NATIONAL HEALTH LAW PROGRAM

Submitted via Regulations.gov

November 19, 2025

Administrator Mehmet Oz
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Model Medicare Advantage and Medicare Prescription Drug Plan Individual Enrollment Request Form (CMS-10718)

Dear Administrator Oz:

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, NHeLP has long advocated for more comprehensive demographic data collection to advance health equity, reduce discrimination, and facilitate the provision of equitable health care. Accordingly, we generally appreciate the opportunity to comment on the Department of Health and Human Services' (HHS) proposed revisions to the Model Medicare Advantage and Prescription Drug Plan Individual Enrollment Form, CMS-10718 (hereinafter "Form CMS-10718" or "Medicare Part C and Part D enrollment forms").[1] We are also using this opportunity to comment on CMS's May 6, 2025 Health Plan Management System letter announcing the removal of voluntary race, ethnicity sexual orientation, and gender identity data fields from Form CMS-10718.

We oppose the removal of voluntary demographic data questions in Form CMS-10718, as demographic data collection is a critical step in advancing health equity. We also strongly oppose the decision to remove previously approved language translations from the collection of information,[2] as doing so unnecessarily removes a critical tool to ensure that eligible individuals with limited English proficiency (LEP) can properly submit Medicare Part C and Part D enrollment forms.

I. CMS Must Reinstate Demographic Fields to the Form CMS-10718

Under 42 U.S.C. § 1395b-10(c), the Secretary of HHS is mandated to implement strategies for the collection and evaluation of race, ethnicity, and gender data to address health care disparities in the Medicare program. The Medicare Part C and Part D enrollment forms provide an opportunity to both maintain and improve the quality and completeness of demographic data collected by the Medicare program. Of Medicare's 69 million enrollees, 51.2% are enrolled in Medicare Advantage and other health plans, and 81% are enrolled in Medicare Prescription Drug plans.[3] The inclusion of voluntary demographic data collection on Form CMS-10718 provides a broader understanding of racial, ethnic, and LGBTQI+ communities that can inform improved health care access, quality, and outcomes and to drive targeted actions to address long-standing health disparities.[4]

A. Collecting Race and Ethnic Data on the Enrollment form Advances Health Equity

On May 6, 2025, leadership from CMS's Center for Medicare and the Office for Information Technology sent a letter to, as relevant here, all Medicare Advantage Organizations and all Prescription Drug Plan sponsors announcing revisions to the enrollment forms for Medicare Parts C and D plans.[5] The letter explained that CMS was removing race and ethnicity

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[1] *Agency Information Collection Activities: Proposed Collection; Comment Request; Exhibit 1: Model Individual Enrollment Request Form to Enroll in a Medicare Advantage Plan (Part C) or Prescription Drug Plan (Part D)*, 90 Fed. Reg. 45929 (Sept. 24, 2025) [hereinafter "Parts C and D Model Form Proposed Collection"], https://www.federalregister.gov/documents/2025/09/24/2025-18448/agency-information-collection-activities-proposed-collection-comment-request.

[2] *Id.,* Supporting Statement Part A, https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10718.

[3] Ctrs. for Medicare & Medicaid Servs., *Medicare Monthly Enrollment June 2025*, https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment, last accessed November 13, 2025.

[4] *See* Naomi Goldberg, Movement Advancement Project & Nat'l Health L. Program, *Administrative Data: Providing Information to Advance Autonomy and Drive Equality* (Feb. 2023), https://healthlaw.org/wp-content/uploads/2023/02/Drive-Equality-MAP-NHeLP-Jan2023-2.pdf.

[5] Letter from Jerry Mulcahey, Director, Medicare Enrollment Appeals Group and Cathy Carter, Director, Enterprise Systems Solution Group to All Medicare Advantage Organizations (MA), Prescription Drug Plan Sponsors (PDP), Cost Plans, Program of All-Inclusive Care for the Elderly (PACE), and Demonstration Organizations (May 6, 2025)

questions from the model form and provided no explanation for this decision. This stated revision, applicable to all enrollment forms dated January 1, 2026 or later, did not go through the notice and comment period required by the Paperwork Reduction Act.[6] An agency is prohibited from conducting the collection of information absent the evaluation of public comments.[7]

In 2022, CMS adopted detailed race and ethnicity categories for the Medicare Part C and D enrollment forms, in compliance with the 2011 HHS Data Collection Standards, "to provide granular information for plans and CMS to understand the diversity of the beneficiary population."[8] These updates improved upon CMS's Medicare patient data-collection related inaccuracies identified by a 2022 report by HHS's Office of the Inspector General (OIG).[9] These deficiencies were a result of categories that were not comprehensive or were missing data; the use of an algorithm to identify race and ethnicity rather than self-reported data; and enrollment data that was inconsistent with Federal data collection standards.[10]

The OIG Report's first recommendation was for CMS to develop its own source of demographic data on Medicare enrollees, such as collecting data at the time of Medicare enrollment.[11] At the time the OIG Report was issued, CMS had already developed detailed race and ethnicity categories to be collected via the Parts C and D enrollment form.[12]

As highlighted in the OIG report, the collection of this data is vital to "evaluate the health needs and outcomes of the Medicare population and assess important issues."[13] Important issues include not just health disparities but ensuring that provider availability and quality of care is consistently provided to *all* beneficiaries.[14] We request their reinstatement on the Form CMS-10718.

