Howard Brown Health

April 11, 2025

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9884-P
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

RE: [CMS-9884-P] RIN 0938-AV61 Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability

Howard Brown Health is the largest LGBTQ+ health center in the Midwest, serving more than 40,000 patients across seven clinic locations in Chicago. Howard Brown serves adults and youth in its diverse health and social service delivery system focused around seven major programmatic divisions: primary medical care, behavioral health, research, HIV/STI prevention, youth services, elder services, and community initiatives. As a federally qualified health center, Howard Brown provides services regardless of a patient's ability to pay or insurance status. A majority (58.8%) of Howard Brown's patients identify as LGBTQ+, with 17.8% identifying as transgender or gender diverse.

We have significant concerns that the proposed rule undermines both the stated goal of the Affordable Care Act to provide quality, affordable health care for all, and over a decade of improvements and achievements resulting in access to care for 50 million people—including Plan Year 2025's record-breaking enrollment of more than 24 million individuals across the nation. While this rule's stated goal is to root out fraud, the rule fails to account for the fact that states like ours, with a State-based Marketplace, have already seen much less fraud than what has been experienced on the federal Marketplace. If this proposed rule is finalized, it will lead to increased administrative burdens and increased healthcare costs for patients and states.

This rule will also erode vital and necessary Essential Health Benefits (EHBs) made available through the Affordable Care Act. EHBs where put in place to allow states to ensure millions of people have access to a variety of essential medical services that they may be unable to afford or access otherwise. Many states include Gender-Affirming Care (GAC) or treatment for gender dysphoria as part of their EHBs because of the overall health benefits to those who access it. Gender-affirming care ranges from hormone replacement therapy for cisgender women experiencing menopause, follicle therapies for cisgender men with hair loss, and various forms of medical and non-medical GAC for trans, nonbinary, and intersex people. Removing state's ability to include GAC as an EHB would significantly burden all people who need these services. This is especially dangerous for trans, nonbinary, and intersex people as GAC for these populations is medically necessary, age-appropriate, and safe health care backed by decades of research and supported by every major medical association, together representing over 1.3 million U.S. doctors.[1;2] **We at Howard Brown Health oppose these proposed updates as they could substantially**

[1] Human Rights Campaign. "Attacks on Gender Affirming Care by State Map." *Human Rights Campaign*, 2023, www.hrc.org/resources/attacks-on-gender-affirming-care-by-state-map.
[2] Advocates For Trans Equality. "Medical Organization Statements on Transgender Health Care - Trans Health Project." *Transhealthproject.org*, transhealthproject.org/resources/medical-organization-statements/.

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harm those who are transgender, nonbinary, or intersex and cause potentially irreplicable harm to accessing healthcare services and increased healthcare costs.

Impact on gender-affirming care access and costs

Prohibition on Coverage of Sex-trait Modification as an EHB (§ 156.115(d))

By excluding this care from state EHB requirements, this proposal will raise health care costs and encourage denials and other limits on medically necessary care, including hormone therapy and other medical interventions for persons diagnosed with gender dysphoria. Such limits are not only unlawful; they are unconscionable.

Gender dysphoria is a serious medical condition characterized by clinically significant distress or impairment in social, occupational, or other important areas of functioning due to a marked incongruence between the patient's gender identity (i.e., the innate sense of one's own gender) and sex assigned at birth.[3] People diagnosed with gender dysphoria can greatly benefit from treatment. The standard of care for treatment of gender dysphoria is outlined in evidence-based clinical guidelines from medical professional associations such as the Endocrine Society and the World Professional Association for Transgender Health.[4]

Not having access to gender affirming care can lead to physical and mental health conditions and should be considered medical conditions when a person's physical and mental health is negatively impacted. Trans and nonbinary (TNB) youths are disproportionately burdened by poor mental health outcomes owing to decreased social support and increased stigma and discrimination.[5]
Multiple studies have shown that providing gender-affirming care is life-saving by dramatically reducing depression and suicidal ideation.[6;7]

