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April 10, 2025

Secretary Robert F. Kennedy, Jr.
Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Re: RIN 0938-AV61; CMS-9894-P
Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability

Dear Secretary Kennedy:

The National Health Law Program (NHeLP) is a public interest law firm that works to advance equitable access to health care and protect the health rights of people with low incomes and underserved populations. For over fifty-five years, we have litigated, advocated, and educated at the federal and state levels to advance health and civil rights in the United States.

Consistent with our mission, we strongly believe that health care is a human right. Every individual should have access to high quality, affordable, and comprehensive health care and be able to achieve their own highest attainable standard of health. Accordingly, we generally appreciate the opportunity to comment on the Department of Health and Human Services' (HHS) proposed rule, *Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability* (hereinafter "Proposed Rule").[1]

§ 147.104(i) Coverage Denials for Failure To Pay Premiums for Prior Coverage

HHS proposes removing § 147.104(i), which would allow qualified health plans (QHPs) to prohibit individuals who owe past due premiums from enrolling in coverage until they satisfy all prior arrearages.[2] HHS proposes a more stringent provision than what was in the Market Stabilization Rule, which limited the policy to unpaid premiums in the last 12 months.[3] We oppose HHS's proposal as it is an unlawful interpretation of the guaranteed availability provision. The statute is clear; an issuer "must accept every employer and individual in the State that applies for such coverage."[4] HHS's misinterpretation violates the right to guaranteed availability of coverage under the ACA and § 147.104(a). Further, in addition to being unlawful, removing § 147.104(i) will create significant hardship for consumers as guaranteed access to affordable health care improves individuals' health outcomes.[5]

HHS introduced § 147.104(i) after it concluded that the guaranteed availability requirement prohibited issuers from denying coverage to individuals for their failure to pay past due premiums. As stated above, our position is that it is improper and illegal to hold new or renewed enrollment contingent on past premiums. The bar to access care is evident under a plain reading of the statute.

The requirement to pay past due premiums to enroll creates barriers to health coverage that disproportionately affects low-income individuals who are more likely to owe past due premiums.[6] Some of these individuals may be punished by the policy through no fault of their own because unpaid premiums may arise through issuer accounting errors or other marketplace recordkeeping mistakes. We have observed numerous case examples where individuals regularly paid their premiums but issuers failed to match the payment to a particular individual's account, issued bills that did not match the amount individuals were supposed to pay, or caused other accounting irregularities that were of no fault to the

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[1] U.S. Dep't. Health & Human Srvs., *Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, Notice of Proposed Rulemaking*, 90 Fed. Reg. 12944 (proposed Mar. 19, 2025), https://www.federalregister.gov/documents/2025/03/19/2025-04083/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability (hereinafter "Proposed Rule").
[2] 90 Fed. Reg. 12942, 12944 (Mar. 19, 2025).
[3] 82 Fed. Reg. 18349.
[4] 42 U.S.C. § 300gg–1(a).
[5] *See, e.g.,* Renuka Tipirneni et al, *Health Insurance Affordability Concerns And Health Care Avoidance Among U.S. Adults Approaching Retirement*, 3 Jama Network Open 6, 8 (2020).
[6] *See* 87 Fed. Reg. 27208 (HHS stating that the requirement for individuals to pay past due premiums in order to enroll "has the unintended consequence of creating barriers to health coverage that disproportionately affect low-income individuals."). *See also* Lunna Lopes et al., Kaiser Family Found., *Americans' Challenges with Health Care Costs* (2024), available at https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/.

individuals.[7] Throughout the proposed rule, however, HHS brands all unpaid premiums as evidence of individuals "gaming" the guaranteed availability requirement. This portrayal neglects the stories of individuals who accumulate these debts due to system or other barriers beyond their control. And it is problematic to attribute misconduct in these scenarios and leverage individuals' health and well-being to compel the resolution of administrative problems.

To address HHS's stated concern that individuals only enroll in, and pay for, coverage when they need medical care, we support measures that allow issuers to recoup unpaid premiums while still maintaining enrollment. Research shows that there are other effective methods of recovering medical debt that do not restrict individuals' access to health care.[8] Thus, HHS can achieve its objective and ensure marketplace payment integrity without blocking enrollment and jeopardizing individuals' health.

If HHS proceeds with implementing this provision, then a number of protections are needed to ensure compliance and understanding from individuals and families. Notably, issuers should be required to notify enrollees and applicants that coverage may be denied due to unpaid past premiums. And in order to protect individuals against the potential adverse health consequences of blocking enrollment due to past due premiums, HHS should also consider: extending existing grace periods, offering alternatives to lump sum repayments, allowing enrollment after partial repayment, and exempting individuals who earn below certain incomes or exempting those who can demonstrate they had (or have) a genuine inability to pay for (or repay) past premiums.

The guaranteed availability requirement recognizes that access to health care is crucial to achieve a healthy population. Severe health consequences may arise when policy-makers impose barriers to affordable care. HHS's proposal will hold individuals' health hostage in an attempt to resolve administrative problems. Instead, issuers can recover unpaid premiums through the lawful and effective means that already exist. Accordingly, we oppose HHS's proposal to remove §147.104(i) as it would violate the guaranteed availability requirement.

§ 155.20 Definitions

NHeLP opposes the proposed modification of the definition of "lawfully present" used to determine eligibility for the Centers for Medicare & Medicaid Services (CMS)' health insurance affordability programs. The modification would exclude "Deferred Action for Childhood Arrivals" (DACA) recipients from enrolling in a Qualified Health Program (QHP)

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[7] *See, e.g.*, Kaiser Health News, *Covered California: Error means thousands surprised by higher premiums* (2017), available at https://www.mercurynews.com/2017/01/19/covered-california-error-means-thousands-surprised-by-higher-premiums/.

[8] Consumer Financial Protection Bureau, *Consumer credit reports: A study of medical and non-medical collections* 7 (2014), available at https://files.consumerfinance.gov/f/201412_cfpb_reports_consumer-credit-medical-and-non-medical-collections.pdf.

through an exchange, receiving advance payments of the premium tax credits (APTC) and cost-sharing reductions (CSRs), and enrolling in a Basic Health Program (BHP) in States that elect to operate a BHP.

People granted deferred action under the DACA program are lawfully present and should be treated as such for health insurance purposes. HHS has maintained eligibility for insurance affordability programs for all others granted "deferred action" over the years.

On May 3, 2024, the U.S. Department of Health and Human Services (HHS) issued a final rule modifying the definition of "lawfully present" to include individuals who receive Deferred Action for Childhood Arrivals (DACA). This would allow DACA recipients meeting all other eligibility requirements to enroll in a Qualified Health Plan through the Marketplace, or a Basic Health Plan.[9] The policy went into effect on November 1, 2024, and was expected to enable 100,000 DACA recipients to enroll in health insurance.[10]

To be eligible for health coverage under the Affordable Care Act (ACA), an individual must either be a U.S. citizen, national, or "lawfully present" in the United States. When the DACA program was first established, existing HHS policies would have classified DACA recipients as "lawfully present," making them eligible to enroll in various insurance affordability programs, such as Qualified Health Plans (QHPs) through the Health Insurance Marketplace, Basic Health Programs (BHPs), and Medicaid or the Children's Health Insurance Program (CHIP) in states that have opted to cover "lawfully residing" pregnant people and children through the CHIPRA 214 option.[11]

However, shortly after the DACA program began, HHS issued regulations and guidance that excluded DACA recipients from the definition of "lawfully present."[12] This exclusion denied DACA recipients access to affordable health coverage, negatively impacting their health outcomes and financial well-being, increasing overall healthcare system costs, and exacerbating health inequities.[13] The Proposed rule would once again exclude DACA recipients from the marketplace and all other health insurance affordability programs.[14]

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[9] 45 C.F.R § 152.2.
[10] Ctrs. for Medicare & Medicaid Srvs., Fact Sheet: *HHS Final Rule Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens* (May 3, 2024) https://www.cms.gov/newsroom/fact-sheets/hhs-final-rule-clarifying-eligibility-deferred-action-childhood-arrivals-daca-recipients-and-certain.
[11] Ctrs. for Medicare & Medicaid Srvs., Dear State Health Official, *SHO #10-006: Medicaid and CHIP Coverage of "Lawfully Residing" Children and Pregnant Women* (Jul. 1, 2010), https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/sho10006.pdf.
[12] Ctrs. for Medicare & Medicaid Srvs., Dear State Health Official, *SHO #12-002: Individuals with Deferred Action for Childhood Arrivals* (Aug. 28, 2012), https://www.medicaid.gov/federal-policy-guidance/downloads/sho-12-002.pdf.
[13] Nat'l Immigr. Law Ctr., *DACA Recipients' Access to Health Care: 2023 Report* (May 2023), https://www.nilc.org/news/special-reports/daca-recipients-access-to-health-care-2023-report/.
[14] Proposed Rule, *supra* note 1

A 2023 survey found that DACA recipients were nearly three times as likely to be uninsured than the general population in the United States.[15] About 20% of survey respondents indicated that they were not covered by any kind of health insurance or health care plan. Excluding DACA recipients from health insurance exchanges and APTCs does not eliminate their needs for health care. While some uninsured DACA recipients can access treatment for emergency medical conditions, they cannot access the comprehensive services necessary to cultivate positive long-term health outcomes.[16] Delaying or forgoing care because of high out-of-pocket costs is not cost-effective, and burdens the health care system with increased emergency department use and avoidable hospitalizations.[17]

Extending ACA coverage to DACA recipients likely had a beneficial effect on Exchange risk pools because they are healthy young adults. DACA recipients generally are between the ages of 21 and 40 with an average of 29.[18] Among individuals likely eligible for DACA, estimates find that 64% report their health as excellent or very good, while an additional 28% report their health as good.[19]

When proposed, the current rule indicates that HHS initially estimated that 100,000 people with DACA were likely to benefit from eligibility for marketplace coverage. However, in the current proposed rule HHS, estimates a reduction to 10,000 people in the QHPs and 1,000 more in the BHP. This is not a fair estimate of the potential harm of excluding DACA recipients from marketplace and BHP eligibility because pending court challenges in 19 states prevented DACA recipients from enrolling in coverage after the first month of open enrollment.[20]

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

A. § 155.305(f)(4) - Failure to File Taxes and Reconcile APTC Process

The failure to reconcile (FTR) process that ensures individuals receive the appropriate APTCs based on their tax filings has been an evolving process since 2017 as the relevant departments dealt with the intricacies of delayed tax data, privacy requirements of tax filers

