NY State of Health and the New York State Department of Financial Services Comments on 90 FR 12942, Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability (Published 3/19/2025)

NY State of Health, the State's Official Health Plan Marketplace, and the New York State Department of Financial Services appreciate the opportunity to provide the following comments in response to the proposed regulations contained in the Marketplace Integrity and Affordability Proposed Rule (Proposed Rule).

New York strongly supports efforts to ensure the integrity of eligibility and enrollment processes. However, as each state has a unique understanding of its population and market dynamics, we encourage allowing state flexibility in how best to achieve this goal. New York also strongly supports efforts to lower the cost of high quality, affordable health insurance by promoting policies that maintain a healthy risk pool and discourage adverse selection. Robust participation in New York's individual market is essential to achieving this goal.

New York's marketplace is uniquely designed with a fully integrated eligibility and enrollment platform across Medicaid, the Children's Health Insurance Program, the Essential Plan (New York's 1332 State Innovation Waiver Program), and Qualified Health Plans with and without Advance Premium Tax Credits (APTC) and Cost-Sharing Reductions (CSRs) in a single system. We highlight in our comments the specific sections where state flexibility would be beneficial. New York, like other State-Based Marketplaces (SBMs), has rigorous internal controls and other safeguards in place to enforce program integrity standards.

A large majority of the Proposed Rule's provisions would go into effect the date the rule is finalized, which raises significant concerns. The complexity, cost, and system changes proposed would strain state resources and disrupt the consumer experience. New York requests flexibility in the timeline to implement any applicable changes. We also are mindful of the significant taxpayer dollars required to implement many of these changes—particularly when we do not believe they address existing problems in New York. Our estimates are that this Proposed Rule, if implemented, will raise premium costs by 4.5% (more than $300 per month for a typical family), and result in up to 6,000 fewer enrollees in Qualified Health Plans, on top of the more than 50,000 enrollees we expect to lose if Congress and the President choose not to extend the enhanced Premium Tax Credits under the Inflation Reduction Act that are expected to expire at the end of 2025.

Provisions of the Proposed Regulations

A. Part 147 - Health Insurance Reform Requirements for the Group and Individual Health

2. Coverage Denials for Failure to Pay Premiums for Prior Coverage (§ 147.104(i))

- Proposed Rule
  The Proposed Rule, in removing § 147.104(i), allows issuers to require consumers to pay past outstanding premiums from prior coverage before they can enroll for the next year. Issuers would be allowed to contractually require enrollees to pay past-due premiums in addition to the initial premium to start coverage (the "binder payment").

- NY State of Health Comments:
  New York appreciates CMS's intention to reduce consumer gaming and adverse selection while preserving consumers' rights to continuous coverage and affordability. We understand the importance of protecting issuers from past-due premiums and ensuring market stability. In New York, issuers are protected from the accrual of outstanding debt from consumers, but New York does not currently allow issuers to add past due premiums to the initial (or "binder") premium.

  New York appreciates the recognition of state flexibility to set rules in this area, as we have existing rules in place to protect issuers.

B. Part 155 - Exchange Standards and Other Related Standards Under the Affordable Care Act

1. Definitions; Deferred Action for Childhood Arrivals (§ 155.20)

- Proposed Rule
  The Proposed Rule seeks to reverse the previous addition of DACA recipients to the list of noncitizens granted deferred action included in the definition of "lawfully present," which is used to determine whether a consumer's immigration status makes them eligible to enroll in coverage through an Exchange.

- NY State of Health Comments:
  Consistent with previous New York State comments, we oppose this proposed change that will exclude Deferred Action for Childhood Arrival (DACA) recipients from eligibility to purchase plans on-Exchange, even at the full cost, and obtain subsidies through the federal marketplace and SBMs. This proposed change will restrict access to health care services, increase the number of uninsured individuals, and increase uncompensated care costs. As CMS states, this change would also negatively impact the risk pool.

