NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
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April 11th, 2025

via electronic submission: http://www.regulations.gov

Centers for Medicare & Medicaid Services
45 CFR Parts 147, 155, and 156
CMS-9884-P
RIN 0938-AV61

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

To Whom it May Concern:

The New York City Department of Health and Mental Hygiene (the NYC Health Department) appreciates the opportunity to provide comments in response to the U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) proposed Marketplace Integrity and Affordability rule, published on March 19, 2025. The NYC Health Department strongly opposes and is concerned by several proposals in the rule that, if implemented, would threaten access to health coverage and services for New Yorkers.

Modifying Definition of "Lawfully Present" for Purposes of Eligibility and Enrollment

CMS solicits comments on modifying the definition of "lawfully present" under Section 1312 of the Patient Protection and Affordable Care Act (ACA) such that Deferred Action for Childhood Arrivals (DACA) recipients are no longer considered eligible for enrollment in a Qualified Health Plan (QHP), coverage under a Basic Health Program (BHP), and for premium tax credits (PTC), advance premium tax credits (APTC), and cost sharing reductions (CSR).

Under this proposal, an estimated 100,000 DACA recipients would lose eligibility for newly granted coverage that went into effect this benefit year.[1] This includes ~11,000 individuals who enrolled in coverage during 2025 Open Enrollment in states where the existing 2024 DACA Rule has

[1] Centers for Medicare and Medicaid Services. HHS Final Rule Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens. 3 May 2024. https://www.cms.gov/newsroom/fact-sheets/hhs-final-rule-clarifying-eligibility-deferred-action-childhood-arrivals-daca-recipients-and-certain

not been enjoined.[2,3] This proposal would also require State Based Exchanges (SBE) to exercise significant resources to modify eligibility systems, terminate existing coverage, and communicate coverage loss to affected consumers. For these reasons, the NYC Health Department makes the following recommendation:

***Recommendation #1*: CMS should maintain its current definition of "lawfully present" for the purposes of enrollment and eligibility, wherein DACA recipients are eligible for coverage under QHPs and BHPs, as well as application for PTCs, APTCs, and CSRs. This recommendation aligns with the NYC Health Department's previous stance supporting the 2024 DACA Rule (CMS-9894-P).**

CMS proposes that the DACA provision take effect immediately upon finalization of the broader Marketplace Integrity and Affordability rule. This means that DACA recipients who have already enrolled in coverage would suddenly lose eligibility in the middle of a plan year. And because many DACA recipients are employed in lower wage jobs[4] and/or industries that typically do not provide employer sponsored insurance (ESI), most would find themselves without affordable coverage options. In doing so, the proposed rule contradicts the Administration's purported goals of creating a healthier country and a more efficient health care system.

On average, DACA recipients tend to be young and healthy. Indeed, CMS concedes that DACA exclusion from the Marketplace may negatively impact the individual market risk pool.[5] Still, lack of insurance generally yields poorer health outcomes and greater health care spending, even among relatively healthy individuals. Numerous studies indicate that having a primary care provider or usual source of care – both of which are strongly influenced by insurance status[6] – improves continuity of and access to preventive services.[7] Consequently, lack of insurance impedes a person's ability to access primary care and specialty services.[8,9]

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[2] U.S. Department of Health and Human Services. CMS-0994-P: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability. 19 Mar 2025. Page 13000. https://www.federalregister.gov/d/2025-04083

[3] U.S. Department of Health and Human Services. CMS-9894-P: Clarifying Eligibility for a Qualified Health Plan Through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, a Basic Health Program, and for Some Medicaid and Children's Health Insurance Programs. 26 Apr 2023. https://www.federalregister.gov/d/2023-08635

[4] Kaiser Family Foundation. "Key Facts on Deferred Action for Childhood Arrivals (DACA)." 11 Feb 2025. https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/

[5] U.S. Department of Health and Human Services. CMS-0994-P: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability. 19 Mar 2025. Page 13010. https://www.federalregister.gov/d/2025-04083

[6] Glied S, Ma S, Borja A. Effect of the Affordable Care Act on health insurance access. The Commonwealth Fund. 8 May 2017. https://www.commonwealthfund.org/publications/issue-briefs/2017/may/effect-affordable-care-act-health-care-access

[7] Blewett LA, Johnson PJ, Lee B, Scal PB. When a usual source of care and usual provider matter: adult prevention and screening services. *J Gen Intern Med.* 2008;23(9):1354–1360. https://doi.org/10.1007/s11606-008-0659-0

[8] Institute of Medicine Committee on the Consequences of Uninsurance. "Care without coverage: too little, too late." Effects of Health Insurance on Health. Washington, DC: National Academies Press. 2002.

