CLASP
The Center for Law and Social Policy

April 11, 2025

Robert F. Kennedy
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
P.O. Box 8016
7500 Security Boulevard
Baltimore, MD 21244

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

To Secretary Kennedy:

The Center for Law and Social Policy (CLASP) appreciates the opportunity to comment on the U.S. Department of Health and Human Services' rule on the Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability. We at CLASP believe that the language proposed in the rule will create a lot of barriers for people who currently have insurance coverage. Additionally, we believe that eliminating recently proposed and enacted rules on the Marketplace without providing enough time to determine their efficacy is not only premature, but will be a significant waste of resources.

CLASP is a national, nonpartisan nonprofit advancing anti-poverty policy solutions that remove barriers blocking people from economic security and opportunity. We work at the federal, state, and local levels, supporting policy and practice that makes a difference in the lives of people living in conditions of poverty.

Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets | Limited Open Enrollment Periods (§ 147.104(b)(2))

CLASP fully disagrees with removing the monthly Special Enrollment Period (SEP) for Advance Premium Tax Credit (APTC) individuals with projected household incomes at or below 150 percent of the Federal Poverty Level (FPL). The SEP allows someone with a low-income or a recent change/reduction in income-level to have the opportunity to enroll in any month throughout the year. Although the argument made in the rule states that this SEP will cause adverse selection because of increased proportional enrollment among people living with low-incomes, removal of this SEP will end up creating this effect. Increased insurance limitations with removing the SEP for low-income individuals, limiting the open enrollment period, and creating additional administrative burdens to obtain APTCs will select healthy individuals out of the market. This unintended consequence will be detrimental to payers and ultimately to patient coverage. We urge CMS not to remove the SEP for projected household incomes at or below 150 percent of FPL.

Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act| Definitions; Deferred Action for Childhood Arrivals (§ 155.20)

CLASP urges HHS not to deny DACA recipients' access to the ACA marketplace and BHP and, instead, retain DACA recipients' current eligibility for these health programs.

Background

Under the Affordable Care Act, marketplace eligibility and financial assistance is limited to U.S. citizens or nationals as well as those who are "lawfully present" in the United States. People granted deferred action under the DACA program are lawfully present and should be treated as such for health insurance purposes. People with DACA should have been classified along with other persons granted deferred action as "lawfully present" and "lawfully residing" under the HHS definitions in the Pre-Existing Condition Insurance Plan (PCIP) program, Medicaid, the Children's Health Insurance Program (CHIP), the Basic Health Program (BHP) and the marketplace. HHS has maintained eligibility for insurance affordability programs for all others granted "deferred action" over the years.

Because the ACA did not define lawfully present, HHS issued an interim final rule that adopted the definition of lawfully residing from a 2010 HHS letter that defined this standard for the Children's Health Insurance Program Reauthorization Act (CHIPRA) state option providing coverage for "lawfully residing" children and pregnant women. It included all those granted deferred action as well as other temporary immigration categories, such as Temporary Protected Status and Deferred Enforced Departure. In March 2012, HHS issued a rule adopting the PCIP definition of lawfully present for eligibility determinations in the ACA marketplaces. Three months later, when the Department of Homeland Security (DHS) announced DACA as its newest deferred action category, people with DACA would have rightfully been classified as "lawfully present" and "lawfully residing" under the existing HHS definition and therefore eligible for CHIPRA's state option.

However, in August 2012, the Centers for Medicare & Medicaid (CMS) issued a letter to states stating that health benefits should not be extended as a result of DHS deferring action under DACA.[1] HHS then issued an interim final rule that modified the PCIP program definition of lawfully present to explicitly exclude people with DACA.[2] HHS and Treasury's marketplace regulations then cross-referenced the PCIP definition, leaving people with DACA excluded from the marketplace and all other health insurance affordability programs.[3]

Last year, the Biden Administration corrected this long-standing injustice, with a regulation making people with DACA eligible for health care through the Affordable Care Act's marketplace system, which is a lifesaving program that the DACA community has been excluded from for far too long.[4] Backed by effective outreach, this policy change could help up to an estimated 100,000 people nationwide to finally access health coverage.

