

**UNITED STATES OF AMERICA
BEFORE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES**

**Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment
Parameters for 2023
Agency Docket No. CMS-9911-P, RIN 0938-AU65**

**COMMENTS OF THE LGBTQI HEALTH POLICY ROUNDTABLE AND THE LGBTQIA+ PRIMARY
CARE ALLIANCE**

Pursuant to the Department's January 5, 2022, notice, 87 Fed. Reg. 584, the LGBTQI Health Policy Roundtable and the LGBTQIA+ Primary Care Alliance submit these comments on the Notice of Benefit and Payment Parameters for 2023 under the Patient Protection and Affordable Care Act (ACA).

The Health Policy Roundtable is a coalition of community health centers and national advocacy organizations that share a focus on laws and policies that affect the health well-being of lesbian, gay, bisexual, transgender and nonbinary, queer, and intersex (LGBTQI) populations. Individually and collectively, our organizations work with agencies and offices within the Department – and with other parts of the Administration – to promote legal reforms and federal policies that advance the health and dignity of sexual and gender diverse people. Our community health center members provide primary health care, gender-affirming care for transgender and nonbinary people, HIV specialty care, and mental health and substance use treatment services to many tens of thousands of individuals and families, very substantial numbers of majorities of whom identify as lesbian, gay, bisexual, transgender, queer, or gender nonbinary. Our health centers have years of experience helping patients navigate the complexities of the ACA and ACA-created health Exchanges and to assess and enroll in

Qualified Health Plans (QHPs). Our membership also includes national advocacy organizations representing LGBTQI communities throughout the country.

The Primary Care Alliance includes FQHCs, State Primary Care Associations, community health centers, and other health care organizations and providers throughout the nation, who promote best practices for providing culturally responsive and compassionate health care and related services for persons identifying as lesbian, gay, bisexual, transgender, and gender diverse, queer, intersex, and/or asexual or on the ace spectrum (LGBTQIA+). The Alliance members joining in these comments collectively serve several hundred thousand individuals and families every year, in the Northeast, Mid-Atlantic, Midwest, South, and West. Our members also advocate for federal, state, and local laws and public policies that advance the health and well-being of sexual and gender diverse people, with particular emphasis on persons of color, immigrants, people with disabilities and chronic illnesses, low-income individuals and families, transgender and gender diverse persons, sex workers, drug users, and other particularly marginalized communities.

The Health Policy Roundtable and Primary Care Alliance members joining in these comments support many of the proposals in this Notice of Proposed Rulemaking. These comments specifically focus on the following issues:

- **We support the addition of sexual orientation and gender identity back into the nondiscrimination regulations applying to ACA title I Exchanges and QHPs.** We encourage the Department to add clarify that gender identity discrimination includes discrimination based on gender expression and transgender status. (Part I, pages 4-14)

- The Department should also expressly **prohibit discrimination on the basis of sex characteristics, including intersex traits**, by Exchanges, issuers, and agents and brokers. (Part II, pages 14-17)
- We support the proposal to provide **guidance on nondiscriminatory plan design and examples of discriminatory designs**, and suggest ways to strengthen the proposed guidance and examples to **increase protections for gender expansive people**. (Part III, pages 17-26)
- We provide additional support for the proposed protections against gender identity discrimination by explaining that the evidence shows that **the actuarial costs of covering gender-affirming surgeries and other care are insubstantial**. (Part IV, pages 26-28)
- We support the proposal to **evaluate QHPs to ensure adequacy of their networks** and to engage in meaningful compliance reviews, and urge CMS to clarify that **network adequacy should include a requirement that providers in the network have LGBTQI clinical and cultural competence**. (Part V, pages 28-31) We also support the proposal to require QHPs to disclose whether and what types of **telehealth services** they provide, particularly given the importance of telehealth services for many LGBTQI individuals who depend on specialized, competent providers located many miles from where they live, often in other states. (Part VI, pages 31-32)
- In order to advance health equity, **CMS should require Exchanges and QHPs to collect data on sexual orientation, gender identity and variations in sex**

characteristics, in a manner that is voluntary, protective of individual privacy, and prohibits discrimination based on that information. (Part VII, pages 32-34)

I. The Proposed Addition of Sexual Orientation and Gender Identity In Exchange-Related Nondiscrimination Rules bHas Ample Statutory Support and is Sound Public Policy

We fully support the Department’s proposal to reverse the previous Administration’s arbitrary removal of sexual orientation and gender identity from nondiscrimination protections:

- 45 CFR § 147.104(e), applicable to health insurance issuers and their officials, employees, agents, and representatives
- 45 CFR § 155.120(c)(1)(ii), applicable to States and Exchanges
- 45 CFR § 155.220(j)(2)(i), applicable to agents and brokers who assist individuals and employers in enrollment and obtaining ACA-related benefits
- 45 CFR § 156.200(e) and § 156.1230(b)(2), applicable to Qualified Health Plan (QHP) issuers

The Proposed Rule correctly notes that these corrections are mandated by the President’s Executive Order 13988, declaring a government-wide policy of combatting sexual orientation and gender identity discrimination.¹ They are also required by Section 1557 of the ACA, which prohibits sex discrimination in any health program or activity, which is administered by the Department, is established by any entity under Title I of the ACA, or any part of which receives federal financial assistance. As the Proposed Rule discusses, the Supreme Court’s decision in *Bostock v. Clayton County*,² although arising under Title VII of the Civil Rights Act, leaves no doubt that sex discrimination includes discrimination based on sexual orientation, gender

¹ Executive Order 13988 of Jan. 20, 2021, Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation, 86 Fed. Reg. 7023.

² 140 S. Ct. 1731 (2020).

identity, and sex characteristics (including intersex traits) across all federal laws that prohibit discrimination based on sex, including Title IX and, therefore, ACA Section 1557.

Apart from Section 1557, the Proposed Rule correctly notes that the Department has ample statutory authority to prohibit sexual orientation and gender identity discrimination in ACA-related health plans and Exchanges. Section 1321(a) of the ACA gives HHS broad rulemaking authority to regulate Exchanges and QHPs.³ ACA Section 1312(c) gives the Department authority to establish procedures for States to allow agents or brokers to enroll individuals and businesses in QHPs.⁴ More specifically, Section 1302(b)(4) directs HHS, in defining Essential Health Benefits (EHBs), to “take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups,”⁵ and Section 1311(c)(1)(A) directs HHS to establish criteria for QHPs to ensure that they will “not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs.”⁶ Moreover, Section 2792 of the Public Health Service Act⁷ provides HHS with broad authority to promulgate regulations that may be necessary or appropriate to carry out the guaranteed availability mandates in Section 2702,⁸ added to the PHS Act by the ACA. As the Proposed Rule notes, “discriminatory marketing practices or benefit designs represent a failure by issuers to comply

³ 42 USC §18041.

⁴ 42 USC §18032.

⁵ 42 USC §18022.

⁶ 42 USC §18031.

⁷ 42 USC §300gg-92.

⁸ 42 USC §300gg-1.

with the guaranteed availability requirements in PHS Act section 2702, as such practices or designs can have the effect of discouraging or preventing the enrollment of individuals in health insurance coverage” (87 Fed. Reg. at 596).

The Department is right to conclude that “explicitly prohibit[ing] discrimination based on sexual orientation and gender identity is warranted in light of the existing trends in health care discrimination and to better address barriers to health equity for LGBTQI+ individuals” (87 Fed. Reg. at 597). Discrimination against sexual- and gender-diverse persons in obtaining health insurance, and in the terms of insurance coverage, is longstanding, and has long been a barrier to accessing health care, which in turn has long contributed to deep and broad health inequalities in sexual and gender diverse populations.⁹

The pervasiveness of insurance discrimination based on gender identity. As noted in the recent consensus report of the National Academies of Sciences, Engineering, and Medicine:

Gender-affirming care for transgender people, including non-binary and other gender diverse people, is an essential and medically necessary intervention to improve health and well-being. . . . Insurance coverage of gender-affirming services and procedures by public and private payers, according to the most updated expert standards in the field and without inappropriate age or other restrictions, is necessary to facilitate access to these services and to avoid discrimination on the basis of sex and gender identity.^[10]

However, transgender people face particularly great difficulty accessing insurance coverage and, therefore, in obtaining medically necessary health care. Transgender adults are more likely than cisgender adults to be uninsured and to report cost as a barrier to receiving care.¹¹ Transgender

⁹ National Academies of Sciences, Engineering, and Medicine, UNDERSTANDING THE WELLBEING OF LGBTQI+ POPULATIONS, at 350-55 (Washington, DC: 2020). Available at: <https://www.nap.edu/catalog/25877/understanding-the-well-being-of-lgbtqi-populations>.