[15] KFF, *Key Facts on Deferred Action for Childhood Arrivals (DACA)* – February 11, 2025 (Mar. 28, 2025), https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/.
[16] 8 U.S.C. § 1611(b)(1)(A).
[17] Jennifer Tolbert et al., Kaiser Fam. Found., *Key Facts about the Uninsured Population* (Dec. 19, 2022), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.
[18] U.S. Citizenship & Immigr. Srvs., *Active DACA Recipients – December 16, 2024* (Mar. 28, 2025), https://www.uscis.gov/sites/default/files/document/data/Active_DACA_Recipients_Dec_FY23_qtr1.pdf.
[19] KFF, *supra note 17.*
[20] KFF, *How Pending Health-Related Lawsuits Could be Impacted by the Incoming Trump Administration*, November 25, 2024 (Mar. 28, 2025) https://www.kff.org/medicare/issue-brief/how-pending-health-related-lawsuits-could-be-impacted-by-the-incoming-trump-administration/.

and providing notice to APTC recipients; notice requirements that comply with due process; and consumer confusion.[21] In the current proposal, HHS seeks to return to a previous policy without a rationale that differs from those already considered in the current FTR policy or specific data to support the claims that individuals are purposefully misstating income or improperly enrolled.[22] In fact, despite the current two consecutive years of FTR status policy, HHS relies on a belief that the "current process could incentivize tax filers to not file and reconcile."[23] When in fact, HHS has access to data that would indicate a basis for this change in policy. The data that is cited indicates that many will be harmed under the proposed one year FTR status rule given that the 2025 OEP data cited shows approximately 1,500,000 potential reenrollments with either a one-year tax FTR status, a tax filing extension, or filed taxes without the APTC reconciliation form.[24] That same 2025 OEP data shows only 356,000 potential reenrollments with a two-tax year FTR status.[25] HHS's proposal to change the FTR policy from a two year to one year FTR leading to ineligibility for APTCs will eliminate coverage for over 1 million people without sufficient reason for the reversal to a previous policy that had well-considered changes.[26]

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[21] NHeLP has consistently commented on this process to ensure that people are not denied the APTCs for which they are eligible and that HHS follows all due process requirements in any action that denies or terminates this benefit and we incorporate those previous comments by reference. *See, e.g.,* Nat'l Health Law Prog., *2025 NBPP Proposed Rule Comments,* 9-13 (Jan. 8, 2024), https://healthlaw.org/resource/comments-on-the-notice-of-benefit-and-payment-parameters-for-2025/; Nat'l Health Law Prog., *2024 NBPP Proposed Rule Comments,* 6-8 (Jan. 30, 2023), https://healthlaw.org/resource/nhelp-comments-on-patient-protection-and-affordable-care-act/ . HHS must meet due process requirements in any changes that create denials or terminations of APTCs. U.S. Const. Amend. XIV; *Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1, 14 (1978); *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 314-15 (1950) (requiring "notice reasonably calculated, under all circumstances, to apprise intended parties of the pendency of the action and afford them an opportunity to present their objections" and that "[t]he means [of notice] employed must be such as one desirous of actually informing the absentee might reasonably adopt to accomplish it."); *Goldberg*, 397 at 267-68 (requiring "timely" notice "detailing the reasons for a proposed action"); *Mathews v. Eldridge*, 424 U.S. 319, 348 1976) (risk of erroneous deprivation through procedures being used); *Carey v. Quern*, 588 F.2d 230, 232 (7th Cir. 1978) (due process requires the assistance program be administered to insure fairness and avoid risk of arbitrary decision making).; *see also Goldberg v. Kelly*, 397 U.S. 254, 267-68 (1970) (requiring detailed reasons in notice, including "the legal and factual bases"); *Gray Panthers v. Schweiker*, 652 F.2d 146, 168 (D.C. Cir. 1981) (without adequate notice of reasons for denial "hearing serves no purpose."); *Barry v. Lyon*, 834 F.3d 706, 720 (6th Cir. 2016) (agency must provide "specific, individualized reasons for the agency action"); *Rodriguez v. Chen*, 985 F. Supp. 1189, 1195 (D. Ariz. 1996) (public interest in assuring health benefits will not be erroneously terminated or denied outweighs inconvenience to the state and the notice must include specific financial information where applicable so that errors may be corrected); *Ortiz v. Eichler*, 616 F. Supp. 1046, 1062 (D. Del. 1985), aff'd 794 F.2d 880 (3d Cir. 1986) (requiring notice include what financial information was considered and include what financial information was considered and relevant calculations of income are involved in the eligibility decision).

[22] Proposed Rule, supra note 1, at 12958-62.

[23] *Id.* at 12959. (emphasis added)

[24] *Id.*

[25] *Id.*

[26] *Id.*; *see also id.* at 12960 (estimating that the number of people who would remain covered under the two-tax year FTR policy would be greater than the 81,600 they previously estimated).

In 2023, HHS proposed that an individual would be ineligible for APTC only if the person has a FTR status for two consecutive years.[27] This decision was based on HHS's experience with the FTR process in which people became ineligible for APTCs after one year of FTR status. Under that policy, there was often significant delays in tax return processing, consumer and tax-preparer confusion, and significant costs associated with FTR-related appeals that could have been avoided with the two-year FTR status process.[28] The tax return processing delays continue and will likely continue to impact the accuracy of FTR status, particularly under a one-year FTR policy.[29] The requirement that an individual have FTR-status for two consecutive years was finalized on the rationale that it was the right balance of protecting the interests of APTC recipients and the government. In addition, the process and notices of the existing FTR procedure would help protect against arbitrary actions by the government that affected benefits provided to individuals, as required by the Constitution.[30]

In adopting the current two-year FTR process, HHS weighed the risks of individuals facing higher tax liabilities due to the two-year process, against the risks of wrongful denials of APTCs due to data issues and delays and found that there was a greater likelihood of harm from the wrongful denials. HHS also weighed the risk to the government in unnecessary appeals, additional processing, and the possibility of fraud.[31] On the fraud concern, HHS cited that individuals were still required to reconcile each year and it would monitor yearly FTR consumer data and that people who abused the system could be subject to enforcement action, including additional tax liability, interest, and penalties.[32]

HHS's proposed change to the FTR process focuses on curbing government spending on APTCs for individuals that may not be eligible, but offers very little proof that this is occurring and little recognition or balancing of the harm from denying APTCs wrongfully. HHS cites the problem of "lead generating companies" that induce improper broker actions, but does not address those issues nor did they address the effectiveness of enforcement actions already taken. Instead, HHS proposes to policy around the individuals harmed by

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[27] 88 Fed. Reg. 25740, 25814-18 (Apr. 27, 2023).
[28] *Id.*
[29] *See generally* TREASURY INSPECTOR GEN. FOR TAX ADMIN., 2024-406-020, THE IRS CONTINUES TO REDUCE BACKLOG INVENTORIES IN THE TAX PROCESSING CENTERS REPORT (2024), https://www.tigta.gov/sites/default/files/reports/2024-03/2024406020fr.pdf (describing significant delays in tax processing).
[30] U.S. Const. Amend. XIV; *Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1, 14 (1978); *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 314-15 (1950) (requiring "notice reasonably calculated, under all circumstances, to apprise intended parties of the pendency of the action and afford them an opportunity to present their objections" and that "[t]he means [of notice] employed must be such as one desirous of actually informing the absentee might reasonably adopt to accomplish it."); *Goldberg*, 397 at 267-68 (requiring "timely" notice "detailing the reasons for a proposed action"); *Mathews v. Eldridge*, 424 U.S. 319, 348 1976) (risk of erroneous deprivation through procedures being used); *Carey v. Quern*, 588 F.2d 230, 232 (7th Cir. 1978) (due process requires the assistance program be administered to insure fairness and avoid risk of arbitrary decision making).
[31] *Id.*
[32] *Id.* at 25818.

those improper broker actions and limit individual access to APTCs. The change from the two-year FTR policy to one-year harms the individuals who rely on APTCs to access health care. This policy change also creates significant confusion among all stakeholders.[33]

Because NHeLP opposes the change from the two-year FTR policy to a one-year FTR policy, we also oppose the removal of the associated notice requirements. Proper FTR notices help individuals understand the potential APTC repercussions of FTR. In addition, as explained in previous comments, the indirect notice sent to the APTC recipient is insufficient to meet due process requirements as the timing of the notices is too spread out to be considered proper notice. Further, the indirect notice will not explain in sufficient detail why the individual is losing their APTCs and what they can do to remediate the issue and be successful in an appeal.[34] The current process of requiring two-consecutive FTR status years and all current notices should remain in place to help ensure that individuals are not denied APTCs for which they are eligible and are not denied merely because of data, delays, and other administrative issues.

B. § 155.320(c)(3)(iii) - Income Verification When Data Sources Indicate Income Less Than 100 Percent of the FPL & § 155.320(c)(5) - Income Verification When Tax Data Is Unavailable

We have a number of concerns with HHS's proposal to address income inconsistencies in circumstances when an individual's attested projected annual household income is less than 100% of the FPL (removal of § 155.320(c)(5)), or equal to or greater than 100% of the FPL and no more than 400% of the FPL (revisions to § 155.320 (c)(3)(iii)). In short, we oppose the additional verification requirements proposed in these sections.

We oppose HHS's proposal to remove § 155.320(c)(5), which requires marketplaces to accept an applicant or enrollee's self-attestation of projected household income when the marketplace requests tax return data from the IRS but the IRS confirms there is no such tax return data available. First, HHS itself notes that many individuals are unable to complete their tax filing requirements due to administrative burdens. Instead of easing this burden, HHS plans to add to it. HHS states that the additional proposed income verifications will yield a minimal, one-hour administrative burden on individuals. However, HHS's time estimate an average, conceals the fact that many administrative barriers are bimodal and averages do not accurately reflect an individual's experience. People with disabilities, for

[33] Proposed Rule, *supra* note 1, at 12960. Although HHS cites program integrity concerns but gives little weight or consideration to the impact on individuals who do not receive the APTCs for which they are eligible but are prohibited from receiving the benefit due to tax data delays or other administrative issues that have been the reason for the two-year FTR status policy.

[34] Proposed Rule, *supra* note 1 (note with previous comments and due process case law); *see also Goldberg, 397 U.S. at 267-68; Goss v. Lopez, 419 U.S. 565, 579 (1975)* (due process has little reality or worth unless a person understands the issue is pending); *see also Waldrop v. New Mexico Dept. Hum. Servs. Dep't,* No. CV 14-047 JH/KBM, 2015 WL 13665460, at *24 (D.N.M. Mar. 10, 2015) (beneficiary must be provided notice about the process).

example, may encounter unique barriers and citing an average will misrepresent individuals' actual experiences.[35] In reality, the administrative burden to verify, and often re-verify, income is high. Additionally, other intangible costs—like stress, psychological harms, and distrusts of the system—may arise when individuals are repeatedly asked to respond to administrative requests.