The proposed rule's elimination of marketplace and Basic Health Program eligibility for DACA recipients would significantly harm families. The current rule indicates that HHS initially estimated in 2023 that about 100,000 people with DACA were likely to benefit from eligibility for marketplace coverage. However, in the current proposed rule HHS estimates a reduced enrollment of only 10,000 people in the qualified health plans and 1,000 more in the basic health plan. This number –11,000 people– is an undercount of the potential harm of excluding DACA recipients from marketplace and BHP eligibility for many reasons, including:

- First, the coverage was brand new. The rule granting eligibility was finalized in May, only six months before open enrollment in November. Many DACA recipients have never had access to health coverage before and may not have known about the opportunity in its first year.

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1 State Health Official Letter (SHO #12-002) from Cindy Mann, Director, Center for Medicaid and CHIP Services, U.S. Department of Health and Human Services, "Individuals with Deferred Action for Childhood Arrivals," August 28, 2012, available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-12-002.pdf . Pre-Existing Condition Insurance Plan Program, 77 Fed. Reg. 52614, August 30, 2012, available at: https://www.govinfo.gov/content/pkg/FR-2012-08-30/pdf/2012- 21519.pdf.

2State Health Official Letter (SHO #12-002) from Cindy Mann, Director, Center for Medicaid and CHIP Services, U.S. Department of Health and Human Services, "Individuals with Deferred Action for Childhood Arrivals," August 28, 2012, available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-12-002.pdf . Pre-Existing Condition Insurance Plan Program, 77 Fed. Reg. 52614, August 30, 2012, available at: https://www.govinfo.gov/content/pkg/FR-2012-08-30/pdf/2012- 21519.pdf.

3 The marketplace eligibility regulations define "lawfully present" at 45 C.F.R. § 155.20 by cross-referencing the PCIP definition at 45 C.F.R. § 155.2, which means the marketplace also excludes people with DACA.

4 Federal Register, "Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens for a Qualified Health Plan through an Exchange, Advance Payments of the Premium Tax Credit, Cost-Sharing Reductions, and a Basic Health Program" May 8, 2024, https://www.federalregister.gov/documents/2024/05/08/2024-09661/clarifying-the-eligibility-of-deferred-action-for-childhood-arrivals-daca-recipients-and-certain.

- Second, due to pending court challenges, DACA recipients in 19 states were unable to enroll in coverage after the first month of open enrollment.[5] One in five DACA recipients in the U.S. live in Florida or Texas, two states where coverage was "closed" for the majority of open enrollment.[6]
- Third, the estimate does not account for the significant chilling effect that the proposed rule will have on immigrant families' access to affordable health coverage options, if finalized. As described in the sections that follow, this proposal not only harms DACA recipients themselves, but also their U.S. citizen children, whose overall health and insurance coverage are closely linked to that of their parents.[7]

The Harm of Eliminating Marketplace Coverage and BHP Eligibility for DACA Recipients

Since its creation in 2012, the DACA program has promoted child well-being by protecting more than 800,000 immigrants who entered the U.S. as children and have grown up in the United States.[8] DACA removed the threat of deportation and family separation, allowed immigrant youth to pursue educational and career opportunities, and opened doors for recipients to provide for their families. Since the program's inception, DACA recipients have continued to further their education, contribute to the workforce, volunteer in their communities, and support civic engagement, all without any certainty of what their future might hold due to the precarious status of the DACA program. Most people with DACA are young adults, with over 60 percent between the ages of 21 and 30.[9]

While most people with DACA are working and in good health, many face challenges accessing health coverage and care, including being uninsured. Ending marketplace eligibility for DACA recipients will cause harm. Estimates show that since the inception of the program, up to 47 percent of DACA-eligible individuals have been uninsured at some point, more than five times the rate of the general U.S. population.[10] More recent research shows that DACA recipients continue to have high uninsured rates, reflecting their limited eligibility for coverage.[11] In a survey, DACA recipients also expressed concerns

