NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

December 22, 2014

The Honorable Sylvia Burwell
Secretary
U.S. Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

Attention: CMS-9944-P

RE: HHS Notice of Benefit and Payment Parameters for 2016

Dear Secretary Burwell,

The National Women's Law Center strongly supports the Department of Health and Human Services' (HHS) efforts to implement the Affordable Care Act (ACA) and make quality, affordable health insurance available to millions. We appreciate the opportunity to comment on the Notice of Benefit and Payment Parameters for 2016 which will have a significant impact on the health coverage available to women and their families.

Since 1972, the National Women's Law Center has worked to protect and advance the progress of women and their families in core aspects of their lives, with an emphasis on the needs of low-income women. With a staff of over sixty, supplemented by legal fellows, interns, and pro bono assistance throughout the year, the Center utilizes a wide range of tools—including public policy research, monitoring, and analysis; litigation, advocacy, and coalition-building; and public education—to achieve gains for women and their families in education, employment, family economic security, health, and other critical areas. The National Women's Law Center has long advocated for women's health care and reproductive rights. The Center's efforts reflect extensive research and expertise regarding women's specific health needs.

We are pleased to submit the following comments in response to the proposed rule issued on November 24, 2014 regarding the Notice of Benefit and Payment Parameters for 2016. We comment on the following previsions of the proposed rule:

- Annual eligibility redetermination
- Special enrollment periods
- Eligibility standards for exemptions
- Provision of EHB
- Collection of data to define essential health benefits
- Prescription drug benefits
- Prohibition on discrimination
- Cost-sharing requirements
- Determination of minimum value
- Network adequacy standards

- Essential community providers
- Meaningful access to qualified health plan information
- Segregation of funds for abortion services

§155.335 – Annual eligibility redetermination

In the preamble to the proposed rule, HHS requests comments on its exploratory idea of offering Federally-Facilitated Marketplace (FFM) enrollees a choice of re-enrollment hierarchies at the time of initial enrollment. One option would be to be automatically re-enrolled into the lowest-premium plan (or plans) within the enrollee's chosen metal level – whether or not this plan is their current plan, or offered by their current issuer. Enrollees could also choose the current re-enrollment hierarchy, which gives preference to their current plan and issuer.

We have several concerns with this proposal. First, the re-enrollment hierarchy emphasizes premium costs, rather than premiums and cost-sharing. As we see from plan offerings in 2014, cost-sharing designs vary considerably, with lower-premium plans carrying a higher risk of significant out-of-pocket cost-sharing, even within metal levels. Individuals who do not qualify for cost-sharing reductions could end up paying more for health care once deductibles, copayments and/or coinsurance, and out-of-pocket limits are taken into account.

Second, re-enrollment into the lowest-premium plan may result in the individual changing issuers and therefore provider networks, or moving from a broader network to a narrower network even within the same issuer's plan offerings. In either case, the enrollee would be in danger of losing access to health care professionals with whom they have established relationships and interrupting their continuity of care.

Third, we are concerned that enrollees would need to understand the potential risks and benefits of this approach to re-enrollment before they have even begun to use their Marketplace coverage, and cannot determine how well their initial plan will ultimately work for them. HHS does not address how it would seek to educate consumers at the time of enrollment about this choice and what it may mean for their future health coverage and costs.

We appreciate HHS's interest in ensuring that FFM enrollees enjoy continuous coverage across plan years. However, we believe that consumers would be better served by efforts to ensure that the FFM has updated income and other eligibility information so that enrollees have accurate estimates of their advance premium tax credit amount and other information they need to make appropriate enrollment choices for the next plan year, including choosing to passively renew into their current plan if the issuer continues to offer it in the Marketplace.

§155.420 Special enrollment periods

§155.420(b)(2)(i)
We are concerned about the proposed changes which would align the coverage effective date for birth, adoption, or placement for adoption with the standard coverage effective dates at §155.420(b)(1). We are concerned this could result in a gap in coverage for newborns. Currently,

enrollees can choose the effective date of coverage as the date of birth, adoption, or placement for adoption or, if the Marketplace allows, choose the first day of the following month for the coverage effective date. We urge the Department to maintain this standard. The proposed change could result in a gap in coverage of over a month. For example, based on the effective coverage dates in §155.420(b)(1), if a woman gives birth after the 15th of the month, she would have to wait for up to a month and a half for coverage to be effective if she chooses this option. This is an important period of time to monitor the newborn's health and a gap in coverage could result in newborns missing important preventive screenings or medical attention for an illness that occurs after leaving the hospital.[1]

§155.420(c)(2)
We also support the proposal to allow for advance availability of a 60-day special enrollment period for people experiencing certain triggering events, including the loss of other minimum essential coverage, loss of Medicaid pregnancy-related coverage, or a permanent move. People experiencing certain life events can avoid gaps in coverage if they can make changes to their health insurance ahead of time..

§155.420(d)
We urge the Department to add an additional special enrollment period for enrollees who become pregnant. Pregnancy should trigger a special enrollment period, enabling women to choose an appropriate coverage option. For example, if a woman holds coverage through a catastrophic plan with a high deductible that applies to maternity services, she should have the option to change her coverage tier.

§155.420(d)(2)(i)-(ii)
We are pleased that enrollees who experience a loss of a dependent or lose dependent status through legal separation, divorce, or death would qualify for a special enrollment period. However, we are concerned that this does not go far enough; some women who are not enrollees in Marketplace coverage also need access to a special enrollment period due to loss of dependent status after a legal separation, divorce, or death.

For example, a woman whose spouse's offer of employer-sponsored coverage is considered affordable based on worker-only coverage may remain uninsured if a family policy is too expensive for her family. If she becomes divorced or legally separated, she will no longer be eligible for minimum essential coverage (MEC) through her former spouse's employer, but will not qualify for a special enrollment period because she has only lost eligibility for MEC, not the coverage itself. Given her change in circumstances, she should qualify for a special enrollment period even though she was not previously enrolled in Marketplace coverage. We urge the Department to expand these qualifying events to individuals who are not currently enrolled in Marketplace coverage.

§155.420 (d)(6)(iv)
We commend the Department for the addition of a special enrollment period for individuals whose income changes to allow them to qualify for Marketplace coverage in states that have not expanded Medicaid coverage. We strongly support the Department's effort to make coverage more available to individuals in states without the Medicaid expansion. At this point, three million women remain uninsured because their state has not expanded Medicaid. This new special enrollment period will allow them to gain coverage if their income rises enough that they

become eligible for the APTC and could purchase Marketplace coverage.[2] We read the language of the regulation, which refers specifically to "changes in household income" to also include changes in household composition or size because these would also affect a household's income-eligibility level. HHS should clarify that this is the case. This proposed SEP will help ensure more low-income people are able to receive the subsidies they are entitled to under the Affordable Care Act without having to wait for the next open enrollment period.

§155.605 Eligibility standards for exemptions

The proposed rule would allow individuals with incomes below the income tax filing threshold to claim a hardship exemption from the individual responsibility penalty without needing to obtain an exemption certificate number from the Marketplace, and notes that the Internal Revenue Service and Treasury Department will finalize policies that will enable these individuals to claim the exemption without filing a tax return. We commend the Department for its attention to this issue.

