

January 27, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9911-P, P.O. Box 8016
Baltimore, MD 21244-8016

Dr. Ellen Montz
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Department of Health and Human Services

**RE: RIN 0938-AU65; CMS-9911-P
Patient Protection and Affordable Care Act: Benefit and Payment Parameters for
2023**

Dear Administrator Brooks-LaSure and Director Montz:

The National Women’s Law Center (the Law Center) has fought for gender justice in the courts, in public policy, and in our society for almost fifty years. We protect women and families in core aspects of their lives, including employment, income security, education, and health and reproductive rights, with an emphasis on the needs of low-income women and those who face multiple and intersecting forms of discrimination.

The Law Center appreciates the opportunity to comment on the proposed rule “Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2023.” We support many of the proposals in the proposed rule, which will expand enrollment opportunities, reduce the number of people without health coverage, and restore important Affordable Care Act (ACA) protections. We also offer several suggestions to strengthen the rule. We strongly support the following recommendations, among others discussed in the comment:

- Restore the prohibition on discrimination based on sexual orientation and gender identity but clarify that sex discrimination also encompasses discrimination based on sex characteristics, including intersex traits
- Clarify that discriminatory benefit designs in EHB are prohibited
- Require issuers to enroll applicants regardless of whether they have paid past-due premiums
- Eliminate federal requirements for pre-enrollment verification, but prohibit states from imposing their own requirements
- Prohibit insurers from substituting benefits between EHB categories, but also prohibit substitution within EHB categories
- Reinstate requirements related to standardized options
- Increase essential community provider standards to 35%
- Expand data collection requirements in order to further health equity

I. Unlawful Discrimination Based on Sex (§§ 155.120, 155.206, 156.1230)

The Law Center strongly supports the proposal to restore protections against discrimination based on sexual orientation and gender identity. We also encourage the Department to expressly prohibit discrimination based on sex characteristics, including intersex traits. These protections are urgently needed to address the disparities and discrimination that LGBTQI people continue to face in insurance coverage.

a. *Discrimination Based on Gender Identity and Sexual Orientation*

LGBTQ people face a range of discriminatory practices in health insurance. Transgender people, for example, experience barriers to coverage for a range of services, with rates of coverage denials higher for transgender people of color. These barriers include denials of coverage for various types of gender-affirming care. Despite widespread recognition of the medical necessity of gender-affirming care, insurers persist in excluding many of these treatments from coverage. Nearly half (43%) of transgender people say their insurer refuses to cover gender-affirming surgery. An additional 38%—and 52% of transgender people of color—say that their insurer does not cover hormone therapy.¹

Even when insurers do not categorically exclude gender-affirming care from coverage, restrictions in benefit designs can still prevent transgender people from accessing the care they need. In 2020, nearly half (48%) of transgender people—and 54% of people of color—reported that, in the previous year, their insurer covered only some gender-affirming surgical care or covered gender-affirming care but had no surgery providers in network.²

Many transgender people are also denied coverage for services considered gender-specific, like mammograms or prostate exams, based on the sex they were assigned at birth or the sex in their insurance records. For example, in the 2020 survey, 22% of transgender respondents, including 31% of transgender people of color, reported that, in the year prior to the survey, a health insurance company denied them preventive care because of the gender associated with the service.³

Insurance discrimination based on sexual orientation also persists. For example, the Law Center recently sued Aetna on behalf of plaintiffs who were denied equal coverage for fertility treatments because of their sexual orientation. The named plaintiff had to pay out of pocket for 12 cycles of intrauterine insemination (IUI) treatment before Aetna would provide her and her same-sex partner with coverage. Meanwhile, Aetna provides immediate coverage, without any out-of-pocket cost, for couples who try to get pregnant through unprotected sex for 12 months. The costs of fertility services can be prohibitively high. A single IUI cycle, for example, can cost up to \$5,000, while a single IVF cycle can cost over \$30,000. Our plaintiff's total out-of-pocket costs reached nearly \$45,000 before she became pregnant.⁴

¹ Sharita Gruberg et al., *The State of the LGBTQ Community in 2020* (Oct. 6, 2020), <https://www.americanprogress.org/article/state-lgbtq-community-2020>.