[9] Bovbjerg RR, Hadley J. Why Health Insurance Is Important. Urban Institute. November 2007. DC-SPG no.1. https://www.urban.org/sites/default/files/publication/46826/411569-Why-Health-Insurance-Is-Important.PDF

Barriers to primary care are associated with higher rates of preventable hospitalization and emergency department (ED) visits, which lead to greater costs for both patients and health care systems, especially when compared with regular primary care expenses.[10,11]

Beyond these impacts, the DACA provision presents significant technical and financial challenges for Exchanges. CMS estimates a collective 21,000 hours and one-time cost of $2 million for Federal and State Based Exchanges to modify their eligibility systems (1000 hours and over $97,000 per SBE). Similarly, CMS estimates a collective 18,000 hours and one-time cost of over $1.75 million for Federal and State Exchanges to terminate existing coverage (1000 hours and over $97,000 per SBE).[12] While CMS argues that terminated coverage will generate recovered savings over time, these estimates do not consider additional state and local spending to educate consumers about eligibility changes nor do they quantify the impact of uncompensated care and increased hospital and ED visits for preventable conditions.

In sum, this provision is harmful to the health and wellbeing of individuals who have federally recognized permission to live and work in the United States. It will also create significant costs and inefficiencies across Federal and State Based Exchanges as they are once again required to modify eligibility and terminate coverage for thousands of current enrollees.

Imposing Premiums Penalties for Automatically Re-Enrolled Consumers

CMS solicits comment on modifying the automatic re-enrollment process for consumers who are currently enrolled in a plan for which APTCs cover their entire premium costs. Under the proposed rule, these enrollees would be subject to a $5 monthly premium penalty until they verify their continued eligibility for coverage. This provision would take effect beginning plan year 2026 for the Federal Exchange and plan year 2027 for SBEs. The NYC Health Department believes that this provision would cause confusion among many New Yorkers and disruptions in their coverage without achieving the stated goals of increased consumer engagement or improved program integrity. We offer the following recommendation on this proposal:

***Recommendation #2*: CMS should not alter the automatic re-enrollment process for consumers paying no premium. Rather, the Agency should maintain current re-enrollment processes that allow individuals who take no action during open enrollment to maintain the APTCs for which they qualify, without financial penalty.**

CMS has already attempted on two separate occasions to modify automatic re-enrollment processes to impose full premium responsibility on individuals who do not verify coverage

[10] Parchman ML, Culler S. Primary care physicians and avoidable hospitalizations. *J Fam Pract.* 1994;39(2):123–128.https://pmc.ncbi.nlm.nih.gov/articles/PMC2146576/

[11] Rosano A, Loha CA, Falvo R, et al. The relationship between avoidable hospitalization and accessibility to primary care: a systematic review. *Eur J Public Health.* 2013;23(3):356–360. https://doi.org/10.1093/eurpub/cks053

[12] U.S. Department of Health and Human Services. CMS-0994-P: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability. 19 Mar 2025. Page 12999. https://www.federalregister.gov/d/2025-04083

eligibility.[13] In both instances, CMS received overwhelming feedback from stakeholders – including the NYC Health Department – opposing changes to automatic re-enrollment. CMS ultimately dropped the proposals in publishing final rules for plan years 2020 and 2021. In fact, CMS acknowledged in the text of its final payment rule for 2020 that automatic re-enrollment provides for risk pool stability and other benefits to payers and consumers.[14] We also saw the benefits of automatic renewal via CMS' continuous coverage mandate for Medicaid beneficiaries during the COVID-19 Federal Public Health Emergency. Studies have found that continuous coverage under the Families First Coronavirus Response Act (FFCRA) reduced Medicaid churn, enhanced coverage stability, and improved access to care.[15,16] The same understanding can be applied to marketplace coverage.

Notwithstanding, CMS is once again proposing to modify the automatic re-enrollment process – this time with a $5 premium penalty, as opposed to full premium responsibility. The NYC Health Department responds similarly: this proposal will cause confusion among consumers about APTC eligibility, disrupt the continuity of coverage and care, and create an administrative burden for payers.