[hereinafter May 2025 CMS Letter], https://www.cms.gov/files/document/hpms-memo-cy-2025-enrollment-form.pdf-1.

[6] 44 U.S.C. § 3506(c)(2).

[7] *Id.* at § 3507(a)(1)(B).

[8] Ctrs. for Medicare & Medicaid Servs., *Agency Information Collection Activities: Submission for OMB Review; Comment Request*, 87 Fed. Reg. 26759 (May 5, 2022), https://www.federalregister.gov/documents/2022/05/05/2022-09685/agency-information-collection-activities-submission-for-omb-review-comment-request.

[9] U.S. Dep't of Health & Hum. Servs., Off. of the Inspector Gen., *Data Brief: Inaccuracies in Medicare's Race and Ethnicity Data Hinder the Ability To Assess Health Disparities* (Jun. 2022), https://oig.hhs.gov/oei/reports/OEI-02-21-00100.pdf [hereinafter OIG Report].

[10] *See generally, id.*

[11] *Id.* at 19.

[12] 87 Fed. Reg. at 26760.

[13] OIG Report, *supra note 9* at 6.

[14] 87 Fed. Reg. at 26760.

B. Collecting SOGI Data on the Enrollment form Advances Health Equity[15]

The May 2025 CMS Letter also referenced a Health Plan Management System (HPMS) memo and an MAPD Help Desk email sent on February 12, 2025, announcing that Medicare Advantage Organizations and all Prescription Drug Plan sponsors would no longer be required to collect and submit voluntary sexual orientation and gender identity (SOGI) data. In addition to no longer being required, should the "sex" code field be left blank or have an invalid entry, the enrollment transaction will be rejected.[16] Similar to the removal of the race and ethnicity data fields, this announcement did not go through the notice and comment period required by the Paperwork Reduction Act, and the agency is prohibited from conducting the collection of information without the evaluation of public comments.[17]

The stated justification for the removal of the SOGI data fields is compliance with Executive Order (E.O.) 14168, "Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government."[18] NHeLP strongly opposes the policy and substance of the E.O., and its implementation through removal of science-based data fields in Form CMS-10718. We further note that the E.O. does not address sexual orientation, and yet CMS has also chosen to voluntarily delete the sexual orientation data field without providing any justification.

There are an estimated 924,300 LGBT individuals 65 and older in the United States,[19] 154,800 of whom are estimated to be transgender.[20] Research consistently demonstrates that LGBTQ+ older adults experience significant disparities in health, disability, and economic security compared to their non-LGBTQ+ peers.[21] Similarly, intersex people comprise a small minority of the U.S. population, currently estimated at 1.7%.[22] There is limited data and information available on the experiences of intersex people when accessing healthcare, and removing critical data elements from the Part C and D enrollment form contribute to the current dearth of information needed to address health disparities and lack of access to care.

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[15] This section cites studies that look at various combinations of the LGBTQI+ population. Where a study is limited, e.g. to just lesbian, gay and bisexual individuals, the appropriate limited acronym is used.

[16] May 2025 CMS Letter, *supra note 5*.

[17] 44 U.S.C. §§ 3506(c)(2), 3507(a)(1)(B).

[18] May 2025 CMS Letter, *supra note* 5 (referencing E.O. 14168, 90 Fed. Reg. 8615 (signed Jan. 20, 2025)).

[19] Andrew R. Flores and Kerith J. Conron, The Williams Institute, *Adult LGBT Population in the United States* (Dec. 2023), https://williamsinstitute.law.ucla.edu/publications/adult-lgbt-pop-us/.

[20] Jody L. Herman and Andrew R. Flores, The Williams Institute, *How Many Adults and Youth Identify as Transgender in the United States?* (Aug. 2025), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Pop-Update-Aug-2025.pdf.

[21] National Academies of Sciences, Engineering, and Medicine. 2020. *Understanding the Well-Being of LGBTQI+ Populations*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25877.

[22] Melanie Blackless et al., *How Sexually Dimorphic Are We? Review and Synthesis*, Am. J. of Hum. Biology (Mar. 2000), https://pubmed.ncbi.nlm.nih.gov/11534012/.

Despite consistent evidence of disparities and inequities in health care access and outcomes faced by LGBTQI+ people, prior to 2022, CMS had not previously collected program administrative data that would identify and track the distinct experiences of lesbian, gay, bisexual, transgender, queer, and intersex populations. The adoption of SOGI fields on Form CMS-10718 provided for an expanded understanding of LGBTQI+ health and health care experiences in Medicare, given the high rates of enrollment in Parts C and D.