§156.115 Provision of EHB

We are pleased that the Department has begun to provide further definition of the EHB categories and proposes a definition for the coverage of habilitative services. However, we remain concerned about the lack of definitions or standards for maternity care. We urge HHS to go further and define the scope of coverage for maternity and newborn care.
Benchmark plans may include "coverage of maternity services," but plan documents do not specify which services constitute maternity coverage or provide details on the scope of coverage including duration and frequency of services that are covered as part of maternity care.

We recommend a comprehensive set of benefits, based on the American College of Obstetrician and Gynecologists' Guidelines for Perinatal Care, which includes preconception, prenatal, labor and delivery, and post-partum care. In addition, a federal definition, or baseline level of maternity coverage, should include coverage for services that are provided by professionals licensed by the laws of the state in which the care is provided or practicing in conjunction with a facility licensed by the laws of the state in which it is located.

§156.120 Collection of data to define essential health benefits

The preamble of the proposed rule indicates that HHS envisions allowing states to choose new base-benchmark plans from the three largest plans available by category through the state's small group market, the state employee benefit plans, and Federal Employee Health Benefit Program (FEHBP) plans, and the largest commercial health maintenance organization benefit plan in the state in 2014. Issuers would then design EHB-compliant plans off of this new benchmark for the 2017 plan year.

We acknowledge the need to update states' EHB benchmark plans. However, we are concerned that many 2014 plans may not be fully compliant with EHB requirements and therefore will not be appropriate base-benchmarks. In our review of qualified health plans (QHPs) offered on 13

state Marketplaces in 2014, we found plans in every state that failed to meet federal standards for preventive services and other elements of EHB. Some plans also included exclusions or other plan designs that violated the prohibition on discriminatory plan design in §156.110(d). State regulators certified these plans, and in some cases the Office of Personnel Management also reviewed the plans prior to their availability on the Marketplace. We do not believe that small group plans, state employee plans, FEHBP plans or the largest commercial HMO in the state are likely to have received greater scrutiny from regulators than plans offered in the 2014 Marketplaces, and may have many of the same limitations.

We note that the preamble envisions that states will supplement benefit categories, if necessary, should they select a base-benchmark plan that does not meet the requirements of §156.110 across all EHB categories. HHS should also require states to examine and remediate plan exclusions and other benefit policies that violate other requirements of §156.110 as they define their new EHB benchmark.

We are also concerned that by encouraging states to update their EHB benchmarks, HHS appears to be committed to the current benchmark approach to defining EHB. We urge HHS to undertake the full review of EHB that it promised in the preamble to the EHB Final Rule.

§156.122 Prescription drug benefits

Interdependence of Preventive Services and EHB Prescription Drug Benefits
The Department has previously recognized that to provide the EHB, a plan must provide the preventive health services described in 45 CFR §147.130.[3] However, we remind the Department that while the women's preventive health services are part of the EHB, this requirement is in addition to (not in lieu of) the legal requirements obligating plans providing the EHB to include complete and non-discriminatory pharmaceutical coverage. Additionally, while the preventive health services are part of the EHB, this does not change the legal requirements for plans to provide the §2713 preventive health services without cost-sharing. The EHB and the §2713 preventive health services have separate legal requirements, and plans must meet all of these requirements to fulfill all of their obligations under the ACA. These requirements are particularly important for women's reproductive health, as the requirements include the obligation of plans to cover all FDA-approved methods of contraception.

§156.122(a)(2)
We oppose the proposal to replace the drug count standard with pharmacy and therapeutics (P&T) committees. P&T committees, which are a common insurance industry practice, review prescription medications and shape plans' drug formularies and utilization management practices. There is no guarantee that all P&T committees will ensure that formularies provide the breadth of coverage required under the EHB. The proposed standards are not sufficient to ensure that formularies would be comprehensive and meet the needs of the population covered by EHB. We recommend a number of improvements to the P&T standards based on existing standards for the Medicare Part D program, requirements in §1302 of the ACA that the EHB "take into account the health care needs of diverse segments of the population, including women" and the statutory obligation for nondiscriminatory plan design and the nondiscrimination requirements of §1557. We could support a requirement for plans to use a P&T committee in developing their

EHB formularies if the Department maintains a strong drug count standard and adopts our recommendations to improve the proposed P&T standards.

The improvements we recommend for P&T committees include:

- The P&T committee must ensure that formularies meet the health care needs of women. We recommend that an additional membership standard be added to the proposed §156.122(a)(2)(i), that at least one P&T committee member be a practicing physician with expertise in women's health and the care of women, and another member be another practicing health care professional with similiar expertise. These members will help ensure that the committee takes into account the health care needs of women.
- At least one member of the P&T committee should represent plan enrollees or health care consumers.
- The P&T committee must consult with appropriate experts, including health care providers and individuals representing health care consumers and patients, with expertise related to the health care conditions and health care needs being addressed by a specific drug under consideration.
- The P&T committee should ensure that plans do not use formulary management techniques in order to undermine access to covered prescription medications. The Department should replicate the Medicare Part D P&T committee requirements for plans providing EHB, specifically that the P&T committee "[r]eviews and approves all clinical prior authorization criteria, step therapy protocols, and quantity limit restrictions applied to each covered drug", with the additional requirement that "[f]ormulary management decisions must be based on scientific evidence" and clinical care standards of practice. [4,5] In particular, we remind the Department that P&T committees, and issuers in general, cannot use utilization management to circumvent the EHB requirements, including coverage of §2713 preventive health services.
- The P&T committee should be required to review a new drug product within 90 days of Food and Drug Administration approval and make a decision on each new drug product within 180 days.
- The P&T committee must consider clinical care standards of practice and the strength of scientific evidence—including the representation of women in studies or trials—in all decisions. Medical research and clinical trials have historically failed to include appropriate numbers of women subjects.[6] P&T committees cannot rely on the National Guideline Clearinghouse and other scientific evidence without analyzing the strength of the scientific evidence and the inclusion of women in the underlying research and still make coverage decisions that meet the health care needs of women.
- In addition to deciding which drugs the plan should include in the formulary to comply with the drug count standard, the P&T committee may decide which drugs to include in the formulary beyond the drug count standard.

Drug Count Standard

We recommend that the Department increase the drug count standard beyond one drug per category and class. Regardless of the categorization used for the drug count, there will be categories and classes with a large number of individual drugs. Requiring plans to cover only one drug in any category or class not included in the benchmark plan is a minimal requirement that does not meet the health needs of the EHB population. We have previously recommended that

the prescription drug benefit for categories and classes not covered by the EHB benchmark be tied to the median percentage of drugs covered by category and class by the EHB benchmark in that state. Adopting this standard would significantly improve the minimum threshold of drug coverage. If states can choose new benchmarks, then it becomes particularly important that this median-driven approach be applied to any categories or classes where the prior benchmark did not cover drugs in that category or class.

We recommend that the regulations require plan formularies to include multiple strengths and dosage forms, when available, for each covered drug. This recommendation is similar to expectations detailed in the Medicare Part D Manual and will ensure that the formularies do not limit access to drugs beyond the intent of the EHB. Drugs can be used to treat different conditions when prescribed at different dosages. For example, Lyrica has been approved for use for fibromyalgia, some forms of neuropathic pain, and partial onset seizures. There are relatively large dosage ranges that vary for each use, with the recommend range for fibromyalgia at 300 to 450 mg/day taken two times a day, whereas the recommended range for neuropathic pain associated with spinal cord injury and the recommend range for partial onset seizures is larger at 150 to 600 mg a day. We are concerned that a plan complying with the EHB formulary could provide access only to Lyrica for spinal cord injury and not fibromyalgia. To avoid this type of adverse effect, in the final rule, the Department must clarify that multiple strengths and dosage forms, when available, must be included.