¹⁰ *Id.* at 380.

¹¹ Wyatt Koma et al., *Demographics, Insurance Coverage, and Access to Care Among Transgender Adults* (Oct. 21, 2020), Kaiser Family Foundation, <https://www.kff.org/health-reform/issue->

people who have health coverage face alarming levels of discrimination. An original analysis by the Center for American Progress (CAP) of data from a nationally representative survey of LGBTQI+ adults conducted in 2020 sheds lights on the pervasiveness of these discriminatory experiences.¹² According to the analysis, 46% of transgender respondents – 56% of transgender people of color—reported that a health insurance company denied them medically necessary care to treat their gender dysphoria (such as surgery or hormone therapy) in the year prior to the survey. Additionally, 48% of transgender respondents – 54% of people of color – reported that, in the year prior to the survey, a health insurance company covered only some surgical treatments for gender dysphoria or covered surgical care but had no providers in network. Further, 22 % of transgender respondents, including 31% of transgender people of color, reported that a health insurance company denied them needed preventive care in the year prior to the survey. Finally, 34% of transgender respondents, including 39% of transgender people of color, reported that an insurance company refused to change their records to reflect their current name or gender in the year prior to the survey.

[brief/demographics-insurance-coverage-and-access-to-care-among-transgender-adults/](#) (concluding that transgender adults are more likely than cisgender adults “to be uninsured (19% vs. 12 %) and to report cost-related barriers to care (19 vs. 13%).

¹² This analysis is based on data from CAP’s 2020 survey of 1,528 LGBTQI+-identifying individuals, including 121 transgender individuals and 57 transgender people of color, conducted with assistance from NORC at the University of Chicago using their AmeriSpeak panel. A sample of U.S. adults ages 18 and older who self-identified as LGBTQI+ was selected for this study, and this sample was weighted to account for both U.S. population characteristics and survey nonresponse. The full results of the study, along with a detailed overview of the methodology, are on file with Caroline Medina, MPA, Senior Policy Analyst, LGBTQI+ Research and Communications Project, Center for American Progress, 1333 H Street NW, Suite 1, Washington, DC 20005, cmedina@americanprogress.org.

Organizations joining in these comments who directly provide gender-affirming health care services, including treatment of gender dysphoria,¹³ and the legal organizations that advocate for individuals seeking such care, encounter these insurance challenges regularly. Many insurance plans continue to restrict coverage of gender-affirming care for transgender people or exclude so-called “sex change” procedures altogether; other plans may not contain express exclusionary language but nonetheless frequently deny coverage of treatments despite clear documentation of medical need.

Although insurance plans that exclude all forms of transgender-related care have become less common since the enactment of the ACA, the health centers and legal advocates joining in these comments still regularly hear from people whose insurance refuses to cover any care that is gender-affirming or sought to alleviate gender dysphoria – hormone therapy or surgery – often because such procedures are mistakenly thought to be “cosmetic”. This is consistent with the uptick in transgender-related exclusions in Marketplace plans following the rollback of Section 1557 regulations under the prior Administration.¹⁴

The Transgender Legal Defense and Education Fund (TLDEF) and Lambda Legal are litigating against the state employee health plan of North Carolina because it contains an explicit

¹³ Gender-affirming care is often described, for many transgender and gender nonbinary persons, as treatment to alleviate gender dysphoria – distress, often severe, resulting when an individual’s gender identity does not coincide with their assigned sex. In these comments, we generally refer more broadly to “gender-affirming care” as including treatments for clinically diagnosed gender dysphoria.

¹⁴ *Summary of Findings: 2022 Marketplace Plan Compliance with 1557*, Out2Enroll (2021), <https://out2enroll.org/out2enroll/wp-content/uploads/2021/12/Report-on-Trans-Exclusions-in-2022-Marketplace-Plans.pdf> (analyzing silver Marketplace plans and concluding that “[w]hile most insurers did not adopt discriminatory transgender-specific exclusions in response to this regulatory rollback, a dozen did”); *Summary of Findings: 2021 Marketplace Plan Compliance with 1557*, Out2Enroll (2020), <https://out2enroll.org/out2enroll/wp-content/uploads/2020/11/Report-on-Trans-Exclusions-in-2021-Marketplace-Plans.pdf> (7% of insurers reviewed used transgender-specific exclusions in their 2021 silver Marketplace plans, though only 3% had such exclusions for the 2020 plan year).

exclusion for transgender-related health care.¹⁵ As detailed in the complaint, in response to the initial Section 1557 regulations, the state health plan removed an exclusion for transition-related care, but aided by the confusion created by *Franciscan Alliance, Inc. v. Burwell*,¹⁶ reinstated the exclusion for 2018.¹⁷ Several plaintiffs had to pay out of pocket or forgo care, to the detriment of their finances and health. One plaintiff had surgery preauthorized in 2017 but scheduled for 2018 and thus was no longer covered. Another plaintiff purchased a separate Marketplace plan in 2019 in order to continue care begun in 2017. A third plaintiff sought additional insurance but found Marketplace plans also excluded the care she needed because it was transgender related.

Transgender people also face denials of insurance coverage pursuant to insurance plans, or insurers' medical policies, that afford limited coverage of treatments for gender dysphoria but nonetheless exclude critical types of transgender-related care. In 2021, the Transgender Law Center's (TLC) Helpdesk staff worked with 73 clients who had had coverage for gender-affirming care denied by their insurance providers. TLDEF and Whitman-Walker Legal Services have also worked with people facing similar denials. For example, TLDEF represented transgender women from North Carolina denied coverage for facial gender reassignment surgery by their employer and Marketplace-based plans because of an insurance company medical policy that falsely labeled such surgery not medically necessary.¹⁸ Numerous major insurance plans,

¹⁵ *Kadel v. Folwell*, 12 F.4th 422, 427-428 (4th Cir. 2021) (describing transgender-related care as “a critical part of transitioning” and nothing that hormones and surgery are not “ ‘cosmetic,’ ‘elective,’ or ‘experimental.’ Rather, they are safe, effective, and often medically necessary.”).

¹⁶ 227 F. Supp. 3d 660 (N.D. Tex. 2016).

¹⁷ *Kadel v. Folwell*, No. 1:19-cv-00272 (M.D.N.C. 1st amended complaint filed March 19, 2021), https://www.lambdalegal.org/in-court/legal-docs/kadel_nc_20190311_complaint.

¹⁸ *TLDEF Advocacy Brings Changes to Blue Cross Blue Shield of NC Coverage of Gender-Affirming Health Care* (July 13, 2021), <https://www.transgenderlegal.org/stay-informed/tldef-advocacy-brings-changes-to-blue-cross-blue-shield-of-nc-coverage-of-gender-affirming-health-care/>. Fortunately, after

including ACA Marketplace plans, continue to retain similar plan terms and medical policies that target facial gender reassignment surgery, breast augmentation, and other vital treatments for gender dysphoria.¹⁹

Request for clarification of gender identity discrimination. We submit that the intended protections against gender identity discrimination would be strengthened if “transgender status” and “gender expression” were expressly added to “gender identity.” Entities often perpetrate discrimination against transgender people because of their gender expression or belief that they are transgender rather than their gender identity itself, which is often private information. Inclusion of “gender identity” alone in antidiscrimination rules leaves room for confusion or evasion of legal obligations, particularly in typically sex-specific domains. For example, a drug treatment facility defended its refusal to hire a transgender man as a male urine monitor by arguing, “While New Jersey law prohibits discrimination on the basis of gender identity or expression, it does not expressly hold the same as to transgender status.”²⁰ The defendants further argued, “Defendants did not discriminate against Plaintiff by not allowing him

advocacy by TLDEF the insurer revised its policy to allow coverage for medically necessary facial gender reassignment surgery.

¹⁹ See, e.g., United Healthcare, Commercial Medical Policy - Gender Dysphoria Treatment, Policy Number: 2021T0580L, Effective Date: November 1, 2021, <https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-medical-drug/gender-dysphoria-treatment.pdf>; Cigna, Medical Coverage Policy – Treatment of Gender Dysphoria, Policy Number: 0266, Effective Date: December 15, 2021, https://static.cigna.com/assets/chcp/pdf/coveragePolicies/medical/mm_0266_coveragepositioncriteria_gender_reassignment_surgery.pdf.