The availability of data on this population continues to be limited, and its collection remains necessary to address disparities faced by older LGBTQI+ adults. For example, a 2024 study concluded that for LGBTQI+ individuals, "Medicare may be associated with closing gaps in self-reported health status, and among states with the highest disparities, it may improve health insurance coverage, access to care, and self-reported health status."[23] It is imperative to continue to collect this data to further close these gaps and address health disparities experienced by LGBTQI+ people.

II. Translated enrollment forms provide critical access to individuals with LEP while keeping costs down for states.

Within the Supporting Statement Part A of this Proposed Collection, CMS states that "previously approved language translations from the collection of information request are being removed to comply with Executive Order 14224."[24] CMS regulations require enrollment forms to be provided in non-English languages where "any non-English language is the primary language for at least 5 percent of the individuals in a plan benefit package (PBP) area."[25] The provisions of translated model enrollment forms not only serves to increase compliance and support accurate translation, but also offset costs borne by entities that no longer need to expend their own finite resources to translate a standardized form.

Data issued by the U.S. Census in 2020 estimates that 8.3% of individuals in the United States over the age of 5 have limited English proficiency, meaning they speak English less than "very well." This number is even higher in some states, such as California (18%), Texas and New York (13%), and Florida (12%).[26] When looking at the Medicare population, findings from the 2023 Medicare Current Beneficiary Survey show that 7% of beneficiaries nationwide have limited English reading proficiency, meaning they read English less than "very well," which translates to roughly 4.8 million individuals.[27] A recent

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[23] Kyle A. Galuvic and Jacob Wallace, *Medicare Eligibility and Changes in Coverage, Access to Care, and Health by Sexual Orientation and Gender Identity*, JAMA Health Forum (July 2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC11227074/.

[24] Parts C and D Model Form Proposed Collection, *supra note* 1; Supporting Statement Part A, *supra* note 2 at 1.

[25] 45 C.F.R §§ 422.2267(a)(2) (Part C), 423.2267(a)(2) (Part D).

[26] Sweta Haldar, Drishti Pallai, and Samantha Artiga, *Overview of Health Coverage and Care for Individuals with Limited English Proficiency (LEP)*, KFF (Jul. 7, 2023) [hereinafter *Coverage and Care*].

[27] Ctrs. for Medicare & Medicaid Servs. Office of Enterprise & Data Analytics, *Limited English Proficiency Among Medicare Beneficiaries Infographic* (Dec. 2024),

study specifically examining Medicare Advantage enrollment by English proficiency status found that enrollment was higher among immigrants with LEP than both U.S. residents and immigrants with English proficiency.[28]

These statistics demonstrate the need for greater availability of translated materials, rather than their removal. Though CMS cites compliance with E.O. 14224, "Designating English as the Official Language of the United States," as the justification for this change, the E.O. does not compel CMS to remove these model notices. Rather, the E.O. explicitly states that "**nothing** in this order…requires or directs **any** change in services provided by an agency."[29] (emphasis added) It goes on further to detail that "Agency heads are **not required** to amend, remove, or otherwise stop production of documents…offered in languages other than English."[30] (emphasis added) Thus, CMS's actions, rather than being in compliance with the directive of the E.O. are actually in direct conflict.

The availability of language assistance services, such as translated enrollment materials, is vital for addressing the barriers encountered by individuals with LEP seeking access to healthcare in the United States. Individuals with LEP are three times as likely as English proficient people to be uninsured, regardless of having similar rates of living with a full-time worker.[31] This is likely due to disproportionate employment in jobs that pay lower wages and do not offer health insurance.[32] For individuals with LEP who are eligible for Medicare, having access to an enrollment form in their primary language is critical to addressing not just the high rates of uninsurance, but also the resulting impacts on lack of access to care.

III. Conclusion

For the reasons outlined above, we ask you to reinstate the voluntary data fields related to race, ethnicity, sexual orientation, and gender identity to Form CMS-10718. At a minimum, we request that CMS provide for a notice and comment period, as required under the Paperwork Reduction Act, so that the public may have an opportunity to comment on the proposed removal of these demographic fields and CMS's justification. We also request that CMS reinstate the availability of the previously approved language translations of Form CMS-10718.

Further, we would like our comment, including any articles, studies, or other supporting materials that we have included in our comment as an active link in the text or in footnotes, to be included as part of the formal administrative record. Please let us know if HHS is unable for any reason to meet our request and include our linked materials, so we will have the chance to otherwise submit copies of the supporting documents into the

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https://www.cms.gov/files/document/2023-limited-english-proficiency-among-medicare-beneficiaries-infographic.pdf.

[28] Sungchul Park et al., *Medicare Advantage Enrollment by Immigration and English Proficiency Status*, Am. J. of Managed Care (2023), https://pubmed.ncbi.nlm.nih.gov/37729534/.

[29] E.O. 14224 § 3(b), 90 Fed. Reg. 11363 (signed March 1, 2025) (emphasis added).

[30] *Id.* (emphasis added).

[31] *Coverage and Care*, *supra* note 26.

[32] *Id.*

record. If you have any questions about anything in the comments or the materials, please contact Mara Youdelman, Managing Director of Federal Advocacy, youdelman@healthlaw.org.

Sincerely,

Elizabeth G. Taylor
Executive Director