For our patients at Howard Brown, GAC is absolutely vital for all aspects of life. For example, one patient noted: "For trans people, access to gender-affirming medical care is not just about being medically healthy, it echoes into all aspects of our lives. For me, medical transition was important not only for my mental and physical health, but for my interpersonal relationships and even my employment. Without it, all aspects of my life suffered. Because of this, when I was in a state that restricted access to it and on an

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[3] See American Psychiatric Association's Diagnostic and Statistical Manual (DSM-5-TR); *Am. Psychiatric Ass'n, Diagnostic and Statistical Manual of Mental Disorders: DSM-5-TR* at 512–13 (2022); see also World Health Org., *International Classification of Diseases*, Eleventh Revision (ICD-11) (2019/2021).
[4] *Ibid.*
[5] Tordoff DM, Wanta JW, Collin A, Stepney C, Inwards-Breland DJ, Ahrens K. Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. JAMA Netw Open. 2022 Feb 1;5(2):e220978. doi: 10.1001/jamanetworkopen.2022.0978. Erratum in: JAMA Netw Open. 2022 Jul 1;5(7):e2229031. doi: 10.1001/jamanetworkopen.2022.29031. PMID: 35212746; PMCID: PMC8881768.
[6] Wernick, Jeremy A., et al. "A Systematic Review of the Psychological Benefits of Gender-Affirming Surgery." *Urologic Clinics of North America*, vol. 46, no. 4, Nov. 2019, pp. 475–486, www.urologic.theclinics.com/article/S0094-0143(19)30049-7/fulltext, https://doi.org/10.1016/j.ucl.2019.07.002.
[7] Turban, Jack L., et al. "Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation." *Pediatrics*, vol. 145, no. 2, 1 Feb. 2020, www.ncbi.nlm.nih.gov/pmc/articles/PMC7073269/, https://doi.org/10.1542/peds.2019-1725.

insurance plan that categorically excluded it, I was forced to seek out unlicensed, unregulated providers to get the care I needed to improve my quality of life. Our community will always seek this care, so facilitating proper access to it is vital for ensuring that the care we receive is high-quality, reliable, and evidence-based."

Discriminatory Plan Design, Coverage, and Utilization

HHS's proposal risks disrupting coverage and access to care for all consumers, regardless of their diagnosis. HHS seeks to discriminatorily exclude from EHB items and services when administered or prescribed for the medically necessary treatment of gender dysphoria. However, the medical services associated with this treatment are not unique to transgender people and are frequently needed by non-transgender people for treatment of other conditions. Services that may be needed for the treatment of gender dysphoria are found across almost every category of EHB and, as the proposed rule itself recognizes, are routinely covered for a variety of indications.

By targeting care for individuals with gender dysphoria—while expressly proposing to create exceptions to cover this care for other indications—this proposal exceeds HHS' authority to define EHBs. Issuing a blanket nationwide rule that would prevent insurers from covering treatment for people with gender dysphoria as EHB is contrary to the requirement that EHBs be defined in a way that protects individuals from discriminatory benefit designs. It is also inconsistent with existing laws and policies, including Section 1557 of the Affordable Care Act (ACA), the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act, that prohibit discrimination against people with gender dysphoria, as the courts have recognized.[8]

This proposal goes beyond the limit imposed by the ACA that ties EHBs to coverage in typical employer plans. HHS claims, without evidence, that treatment for gender dysphoria is not typically covered in employer plans. This is false. In the 2025 Corporate Equality Index, the Human Rights Campaign Foundation found that 72% of Fortune 500 businesses (and 91% of businesses listed on the Corporate Equality Index) offer coverage of treatment for gender dysphoria.[9] As a result, over 1,300 major employers nationwide cover this care, 28 times as many businesses as in 2009.[10] Similarly, coverage for gender dysphoria is widespread among state employee plans (24 states and DC), Medicaid (27 states, Puerto Rico, and DC), the Health Insurance Marketplaces (55% of plans across all 50 states covered this care in plan year 2025), and state-regulated coverage (24 states and DC prohibit exclusions of coverage for gender dysphoria).[11]

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

[9] See Human Rights Campaign, Corporate Equality Index 2025: Rating Workplaces on Lesbian, Gay, Bisexual, Transgender, and Queer Equality (Jan. 2025).