² *Id.*

³ *Id.*

⁴ Complaint at *Goidel v. Aetna Inc.*, No. 21-cv-07619 (S.D.N.Y. 2021). The complaint is available at <https://nwlc.org/wp-content/uploads/2021/09/2021.09.13-Complaint.pdf>.

Insurance denials undermine trust in our health care systems, force many LGBTQ people to pay higher out-of-pocket costs, and may discourage them enrolling at all. High out-of-pocket costs or uninsurance may lead some LGBTQ people to avoid getting the care they need. In a 2020 survey of LGBTQ people, 29% reported that they delayed or avoided care because they could not afford it, and one quarter reported postponing preventive screenings due to costs.⁵ Cost was an especially significant barrier for transgender respondents: 51% postponed or avoided care and 40% postponed or avoided preventive screenings due to cost.⁶ Other studies have similarly found that transgender people are more likely than cisgender people to be uninsured and to report cost as a barrier to receiving care.⁷

The barriers resulting from anti-LGBTQ discrimination decrease access to care, which in turn exacerbates existing health disparities among LGBTQ people. LGBTQ people are more likely to report being in poor health than non-LGBTQ people, and they experience many conditions at higher rates, including substance use disorders, mental health conditions, HIV, cancer, and cardiovascular disease.⁸ Disparities are especially pronounced among Black, Latinx, and Native American LGBTQ people. For example, the CDC recently reported that nearly two-thirds of Native and Black transgender women have been diagnosed with HIV.⁹ These health disparities underscore the urgent need for protections against health care discrimination based on sexual orientation and gender identity.

b. Discrimination Based on Sex Characteristics

The Law Center further recommends that the Department clarify that sex discrimination includes discrimination based on sex characteristics, including intersex traits. Intersex people face significant disparities in health and health care, including barriers to nondiscriminatory insurance coverage.¹⁰ While there is a “significant gap” in data regarding intersex people and their health-related experiences,¹¹ we are aware of several insurance practices that discriminate against intersex people. For example, some insurers deny enrollees coverage for gender-affirming care on the basis of their intersex traits. And some insurers use gender coding to restrict coverage, leading some intersex people to be denied the care most appropriate for their medical needs. Like for LGBTQ

⁵ Gruberg et al., *supra* note 1.

⁶ *Id.*

⁷ E.g., Wyatt Koma et al., *Demographics, Insurance Coverage, and Access to Care Among Transgender Adults* (Oct. 21, 2020), <https://www.kff.org/health-reform/issue-brief/demographics-insurance-coverage-and-access-to-care-among-transgender-adults>.

⁸ See, e.g., Hilary Daniel et al, *Annals of Internal Medicine Position Papers, Lesbian, Gay, Bisexual, and Transgender Health Disparities: Executive Summary of a Policy Position Paper from the American College of Physicians* (July 21, 2015), <https://www.acpjournals.org/doi/full/10.7326/M14-2482?journalCode=aim>.

⁹ Centers for Disease Control and Prevention. *HIV Infection, Risk, Prevention, and Testing Behaviors Among Transgender Women—National HIV Behavioral Surveillance, 7 U.S. Cities 2019–2020* 5 (Apr. 2021), <https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-27.pdf>.

¹⁰ See, e.g., Amy Rosenwohl-Mack et al., *A National Study on the Physical and Mental Health of Intersex Adults in the U.S.*, 15 PLOS ONE e0240088, <https://doi.org/10.1371/journal.pone.0240088>; Laetitia Zeeman & Kay Aranda, *A Systematic Review of the Health and Healthcare Inequalities for People with Intersex Variance*, 17 INTERNATIONAL JOURNAL OF ENVIRONMENTAL RESEARCH AND PUBLIC HEALTH 6533, <https://doi.org/10.3390/ijerph17186533>.

¹¹ National Academies of Sciences, Engineering, and Medicine, *Understanding the Well-Being of LGBTQI+ Populations* 67 (2020), <https://doi.org/10.17226/25877>.

people, coverage restrictions that discriminate against intersex people exacerbate the health disparities they already face.