²⁰ Memorandum of Law in Opposition to Plaintiff’s Cross-Motion for Summary Judgment and in Further Support of Defendants’ Motion for Summary Judgment at 4, *Devoureau vs. Camden Treatment Assoc.*, No. L-1825-11 (New Jersey Superior Ct. filed July 23, 2013). Document available on request from TLDEF, 520 8th Ave., Suite 2204, New York, NY 10018, (646) 862-9396, contact Ezra Cukor, Senior Staff Attorney, ecukor@transgenderlegal.org.

the freedom to express his gender identity. Instead, Defendants decided not to hire Plaintiff for the open male urine monitor position on the basis that he could not do the job function that requires a bona fide occupational qualification [namely, being male].”²¹ In the ACA context, and insurance company might, for example, deploy similar arguments to avoid covering a mammogram for a transgender woman. Though such a denial would be legally unmeritorious, expressly incorporating transgender status into HHS regulations would provide additional clarity. Moreover, inclusion of transgender status and gender expression will conform the regulation to contemporary protections against discrimination. The *Bostock* decision affirms that discrimination against someone for being transgender is necessarily sex discrimination.²² “Transgender status” is part of anti-discrimination legislation in other jurisdictions, for example New York State and Colorado.²³ HHS’ 2016 rule under ACA Section 1557 declared that prohibited sex discrimination included “gender expression” as well as “gender identity.”²⁴

²¹ Memorandum of Law in Support of Defendants’ Motion for Summary Judgment at 29, *Devoureau vs. Camden Treatment Associates*, No. L-1825-11 (New Jersey Superior Ct. filed June 26, 2013). Document available on request from TLDEF, 520 8th Ave., Suite 2204, New York, NY 10018, (646) 862-9396, contact Ezra Cukor, Senior Staff Attorney, ecukor@transgenderlegal.org.

²² 140 S. Ct. at 1747.

²³ N.Y. A04558A (Feb. 3, 2015), http://assembly.state.ny.us/leg/?default_fld=&bn=A04558&term=2015&Text=Y (“The term ‘gender identity or expression’ means a person’s actual or perceived gender-related identity, appearance, behavior, expression, or other gender-related characteristic regardless of the sex assigned to that person at birth, including, but not limited to, the status of being transgender”); N.Y. Division of Human Rights, *Gender Identity Discrimination*, I.D. No. HRT-44-15-00033-P, New York Register (Nov. 4, 2015), <http://docs.dos.ny.gov/info/register/2015/november4/pdf/rulemaking.pdf> (“The term “sex” when used in the Human Rights Law includes gender identity and the status of being transgender.”); N.Y. Exec. Law § 292(35) (defining gender identity to include actual or perceived gender expression and “status of being transgender”); Colo. Rev. Stat. § 24-34-301(7) (2015) (defining “sexual orientation” to include “transgender status”).

²⁴ Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31376, 31384 (2016).

The persistence of sexual orientation discrimination in insurance. Although less pervasive than a decade or two ago, forms of sexual orientation discrimination unfortunately persist, and there remains a need to expressly prohibit sexual orientation discrimination in Exchanges and Exchange agents and brokers, QHPs, and EHBs. For instance, although same-sex couples have a legal right to marriage throughout the United States, and spousal health insurance coverage cannot be lawfully denied to a same-sex spouse, many same-sex partners are not married, largely due to the long history of legally sanctioned discrimination and stigma, and insurance coverage available to an unmarried domestic partner as a dependent might be denied to a same-sex unmarried partner but offered to a different-sex unmarried partner. Moreover, given the persistence of stigma and implicit if not explicit bias against lesbian, gay and bisexual people, there is a benefit to strong regulatory declarations against discriminatory actions by ACA Marketplace agents and brokers and state regulators.

Moreover, at least some health plans likely contain provisions that discriminate against same-sex couples and others not in cisgender heterosexual relationships who seek assistance with parenting through assisted reproductive technology – such as in vitro fertilization or infertility treatments. Some plans limit such coverage to individuals in heterosexual relationships. Some plans condition coverage on first trying for a year to conceive through intercourse, thus forcing lesbian, gay and bisexual couples to incur the cost of ART for a year before they are eligible for care.²⁵

²⁵ See, e.g., *Goidel v. Aetna Inc.*, Case No. 1:21-cv-07619 (VSB) (S.D. N.Y. filed Sept. 13, 2021, <https://nwlc.org/wp-content/uploads/2021/09/2021.09.13-Complaint.pdf>); First Amended Complaint filed Nov. 4, 2021, <https://nwlc.org/wp-content/uploads/2021/09/19-2021.11.04-First-Amended-Complaint.pdf>). For descriptions of the litigation, see Lauren Gorodetsky, *Aetna's Fertility Benefits Discriminate on the Basis of Sex. So We Sued* (Sept. 14, 2021), National Women's Law Center, <https://nwlc.org/blog/aetnas-fertility-benefits-discriminate-on-the-basis-of-sex-so-we-sued>; Brendan Pierson, *Aetna LGBT+ Discrimination Suit Expands to Employer Plans*, Reuters (Nov. 4, 2021),

In addition, health plans that engage in adverse tiering of HIV drugs adversely affect people living with HIV, which disproportionately include gay and bisexual men (as well as transgender women and anyone assigned male at birth), and plans that exclude or limit coverage of Pre-Exposure Prophylaxis (PrEP), a drug treatment to prevent HIV infection, adversely affect people at higher risk of HIV, including gay and bisexual men (and transgender women).

Finally, given the widespread lack of clinical and cultural competence of many health care providers with LGBTQ patients, insurance plans that do not take reasonable measures to ensure that their networks include LGBTQ competent providers are indirectly discriminatory. (See Section V, below, for a discussion of the importance of including LGBTQI competent providers in QHP networks.)

The important regulatory changes at issue here must be supplemented with a new rule under ACA Section 1557, and proceedings to correct damage inflicted on Medicaid and Medicare regulations by the previous Administration. Although we salute these proposed regulations as important steps forward, they are of course no substitute for a new, comprehensive rule under Section 1557. That statute imposes nondiscrimination mandates on all (private, state, and local government) health care providers and health programs receiving federal financial assistance; on all federal health care programs; and on all health insurance that is

<https://www.reuters.com/legal/transactional/aetna-lgbt-discrimination-suit-expands-employer-plans-2021-11-04/>.

In Illinois, a similar longstanding insurance law defined infertility as the inability to conceive after one year of unprotected intercourse, which excluded same-sex couples and single people or forced them to pay for expensive in vitro fertilization treatments for a year before obtaining insurance coverage. Advocates succeeded in obtaining passage of a state bill to address the issue, but the problem remains widespread. Nara Schoenberg, *LGBTQ and Single Prospective Parents in Illinois Would Have Access to Fertility Benefits That Heterosexual Couples Have Enjoyed for 30 Years, Under Proposed Law: "This is an Anti-Discrimination Bill*, Chicago Tribune (April 1, 2021), <https://www.chicagotribune.com/living/health/ct-life-lgbt-fertility-coverage-illinois-bill-03312021-20210401-sfcphygsvff5rfdihegwqwnkpe-story.html>.

directly or indirectly federally supported. A new Section 1557 rule will reach more broadly than the regulations at issue here, and can reach types of discriminatory behavior beyond the scope of these regulations: for instance, programs, providers and insurance plans that deny medically needed care to transgender women or to transgender men because of a policy limiting the care in question to a particular sex.²⁶ Such “gender-coded” or “sex-specific” insurance policies are employed to deny coverage of critical preventive care to transgender people. We look forward to working with HHS on the upcoming Section 1557 rule to address these and many other abuses. We also look forward to a future rulemaking proceeding to add sexual orientation, gender identity and intersex characteristics into regulations prohibiting discrimination in Medicaid services²⁷ and in Medicaid and Medicare services to participants in the PACE program.²⁸

II. The Exchange- and QHP-Related Nondiscrimination Regulations Should Be Further Amended to Protect Persons With Intersex Characteristics

HHS should also amend sections 45 CFR §§ 147.104(e), 155.120(c), 155.220(j)(2)(i), 156.200(e), and 156.1230 to expressly prohibit discrimination on the basis of sex characteristics (including intersex traits). This approach would be consistent with the recent Title X family

²⁶ For example, in 2012, a transgender woman who was denied coverage for a mammogram because her insurance company had recorded her sex as male required TLDEF’s assistance to get this critical preventative procedure. Susan Donaldson James, *Transgender Woman Wins Insurance Coverage for Mammogram*, ABC News, May 1, 2012, <https://abcnews.go.com/Health/transgender-woman-wins-health-coverage-mammogram/story?id=16246219>. Similarly, OCR investigated the discriminatory exclusion of transgender women from a CDC-funded mammogram program, resulting in the CDC issuing new guidance clarifying that transgender women can participate in the program. U.S. Dep’t of Health and Human Services, *OCR Enforcement under Section 1557 of the Affordable Care Act Sex Discrimination Cases*, (Sept. 23, 2015), <https://web.archive.org/web/20150923030557/http://www.hhs.gov/ocr/civilrights/understanding/section1557/casesum.html>.