American Hospital Formulary System Proposal

We share many of the Department's concerns related to the inadequacies of the United States Pharmacopeia (USP) classification system. As we noted in previous comments submitted in January of 2012, the USP 5.0 has inadequacies when it comes to meeting women's health care needs, particularly for women of reproductive age. The USP 5.0 category and class system was developed for the Medicare population, classifies drugs with different clinical purposes together, does not classify some drugs women regularly use, and adopts a definition of "chemically distinct" which could limit coverage of forms of drugs important to women. The USP, whether the 5.0 version used to establish the benchmarks for 2014 and 2015 plan years or any newer version, is not an appropriate standard to establish the benchmark. Over time, the Department should replace the USP.

The preamble's proposal to use the American Hospital Formulary System (AHFS) instead of USP 5.0 raises separate concerns. The AHFS drug information is a privately established guide created by health systems pharmacists. Similar to the USP 5.0, the AHFS drug information was not created to meet the requirements of § 1302 of the ACA, such as meeting the health needs of diverse populations including women. The AHFS drug information is updated regularly, but there is no guarantee that AHFS will change the frequency of their updates or methodology. Because the AHFS is a private organization, future changes could be made without any opportunity for input from consumers. Unlike the USP, the AHFS drug information is not available free of charge so individuals or organizations wishing to review the information must pay for access.

Technical differences between the categorization of drugs in the USP 5.0 and the AHFS drug information appear to be likely to improve coverage for some populations and potentially weaken coverage for others. For some types of drugs, the AHFS has more granular

categorizations so that a quantitative standard could provide for better coverage in certain instances. However, other drugs have less granular categorization that could weaken coverage. For example, contraceptives and antineoplastics are a subclass and major class, respectively, without any granularity, which would give plans more leeway to exclude coverage of some medications for birth control and cancer treatment than for other conditions. Many combination drugs that were not categorized within a category or class on USP 5.0 are included in the AHFS drug information. However, many combination drugs, including those treating HIV/AIDS and pain, are classified according to each component. These drugs are therefore not listed separately as the combination which could allow for plans to meet the drug count minimum without including important combination drugs. Because the drugs are listed in multiple classifications, there may also be potential for plans to count one drug towards multiple classifications.

We are concerned that plans could misinterpret the requirements of EHB and the AHFS categorization system, and as a result fail to cover all FDA-approved contraceptive methods. The AHFS categorizes all hormonal contraceptives into one class of drugs. Unlike most classes of drugs in the AHFS, the class "Contraceptives" has no subclasses. As a result, oral contraceptives, vaginal contraceptive rings, contraceptive patches, contraceptive shots, subdermal implants, hormonal intrauterine devices, and two emergency contraceptive methods are categorized together. In contrast, there are currently 20 unique FDA-approve contraceptive methods that plans are required to cover without cost-sharing under the ACA's preventive service requirement.[7] Furthermore, the AHFS has one class of contraceptives currently in use ("Contraceptives") and one class of contraceptives that is currently not in use ("Contraceptives (foams, devices)").[8] We are concerned that plans could assume that because the "Contraceptives (foams, devices)" category is not currently in use, that the plans do not have to cover certain prescription contraceptives that are devices, such as diaphragms and cervical caps. EHB and the § 2713 preventive health services have separate legal requirements which must be met by all plans to which they apply.

If HHS does rely on the AHFS drug information as a baseline for drug counts, we make the following recommendations:

- The Department should work with AHFS to find a way to make information publicly available so that there is a continued opportunity for consumer and patient advocates to review the adequacy of the drug information.
- The Department should identify areas of weakness of the AHFS drug information that need to be supplemented by insurance plans as part of the EHB.
- The regulations should include clear procedures for including and counting combination drugs.
- A standard based on the AHFS drug information should be based on the most granular tier of data for each classification.
- The final regulation should be clear that plans must also comply with the § 2713 preventive health services requirement to cover all FDA-approved birth control methods.

Most importantly, we urge HHS to work towards a categorization system designed under the direction of CMS, based on the needs of the EHB population—including the needs of women—and specifically designed for use as a standard for drug counts that enforce EHB.

§156.122(c)
We support the inclusion of a more detailed exceptions process for an enrollee to request and gain access to clinically appropriate drugs not otherwise covered by the health plan. It is very important that the Department retain the timelines of 72 hours from receipt of the request for a standard exception request and 24 hours from receipt of the request for an expedited exception request for notifying enrollees of coverage determinations, as stated in the proposed rule. These timelines will prevent delays or gaps in coverage.

We are concerned that some individuals may be required to repeat the exception process multiple times to maintain continued approval of maintenance drugs. The proposed rule requires that a health plan that grants a standard request to provide coverage for the non-formulary drug for the duration of the prescription, including refills. Individuals who are prescribed maintenance drugs could be required, under this proposal, to request a new exception when the prescription is renewed. Allowing plans to require an individual to request an exception for continued use of a medication is an unnecessary burden on the enrollee and the prescribing health care provider. In addition, enrollees may not be aware of this requirement and believe that the exception covers the duration of their treatment, but then discover at the pharmacy that the prescription is not covered. We recommend that the duration of the coverage for the standard exception request be changed to read that the plan must provide coverage of the non-formulary drug for the duration of treatment.

We support the inclusion of an external exception request review. An external exception request review provides similarity between the exception process and the general appeals process which requires an external review. The external review will ensure additional protections for enrollees so that the decision is based on medical need.

§156.122(d)
We strongly support the proposed requirements for publication by health plans of the formulary drug list. This will help consumers find the formulary that corresponds with their health plan and could prevent consumers from making decisions based on an incorrect drug list.

We support the proposal in the preamble that formulary tiering information include cost-sharing information. The current industry practice of having a formulary list that includes tiers without the information on cost-sharing requires consumers to compare the formulary back to the SBC or a plan summary. If plans must include cost-sharing on up-to-date formularies, consumers would know their out-of-pocket responsibility when they look up a prescription drug. There will still be complexities when the plan uses coinsurance rather than copayments for one or more prescription drug tiers. We urge the Department to consider ways plans can provide accurate cost information on the formulary for drugs covered with coinsurance amount.

We support additional changes discussed in the preamble related to the formulary including:

- The formulary drug list must be easily accessible by the general public so that consumers can access and compare formularies prior to enrolling in coverage.
- The plan associated with each formulary must be clearly identified on the plan's web site.

- The information be up-to-date, including the interpretation that up to date means the "URL must accurately list all of the health plan's covered drugs at that time" rather than allowing for a grace period that could result in a consumer receiving misinformation.
- The formulary information should be provided in a machine-readable file and format, as this would allow for the exchanges or other entities to create tools to help consumers compare health plans and understand their drug coverage.
- Consumers who cannot access plan information through an issuer's website will also be guaranteed access to the same information.