  The Proposed Rule notes that this change, if finalized, would be effective on the final rule's effective date. If implemented as written, Marketplaces would be required to terminate existing coverage for DACA recipients, causing a loss in coverage midway through the coverage year, including for members who are in the middle of a course of treatment. While

a loss of coverage will adversely impact all affected individuals, this will be particularly disruptive to those who have chronic conditions, are pregnant, or are currently in receipt of life-saving medical treatment, such as chemotherapy.

NY State of Health also notes that mid-year implementation of this change would pose a significant administrative and financial burden for Marketplaces. IT system changes to the current eligibility rules, including consumer notices, informational pages, and the requisite testing to ensure changes are applied correctly will take ten to twelve months to implement and cost up to $1 million. To prepare to assist consumers, NY State of Health would need to re-train enrollment assistors and Customer Service Center staff, and potentially need to add additional staff.

If CMS finalizes this change, NY State of Health requests the effective date be extended to, at the earliest, January 1, 2026, if not longer, to minimize operational burdens to states and reduce consumer confusion. Alternatively, NY State of Health requests flexibility in the timeline for notifying and terminating coverage for current enrollees without penalty to consumers.

3. Verification Process Related to Income Eligibility for Insurance Affordability Programs (§§ 155.305, 155.315, and 155.320)

a. Failure to File Taxes and Reconcile (FTR) APTC Process (§ 155.305(f)(4))

i. Delay of FTR Process until after 2-consecutive years of FTR removed

- Proposed Rule
  The Proposed Rule seeks to amend paragraph § 155.305(f)(4) to reinstate the previous policy that an Exchange may not determine a tax filer or their enrollee eligible for APTC if: (1) for a year for which tax data would be utilized for verification of household and family size, CMS notifies the Exchange that APTC were paid on behalf of the tax filer, or their spouse if the tax filer is a married couple, and (2) the tax filer did not file a Federal income tax return and reconcile APTC for that year.

- NY State of Health Comments:
  The requirement that is currently in place, to find an enrollee ineligible for APTC if there is a failure to reconcile for *two* consecutive years (for which tax data would be utilized for verification) provides a balance between program integrity and administrative burden to consumers and SBMs. In reliance on federal rules, New York has recently completed several months of system work to comply with the two-year requirement in 155.305(f)(4). Additional resources and lead time would be required to revert to a one-year requirement, and to generate additional consumer notices in compliance with IRS safeguard requirements. Remedying FTR under the previous policy for individuals who did in fact file their taxes

presented a significant burden for many consumers, and if reinstated may worsen the risk pool as healthier individuals would have less incentive to satisfy those additional documentation requirements.

ii. Conforming Change to Notice Requirements

- Proposed Rule
  The Proposed Rule seeks to revise the notice requirement at § 155.305(f)(4)(i) and remove the notice requirement at § 155.305(f)(4)(ii).

- NY State of Health Comments:
  New York supports the indirect notice to the tax filer or enrollee set forth in 155.305(f)(4)(i)(B), which reminds consumers of their ongoing obligations to maintain tax credits and coverage.

b. 60-Day Extension to Resolve Income Inconsistency (§ 155.315)

- Proposed Rule
  The Proposed Rule seeks to remove § 155.315(f)(7), which requires Exchanges to provide an automatic 60-day extension in addition to the 90 days currently provided by § 155.315(f)(2)(ii) to allow applicants sufficient time to provide documentation to verify household income.

- NY State of Health Comments:
  New York has strong processes in place to verify APTC eligibility, as confirmed by regular state and federal audits, as well as an annual external program integrity audit conducted by a third-party accounting firm. As such, we support allowing state flexibility to align with established rules to ensure individuals are enrolled with the amount of APTC for which they are eligible.

c. Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL (§ 155.320(c)(3)(iii))

- Proposed Rule
  The Proposed Rule seeks to revise § 155.320(c)(3)(iii) to require Exchanges to require consumers to verify attested income when a tax filer's attested projected annual household income is between 100 percent of the FPL and 400 percent of the FPL and inconsistent with income data returned to the Exchange by IRS, the SSA, and current income data sources showing income less than 100 percent of the FPL.

