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Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9884-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically

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

The National Women's Law Center (NWLC) comments to express our strong opposition to the proposed rule "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability."[1] Since 1972, NWLC has fought for gender justice in the courts, in public policy, and in our society. We have worked to advance the progress of women and their families in core aspects of their lives, including health and reproductive rights, income security, employment, and education, with an emphasis on the needs of people who face multiple and compounding forms of discrimination. Through our work to advance and implement the Affordable Care Act (ACA), we have seen its impact on the health and wellbeing of women and LGBTQI+ people, and we firmly believe that robust enforcement of its provisions is needed to continue to improve access to coverage and care.

Rather than enforcing the ACA and furthering its aims, however, the Department of Health and Human Services ("the Department") proposes to weaken and destabilize it. The proposed rule would reverse many recent changes that contributed to improved Marketplace enrollment rates[2] and inflict far-reaching harms on the individuals and communities the ACA itself was designed to benefit. If promulgated, this proposed rule would deprive eligible individuals of affordable coverage, limit their enrollment opportunities, and erode the value of their Marketplace coverage. For example, it would strip Deferred Action for Childhood Arrival (DACA) recipients of their eligibility to enroll in Marketplace plans; create unwarranted barriers to coverage and subsidies; undermine both the Open Enrollment Period and Special Enrollment Periods; and prohibit the

[1] 90 Fed. Reg. 12942 (proposed Mar. 19, 2025) (to be codified at 45 C.F.R. pts. 147, 155, and 156) (hereinafter "Proposed Rule").
[2] *See* Press Release, Centers for Medicare & Medicaid Services, Over 24 Million Consumers Selected Affordable Health Coverage in ACA Marketplace for 2025 (Jan. 17, 2025), https://www.cms.gov/newsroom/press-releases/over-24-million-consumers-selected-affordable-health-coverage-aca-marketplace-2025 (documenting record-high enrollment).

coverage of health care for transgender people as an Essential Health Benefit. We oppose this rule and urge its withdrawal.

I. The proposed rule is harmful, unjustified, and inconsistent with the ACA.

The proposed rule would jeopardize access to affordable coverage and comprehensive care—harms that the Department cannot and does not reconcile with the intent of the ACA. While we comment on individual provisions in subsequent sections of this comment, we first highlight the impacts of this proposed rule when considered as a whole.

a. The proposed rule would create severe hardships for consumers.

The proposed rule would increase administrative burdens for consumers, limit their eligibility and enrollment opportunities, put them at risk of losing subsidies, and undermine comprehensive coverage. Taken together, these provisions can be expected to lead to substantial loss of insurance for eligible individuals. According to the Department's own estimates, up to two million people could lose coverage in 2026 alone as a result of this rule.[3] Given that the Department repeatedly understates the barriers and administrative burdens that the proposed rule would create, it is likely that the loss of coverage would be even more widespread.

People who lose coverage often have lengthy gaps in insurance, or in some cases simply remain uninsured.[4] This proposed rule is therefore likely to worsen uninsurance rates. And because of the proposed rule's disproportionate impacts on people who already face barriers to enrollment, it would widen existing demographic gaps in coverage, including gaps affecting women and girls of color. NWLC found substantial racial and ethnic disparities among the 11.7 million women and girls who were uninsured in 2023: Latinas were three times more likely than white, non-Hispanic women and girls to be uninsured, with Black women and girls also facing higher rates of uninsurance.[5] Similarly, an analysis of the nonelderly population in 2023 found that while 6.5% of white individuals were uninsured, the rate was substantially higher among those who were Indigenous (19%), Latine (18%), Native Hawai'ian or Pacific Islander (13%), or Black (10%).[6] Uninsurance rates are also higher among transgender people and among LGBTQI+ people of color. For example, a 2022 study found that transgender people were over twice as likely as cisgender people to be uninsured, with nearly a quarter (22%) reporting that they were not currently covered.[7]

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[3] Proposed Rule at 13025.
[4] Liran Einav & Amy Finklestein, *The Risk of Losing Health Insurance in the United States Is Large, and Remained So After the Affordable Care Act*, 120 ECONOMIC SCIENCES e2222100120 (Apr. 24, 2023), https://doi.org/10.1073/pnas.2222100120
[5] National Women's Law Center, *NWLC Resources on Poverty, Income, and Health Insurance in 2023* (Sep. 10, 2024), https://nwlc.org/resource/nwlc-resources-on-poverty-income-and-health-insurance.
[6] Jennifer Tolbert et al., *Key Facts About the Uninsured Population* (Dec. 18, 2024), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population.
[7] Caroline Medina & Lindsay Mahowald, *Discrimination and Barriers to Well-Being: The State of the LGBTQI+ Community in 2022* (Jan. 12, 2023), https://www.americanprogress.org/article/discrimination-and-barriers-to-well-being-the-state-of-the-lgbtqi-community-in-2022.