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5 KFF, How Pending Health-Related Lawsuits Could be Impacted by the Incoming Trump Administration, November 25, 2024, https://www.kff.org/medicare/issue-brief/how-pending-health-related-lawsuits-could-be-impacted-by-the-incoming-trump-administration/ The impacted states were Alabama, Arkansas, Florida, Iowa, Idaho, Indiana, Kansas, Kentucky, Mississippi, Montana, North Dakota, Nebraska, New Hampshire, Ohio, South Carolina, South Dakota, Tennessee, Texas, and Virginia, The District Court blocked coverage on December 9, There was a one week re-opening of enrollment from Dec 16 to 23, and then it was blocked by a federal court again.

6 KFF, Key Facts on Deferred Action for Childhood Arrivals (DACA), February 11, 202g, https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/

7 Jessica Schubel, "Expanding Medicaid for Parents Improves Coverage and Health for Both Parents and Children," Center on Budget and Policy Priorities (June 14, 2021), https://www.cbpp.org/research/health/expanding-medicaid-for-parents-improves-coverage-and-health-for-both-parents-and.

8 Nicole Prchal Svajlenka and Trinh Q. Truong, "The Demographic and Economic Impacts of DACA Recipients: Fall 2021 Edition," Center for American Progress (November 24, 2021), https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition/.

9 "Key Facts on Deferred Action for Childhood Arrivals," KFF (April 13, 2023), https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/.

10 "Key Facts on Deferred Action for Childhood Arrivals," KFF; Svajlenka and Truong, "The Demographic and Economic Impacts of DACA Recipients"; Jennifer Tolbert, Patrick Drake, and Anthony Damico, "Key Facts about the Uninsured Populations," KFF (December 19, 2022), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

11 KFF, Key Facts on Deferred Action for Childhood Arrivals (DACA), February 11, 2025, https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/

about out of pocket and lack of access to mental health care due to their lack of affordable coverage options.[12]

Younger DACA recipients who cannot work may not be able to obtain coverage if their parents lack coverage, and those with employer-based coverage are often left without other options if they lose their job or have their work hours decreased and are no longer eligible for employer-based health insurance. The COVID-19 pandemic provided an example of this instability–nearly 20 percent of respondents to a 2021 survey of DACA recipients lost their employer-provided health insurance during the COVID-19 pandemic.[13]

Ultimately, HHS' proposal to exclude DACA recipients from affordable health care programs undermines the Affordable Care Act (ACA)'s goal to increase access to equitable health care coverage, and it also hinders the full potential benefits of the DACA program.

The Harm of Eliminating Marketplace Coverage on DACA Recipients' Families

Eliminating marketplace coverage for DACA recipients under the proposed rule would harm immigrant families, especially children of DACA recipients. Across the United States, over 1.3 million people live with a DACA recipient, including 300,000 U.S.-born children who have at least one parent with DACA.[14] For years, uninsured rates for U.S. citizen children of immigrants have been double that of their peers with citizen parents despite their eligibility for federal health care programs, as their immigrant parents often face restrictions for coverage.[15] Eliminating access to marketplace coverage for DACA recipients under the proposed rule would cause children in immigrant families to lose out on the positive benefits associated with parents who are insured.

Children are more likely to access health insurance and health services when their parents are insured

When parents gain access to health coverage, their children also gain access to health coverage, otherwise known as the "welcome mat" effect.[16] A comprehensive body of research highlights the powerful effect of increases in parental access to insurance coverage on their children's access to insurance coverage. Following the ACA's passage, from 2013-2015, 710,000 children gained coverage, despite the fact that

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12 National Immigration Law Center, DACA Recipients' Access to Health Care: 2024 Report, May 2024, https://www.nilc.org/wp-content/uploads/2024/05/NILC_DACA-Report_2024_06-27-24.pdf

13 "Key Facts on Deferred Action for Childhood Arrivals," KFF; Wong, Kmec, and Pliego, "DACA Boosts Recipients' Well-Being and Economic Contributions"; Kat Lundie, Ben D'Avanzo, Isobel Mohyeddin, Ignacia Rodriguez Kmec, Tanya Broder, et al., "Tracking DACA Recipients' Access to Health Care," National Immigration Law Center (June 1, 2022) https://www.nilc.org/wp-content/uploads/2022/06/NILC_DACA-Report_060122.pdf.