Enrolling in health insurance is a confusing process for most consumers, particularly those with low health and financial literacy.[17] Weighing plan options presents a significant challenge for this population, which is best addressed through policies that streamline the decision-making process and relieve consumer burden. CMS' proposal to alter automatic re-enrollment would do the opposite.

Instead of encouraging consumers to keep consistent with their coverage from year to year, these technical changes would exacerbate the confusion many applicants and enrollees experience regarding the health insurance enrollment process. An important advantage of automatic re-enrollment is continuity—allowing consumers who are satisfied with the affordability and coverage of their plan to keep it from year to year. By adding a burden to the re-enrollment process, CMS would make it more difficult for consumers to maintain continuity of coverage, which plays a significant role in patient outcomes.[18] In fact, consumers' inability to rely on the same

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[13] U.S. Department of Health and Human Services. CMS-9916-P: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans. 6 Feb 2020. https://www.federalregister.gov/d/2020-02021

[14] U.S. Department of Health and Human Services. CMS-9926-F: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020. 25 Apr 2019. https://www.federalregister.gov/d/2019-08017

[15] Nelson DB, Goldman AL, Zhang F, et al. Continuous Medicaid coverage during the COVID-19 public health emergency reduced churning, but did not eliminate it. *Health Aff Sch.* 2023;1(5):qxad055. https://pmc.ncbi.nlm.nih.gov/articles/PMC10786332/

[16] Lyu W, Wehby GL. Effects of the Families First Coronavirus Response Act on Coverage Continuity and Access for Medicaid Beneficiaries. *INQUIRY*. 2024;61. https://doi.org/10.1177/00469580241282052

[17] Housten AJ, Furtado K, Kaphingst KA, et al. Stakeholders' perceptions of ways to support decisions about health insurance marketplace enrollment: a qualitative study. *BMC Health Services Research.* 2016;16:634.

[18] Sommers BD, Gourevitch R, Maylone B, et al. Insurance Churing Rates for Low-Income Adults Under Health Reform: Lower Than Expected But Still Harmful for Many. The Commonwealth Fund. 16 Oct 2016. https://www.commonwealthfund.org/publications/journal-article/2016/oct/insurance-churning-rates-low-income-adults-under-health?redirect_source=/publications/in-the-literature/2016/oct/insurance-churning-low-income-adults

level of APTC support has the potential to render the automatic re-enrollment feature meaningless.

In the 2021 version of this proposed policy, CMS said it would seek to minimize coverage disruptions by educating consumers via ACA Navigators. Under the current proposal, CMS does not offer this same remediation. In fact, CMS recently announced plans to drastically reduce funding for Navigator programs, as discussed elsewhere in this comment. As such, the NYC Health Department firmly opposes CMS' current proposal to impose $5 premiums on consumers who are automatically re-enrolled in coverage without eligibility verification.

Annual Open Enrollment Period (OEP)

CMS proposes to shorten the annual OEP to 45 days beginning for plan year 2026, about one month shorter than the previous year on the federally facilitated marketplace, and about half as long as the New York State of Health (New York State's State Based Exchange) has previously allowed individuals to enroll. While there is precedent for changing the length of the OEP, this change would mark the first time that CMS has required SBEs to limit their OEP to match that of the federally facilitated exchange. With that in mind, the NYC Health Department makes the following recommendation:

***Recommendation #3*: CMS should continue to allow states with SBEs the flexibility to adjust the length of the OEP, if they meet minimum federal standards.**

Since the implementation of the ACA, New York has taken advantage of the flexibility afforded by CMS to create an SBE that meets New Yorkers' needs. New York State of Health (NYSOH) is an integrated marketplace, allowing a "no wrong door" approach to enrollment. Consumers can enroll in Medicaid, Child Health Plus (the state's Children's Health Insurance Program [CHIP]), the Essential Plan, or a qualified health plan through one seamless platform.[19] The New York State OEP has historically run from November 1 through mid- to late-January annually, allowing New Yorkers additional time to determine their needs for the following year. We believe this abrupt change to New York's OEP will cause confusion and decrease enrollment while increasing costs and burden on City resources.

The NYC Health Department employs a team of multilingual certified application counselors (CAC) who assist New Yorkers with enrollment in all programs available through the New York State of Health marketplace both in person and over the phone. The Department regularly runs large-scale public awareness campaigns advertising the OEP and encouraging New Yorkers to reach out for help with their applications. Such campaigns require extensive planning, staff time and resources. Based on the timing of potential finalization of this rule, the NYC Health Department is concerned that this abrupt change will not afford us the opportunity to conduct proper outreach, including public awareness media campaigns.