LGBTQI+ people of color also experience high rates of uninsurance: One study, for example, found that 25% of Black lesbian, gay, and bisexual people were uninsured.[8]

The consequences of losing insurance are multifold. Numerous studies have demonstrated that uninsured individuals are less likely to receive preventive care or access services for major health conditions and chronic diseases.[9] Uninsured women—disproportionately Black, Latina, and Indigenous women—are less likely to have a regular doctor and to receive services like mammograms, Pap tests, and blood pressure checks.[10] They also get less adequate and lower quality care.[11] As a result, uninsured women are more likely to have unmet medical needs and worse health outcomes, from higher rates of maternal mortality, especially among Black women,[12] to later-stage cancer diagnoses.[13]

Uninsured adults broadly are more likely to forgo needed care than those who are insured: In 2023, nearly half (47%) of uninsured people aged 18 to 64 reported that they had not seen a health care professional in the previous year, approximately three times the rate among insured people.[14] Uninsured people are consequently more likely to be hospitalized for avoidable health problems.[15] And when they are hospitalized, they receive fewer medical tests and services and suffer from higher mortality rates than those with insurance.[16] The health impacts are further compounded by financial ones: 62% of uninsured adults report health care debt,[17] which itself leads to wide-ranging impacts on health and wellbeing.[18]

Throughout the proposed rule, the Department fails to adequately consider, and in some cases entirely disregards, these numerous harms. Even when it does acknowledge these harms, it vastly underestimates the burdens its proposed policies would impose on applicants and enrollees, the risk of loss of coverage for eligible individuals, and the downstream effects of uninsurance. This repeated deficiency strongly suggests that the rule, if finalized, would be arbitrary and capricious for failure to "examine the relevant data" and consider "important aspect[s] of the problem."[19]

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[8] Thomas Waldrop, *Equitable Insurance Coverage and Access Can Advance LGBT Health* (Oct. 2, 2023), https://tcf.org/content/commentary/equitable-insurance-coverage-and-access-can-advance-lgbt-health.
[9] Tolbert et al., *supra* note 6.
[10] Kaiser Family Foundation, *Women's Health Insurance Coverage* (Dec. 12, 2024), https://www.kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage.
[11] *Id*.
[12] Judith Solomon, *Closing the Coverage Gap Would Improve Black Maternal Health* (Jul. 26, 2021), https://www.cbpp.org/research/health/closing-the-coverage-gap-would-improve-black-maternal-health.
[13] Gerard A. Silvestri et al., *Cancer Outcomes Among Medicare Beneficiaries and Their Younger Uninsured Counterparts*, HEALTH AFFAIRS (May 2021), https://doi.org/10.1377/hlthaff.2020.01839.
[14] Tolbert et al., *supra* note 6.
[15] *Id*.
[16] *Id*.
[17] *Id*.
[18] Lunna Lopes et al., *Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills* (Jun. 16, 2022), https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings.
[19] *See Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

b. The Department fails to provide a reasoned justification for its proposed changes.

In contrast to the clear and compelling harms that would result from this rule, the Department's justifications for these harms are inadequate and unsupported. In many cases, the Department fails to provide even minimal evidence to justify its proposals. Instead, it repeatedly offers conclusory statements, bare speculation, and ideologically driven inferences from data with limited relevance. For example, the Department misrepresents the risk of improper enrollments, "misuse and abuse," and threats to program integrity. The preamble frequently suggests that consumers are deliberately "manipulating" coverage,[20] "gaming" the system,[21] or "exploiting…loopholes,"[22] but it fails to provide direct evidence for this accusation. Indeed, numerous studies suggest that consumers face significant information gaps regarding enrollment and health insurance, such that many do not have the resources to navigate its basic processes—let alone have the in-depth knowledge needed to "game" this complex system.[23] The proposed rule also claims that recent policy changes have led to fraud and abuse, an assertion undermined by the fact that many of the policies it seeks to reverse have either just come into effect or have not yet come into effect at all.

The Department attempts to moderate its claims that consumers are "gaming" and "manipulating" coverage by noting that "improper enrollments" include fraud or misrepresentation by agents, brokers, and web-brokers in addition to purported abuse by consumers themselves. Taken as a whole, however, the proposed rule suggests that the Department's concern with the former is negligible: In contrast to the numerous provisions targeting consumers, only a single provision in this rule relates to agents, brokers, and web-brokers, and even that provision has only a minor impact of clarifying the evidentiary standard used to assess noncompliance.[24]

Courts have previously rejected the Department's reliance on unsubstantiated claims of fraud and improper enrollments in its pursuit of policies that limit eligibility.[25] In this proposed rule, the Department has once again "improperly elevated the objective of fraud prevention, for which it had no evidence, above the ACA's primary purpose of providing health insurance."[26] As with prior vacated rules, the Department's attempts here "to prioritize a hypothetical risk of fraud over the substantiated risk that its decision result in immense administrative burdens at best, and a loss of coverage for eligible individuals at worst, defies logic."[27]

c. The proposed changes run contrary to the ACA.

As the Supreme Court has repeatedly recognized, one of the ACA's primary objectives is to "increase the number of Americans covered by health insurance," such as by encouraging enrollment and expanding eligibility.[28] Additionally, the ACA aims to expand coverage of services

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[20] Proposed Rule at 12944.
[21] *E.g.*, Proposed Rule at 12950.
[22] *E.g.*, Proposed Rule at 13009.
[23] *See, e.g.,* Rebecca Myerson & Honglin Li, *Information Gaps and Health Insurance Enrollment*, 22 AMERICAN JOURNAL OF HEALTH ECONOMICS 477 (Sep. 2022), https://doi.org/10.1086/721569.
[24] *See* Proposed Rule at 12955.
[25] *See, e.g., City of Columbus v. Cochran*, 523 F. Supp. 3d 731 (D. Md. 2021).
[26] *Id*. at 761.
[27] *Id*. at 763.
[28] *Nat'l Fed'n of Indep. Bus. v. Sebelius,* 567 U.S. 519, 519 (2012).

that have historically been excluded from insurance plans, including by implementing robust standards for Essential Health Benefits (EHB). Perversely, the Department is now promoting policies that by its own account will result in loss of coverage, as well as policies that encourage discriminatory exclusions in EHB. The Department tries to justify these proposals by reinterpreting provisions of the ACA in a manner that runs contrary to its clear intent and at times contravenes statutory language. A rule that frustrates the ACA's objectives and disregards the letter of the law exceeds the Department's authority to enforce the statute.