²⁷ 42 CFR §§ 438.3(d)(4), 438.206(c)(2), 440.262.

²⁸ 42 CFR §§ 460.98(b)(3), 460.112(a).

planning program final rule,²⁹ as well as the Department’s past interpretation (which it has never expressly disavowed) of Section 1557 of the ACA.³⁰ As with other grounds of discrimination prohibited under the rule, HHS has clear authority to adopt this prohibition to advance the purposes of the statute.

Discrimination based on sex characteristics, including intersex traits, is necessarily discrimination on the basis of sex. This conclusion flows directly from *Bostock v. Clayton County*,³¹ and is supported by other precedents including *Price Waterhouse v. Hopkins*.³² Prior to *Bostock*, HHS interpreted Section 1557’s sex discrimination prohibition to reach discrimination based on sex characteristics, including intersex traits.³³ Following *Bostock*, the Department of Justice (DOJ) updated its *Title IX Legal Manual* to clarify that the *Bostock* Court’s reasoning “applies with equal force to discrimination against intersex people,” concluding:

Discrimination against intersex individuals is similarly motivated by perceived differences between an individual’s specific sex characteristics and their sex category (either as identified at birth or some subsequent time). Additionally, discrimination based on anatomical or physiological sex characteristics (such as genitals, gonads, chromosomes, and hormone function) is inherently sex-based. Intersex traits, like gender identity and sexual orientation, are “inextricably bound up with” sex. In other words, it is impossible to discuss intersex status without also referring to sex. Lastly, discrimination

²⁹ HHS, Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services, 86 Fed. Reg. 56144, 56159, 56178 (Oct. 7, 2021), *to be codified at* 42 CFR § 59.5.

³⁰ Nondiscrimination in Health Programs and Activities, *supra* n.24, at 31389 (“the prohibition on sex discrimination extends to discrimination on the basis of intersex traits or atypical sex characteristics”).

³¹ 140 S. Ct. 1731 (2020).

³² 490 U.S. 228 (1989).

³³ Nondiscrimination in Health Programs and Activities, *supra* n.24.

based on intersex traits may also involve sex stereotypes, as intersex people by definition have traits that do not conform to stereotypes about male or female bodies.^[34]

While recognizing the discrimination based on sexual orientation, gender identity, and sex characteristics are all inherently sex-linked, HHS rightly chose to expressly enumerate these grounds in the nondiscrimination provision of the recent Title X rule, and should follow the same approach here.³⁵

Like other LGBTQI+ populations, intersex people face pervasive health and health care disparities, and face barriers to receiving appropriate health care and coverage. While the National Academies recently called for addressing a “significant gap” in data collection on intersex populations,³⁶ substantial evidence already exists of these disparities and barriers to care.³⁷ As with sexual orientation and gender identity, HHS has statutory authority independent of Section 1557 to prohibit discrimination based on sex characteristics, including intersex traits, by Exchanges, issuers, and agents and brokers.³⁸ As for other members of LGBTQI+ communities, without this protection intersex individuals and their families may continue to face discriminatory barriers to appropriate and necessary health care.

³⁴ US Department of Justice, *Title IX Legal Manual* (updated Aug. 12, 2021) (internal citations omitted), <https://www.justice.gov/crt/title-ix#Bostock>.

³⁵ HHS, Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services, *supra* n.30.

³⁶ National Academies, UNDERSTANDING THE WELL-BEING OF LGBTQI+ POPULATIONS, *supra* n.9, at 67.

³⁷ Rosenwohl-Mack A, et al. A national study on the physical and mental health of intersex adults in the U.S., *PLoS ONE* 5(10): e0240088 (2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7546494/>; Zeeman L. & Aranda K. A systematic review of the health and healthcare inequalities for people with intersex variance, *Int. J. Environ. Res. Public Health*, 17(18):6533 (2020), <https://www.mdpi.com/1660-4601/17/18/6533>; National Academies, UNDERSTANDING THE WELL-BEING OF LGBTQI+ POPULATIONS, *supra* n.9.

³⁸ 42 U.S.C. §§ 300gg–6(a), §300gg–92, 18022(b), 18032(e), 18041(a)(1)(B) and (D).

Discrimination against intersex people in health *insurance* can take a number of forms, and the Department should provide one or more illustrative examples, such as the following:

- Pursuant to §§ 156.125 and 156.200(e), benefit designs that restrict coverage of EHB solely due to sex characteristics (including intersex traits) are presumptively discriminatory. For example, some health plans have adopted clinical policies for gender-affirming care that exclude such care for all adults or adolescents with intersex traits. Such a benefit design is presumed to be discriminatory if it limits coverage of an EHB when clinical evidence demonstrates that such coverage is medically necessary.
- Pursuant to §§ 156.125 and 156.200(e), benefit designs that restrict coverage of EHB due to gender coding are discriminatory to the extent that they result in restricting coverage of clinically appropriate services based on a person's gender identity, transgender status, or intersex traits. A health plan design, for example, is presumed to be discriminatory if gender coding results in denying coverage of cervical, breast, or prostate cancer screening or treatment for a transgender or intersex individual who possesses the relevant anatomy and otherwise meets criteria for coverage.

III. The Proposed Guidance on Nondiscriminatory Benefit Design and Examples of Discriminatory Designs Should Be Strengthened Regarding Gender-Affirming Care

We support the proposal to refine the nondiscrimination policy for EHB by providing more detailed guidance on when a plan benefit design is discriminatory. For instance, we applaud the express acknowledgment that adverse tiering of prescription drugs used for certain disabilities and other chronic health conditions, such as HIV infection and mental illness, is a significant problem, and that an issuer cannot single out particular conditions for adverse tiering,

or rely on the cost of particular drugs alone if other drugs of comparable or greater cost, used for other conditions, are treated more favorably.

We are gratified that the Department has taken the important step of expressly declaring that “benefit designs that restrict coverage of EHB due to gender identity are presumptively discriminatory” (87 Fed. Reg. at 667). Moreover, the proposed amendment of 45 C.F.R. § 156.125(a) to state that “[a] non-discriminatory benefit design that provides EHB is one that is clinically-based, incorporates evidence-based guidelines into coverage and programmatic decisions, and relies on current and relevant peer-reviewed medical journal article(s), practice guidelines, recommendations from reputable governing bodies, or similar sources” will go a long way to clarifying that insurance plans cannot exclude or limit well-documented and well-recognized gender-affirming treatments. We also support the Department’s proposal that “unscientific evidence, disreputable sources, and other bases or justifications that lack the support of relevant, clinically based evidence would be an unacceptable basis upon which to dispute a claim that an issuer’s benefit design is discriminatory” (87 Fed. Reg. at 664).³⁹ However, in order to fully realize the promise of these steps, we respectfully submit that the Final Rule should say more.

³⁹ Unfortunately, some entities do invoke such material as reason to refuse coverage for transgender related care. *See, e.g., Flack v. Wisconsin*, 395 F. Supp. 1001, 1013-14, 1016 (W. D. Wis. 2019) (criticizing the quality of evidence used by Wisconsin to defend Medicaid exclusion of gender affirming care and concluding it created no dispute of fact as to the safety and efficacy of gender affirming care.). The American College of Pediatricians is an organization founded in 2002 and has used research that lacks scientific integrity in order to marginalize the transgender community and perpetuate harmful misinformation on gender affirming care. According to the Southern Poverty Law Center: “The American College of Pediatricians (ACPeds) is a fringe anti-LGBTQ hate group that masquerades as the premier U.S. association of pediatricians to push anti-LGBTQ junk science, primarily via far-right conservative media and filing amicus briefs in cases related to gay adoption and marriage equality.” Southern Poverty Law Center, *American College of Pediatricians*, <https://www.splcenter.org/fighting-hate/extremist-files/group/american-college-pediatricians> (visited Jan. 25, 2022).