Administrative burdens will also increase under HHS's revisions to § 155.320(c)(3)(iii). For example, marketplaces would now need to verify information with other trusted data sources instead of accepting the attestation. To that end, the proposal estimates an increase of approximately $32 million in annual costs to the federal government and state marketplaces due to additional DMIs projected under § 155.320(c)(3)(iii) alone.[36] These resources would be better used for educational materials for individuals to help improve income reporting accuracy. HHS's sweeping proposal underestimates the potential harms. As such, we urge HHS to continue to allow attestations of income for these populations, and instead increase its front-end consumer education to address potential APTC overpayments or fraud.

We are also concerned that the proposed language in § 155.320 (c)(3)(iii) and the removal of § 155.320(c)(5) could allow a state to perform periodic data matching more than two times per year. We believe twice a year, as currently enforced by HHS, is the correct balance between program integrity and consumer protection. Allowing states to perform data matching more than twice per year, especially with the problems we have sometimes seen when data matching is done (especially in states without integrated eligibility systems), could result in consumers erroneously losing their coverage without a legitimate increase in program integrity.

In the proposed rule, HHS disproportionately attributes weakening program integrity to lower income individuals. For example, HHS draws attention to recent increases in excess APTCs among households below 100% FPL, but does not acknowledge that higher income households have even greater rates of excess APTCs.[37] It is unclear whether these increases in APTCs is evidence of weakening program integrity, or whether consumers of all incomes struggle to accurately project and verify their income.

We are concerned that HHS's proposals will increase administrative burdens on consumers while not achieving the presumed benefits. Namely, it is unclear that additional verifications will reduce APTC overpayments among lower income households and strengthen program integrity considering low-income households' rate of excess APTCs is less than other

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[35] *See* Pamela Heard et al., *Health care administrative burdens: Centering patient experiences* (2021), available at https://pmc.ncbi.nlm.nih.gov/articles/PMC8522557/. *See also* Marla McDaniel et al., Urban Inst., *Customer Service Experiences and Enrollment Difficulties Vary Widely across Safety Net Programs* 12 (2023) (finding that fulfilling documentation requests for public benefits was more challenging for individuals with diagnosed mental health conditions than those without).
[36] *See* 90 Fed. Reg. 12942, 13013 (Mar. 19, 2025).
[37] *See Id* at 12965 (Table 2 shows the percent of APTC tax returns with excess APTCs increase as income increases).

populations.[38] Verifying income can be more challenging for individuals with lower incomes because they may lack formal documentation or may have inconsistent income streams.[39] These proposed changes appear to only impose additional barriers to affordable health care, increase instability for low-income families, and strain administrative systems.

C. § 155.315 60-Day Extension To Resolve Income Inconsistency

Similarly, we oppose HHS's proposal to remove § 155.315(f)(7) which requires marketplaces to provide a 60-day extension in addition to the 90 days currently provided to allow applicants sufficient time to provide documentation to verify household income. HHS acknowledges the value of the extended window as a significant percentage of individuals who successfully reconcile their matching errors make use of the 60-day extension.

The proposed rule states that in 2024, over half of consumers who successfully reconciled their data matching issues (DMIs) availed themselves of the 60-day extension.[40] And prior years showed that around one third of consumers required more than 90 days to reconcile DMIs. Meaning that the majority of those needing to verify their income benefit from the 60-day extension. Also, the error rate of the extension is low as these statistics measure successful reconciliations. HHS diminishes the value of these statistics by concluding that the remaining individuals who did not reconcile DMIs were inappropriately receiving APTCs despite the fact that other conclusions remaining equally likely (*e.g.* some consumers who failed to reconcile DMIs within these timeframes were still income-eligible for APTCs). Conversely, we believe the statistics alert us to the fact that the 90-day window does not reflect the reality and needs of consumers who wish to resolve DMIs. Sections 1411(c)(4)(B) and (e)(4)(A) of the ACA grant HHS authority to address the potential arbitrariness of the 90-day deadline and expressly allow deadline modifications to reduce the administrative costs and burdens on individuals. Accordingly, HHS acted within its authority when it added a 60-day extension.

We disagree with HHS's current characterization that the additional 60 days "only" serves to maintain the coverage of people who were able to provide documentation within the extended deadline. HHS previously argued that maintaining APTCs through the 60-day window ensured continuous coverage.[41] We align with these previous findings, and add that reducing coverage losses for income-eligible individuals are important legal and moral obligations. Observing these duties maintains program integrity. Contrary to HHS's assessment, the integrity of marketplaces are not preserved when it encourages the loss of coverage of those who remain income-eligible for its programs.

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[38] *Id.*
[39] *See generally* Marla McDaniel et al., Urban Inst., *Customer Service Experiences and Enrollment Difficulties Vary Widely across Safety Net Programs* 7–12 (2023) (listing a variety of barriers low-income individuals face when applying for public health benefits).
[40] 90 Fed. Reg. 12942, 12963 (Mar. 19, 2025).
[41] 88 Fed. Reg. 25819.

We oppose the removal § 155.315(f)(7) due in large part to the statistics cited by HHS. The data reveals that the majority of consumers need more than 90 days to resolve income verification issues. HHS acted within its ACA authority to address these concerns by extending the 90-day deadline. Removing the extension would have harmful impacts on individuals' ability to access affordable care. Many income-eligible individuals would lose coverage if HHS removes the provision. Thus, any financial gains credited to this policy change would not be a true savings but rather a harmful cut at the expense of people's ability to access affordable health care.

§ 155.335 Annual Eligibility Redetermination

We have serious concerns about HHS's proposal to impose a $5 premium penalty on individuals who are currently automatically re-enrolled into $0 premium Marketplace plans in states with FFEs and SBEs. Specifically, HHS proposes to amend the annual eligibility redetermination procedure by adding § 155.335(a)(3) and (n) to prevent enrollees from being automatically re-enrolled in coverage with APTC that fully covers their premium if they do not actively confirm their eligibility. If HHS does enact a premium penalty on such individuals, we oppose making it more than $5.

Automatic re-enrollment benefits everyone. It reduces the administrative burden on enrollees and marketplace service centers, and it promotes continuous enrollment. HHS's proposal would create confusion for enrollees, increase premium costs for enrollees, and ultimately result in coverage loss throughout the country, risking chaos in the marketplaces.

The ACA significantly modernized and streamlined the process of enrolling in a health plan, and its procedures—including automatic re-enrollment—have become the standard to which people living in the United States who obtain their health care through the marketplaces are accustomed. And since 2021, households with income below 150% FPL have been able to avail themselves of both $0 premium plans *and* automatic re-enrollment in those plans.

HHS's proposal, which would decrease the APTC amount by $5 for individuals who are currently automatically re-enrolled into a $0 premium plan, and then send them bills for that amount every month until eligibility is confirmed, will create mass confusion for these enrollees. Enrollees who understood themselves to be enrolled in a $0 premium plan (and who, in actuality, still are) will be surprised and perplexed to receive a notice from the marketplace, and a bill from their qualified health plan (QHP), for a premium that they should not owe.

This confusion will place a considerable administrative burden on enrollees as they attempt to determine the origin of the bill, reconcile the existence of the bill with their understanding of their plan eligibility, pay the bill so they do not have their coverage terminated, and then confirm the eligibility information HHS proposes must be confirmed so they do not continue to receive the $5 premium penalty. It is important to note that these enrollees do not presently have payment information on file, which is yet another administrative step they

will be required to take. Forcing enrollees to undertake these extra steps erodes enrollee trust and satisfaction, and doing so in the name of program integrity is unnecessary given the availability of other interventions that do not place such a burden on enrollees. Moreover, such confusion and administrative burden has been linked to coverage loss; even "minor hassles" impact people's ability to "secur[e] and maintain health coverage."[42]

HHS's proposal also puts enrollees who are typically automatically re-enrolled, but who are enrolled into new plans because their old plans have been discontinued, at risk of coverage loss. If they are enrolled into a new $0 premium plan but they do not verify their information in accordance with the proposed requirements, then the $5 premium penalty becomes, in effect, a binder payment. If the affected enrollee does not make the binder payment, then their coverage does not effectuate. That enrollee is then without coverage until the next OEP (assuming they do not become eligible for an SEP). Moreover, they likely will not realize they are not covered until they attempt to use their coverage, leaving them in need of yet unable to obtain care.

The proposed rule also stands to place an additional financial burden on the country's most economically vulnerable households, making their coverage costlier in the short term and ultimately placing them at greater risk of uninsurance, should they be unable to pay the $5 premium penalty. It is unclear from the proposed rule how the premium penalty will be credited back to enrollees once they verify their information, and we have serious concerns about enrollees losing that money. The proposed rule could also be particularly catastrophic for an enrollee who misses the marketplace notice informing them of the $5 premium penalty for several months in a row. It could also have a ripple effect for affected enrollees: for example, an enrollee whose coverage is terminated for failure to pay the premium penalty over several months may, with the proposed elimination of 45 C.F.R. § 147.104(i), be required to pay those past-due premium amounts before they can effectuate new coverage in another year. HHS's proposal also comes at a time of uncertainty for the federal enhanced premium tax credits, which are in danger of expiring at the end of 2025—meaning even fewer enrollees may have access to $0 premium plans. Those who retain marketplace coverage also stand to be harmed: the potential coverage losses that HHS's proposal risks setting in motion will destabilize the risk pool, resulting in higher costs for everyone.[43]

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[42] Adrianna McIntyre & Mark Shepard, *Automatic Insurance Policies—Important Tools for Preventing Coverage Loss*, 386 New Eng. J. Med. 408, 408 (2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC9597888/; *see also* Keith Marzilli Ericson, et al., *Reducing Administrative Barriers Increases Take-Up of Subsidized Health Insurance Coverage: Evidence from a Field Experiment* (Nat'l Bureau of Econ. Research, Working Paper No. 30885, 2023), https://sacarny.com/wp-content/uploads/2024/06/ELMS-Admin-Barriers-2024-05.pdf (the act of having to pay the premium is an additional hassle that impacts getting and keeping coverage).

[43] A 2019 analysis estimated that eliminating automatic re-enrollment as proposed in the 2020 NBPP would have increased premiums by 5.7% by 2025, in part because of the projected coverage losses that would have resulted. *See* Avalere, *HHS Proposed Changes Could Reduce ACA Coverage and Increase Premiums* (Feb. 18, 2019), https://avalere.com/press-releases/hhs-proposed-changes-could-reduce-aca-coverage-and-increase-premiums.