II. The proposed rule would reduce eligibility and lead to denials of affordable coverage.

If finalized, the proposed rule would compromise eligibility for Marketplace enrollment, Advance Payment of the Premium Tax Credit (APTC), and Cost-Sharing Reductions (CSR), as well as increasing administrative barriers for eligible individuals.

a. Eligibility for DACA Recipients [§ 155.20]

We strongly oppose the exclusion of DACA recipients from the definition of "lawfully present." This proposal would strip DACA recipients of their eligibility to enroll in Qualified Health Plans (QHPs) through an Exchange, apply for APTC or CSR, and enroll in coverage through Basic Health Programs. It is harmful and unnecessary, and it lacks sufficient legal or policy justification.

This proposed rule would reinforce barriers to coverage and care DACA recipients already face. In 2023, one fifth (20%) of DACA recipients were uninsured, nearly three times the rate of the general U.S. population at the time (7.7%).[29] Without eligibility for Marketplace coverage, many DACA recipients have few options for insurance and largely rely on employment-based coverage.[30] However, while the vast majority (94%) of DACA recipients are employed,[31] many do not have access to employer-sponsored insurance, since DACA recipients are overrepresented in low-paying jobs that are less likely to provide health benefits.[32]

Data on uninsured immigrants overall demonstrate the compounding impacts that uninsurance can have for this population. Compared to U.S.-born uninsured people, uninsured immigrants are far more likely to report lacking a usual source of care other than an emergency room, not having had a doctor's visit in the previous year, and skipping or postponing care.[33] These barriers directly

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[29] Isobel Mohyeddin, *DACA Recipients' Access to Health Care: 2024 Report* 1 (Jun. 27, 2024), https://www.nilc.org/wp-content/uploads/2024/05/NILC_DACA-Report_2024_06-27-24.pdf

[30] *Id*. (finding that 82% of DACA recipients with insurance receive it through their employer, compared to around 50% of the general population).

[31] Tom K. Wong et al., *2023 Survey of DACA Recipients Highlights Economic Advancement, Continued Uncertainty Amid Legal Limbo* (Mar. 25, 2024), https://www.americanprogress.org/article/2023-survey-of-daca-recipients-highlights-economic-advancement-continued-uncertainty-amid-legal-limbo.

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

[33] Kaiser Family Foundation, *Key Facts on Health Coverage of Immigrants* (Jan. 15, 2025), https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants.

contribute to negative health outcomes: 40% of uninsured immigrants who skipped or postponed care say their health got worse as a result.[34]

Studies focusing on immigrant women also document disparities related to health care and outcomes. For example, immigrant women experience higher incidence of and mortality from breast and cervical cancer and are less likely to undergo preventive screenings than U.S.-born women.[35] Particularly as these types of screenings are provided without cost-sharing through QHPs on the ACA Exchanges,[36] depriving certain immigrants of eligibility to enroll in these plans could cause these disparities to continue to widen.

Data on DACA recipients specifically further shows how high rates of uninsurance and underinsurance contribute to cost-related barriers to care. Nearly three-quarters (71%) of DACA recipients report that they have previously been unable to pay medical bills or expenses.[37] A 2023 study of DACA recipients found that, due to the cost of care, 36% skipped recommended medical tests or treatment and 42% skipped dental tests or treatment.[38] More than a third (36%) reported that the cost of mental health care was too expensive for them to access it,[39] and 17% reported that they did not fill a prescription, rationed their prescription, or skipped entire doses because of the cost of medication.[40]

These disparities are further compounded by the uncertainty and hardship related to DACA recipients' immigration status. In the 2023 study, more than one-fifth (21%) of respondents experienced worse health conditions because of concerns related to their immigration status.[41] Studies have also shown that anti-immigrant policies worsen mental health outcomes[42] and overall health[43] among DACA recipients.

Ensuring paths to coverage is critical for improving insurance rates and access to adequate care for DACA recipients. Conversely, by denying DACA recipients eligibility for Marketplace coverage, this proposed rule would likely lead to persisting disparities in care, coverage, and health

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[34] Drishti Pillai et al., *Health and Health Care Experiences of Immigrants: The 2023 KFF/LA Times Survey of Immigrants* (Sep. 17, 2023), https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-health-care-experiences-of-immigrants-the-2023-kff-la-times-survey-of-immigrants.

[35] Tainya C. Clarke et al., *Breast Cancer Screening Among Women by Nativity, Birthplace, and Length of Time in the United States*, 129 NATIONAL HEALTH STATISTICS REPORTS 1 (Oct. 2019), https://pubmed.ncbi.nlm.nih.gov/31751203; Meheret Endeshaw et al., *Cervical Cancer Screening Among Women by Birthplace and Percent of Lifetime Living in the United States*, 22 JOURNAL OF LOWER GENITAL TRACT DISEASE 280 (Oct. 2019), http://doi.org/10.1097/LGT.0000000000000422.