It is critical to explicitly address insurers' internal coverage guidelines on the treatment of gender dysphoria as employed in the utilization management process. Even when health plans do not include categorical exclusions of all gender affirming care in their benefit design, issuers have continued to maintain internal coverage guidelines that exclude a wide range of medically necessary gender affirming surgeries – frequently procedures such as facial gender affirming surgery (also known as facial feminization surgery). Insurers often designate these procedures as “cosmetic” or “not medically necessary,” despite ample clinical evidence and standards of care that find them necessary to treat gender dysphoria, improve mental health, and increase quality of life.⁴⁰ This has led to many transgender people being denied access to the specific care they require to alleviate their gender dysphoria and affirm their actual gender. In addition, some insurers impose onerous requirements without basis in medicine for coverage of transgender-related care. For example, a major insurance company offering Marketplace plans in Arkansas makes a legal name change a prerequisite for gender affirming care.⁴¹ This requirement lacks any clinical or evidentiary basis as a criterion for treating gender dysphoria or providing gender-affirming care. In addition to being at odds with standards of care, intrusive, rife with gender-stereotypes, the requirement may delay care or prevent people from obtaining care entirely because financial, legal, social barriers can prevent transgender people from changing their names. TLDEF with the ACLU of Kansas recently advocated for removal of a similar

⁴⁰ State of Connecticut Commission on Human Rights and Opportunities, *Declaratory Ruling on Petition Regarding Health Insurers' Categorization of Certain Gender-Confirming Procedures as Cosmetic* (April 17, 2020), at 10-12, available at https://www.glad.org/wp-content/uploads/2020/04/Dec-Rule_04152020.pdf (finding that it is discriminatory to offer or implement a plan that categorically excludes certain for all individuals with gender dysphoria).

⁴¹ Arkansas BlueCross BlueShield, Policy #2016024, Gender Reassignment Surgery for Gender Dysphoria, Initiated Jan. 2017, Last Review Oct. 2021, <https://secure.arkansasbluecross.com/members/report.aspx?policyNumber=2016024> (visited Jan. 26, 2022).

requirement after it resulted in an initial denial of coverage and substantial delay in surgery for a transgender Kansan enrolled in a Marketplace plan.⁴²

In order to assure that plan designs that discriminate on the basis of gender identity are effectively identified and eliminated, we recommend several improvements in the Final Rule. First, the Final Rule should expressly list guidelines issued by World Professional Association for Transgender Health (WPATH),⁴³ the Endocrine Society,⁴⁴ and the University of California at San Francisco's Center of Excellence for Transgender Health⁴⁵ as clinically- and evidence-based guidelines that insurance plans should rely on in making coverage decisions on gender-affirming

⁴² ACLU Kansas, *Blue Cross Blue Shield Kansas Changes Policy on Gender-Affirming Surgeries*, *ACLU of Kansas and TLDEF Urge Further Reforms* (Dec. 9, 2021), <https://www.aclukansas.org/en/press-releases/blue-cross-blue-shield-kansas-changes-policy-gender-affirming-surgeries-aclu-kansas>.

⁴³ World Professional Assn for Transgender Health, *STANDARDS OF CARE VERSION 7* (2018), available at <https://www.wpath.org/publications/>.

⁴⁴ Hembree, W.C., et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: An Endocrine Society clinical practice guideline. 2017 *J. Clin. Endocrinology & Metabolism* 102(11): 3869-3903, <https://academic.oup.com/jcem/article/102/11/3869/4157558>.

⁴⁵ UCSF Transgender Care. *GUIDELINES FOR THE PRIMARY AND GENDER-AFFIRMING CARE OF TRANSGENDER AND GENDER NONBINARY PEOPLE* (2nd ed.) (Deutsch, M.B. ed.). San Francisco, CA: 2016). <https://transcare.ucsf.edu/guidelines>.

hormone treatments and surgical procedures. Medical authorities,⁴⁶ courts,⁴⁷ and the U.S. Department of Justice⁴⁸ widely recognize WPATH as setting the standard for gender-affirming care. Endocrine Society guidelines are also widely recognized,⁴⁹ as are the UCSF standards.⁵⁰

Second, we urge CMS to require review of issuers' internal coverage guidelines for discriminatory benefit design as part of the QHP certification process. New York provides an illustrative example of the need to include review of issuer's internal coverage guidelines for the treatment of gender dysphoria in the certification of health plans. In 2014, New York prohibited

⁴⁶ See Am. Med. Ass'n House of Delegates, Resolution 122 (A-08), *Removing Financial Barriers to Care for Transgender Patients*, at 1, http://www.tgender.net/taw/ama_resolutions.pdf (characterizing WPATH as “the leading international, interdisciplinary professional organization devoted to the understanding and treatment of gender identity disorders” and WPATH’s Standards of Care as “internationally accepted” by the medical community); Am. Psychological Ass’n, *Report of the APA Task Force Report on Gender Identity and Gender Variance* (2009), at 32, <http://www.apa.org/pi/lgbt/resources/policy/gender-identity-report.pdf> (noting that the Standards of Care reflect “the consensus in expert opinion among professionals in this field on the basis of their collective clinical experience as well as a large body of outcome research”); Rafferty J., *Am. Acad. of Pediatrics Policy Statement: Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 2018 *Pediatrics* 142(4), <https://doi.org/10.1542/peds.2018-2162> (acknowledging that “[m]ost protocols for gender-affirming interventions incorporate World Professional Association of Transgender Health and Endocrine Society recommendations” and applying the SOC to recommendations and conclusions throughout).

⁴⁷ See, e.g., *Grimm v. Gloucester Cty. Sch. Bd.*, 972 F.3d 586, 595–96 (4th Cir. 2020), *cert. denied* by 141 S. Ct 2878 (2021) (“the [WPATH Standards of Care] represent the consensus approach of the medical and mental health community ... and have been recognized by various courts, including this one, as the authoritative standards of care [citations omitted]”); *Kadel v. Folwell*, 14 F.4th 422, 427 (4th Cir. 2020), *cert. denied*, 2022 WL 145183 (U.S. Jan. 18, 2022); *Edmo v. Corizon, Inc.*, 935 F.3d 757, 769 (9th Cir. 2019), *cert denied sub nom Idaho Dep’t of Correction v. Edmo*, 141 S Ct. 610 (2020).

⁴⁸ Statement of Interest of the United States, filed April 22, 2021 in *Diamond v. Ward*, No. 5:20-cv-00453-MTT (M. D. Ga.), https://ccrjustice.org/sites/default/files/attach/2021/04/65_4-22-21_DOJ-SOI_w.pdf; Statement of Interest of the United States, filed April 3, 2015 in *Diamond v. Owens*, No. 15-cv-50-MTT-CHW (M. D. Ga.), https://www.justice.gov/sites/default/files/crt/legacy/2015/06/12/diamond_soi_4-3-15.pdf.

⁴⁹ See, e.g., *Am. Acad. of Pediatrics Policy Statement: Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, *supra* n.46; National Academies, UNDERSTANDING THE WELL-BEING OF LGBTQI+ POPULATIONS, *supra* n.9, at 361.

⁵⁰ National Academies, UNDERSTANDING THE WELL-BEING OF LGBTQI+ POPULATIONS, *supra* n.9, at 361.

categorical exclusion of gender affirming care as a covered benefit in all health insurance plans certified to be sold in New York.⁵¹ As a result, issuers in New York began covering hormone replacement therapy and genital gender affirming surgery. However, issuers continued to categorically exclude a wide range of medically necessary gender affirming surgeries, by designating these procedures as “cosmetic” or “not medically necessary” within their internal coverage guidelines. As a result, many transgender New Yorkers were automatically denied coverage of gender affirming care during the utilization management process, without consideration to their specific medical needs. A review of New York’s public external appeal database reveals that health insurance denials of gender affirming care were overturned by Independent Review Organizations at nearly twice the rate they were upheld.⁵² In response, New York announced that it would require issuers to submit their internal coverage guidelines on the treatment of gender dysphoria for review and approval prior to certification to participate in the New York insurance market.⁵³ New York required issuers to use evidence-based and peer-reviewed internal coverage guidelines, and explicitly stated that New York would not approve any internal coverage guidelines that include categorical exclusions of any gender-affirming treatments.⁵⁴

⁵¹ New York Dept. of Financial Services, Insurance Circular Letter No. 7, Dec. 11, 2014, https://www.dfs.ny.gov/insurance/circltr/2014/cl2014_07.htm.