The NYC Health Department CACs also regularly report increased volume in enrollment toward the end of the OEP, mid- to late-January, as many clients may lose track of enrolling or renewing

[19] New York State Department of Health. New York State of Health Marketplace. https://nystateofhealth.ny.gov/

coverage during the busy holiday season from November into December. New Yorkers have now become accustomed to a January OEP end date and may be confused by this change. CMS acknowledges that the 2022 Payment Notice "identified negative impacts from a 45-day OEP that ends December 15," causing the agency to adjust to a 76- or 77-day OEP on the FFE for plan years 2022 through 2025. The Agency further acknowledges that the shortened OEP may cause consumers to pay higher costs and leaves Navigators and CACs unable to adequately assist with plan comparisons for the following year.[20] Despite this acknowledgment, CMS plans to cut funding to the ACA Navigator program by 90% (from $98 million down to just $10 million annually),[21] the largest cut since the start of the program. This will leave even fewer resources for health insurance enrollment assistance and compound the coverage losses caused by a shortened OEP.

Finally, CMS' proposal to shorten the OEP to 45 days is particularly misguided in the context of the looming expiration of enhanced premium subsidies put in place through the American Rescue Plan Act (ARPA) and Inflation Reduction Act (IRA). Statewide, 140,000 New Yorkers benefit from these enhanced tax credits. If they are allowed to expire at the end of 2025, premiums for these individuals will increase by 38%, or an average of $114 per month (from $300 to $414.) In some Congressional districts, the increase would be much higher. In Congressional District 15 in the Bronx, one of the nation's most under-resourced communities, consumers face a 68% increase in premiums if enhanced subsidies expire.[22] Shortening the OEP for plan year 2026 will give consumers less time to evaluate their options. This would particularly impact those whose costs are rising steeply. It is reasonable to assume that, if the subsidies are allowed to expire, more consumers will either change plans or drop coverage altogether due to lack of affordability. While we hope Congress will extend these subsidies, we urge CMS to prepare for the eventuality that consumers will have a more complex choice than usual for plan year 2026.

Limiting SBEs to a 45-day OEP amounts to a federal overreach that flies in the face of Congressional intent. SBEs were designed to allow states to be innovative and creative in their approaches to running their exchanges, relying on the federalist principles that states often understand the needs of their constituents better than the federal government. New York has proven this time and again through NYSOH. SBEs generally have had more success lowering the uninsured rate since implementation of the ACA,[23] and New York specifically has an uninsured rate of only 4.8%, compared to 8% nationally.[24] The proposal to limit New York's OEP threatens this progress and the health of New Yorkers.

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[20] U.S. Department of Health and Human Services. CMS-0994-P: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability. 19 Mar 2025. Page 12978. https://www.federalregister.gov/d/2025-04083

[21] Centers for Medicare & Medicaid Services. CMS Announcement on Federal Navigator Program Funding. https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding

[22] New York State Department of Health. New York State of Health Marketplace. Congressional District Fact Sheet. January 2025. https://info.nystateofhealth.ny.gov/sites/default/files/Congressional%20District%20Fact%20Sheet%202025.pdf

[23] National Academy for State Health Policy. State-based Health Insurance Marketplace Performance. Sept 2019. https://nashp.org/wp-content/uploads/2019/09/SBM-slides-final_SeptMtgs-9_23_2019.pdf

[24] Kaiser Family Foundation. Health Care in New York. 2024. https://www.kff.org/statedata/election-state-fact-sheets/new-york/

NEW YORK CITY DEPARTMENT OF
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Prohibiting Coverage of Sex-Trait Modification Services as Essential Health Benefit (EHB)

CMS proposes to prohibit coverage of what it calls Sex-Trait Modification Services as an Essential Health Benefit. For states that currently require coverage of these gender-affirming services, this will likely cause an increase of both state and patient costs. The NYC Health Department strongly opposes the federal government's proposal to ban certain types of care from coverage under the EHBs. Gender-affirming care is widely recognized as safe and necessary for individuals experiencing gender dysphoria. Limiting coverage of these services is both ill-advised and discriminatory. Therefore, we recommend the following:

Recommendation #4: CMS should not prohibit coverage of "Sex Trait Modification" Services as Essential Health Benefits and, instead, continue to allow flexibility as states create plans that work best for their unique populations.