[36] *See* 42 U.S.C. § 300 gg-13.

[37] Isobel Mohyeddin & Ben D'Avanzo, *DACA Recipients' Access to Health Care: 2023 Report* 2 (May 2023), https://www.nilc.org/wp-content/uploads/2023/05/NILC_DACA-Report_2023-1.pdf.

[38] Mohyeddin, *supra* note 29 at 3.

[39] *Id*. at 2.

[40] *Id.* at 3.

[41] *Id.* at 1.

[42] Luz M. Garcini et al., *Anti-Immigration Policy and Mental Health: Risk of Distress and Trauma Among Deferred Action for Childhood Arrivals Recipients in the United States*, 15 PSYCHOLOGICAL TRAUMA 1067 (Oct. 2023), https://dx.doi.org/10.1037/tra0001228.

[43] Caitlin Patler et al., *Uncertainty About DACA May Undermine Its Positive Impact on Health for Recipients and Their Children*, 38 HEALTH AFFAIRS 738 (May 2019), https://doi.org/10.1377/hlthaff.2018.05495.

outcomes. Further, the proposed rule would not only prevent DACA recipients from enrolling in coverage in future years: Since this provision will be applied on the effective date of the final rule, it would cut DACA recipients off from their coverage midway through the plan year. These harms are unwarranted, and the Department offers little by way of justification for its proposed policy.

b. Past-Due Premium Payments [§ 147.104(i)]

We oppose allowing issuers to lock consumers out of coverage based on past-due premium payments owed under a prior policy. Conditioning enrollment on payment of past-due premiums violates the statutory guaranteed availability provision, which requires issuers to accept every individual who applies for coverage.[44] Nothing in the statute allows the Department to make an exception to this guarantee for individuals with past-due premiums.

Denying coverage based on past-due premiums would lead to higher levels of uninsurance, particularly among those with low incomes and others experiencing financial hardship. It may also lead to loss of coverage for individuals who were not aware of their past-due premiums and only learn of them when they are denied enrollment.

The Department disregards these harms, claiming that the impact of this policy would be "minimal" because "the amount most individuals owe in past-due premiums is relatively small and thus having to pay those amounts generally would not impose a substantial financial burden to enroll in coverage."[45] This broad claim—made without supporting evidence—disregards the impacts that even "relatively small" amounts in past-due premiums can have for people with low incomes, as well as the significant negative consequences for those who lose coverage. The Department briefly acknowledges but dismisses the impact of loss of coverage, noting that enrollees who face difficulty paying past-due premiums "might need to adjust their household budgeting to maintain coverage, or, if they are not able to, become uninsured."[46] These harms are especially likely given that the proposed rule allows the denial of coverage based on past-due premiums from *any* prior year, a policy that exceeds the Department's similar rule in 2017, which allowed denials based on past-due premiums only from the prior 12 months.[47] We are also troubled that the Department is considering as an alternative to *require* issuers to adopt this policy.

The Department fails to justify this proposal with adequate evidence. For example, the preamble speculates that "people are manipulating guaranteed availability and grace periods to time coverage to when they need health services." Its support for this claim is largely based on speculation: The Department points to a reported decrease in enrollees whose coverage was terminated for non-payment of premiums between 2017 and 2020 and hypothesizes, without evidence, that this decrease is due to consumers being encouraged by a previous rule to pay their past-due premiums. The Department also fails to demonstrate why this punitive measure is necessary given that issuers have other tools available to recoup unpaid premiums without denying enrollment.

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[44] *See* 42 U.S.C. § 300gg–1(a).
[45] Proposed Rule at 12952.
[46] Proposed Rule at 13010.
[47] *See* Patient Protection and Affordable Care Act; Market Stabilization, 82 Fed. Reg. 18346, 18349.

c. Failure to File and Reconcile [§ 155.305(f)(4)]

The Department proposes to require all Exchanges to determine tax filers ineligible for APTC if they did not reconcile their APTC for a single year, rather than for two consecutive years. This proposal would lead to substantial losses of APTC for eligible individuals, causing harms that far outweigh any deterrent value this policy may have.

With little evidence, the Department claims that many of those with a failure-to-reconcile (FTR) status are appropriately denied APTC because "a large number of people with FTR status are ineligible for APTC."[48] On the contrary, there are numerous reasons why eligible individuals fail to reconcile their APTC. For example, many consumers and even third-party tax preparers are unaware of the responsibility to reconcile APTC. Even consumers who are aware of their responsibilities might find that unintended errors in this potentially complex filing leave them in FTR status. Additionally, notices that consumers receive regarding their tax responsibility are often ineffective. Consumers may find those notices difficult to understand or navigate, a common challenge that may be further compounded by barriers related to language, literacy, or disability. We are further concerned that existing FTR notices are often constitutionally insufficient: They may be too vague to adequately inform individuals of their FTR status and may lack minimally sufficient information, raising serious due process concerns.

