family Foundation. https://files.kff.org/attachment/Report-The-Uninsured-A%20Primer-Key-Facts-about-Health-Insurance-and-the-Unisured-in-America-in-the-Era-of-Health-Reform

[37] Healthy People 2030 (n.d.). *Access to Health Services.* U.S. Department of Health and Human Services: Office of Disease Prevention and Health Promotion. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services#cit10

[38] Healthy People 2030 (n.d.). *Access to Primary Care.* U.S. Department of Health and Human Services: Office of Disease Prevention and Health Promotion. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care

[39] Institute of Medicine (US) Committee on Health Insurance Status and Its Consequences. (2009). *America's Uninsured Crisis: Consequences for Health and Health Care*. National Academies Press. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK214966/. DOI: 10.17226/12511

[40] Tolbert, J., Singh, R., & Drake, P. (2024, May 28). *The Uninsured Population and Health Coverage.* KFF. https://www.kff.org/health-policy-101-the-uninsured-population-and-health-coverage/?entry=table-of-contents-introduction

[41] *Primary Care*. (2023, August 14). CMS.gov. Retrieved March 21, 2025 from https://www.cms.gov/priorities/innovation/key-concepts/primary-care#:~:text=Primary%20care%20is%20important%20for%20patient%20health&text=They%20may%20also%20serve%20as,on%20top%20of%20chronic%20diseases.

[42] Savoy, M., Hazlett-O'Brien, C., & Rapacciuolo, J. (2017). The Role of Primary Care Physicians in Managing Chronic Disease. *Delaware journal of public health*, *3*(1), 86–93. https://doi.org/10.32481/djph.2017.03.012

[43] Goodwin, J. S. (2021). Continuity of Care Matters in All Health Care Settings. *JAMA Netw Open, 4*(3):e213842. https://10.1001/jamanetworkopen.2021.3842

[44] Care Coordination (2024, November). Agency for Healthcare Research and Quality. Retrieved March 21, 2025 from https://www.ahrq.gov/ncepcr/care/coordination.html

[45] Rittenhouse, D. R., O'Malley, A.S. (2024). Primary Care's Essential Role in Advancing Health Equity. *The Journal of the American Board of Family Medicine, 37:S1–S3.* https://doi.org/10.3122/jabfm.2023.230423R0

[46] Waldrop, T. (2023, March 21). *Access to Preventive Care Is Essential to Achieving Health Equity*. The Century Foundation. https://tcf.org/content/commentary/access-to-preventive-care-is-essential-to-achieving-health-equity/

Forgoing needed health care

Being uninsured causes people to forgo needed care, and uninsured individuals are more likely to forgo needed care than insured individuals.[47] In 2023, 46.6% of uninsured adults had not seen a doctor within the last year, compared to 15.5% of adults with private insurance and 14.2% with public insurance. Furthermore, of the adults who had gone without care in the past year, 22.6% of uninsured adults indicated that they went without needed care because of the cost, compared to only 5.1% of adults with private insurance and 7.7% of adults with public insurance. Similarly, uninsured children were also more likely to forgo care than insured children, with 9.5% of children going without needed care due to cost in 2023 compared to 0.7% of children with private insurance and 1.0% of children with public insurance.[48]

Studies demonstrate that individuals who forgo needed health care experience higher rates of morbidity and mortality, [49] and 41% of adults who delayed care due to cost reported that a health problem worsened as a result.[50] Individuals without insurance are more likely to delay necessary care, with attendant health consequences. [51]

Personal financial impact

Uninsurance reduces the likelihood that individuals seek care. However, when they do seek care, uninsured individuals often face unaffordable medical bills that can lead to financial hardship or medical debt, and hospitals often charge uninsured individuals more than insured individuals for the same services.[52] Nearly half (49%) of all uninsured adults reported that they or a family member have trouble paying for health care compared to 21% of insured adults, and 62% of uninsured adults have medical debt, compared to 44% of insured adults. Moreover, as a result of

[47] Healthy People 2030 (n.d.). *Access to Primary Care.* U.S. Department of Health and Human Services: Office of Disease Prevention and Health Promotion. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care

[48] Tolbert, J., Cervantes, S., Bell, C., & Damico, A. (2024, December 18). *Key Facts about the Uninsured Population.* KFF. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

[49] Tanne J. H. (2008). More than 26,000 Americans die each year because of lack of health insurance. *BMJ (Clinical research ed.)*, *336*(7649), 855. https://doi.org/10.1136/bmj.39549.693981.DB