The Department requests comment on what other information should be required on the formulary drug lists. Our recommendations include:

- Formularies should include information on the contraceptive waiver process;
- Formularies should include notations when utilization management applies to a particular drug with information on what type of utilization management, such as prior authorization or step therapy, applies; and
- Formularies should provide clear information when a particular drug may be available without cost-sharing as a preventive service in accordance with § 2713.

In guidance released in February 2013, the Department, along with the Department of Labor and the Treasury Department, made clear that a plan must have a waiver process in place to enable the woman to access coverage without cost-sharing of the specific contraceptive determined medically appropriate by her health care provider.[9] Despite the requirement that this process exist, the Law Center's *CoverHer Hotline* regularly hears from women who have difficulty finding accurate information about their plan's waiver process. Including information about the waiver process on the formulary drug list will enable women to access the contraceptives deemed medically appropriate by their health care providers without facing cost-sharing that is not allowed under the law.

In addition, if the Department does not require the formulary tiering information to include cost-sharing information, the lists should indicate which drugs could be covered as a preventive service without cost-sharing. This could be done with a symbol such as an asterisk. Unfortunately, many enrollees do not yet know that preventive services are covered without cost-sharing. Indicating this coverage to them could increase the likelihood that they would use a preventive service, the intent behind this section of the ACA.

§156.122(e)

We applaud the Department's recognition that often individuals need confidential access to prescription drugs and/or need access to prescription drugs immediately. This is particularly the case for women. The preferred method of access varies for different women based on their individual circumstances, including whether they have access to transportation or whether receiving contraceptives, and other prescriptions, in the mail might place them in danger from a partner. We support the Department's proposal to require plans to allow enrollees to access prescription drug benefits at retail pharmacies in addition to mail-order pharmacies.

However, the preamble to the proposed rule indicates that plans would be allowed to charge higher cost-sharing when an enrollee accesses drugs at an in-network retail pharmacy instead of through mail-order. The Department should clarify that plans may not charge higher cost-sharing for drugs that are covered as preventive services.

§156.125 Prohibition on discrimination

We are pleased that the Department included the need for non-discriminatory plan design in the preamble. However, the final rule itself must explicitly state that plans offering the EHB must comply with all of the ACA's nondiscrimination requirements, including §1557 and should provide clear guidance to states and issuers. The Department must not only publish a final rule that clarifies the full extent of plans' obligation to non-discriminatory coverage but also fully enforce the law itself and to work with the states so that they do as well.

There are four provisions of the ACA that the Secretary must consider as she uses her authority to ensure that plans offering the EHB do not discriminate:

- §1557 prohibits discrimination on the basis of race, color, national origin, sex, age, sex stereotyping and gender identity and disability in health programs or activities that receive federal financial assistance, are administered by an Executive agency, or were established by Title I of the ACA.[10]
- §1302(b)(4)(B) requires that the Secretary "not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life."[11]
- §1302(b)(4)(C) requires the Secretary to "take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups."[12]
- §1302(b)(4)(D) requires the Secretary to ensure "that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or the individuals' present or predicted disability, degree of medical dependency, or quality of life."[13]

Reading the requirements of §1302(b) in concert with §1557's prohibition on discrimination based on sex (among other characteristics) reinforces the Secretary's obligation to address the needs of women and other groups against whom the insurance market has historically discriminated. The Department must make certain issuers no longer engage in these or similar discriminatory practices.

A nondiscriminatory plan must provide comprehensive coverage for women
Existing civil rights laws provide guidance as to whether a plan's benefit design is discriminatory. For example, interpreting Title VII, the Equal Employment Opportunity Commission (EEOC) has stated that an employer may not discriminate based on a person's sex (including pregnancy) in determining eligibility for, amount of, or charge for employee benefits.[14] Moreover, "the cost of benefits is not a defense."[15] Therefore, as a general matter, women can be neither charged more, nor be provided lesser benefits, than men.[16]

Moreover, in the specific context of maternity care, Title IX and Title VII, offer further specific guidance on how the Secretary should determine whether plans engage in prohibited sex discrimination with respect to pregnancy. As these laws make clear, pregnancy must be treated like temporary disabilities; services under maternity care in the EHB must therefore be as comprehensive as coverage provided for comparable conditions. For example, the EEOC has interpreted Title VII to require routine sonograms during the course of a pregnancy to be covered if the costs of other routine diagnostic tests, such as dental X-rays and Pap smears, are covered, and to a comparable extent.[17] Likewise, a woman's hospital charges for early delivery while out-of-state must be covered if the costs for emergencies incurred at non-local hospitals are typically covered.[18] To summarize, the EEOC states, "to offer coverage for pregnancy, childbirth, and related medical conditions on the same terms as for other medical conditions, an employer's health plan must provide for, among other things: the same deductibles; the same level of coinsurance payments; the same choices of physicians and hospitals; the same basis for reimbursement (e.g., by flat dollar amount or by a percentage of actual charges); and the same apportionment of charges for premiums."[19]

Similarly, the Department of Justice makes clear that Title IX's provisions requiring nondiscrimination in health services or insurance benefits require that "any recipient that provides full coverage health service must provide gynecological care."[20] As plans providing the EHB intend to provide full coverage, they must comply with these rules and not incorporate limits and exclusions that discriminate based on sex.

A nondiscriminatory plan cannot deny medically necessary services based on sex or gender identity

Title VII provides that men and women cannot be offered different coverage "where the underlying condition affects, or where the treatment/test is available to, both men and women."[21] Put another way, "[w]here both men and women are, or could be, affected by the same condition or helped by the same treatment, the employer will be liable for sex discrimination if it provides different coverage to employees of each gender on the basis of gender."[22] Likewise, exclusions that deny critical services to transgender or gender nonconforming individuals solely because they are enrolled as a gender different from that typically associated with needing a particular service would be discriminatory.[23] In addition, the Administration has explicitly stated that sex discrimination includes discrimination based on gender identity.[24]

Examples of discriminatory plan design in 2014 plans

When considering whether a plan design is discriminatory, the Secretary must take into account whether the plan meets the heath care needs of diverse segments of the population, including women, as well as whether specific denials or exclusions violate the requirements of §1557 and/or §1302(b)(4)(B). The preamble currently notes that, "Since [the Department] finalized §156.125, we have become aware of benefit designs that we believe would discourage enrollment by individuals based on age or based on health conditions, in effect making those plan designs discriminatory, thus violating this prohibition." In the Center's review of publically available plan documents from QHPs in 13 states and information obtained from consumers through our *CoverHer* hotline, we have found a variety of discriminatory benefit designs, including:

- **Exclusions of maternity care outside of the service area.** Several issuers exclude coverage of maternity care or services related to labor and delivery outside the service area. Not only do these plans fail to meet women's health care needs, as required by §1302(b)(4)(C), but they also discriminate on the basis of sex, in violation of §1557. The exclusions cover the duration of pregnancy, the final trimester of pregnancy, or the final thirty days of pregnancy. These unallowable coverage exclusions limit pregnant women's ability to travel outside of their service area by placing them at financial risk for the full cost of any maternity care if an emergency situation occurs outside of the service area. This restriction erodes the requirement that all plans must cover maternity care by creating unreasonable conditions whereby the issuer would not provide coverage. Under the ACA, health plans must cover emergency services whether or not the provider is part of the plan network and without imposing coverage limits or other requirements that are "more restrictive" than the plan's coverage of emergency services delivered by in-network providers.[25] Emergency services received outside of the service area may be out-of-network, but plans must cover these services for all enrollees, including pregnant women.[26]