Taken together, these barriers suggest a substantial risk of unwarranted denials of APTC, even under the existing standard requiring two consecutive years of FTR. But instead of mitigating this ongoing problem, the Department is aggravating it: Under the proposed rule, applicants will have no opportunity to address their FTR status after just a single year of not reconciling their APTC. The resulting consequences for consumers can be severe. By definition, individuals who qualify for APTC but are denied it would no longer have access to affordable coverage. Losing APTC can therefore lead consumers who cannot afford unsubsidized coverage to experience lengthy periods of uninsurance.

d. Eligibility Verifications for APTC and CSR

The Department seeks to limit access to APTC and CSR through a series of income verification barriers. Each of these provisions is harmful and unjustified.

i. Income inconsistencies when sources show projected income below 100% FPL [§ 144.320(c)(3)(iii)]

The Department proposes to require all Exchanges to generate Data Matching Issues (DMIs) for income inconsistencies when IRS or SSA data show a projected income below 100% of the Federal Poverty Line (FPL), while the tax filer attests to a projected income between 100% and 400% FPL. This policy would require tax filers to answer verification questions and submit documentation of income, potentially creating substantial administrative burdens for people with low incomes and ultimately resulting in loss of coverage.

[48] Proposed Rule at 12961.

While the Department claims that answering verification questions and submitting documentation would take the average consumer only an hour, this is likely a substantial underestimate, particularly for those with more complex documentation requirements. Such consumers are more likely to be women, people of color, and people with low incomes—all of whom are more likely to work multiple jobs or have precarious employment[49] and thus have more complex documentation requirements and less predictable income. Similarly, workers who rely on tipped wages are more likely to have unpredictable incomes and complex documentation needs. Women are particularly likely to work in industries where tips make up the largest portion of their earnings: For example, among servers (such as waitstaff and barkeepers), who make the majority of workers in tipped minimum wage occupations, women represent nearly two-thirds (65.5%) of workers.[50] The loss of coverage that can result from this proposed policy would therefore disproportionately impact women and especially women of color, exacerbating the disparities in coverage and health outcomes they already face.

The Department does not offer an adequate basis to distinguish this proposal from its previous iteration in the Notice of Benefit and Payment Parameters for 2019. The prior policy was vacated as arbitrary and capricious, as the Department "failed to support its decision with anything more than unsubstantiated conclusions and failed to acknowledge the impracticability of low-income applicants being able to meet this requirement."[51] The Department claims to now have "clear evidence" that "millions of applicants are inflating their incomes,"[52] and that the inconsistencies result not from the unpredictability of low-wage work but from consumers manipulating their income "intentionally."[53] The "clear evidence," however, consists of speculation about consumers' motivation based on circumstantial observations.[54] This is insufficient to either support the Department's conclusion or differentiate this policy from the previously vacated one.

ii. Income verification when IRS data is unavailable [§ 155.320(c)(3)(iii)]

Currently, Exchanges are required to accept an applicant's attested income when tax return data is unavailable, such as when an individual falls below the tax filing threshold. The proposed rule would instead require all Exchanges to "follow the full alternative verification process" in these circumstances and require documentation from applicants to resolve DMIs.[55]

Despite its claim that eligible individuals would be able to meet documentation requirements "with relative ease," this proposed rule would in fact create substantial burdens on applicants with low

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[49] U.S. Bureau of Labor Statistics, Labor Force Statistics from the Current Population Survey: Multiple Jobholders by Selected Characteristics (Jan. 29, 2025), https://www.bls.gov/cps/cpsaat36.htm; Vanessa M. Oddo et al., *Changes in Precarious Employment in the United States: A Longitudinal Analysis*, 47 SCANDINAVIAN JOURNAL OF WORK, ENVIRONMENT & HEALTH 171 (Dec. 7, 2020), www.doi.org/10.5271/sjweh.3939; Urban Institute, *Unstable Work Is All Too Common, Especially for Black Women* (Sep. 12, 2024), https://www.urban.org/data-tools/black-women-precarious-gig-work.

[50] Institute for Women's Policy Research, *Want to Help Women? Get Rid of the Tipped Minimum Wage* 1 (Dec. 2024), https://iwpr.org/wp-content/uploads/2024/12/Tipped-Minimum-Wage-Fact-Sheet-2024-1.pdf.

[51] *City of Columbus v. Cochran*, 523 F. Supp. 3d 731, 762 (D. Md. 2021).

[52] Proposed Rule at 12963.

[53] Proposed Rule at 12964.

[54] *See* Proposed Rule at 12964–12965.

[55] Proposed Rule at 12967.

incomes, potentially leading to loss of APTC for eligible individuals. As noted, because people eligible for APTC typically cannot afford to pay for unsubsidized insurance, the loss of APTC would frequently amount to a denial of coverage. Due to high rates of poverty, single mothers, women of color, disabled women, and women overall are more likely to fall under the tax filing threshold[56] and thus be disadvantaged by the proposed policy.

To justify this proposal, the Department claims without evidence that allowing applicants to self-attest income when IRS data is unavailable has "played a key role in weakening the Exchange eligibility system."[57] Asserting that the administrative burden of this proposed policy "is more than offset by the program integrity benefits,"[58] the Department both underestimates the harms for applicants and overstates the risk the existing policy poses to program integrity.

e. Annual Eligibility Redeterminations [§ 155.335]

The Department proposes to impose a $5-per-month charge on certain enrollees to prompt them to confirm their APTC eligibility: Under the proposed rule, when an enrollee does not actively select a plan and their portion of the premium would be $0 after the application of APTC, the Exchange must decrease the amount of APTC applied so that the enrollee owes $5 for every month that they do not confirm their APTC eligibility.