- NY State of Health Comments
  New York appreciates CMS's goal of capturing accurate projected incomes from consumers. This proposed change is relevant to states that did not expand Medicaid eligibility levels, and New York opposes it because it would impose unnecessary burdens on Medicaid expansion states such as New York. For SBMs in Medicaid expansion states, including New York, states should have the option to follow current rules to avoid significant paperwork burdens for staff and consumers. Implementing this proposed change in Medicaid expansion states would require states to expend significant IT system and Customer Service Center costs, without altering resulting consumer eligibility. In addition, increasing the paperwork burden is likely to deter healthier individuals from completing enrollment.

d. Income Verification When Tax Data is Unavailable (§ 155.320(c)(5))

- Proposed Rule
  The Proposed Rule seeks to remove § 155.320(c)(5), which requires Exchanges to accept an applicant's or enrollee's self-attestation of projected annual household income when the Exchange requests tax return data from the IRS, but the IRS confirms there is no such tax return data available.

- NY State of Health Comment:
  New York supports CMS's goal of ensuring accurate eligibility determinations. As approved by CMS every year since the Marketplace's inception, New York leverages trusted state data sources, in addition to IRS data, to increase the number of individuals whose income can be verified without generating a data matching issue and requiring verification. New York recommends that CMS make this Proposed Rule optional for SBMs (at a minimum) to avoid unnecessary burdens.

4. Annual Eligibility Redetermination (§ 155.335)

- Proposed Rule
  The Proposed Rule seeks to amend § 155.335 to require a minimum $5.00 monthly premium be charged to consumers who would currently be automatically reenrolled in a $0 premium plan (after application of APTC) if they do not apply for an updated eligibility determination on or before the last day to select a plan for January 1 coverage. In imposing a $5.00 premium, the rule proposes to require all Exchanges to decrease the amount of APTC applied such that the monthly premium is a minimum of $5.00. This $5.00 premium would be eliminated after the first month, after the enrollee confirmed their eligibility.

- NY State of Health Comments:
  New York supports efforts to strengthen program integrity and protect consumers; however, there is no evidence that consumers in New York have been fraudulently enrolled in $0

plans. The twelve QHP issuers in New York have operational policies in place to prevent enrollees from being fraudulently enrolled in $0 plans. Given this, New York believes this proposed change would be an unnecessary administrative and financial burden on issuers and SBMs, given IT system changes and additional customer service center costs. Furthermore, the intent of APTC is to make coverage more affordable during the entire year; restricting enrollees' ability to use the maximum APTC is counter to that statutory goal.

We oppose any actions restricting marketplaces from automatically reenrolling individuals who qualify for fully or partially subsidized plans. Auto-enrollment is a common practice in the commercial health insurance market and has long been part of our standard practice. Requiring all subsidized enrollees to manually re-enroll in coverage will likely harm the individual market risk pool, and place a significant operational burden on the state, including increased costs for IT system, Customer Service Center, outreach and enrollment assistance.

Lastly, § 36B of the Internal Revenue Code defines the criteria for determining advance payments of Premium Tax Credit, without consideration of any modifications to this methodology for purposes outlined in this Proposed Rule. In short, we do not believe SBMs have the authority to prevent consumers from applying the full amount of APTC for which they are eligible. We further emphasize that this statute requires regulations on household income to be designed to ensure the "least burden is placed on individuals. . . ."

5. Annual Open Enrollment Period (§ 155.410)

- Proposed Rule
  The Proposed Rule seeks to amend § 155.410(e) to change the Open Enrollment Period (OEP) for all Exchanges to November 1 through December 15 for the 2026 Coverage Year and beyond. The Exchange would have to ensure coverage is effective January 1.

- NY State of Health Comments:
  NY State of Health has maintained a consistent OEP since 2016. New York opposes in the strongest terms shortening the OEP as outlined in the proposed rule, as doing so would have substantial, negative marketplace impacts and harm individuals and families. In particular, significantly shortening this timeframe would create substantial challenges across multiple dimensions: consumer confusion, destabilization of our individual market risk pool, increased operational costs, and significant new marketing expenditures.