14 Nicole Prchal Svajlenka and Trinh Q. Truong, "The Demographic and Economic Impacts of DACA Recipients: Fall 2021 Edition," Center for American Progress (November 24, 2021), https://www.americanprogress.org/article/the-demographic-and-economic-impacts-of-daca-recipients-fall-2021-edition/.

15 "Health Coverage of Immigrants," KFF (July 15, 2021), https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-and-care-of-immigrants/.

16 Julie L. Hudson and Asako S. Moriya, "Medicaid Expansion For Adults Had Measurable 'Welcome Mat' Effects On Their Children," *Health Affairs*, 36, no. 9, (2017): 1643-1651, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.034.

children's eligibility for coverage did not change under the ACA.[17] This research also shows that when parents have health insurance coverage, children are more likely to access the routine and preventative health care they need to be healthy and thrive.[18] A large body of research has also documented the long term benefits when children have access to health care, including greater educational attainment and economic outcomes.[19] Research also shows that children's access to health care coverage increases their use of preventive care, leading to better health as adults with fewer hospitalizations and emergency room visits.[20]

Conversely, lack of health care coverage and the inability to afford medical costs leads to significant burdens on families, including the accumulation of medical debt or bills, stress around out-of-pocket costs, and the delaying or forgoing of treatment due to financial constraints.[21] For uninsured parents, this can mean choosing between securing food for their family or receiving needed treatment and medical care to maintain a healthy life and therefore, providing and supporting their children.

Parental health is positively associated with child health

Parents and caregivers play a primary role in children's development, and research shows that good or excellent parental health is positively associated with child health.[22] Parents who receive adequate health care are better equipped to take care of, provide for, and support their children. Improved parental insurance coverage and health outcomes consistently benefit children in the short- and long-term through improved family health and financial security.[23] Similarly, a parent's mental health is strongly correlated to a child's mental health as demonstrated by research showing that maternal depression affects children's development, academic success, and overall future professional achievement.[24]

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17 Julie L. Hudson and Asako S. Moriya, "Medicaid Expansion For Adults Had Measurable 'Welcome Mat' Effects On Their Children," *Health Affairs*, 36, no. 9, (2017): 1643-1651, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.0347.

18 Maya Venkataramani, Craig Evan Pollack, and Eric T Roberts, "Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services," *Pediatrics* 160, no. 6 (2017), DOI: 10.1542/peds.2017-0953.

19 Karina Wagnerman, Alisa Chester, and Joan Alker, "Medicaid is a Smart Investment in Children," Georgetown University Health Policy Institute: Center for Children and Families (March 2017) https://ccf.georgetown.edu/wp-content/uploads/2017/03/MedicaidSmartInvestment.pdf.

20 Julia Paradise, "The Impact of the Children's Health Insurance Program: What Does the Research Tell Us?," KFF, (July 17, 2014), https://www.kff.org/medicaid/issue-brief/the-impact-of-the-childrens-health-insurance-program-chip-what-does-the-research-tell-us/; Laura Wherry, Sarah Miller, Robert Kaestner, and Bruce D. Meyer, "Childhood Medicaid Coverage and Later Life Health Care Utilization," National Bureau for Economic Research (February 2015), http://www.nber.org/papers/w20929.pdf.

21 Alejandra Muñoz-Rivera, "How do health care costs impact household finances and access to care?" Social Policy Institute, Washington University in St. Louis (2022), https://socialpolicyinstitute.wustl.edu/how-healthcare-costs-impact-household-finances-and-access-to-care/.

22 David Murphey, Elizabeth Cook, Samuel Beckwith, and Jonathan Belford, "The Health of Parents and Their Children: A Two-Generation Inquiry," Child Trends (2018) https://cms.childtrends.org/wp-content/uploads/2018/10/AECFTwoGenerationHealth_ChildTrends_October2018.pdf.