HHS contends that this proposed policy will benefit enrollees by reducing surprise tax liabilities, increasing their awareness and engagement in their health coverage decisions, and ensuring that their coverage aligns with their current needs and eligibility. But the enrollees who are and remain eligible for $0 premium plans (as evidenced by their re-enrollment into such a plan) are unlikely to accrue any tax liability. If their needs change, they have the choice to enroll in a new plan that meets those changing needs—or not. If they are being automatically re-enrolled into the same plan, then their eligibility has not changed, and their coverage is already aligned with their eligibility. In all of these situations, a financial penalty is unnecessary at best and punitive at worst.

There are already ample safeguards in place that protect against erroneous eligibility determinations and the "increased federal spending" about which HHS states it is concerned. For example, excess APTC is paid back in part or entirely, depending on the tax filer's income, at reconciliation. And eligibility for health plans is still redetermined annually, including for those who are automatically re-enrolled. If HHS wishes to redouble its efforts to increase enrollee engagement with the enrollment process, there are less potentially harmful ways to do so, such as increasing education and outreach efforts (the success of which HHS acknowledges).[44]

HHS also seeks comment on its renewed proposal to automatically re-enroll eligible individuals who do not confirm their information into a policy *without any* APTCs at all. We strongly oppose this proposal. As HHS itself acknowledges, this approach is likely to place enrollees in significant debt to issuers, which will financially harm enrollees and create "significant barrier[s] to accessing health coverage."[45] No degree of concern regarding program integrity—especially when such concern is addressed so readily by other, less draconian interventions, as described above—justifies upending the health care access and finances of enrollees in the way that HHS's proposal would do.

We also have concerns about HHS's proposal to eliminate the automatic enrollment hierarchy at § 155.335(j)(4) that allows marketplaces to move enrollees from bronze to silver QHPs if a silver QHP is available in the same product, with the same provider network and with a lower or equivalent net premium at the bronze plan. The enrollment hierarchy vastly improves enrollee experience by providing more comprehensive coverage for the same or lesser cost. Further, as HHS notes, eliminating it would result in only a small reduction in APTC expenditures.[46] As such, any potential cost savings to HHS is clearly outweighed by the benefit to enrollees, and does not justify the proposal.

Finally, if this provision is finalized, state-based exchanges (SBEs) should not be required to modify their re-enrollment procedures to implement a $5 premium penalty. SBEs should retain the flexibility to determine their own enrollment procedures, factoring in state-specific considerations.

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[44] 90 Fed. Reg. 12942, 12970 (Mar. 19, 2025).
[45] *Id*.
[46] 90 Fed. Reg. 12942, 13015 (Mar. 19, 2025).

§§ 147.104(b)(2), 155.410 Limited Open Enrollment Periods, Annual Open Enrollment Period

We are concerned about HHS's proposal to shorten the annual open enrollment period (OEP). A longer OEP benefits enrollees, issuers, and enrollment assisters. Shortening the OEP will increase the burden on enrollees and hurt overall enrollment numbers.

HHS contends that shortening the OEP will reduce enrollee confusion and prevent people from missing a month of coverage because they enrolled in January instead of December. But HHS does not explain how shortening the OEP will, in itself, ensure that people sign up by the December 15 deadline. We are concerned that the same people will continue to wait until January 15 to sign up for coverage, but now risk being without coverage for an entire year—not just a month—if they are not otherwise eligible for a SEP. HHS further asserts that most people have become accustomed to enrolling in coverage by December 15, so the January 15 deadline is unnecessary. Even if most people sign up for coverage by an earlier date, that does not support eliminating the later deadline if it is still capturing people who would otherwise be uninsured.[47]

Closing open enrollment on December 15 is also problematic because it puts enrollees in the position of having to pick a plan during the holiday season, which is generally a time of increased financial and psychological burden; one analysis called this period "the worst time of the year to require complex health insurance enrollment decisions."[48] A January 15 deadline gives people additional time to make competent, informed decisions about their coverage without being distracted by the demands of one of the most stressful periods of the year.

As HHS notes, retaining a longer OEP also allows time for people who are automatically re-enrolled into plans with cost increases—which often do not become apparent until enrollees receive their first bill in early January—to change to a more affordable plan.[49] Without that opportunity, people in this situation may end up stuck in a plan that they cannot afford. And, if they are unable to pay the costlier premiums, they risk having their health insurance terminated and being without coverage until the next OEP.

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[47] For example, in the final five days of California's 2025 OEP, more than 46,000 people newly enrolled in coverage through California's SBE. *See* Covered California, *Covered California Reaches Record-Breaking 1.9M Enrollees Before Open Enrollment's Jan. 31 Deadline* (Jan. 29, 2025), https://www.coveredca.com/newsroom/news-releases/2025/01/29/covered-california-reaches-record-breaking-1-9m-enrollees-before-open-enrollment-s-jan-31-deadline/ (299,060 new enrollees as of January 26, 2025); *see also* Covered California, *Covered California Reaches Landmark Achievement with Nearly 2 Million Enrolled as Open Enrollment Concludes* (Feb. 20, 2025), https://www.coveredca.com/newsroom/news-releases/2025/02/20/covered-california-reaches-landmark-achievement-with-nearly-2-million-enrolled-as-open-enrollment-concludes/ (345,711 new enrollees at the end of the OEP).

[48] Katherine Swartz & John A. Graves, *Shifting the Open Enrollment Period for ACA Marketplaces Could Increase Enrollment and Improve Plan Choices*, 30 Health Affairs 1286 (2014).

[49] 90 Fed. Reg. 12942, 12978 (Mar. 19, 2025).

Shortening the OEP will also impact enrollment assisters' work. Navigators, insurance agents and brokers, Certified Application Counselors, and other enrollment assisters already work long hours to reach prospective and active enrollees during the OEP; shortening that period will leave them with less time to reach all who need assistance.[50] This is especially concerning following the recent massive cuts to the federal Navigator program. With less funding *and* a shorter OEP, there will be fewer helpers to meet the needs of enrollees, and less time for them to try. Inevitably, people will be left behind, and coverage loss will result.

HHS also asserts, without explaining how, that shortening the OEP will reduce the risk of adverse selection. But research has found that making health insurance enrollment easier in general—including through expanded enrollment periods—does not increase the risk of adverse selection.[51] Additionally, previous comments from states running SBEs noted that extending the OEP until January in their states did not introduce adverse selection into their markets.[52] In fact, a longer OEP allowed these states to ensure additional eligible individuals could enroll in coverage.[53]

If HHS does shorten the OEP, we recommend that the shorter OEP should not take effect until plan year 2027. This will provide the marketplaces additional time to strategize how to perform outreach, education, and marketing for a shorter OEP. This will also ensure that, if enhanced subsidies are allowed to expire at the end of 2025, people will have the chance to make informed decisions regarding their coverage once they see the new, higher cost for coverage starting January 2026.

Additionally, should HHS implement this proposal, we urge HHS to engage in extensive outreach to inform enrollees as widely as possible about the changes. Broad public information campaigns, as HHS suggests it may undertake, are a good start and an approach we support. We also urge HHS to develop outreach materials in multiple languages and to employ additional, targeted outreach strategies such as personalized mailers and phone calls; such approaches have been associated with increased enrollment and fewer plan choice errors.[54]

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[50] Families USA, *Navigators Help Open the Door to Health Coverage During Open Enrollment* (Jan. 3, 2023), https://familiesusa.org/resources/navigators-help-open-the-door-to-health-coverage-during-open-enrollment/ (commenting on the particular importance of Navigators during the OEP).
[51] *See, e.g.*, Sarah Lueck, *Proposed Change to ACA Enrollment Policies Would Boost Insured Rate, Improve Continuity of Coverage*, Ctr. on Budget and Pol'y Priorities (Jun. 5, 2019), https://www.cbpp.org/research/health/proposed-change-to-aca-enrollment-policies-would-boost-insured-rate-improve.
[52] 90 Fed. Reg. 12942, 12979 (Mar. 19, 2025).
[53] *Id*. (commenting on "the benefits of increased consumer enrollments.")
[54] HHS, *Reaching the Remaining Uninsured: An Evidence Review on Outreach & Enrollment* at 7 (2021), https://aspe.hhs.gov/sites/default/files/documents/666bcb121e373ec517def3b1fcd4af23/aspe-remaining-uninsured-outreach-enrollment.pdf.

Finally, we oppose the proposed requirement that SBEs shorten their OEPs to 45 days. We also oppose any restrictions on SBEs using blanket SEPs to extend their OEPs. SBEs are in the best position to decide their own enrollment periods, factoring in state-specific considerations.

§ 155.400 Premium Payment Threshold

At § 155.400(g), HHS proposes to revoke the provision in the recently finalized 2026 Final Regulations that gives qualified health plans (QHPs) additional ways to avoid terminating coverage for individuals who underpay premiums by a de minimus amount. Specifically, the rule proposes to remove paragraphs (2) and (3), which allow QHPs to implement a fixed dollar and gross percentage-based premium payment threshold policy. If implemented, the rule would limit QHPs to the net percentage-based premium payment threshold at § 155.400(g)(1), which restricts QHPs to setting a premium payment threshold policy at 95% of the net premium or higher.

This proposed change will negatively impact enrollment in the marketplaces. QHPs need additional flexibilities to maintain coverage for enrollees who only owe a de minimus amount of their premiums. Individuals may be unaware of the small premium amounts that are outstanding, and the additional flexibilities laid out in the 2026 Final Regulations prevent unnecessary disruptions in health insurance coverage and medical care. Also, in many instances, triggering grace period notices or cancelling the plan of an individual for non-payment of a de minimus amount of the premium is too severe of a consequence. This provision, coupled with the proposal to impose a $5 premium penalty for individuals who currently are automatically re-enrolled in a plan, will result in marked declines in marketplace enrollment.

§ 155.420 Monthly Special Enrollment Period for APTC-Eligible Qualified Individuals with a Projected Household Income at or Below 150 Percent of the Federal Poverty Level

HHS proposes to eliminate the low-income special enrollment period (SEP) currently available at § 155.420(d)(16) for enrollees and their dependents who are eligible for APTC and whose projected household income is at or below 150% of the federal poverty level (FPL). HHS also proposes a conforming amendment to remove § 147.104(b)(2)(i)(G), which excludes § 155.420(d)(16) as a triggering event for a limited open enrollment period for coverage outside of the marketplace. Additional conforming changes are proposed to remove § 155.420(a)(4)(ii)(D) and § 155.420(b)(2)(vii) and to amend the introductory text of § 155.420(a)(4)(iii) to remove reference to paragraph (d)(16).