- **Age restrictions on coverage of contraception.** Denials of coverage based on age rather than medical necessity violate § 1302(b)(4)(B)'s prohibition against plan designs that discriminate based on age. In addition, plan designs that include these provisions do not meet women's health care needs, as required by § 1302(b)(4)(C).
    - *Denials of coverage for contraception for women over 50.* According to the National Institutes of Health, Institute on Aging, the average onset for menopause is 51 years old, meaning that many women continue to menstruate and have the possibility of becoming pregnant at age 51 or older.[27] The Center's *CoverHer* Hotline has heard from several women who are over 50 years old, prescribed birth control for contraception, and have been denied coverage of birth control by their health plan based on their age.[28] These health plans impermissibly place an upper age limit on contraceptive coverage. As detailed above, the ACA requires coverage of contraceptives and sterilization for *all* women with reproductive capacity. Categorical denials of coverage based on age rather than medical necessity violate not only the ACA's preventive service requirements, but also violate §1302(b)(4)(B)'s prohibition against plan designs that discriminate based on age.
    - *Sterilization for dependents*. Female sterilization is one of the most commonly used contraceptive methods. More than a quarter of all contraceptive users rely on female sterilization, and 16.5 percent of all women of reproductive age have undergone a female sterilization procedure.[29] Sterilization is also more likely to be used by women of color, women living below 150 percent of the federal poverty level, and women living in rural areas.[30] The exclusion of coverage of sterilization for dependents violates the ACA's women's preventive services requirement, which requires plans to cover "all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for *all women with reproductive capacity* [emphasis added]."[31] The ACA requires plans to allow dependents to remain enrolled in a parent's

health plan until the age of 26 and as a result an additional 7.8 million young adults have health insurance coverage.[32] Plans must coverage sterilization for all women enrolled in the plan, regardless of their status as dependents and cannot use their status as dependents as a proxy to discriminate on the basis of sex and age.

- **Exclusions of transition related care.** Such exclusions discriminate on the basis of sex and gender identity in violation of §1557. Many medical interventions used to treat gender dysphoria are also part of the course of care for other medical conditions. For example, hormone therapies may be utilized for patients experiencing hypogonadism and other endocrine disorders as well as menopausal symptoms. Likewise, psychotherapy and speech therapy are recognized as medically necessary treatment for a wide variety of conditions and for holistic wellness and preventive care. The majority of transition-related services fall within the ACA's statutory categories of ambulatory care, mental health services, prescription drugs, and laboratory services. Most if not all treatments excluded for transgender insureds are routinely covered for non-transgender people to treat other medical conditions.[33] Transgender exclusions violate EHB by discriminating on the basis of sex, gender identity, and health condition.[34]

- **Exclusions of services for treatment of intractable and chronic pain, which constitutes discrimination based on health condition.** Plans with these exclusions discriminate against individuals with disabilities and reduced quality of life due to conditions with chronic pain in violation of §1302(b)(4)(B) of the ACA. Chronic pain conditions, such as arthritis or rheumatism, and back or spine problems are the two leading causes of disability, and untreated pain has a detrimental effect on quality of life.[35,36] Twenty nine percent of women report low back pain and ten percent of women report severe joint pain.[37] Individuals with these and other chronic pain conditions are discouraged from enrolling in plans with issuers that exclude services to treat their pain.

These limits and exclusions are but some examples of discriminatory plan design that particularly affect women. Given the Secretary's obligation to ensure that plans providing the EHB are nondiscriminatory, the Department should:

- Require states to evaluate and affirm that plans do not discriminate before allowing them to be sold as plans that offer the EHB. [38] In states where Center for Medicaid and Medicare Services (CMS) is enforcing the EHB, this requirement would apply to CMS as well.
- Specifically prohibit issuers from discriminating in marketing and benefit design based on sex as well as other protected characteristics in the final rule. Simply put, the full range of nondiscrimination protections available under §1557 and §156.200(e) must be expressly enumerated in §156.125.
- Make clear the federal enforcement role in ensuring that plans providing the EHB are nondiscriminatory through a direct reference to §1557.

Explicitly state the full range of nondiscrimination protections
Section 156.125 fails to state expressly the full range of nondiscrimination protections applicable to issuers of plans that offer the EHB. This section enumerates some of the bases on which the EHB cannot discriminate ("age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions").[39] This list does not make clear the full range of protections from §1557 or available under other ACA regulations. In fact, the only statement of the protections based on race, color, national origin, sex, gender identity, or sexual orientation is that a plan providing the EHB "must comply with the requirements of §156.200(e)"[40] which applies to QHPs.[41] The proposed rule, however, applies to *all plans* providing the EHB inside or outside of the exchanges—not solely to QHPs. So, not only does this section fail to enumerate clearly the nondiscrimination standard, it references a narrower rule and may misleadingly suggest that only QHPs offering the EHB are bound by these requirements. The final rule must specifically prohibit issuers from discriminating in marketing and benefit design based on sex as well as other protected characteristics. Simply put, the full range of nondiscrimination protections available under §1557 and §156.200(e) must be expressly enumerated in §156.125.

Federal enforcement role in nondiscrimination
The Department has the authority and obligation to administer and enforce §1557. Because the proposed rule does not include any direct reference to this section, it fails to address the federal government's role in enforcing the ACA's nondiscrimination provisions. The final rule must make clear the Secretary's obligation to ensure that plans providing the EHB are nondiscriminatory.

§156.130 Cost-sharing requirements

We strongly support the three proposed changes to the cost-sharing requirements in §156.130. The annual limitation on cost-sharing protects individuals and families from high health care costs and helps protect against medical bankruptcy. The limitation is an extremely important protection to ensure that health insurance provides protections against catastrophic costs. The changes proposed by the Department will ensure that the annual limits protection meets the intent of the law while allowing insurance plans flexibility to offer additional cost-sharing protections. The new §156.130(b), which ensures that the annual cost-sharing limit applies to the plan year will protect individuals who enroll in plans that do not have a calendar year plan year. Without this proposed change, women enrolling in health plans with a non-calendar plan year could face out of pocket charges up to twice the annual limit in one plan year. Similarly, the proposed clarification for application of annual limits for individuals enrolled in non-self only plans will help protect women from extremely high out of pocket charges. Without this change, when one member of a family has very high health spending, that individual could accrue out of pocket costs up to twice the individual limitation.

We also support the technical correction to the text of §156.130(c). While the ACA does not require plans to cover out-of-network cost-sharing towards the annual limitation on cost-sharing, there is nothing in the statute that prevents a plan from choosing to count such cost-sharing

towards the annual limit. Plans should continue to be given the opportunity to add additional consumer protections to their plan design.

§156.145 Determination of minimum value

We commend the Department for clarifying that minimum value for employer-sponsored health coverage must include substantial coverage of inpatient hospital services and physician services. This is an important addition to the section, which ensures that employees are protected from financial risk if they need inpatient services. For women, this clarification ensures that employer-sponsored plans must cover labor and delivery as part of inpatient hospital services, as required by the Pregnancy Discrimination Act.