⁵² **See** New York Dept. of Financial Services, External Appeals Searchable Archive, <https://www.dfs.ny.gov/public-appeal/search> (searched by TLDEF Jan. 20, 2022).

⁵³ New York Dept. of Financial Services, Insurance Circular Letter No. 13, June 28, 2020, https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2020_13.

⁵⁴ *Id.*

In addition, the Proposed Rule’s example of a discriminatory design – that “excluding coverage of medically necessary hormone therapy for treatment of gender dysphoria where hormone therapy is otherwise a covered EHB is presumptively discriminatory” (87 Fed. Reg. at 667) – should be amended or supplemented to include surgical care. While some health plans persist in refusing to cover hormone replacement therapy for transgender people, in our experience, this usually occurs in plans that explicitly refuse to cover all transgender-related care/gender dysphoria treatment, which means that surgical care to alleviate gender dysphoria or affirm gender is also excluded. An overwhelming majority of plans in ACA Marketplaces have abandoned such blanket exclusions,⁵⁵ but many insurers whose plans cover some transgender-related care continue to exclude or restrict many surgeries that are medically necessary to treat gender dysphoria or affirm a patient’s gender. For example, facial gender reassignment surgery is critically important to many transfeminine people,⁵⁶ but is incorrectly deemed cosmetic and categorically excluded by many major insurers’ policies.⁵⁷ In addition, many insurers rule out

⁵⁵ *Summary of findings: 2022 Marketplace Plan Compliance with 1557*, Out2Enroll (2021), <https://out2enroll.org/out2enroll/wp-content/uploads/2021/12/Report-on-Trans-Exclusions-in-2022-Marketplace-Plans.pdf>.

⁵⁶ Capitán L., et al. Facial feminization surgery: The forehead. Surgical techniques and analysis of results, 134 *Plastic and Reconstructive Surgery* 2014 134(4): 609-619. doi: 10.1097/PRS.0000000000000545; Salibian A.A. & Bluebond-Langner R. Lip lift. 2019 *Facial Plastic Surgery Clinics N. Am.* 27(2):261-266. doi: 10.1016/j.fsc.2019.01.004 (noting that facial surgeries “are as effective in treating gender dysphoria in certain cases [as breast surgeries and genital surgeries]”) (full text available on request from TLDEF, 520 8th Ave., Suite 2204, New York, NY 10018, (646) 862-9396, contact Ezra Cukor, Senior Staff Attorney, ecukor@transgenderlegal.org).

⁵⁷ See e.g., Aetna, *Gender Affirming Surgery*, Medical Clinical Policy Bulletin No. 0615 (Last Review 11/23/2021), http://www.aetna.com/cpb/medical/data/600_699/0615.html#dummyLink4; United Healthcare Community Plan, *Gender Dysphoria Treatment*, Policy No. CS145.J (Effective Date Nov. 1, 2021), <https://www.uhcprovider.com/content/provider/en/viewer.html?file=%2Fcontent%2Fdam%2Fprovider%2Fdocs%2Fpublic%2Fpolicies%2Fmedicaid-comm-plan%2Fgender-dysphoria-treatment-cs.pdf>. See also, National Center for Lesbian Rights, *Parties Settle Landmark Lawsuit by Transgender Employee Who Was Unlawfully Denied Medically Necessary Care* (Mar. 3, 2020), <http://www.nclrights.org/press->

any possibility coverage of surgery for minors which—though rare—can be indispensable and even life-saving.⁵⁸ Without insurance coverage, transgender people are forced to pay for care out of pocket, for many at the expense of meeting other basic needs or, more frequently, delay or forgo treatments entirely, and endure ongoing harms of untreated gender dysphoria. These exclusions are as discriminatory as exclusions of hormones, or categorical exclusions of all transgender-related care.⁵⁹ Therefore, the Final Rule should clarify that excluding coverage of medically necessary hormone therapy or surgery for the treatment of gender dysphoria is presumptively discriminatory.

Moreover, the Final Rule should adjust the discussion of comparators in the example or examples of gender identity discrimination. The discussion in the Proposed Rule assumes cisgender (non-transgender) people’s health needs as the yardstick for measuring transgender

[room/press-release/parties-settle-landmark-lawsuit-bytransgender-employee-who-was-unlawfully-denied-medically-necessary-care](https://www.nclrights.org/our-work/cases/ketcham-v-regence-bluecross-blueshield-of-oregon/) (discussing resolution of challenge to exclusion of facial gender reassignment surgeries from Oregon state employee health plan; the pending lawsuit against Regence BlueCross BlueShield of Oregon is described at <https://www.nclrights.org/our-work/cases/ketcham-v-regence-bluecross-blueshield-of-oregon/> (visited Jan. 26, 2022)).

⁵⁸ See, e.g., American Academy of Pediatrics, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, *supra* n.46, at 6-7 (noting that surgical care is usually reserved for adults, but may be appropriate for adolescents based on “the necessity and benefit to the adolescent’s overall health” an analysis that often includes “multidisciplinary input from medical, mental health, and surgical providers as well as from the adolescent and family”); Letter from James L. Madara, MD, CEO, American Medical Assoc., to Bill McBride, Exec. Dir., Nat’l Governors Assoc., (Apr. 26, 2021), <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-4-26-Bill-McBride-opposing-anti-trans-bills-Final.pdf> (opposing legislation that would restrict health care for transgender youth and noting, *inter alia*, that “[t]ransgender children, like all children, have the best chance to thrive when they are supported and can obtain the health care they need.”).

⁵⁹ Connecticut Commission on Human Rights and Opportunities, *Declaratory Ruling on Petition Regarding Health Insurers’ Categorization of Certain Gender-Confirming Procedures as Cosmetic*, *supra* n.40, at 10-12 (concluding that categorically excluding as cosmetic some treatments for gender dysphoria is facially discriminatory, and treating the coverage of the same treatments for other diagnoses as additional evidence of discrimination but not necessary to a discrimination claim).

people's health needs. This model suggests that transgender people can only access health care to the extent that the care they need happens to be the same care provided to cisgender people. Many of the treatments that transgender people require to alleviate gender dysphoria are also used by non-transgender people with other health conditions, but that overlap cannot define the limit of anti-discrimination protections. This approach does not make any sense when applied to health conditions generally, and gender dysphoria is no exception. To obtain coverage, an HIV positive person would not need to show that the drug they needed was already covered for some unrelated medical condition. If a plan excluded drugs needed to treat HIV, the relevant inquiry would be whether the plan covered prescription drugs generally, not whether HIV negative people need the same drug for some other reason. And if a plan excludes hormones or surgery needed to alleviate gender dysphoria, the relevant inquiry is whether the plan covers prescription drugs or surgical care, respectively. The Final Rule should adjust the discussion accordingly to avoid suggesting a too-limited extent of anti-discrimination protections.

Finally, we applaud CMS's recent approval of Colorado's 2023 EHB benchmark plan, and we urge CMS to direct other states to adopt similar provisions to their EHB benchmark plans.⁶⁰ Colorado affirmative and explicit inclusion of gender affirming care within the state's EHB benchmark provides an excellent model for ensuring genuine access to medically necessary gender affirming care. Colorado's EHB benchmark plan includes an explicit requirement to cover gender affirming care, and enumerates a non-exhaustive list of procedures that must be covered in addition to hormone replacement therapy and genital gender affirming surgery.⁶¹

⁶⁰ Center for Medicare and Medicaid Services, EHB Approval Letter to Colorado, October 12, 2021, https://drive.google.com/file/d/1Q9w_G1UKR8KK2HoajegufwH6FZ348ASH/view.

⁶¹ The Colorado Benchmark Plan for 2023 is available at https://drive.google.com/file/d/0BwguXutc4vbpY2dCZGdpZld2blk/view?resourcekey=0-X1w4xWYkib9NF6E58a_OOg.

Notably, Colorado requires coverage of facial gender confirmation surgery, a procedure that is routinely categorized by many insurers as “cosmetic” despite medical literature finding that such care cannot be classified as such and is medically necessary for the treatment of gender dysphoria or otherwise to affirm an individual’s gender identity.⁶²

IV. Cost is No Justification for Health Insurance Discrimination Based on Gender Identity

An argument has been raised from time to time that excluding or restricting coverage of gender-affirming surgery is justified because of the cost of such procedures. In fact, such an argument is completely unsupported by the evidence. In reality, the evidence shows that removing transgender exclusions in insurance plans is cost-neutral or cost-saving. There is no actuarial basis to price transgender-related surgeries separately from any other type of surgery.