[10] *Ibid.*

[11] Out2Enroll, *Summary of Findings: 2025 Marketplace Plan Compliance with Section 1557 of the Affordable Care Act*, https://drive.google.com/file/d/1FpSNyaZVfC25o3zXnYBWUVaYRWokwbwg/view; Comm. Ricardo Lara et al., Letter to Sec. Xavier Becerra, U.S. Depart. of Health & Human Srvs., *Re: Proposed rule Section 1557 of the Affordable Care Act RIN 0945-AA17, Docket ID number HHS-OCR-2022-0012* (Sept. 30, 2022), https://www.insurance.ca.gov/0400-news/0100-press-releases/2022/upload/joint-Letter-Final_ACA_SECTION_1557_NPRM_sign-on_letter_2022-2.pdf.

This proposed rule argues that the low utilization of GAC among employer insurance means it shouldn't be covered under the EHB of the ACA. There are many medical interventions and procedures have low utilization among the population and are still covered by most employer (heart transplant, certain rare cancer treatments). Utilization of gender affirming care services is lower than in the population overall because only a small share of the population is trans and not all trans people seek GAC.[1213] Further, utilization of a service may be a poor proxy for how commonly it is covered. There are plenty of other cases where a small share of the population uses a service that is generally covered by insurance. For example, there were fewer than 5,000 heart transplants in the US in 2023 (equaling one ten thousandth of a percent of the population) but public and commercial insurance typically covers this service.[14;15]

This proposal would also disrupt the balance HHS has established between safeguarding access to a minimum level of services across the country and state flexibility to address the health care needs of their populations. Since HHS established the EHB benchmarking process, the agency has often used its authority to define EHBs to create national coverage standards as minimum requirements, but it has never utilized the EHB framework to force states to categorically exclude benefits that target populations with a particular condition. The existing approach, which this proposed rule would eviscerate, has been an essential tool that appropriately affords states the opportunity to use EHBs as a tool to ensure that coverage is nondiscriminatory and responsive to the needs of their populations.

HHS's proposed exclusion of "sex-trait modification" will inflict higher costs, limit access to care, and cause harm to transgender people, who already experience discrimination and coverage denials at an unprecedented level. This proposal should be withdrawn. This proposed rule could result in increases of state's funding gender-affirming care if they mandate protections for GAC insurance coverage. This might result in states altering their policies to remove GAC from being required, increasing the costs of GAC, or making GAC completely out of reach.

Deferred Action for Childhood Arrivals (§ 155.20)

We strongly oppose the proposed rule's intent to eliminate coverage for DACA recipients. This will unduly eliminate healthcare coverage to thousands of people and send the cost of accessing healthcare skyrocketing for an already vulnerable population. This exclusion could result in an estimated 100,000 DACA recipients losing insurance coverage.[16] Some DACA recipients may find it difficult to afford services without the subsidized EHB benefits and mandated coverage, contributing to delayed healthcare access, worse healthcare outcomes, increased health disparities, and increased healthcare costs for more serious conditions.

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[12] Flores, Andrew, et al. "How Many Adults and Youth Identify as Transgender in the United States?" *Williams Institute*, UCLA School of Law, June 2022, williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/.
[13] Montero, Alex, and 2023. "KFF/the Washington Post Trans Survey - Trans in America." *KFF*, 24 Mar. 2023, www.kff.org/report-section/kff-the-washington-post-trans-survey-trans-in-america/.
[14] "Detailed Description of Data | Organdonor.gov." *Www.organdonor.gov*, Mar. 2024, www.organdonor.gov/learn/organ-donation-statistics/detailed-description.
[15] *Ibid.*
[16] "HHS Final Rule Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Recipients and Certain Other Noncitizens | CMS." *Www.cms.gov*, 3 May 2024, www.cms.gov/newsroom/fact-sheets/hhs-final-rule-clarifying-eligibility-deferred-action-childhood-arrivals-daca-recipients-and-certain.