Individuals have limited opportunities to enroll in marketplace coverage, and if they miss the annual open enrollment period (OEP), they may not be able to enroll later unless they experience a qualifying life event (QLE). The 2025 Final Regulations made the 150% FPL SEP permanent, recognizing the continued need to provide additional opportunities for low-income individuals and families to enroll in free or low-cost coverage that was previously

available on a temporary basis during the COVID public health emergency.[55] In finalizing this SEP, HHS expressly stated that there would be no fiscal impact to implementing the 150% FPL SEP if the federal enhanced subsidies under the Inflation Reduction Act are continued beyond 2025.[56]

The 150% FPL SEP is critical to providing low-income individuals and families a monthly opportunity to enroll in affordable marketplace coverage. The SEP also allows individuals to switch plans, so that they can take advantage of Silver plans with $0 cost-sharing. Many individuals who use the 150% FPL SEP, and did not enroll during the OEP, may not have been aware of their option to enroll in a plan with no monthly premium through the marketplace. For example, low-income individuals who are juggling multiple jobs may miss the annual OEP entirely because they are focused on meeting their basic needs, and may be unaware of the option for zero-cost or low-cost plans. The 150% FPL SPE is particularly important for individuals who churn off Medicaid, young people, and people of color.[57]

The 150% FPL SEP helps ensure that low-income individuals and families have multiple opportunities to access coverage so that they do not go uninsured for long periods of time. This SEP helps enroll chronically uninsured individuals who would not otherwise enroll, despite outreach and marketing efforts. This SEP also helps low-income individuals stay on top of their preventive care, so that health conditions do not go unchecked and end up costing the health care system more money.

HHS argues that eliminating the 150% FPL SEP would improve the risk pool by reducing adverse selection by people who wait to enroll until they need health care services. We do not find this argument persuasive. Individuals and families eligible for the 150% FPL SEP are likely young and healthy, and with zero dollar or low-cost premiums, there is no cost-related reason that individuals in this population would delay enrollment. Also, health services are not immediately available through the 150% FPL SEP, so it is a flawed argument to suggest that individuals and families enroll to receive medical care right away. State experiences with low-income SEPs also demonstrates that they do not lead to adverse selection. For example, Massachusetts has had a low-income SEP for individuals and families in place since 2014 that is touted as key to "boosting the health and stability" of the marketplace.[58]

The 150% FPL SEP has been widely used by marketplaces across the country. A recent survey found that 21 states, in addition to the FFM, have a low-income SEP.[59] Of these

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[55] 89 Fed. Reg. 26218, 26405 (Apr. 15, 2024).
[56] *Id.*
[57] Keith, Katie, *New Special Enrollment Period for Low-Income People Could Boost Coverage,* The Commonwealth Fund (Sept. 7, 2021), https://www.commonwealthfund.org/blog/2021/new-special-enrollment-period-low-income-people-could-boost-coverage.
[58] *Id.*
[59] Rachel Swindle et al., *ACA Marketplace Models and Key Policy Decisions,* The Commonwealth Fund (last visited March 27, 2025), https://www.commonwealthfund.org/publications/maps-and-interactives/aca-state-marketplace-models-and-key-policy-decisions.

states, 8 states offer a SEP for populations above 150% FPL.[60] This illustrates the broad support for, and awareness of, low-income SEPs across the country. It will certainly take a substantial amount of time and resources to dismantle the 150% FPL SEP functionality in each state's marketplace, and there may be costly functionality changes associated with this process.

HHS states that after analyzing use of this SEP over time, there is an immediate need to halt this SEP. HHS proposes to stop this SEP across *all* marketplaces by the effective date of the rule, not in December 2025, due to the "growth of improper enrollments."[61] HHS states that the 150% FPL SEP has been used by insurance agents, brokers and web-brokers to improperly enroll individuals in marketplace plans. To the extent these improper enrollments exists, HHS should establish more guardrails on agents, brokers and web-brokers, not punitive policy changes against low-income individuals and families that will restrict their ability to enroll in marketplace coverage. Also, the speed at which HHS wants to dismantle the 150% FPL SEP is unrealistic. Marketplaces need time to reprogram systems, update notices, and change call center talking points. If HHS proceeds with implementing this provision, we urge HHS to eliminate the 150% FPL SEP on a less aggressive timeline.

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

HHS proposes to amend § 155.420(g) to reinstate pre-enrollment verification requirements for individuals and families to enroll in special enrollment periods (SEPs). Specifically, HHS proposes to require individuals and families to verify eligibility for several SEPs (marriage, adoption, moving to a new coverage area, loss of MEC, and Medicaid/CHIP denials) in the federal marketplace. The proposed rule also requires state-based marketplaces to newly conduct SEP eligibility verification for at least 75% of new enrollments through SEPs for individuals not already enrolled in coverage. Individuals would have their eligibility verified electronically, or would be asked to submit documentation to confirm eligibility for the SEP, and this process would need to be complete before coverage takes effect.

The burden of imposing pre-enrollment verification requirements on individuals and families seeking marketplace coverage outweighs HHS's concern about fraudulent enrollment and program integrity. SEP proofs, like paperwork confirming an adoption or marriage, are often difficult to track down from government agencies. Paperwork requests from government agencies and county offices also take time to process and mail to the consumer. Once the individual submits their proofs to their marketplace, incorrect information and errors in processing documents can cause delays in proving eligibility for the SEP. All of these administrative barriers could delay enrollment, or deter enrollment altogether.

It is well documented that the use of SEPs is grossly underutilized, so the additional administrative burden of pre-enrollment verifications will only further hinder marketplace

[60] *Id.*
[61] 90 Fed. Reg. 12942, 12980 (Mar. 19, 2025).

enrollment. One study which relied on CMS data found that fewer than 15% of uninsured SEP eligible individuals enroll in coverage.[62] Consumers may not be enrolling due to factors like lack of awareness, affordability concerns, or because of the difficulty of the enrollment and SEP verification process.[63] Regardless, the underutilization of SEPs contributes to annual enrollment declines, which ultimately results in a higher uninsured rate. Individuals and families will only be more deterred from enrolling in marketplace coverage through SEPs if pre-enrollment verifications are mandated.

Requiring SEP pre-enrollment verifications will likely deter healthy individuals and families from enrolling when they are eligible for a SEP. Data indicates that younger, healthier consumers submit SEP verification requirements at much lower rates than older consumers.[64] This is in part why the 2023 Final Regulations removed SEP verification requirements for all SEPs except loss of minimum essential coverage (MEC) for new consumers.[65] HHS also acknowledges in the preamble to this proposed rule that verifications can undermine the risk pool by ”imposing a barrier to eligible enrollees, which may deter healthier, less motivated individuals from enrolling.”[66] Overall, imposing pre-verification requirements for more SEPs will negatively impact the risk pool and adversely impact premium rates.

This proposed change will also be cumbersome for the federal marketplace and state marketplaces to implement. Requiring marketplaces to newly conduct SEP eligibility verification for at least 75% of new enrollments requires complex programmatic changes to the marketplace’s system, as well as the development of consumer notices, training for marketplace service center staff, and protocols for verifying proofs of income (both manually and electronically). Each SEP also requires different paperwork, and even if a SBE is only requiring pre-enrollment for 2 to 3 SEPs, this will require extensive training to ensure marketplace service center staff understand the requirements for each SEP.

The cost associated with implementing this provision is also prohibitive. HHS states that these changes will cost a state using the federal exchange approximately $12 million in one-time expenses, whereas the 5 states that did not previously conduct SEP verifications for at least 75% of enrollments would spend $60 million in one-time expenses.[67] Since marketplaces will have to perform additional pre-enrollment verifications, they are projected to incur ongoing costs of $46.7 million for fiscal years 2026 to 2029.[68] Additionally,

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[62] Matthew Buettgens et al., *More than 10 Million Uninsured Could Obtain Marketplace Coverage through Special Enrollment Periods,* Urban Inst. (Nov. 20, 2015), https://www.urban.org/sites/default/files/publication/74561/2000522-More-than-10-Million-Uninsured-Could-Obtain-Marketplace-Coverage-through-Special-Enrollment-Periods.pdf.
[63] *Id.*
[64] 87 Fed. Reg. 27208, 27278 (May 6, 2022).
[65] *Id.*
[66] 90 Fed. Reg. 12942, 12984 (Mar. 19, 2025).
[67] 90 Fed. Reg. 12942, 13017 (Mar. 19, 2025).
[68] *Id.*

marketplaces using the federal platform will incur annual labor costs of $2.8 million, whereas state marketplaces will incur annual labor costs of $1.7 million.[69]

For the reasons stated above, we opposed these proposed changes. If HHS proceeds with requiring more extensive pre-enrollment verifications across marketplaces, we urge HHS to track and make publicly available data on how many individuals and families have incomplete enrollment applications because of a problem with their SEP verification. Prior CMS data indicates that implementing a pre-enrollment verification process decreases the already low enrollment numbers through SEPs, and we anticipate that this proposed provision will negatively impacting enrollment numbers.[70]

§ 156.115(d) – Provision of EHB

HHS proposes to prohibit issuers of non-grandfathered individual and small-group market plans from covering "sex-trait modifications" as an essential health benefit (EHB), which would also allow insurers to impose annual or lifetime caps on such benefits. In essence, this proposal would prohibit states from updating their EHB base-benchmark plan in order to incorporate key gender-affirming care services for individuals experiencing gender dysphoria, regardless of whether such update complies with other regulatory EHB benchmarking and actuarial requirements, or otherwise required by law. For the reasons outlined below, NHeLP strongly opposes this proposal.

Gender dysphoria is a serious medical condition characterized by clinically significant distress or impairment in social, occupational, or other important areas of functioning due to a marked incongruence between the patient's gender identity (*i.e.*, the innate sense of one's own gender) and sex assigned at birth.[71] People diagnosed with gender dysphoria can greatly benefit from treatment. The standard of care for treatment of gender dysphoria is outlined in evidence-based clinical guidelines from medical professional associations such as the Endocrine Society and the World Professional Association for Transgender Health (WPATH).[72]

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[69] *Supra* note 53.
[70] U.S. Dept. of Health & Human Servs., *FAQs Regarding Verifications of SEPs* (Sept. 6, 2016), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/FAQ-Regarding-Verification-of-SEPs.pdf.
[71] *See* American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5-TR); *Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders: DSM-5-TR* at 512–13 (2022); see also World Health Org., *International Classification of Diseases*, Eleventh Revision (ICD-11) (2019/2021).
[72] Wylie C. Hembree, et al., *Endocrine Treatment of Gender Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLIN. ENDOCRINOL. & METAB. 3869 (2017), https://perma.cc/3L9J-428B; Eli Coleman, et al., *Standards of Care for the Health of Transgender and Gender Diverse People*, 23 INT'L J. TRANSGENDER HEALTH S1 (8th ed. 2022), https://perma.cc/7SU3-RPK9.