[50] Collins, S. R., Gupta, A. (2024, November 21). *The State of Health Insurance Coverage in the U.S.* The Commonwealth Fund. https://www.commonwealthfund.org/publications/surveys/2024/nov/state-health-insurance-coverage-us-2024-biennial-survey

[51] Tolbert, J., Cervantes, S., Bell, C., & Damico, A. (2024, December 18). *Key Facts about the Uninsured Population.* KFF. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

[52] Tolbert, J., Cervantes, S., Bell, C., & Damico, A. (2024, December 18). *Key Facts about the Uninsured Population.* KFF. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

these high health expenses, many uninsured adults have difficulty maintaining their savings and paying for basic living expenses,[53] including rent, food, and utilities.[54]

The especially harsh impact of being uninsured on low-income people

The proposed rules will disproportionately affect low-income populations. Low- and moderate-income families already make up the vast majority of the uninsured population, with half having a family income at or below 200% of poverty.[55] While low income contributes to high morbidity, high morbidity also contributes to low income, creating a negative cycle that is referred to as the health-poverty trap.[56] Low-income adults are five times as likely to report being in poor or fair health than middle- or high-income adults, and have higher rates of smoking, obesity, substance use, and chronic stress.[57] Low-income individuals also have lower maternal and child health outcomes.[58] Furthermore, Black Americans are more likely to have lower income and higher morbidity and mortality than White Americans.[59] Therefore, the proposed rule will also have a disproportionate burden on Black communities, who already have worse health outcomes, thereby exacerbating health inequity on the basis of race.

Impact of out-of-pocket health care costs

CMS proposes to charge people entitled to zero-premium insurance $5.00 monthly until they reapply for assistance at the start of each new plan year. This requirement acts as an economic barrier to health care. Research shows that cost-sharing among low-income populations reduces

[53] Tolbert, J., Cervantes, S., Bell, C., & Damico, A. (2024, December 18). *Key Facts about the Uninsured Population.* KFF. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

[54] Garfield, R., Majerol, M., Damico, A., & Foutz, J. (2016, November). *The Uninsured: A Primer.* The Kaiser Family Foundation. https://files.kff.org/attachment/Report-The-Uninsured-A%20Primer-Key-Facts-about-Health-Insurance-and-the-Unisured-in-America-in-the-Era-of-Health-Reform

[55] Garfield, R., Majerol, M., Damico, A., & Foutz, J. (2016, November). *The Uninsured: A Primer.* The Kaiser Family Foundation. https://files.kff.org/attachment/Report-The-Uninsured-A%20Primer-Key-Facts-about-Health-Insurance-and-the-Unisured-in-America-in-the-Era-of-Health-Reform

[56] Khullar, D., Chokshi, D. A. (2018, October 4). *Health, Income, & Poverty: Where We Are & What Could Help.* Health Affairs. https://www.healthaffairs.org/content/briefs/health-income-poverty-we-could-help

[57] Khullar, D., Chokshi, D. A. (2018, October 4). *Health, Income, & Poverty: Where We Are & What Could Help.* Health Affairs. https://www.healthaffairs.org/content/briefs/health-income-poverty-we-could-help

[58] Woolf, S. H., Aron, L., Dubay, L., Simon, S., Zimmerman, E., & Luk, K. X. (2015, April). *Income and Health Initiative: Brief One: How are income and wealth linked to health and longevity?* Urban Institute. https://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf#:~:text=Health%20and%20Have%20a%20Higher%20Risk%20of,chronic%20disorders%20than%20wealthier%20Americans%20(table%201).

[59] Khullar, D., Chokshi, D. A. (2018, October 4). *Health, Income, & Poverty: Where We Are & What Could Help.* Health Affairs. https://www.healthaffairs.org/content/briefs/health-income-poverty-we-could-help

coverage, decreases access to care, increases the financial burden of care, and is associated with worse health outcomes including increased mortality.[60] [61]

Economic impact

Increases in uninsurance have consequences not only for individual financial wellbeing but also the financial wellbeing of whole communities and economies. Increases in insurance will lead to a rise in uncompensated care costs across the country, affecting health providers and federal, state, and local governments.[62] In 2017, over two-thirds ($33.6 billion) of uncompensated care costs were paid with public funds.[63] Uncompensated care hits nonprofit hospitals especially hard,[64] and has been shown to lead to hospital closures in rural areas.[65] High uninsured rates also contribute to strain on community health centers and other safety net providers due both to uncompensated care costs and because uninsured individuals have more health problems and poorer health.