These practices call for the Department’s express prohibition on discrimination based on intersex traits. This clarification would be consistent with the recent Title X family planning program final rule,¹² as well as the Department’s past interpretation of Section 1557 of the ACA.¹³ This rule is also consistent with the approach adopted by the Department of Justice following the decision in *Bostock v. Clayton County*. In an amendment to its *Title IX Legal Manual*, it clarified that the reasoning in *Bostock* “applies with equal force to discrimination against intersex people,” since intersex traits “are ‘inextricably bound up with’ sex.”¹⁴

II. Enrollment Processes and Requirements

a. *Non-Enrollment Based on Past-Due Premiums (§ 147.104)*

The Law Center supports eliminating the previously adopted policy on past-due premiums, which allowed insurers to lock an applicant out of coverage if the applicant had not paid outstanding premium debt from the previous year. For many people with lower incomes—disproportionately women of color, disabled women, and LGBTQ people—this policy would have created substantial delays in coverage, and in some cases it would have prevented enrollment entirely. Conditioning enrollment on payment of past premiums also violates the guaranteed availability provision, which requires issuers to “accept every employer and individual in the State that applies for...coverage.”¹⁵

b. *Agents, Brokers, and Web-Brokers (§ 155.220)*

The Law Center supports the proposed requirements related to agents, brokers, and web-brokers. In particular, we support the standards related to web-brokers’ display of QHP information, including the requirement that web-brokers display information comparable to that available on HealthCare.gov; the prohibition on showing ads for QHPs and displaying plans preferentially based on compensation; and the requirement that web-brokers provide a clear rationale for their QHP recommendations.

These standards are necessary to ensure that when people purchase plans outside of the HealthCare.gov platform, they are provided with more reliable, comprehensive, and unbiased information about the coverage options available to them. The standards also help address misleading display practices that lead some people to be inadvertently enrolled in non-ACA-compliant plans. In the absence of clear regulations, some web-brokers have failed to present all available marketplace plans, or they have failed to display information that allows people to

¹² See Ensuring Access to Equitable, Affordable, Client-Centered, Quality Family Planning Services, 86 Fed. Reg. 56144, 56159, 56178 (proposed Oct. 7, 2021) (to be codified at 42 CFR pt. 59.5).

¹³ See Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31375, 31389 (May 18, 2016) (“the prohibition on sex discrimination extends to discrimination on the basis of intersex traits or atypical sex characteristics”).

¹⁴ Department of Justice, *Title IX Legal Manual* (updated Aug. 12, 2021), <https://www.justice.gov/crt/title-ix#Bostock> (quoting *Bostock v. Clayton County, Georgia*, 140 S. Ct. 1731, 1742 (2020)).

¹⁵ 42 U.S.C. § 300gg-1(a).

compare available plans based on price and quality.¹⁶ For example, many web brokers display their preferred plans in full but display only the insurer, plan name and type, and metal tier for non-preferred plans. Web-brokers may also be incentivized by compensation to display plans in a biased and inaccurate manner, including by promoting substandard, non-ACA-compliant plans. This is particularly true because non-ACA plans, including short-term plans, tend to pay substantially higher commissions to web-brokers compared with ACA-compliant plans.¹⁷

Practices that steer people towards non-ACA-compliant plans particularly harm women. The ACA's prohibition on sex discrimination in insurance has been critical in advancing health equity for women, including its prohibition on gender rating and its coverage requirement for preventive services.¹⁸ Similarly, the ACA's protections for people with pre-existing conditions have been vital for many women: Women are more likely than men to have pre-existing conditions, with estimates of the proportion of non-elderly women with pre-existing conditions ranging from 30% to more than half.¹⁹ LGBTQ people,²⁰ people of color,²¹ and disabled people²² are also more likely to have pre-existing conditions. Non-ACA plans, which do not need to comply with these protections, may be more likely to provide unequal benefits based on sex and pre-existing conditions. The promotion of these plans increases the likelihood of people enrolling in them and subsequently being denied care or incurring higher medical costs for care.