  Shortening the Open Enrollment Period Could Have a Negative Impact on the Individual Risk Pool.

  We analyzed the NY State of Health's enrollment data to determine the relative risk of those individuals who enroll in later weeks of the OEP compared to those individuals who enroll in

the earlier weeks. Using age as a proxy for risk, we found that younger, likely healthier enrollees comprise a higher share of total enrollment at the end of January than they do at earlier points in the OEP. Conversely, prior to January, enrollees aged 55 and above comprise a larger share of QHP enrollees.

This pattern extends to plan selection as well, with a greater proportion of higher-tier (Platinum and Gold) enrollments occurring early in the OEP, while Bronze and Silver enrollments peak in the final month. These data strongly suggest that truncating the enrollment period would adversely impact the individual market risk pool, as younger, healthier individuals critical to premium stabilization would have less opportunity to enroll.

Shortening the Open Enrollment Period Will Impose Significant Operational Challenges.

As of the close of Open Enrollment on January 31, 2025, over 6.7 million New Yorkers are enrolled through NY State of Health, across all program types. With an estimated 800,000 members going through renewal during this period, shortening the enrollment window would place substantial strain on the Customer Service Center, enrollment assistors, and IT and notices operations—necessitating significant additional resources to manage increased demand.

During the 2025 OEP, NY State of Health's Customer Service Center handled nearly 1.3 million calls, evenly distributed with 650,000 during the period November 1 through December 15, and 650,000 calls between December 16 and January 31. Daily average call volume ranged from 20,000-25,000 and was fairly consistent across the entire open enrollment period, with the exception of the last two weeks, where it averaged above 30,000 calls per day. Compressing the open enrollment period to November 1 through December 15 would increase daily call volume and call wait times, which remained under one minute on average during the 2025 OEP. Such delays would likely negatively impact enrollment.

Additional Marketing Costs

Beyond these operational challenges, a shortened enrollment window would necessitate substantial unplanned marketing expenditures and increased outreach activity to ensure consumer awareness of the new enrollment deadline. New York would need to launch an intensified campaign specifically addressing the shortened timeframe, to ensure consumers understand the new deadline during the holiday season, which is typically the most expensive time to pay for advertising. Failure to adequately communicate this change would risk coverage lapses for New Yorkers who attempt to enroll during the previously established timeframe. This represents an unfunded mandate requiring significant new investment in multichannel communications without clear benefit to consumers or the Marketplace.

The data presented clearly demonstrate that a shortened OEP would likely worsen individual market risk pool and create costly operational challenges for New York. Accordingly, New York urges CMS to maintain state flexibility in establishing OEPs for the 2026 plan year and beyond.

6. Pre-enrollment Verification for Special Enrollment Period (§ 155.420(g))

- Proposed Rule
  The Proposed Rule seeks to amend 155.420(g) to require Exchanges to conduct pre-enrollment Special Enrollment Period (SEP) verification for at least 75 percent of new enrollments.

- NY State of Health Comments:
  New York supports efforts to reduce adverse selection in the individual insurance market, while minimizing unnecessary administrative burdens on consumers. However, New York opposes the proposal to require SBMs to verify 75 percent of SEP requests.

  New York's Marketplace currently requires applicants seeking a SEP to answer detailed questions during the application process. As a fully integrated marketplace, NY State of Health is able to verify loss of minimum essential coverage (MEC) for persons previously covered by Marketplace programs - Medicaid, the Essential Plan, the Children's Health Insurance Program, and through the New York State Health Insurance Program (NYSHIP). These comprise the vast majority of SEPs requested.

  Imposing a 75 percent verification requirement would result in significant unfunded costs to implement and operationalize, especially in the absence of evidence that misuse of the SEP is widespread and where targeted reviews may prove more effective and less disruptive for consumers. In addition, increasing the paperwork burden is likely to deter healthier individuals from completing enrollment.

  Given the unique nature of each SBM, New York strongly encourages CMS to maintain state flexibility to establish systems in collaboration with the state's insurers that will ensure the integrity of the SEP application process and meet the needs of their consumers.