This policy would achieve little other than harming individuals with low incomes, who may not be aware of the new requirement to confirm their eligibility or may not receive notice regarding the process for doing so. While the proposed rule treats the accumulating $5-a-month charge as negligible, it in fact can have a significant impact on those who are already facing financial hardship. We are particularly concerned that the Department is considering an even more punitive policy as an alternative, where individuals who qualify for fully subsidized plans must reconfirm their plan and reverify their income before they are eligible to receive APTC.

f. Premium Payment Threshold [§ 155.400(g)]

Existing regulations allow issuers to implement a threshold where enrollees are considered to have paid the full amount of their premium payment, such as that non-payment of de minimis amounts does not lead to termination of enrollment or trigger a grace period. Specifically, issuers can adopt a net-percentage threshold, a gross-percentage threshold, or a fixed-dollar threshold. These regulations were adopted because the Department previously recognized that terminating enrollment or triggering a grace period was an overly severe consequence for non-payment of de minimis amounts. The Department added the gross-percentage and fixed-dollar thresholds because the net-percentage threshold on its own was not sufficient to alleviate the risk of this outcome.

Now, the Department is reversing course and seeking to prohibit issuers from relying on gross-percentage and fixed-dollar thresholds, leaving them with the sole option of using the net-

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[56] Sarah Javaid, *National Snapshot: Poverty Among Women & Families in 2023* (Dec. 2024), https://nwlc.org/wp-content/uploads/2024/12/National-Snapshot-Poverty-Among-Women-Families-in-2023-FINAL.pdf; National Women's Law Center, *NWLC Resources on Poverty, Income, and Health Insurance in 2023* (Sep. 10, 2024), https://nwlc.org/resource/nwlc-resources-on-poverty-income-and-health-insurance.

[57] Proposed Rule at 12967.

[58] Proposed Rule at 12967.

percentage threshold. This proposal would result in de minimis non-payments continuing to lead to unwarranted coverage loss, particularly for enrollees who are unable to pay their full premiums due to financial hardship. While the Department claims that this rollback is needed to counter fraud and improper enrollments, it can rely only on speculation that the fixed-dollar and gross-percentage thresholds make it "possible for enrollees in certain circumstances" to avoid paying premiums for a period of time: These two threshold options came into effect only two months before the proposed rule was published, so any evidence that they led to fraud could not have yet emerged.

III. The proposed rule would limit enrollment opportunities.

We oppose the Department's attempt to shorten the Open Enrollment Period, end the low-income Special Enrollment Period (SEP), and impose pre-enrollment verification for SEPs.

a. Annual Open Enrollment Period [§ 155.410]

The Department proposes to require all Exchanges to shorten their Open Enrollment Period (OEP) to 45 days, from November 1 to December 15. This proposal is unwarranted and harmful. An adequate enrollment period is necessary so that consumers can fully evaluate their options, consult Navigators and assisters, benefit from outreach efforts, and make informed decisions about their coverage. This is particularly important for people who might need additional time to choose a plan, including people with complex health needs and those who may face barriers related to disability, language, health literacy, and limited resources. An OEP that extends into the new year also offers consumers who are only notified of plan cost increases in January more time to consider their coverage options.

Shortening the OEP denies consumers these benefits. The Department claims without evidence that a 45-day OEP would not "have a negative impact on enrollment or the consumer experience due to the maturity of the enrollment systems."[59] To the contrary, this policy would likely lead to depressed enrollment overall, with especially significant harms in communities that already face higher rates of uninsurance and would particularly benefit from robust outreach.[60] A shorter enrollment period also offers consumers less time to explore a range of plans, leading many to remain in their current plan even if it is suboptimal for their needs. This risk undercuts the Department's insistence throughout the preamble that it seeking to create "more active engagement" in plan selection.[61]

The harms of this proposal are especially severe given that the Department recently slashed Navigator program funding by nearly 90%, from $98 million to a mere $10 million.[62] Coupled with the loss of Navigator and outreach resources, a shorter OEP would make it difficult for many consumers to choose a plan, provide documentation, and complete the enrollment process in time.

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[59] Proposed Rule at 13015.
[60] *See supra* notes 5–8.
[61] *See, e.g.,* Proposed Rule at 12969.
[62] Press Release, Centers for Medicare & Medicaid Services, CMS Announcement on Federal Navigator Program Funding (Feb. 14, 2025), https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding.

While the Department's claim that a shortened OEP is necessary to prevent consumer confusion,[63] this proposal will likely increase rather than decrease confusion due to inadequate opportunity for outreach and Navigator support. Compounding these harms is the fact that the Department is requiring all Exchanges, including state-based Exchanges, to adopt this shortened OEP, regardless of state-specific needs and priorities.

b. Low-Income Special Enrollment Period [§ 155.420(d)(16)]

The proposed rule would eliminate the monthly SEP for consumers with a projected income at or below 150% FPL. Repealing the existing SEP would deprive individuals of an important safety net and opportunities to enroll in free or low-cost coverage.

The Department fails to justify this proposal. It claims this SEP has been "one of the primary mechanisms" for improper enrollment, but its only source is a comparison between two non-comparable data sources—the estimated income of enrollees in 2024 Marketplace coverage and the income of respondents in 2022 American Community Survey data. The Department also speculates without evidence that Navigators are incentivized to encourage applicants to underestimate their income so that they qualify for the SEP.