The Law Center also supports the proposal to tighten standards of conduct for agents, brokers, and web-brokers. The practices identified in the proposed rule, like the submission of inaccurate client contact information, of email addresses that consumers cannot access, or of false income information, ultimately compromise people's access to plans that meet their needs.

c. Pre-Enrollment Verification (§ 155.420)

The Law Center supports the Department's proposal to rescind the previous administration's pre-enrollment verification requirements for special enrollment periods. Requiring enrollees to submit documentation to confirm eligibility before coverage takes effect discourages people from

¹⁶ Tara Straw, "Direct Enrollment" in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm (Mar. 15, 2019), <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>.

¹⁷ *Id.*

¹⁸ National Women's Law Center, *The Risk of Repeal: How ACA Repeal Will Hurt Women's Health and Economic Security* (2016), <https://nwlc.org/wp-content/uploads/2016/12/The-Risk-of-Repeal-FS-1.pdf>.

¹⁹ See, e.g., Michelle Long & Alina Salganicoff, *Pre-Existing Condition Prevalence Among Women Under Age 65* (2020), <https://www.kff.org/womens-health-policy/issue-brief/pre-existing-condition-prevalence-among-women-under-age-65>; APSE, Department of Health and Human Services, *Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act* (2017), <https://aspe.hhs.gov/sites/default/files/private/pdf/255396/Pre-ExistingConditions.pdf>.

²⁰ Carolina Medina & Lindsay Mahowald, *Repealing the Affordable Care Act Would Have Devastating Impacts on LGBTQ People* (Oct. 15, 2020), <https://www.americanprogress.org/article/repealing-affordable-care-act-devastating-impacts-lgbtq-people>.

²¹ Latoya Hill et al., *Key Facts on Health and Health Care by Race and Ethnicity* (Jan. 26, 2022), <https://www.kff.org/racial-equity-and-health-policy/report/key-facts-on-health-and-health-care-by-race-and-ethnicity>.

²² Centers for Disease Control and Prevention, "Disability and Related Conditions," *Disability and Health Promotion* (Sep. 16, 2020), <https://www.cdc.gov/ncbddd/disabilityandhealth/relatedconditions.html>.

enrolling and delays their coverage.²³ This is particularly true for people with low incomes, who are more likely to have inadequate internet access,²⁴ use a primary language other than English,²⁵ and face other barriers to submitting documentation.

However, we urge the Department to prohibit state-based Exchanges (SBEs) from imposing their own pre-enrollment verification requirements, rather than leaving them with the discretion to do so at will. Allowing SBEs to impose pre-enrollment verification requirements—especially in the absence of clear federal guidance or meaningful limitations on this practice—leaves many enrollees with the same documentation barriers that they would have faced under the previous administration’s policy.

d. Annual Eligibility Redeterminations (§ 155.335)

The Law Center appreciates the Department’s solicitation of input on policies related to annual eligibility determination. We recommend a change to one current policy, where enrollees are kept on their past plan when a shift in market conditions has significantly raised that plan’s cost to the enrollee. Researchers found that in Covered California’s 2018 market, a full 30% of households whose coverage was automatically renewed were certain to be better off in a different plan. On average, families were charged an extra \$466 a year in annual premiums as a result of remaining with a plan that no longer served their interests.²⁶ To avoid this outcome, we recommend HHS change this policy so that when the enrollee is certain to be better off in a different plan, the enrollee is shifted to that plan unless they opt out.

III. EHB Benefit Design

a. Substitution of EHB Benefits (§ 156.115)

We support removing issuers’ ability to substitute benefits between EHB categories. The previous policy of allowing substitution between categories permitted issuers to effectively eliminate certain EHB categories. The harms of such a policy fall particularly on disabled people and people with chronic conditions, who may find that services they need are replaced with less costly services intended to attract people without chronic illnesses or disabilities. This practice disadvantages women, particularly women of color, who are more likely to have chronic conditions or disabilities.²⁷ We are concerned, however, that allowing substitution *within* EHB categories could have similar results, and we urge HHS to ban substitution not only between categories, but also within EHB categories.

²³ Matthew Fiedler, *Trump Administration’s Proposed Change to ACA Special Enrollment Periods Could Backfire* (Feb. 17, 2017), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2017/02/17/trump-administrations-proposed-change-to-aca-special-enrollment-periods-could-backfire>.