23 Jessica Schubel, "Expanding Medicaid for Parents Improves Coverage and Health for Both Parents and Children."

24 "Affordable Health Care Keeps Children And Families Healthy," Center for Hunger-Free Communities, Drexel University (2009), https://drexel.edu/hunger-free-center/research/briefs-and-reports/affordable-healthcare/#:~:text=High%20medical%20care%20and%20prescription,of%20their%20mothers%20also%20suffer; Jessica Schubel, "Expanding Medicaid for Parents Improves Coverage and Health for Both Parents and Children."

DACA parents face unique stressors given the uncertainty of their status which often trickle down to their children.[25] A wide range of child development literature has found that exposure to such stress and trauma can have detrimental long-term developmental impacts, especially for young children.[26] Further, a recent study examined how state-level social policy exclusions for immigrants are associated with the well-being of immigrant parents and development of their children. Results indicated that immigrant parents with young children experienced greater stressors in states with more restrictive policies toward immigrants and children born in more exclusionary states had lower reading skills.[27]

CLASP urges HHS not to eliminate marketplace coverage and BHP eligibility for DACA recipients and keep the current policy in place. Eliminating DACA recipients from the definition of "lawfully present" for the purposes of marketplace coverage would significantly harm DACA recipients themselves and their families, worsening access public health, access to health coverage, and healthy outcomes for immigrant families. HHS should retain DACA recipients' current eligibility for the marketplace and BHP.

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

The proposed rule notes a plan to reinstate the one year non-reconciliation rule, which would impact the number of individuals covered in 2026. One stated intent is to prevent tax liabilities from inaccurate income estimates, but there is no evidence to support that the rule would do so. Once again, the change in the rule to ensure individuals reconcile their tax credits within one year will result in increased administrative burden and disincentivize healthy individuals from joining the Marketplace. It is estimated that 265,000-424,000 individuals would lose APTC eligibility. This will impact the risk pool, and increase premiums for many. We ask that CMS not finalize this proposal.

Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges | Prohibition on Coverage of Sex-trait Modification as an EHB (§ 156.115(d))

CLASP strongly opposes the proposed language to prohibit the inclusion of what are noted as "sex trait modifications" in the proposed rule. The term "sex trait modifications" are not used in practice in law, policy, or medicine. Furthermore, language in the rule that states that treating gender dysphoria cannot be included as an Essential Health Benefit (EHB) is unethical, inhumane, and against basic civil rights. Treatment of gender dysphoria includes a number of services, including mental health care, medication management, laboratory services, hospitalization, and outpatient care. Barring public and private plans from the option to provide no/little cost-sharing for these services to treat gender dysphoria would be

[25] Jorge M. Chavez, Anayeli Lopez, Christine M. Englebrecht, & Ruben P. Viramontez Anguiano, "Sufren Los Niños: Exploring the impact of unauthorized immigration status on children's well-being," *Family Court Review* 50, no. 4 ((2012): 638–649, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3821695/.

[26] Hirokazu Yoshikawa, *Immigrants Raising Citizens: Undocumented Parents and Their Young Children* (New York: Russell Sage Foundation, 2011), pgs 14-15.

[27] Kevin Ferreira van Leer, et al., "Implications of state policy context for the well-being of immigrant families with young children" Wiley Online Library, January 15, 2025, https://onlinelibrary.wiley.com/doi/10.1002/ajcp.12783

detrimental to transgender populations. Barriers towards specific treatment for gender dysphoria would make processes very difficult for payers to make coverage determinations for mental health and substance use services and laboratory services, for example.