The Department further claims that this SEP leads to adverse selection, but data from similar low-income SEPs shows little risk of this outcome. An analysis of pandemic-related SEPs found that they in fact led to favorable selection: States that adopted more lenient enrollment policies experienced an improvement in their risk pools at almost double the rate of states that maintained pre-pandemic eligibility standards.[64] State experiences with low-income SEPs provide further evidence that the risk of adverse selection is low. For example, since 2014, Massachusetts has made an SEP available to certain individuals with incomes up to 300% FPL without seeing adverse selection and destabilization.[65] Similar trends have emerged in Minnesota and New York.[66] The data from these and other states suggest that maintaining the low-income SEP would come with minimal risks while significantly improving insurance rates.

c. SEP Pre-Enrollment Verification [§ 155.420(g)]

The proposed rule would require federal and federally facilitated Exchanges to conduct pre-enrollment eligibility verification for SEPs, as well as requiring state-based Exchanges to conduct this verification for at least 75% of new enrollments. We oppose this provision.

Contrary to the Department's claim that "the verification process does not impose a substantial burden and therefore should not be a barrier to enrollment,"[67] requiring enrollees to submit

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[63] *See* Proposed Rule at 12978.
[64] Mark A. Hall & Michael J. McCue, *Does Making Health Insurance Enrollment Easier Cause Adverse Selection?* (Apr. 4, 2022), https://www.commonwealthfund.org/blog/2022/does-making-health-insurance-enrollment-easier-cause-adverse-selection.
[65] Sarah Lueck, *Proposed Changes to ACA Enrollment Policies Would Boost Insured Rate, Improve Continuity of Coverage* (Jun. 5, 2019), https://www.cbpp.org/research/health/proposed-change-to-aca-enrollment-policies-would-boost-insured-rate-improve.
[66] *Id*.
[67] Proposed Rule at 12984.

documentation to confirm eligibility before coverage takes effect discourages people from enrolling and delays their coverage.[68] This is particularly true for people with low incomes, who are more likely to have inadequate internet access,[69] use a primary language other than English,[70] and face other barriers to submitting documentation.

The Department does not offer sufficient justification for this proposal. For example, it claims that there is evidence "suggesting an increase in the misuse and abuse of SEPs to gain coverage outside of the OEP" but fails to provide this evidence. And despite the Department's stated goal of reducing adverse selection, this policy may in fact have the opposite effect: Forcing applicants to jump through additional hoops may deter healthier people from enrolling in SEPs, leading some to decide to simply wait for the OEP to gain coverage, while those with more immediate health needs may be more motivated to complete the pre-enrollment verification process.[71]

IV. Prohibiting coverage of gender-affirming care as an EHB is harmful and unjustified [§ 156.115(d)].

The Department proposes to prohibit issuers subject to EHB requirements from covering health care for transgender people as an EHB. This policy would make it more difficult for transgender people to access to this necessary medical care, referred to here as gender-affirming care, and it runs contrary to statutory requirements for EHB benchmark plans. We urge the Department to withdraw this proposal.

a. Gender-affirming care is critical for many transgender people's wellbeing, but they often face barriers to accessing it.

Gender-affirming care is best practice medical care that many transgender people need in order to thrive. It is provided in an individualized, age-appropriate manner and according to well-established standards.[72] There is an overwhelming consensus among medical experts that gender-affirming care is necessary, effective, and safe. All major medical associations in the United States—including the American Medical Association, the American Psychological Association, the American Psychiatric Association, and American Academy of Family Physicians, the Endocrine Society, and the American Congress of Obstetricians and Gynecologists—have affirmed the need for access to this care.[73] In addition, a large body of research supports the safety,

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[68] 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.

[69] Kelly Wert, *Every State Identifies Broadband Affordability as Primary Barrier to Closing Digital Divide* (Oct. 4, 2024), https://www.pewtrusts.org/en/research-and-analysis/articles/2024/10/04/every-state-identifies-broadband-affordability-as-primary-barrier-to-closing-digital-divide.

[70] Sweta Haldar, *Overview of Health Coverage and Care for Individuals with Limited English Proficiency (LEP)* (Jul. 7, 2023), https://www.kff.org/racial-equity-and-health-policy/issue-brief/overview-of-health-coverage-and-care-for-individuals-with-limited-english-proficiency.

[71] *See* Fiedler, *supra* note 68.

[72] *See* Eli Coleman et al., *Standards of Care for the Health of Transgender and Gender Nonconforming People, Version 8*, 23 INTERNATIONAL JOURNAL OF TRANSGENDER HEALTH 1 (Sep. 6, 2022), https://doi.org/10.1080/26895269.2022.2100644.

[73] Advocates for Trans Equality, *Medical Organization Statements* (last accessed Mar. 27, 2025), https://transhealthproject.org/resources/medical-organization-statements.

effectiveness, and benefits of gender-affirming care for those who seek it: Access to gender-affirming care is associated with better overall wellness, improved mental health, and higher quality of life in both the short and long term, while inadequate access to care worsens transgender people's health outcomes.[74]

Despite the evidence supporting the necessity of this care, transgender people continue to face barriers to receiving it, including cost-related barriers. While the overall cost of gender-affirming care for issuers is negligible, for transgender individuals themselves, out-of-pocket costs can impose substantial burdens.[75] Cost-related barriers have outsized impacts given that transgender people, especially transgender people of color, are more likely to have lower incomes than cisgender people.[76] Barriers transgender people face to accessing care, including gender-affirming care, have in turn contributed to significant health disparities.[77]

b. The proposed rule would exacerbate the barriers to care and coverage that transgender people already face.