²⁴ Andrew Perrin & Sara Atske, *7% of Americans Don’t Use the Internet. Who Are They?* (Apr. 2, 2021), <https://www.pewresearch.org/fact-tank/2021/04/02/7-of-americans-dont-use-the-internet-who-are-they>.

²⁵ Andriana M. Foiles Sifuentes et al., *The Role of Limited English Proficiency and Access to Health Insurance and Health Care in the Affordable Care Act Era*, 4 HEALTH EQUITY 509 (2020), <https://doi.org/10.1089/heq.2020.0057>.

²⁶ Petra W. Rasmussen & David Anderson, *When All That Glitters Is Gold: Dominated Plan Choice on Covered California for the 2018 Plan Year* (Dec. 2021), <https://www.milbank.org/quarterly/articles/when-all-that-glitters-is-gold-dominated-plan-choice-on-covered-california-for-the-2018-plan-year>.

²⁷ See, e.g., Long and Salganicoff, *supra* note 19.

b. *Discriminatory Benefit Designs (§ 156.125)*

We support the Department’s clarification on unlawful discrimination in EHB benefit design. Discriminatory benefit designs persist in spite of the ACA’s prohibition on discrimination, and insurers have manipulated benefit designs to deny needed coverage or discourage people with significant health needs from enrolling in their plans. These include exclusions, cost sharing, formularies, visit limits, provider networks, prior authorization, and other arbitrary utilization management.

Conditions that are commonly targeted with discriminatory benefit designs, including HIV, diabetes, cancer, and mental health conditions, disproportionately affect women of color²⁸ and LGBTQ people.²⁹ For example:

- As noted, nearly two-thirds of Native and Black transgender women have been diagnosed with HIV,³⁰ an astronomical rate compared to the HIV prevalence in the general population of less than half of one percent.³¹ Black women overall, who account for 15% of women in the U.S., make up 60% of all new HIV infections among women.³²
- Native women are nearly three times more likely than white women to be diagnosed with diabetes, and Black and Latina women are nearly twice as likely.³³
- LGBTQ people, particularly transgender people, are far more likely to experience depression and anxiety than non-LGBTQ people.³⁴

The Department should clearly prohibit insurance practices that restrict coverage for such conditions, including offering no or limited specialists in a field in provider networks, imposing mandatory step therapy and prior authorization, adverse tiering of drugs for many chronic conditions, and clinically inappropriate age limits on services like fertility treatments, hearing aids, and services for autistic people. It should also clarify that benefit designs that restrict coverage to certain services based on enrollees’ recorded sex or sex assigned at birth, regardless of medical necessity, are discriminatory.

²⁸ See generally HHS Office of Minority Health, *Minority Population Profiles* (2018), <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=26>.

²⁹ See Office of Disease Prevention and Health Promotion, “Lesbian, Gay, Bisexual, and Transgender Health,” *HealthyPeople.gov* (accessed Jan. 21, 2022), <https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health>.

³⁰ Centers for Disease Control and Prevention. *HIV Infection, Risk, Prevention, and Testing Behaviors Among Transgender Women—National HIV Behavioral Surveillance, 7 U.S. Cities 2019–2020* 5 (Apr. 2021), <https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-special-report-number-27.pdf>.

³¹ Centers for Disease Control and Prevention, HIV Surveillance Report: Statistics Overview, *HIV* (2021), <https://www.cdc.gov/hiv/statistics/overview/index.html>.

³² Bisola O. Ojikutu & Kenneth Mayer, *HIV Prevention Among Black Women in the US—Time for Multimodal Integrated Strategies*, 4 *JAMA NETWORK OPEN* e215356 (2021), <https://doi.org/10.1001/jamanetworkopen.2021.5356>.

³³ Office of Research on Women’s Health, *Diabetes Mellitus* 8 (2011), <https://orwh.od.nih.gov/sites/orwh/files/docs/ORWH-HIC-Diabetes-Mellitus.pdf>.

³⁴ American Psychiatric Association, *Mental Health Disparities: LGBTQ 2* (2017), <https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental-Health-Disparities/Mental-Health-Facts-for-LGBTQ.pdf>.