Barriers to enrollment

Confusion and limited understanding of the enrollment process as well as administrative obstacles and complexity of insurance plan materials are known barriers to health insurance

[60] Guth, M., Ammula, M., & Hinton, E. (2021, September 9). *Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers.* KFF. https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/

[61] Kaplan, E., & Dairkee, A. (2024). The Broken Link: Braidwood, the United States Preventive Services Task Force (USPSTF), and the Health Equity Implications of Losing Free Access to Preventive Care. *American Journal of Law & Medicine*, *50*(1–2), 100–120. doi:10.1017/amj.2024.18

[62] Broaddus, M. (2020, October 21). *Uncompensated Care Costs Well Down in ACA Medicaid Expansion States.* Center on Budget and Policy Priorities. https://www.cbpp.org/blog/uncompensated-care-costs-well-down-in-aca-medicaid-expansion-states

[63] Coughlin, T. A., Samuel-Jakubos, H., & Garfield, R. (2021, April 6). *Sources of Payment for Uncompensated Care for the Uninsured.* KFF. https://www.kff.org/uninsured/issue-brief/sources-of-payment-for-uncompensated-care-for-the-uninsured/

[64] *Who Bears the Cost of the Uninsured? Nonprofit Hospitals.* (2015, June 22). Kellogg Insight. Retrieved March 21, 2025, from https://insight.kellogg.northwestern.edu/article/who-bears-the-cost-of-the-uninsured-nonprofit-hospitals

[65] Tolbert, J., Cervantes, S., Bell, C., & Damico, A. (2024, December 18). *Key Facts about the Uninsured Population.* KFF. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

enrollment.[66] [67] [68] [69] The proposed rule will make Marketplace enrollment more confusing, thereby creating an enrollment barrier. Furthermore, some studies show that Black individuals, individuals with mental health problems, those with less education, and women are already more likely to experience insurance enrollment barriers.[70] Therefore, enrollment barriers that result from this proposed rule could exacerbate health inequity based on race, health status, education, and gender.

The impact on critical health services

Contraceptives and family planning. Loss of ACA coverage means loss of contraception and related preventive reproductive health care. Contraception is the critical means for preventing unwanted pregnancies and has been shown to have a large positive impact on access to education, labor force participation, and earnings.[71] [72]

Cancer treatment. Being uninsured will cause individuals to lose access to important preventive cancer screenings. The ACA guarantees free access to clinically recommended colorectal cancer screenings, which have lowered colorectal cancer mortality rates.[73] In addition, the decline in cervical cancer can be attributed to the ACA's preventive service provisions related to screening

[66] Martin, L. T., Bharmal, N., Blanchard, J. C., Harvey, M., & Williams, M. (2015). Barriers to Enrollment in Health Coverage in Colorado. *Rand health quarterly*, *4*(4), 2.
[67] Giovannelli, J., Curran, E. (2016, July 22). *Factors Affecting Health Insurance Enrollment Through the State Marketplaces: Observations on the ACA's Third Open Enrollment Period*. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2016/jul/factors-affecting-health-insurance-enrollment-through-state
[68] Young, C. L., Capretta, J. C., Dorn, S., Kendall, D., & Antos, J. R. (2020, August 17). *How To Boost Health Insurance Enrollment: Three Practical Steps That Merit Bipartisan Support.* Health Affairs. https://www.healthaffairs.org/content/forefront/boost-health-insurance-enrollment-three-practical-steps-merit-bipartisan-support
[69] Kennedy, A. J., Bakalov, V., Reyes-Uribe, L., Kensler, C., Connor, S. E., Benson, M., Bui, T., & Radomski, T. R. (2020). Free Clinic Patients' Perceptions and Barriers to Applying for Health Insurance After Implementation of the Affordable Care Act. *Journal of community health*, *45*(3), 492–500. https://doi.org/10.1007/s10900-019-00766-y
[70] Stuber, J., & Bradley, E. (2005). Barriers to Medicaid enrollment: who is at risk?. *American journal of public health*, *95*(2), 292–298. https://doi.org/10.2105/AJPH.2002.006254
[71] Waldrop, T. (2023, March 21). *Access to Preventive Care Is Essential to Achieving Health Equity*. The Century Foundation. https://tcf.org/content/commentary/access-to-preventive-care-is-essential-to-achieving-health-equity/
[72] Horstman, C., Baumgartner, J. C., & Shah, A. (2023, January 5). *Millions Could Lose Access to Free Preventive Care Services.* The Commonwealth Fund. https://www.commonwealthfund.org/blog/2023/millions-could-lose-access-free-preventive-care-services#:~:text=Losing%20the%20Preventive%20Service%20Provision%20Could%20Impact,require%20cost%20sharing%20for%20these%20critical%20services.
[73] Horstman, C., Baumgartner, J. C., & Shah, A. (2023, January 5). *Millions Could Lose Access to Free Preventive Care Services.* The Commonwealth Fund. https://www.commonwealthfund.org/blog/2023/millions-could-lose-access-free-preventive-care-services#:~:text=Losing%20the%20Preventive%20Service%20Provision%20Could%20Impact,require%20cost%20sharing%20for%20these%20critical%20services.