Barring medical care for individuals with gender dysphoria — while expressly proposing to create exceptions to cover these same services for other indications — is discriminatory.[73] In fact, the use of the term "sex-trait modifications" specifically targets individuals experiencing gender dysphoria and the transgender population to be denied care, since the Proposed Rule purports to allow states to require coverage of the same services, as EHB, when medically necessary to treat cisgender individuals.[74]

As support for the Proposed Rule, HHS references Executive Order 14168, which as HHS acknowledges is currently subject to two preliminary injunctions. That Executive Order is riddled with misinformation and misconceptions that are solely based on stigma towards transgender individuals and not on real science or medicine. Neither the Executive Order or the Proposed Rule explain why banning coverage of treatment for gender dysphoria represents a policy solution for a real and actual problem. Moreover, the Executive Order is limited to gender-affirming care for minors, while the Proposed Rule applies to treatment for gender dysphoria for both minors and adults.

In addition, by finalizing the proposed § 156.115(d), HHS would unnecessarily disrupt the carefully crafted balance that has been established between the need to ensure access to a minimum set of benefits for enrollees across the country and the idea that, as HHS expressed when it adopted the current EHB benchmarking framework in 2018, "states should have additional choices with respect to benefits, which may foster innovation in plan design and greater access to coverage…"[75] A wide range of states, from Illinois to South Dakota, have used the current benchmarking standard to update their benchmark plans in

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[73] For analysis of anti-trans animus underlying recent state bans on gender-affirming care and its parallels with anti-Black discrimination, both of which violate the Equal Protection Clause of the U.S. Constitution, see *Skrmetti v. U.S.*, Brief of Amicus Curiae NAACP Legal Defense & Educational Fund, Inc., In Support of Petitioner and Respondents in Support of Petitioner, (Sept. 2024), https://www.supremecourt.gov/DocketPDF/23/23-477/323943/20240903152518831_US%20v.%20Skrmetti%20-%20LDF%20Amicus%20Brief.pdf.

[74] While we believe it is clear that the Proposed Rule discriminatorily targets transgender people and individuals diagnosed with gender dysphoria, we caution that inadvertently, the Proposed Rule may also impact other medically necessary services. Cisgender people, or those who identify with their assigned sex at birth, frequently use the same medical care that is being questioned by HHS in the Proposed Rule. "Sex trait modification" is undefined in the Proposed Rule and indistinguishable from a host of medical interventions provided to cisgender persons, such as hormone replacement therapy for treatment of menopause, hormone blockers in the treatment of precocious puberty, mammoplasty, testicular implants, and circumcision. *See* Theodore E. Schall and Jacob D. Moses. *Gender-Affirming Care for Cisgender People*, 3 HASTINGS CTR. REP. 15–24 (2023), https://pubmed.ncbi.nlm.nih.gov/37285414/. HHS provides no indication on how it might differentiate how these services are provided, or the administrative burden and cost to issuers and regulators. For example, reconstructive mammoplasty is a normalized part of breast-cancer surgical care. In 1976, one psychoanalyst stated that mammoplasty "represented the restitution of loss, the restoration of an ideal or former self which [patients] could experience as their 'real' self, not as something artificial or added on, not a new identity but as 'really me.'" Similarly, the use of testicular implants has been found to be medically necessary in the treatment of cisgender men. Experts agree that that is not uncommon for cisgender men to be depressed following the loss of a testicle and that the procedure "frequently induced considerable psychic trauma," pointing to the need for testicular implants beyond the context of gender-affirming care for transgender individuals.

[75] 83 Fed. Reg. 17010 (April 17, 2018).

order to address specific gaps in coverage affecting their populations. This shows that the current approach, whereby HHS sets some minimum coverage standards and states decide when and to what extent to go beyond those standards, is working in the absence of national standards across EHB. It would also be contrary to the current administration's policies in many areas to return power to the states to prohibit them from covering certain services.[76]

A. HHS has no legal authority to categorically exclude gender dysphoria treatment as EHB

Congress gave the Secretary of HHS broad authority to define EHB.[77] However, that authority is not unlimited. For instance, the ACA requires the Secretary to ensure that EHB coverage and benefit design does not "discriminate against individuals because of their age, disability or expected length of life."[78] The Secretary also must "take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups."[79] Because gender dysphoria is recognized by experts as a disability, HHS's proposal to prohibit treatment for gender dysphoria as EHB is directly contrary to the plain language and intent of the law to provide patient protections and access to care.

The proposed ban on gender dysphoria treatment is unprecedented. When HHS originally promulgated § 156.115(d), it noted that "[i]n contrast with the benefits covered by a typical employer health plan, [routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, and non-medically necessary orthodontia] often qualify as excepted benefits."[80] However, HHS provides no evidence (and we are unaware of any evidence) that treatment for gender dysphoria has ever been offered by insurers as an excepted benefit plan.[81]

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[76] We have received reports that HHS has cancelled the EHB-Benchmark Plan Modernization Grant for States with a Federally-Facilitated Exchange, https://www.grants.gov/search-results-detail/356740. We are concerned that, if true, the cancellation of these grant funds will further impede state flexibility and efforts to upgrade their EHB benchmark plans.

[77] 42 U.S.C. § 18022(b)(1).

[78] *Id.* § 18022(b)(2)(A); (4)(B).

[79] 42 U.S.C. § 18022(b)(4)(C).

[80] *See* Dep't of Health and Hum. Srvs., Patient Protection and Affordable Care Act, *Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Proposed Rule*, 77 Fed. Reg. 70644, 70651 (Nov. 26, 2012); 78 Fed. Reg. 12845.

[81] As we have noted previously, the statutory language of the ACA does not mandate any express exclusion of benefits traditionally provided in excepted benefits plans from EHB. *See* Nat'l Health Law Prog., Letter to Dr. Ellen Montz Re: Potential Changes to Essential Health Benefits Regulations in the Notice of Benefit and Payment Parameters for 2025 (Sept. 13, 2023), https://healthlaw.org/wp-content/uploads/2023/09/NHeLP-Letter-to-CCIIO-on-EHB-authorities-9.2023.pdf; Nat'l Health Law Prog., RIN 0938-AV22; CMS-9895-P Patient Protection and Affordable Care Act, *HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (COOP) Program; and Basic Health Program* (Jan 8, 2024), https://healthlaw.org/resource/comments-on-the-notice-of-benefit-and-payment-parameters-for-2025/. Moreover, in 2024, HHS recognized that "oral health has a significant impact on overall health and quality of life" when it lifted the regulatory prohibition

Unlike § 156.115(d)'s general designation of eye exam services, home care benefits, and non-medically necessary orthodontia as non-EHB, HHS here seeks to prohibit specific medical services used by a specific population — transgender people diagnosed with gender dysphoria — even when they are medically necessary. This not only harms transgender people; it creates a dangerous precedent whereby HHS can ban medical treatments for other populations subject to stigma and discrimination. What is next? Banning treatment for HIV, substance use disorder, or sickle cell simply because a particular administration opposes it? The ACA's EHB provision, as well civil rights laws including Section 1557 of the ACA, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act, prohibit discrimination, including discrimination against people with gender dysphoria.[82]

In the past, HHS has used its authority to define, within the benchmarking framework, minimum standards for states to follow or to expand the flexibilities afforded to states.[83] The agency has never sought to ban states from including non-excepted benefits that comply with the actuarial limitations, much less when those bans involve potential violations of nondiscrimination protections that would contravene the EHB standards. Subjecting services for gender dysphoria to this unprecedented standard would be a radical departure and would exceed HHS' legal and regulatory authority.

B. HHS falsely claims that employer-sponsored plans exclude coverage of gender-affirming care

HHS bases the Proposed Rule on the ACA's provision requiring that EHB be equal in scope to coverage in typical employer plans. There are various problems with HHS' rationale. First, HHS claims that the fact that treatment for gender dysphoria does not squarely fit within any of the ten listed EHB categories, supports the exclusion of these services from coverage as EHB. This analysis is factually and legally incorrect. All gender-affirming care services can be classified under some of the ten listed categories, such as hospitalization, ambulatory care, and prescription drugs.[84] Even if the services were outside

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on non-pediatric, non-routine oral health services as EHB, proving that even for benefits considered excepted benefits, the agency has been willing to expand state flexibility when the evidence points towards significant need and benefit of covering a specific service. Dep't of Health & Human Srvs., *Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO–OP) Program; and Basic Health Program Final Rule*, 89 Fed. Reg. 26218, 26342 (Apr, 15, 2024), https://www.govinfo.gov/content/pkg/FR-2024-04-15/pdf/2024-07274.pdf.

[82] *See*, *e.g.*, *Prescott v. Rady Children's Hosp*. (S.D.C.A. 2016), *Flack v. Wisconsin Dept. of Health Srvs.* (W.D. Wis. 2018), Boyden v. Conlin (W.D. Wis. 2018), *Tovar v. Essentia Health* (D. Minn. 2018), *Williams v. Kincaid,* 45 F.4th 759, 766 (4th Cir. 2022).

[83] *See*, for example, 45 C.F.R. § 156.115(a)(3) (requiring that plans comply with mental health and substance use disorder parity laws); *Id.* § 156.115(a)(5) (requiring plans to cover habilitative services on the same level as rehabilitative services); and *Id.* § 156.122 (establishing minimum coverage requirements for prescription drugs).

[84] Katie K. & Jason L., *HHS Proposes to Restrict Marketplace Eligibility, Enrollment, and Affordability in First Major Rule Under Trump Admin (Part 1)*, HEALTH AFF. FOREFRONT (2025),

the scope of the ten listed categories, however, a plain reading of the statute shows that Congress' intent was for HHS to ensure that, *at a minimum*, EHB were defined as including services in the ten categories listed in the statute. It is clear that HHS, and states through benchmarking, have authority to require coverage of services outside of the scope of the ten categories as EHB. Any other conclusion would make the words "at least" meaningless.

Second, the way HHS references typical employer plans is not in line with the way the agency has defined typicality in recent rules. Current EHB rules define a "typical employer plan" as "one of the selecting State's ten base-benchmark plan options established at § 156.100, and available for the selecting State's selection for the 2017 plan year; or the largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the State."[85] Using that definition, a state should be allowed to require coverage of services for gender dysphoria as EHB if *any one* of those options provides coverage for the services in question. Instead, HHS vaguely and generally discusses the supposed lack of coverage in some of those plans, a standard that is contrary to the current rule on typicality.