An additional example of a common discriminatory benefit design is the exclusion of gender-affirming care. Even insurers who have removed their blanket exclusions for gender-affirming care often cover only certain forms of care, such as only hormone therapy or only hormone therapy and certain surgeries.³⁵ Surgeries such as facial surgeries and augmentation mammoplasty, which are most often used by transgender women, are frequently classified as “cosmetic” and excluded from coverage, despite the robust clinical evidence of their efficacy and necessity for many transgender people.³⁶

These practices undermine the ACA’s protections for people with preexisting conditions and its prohibition on discrimination based on race, sex, and disability. Benefit designs of this nature disadvantage people with particular disabilities or health conditions, either by leaving them with a substantial out-of-pocket burden or discouraging them from enrolling in the plan at all.³⁷

In order to ensure that this protection is as robust as possible, we encourage the Department to provide additional examples of presumptively discriminatory benefit designs in the preamble to its final rule. The Department currently provides one example of discriminatory benefit design with regard to gender-affirming care: the exclusion of hormone therapy when it is covered to treat conditions other than gender dysphoria. We are concerned that, on its own, this example may offer a misleading picture of the full range of prohibited practices. First, while exclusions of hormone therapy continue to create barriers for many Marketplace enrollees, they are not as common as other kinds of exclusions.³⁸ Marketplace plans are more likely to exclude surgeries overall or specific surgeries, such as facial and breast surgeries, even though these exclusions are as blatantly discriminatory as exclusions of hormone therapy. In order to make the preamble examples relevant to current practices, we encourage the Department to clarify that exclusions of gender-affirming surgeries are also presumptively discriminatory.

Secondly, we are concerned that the example provided in the preamble might inadvertently suggest that exclusions of treatments for gender dysphoria are only discriminatory when those treatments are covered for other conditions. This approach suggests that transgender people can only access health care to the extent that the care they need happens to be the same care provided to cisgender people. Many of the treatments that transgender people require to alleviate gender dysphoria are also used by non-transgender people for other health conditions, but that overlap cannot define the limit of nondiscrimination protections. By analogy, if a plan excludes drugs to treat HIV, it may

³⁵ See e.g., Aetna, *Gender Affirming Surgery*, Clinical Policy Bulletin 0615 (last updated Nov. 23, 2021), http://www.aetna.com/cpb/medical/data/600_699/0615.html#dummyLink4; United Healthcare, *Gender Dysphoria Treatment*, Policy No. CS145.J (Nov. 1, 2021), <https://www.uhcprovider.com/content/provider/en/viewer.html?file=%2Fcontent%2Fdam%2Fprovider%2Fdocs%2Fpublic%2Fpolicies%2Fmedicaid-comm-plan%2Fgender-dysphoria-treatment-cs.pdf>.

³⁶ See, e.g., Jens U. Berli et al., *Facial Gender Confirmation Surgery—Review of the Literature and Recommendations for Version 8 of the WPATH Standards of Care*, 18 INTERNATIONAL JOURNAL OF TRANSGENDERISM 264, <https://doi.org/10.1080/15532739.2017.1302862>.

³⁷ See, e.g., Douglas B. Jacobs & Benjamin D. Sommers, *Using Drugs to Discriminate—Adverse Selection in the Insurance Marketplace*, 372 NEW ENG. J. MED. 399 (2015), <https://doi.org/10.1056/NEJMp1411376>; Stephen C. Dorner et al., *Adequacy of Outpatient Specialty Care Access in Marketplace Plans Under the Affordable Care Act*, 314 JAMA 1749 (2015).

³⁸ Out2Enroll, *Summary of Findings: 2022 Marketplace Plan Compliance with Section 1557* (2021), <https://out2enroll.org/out2enroll/wp-content/uploads/2021/12/Report-on-Trans-Exclusions-in-2022-Marketplace-Plans.pdf>.

be engaging in discriminatory conduct even if it does not cover those same drugs for any other condition. The relevant inquiry for such a plan is not whether it covers HIV drugs for other conditions, but rather whether it covers prescription drugs in general. Similarly, if a plan excludes hormones or certain surgeries needed to alleviate gender dysphoria, the relevant inquiry is not whether the plan covers those particular treatments for other conditions, but rather if it generally covers prescription drugs or surgical care, respectively. We encourage the Department to amend its example to avoid suggesting an overly narrow interpretation of nondiscrimination protections.