Under the ACA, the ten EHBs are defined in broad terms, intentionally leaving room for states to interpret and implement these benefits in ways they determine are most beneficial for their unique populations. Each EHB represents a broad category of care, under which a number of specific benefits might fall. By statutory design, these benefits often look different from state to state. In fact, CMS' own regulations aim to ensure that EHBs are comprehensive and flexible for each state by defining the specifics of EHBs based on state-specific benchmark plans.

CMS has previously acknowledged the importance of flexibility related to EHBs. For example, when CMS finalized changes in the 2020 Payment Notice to allow states additional options in selecting benchmark plans, it included the option to select an EHB benchmark plan used by another state or create a unique set of benefits to become the state's benchmark plan.[25] It would be counterproductive for CMS to offer this tremendous increase in state flexibility, only to later prohibit coverage of specific services under the benchmark plan. For states where coverage of gender affirming care is required, this will only serve to increase state defrayal costs, putting further strain on state budgets and, ultimately, taxpayers.

The proposed rule cites as justification for this prohibition the fact that these services are not typically covered by employer-based health insurance plans.[26] However, CMS provides no evidence for this, nor any examples of a "typical" employer plan. While comprehensive data on states requiring coverage for gender-affirming care are limited, as of 2019, 20 states (including New York) and the District of Columbia prohibited health insurers from excluding coverage for transgender health services.[27] Several states have since passed additional protections to ensure

[25] U.S. Department of Health and Human Services. CMS-9926-F: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020. 25 Apr 2019. https://www.federalregister.gov/d/2019-08017
[26] U.S. Department of Health and Human Services. CMS-0994-P: Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability. 19 Mar 2025. Page 12985. https://www.federalregister.gov/d/2025-04083
[27] American Medical Association. Issue Brief: Health Insurance Coverage for Gender-affirming Care of Transgender Patients. 2019. https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf

access to services for transgender people.[28] In New York State, state-regulated employee-sponsored health insurance plans are required to cover medically necessary treatment for gender dysphoria and are prohibited from categorically excluding medically necessary gender-affirming treatment.[29] According to national survey data from 2024, nearly 40% of employer-sponsored plans are not self-funded (i.e., are state regulated).[30] Assuming New York follows national trends, roughly 40% of all employer-sponsored plans in the state are required to cover gender affirming services. This does not account for any plans that may do so voluntarily. It is, therefore, inaccurate to claim that a "typical" employer plan in New York State does not cover these services. The disparate state landscape underscores the need for CMS to continue to allow states the flexibility to choose which services are covered as EHBs.

An abundance of evidence indicates that transgender, nonbinary, and/or gender-nonconforming (TGNBNC) individuals may be at an increased risk of a multitude of physical and behavioral health conditions, including acute myocardial infarction, stroke, generalized anxiety disorder, depression, and self-harm behaviors including suicide.[31] Addressing these disparities requires the opposite of what CMS proposes—a system that makes it easier to access the full range of services that can help TGNBNC people live healthy, productive lives. A multitude of studies also demonstrate that gender affirming care is associated with improvements in physical and mental health and quality of life.[32] Despite this, CMS proposes to make it more difficult for this population to access high-quality affordable health care using insurance purchased via ACA exchanges. This is both inhumane and counterproductive for improving health outcomes.

The NYC Health Department appreciates the opportunity to submit these comments.

Sincerely,

[redacted]

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[28] Ferguson D, Maucione S, Birkeland B, Pluta R, Jackson C, Squires A. Minnesota to Join at Least 4 Other States in Protecting Transgender Care This Year. NPR. 21 Apr 2023. https://www.npr.org/2023/04/21/1171069066/states-protect-transgender-affirming-care-minnesota-colorado-maryland-illinois

[29] New York State Department of Financial Services. Health Coverage Information for Transgender New Yorkers. https://www.dfs.ny.gov/consumers/health_insurance/transgender_healthcare

[30] Kaiser Family Foundation. 2024 Employer Health Benefits Survey. 9 October 2024. https://www.kff.org/report-section/ehbs-2024-summary-of-findings/

[31] D'Hoore L, T'Sjoen G. Gender-affirming Hormone Therapy: An Updated Literature Review with an Eye on the Future. *Journal of Internal Medicine.* 04 January 2022. https://doi.org/10.1111/joim.13441

[32] Scheim AI, Baker KE, Restar AJ, Sell RL. Health and Health Care Among Transgender Adults in the United States. *Annual Review of Public Health* 43:503-523. 2022. https://doi.org/10.1146/annurev-publhealth-052620-100313