Every major health association in the United States, including the American Medical Association,[28] the American Academy of Family Physicians,[29] The American Academy of Pediatrics,[30] the Endocrine Society,[31] the American Psychological Association,[32] the American Academy of Child and Adolescent Psychiatry,[33] and the American Psychiatric Association[34] support gender affirming care. There is a large body of research showing the efficacy and importance of gender affirming care, including research showing that gender-affirming care improves short- and long-term mental health outcomes for transgender and nonbinary young people, while denial of care worsens mental health outcomes, increasing rates of depression and suicidality.[35]

Denying transgender individuals critical care would greatly exacerbate adverse health outcomes. Results from the 2022 United States Trans Survey (n= 92,329) state that of individuals who saw a healthcare provider, 48% reported a negative experience due to being transgender, including being misgendered, encountering harsh or abusive language, or having a provider be physically rough or abusive. No one should have any type of negative experience during a clinical encounter. These negative experiences can lead to adverse physical and mental health concerns. Additionally, the U.S. Trans Survey data states that more than one-third of respondents are experiencing poverty.[36] Creating additional barriers to care through limiting EHB requirements would exacerbate health inequities, as transgender individuals would more likely have to pay for these services out of pocket. Increased expenses for services may make individuals have to choose between gender affirming therapy and other critical care; a choice which no person should have to make.

Making federal changes to what an EHB can cover is against the principle of allowing states to choose what is right for them. It creates a dangerous precedent for the federal government to decide what care is

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[28] American Medical Association, "AMA to States: Stop interfering in health care of transgender children," April 26, 2021, https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children.
[29] American Academy of Family Physicians, "Care for the Transgender and Gender Nonbinary Patient," October 2020, https://www.aafp.org/about/policies/all/transgender-nonbinary.html.
[30] American Academy of Pediatrics, "AAP reaffirms gender-affirming care policy, authorizes systemic review of evidence to guide update," August 4, 2023, https://publications.aap.org/aapnews/news/25340/AAP-reaffirms-gender-affirming-care-policy?autologincheck=redirected.
[31] Endocrine Society, "Endocrine Society Statement in Support of Gender-Affirming Care," May 8, 2024, https://www.endocrine.org/news-and-advocacy/news-room/2024/statement-in-support-of-gender-affirming-care.
[32] American Psychological Association, "APA adopts groundbreaking policy supporting transgender, gender diverse, nonbinary individuals," February 28, 2024, https://www.apa.org/news/press/releases/2024/02/policy-supporting-transgender-nonbinary.
[33] American Academy of Child & Adolescent Psychiatry, "Policy Statement on Access to Gender-Affirming Healthcare," June 2024, https://www.aacap.org/AACAP/Policy_Statements/2024/Access_Gender-Affirming_Healthcare.aspx.
[34] American Psychiatric Association, "Position Statement on Access to Care for Transgender and Gender Diverse Individuals," July 2018, https://www.psychiatry.org/getattachment/d3ef4763-8a0e-4da3-ab01-efe932ca9478/Position-2018-Access-to-Care-for-Transgender-and-Gender-Diverse-Individuals.pdf.
[35] Diana M. Tordoff et al., "Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care," Pediatrics, 2022; 5(2): e220978, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789423.
[36] U.S. Trans Survey. 2022. https://ustranssurvey.org/

"worthy" of being covered by the Affordable Care Act, while limiting state freedom. A critical cost-effective analysis done of gender-affirming therapy noted that if states were to assume costs, insurance companies would have to account for $7.5 million per state. That is in contrast to a cost to the U.S. health care system of $0.016 per member/month or $10, 614 per person seeking coverage.[37] Moving the prohibitive provision forward restricting EHBs would therefore create a huge cost burden to states. We strongly urge CMS not to move forward with prohibiting coverage of treatment for gender dysphoria from EHBs.

As an organization who works with and for people experiencing poverty, we believe it is imperative to note why the proposed rule will adversely impact many individuals---healthy and not. It will also ultimately result in increased costs to the system over time. We thank you for the opportunity to provide comments. If you have any questions or would like to follow up, please reach out to Wendy Cervantes, director of CLASP's immigration and immigrant families team at wcervantes@clasp.org, or Isha Weerasinghe, associate director of mental health and well-being at iweerasinghe@clasp.org.

Thank you.

[37] William Padula et al., "Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis," J Gen Intern Med, 2015 Oct 19; 31(4): 394-401, doi: 10.1007/s11606-015-3529-6.