We support drawing on clinical evidence as one basis for identifying discriminatory benefit design. However, we encourage the Department not to confine its assessment of discriminatory practices to clinical evidence standards. Some needed health services are not conducive to conventional methodologies for developing a clinical evidence-base, including services where clinical trials are not feasible or ethical. Further, biases in medical research and the funding supporting it mean that many conditions are not sufficiently researched and documented in medical journals, particularly conditions that disproportionately affect underserved communities.³⁹ If the Department restricts the standard for identifying discriminatory benefit to yardsticks like the research in peer-reviewed medical journals, it risks replicating the same discrimination and bias leads certain conditions to be under-researched.

We also urge the Department to ensure that the clinical evidence used is not biased or discriminatory itself. Historically, much racist and eugenicist scholarship has been published in medical journals, and racism and ableism persist in the medical research field. Prominent bioethicists still question whether older people, disabled people, and people with chronic health conditions are worth treating. Many health economists continue to use the quality-adjusted life year (QALY), a measure that the National Council on Disability has recommended be banned from federal and state programs.⁴⁰ We urge the Department, when reviewing the clinical evidence used to defend plan design, to ensure that the evidence itself is not discriminatory in nature.

c. Annual Reporting Requirements (§ 156.111)

We support removing annual reporting requirements for state benefit mandates that exceed EHB standards. This policy is unnecessary, burdensome, and patently designed to discourage states from expanding beyond the EHB floor. Enhanced EHB benefits are particularly beneficial for people with chronic conditions and disabilities, who are disproportionately women, LGBTQ people, and people of color. For example, Colorado's enhanced EHB plan for 2023 includes coverage of an annual mental wellness exam, services related to substance use disorder, and comprehensive gender-affirming care.⁴¹

³⁹ See, e.g., Natalie Jacewicz, *Why Are Health Studies So White?*, THE ATLANTIC (June 6, 2016), <https://www.theatlantic.com/health/archive/2016/06/why-are-health-studies-so-white/487046>.

⁴⁰ National Council on Disability, *Quality-Adjusted Life Years and the Devaluation of Life with Disability* (2019), https://ncd.gov/sites/default/files/NCD_Quality_Adjusted_Life_Report_508.pdf.

⁴¹ Press Release, Governor Jared Polis, Biden Administration Announced Approval of Colorado's Inclusive Health Care Plan to Set Colorado's Essential Health Benefits (Oct. 12, 2021), <https://www.colorado.gov/governor/news/6446-biden-administration-announces-approval-colorados-inclusive-health-care-plan-set>.

IV. Standardized Options (§ 156.201)

We support the Department's proposal to reinstate requirements related to standardized plans, specifically its proposal to require issuers to offer at least one standardized plan at every product network type, at every metal level, and in every service area where they also offer non-standardized plans.

Standardized plans help simplify the often-complex process of navigating insurance. There is significant variation in non-standardized plans, much of which cannot be identified without a detailed analysis of benefit designs. But many people do not have the time, resources, and health literacy required for this level of analysis. For example, one study of Medicare Part D enrollees found that they typically chose plans based on comparison points that were readily available, like premiums, rather than factors that a more detailed examination of the benefit design, like expected out-of-pocket costs.⁴² Barriers to conducting a detailed analysis of plans may be particularly pronounced for people whose resources for navigating insurance are already constrained, including people with limited English proficiency,⁴³ complex health needs, and inadequate internet access.⁴⁴

Standardized plans have also been shown to reduce instances of discriminatory benefit designs.⁴⁵ Requiring and clearly designating standardized plans helps people avoid plans that have these benefit designs, such as adverse tiering of drugs for a particular condition or the exclusion of all specialists in a certain field. As discussed in a previous section of this comment, such discriminatory benefit designs disproportionately impact women, especially women of color, disabled women, and LGBTQ women.

In addition, standardization helps improve affordability in the Marketplace: It ensures that people have access to at least one plan that exempts certain important services from deductibles. States that have standardized plans have exempted services like primary care and mental health care from deductibles. Some states have used this feature to promote gender and racial health equity. Washington, D.C., for example, recently decided to eliminate deductibles and other forms of cost-sharing for services that disproportionately affect people of color.⁴⁶ Similarly, Colorado requires standard plans to promote health equity, including by improving affordability.⁴⁷ We also support requiring standardized plans to use fixed copays instead of coinsurance, which disproportionately burdens disabled people and people with chronic conditions.

