The Enrollment Coalition

September 21, 2026

Dr. Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicaid Program; Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes (CMS-2452-P)

Administrator Oz,

On behalf of the Enrollment Coalition, we appreciate the opportunity to comment on the proposed rule amending the indirect hold harmless threshold for health care-related taxes. Our comments addressed one provision: the proposal to establish a new permissible class at § 433.56(a)(19) for "services of health insurers."

About the Enrollment Coalition

The Enrollment Coalition is an alliance of organizations from across the health care community – patient and consumer advocates, health plans, health care providers, employers, and technology and data organizations. Our mission is to help eligible uninsured individuals enroll in, and stay enrolled in, the coverage for which they already qualify. We believe a top policy priority for the coming years is ensuring that those eligible for coverage today are enrolled and retained.

Proposed Addition of "Services of Health Insurers"

In the proposed rule, CMS proposes to apply the indirect hold harmless threshold requirements to "services of health insurers." The description of "services of health insurers" resembles how many states fund State-Based Marketplace operations, Section 1332 reinsurance programs, and state affordability programs. If these activities are incorporated, states would be barred from creating a new assessment, and existing assessments would be frozen at their current level. The Enrollment Coalition is particularly concerned about the downstream effects of the proposal on consumers' ability to enroll in and retain health coverage.

Current law requires that each Exchange be self-sustaining, "including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations." State-Based Marketplaces rely on sustainable operating revenue to maintain eligibility and enrollment portals, call centers, plan-comparison tools, consumer notices, data interfaces, outreach campaigns, navigator programs, brokers, and other consumer-assistance functions.[1] For plan year 2027, 21 states and the District of Columbia operate their own Marketplaces, and two additional states operate State-Based Marketplaces on the federal platform.[2] Pennsylvania's user fee funds both Marketplace operations and the state's section 1332

[1] Section 1311(d)(5)(A) of the Affordable Care Act
[2] https://www.cms.gov/marketplace/in-person-assisters/training-webinars/training/marketplaces-map

reinsurance program.[3] New Jersey runs two separate assessments: one of 3.5 percent of individual market premiums, and up to 4.0 percent at the department's discretion, deposited in the Health Insurance Exchange Trust Fund to pay for exchange operations, outreach, and enrollment; and a second of 2.5 percent of net written premiums, imposed on entities that were subject to the federal section 9010 fee, deposited in the Health Insurance Affordability Fund and used for state subsidies and the state's reinsurance program.[4]

If an insurer assessment used to finance these activities is frozen or constrained, a State-Based Marketplace could face an effective operating-revenue restraints impacting a Marketplace's ability to:

- Maintain reliable enrollment and eligibility systems, including updating information technology systems and maintaining cybersecurity protections;
- Conduct broad and targeted outreach;
- Support navigators, assisters, brokers, and call centers;
- Improve coordination with Medicaid and CHIP;
- Process account transfers efficiently;
- Help consumers transition between coverage programs;
- Provide timely assistance during open enrollment and special enrollment periods; and
- Respond to federal eligibility and policy changes.

Additionally, the proposed framework could also disadvantage states that seek to establish a State-Based Marketplace, create a reinsurance program, or adopt a new affordability initiative after July 4, 2025. Applying those restrictions to non-Medicaid insurer assessments could eliminate one of the principal mechanisms states use to finance new coverage and enrollment initiatives. States that had acted before July 4, 2025 could retain at least some financing capacity, while states acting later could be prevented from adopting similar programs. That result would lock in historical differences among states and inhibit future innovation. The Enrollment Coalition encourage CMS to consider the effect on states now transitioning to state-based Marketplaces or evaluating section 1332 waivers. A rule that forecloses the primary financing mechanism for states that had not adopted it by July 4, 2025 would close that pathway for the remaining states.

This concern is especially significant as states and consumers adjust to substantial changes affecting Medicaid and individual-market coverage. States should retain reasonable flexibility to improve enrollment systems, establish affordable coverage options, facilitate transitions between programs, and respond to future changes in their insurance markets.

For these reasons, the Enrollment Coalition respectfully recommends that CMS ensure that assessments dedicated to State-Based Marketplace operations, Section 1332 reinsurance programs, state premium or cost-sharing assistance, and other non-Medicaid affordability initiatives are excluded from the proposed "services of health insurers" class. Accordingly, the Coalition recommends that CMS:

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[3] https://www.cbpp.org/research/health/adopting-a-state-based-health-insurance-marketplace-poses-risks-and-challenges
[4] https://pub.njleg.gov/publications/budget/governors-budget/2023/DOBI_response_2023.pdf ; https://pub.njleg.gov/bills/2020/AL20/61_.HTM; https://pub.njleg.state.nj.us/publications/budget/governors-budget/2027/dobi_response_2027.pdf

- State expressly, in regulation text rather than preamble, that assessments imposed on health insurers whose proceeds are dedicated exclusively to State-Based Marketplace operations, section 1332 reinsurance programs, state premium or cost-sharing assistance, or other non-Medicaid coverage purposes are outside the class; and
- In the alternative, sever the class from the balance of the rule — consistent with the severability provision CMS has included — and defer it pending a request for information establishing which assessments exist, which entities administer them, and what they fund. The remainder of the rule implements section 71115 and can be finalized on schedule without this provision.

Should CMS proceed with the class, the Coalition recommends that CMS:

- Apply the class prospectively, setting the applicable percent for services of health insurers based on assessments enacted and imposed as of the effective date of the final rule rather than July 4, 2025;
- Provide a longer remediation period for this class than the two-year period proposed for pre-existing classes, recognizing that adjusting assessments enacted for non-Medicaid purposes and administered outside the Medicaid agency will require state legislative action in many cases.

Of note, the regulatory impact analysis does not separately analyze the proposed health insurer class or estimate any effect on Marketplace enrollment, premiums, Marketplace operations, or state affordability programs. The Coalition recommends that CMS model the effects of the proposed class on Marketplace enrollment, individual market premiums, and State-Based Marketplace operating budgets, and publish that analysis for comment before finalizing.

Finally, the proposal to defer to state law in determining which entities are health insurers compounds the uncertainty. Functionally identical assessments could be treated differently across states based on how each state's insurance code is written, producing inconsistent federal treatment of similar arrangements — the opposite of the consistency the rule seeks. If CMS retains that approach, we encourage the agency to publish a crosswalk identifying how it understands each state's existing assessments to be classified, and to give states an opportunity to correct that understanding before thresholds are set.

Conclusion

The Enrollment Coalition is concerned that the proposed inclusion of "services of health insurers" could have significant unintended consequences for State-Based Marketplaces and the enrollment infrastructure that helps eligible individuals obtain and maintain health coverage. Preserving state flexibility to finance outreach, enrollment assistance, eligibility systems, and affordability programs is essential to maintaining coverage and preventing eligible individuals from falling through the cracks.

For these reasons, we respectfully urge CMS to exclude assessments that support State-Based Marketplace operations, Section 1332 reinsurance programs, and other non-Medicaid coverage and affordability initiatives from the proposed class, or alternatively defer finalizing this provision until CMS can fully evaluate its effects on consumers, state programs, and insurance markets. We appreciate CMS's consideration of these comments and look forward to continued engagement on

policies that promote enrollment, retention, and access to affordable health coverage. Please reach out to Laura Pence at laura.pence@leavittpartners.com with any questions.

Sincerely,

The Enrollment Coalition