The City and County of San Francisco initially raised premiums when they became the first major U.S. employers to remove blanket exclusions for transgender-related care in 2001. But after five years, “beneficial cost data led Kaiser and Blue Shield to no longer separately rate and price the transgender benefit—in other words, to treat the benefit the same as other medical procedures such as gall bladder removal or heart surgery.”⁶³ A 2013 survey by the Williams Institute of employers providing transition-related coverage to employees through their health plans found that two-thirds of the employers that provided information on actual costs of employee utilization of gender dysphoria

⁶² “The current level of evidence is close to the maximal level of evidence that can be expected for a surgical procedure, as randomized clinical trials will likely never be offered for these procedures. As such, FGCS can no longer be deemed as an aesthetic component of gender-confirming care.” Berli J.U., et al. Facial gender confirmation surgery – review of the literature and recommendations for Version 8 of the WPATH Standards of Care. 2017 *Int. J. of Transgenderism*, 18(3): 264-270, at 268. DOI: 10.1080/15532739.2017.1302862. Available at [file:///C:/Users/pdani/OneDrive/Downloads/PlemonsFGCSWPATHRecs%20\(1\).pdf](file:///C:/Users/pdani/OneDrive/Downloads/PlemonsFGCSWPATHRecs%20(1).pdf).

⁶³ City and County of San Francisco Human Rights Commission, *San Francisco City and County Transgender Health Benefit* (Aug. 7, 2007), https://transhealthproject.org/documents/19/SF_transgender_health_benefit.pdf.

coverage reported zero costs, and those employers who reported some costs said that the costs were very low or minimal.⁶⁴ An analysis of the utilization of transgender-related care over 6.5 years in one California health plan found a utilization rate of 0.062 per 1,000 covered persons.⁶⁵ Estimates from other state health plans show equally low costs with North Carolina estimating 0.011% to 0.027% of premium;⁶⁶ in Alaska, 0.03% to 0.05%;⁶⁷ and in Wisconsin, the costs at most were “immaterial at 0.1% to 0.2% of the total cost.”⁶⁸ Cost estimates under Wisconsin Medicaid were “actuarially immaterial as they are equal to approximately 0.008% to 0.03%” of Wisconsin’s share of its Medicaid budget.⁶⁹ An analysis in the military context concluded that the financial cost was “too low to matter”⁷⁰ or, as military leadership noted, “‘budget dust,’

⁶⁴ Jody L. Herman, The Williams Institute, *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans: Findings From a Survey of Employers* (Sept. 2013), <https://escholarship.org/content/qt5z38157s/qt5z38157s.pdf?t=n2ff2l>.

⁶⁵ State of California Department of Insurance, *Economic Impact Assessment: Gender Nondiscrimination in Health Insurance*, Reg. File No. REG-2011-00023 (Apr. 13, 2012), at 5, <http://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf>.

⁶⁶ Segal Consulting memorandum to Mona Moon, Executive Administrator of the North Carolina State Health Plan, re: Transgender Cost Estimate, Nov. 29, 2016, <https://files.nc.gov/ncshp/documents/board-of-trustees/3aii-3-The-Segal-Company-Transgender-Cost-Estimate-Memorandum.pdf>.

⁶⁷ Plaintiffs’ Motion for Partial Summary Judgment, *Fletcher v. Alaska*, No. 1:18-cv-00007-HRH (D. Alaska July 1, 2019), https://www.lambdalegal.org/sites/default/files/legal-docs/downloads/fletcher_ak_20190701_plaintiffs-motion-for-partial-summary-judgment.pdf.

⁶⁸ *Boyden v. Conlin*, 341 F. Supp. 3d 979, 1000 (W.D. Wis. 2018).

⁶⁹ *Flack v. Wis. Dep-t of Health Servs.*, 395 F. Supp. 3d 1001, 1008 (W.D. Wis. 2019).

⁷⁰ Belkin A. Caring for our transgender troops – The negligible cost of transition-related care, 2015 *N.E. J. Med.* 373:1089-1092, at 1092, <https://www.nejm.org/doi/full/10.1056/NEJMp1509230>.

hardly even a rounding error.”⁷¹ This is because only a small percentage of the population is transgender⁷² and not all transgender individuals undergo all available treatments.

V. Network Adequacy Should Include LGBTQI-Competent Care

We commend HHS for revisiting its regulations to add new provisions aimed at ensuring that QHP enrollees have meaningful access to all essential health benefits. We support HHS’s proposal to evaluate networks of QHPs and potential QHPs in the Federally Facilitated Exchange prior to their certification, and post-certification review of compliance in response to random sampling or complaints. We urge HHS to closely scrutinize both the standards and review process before allowing states that perform plan management functions to perform their own reviews of network adequacy to ensure that both are indeed at least as stringent as the established federal standards, and that networks are reviewed before QHPs are certified. Similarly, we believe that in future rulemaking, HHS should consider establishing the same standards for State-Based Exchanges that it uses in the FFE, while allowing states to perform their own reviews of network adequacy as long as both the standards and review process are at least as stringent as the established federal standards and process. We emphasize that network adequacy reviews, whether performed by HHS or by states, must include direct testing, such as secret shopper surveys, or data systems that capture appointment details.

⁷¹ Declaration. of Raymond Edwin Mabus, Jr., Former U.S. Secretary of the Navy, in Support of Plaintiff’s Motion for Preliminary Injunction, *Doe v. Trump*, No. 17-cv-1597-CKK (D.D.C.) filed Aug. 31, 2017, at ¶ 41), available at <http://files.eqcf.org/wp-content/uploads/2017/09/13-Ps-App-PI.pdf> (visited Jan. 26, 2022).

⁷² Transgender people are estimated to comprise approximately 0.6% of the population. Jan Hoffman, *Estimate of U.S. Transgender Population Doubles to 1.4 Million Adults*, N.Y. Times (June 30, 2016), <https://www.nytimes.com/2016/07/01/health/transgender-population.html>; State of California Department of Insurance, *Economic Impact Assessment: Gender Nondiscrimination in Health Insurance Cal.* Economic Impact Assessment, *supra* n.65, at 2 (concluding that requiring equal benefits for transgender people “will have an immaterial impact on extra demands for treatments, because of the low prevalence of the impacted population.”).

In assuring network adequacy, it is essential to consider whether a network includes providers who are clinically and culturally competent to serve LGBTQI patients. The lack of provider knowledge of the health issues and needs of lesbians, gay men, and bisexual persons; of transgender and gender nonbinary patients; and individuals with intersex traits; and lack of provider comfort and skill in effectively communicating with such patients, are major barriers to health care for sexual- and gender-diverse patients. Lack of provider clinical and cultural competence results in failure to diagnose or misdiagnosis of health conditions, resulting in lack of effective treatment; and discourages LGBTQI people from seeking regular medical care and from full disclosure to health care providers.⁷³ Lack of community engagement which is vital for trust building with the community and medical education.⁷⁴ Therefore, in addition to prohibiting discrimination, the Department needs to encourage provider competence. Making LGBTQI competence and community engagement an essential element of network adequacy for QHPs would be an important step.

We particularly recommend adding a category for providers of surgical care for gender affirming care. While some general surgeons or plastic surgeons provide these procedures, many

⁷³ National Academies, UNDERSTANDING THE WELLBEING OF LGBTQI+ POPULATIONS, *supra* n.9, at pp. 357-59; American Association of Medical Schools, IMPLEMENTING CURRICULAR AND INSTITUTIONAL CLIMATE CHANGES TO IMPROVE HEALTH CARE FOR INDIVIDUALS WHO ARE LGBT, GENDER NONCONFORMING, OR BORN WITH DSD: A RESOURCE FOR MEDICAL EDUCATORS (2014), available at <http://offers.aamc.org/lgbt-dsd-health>; The Joint Commission, ADVANCING EFFECTIVE COMMUNICATION, CULTURAL COMPETENCE, AND PATIENT- AND FAMILY-CENTERED CARE FOR THE LESBIAN, GAY, BISEXUAL, AND TRANSGENDER (LGBT) COMMUNITY: A FIELD GUIDE (2011), available at <http://www.jointcommission.org/lgbt>.