Given the importance of minimum value coverage, however, for workers and their families, we recommend several improvements to the NPRM. First, we urge the Department to clarify that "inpatient" refers to "hospital services" only, and that employer-sponsored plans meet minimum value only if they cover inpatient hospital services as well as ambulatory services. In addition, given the critical role that prescription drugs play in medical treatment, we urge the Department to require employers to cover prescription drugs in order to meet minimum value. We are also concerned that "substantial coverage" is undefined in the text of regulation. We urge the Department to issue guidance on what will constitute "substantial coverage." Substantial coverage for inpatient hospital services, physician services and prescription drugs cannot include arbitrary limits which would undermine the scope of the coverage.

§156.230 Network adequacy standards

We support the establishment of stronger network adequacy standards. NWLC supports and participates in the National Association of Insurance Commissioners' (NAIC) work to establish a model act for network adequacy. However, we do not believe the NAIC's work can supplant the role of HHS in ensuring that QHPs meet network adequacy standards. Ultimately, adoption of the NAIC's updated model act will be voluntary for states, and will depend on that each state's priorities and politics. To ensure that all marketplace consumers nationwide are guaranteed access to appropriate, geographically accessible providers who can deliver medically necessary services in accordance with their insurance contracts, we believe that HHS should adopt specific network adequacy standards in regulation to uphold the statutory requirements for network adequacy under the Affordable Care Act.

To ensure an adequate network for women, the Department should issue network adequacy standards that ensure access to women's health providers and providers who specialize in obstetrics and/or gynecology. Women's health providers should include a range of providers that specialize in women's health needs ranging from, but not limited to, providers who offer primary care and sexual health services such as Title X clinics to settings such as breast care centers that offer specialty services. Women must have access to health professionals who provide the full range of reproductive health services and providers who are trained in other specialties such as reproductive endocrinology and infertility; gynecological oncology; female urology; and menopausal gynecology. Without this requirement, we are concerned that QHPs could contract

with too few women's health providers to serve one or all of its networks, and purport to satisfy a network adequacy standard.

Further, the Department should also require QHPs to establish a sufficient number of in-network medical providers so that women have access to the Women's Preventive Services Guidelines developed by the Institute of Medicine (IOM) and supported by the Health Resources and Services Administration (HRSA) without incurring cost-sharing responsibilities.[42] It is crucial that QHPs have a sufficient network to provide access to the full range of FDA-approved contraceptive drugs and devices, and the outpatient services associated with their use. In addition, QHPs must contract with lactation consultants, and be able to provide women with a list of in-network consultants, so that women can access breastfeeding support and supplies within their plan networks.[43]We also urge HHS to clarify that, for plans with tiered networks, only providers available through the plan's lowest tier of cost-sharing may be counted for purposes of network adequacy. In practice, providers in the higher cost-sharing tiers may be too expensive for women to access services.

We are concerned that the Department continues to rely on the reasonable access standard adopted in the 2015 Letter to Issuers. The current standards limit the focus to areas which have "historically raised network adequacy concerns." These include: hospital systems, mental health providers, oncology providers, and primary care providers. As stated above, we strongly support a greater focus on the adequacy of networks for women and urge the Department to include women's health care providers in this list.

We support the Department's efforts in the preamble to encourage continuity of care for new QHP enrollees by urging QHP issuers to allow new enrollees in the midst of an ongoing course of treatment to continue that treatment with their current providers, even if those providers are not in their new QHP's network. These protections would be more meaningful to all QHP enrollees if this was in the text of the regulation as a requirement for the QHP issuers. Further, we urge the Department to include pregnant women in their second or third trimester under this provision so they can maintain continuity of care throughout the duration of their pregnancy if they move to a new QHP.

§156.230 (b)

We support the new provider directory requirements of §156.230(b). Explicitly requiring QHP issuers' provider directories to be "up-to-date, accurate, and complete" is an important protection for consumers, and we support the rule's specification that information on all current providers is accessible to the general public. It is also important that the rule codifies protections requiring directories to be available without consumers having to create or access accounts on issuer websites or having to enter policy numbers, and that consumers can easily discern which directories correspond to which specific health plans from a given issuer. The Department should clarify that QHP issuers must meet the requirements in 156.230(b) year-round and not only during open enrollment season. This is important as enrollees need access to provider directories to find new providers at all times during the year, and new enrollees join plans mid-year due to special enrollment opportunities and therefore many need to compare different plans' directories at various times during the year.

We also support the information that must be included in the directories, including "information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations." In addition, we request that the Department require plans to include tiering information for each provider in their directory, so consumers can be informed about the cost associated with consulting specific providers.

§156.235 Essential community providers

§156.235(a)(2)
We commend the Department for proposing to incorporate standards from the annual Letter to Issuers into the ECP regulation. We urge HHS to apply these standards to all QHPs, not only QHPs in the FFM, and affirm that states can adopt greater state-specific ECP and network adequacy standards for QHPs in the state.

We strongly urge the Department to clarify that issuers must include in their QHP networks at least one ECP in each category in each county in the service area, rather than merely offering a contract to one ECP in each ECP category per county. Similar to above, we urge HHS to apply this to all QHPs, not just QHPs in the FFM, and affirm that states can adopt greater protections and standards to enhance access to ECPs.

We support requiring QHPs to include a specified percentage of available ECPs within their network, with the percentage established annually in guidance. It is important to establish a federal floor while also providing flexibility for an increased percentage threshold, especially as access concerns and challenges evolve over time. As such, we urge the Department to require QHPs to demonstrate that at least 30 percent of available ECPs within the service area are included in their plan networks, and specify that this percentage may increase in future guidance to issuers. Likewise, the Department should affirm that states may adopt standards that exceed the 30 percent threshold, to address access needs in the state. Additionally, in states where Medicaid expansion occurs by enrolling individuals with incomes below the federal poverty level in qualified health plans, regulators should pay special attention to the availability of ECPs within networks. When the Medicaid expansion population is enrolled in QHPs, ECPs, who have historically served low-income communities, will be an even more critical component of health plan networks. In such states, the federal standard may not be sufficient to meet the needs of enrollees.

We support the Department's clarification that to be considered a good faith offer, a contract must offer rates and contract provisions that a "willing, similarly situated non-ECP provider would accept or has accepted." The Department should clarify that good faith contract terms must include all of the services the plan covers and the ECP provides and include reimbursement at generally applicable payment rates. We urge the Department to apply this to all QHPs, not just QHPs in the FFM, and affirm that states can adopt greater protections and standards. Also, this clarification about "good faith" contract offers is only included in the preamble, and we strongly urge HHS to include this clarification in the regulatory text.

The Department should eliminate the option that permits issuers to forgo the ECP standard completely by submitting a narrative justification that describes why they could not meet the standard but still have a network that is sufficient to meet the needs of low-income and medically underserved enrollees. Allowing QHP issuers to submit a narrative justification attesting that its network provides an adequate level of service for the medically underserved does not sufficiently protect consumer access to health care. The Department should eliminate the "narrative justification" option and clarify that issuers will not be certified if they fail to meet the standard.

Robust monitoring and enforcement of the ECP standards is just as critical as initial Marketplace plan certification. We urge the Department to add monitoring policies so that there are procedures for monitoring QHP networks for compliance with ECP standards throughout the coverage year.