Third, HHS claims, without evidence, that treatment for gender dysphoria is not typically covered in employer plans.[86] This is false. The Proposed Rule only cites one report from the Movement Advancement Project (MAP) to support HHS' claim that employer-sponsored plans do not typically cover treatment for gender dysphoria, despite numerous studies that show otherwise and are discussed below.[87] In addition, MAP's report does not show what the proposed rule claims. The report suggests that 55% of transgender people live in states with bans on gender-affirming care. However, that's not the same thing as an analysis of how many employers categorically exclude treatment for gender dysphoria from coverage (especially since many large group employers self-insure and will not be subject to those state laws). Further, HHS cherry-picked their statistics from MAP's report, which also states that twenty-four states and DC explicitly *include* gender-affirming care in their health benefits for state employees.[88]

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https://www.healthaffairs.org/content/forefront/hhs-proposes-restrict-marketplace-eligibility-enrollment-and-affordability-first-major.

[85] 45 C.F.R. § 156.111(b)(2)(i)(A)

[86] As we discuss in our comments, we strongly object to HHS' position that services for gender dysphoria are not covered by typical employer plans. However, even if that were the case, we believe it would make little sense for the typicality requirement to exclude services that are not typically covered from coverage because Congress' intent, in passing the ACA, was to improve upon pre-ACA coverage. Before the ACA, it was common for plans to exclude services we now consider typically covered, such as services within the maternity and newborn services and mental health and substance use disorders categories. Therefore, we believe the typicality requirement should be read as a floor or minimum level of coverage and should not be read to allow a ban on coverage of services that have traditionally not been covered by employer plans, but are now considered essential. This reading aligns with HHS' authority to periodically review and update EHB coverage to keep up with medical evidence or scientific advancement. *See* 42 U.S.C. § 18022(4)(G).

[87] Movement Advancement Project, *Equality Maps: Healthcare Laws and Policies* (Mar. 28 2025), https://www.mapresearch.org/equality-maps/healthcare_laws_and_policies.

[88] *Id.*

HHS attempts to justify the Proposed Rule by saying that twelve states do not mention or have no clear policy regarding gender-affirming care. However, this lack of clarity is likely because gender-affirming care encompasses a wide array of services that are also used to treat other health conditions, in addition to treatment for gender dysphoria, so coverage may not explicitly be stated in some health plans. Apparent silence or omission in state employee health plans does not justify entirely excluding these services from EHB.

HHS also ignores various other studies and reports documenting how employers are providing and expanding coverage of treatment for gender dysphoria and gender-affirming care. In fact, employers increasingly work to ensure their health insurance plans cover treatments for gender dysphoria for their employees. In its annual assessment of corporate benefits, policies, and practices, the Human Rights Campaign found that 72% of Fortune 500 businesses offer coverage of gender-affirming care, as well as 91% of businesses listed on the Corporate Equality Index.[89] This means that over 1,300 of the largest corporations in the United States cover treatment for gender dysphoria, twenty-eight times as many employers as in 2009, showing the increasing coverage of these services.[90]

An October 2024 peer-reviewed study found that in 2023, over 72% of all people seeking gender-affirming care had their care covered by commercial health insurance.[91] In practice, this means that a vast majority of people seeking gender-affirming care are primarily covered by commercial insurance.[92] A 2025 study found that over 92% of ACA marketplace silver plans from all fifty states plus DC did not exclude gender-affirming care and over 54% of all plans specifically included language indicating that at least some medically necessary care would be covered.[93] Further, a 2022 peer-reviewed study found that people receiving and accessing gender-affirming care through private insurance increased rapidly from 2011 to 2019.[94] Even if states are not explicitly mandating coverage of treatment for gender dysphoria, which at least twenty-four states and DC do, employers are continuing to provide and even expand coverage of these services.

C. Banning gender-affirming care as EHB will harm persons diagnosed with gender dysphoria

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[89] Human Rights Campaign, *Corporate Equality Index 2025: Rating Workplaces on Lesbian, Gay, Bisexual, Transgender, and Queer Equality* (Jan. 2025), https://www.hrc.org/resources/corporate-equality-index.
[90] *Id.*
[91] Jason Brian Gibbons, et al., *Insurance Type and Social Determinants of Health for Individuals Seeking Gender-Affirming Care in the United States*. J Gen. Intern. Med. (Oct. 2024). https://doi.org/10.1007/s11606-024-09040-x.
[92] *Id.*
[93] Out2Enroll, *Summary of Findings: 2025 Marketplace Plan Compliance with Section 1557 of the Affordable Care Act* (2024), *available at* https://drive.google.com/file/d/1FpSNyaZVfC25o3zXnYBWUVaYRWokwbwg/view?usp=sharing.
[94] Kellan Baker & Arjee Restar, *Utilization and Costs of Gender-Affirming Care in a Commercially Insured Transgender Population*, 50(3) J. LAW MED. ETHICS 456 (2022), https://doi.org/10.1017/jme.2022.87.

The definitions HHS uses in this Proposed Rule are unscientific and lack an understanding of human biology. The preamble defines "sex" as a "person's immutable biological classification as either male or female," with the term "female" described as a person "of the sex characterized by a reproductive system with the biological function of producing eggs," and "male" as a person "of the sex characterized by a reproductive system with the biological function of producing sperm." This definition is simplified to the point of fatuousness as it excludes individuals who identify with their sex assigned at birth but who have medical conditions that make them unable to reproduce.

Moreover, as the Williams Institute notes, while there is no universal definition of the word "sex," medical professionals and social scientists have long understood that sex and gender are complex and intertwined concepts.[95] Researchers also note there is evidence to suggest there are biological bases for a gender identity that is incongruent with a person's sex assigned at birth.[96] In addition, there can be considerable variation in sex characteristics, like reproductive systems, that this definition does not consider.[97] This uninformed and unscientific proposed rule will have far-reaching consequences beyond the intended target of transgender people.

1. *Gender-affirming care is scientifically and medically well-established*

The proposed rule states that "[w]e are also concerned about the scientific integrity of claims made to support [the] use [of gender-affirming care services] in health settings."[98] It is unclear what concerns HHS has regarding the scientific integrity of gender-affirming care in health care settings. Gender dysphoria is clearly defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as a serious health condition. It is defined as "the marked incongruence between a person's experienced or expressed gender and the one they were assigned at birth" and associated clinically significant distress or impairment in social, occupational, or other important areas of functioning.[99] Gender dysphoria is recognized by national medical associations like the American Academy of Pediatrics (AAP), the American Medical Society (AMA), and the American Psychological Associations (APA).[100] Treatment of gender dysphoria is established by evidence-based medical standards of care that are maintained by medical experts such as the Endocrine Society

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[95] Elana R., Williams Inst., *Impact of the Executive Order Redefining Sex on Transgender, Nonbinary, and Intersex People* (Jan 2025). https://williamsinstitute.law.ucla.edu/publications/impact-eo-redefine-sex-tbi/.

[96] E. C., et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*. 23(sup1) INT'L J. OF TRANSGENDER HEALTH S1 (2022) https://www.tandfonline.com/doi/10.1080/26895269.2022.2100644.

[97] *Id.*

[98] 90 Fed. Reg. 12987.

[99] Garima G., et al., *Gender Dysphoria* (2023). StatPearls https://www.ncbi.nlm.nih.gov/books/NBK532313/; American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders at 452 (5th ed., 2013).

[100] *Skrmetti v. U.S.*, Brief of Amicus Curiae NAACP Legal Defense & Educational Fund, Inc., *supra* note 73.

and are endorsed by every major U.S. medical association such as the AMA and the APA.[101]

International organizations also recognize that gender-affirming care is medically necessary, effective, and safe as a treatment of gender dysphoria.[102] The WPATH is an international, multidisciplinary professional association that promotes evidence-based care, education, research, and public policy in regards to transgender health care. WPATH promotes a high standard of care for transgender and gender diverse people. WPATH first established a Standard of Care (SOC) in 1979 and has since released an updated version in 2022 (SOC-8). This resource is based on the best available science and professional consensus and provides health care professionals with clinical guidance on providing safe and effective care to transgender individuals through physical and mental health care.[103]

The Endocrine Society is a global community of physicians and scientists dedicated to accelerating scientific breakthroughs and improving patient care. The Endocrine Society takes the position that their Clinical Practice Guidelines on gender dysphoria establishes a "methodical, conservative framework for gender-affirming care, including pubertal suppression, hormones, surgery, and standardized terminology for health care professionals." These recommendations include evidence that treatment for gender dysphoria is medically necessary and should be covered by insurance.[104]

2. Gender-affirming care saves lives and limiting gender-affirming care causes harm

Cornell University researchers conducted a systematic literature review of all peer-reviewed articles published between 1991 and 2017 that assessed the effect of gender transition and transgender individuals' well-being. Ninety-three of the analyzed studies found that gender transition improves the well-being of transgender people, while no studies concluded that gender transition causes overall harm.[105] The researchers also found that gender transition is effective for treating gender dysphoria. Gender-affirming care can significantly improve mental health conditions like anxiety, depression, suicidality, and substance use while those who cannot access treatment are more likely to experience those harms.[106]

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[101] Katie K. & Jason L., *supra* note 84; *See* Advocates for Trans Equality, *Medical Organizations Statements*. https://transhealthproject.org/resources/medical-organization-statements/. Theodore E. Schall & Jacob D. Moses. *Gender-Affirming Care for Cisgender People*, 3 HASTINGS CENTR. REP. 15 (2023), https://pubmed.ncbi.nlm.nih.gov/37285414/.
[102] Advocates for Trans Equality, Medical Organization Statements, https://transhealthproject.org/resources/medical-organization-statements/.
[103] Katie K. & Jason L., *supra* note 84.
[104] Endocrine Soc'y, Transgender Health An Endocrine Society Position Statement (2020), https://www.endocrine.org/advocacy/position-statements/transgender-health.
[105] What We Know Project, Cornell University, *"What Does the Scholarly Research Say about the Effect of Gender Transition on Transgender Well-Being?"* (online literature review), 2018.
[106] *Id. See also* van der Miesen, et al., *Psychological Functioning in Transgender Adolescents Before and After Gender-Affirmative Care Compared with Cisgender General Population Peers*, 66(6) J. OF ADOLESCENT HEALTH 699 (2020) (finding that pubertal suppression in youth with GD has a positive effect on psychological functioning including a decrease in behavioral and emotional problems, a decrease in depressive symptoms, and improvement in general functioning); L.E.