C. Part 156 - Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. Prohibition on Coverage of Sex-Trait Modification as an Essential Health Benefit (EHB) (§ 156.115(d))

- Proposed Rule
  The Proposed Rule seeks to amend § 156.115(d) to provide that issuers of non-grandfathered individual and small group market health insurance coverage—that is, issuers of coverage subject to EHB requirements—may not provide coverage for sex-trait modification as an EHB beginning with PY 2026.

- NY State of Health & DFS Comments:
  Gender affirming care is covered by all fully insured individual and employer group plans in New York, which currently cover over 3.7 million New Yorkers. Medical and scientific organizations including the American Medical Association, the American College of Physicians, and the American Nurses Association have affirmed the medical necessity and efficacy of these services. We encourage CMS to engage with the medical community on this issue, which overwhelmingly supports providing this needed care to patients. Additionally, benefits that states mandated prior to January 1, 2012 were properly incorporated into EHB-benchmark plans, and removing such benefits is contrary to the intent of the Affordable Care Act ("ACA") and contrary to state non-discrimination requirements. Further, New York notes that treatment for gender dysphoria falls into a number of the EHB categories including, ambulatory patient services, mental health and substance use disorder, hospitalization, prescription drugs, and laboratory services.

  Furthermore, New York State considers the Proposed Rule a violation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). Gender dysphoria is a mental health condition recognized by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM"). As such, MHPAEA, codified at 29 U.S.C. § 1185a, and its implementing regulations, 45 C.F.R. §§ 146.136 and 147.160, prohibit issuers providing both medical and surgical benefits and mental health or substance use disorder benefits from applying any treatment limitation to mental health or substance use disorder benefits that they do not apply to substantially all medical and surgical benefits in the same classification. In short, CMS' proposed amendments to interfere with gender affirming care violate federal law.

2. *Premium Adjustment Percentage (§ 156.130(e))*

- Proposed Rule
  The Proposed Rule seeks to use average per enrollee private health insurance premiums (excluding Medigap and property and casualty insurance), instead of ESI premiums, which have been used in the calculation since PY 2022, for purposes of calculating the premium adjustment percentage for PY 2026 and beyond.

- NY State of Health Comments:
  New York opposes the methodological change as it will reduce financial assistance for consumers, making coverage less affordable and less appealing to younger, healthier individuals. It is estimated that this methodology will raise the cost of the benchmark plan premium costs by 4.5%, more than $300 per month for the typical family, and by an estimated $900 in annual cost-sharing.

3. *Levels of Coverage (Actuarial Value) (§§ 156.140, 156.200, 156.400)*

- Proposed Rule
  The Proposed Rule seeks to change the de minimis ranges at § 156.140(c) beginning in PY 2026 to +2/−4 percentage points for all individual and small group market plans subject to the AV requirements under the EHB package, other than for expanded bronze plans, for which the rule proposes a de minimis range of +5/−4 percentage points. The rule also proposes to amend the definition of "de minimis variation for a silver plan variation" in § 156.400 to specify a de minimis range of +1/−1 percentage points for income-based silver CSR plan variations.

- NY State of Health Comments:
  We appreciate CMS's intentions of reducing premiums to make coverage more affordable. While New York supports efforts to reduce premiums the effect of allowing lower AV of plans would primarily represent a cost-shift to consumers, making the value proposition of health plans less appealing.

  Lowering the AV will result in higher deductibles, copayments, and other cost-sharing while rising health care costs continue to be a primary concern for households.

  Second, since APTC amounts are based on the Second Lowest Cost Silver Plan available to consumers, the premiums reductions resulting from the AV change will reduce APTC available to consumers. Our data indicate that consumers offered less APTC are less likely to enroll in any coverage.

  Third, under the proposed rule, the differential between some metal tiers will be as low as one percentage point. As a result, there may not be meaningful differences between metal tiers, and consumers might have difficulty comparing plans.

  We urge CMS not to adopt this change. However, if it is adopted, states should have the flexibility to establish alternative standards.