DACA recipients are critical members of families and communities across the U.S. A majority of DACA recipients are employed, and three quarters of DACA recipients in the workforce are essential workers, including 45,000 healthcare professionals and 20,000 educators. DACA recipients are disproportionately uninsured and continue to be excluded from programs like Medicaid.[17] This proposed action will hurt the health of individuals and the economies of communities and states.

Increasing Administrative Burdens

We strongly oppose additional barriers to enrollment, including shortened enrollment periods. Changing enrollment periods leads to confusion among enrollees, requires additional education in outreach, and heightens pressure for enrollers in a shorter window of time. We also oppose new barriers that would prevent state-based marketplaces (SBMs) from adopting longer enrollment windows for their residents. The extension from December 15 to January 15 is a window that helps people who qualify for premium tax credits and are auto enrolled to change their selections in January. We understand HHS would like to align open enrollment periods with states to reduce confusion, but changing this may cause further confusion. Further, limiting our state's ability to define the annual open enrollment period that works best for the people of Illinois infringes on our state's rights and our ability to flexibly manage our unique health insurance markets.

If this rule goes into effect, we recommend HHS invest in extensive outreach to ensure people affected know about this change. We also encourage HHS to invest in its navigator programs to conduct this outreach in the communities they serve and reverse recent cuts to funding for navigators across states.

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

We oppose any barriers to enrollment, including eliminating the special enrollment period (SEP) for households with projected incomes at or below 150% of the federal poverty level (FPL). The monthly low-income SEP is an effective tool for promoting access to health coverage, particularly for individuals who experience administrative challenges during other enrollment periods. Given the additional enrollment barriers proposed by CMS, eliminating this SEP would place even greater burdens on low-income individuals who may need additional time to meet new documentation requirements or access enrollment assistance. This would affect many potential enrollees. The most recent Census data shows that around 37.9 million people are living in poverty.[18] Around 22% of LGBTQ+ are experiencing poverty.[19] This greatly reduces their ability to have access to resources (computers, smart phones, etc.) to help them enroll in marketplace plans in a timely manner. Eliminating the special enrollment period will

[17] Published: Feb 11, 2025. (2025, March 12). *Key Facts on Deferred Action for Childhood Arrivals (DACA)*. KFF. https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-deferred-action-for-childhood-arrivals-daca/

[18] US Census Bureau. "Income, Poverty and Health Insurance Coverage in the United States: 2022." *Census.gov*, 12 Sept. 2023, www.census.gov/newsroom/press-releases/2023/income-poverty-health-insurance-coverage.html.

[19] Siers-Poisson, Judith. "The Complexity of LGBT Poverty in the United States – INSTITUTE for RESEARCH on POVERTY – UW–Madison." *Www.irp.wisc.edu*, June 2021, www.irp.wisc.edu/resource/the-complexity-of-lgbt-poverty-in-the-united-states/.

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exasperate LGBTQ+ people who are already more likely to face barriers when seeking health insurance. This concern is particularly urgent given recent federal funding cuts to Navigator programs in FFM states, which will likely result in reduced staff capacity and fewer hours for enrollment support. Without the low-income SEP, many eligible individuals could be left uninsured simply because they are unable to navigate these challenges.

This proposed rule has the potentially to increase the costs or eliminate insurance coverage for necessary and vital healthcare for millions of people. This rule will further exasperate barriers to healthcare for already vulnerable communities. In addition, state exchanges should be allowed to maintain flexibility, including notice and recheck requirements. Because State-based Marketplaces (SBM) are beholden to local policies in addition to the ACA, forced alignment with federal Marketplace notice requirements could open states to burdensome amendments and even litigation. State's operating SBMs assume additional risk and have been afforded flexibilities to determine their own requirements for attestation and data matching and therefore should maintain control over notice requirements to ensure alignment with their state specific policies. We greatly appreciate the opportunity to provide comments on this proposed rule. Should you have any questions about our comments, please feel free to contact Timothy Wang, Director of Policy and Advocacy at timothyw@howardbrown.org

Sincerely,

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