⁴² Jason Abaluck & Jonathan Gruber, *Choice Inconsistencies Among the Elderly: Evidence from Plan Choice in the Medicare Part D Program*, 101 AMERICAN ECONOMIC REVIEW 1180 (2011), <https://doi.org/10.1257/aer.101.4.1180>.

⁴³ Tianyi Lu & Rebecca Myerson, *Disparities in Health Insurance Coverage and Access to Care by English Language Proficiency in the USA, 2006–2016*, 35 J. GENERAL INTERNAL MEDICINE 1490 (2020), <https://doi.org/10.1007/s11606-019-05609-z>.

⁴⁴ See, e.g., Krutika Amin et al., *How Might Internet Connectivity Affect Health Care Access?* (2020), <https://www.healthsystemtracker.org/chart-collection/how-might-internet-connectivity-affect-health-care-access>.

⁴⁵ Douglas Jacobs, *CMS' Standardized Plan Option Could Reduce Discrimination*, HEALTH AFFAIRS (Jan. 6, 2016), <https://www.healthaffairs.org/doi/10.1377/hblog20160106.052546/full>.

⁴⁶ Press Release, DC Health Link, DC Health Benefit Exchange Authority Takes Action to Achieve Social Justice and Equity in Health Insurance Coverage (July 15, 2021), <https://www.dchealthlink.com/node/3569>.

⁴⁷ Justin Giovannelli et al., *State Efforts to Standardize Marketplace Health Plans Show How the Biden Administration Could Improve Value and Reduce Disparities* (July 28, 2021), <https://www.commonwealthfund.org/blog/2021/state-efforts-standardize-marketplace-health-plans>.

V. Essential Community Providers (§ 156.235)

The Law Center supports increasing essential community provider (ECP) participation standards from 20% to 35%. ECPs, which serve predominantly low-income, medically underserved communities, provide vital care for women, people of color, LGBTQ people, and disabled people. For example, many women rely on ECPs like family planning clinics for sexual and reproductive health, preventive health screenings, and other care. And Ryan White clinics are critical for people living with HIV, who are disproportionately LGBTQ people and people of color, and who have historically faced stigma and discrimination in other health care settings.

We urge the Department to require QHPs to meet this standard for each category of ECPs rather than for all ECPs taken as a whole. This helps ensure that QHP enrollees have adequate access to all important types of ECPs, including those that serve people with specific health needs, like family planning clinics and Ryan White providers. We also support the Department's proposal that, in order to satisfy the ECP standards, tiered plans must contract with ECPs within the network tier that results in the lowest cost-sharing obligation for enrollees.

VI. Other Standards to Advance Health Equity

Data collection is a critical tool for advancing health equity: It enables the identification and monitoring of health disparities and gaps in access to care. The Department should expand its data collection requirements, including by adopting requirements for QHPs to collect information about enrollees' race and ethnicity, gender identity, sexual orientation, intersex traits, primary language, and disability. Expert bodies such as the Williams Institute have proposed standards to collect this data accurately and in a manner that protects individual privacy and prevents discrimination based on that data.⁴⁸ The Department should also require QHPs to engage in systematic review of enrollee data and correct disparities identified through this review.

VII. Conclusion

We appreciate the opportunity to submit comments on this proposed rule. However, we object to the truncated comment period. The NPRM was posted on the Federal Register on January 5, and the January 27 deadline offers commenters only 22 days to respond—falling short of the 30-day minimum, let alone the standard comment period length of 60 days. An abbreviated comment period must not become the norm, particularly for a rule of this level of breadth, detail, and importance.

Thank you for considering our comments. For further questions, please contact Ma'ayan Anafi, Senior Counsel for Health Equity and Justice, at manafi@nwlc.org.

⁴⁸ See, e.g., Andrew Park, *Data Collection Methods for Sexual Orientation and Gender Identity* (2016), <https://williamsinstitute.law.ucla.edu/publications/data-collection-sogi>.