⁷⁴ Noonan, E. J., et al. Engaging the transgender community to improve medical education and prioritize healthcare initiatives. 2018 *Teaching and Learning in Medicine*, 30(2): 119-132. <https://doi.org/10.1080/10401334.2017.1365718>; Everhart, A. R., et al. (2022). “I’m not interested in research; i’m interested in services”: How to better health and social services for transgender women living with and affected by HIV. 2022 *Social Science & Medicine*, 292, <https://www.sciencedirect.com/science/article/pii/S0277953621009424>.

do not, and it can be difficult for transgender QHP enrollees to identify providers who are qualified and competent to perform such surgical care. For example, Louisiana healthcare providers report that there was no in-state surgeons who perform vaginoplasty or phalloplasty for the treatment of gender dysphoria, and only two marketplace plans contract with out-of-state surgeons who do perform such surgeries.

We strongly support HHS's proposal to codify provider and facility types that will be subject to time and distance standards. Placing this information in the regulation is an important step toward ensuring that QHP enrollees have meaningful access to essential health benefits. This information is likely to be particularly important for individuals needing LGBTQI-specialist care, because the number of providers may be more limited, and they may be more geographically dispersed.

We also strongly support HHS's proposal that for plans that use tiered networks, to count toward the issuer's satisfaction of the network adequacy standards, providers must be contracted within the network tier that results in the lowest cost-sharing obligation. In addition, we urge HHS to provide clarity in this rule about QHPs obligations to their enrollees when they are unable to meet time and distance standards, or appointment wait time standards. Even the most robust networks will occasionally be unable to provide extremely rare and specialized services, and may experience times when providers are temporarily unavailable, which can require enrollees to travel further and wait longer to access care. This point has been driven home over the last few months as many health care providers have experienced temporary staff shortages due to COVID infections. And, as noted above, LGBTQI-specialist providers may be less numerous within a network and more geographically dispersed. We urge HHS to make clear that

in these situations, QHPs must hold their enrollees financially harmless for seeking care from out-of-network or higher tier providers.

We support HHS’s proposal to raise the Essential Community Provider participation standard to 35 percent. We urge HHS to require QHPs to meet this standard for each category of ECP rather than for all ECPs taken as a whole, to ensure that QHP enrollees have adequate access to all of the important types of ECPs which range from Ryan White providers to FQHCs. In particular, OHPs should, when possible, include in their networks ECPs that are LGBTQI-focused. We strongly support HHS’s proposal that for plans that use tiered networks, to count toward the issuer's satisfaction of the ECP standards, ECPs must be contracted within the network tier that results in the lowest cost-sharing obligation.

VI. Issuers Seeking QHP Status Should Disclose Their Telehealth Services

We support the proposal to require all issuers seeking certification of plans to be offered as QHPs through the Federally Facilitated Exchange to submit information about whether network providers offer telehealth services. Many LGBTQI people live in areas that lack clinically and culturally competent – and nondiscriminatory and welcoming – providers in their geographic area, and depend for their medical care, and mental health support, on our health centers and similar LGBTQI-specialist providers located at some distance from them. According to the US Transgender Survey in 2015, transgender people were three times more likely to must travel more than 50 miles for transgender-related care than for routine care.⁷⁵ Remote access to competent and welcoming providers through audio and video telehealth encounters is essential for their health and well-being. As we emerge from the COVID-19 pandemic and the

⁷⁵ James, S. E., et al., THE REPORT OF THE 2015 U.S. TRANSGENDER SURVEY, National Center for Transgender Equality (Washington, DC: 2016), <https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf>.

Department, other federal agencies, state and local regulators, and the health care professions consider how telehealth expansions initially implemented as emergency measures can and should be continued and even expanded, it is critical for consumers, regulators, and researchers to have as much information as possible on telehealth practices and outcomes.

VII. Collection of Data on Sexual Orientation, Gender Identity and Variations in Sex Characteristics is Fundamental to Advancing Health Equity Through Exchanges and Qualified Health Plans

We applaud the Department's commitment to implementing Executive Order 13985 by exploring ways to encourage QHPs to advance health equity and to assess their progress. We submit that any and all such efforts must depend on the collection of relevant demographic data and data on the social determinants of health applicable to the relevant communities. In particular, assessing and advancing health equity in LGBTQI populations requires collecting adequate data on sexual orientation, gender identity and variations in sex characteristics (also known as intersex traits). Comprehensive data collection is critical to advancing health equity and improving the healthcare delivery system for all patients, including patients from historically marginalized communities. A lack of data stymies policymakers' ability to identify systemic issues in access to coverage, claims denials, appeals, and other measures. Limited or inaccurate data also makes it difficult to implement serious investments in improving quality of care for patients and reducing racial and ethnic health disparities. Comprehensive data is especially important to addressing disparities that are made worse when compounded with marginalized identities based on disability, gender identity, sexual orientation, and intersex traits.

CMS and its Center for Consumer Information and Insurance Oversight (CCIIO) can draw on several sources to inform this data collection. For example, Covered California had

added gender identity and sexual orientation questions to their Marketplace application form.⁷⁶ Oregon recently enacted legislation⁷⁷ that will require coordinated care organizations, healthcare providers, and health insurers to collect data on race, ethnicity, preferred spoken and written languages, disability status, sexual orientation and gender identity. All insurers should have the capability to collect, maintain, and report these data, which are already often collected by other health system entities, such as hospitals and clinician practices that use electronic medical record (EMR) systems. In addition, recognizing the importance of sexual and gender data to the provision of healthcare services, HHS recently adopted a new version of the US Core Data for Interoperability (USCDI) that includes sexual orientation and gender identity as core elements.⁷⁸ Some insurers have also already developed new tools to leverage gender identity data elements to improve the experience of their diverse enrollees, such as the ability for transgender and nonbinary clients to include their authentic names, pronouns, and gender identities in their insurance record, and to avoid inappropriate denials of care for transgender, nonbinary, and intersex individuals based on sex coding.⁷⁹

⁷⁶ Covered California, Covered California Holding Health Plans Accountable for Quality and Delivery System Reform (Dec. 2019), https://hbex.coveredca.com/data-research/library/CoveredCA_Holding_Plans_Accountable_Dec2019.pdf.

⁷⁷ Oregon Rev. Statutes § 413.161, amended by Oregon House Bill 3159.

⁷⁸ *HHS updates interoperability standards to support the electronic exchange of sexual orientation, gender identity and social determinants of health* (July 9, 2021), <https://www.hhs.gov/about/news/2021/07/09/hhs-updates-interoperability-standards-to-support-electronic-exchange-of-sogi-sdoh.html>

⁷⁹ Page Minemyer, *Oscar launches new functionality for transgender, nonbinary members*, . Fierce Healthcare (July 14, 2021), <https://www.fiercehealthcare.com/payer/oscar-launches-new-functionality-for-transgender-nonbinary-members>.

The National Association of Insurance Commissioners Special Committee on Race and Insurance has developed detailed, thoughtful guidance for insurance regulators and insurance companies on data collection methodologies that respect individual autonomy and protect privacy while providing essential information for policymakers.⁸⁰ In addition, the forthcoming National Academies of Science, Engineering and Medicine report *Measuring Sex, Gender Identity, and Sexual Orientation* will also discuss guiding principles and recommended measures for testing, including for administrative settings such as health plan enrollment.⁸¹

⁸⁰ *National Association of Insurance Commissioners Special Committee on Race and Insurance – Workstream 5 (Health), Principles for Data Collection, Draft 12/20/21, available https://content.naic.org/cmt_e_ex_race_and_insurance.htm.*

⁸¹ See <https://www.nationalacademies.org/our-work/measuring-sex-gender-identity-and-sexual-orientation-for-the-national-institutes-of-health>.

VIII. Conclusion

The LGBTQI Health Policy Roundtable and the LGBTQIA+ Primary Care Alliance are pleased to participate in this important discussion. We would be happy to provide additional information or to assist CMS or the Department in any other way.

Respectfully submitted, *

AIDS United
Callen-Lorde Community Health Center
(New York, NY)
Cascade AIDS Project (Portland, OR)
Community Healthcare Network (New
York, NY)
CrescentCare (New Orleans)
Fenway Health (Boston)
GLMA – Health Professionals Advancing
LGBTQ Equality
Howard Brown Health (Chicago)
interACT – Advocates for Intersex Youth
Lambda Legal

Legacy Community Health (Houston)
National Black Justice Coalition
National Center for Lesbian Rights
National Center for Transgender Equality
National LGBT Cancer Network
Transgender Law Center
Transgender Legal Defense and Education
Fund
Transhealth Northampton (Massachusetts)
Trillium Health (Rochester, NY)
Whitman-Walker Institute and Whitman-
Walker Health (Washington, DC)

** Health centers are identified by their location*

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