Gender-affirming care improves life satisfaction as well. The 2022 U.S. Transgender Survey asked participants about their life satisfaction when living in a gender different from the one they were assigned at birth. Ninety-four percent of participants reported that they were either a lot more satisfied or a little more satisfied with their life. Further, 98% of those who were receiving hormone treatment reported that receiving hormones made them feel a lot more satisfied or a little more satisfied. Of those who had at least one form of gender-affirming surgery 97% felt that they were a lot more satisfied or a little more satisfied with their lives.[107]

The AMA urged state governors to oppose legislation that would prohibit medically necessary gender transition-related care for minors. They aptly called this effort to restrict care "a dangerous intrusion into the practice of medicine."[108] The AMA recognizes that transgender identity and other gender expansive identities are normal variations of human identity and expression. There is evidence that transgender people are more likely to be diagnosed with mental health disorders.

The Trevor Project's 2022 National Survey on LGBTQ Youth Mental Health found alarming rates of depression and anxiety among transgender youth. Overall, 58% of LGBTQ youth reported experiencing symptoms of depression including nearly two-thirds of transgender and non-binary youth. Seventy-three percent of LGBTQ youth reported experiencing symptoms of anxiety, including more than three-quarters of transgender and non-binary youth.[109] This increased prevalence of mental health conditions is likely to be a consequence of the chronic stress from experiencing societal stigma and discrimination based on a person's gender identity and expression.[110]

Similarly, the Williams Institute found that access to gender-affirming care is associated with a lower prevalence of suicidal ideation and attempts among adults. The researchers

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Kuper, et al., *Body Dissatisfaction and Mental Health Outcomes of Youth on Gender-Affirming Hormone Therapy*, 145(4) PEDIATRICS e20193006 (2020) (finding that transgender and non-binary youth starting either pubertal blockade or gender-affirming hormone treatment demonstrated improvement at follow up (around a year) in depression, anxiety and body esteem); A.N. Almazan & A.S. Keuroghlian, *Association Between Gender-Affirming Surgeries and Mental Health Outcomes* 156 JAMA SURGERY 611 (2021) (finding that gender-affirming surgeries are effective in treating gender dysphoria); K.E. Baker, et al., *Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review*, 5(4) J. OF THE ENDOCRINE SOC'Y 1 (2021) (A systematic review of 20 studies showing improved quality of life, decreased depression, and decreased anxiety with hormonal treatment in transgender people).

[107] Sandy E. James, et al., *Early Insights: A Report of the 2022 U.S. Transgender Survey. Nat'l Cent. for Transgender Equality* (2024), https://transequality.org/sites/default/files/2024-02/2022%20USTS%20Early%20Insights%20Report_FINAL.pdf.

[108] James L. Madara, AMA to States: Stop Interfering in Healthcare of Transgender Children, Am. Med. Ass'n (Apr. 26, 2021), https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children.

[109] The Trevor Project, 2022 National Survey on LGBTQ Youth Mental Health (2022), https://www.thetrevorproject.org/survey-2022/assets/static/trevor01_2022survey_final.pdf.

[110] *Id.*

also found that those who have been living in their gender identity for longer were less likely to experience suicidal ideation and attempts than those who had more recently transitioned.[111] This study found that of those who wanted and received gender-affirming care like hormone therapy or surgical care had significantly lower prevalence of suicidal thoughts and attempts than those who wanted gender-affirming care and did not receive it.[112] Other studies have found similar results. For example, one study found that transgender people who were ready but were unable to medically transition were more likely to have symptoms of depression than those who were able to medically transition.[113]

Gender-affirming care may also have an impact on substance use disorder. A study of transwomen found that access to gender-affirming care resulted in significantly lower odds of binge drinking and non-injection substance use than those who did not access gender-affirming care.[114] Substance use can be a coping mechanism for the chronic stress of discrimination and gender-affirming care may help mitigate this stress.[115]

In addition to the well-researched data on the harms of untreated gender dysphoria and the positive outcomes associated with gender-affirming care, efforts to change a person's gender identity to match with their gender assigned at birth are established to be ineffective and harmful.[116] The Williams Institute found that "de-transitioning," which is characterized by a transgender person returning to living as their assigned sex at birth, may be harmful. The researchers found that those who de-transitioned were significantly more likely to report suicidal ideation and attempts than those who did not de-transition. Of those who reported de-transitioning, almost 12% attempted suicide compared to nearly seven percent of those who did not de-transition.[117] Those that reported de-transitioning noted they did so because of social pressure and experiencing harassment and discrimination.

Mental health conditions like depression, anxiety, and substance use disorders are associated with premature mortality.[118] Studies have shown that people with mental health

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[111] Jody L. Herman, et al., *Suicidal Thoughts and Attempts Among Transgender Adults Findings from the 2015 U.S. Transgender Survey*. Williams Inst. (2019), https://williamsinstitute.law.ucla.edu/publications/suicidality-transgender-adults/.
[112] *Id.*
[113] Nooshin Khobzi Rotondi, et al., *Nonprescribed Hormone Use and Self-Performed Surgeries: "Do-It-Yourself" Transition in Transgender Communities in Ontario, Canada*, 103(10) AM. J. PUBLIC HEALTH 1830 (2013), https://pmc.ncbi.nlm.nih.gov/articles/PMC3780733/.
[114] Erin C. Wilson, et al., *Connecting the Dots: Examining Transgender Women's Utilization of Transition-Related Medical Care and Associations with Mental Health, Substance Use, and HIV*, 91(1) J. URBAN HEALTH 182 (2015), https://pmc.ncbi.nlm.nih.gov/articles/PMC4338120/.
[115] *Id.*
[116] Christy Mallory, et al., *Conversion Therapy and LGBT Youth*, Williams Inst. (2019), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Conversion-Therapy-Update-Jun-2019.pdf.
[117] Jody Herman, et al., *supra* note 111.
[118] Joe Kwun Nam Chan, et al., *Life Expectancy and Years of Potential Life Lost in People with Mental Disorders: A Systematic Review and Meta-Analysis*, 65 ECLINICALMEDICINE (2023). https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(23)00471-6/fulltext.

conditions have substantially reduced life expectancy relative to the general population.[119] With the well-established research on the negative effects of mental health conditions and on the importance of gender-affirming care for reducing the prevalence of mental health conditions for transgender people, it is cruel and unjust to apply unscientific barriers to life-saving care.

3. *Treatment Services for gender dysphoria are cost-effective*

Not only are the services that HHS seeks to ban effective in treating gender dysphoria and improving the mental health of transgender individuals, but studies have shown that the cost of providing the services is minimal. In fact, some states have used the current benchmarking flexibilities to add gender-affirming care services to their benchmarks and have done so precisely because an actuarial report showed that, because of the expected low utilization rates, the addition of the services would not exceed the actuarial limitations imposed by HHS. Colorado, for example, added gender-affirming care as well as other services because the State still had actuarial room to expand coverage even after adding gender-affirming care services.[120] These findings highlight that the services that HHS seeks to ban from coverage as EHBs can have an invaluable, often life-saving, impact on the lives of transgender individuals across the country, while having a negligible effect on premiums enrollees.

4. *The Proposed Rule affects individuals receiving treatment for gender dysphoria in states with benchmarks that already cover these services*

It is unclear to us whether gender-affirming care services would continue to be covered as EHB in states that currently include these services as part of their benchmark plans. The Proposed Rule states that "If a State mandates coverage of a benefit that is in its EHB-benchmark plan, the benefit will continue to be considered EHB…"[121] Later, however, the Proposed Rule states that "If this proposal is finalized as proposed, health insurance issuers will be prohibited from providing coverage for sex-trait modification as an EHB beginning in PY 2026."[122] Those sentences appear to contradict each other and HHS should clarify the agency's intentions. If, as we believe, HHS' intent is to allow issuers to stop covering treatment for gender dysphoria unless a state defrays the cost of coverage, then this policy will lead to massive disruption in those states that have relied on HHS' previous rules and guidance to update their benchmarks to add services without running afoul of defrayal requirements. The practical effect of this policy would be that enrollees that are currently receiving necessary services will have to face the reality that their

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[119] *Id.*; Sandra M. Meier, et al., *Increased Mortality Among People with Anxiety Disorders: Total Population Study*, 209(3) BRIT. J. PSYCHIATRY 216 (2016), https://pmc.ncbi.nlm.nih.gov/articles/PMC5082973/.
[120] *See* CMS, Information on Essential Health Benefit (EHB) Benchmark Plans, Colorado 2023–2026 EHB Benchmark Plan Information, https://www.cms.gov/files/zip/co-ehb-benchmark.zip.
[121] 90 Fed. Reg. 12987 (Mar. 19, 2025).
[122] *Id.*

insurance will likely stop paying for the services, and will have to either pay for them out-of-pocket or end their treatment altogether.

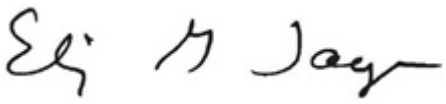
Transgender individuals whose insurance stops paying for their gender dysphoria treatment are thus likely to be forced to detransition. The vast majority of individuals who detransition attribute their detransition to external factors, including lack of coverage of services.[123] When individuals detransition for factors outside of their control, it can lead to harmful health consequences, including anxiety, depression, and increased risk of suicidal tendencies.[124]

Conclusion

We have included numerous citations to supporting research, including direct links to the research. We direct HHS to each of the materials we have cited and made available through active links, and we request that the full text of each of the studies and articles cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If HHS is not planning to consider these materials part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies and articles into the record.

Thank you for your attention to our comments. If you have any questions or need further information, please reach out to Mara Youdelman, Managing Director of Federal Advocacy, at youdelman@healthlaw.org.

Sincerely,



Elizabeth G. Taylor
Executive Director

[123] Jack L. Turban, et al., *Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis*, 8 LGBT HEALTH 273 (2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC8213007/pdf/lgbt.2020.0437.pdf.

[124] *See* N. Eugene Walls, et al., *Interrupted Gender Transitions: Underlying Motivations as Correlates of Psychosocial Risks*, 26 INT. J. TRANSGENDER HEALTH 119 (2024), https://www.tandfonline.com/doi/full/10.1080/26895269.2023.2299020?scroll=top&needAccess=true; Landon D. Hughes, et al., *"These Laws Will be Devastating": Provider Perspective on Legislation Banning Gender-Affirming Care for Transgender Adolescents*, 69 J. ADOLESCENT HEALTH 976 (2021), https://www.jahonline.org/article/S1054-139X(21)00435-3/pdf.