and immunization.[74] Being uninsured is associated with the reduced likelihood of surviving cancer.[75]

Maternal and child health. The ACA has improved access to prenatal care, vital to healthy maternal and child health outcomes.[76] More than 80% of pregnancy-related deaths are preventable, and prenatal care reduces the likelihood of preventable maternal mortality.[77] In only seven states are Medicaid and CHIP eligibility standards during pregnancy set at 300% of the federal poverty level or higher, leaving most lower-income pregnant women without access to affordable insurance should they lose coverage.[78]

Community-wide effects of being uninsured

The effects of being uninsured are not confined to individuals. People who are low income, particularly those who are members of communities of color or other historically disadvantaged populations, tend to live in communities with more concentrated poverty.[79] In these communities, resources are fewer and as uninsured rates climb, those who lose their health insurance or are barred from coverage and who live in lower-income communities face greater barriers to finding basic health care.[80] Widespread uninsurance also affects the stability of the health care market itself, increasing the challenges health care providers face in anchoring and maintaining their services. A systematic review of research focusing on health care in urban areas concluded that the proportion of community residents who are uninsured affects access to care

[74] Sonfield, A. (2012, October 17). *Beyond Contraception: The Overlooked Reproductive Health Benefits of Health Reform's Preventive Services Requirement.* Guttmacher Policy Review. https://www.guttmacher.org/gpr/2012/10/beyond-contraception-overlooked-reproductive-health-benefits-health-reforms-preventive

[75] Yabroff, K. R., Reeder-Hayes, K., Zhao, J., Halpern, M. T., Lopez, A. M., Bernal-Mizrachi, L., Collier, A. B., Neuner, J., Phillips, J., Blackstock, W., & Patel, M. (2020). Health Insurance Coverage Disruptions and Cancer Care and Outcomes: Systematic Review of Published Research. *Journal of the National Cancer Institute*, *112*(7), 671–687. https://doi.org/10.1093/jnci/djaa048

[76] Sonfield, A. (2012, October 17). *Beyond Contraception: The Overlooked Reproductive Health Benefits of Health Reform's Preventive Services Requirement.* Guttmacher Policy Review. https://www.guttmacher.org/gpr/2012/10/beyond-contraception-overlooked-reproductive-health-benefits-health-reforms-preventive

[77] Preventing Pregnancy-Related Deaths. (2024, September 25). CDC. Retrieved March 24, 2025 from https://www.cdc.gov/maternal-mortality/preventing-pregnancy-related-deaths/index.html#:~:text=Starting%20prenatal%20care%20early%2C%20seeing,any%20potential%20problems%20during%20pregnancy.

[78] KFF State Health Facts, *Medicaid and CHIP Income Eligibility Limits for Pregnant Women 2003-2024* https://www.kff.org/medicaid/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (Accessed March 30, 2025)

[79] National Equity Atlas, *Neighborhood Poverty: United States* *https://nationalequityatlas.org/indicators/Neighborhood_poverty* (Accessed March 30, 2025)

[80] National Academy of Sciences, *A Shared Destiny: Community Effects of Uninsurance* (2003). file:///C:/Users/sarar/Downloads/82-119%20(1).pdf (Accessed March 30, 2025)

not only for those without coverage but also for the "ability of uninsured and of moderate- and lower-income residents to obtain needed and regular health care."[81]

For the foregoing reasons, we urge CMS to withdraw the proposed rules that alter access to coverage, given their cumulative impact on insurance and their harmful effects to individual and population health.

[81] Id.

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