§156.235(c)

We are pleased that HHS clarified that the definition of an ECP includes state-owned, government, and not-for-profit providers, including family planning service sites, regardless of whether they receive federal funding under specific federal programs. This reinforces that family planning providers that do not participate in the 340B program or do not receive Title X program (e.g. Title X 'look alikes') are considered ECPs. However, this clarification is only in the rule's preamble, and we urge HHS to include this clarification about non-Title X family planning providers in the regulation text itself. Specifically, we recommend that §156.235(c) read:

> "An essential community provider is a provider that serves predominantly low-income medically underserved individuals, including a health care provider defined in section 340B(a)(4) of the PHS Act; or described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Public Law 111-8, *including state-owned, governmental, and not-for-profit family planning service sites that do not receive federal funding under special programs, including Title X of the PHS Act..."* [emphasis added].

Finally, Marketplace regulations include an important non-discrimination provision to prevent any attempts to unfairly exclude or restrict specific ECPs from the Marketplace. Under 45 CFR § 155.1050(c), a QHP "may not be prohibited from contracting with any essential community provider…" This protection was specifically designed to prevent attempts to unfairly exclude or restrict certain providers—including women's health and family planning providers—from plans offered in the Marketplace. In line with this nondiscrimination provision, we urge the Department to clarify that states may not narrow the definition of family planning ECPs as a way to restrict access to women's health care. Additionally, we urge the Department to reinforce that Marketplace issuers may not attempt to exclude or limit participation of women's health ECPs.

§156.250 Meaningful access to qualified health plan information

We urge the Department to also require meaningful access to QHP issuers' Certificates of the Coverage. These Certificates of Coverage should be available to enrollees, prospective enrollees, navigators, assisters and other interested parties during open enrollment and throughout the MSP option's coverage year. These documents include critical information on covered benefits,

excluded benefits, pre-authorization requirements and other aspects of coverage which, although not in plain language, provide potentially important detail to consumers as they make coverage choices. Certificates of Coverage should be publicly available through the same mechanisms as provider directories and other benefit plan materials.

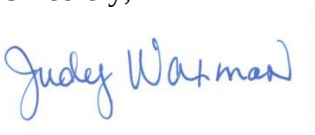
§156.280 Segregation of funds for abortion services

We continue to strongly oppose the provisions in the ACA that treat abortion differently from all other health care services. Nevertheless, the Department must ensure compliance with the law. To that end, we appreciate that the preamble clarifies that consumers may pay the premium for coverage of non-excepted abortion services in a single transaction. This is the most efficient, practical, and commonsense way to comply with § 1303 and should be included in the final rule, not just the preamble. It is also consistent with what states are currently doing. As the preamble recognizes, state insurance commissioners are primarily responsible for implementing and enforcing §1303. Every state that has issued guidance or regulations implementing §1303 permits QHPs to accept one premium payment for non-excepted abortion services alongside all other health services, allowing issuers to segregate the funds once they receive the payment. [44] This is, in fact, what § 1303 does: merely create an accounting mechanism with the QHP issuer handling the required segregation on the back end.

In addition, we appreciate that the preamble clarifies that issuers are not required to separately identify the premium for non-excepted abortion services on the monthly premium bill. No state that has issued guidance requires plans to separately identify the premium for non-excepted abortion services in an itemized bill. Section 1303(b)(3)(A) requires notice of coverage for non-excepted abortion services to be provided "only as part of the summary of benefits and coverage explanation." Further, §1303(b)(3)(B) states "any advertising used by the issuer with respect to the plan, any information provided by the exchange, and any other information specified by the Secretary" relating to payments for coverage for non- excepted abortion services can only include "the total amount of the combined payments." Thus, neither the Secretary nor an Exchange may require plans to provide notice that separately identifies the premium for coverage of non-excepted abortion services. However, the preamble strongly suggests that such notice is required. Although not stated directly, the examples in the preamble of how issuers can comply with §1303 all include some notice to consumers. These examples should not be included in the final rule. Instead, the final rule should make clear that QHP issuers can accept the premium payments for non-excepted abortion services and all other health services in a single transaction without providing an itemized bill or any other notice. Allowing a single transaction without notice to the consumer will meet the dual goals of minimizing administrative complexity for plan issuers and facilitating consumer enrollment.

We appreciate this opportunity to submit comments in response to the HHS Notice of Benefit and Payment Parameters for 2016.

Sincerely,



Judith Waxman
Vice President, Health and Reproductive Rights
National Women's Law Center

---

[1] The American Academy of Pediatrics recommends preventive visits at three to five days and one month. Recommendations for Preventive Pediatric Health Care from the American Academy of Pediatrics are available here: http://www.aap.org/en-us/professional-resources/practice-support/periodicity/periodicity%20schedule_FINAL.pdf.

[2] STEPHANIE GLOVER, NAT'L WOMEN'S LAW CTR. (NWLC), STATES MUST CLOSE THE GAP: LOW-INCOME WOMEN NEED HEALTH INSURANCE (Oct. 2014), *available at* http://www.nwlc.org/resource/states-must-close-gap-low-income-women-need-health-insurance.

[3] 45 C.F.R. § 156.115(a)(4) (2013).

[4] 42 C.F.R. § 423.120(b)(1)(ix) (2010).

[5] MEDICARE PRESCRIPTION DRUG MANUAL, Chapter 6, Section 30.1.5 (Ctrs. for Medicare and Medicaid Servs. 2014), *available at* http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartDManuals.html.

[6] PAULA A. JOHNSON ET AL., SEX-SPECIFIC MEDICAL RESEARCH: WHY WOMEN'S HEALTH CAN'T WAIT (2014), *available at* http://www.brighamandwomens.org/Departments_and_Services/womenshealth/ConnorsCenter/Policy/ConnorsReportFINAL.pdf.

[7] The list of methods is available on the FDA Birth Control Guide, *available at* http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM356451.pdf.

[8] AM. SOC'Y OF HEALTH-SYSTEM PHARMACISTS, AHFS DRUG INFORMATION 2015 ix-x (2014), *available at* http://www.ahfsdruginformation.com/product-ahfs-di.aspx.

[9] *FAQs about Affordable Care Act Implementation Part XII*, U.S. DEP'T OF LABOR, http://www.dol.gov/ebsa/faqs/faq-aca12.html.

[10] Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010), § 1557, *amended by* 42 U.S.C. § 18116.

[11] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), § 1302(b)(2)(B), *amended by* 42 U.S.C. § 18022.

[12] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), § 1302(b)(4)(C), *amended by* 42 U.S.C. § 18022.

[13] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), § 1302(b)(4)(D), *amended by* 42 U.S.C. § 18022.

[14] EEOC Compl. Man. (BNA), Section 3: Employee Benefits, Health Insurance Benefits (Title VII/EPA Issues), *available at* http://www.eeoc.gov/policy/docs/benefits.html#B.

[15] *Id.*

[16] *Id.* ("[E]ven if it costs an employer more to provide benefits to women as a class than to men, the employer may not either charge women more, or provide lesser benefits, to make up the difference.")

[17] *Id.*

[18] *Id.*

[19] *Id.*

[20] 34 C.F.R. § 106.39 (2012). *See also* TITLE IX LEGAL MANUAL (U.S. Dep't of Justice Civil Rights Division 2001), *available at* http://www.justice.gov/crt/cor/coord/ixlegal.php.

[21] EEOC Compl. Man. (BNA), *supra* note 14.

[22] *Id.*
[23] [23] Examples of these services include cervical or prostate exams, bone density scans, hysterectomies, or treatment for breast cancer and polycystic ovary syndrome. Excluding services because they are related to transition would also be discriminatory. *See, e.g.*, LAMBDA LEGAL, WHEN HEALTH CARE ISN'T CARING: LAMBDA LEGAL'S SURVEY OF DISCRIMINATION AGAINST LGBT PEOPLE AND PEOPLE WITH HIV (2010), *available at* http://www.lambdalegal.org/publications/when-health-care-isnt-caring.
[24] Letter from Director, Department of Health and Human Services Office of Civil Rights, to Maya Rupert, Federal Policy Director, National Center for Lesbian Rights (July 12, 2012), *available at* http://hrc-assets.s3-website-us-east-1.amazonaws.com//files/assets/resources/HHSResponse8612.pdf#__utma=149406063.660485367.1383069608.1413481670.1418845589.4&__utmb=149406063.1.10.1418845589&__utmc=149406063&__utmx=-&__utmz=149406063.1418845589.4.3.utmcsr=google|utmccn=(organic)|utmcmd=organic|utmctr=(not%20provided)&__utmv=-&__utmk=33348670.
[25] 45 C.F.R. § 147.138(b)(2)(ii)-(iii) (2010).
[26] Regulations define an emergency medical condition as a medical condition that a "prudent layperson" could reasonably expect to place the patient's health in serious jeopardy if they went without medical care. In the case of pregnant women, the criterion of serious jeopardy also applies to the health of the unborn child. 45 C.F.R. § 147.138 (b)(4)(i) (2010). If a pregnant woman goes into early labor, a prudent layperson—and the standard of medical care—would expect that she needs immediate medical attention. In fact, 98 percent of U.S. births occur in hospitals which indicate that an emergency room would be a prudent place for a pregnant woman to go if she was experiencing symptoms of labor outside of her service area. MARIAN F. MACDORMAN ET AL., CTRS. FOR DISEASE CONTROL AND PREVENTION, TRENDS IN OUT-OF-HOSPITAL BIRTHS IN THE UNITED STATES 1990 - 2012 (Mar. 2014), *available at* http://www.cdc.gov/nchs/data/databriefs/db144.htm. Plans must therefore cover unexpected labor, delivery, and urgent pregnancy-related complications as an emergency outside of the service area.
[27] NATIONAL INSTITUTE ON AGING, MENOPAUSE: TIME FOR A CHANGE (Jan. 2008, reprt. Aug. 2010), *available at* http://www.nia.nih.gov/health/publication/menopause-time-change/introduction-menopause?utm_source=ad_box&utm_medium=website&utm_content=pregnancy&utm_campaign=menopauseFAQ.
[28] The Law Center's CoverHer Hotline provides information and assistance to women who are still paying cost-sharing for preventive health services, particularly contraception.
[29] *Contraceptive Use in the United States*, GUTTMACHER (June 2014), http://www.guttmacher.org/pubs/fb_contr_use.html.
[30] *Id.*
[31] *Women's Preventative Services Guidelines*, HEALTH RES. AND SERVS. ADMIN., http://www.hrsa.gov/womensguidelines/.
[32] SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, COVERING YOUNG ADULTS UNDER THE AFFORDABLE CARE ACT: THE IMPORTANCE OF OUTREACH AND MEDICAID EXPANSION, *available at* http://www.commonwealthfund.org/publications/issue-briefs/2013/aug/covering-young-adults-under-the-affordable-care-act. *See also* Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010), § 2713, *amended by* 42 U.S.C. § 300gg-14.
[33] *See, e.g.*, CAL. CODE REGS. tit.10 § 2561.2(a)(4)(A) (listing hormone therapy, hysterectomy, mastectomy, and vocal training as illustrative examples of treatments commonly covered for other conditions which may not be excluded for gender dysphoria); OR. BULL. INS 2012-1, Application of Senate Bill 2 (2007 Legislative Session) to Gender Identity Issues in the Transaction & Regulation of Insurance in Oregon 3 (2012), *available at* http://www.oregon.gov/DCBS/insurance/legal/bulletins/Documents/bulletin2012-01.pdf.
[34] 45 C.F.R. § 156.125(a)-(b) (2013); 45 C.F.R. § 156.200(e) (2013).
[35] *Prevalence and Most Common Causes of Disability Among Adults*, CTRS. FOR DISEASE CONTROL AND PREVENTION (2005), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5816a2.htm.
[36] Nathaniel Katz, *The Impact of Pain Management on Quality of Life*, 24 J. PAIN SYMPTOM MGMT. S38 (2002).
[37] *AAPM Facts and Figures on Pain*, THE AM. ACAD. OF PAIN MED., http://www.painmed.org/patientcenter/facts_on_pain.aspx.
As the preamble to the rule states, "[A]n issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions." *See also* Patient Protection and

Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), §§ 1302(b)(4)(B), (b)(4)(C), and (b)(4)(D), *amended by* 42 U.S.C. § 18022. *See also* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), § 1557, *amended by* 42 U.S.C. § 18116.

[39] 45 C.F.R. § 156.125(a)) (2013).

[40] 45 C.F.R. § 156.125(b)) (2013).

[41] 45 C.F.R. § 156.200(e) (2012) ("A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.").

[42] HEALTH RES. AND SERVS. ADMIN, *supra* note 29.

[43] *Affordable Care Act Implementation FAQs - Set 12*, CTRS. FOR MEDICARE AND MEDICAID SERVS., THE CTR. FOR CONSUMER INFO. AND INS. OVERSIGHT, http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html.

[44] New York issued guidance stipulating that "QHP issuers will be in compliance with the ACA if they do not itemize non-excepted abortion services on the premium bill and collect both premiums through a single transfer of funds." N.Y. DEP'T OF FIN. SERVS., INS. CIRCULAR LETTER NO. 7 (Sept. 18, 2013), *available at* http://www.dfs.ny.gov/insurance/circltr/2013/cl2013_07.pdf. Washington State regulation explains "[t]his rule does not require an issuer to conduct two separate premium transactions with enrollees. For the purposes of approval by the commissioner, the segregation of premium may occur solely as an accounting transaction." WASH. ADMIN. CODE § 284-07-540(2)(c) (2013). Maryland guidance states that "issuers are not required to provide enrollees with separate invoices for non-excepted abortion services and all other services covered under a QHP, nor to provide enrollees with itemization on a single invoice for non-excepted abortion services, and all other services covered under a QHP." Connecticut guidance is silent with respect to itemized billing and the single transaction, indicating that QHP issuers have flexibility on how they bill and collect payment from consumers. CONN. INS. DEP'T, BULLETIN NO. FS-27 (Sept. 10, 2013), *available at* http://www.ct.gov/cid/lib/cid/FS_27_-_Abortion_Fund_Segregation.pdf. Minnesota issued an Administrative Bulletin, stating, "issuers are not required to provide enrollees with a separate invoice for services for which federal funding is prohibited nor a single invoice with itemization of these services." MINN. DEP'T OF COMMERCE, ADMIN. BULLETIN #2013-4 (Nov. 1, 2013).