Prohibiting gender-affirming care from being covered as an EHB would lead to higher out-of-pocket costs for transgender people and discourage states from requiring coverage of this care. This in turn would exacerbate the barriers that transgender people already face to accessing care and affordable coverage.

If gender-affirming care is prohibited from being covered as an EHB, it loses numerous protections: This care would not be subject to limitations on cost-sharing, to the prohibition of annual or lifetime dollar caps, or to the prohibitions on nondiscriminatory EHB benefit design and implementation, while costs accrued would not be required to count towards deductibles or out-

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[74] *E.g.,* Sari L. Reisner et al., *Gender-Affirming Hormone Therapy and Depressive Symptoms Among Transgender Adults*, 8 JAMA NETWORK OPEN e250955 (Mar. 17, 2025), http://doi.org/10.1001/jamanetworkopen.2025.0955; Kellan E. Baker et al., *Hormone Therapy, Mental Health, and Quality of Life Among Transgender People: A Systematic Review*, 5 JOURNAL OF THE ENDOCRINE SOCIETY bvab011 (Feb. 2, 2021), https://doi.org/10.1210/jendso/bvab011; Jeremy A. Wernick et al., *A Systematic Review of the Psychological Benefits of Gender-Affirming Surgery*, 46 UROLOGIC CLINICS OF NORTH AMERICA 475 (2019), https://doi.org/10.1016/j.ucl.2019.07.002; Zoe Aldridge et al., *Long-Term Effect of Gender-Affirming Hormone Treatment on Depression and Anxiety Symptoms in Transgender People: A Prospective Cohort Study*, 9 ANDROLOGY 1808 (Nov. 2021), https://doi.org/10.1111/andr.12884; Diana M. Tordoff, et al., *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, 5 JAMA NETWORK OPEN e220978 (Feb. 25, 2022), http://doi.org/10.1001/jamanetworkopen.2022.0978.

[75] *See e.g.,* Kellan Baker & Arjee Restar, *Utilization and Costs of Gender-Affirming Care in a Commercially Insured Transgender Population*, 50 JOURNAL OF LAW, MEDICINE & ETHICS 456 (Nov. 2022), https://doi.org/10.1017/jme.2022.87. *See also* Caleb Smith & Haley Norris, *The LGBTQI+ Community Reported High Rates of Discrimination in 2024* (Mar. 12, 2025), https://www.americanprogress.org/article/the-lgbtqi-community-reported-high-rates-of-discrimination-in-2024 (finding that 45% of transgender people reported being unable to access needed health care due to cost in the previous year, three times the rate among non-LGBTQ people).

[76] *E.g.*, Lindsey Dawson et al., *Trans People in the U.S.: Identities, Demographics, and Wellbeing* (Sep. 28, 2023), https://www.kff.org/other/issue-brief/trans-people-in-the-u-s-identities-demographics-and-wellbeing; Sandy E. James et al., *The Report of the 2015 U.S. Transgender Survey* 144 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[77] *See, e.g.,* Caroline Medina et al., *Protecting and Advancing Health Care for Transgender Adult Communities* (Aug. 18, 2021), https://www.americanprogress.org/article/protecting-advancing-health-care-transgender-adult-communities/#Ca=10.

of-pocket maximums. As a result, transgender people would be saddled with a higher cost responsibility that many are unable to afford.

Meanwhile, states that require plans to cover this care could be required to defray it. Subjecting gender-affirming care to defrayal requirements could discourage states from adopting coverage requirements for gender-affirming care or enforcing their existing requirements. These impacts may reach not only the states that have specifically included gender-affirming care on their benchmark plans, but also the states that prohibit exclusions through laws and regulations. Twenty-four states and Washington, D.C., have interpreted federal and state nondiscrimination laws to prohibit insurers from excluding coverage for this care.[78]

c. The proposed rule conflicts with the prohibition on discrimination in EHB.

The proposed rule contradicts nondiscrimination requirements applying to EHB and benchmark plans on several counts. First, both under EHB-specific regulations[79] and under the nondiscrimination prohibitions of Section 504 of the Rehabilitation Act and Section 1557 of the Affordable Care Act, benchmark plans are prohibited from relying on benefit designs that discriminate based on disabilities or health conditions. Here, the Department proposes to single out one health condition—gender dysphoria—for differential treatment. As the Department itself alludes to,[80] care that is provided for the treatment of gender dysphoria is routinely covered for other conditions, including in EHB benchmark plans. For example, the same hormone therapy used in the treatment of gender dysphoria is provided to patients with endocrine disorders and menopausal symptoms, while the surgical procedures that may be used in a transgender person's care are regularly covered for purposes such as treating injuries or for cancer treatment or prevention. Under the proposed rule, benchmark plans must discriminate by excluding these and other services when they are used to treat one health condition (gender dysphoria) even when they cover them for other health conditions.

Benchmark plans are also prohibited from discriminating on the basis of sex under EHB-specific regulations[81] as well as under Section 1557. The Department notes that its term "sex-trait modification" refers to medical procedures "that attempt to transform an individual's physical appearance to align with an identity that differs from his or her sex."[82] In other words, the Department is promoting a policy that explicitly conditions the coverage of medical care in benchmark plans on the sex of the individual. For example, under the proposed rule, medically necessary hormone therapy may be covered as EHB for conditions other than gender dysphoria, when it is provided in a way deemed consistent with a patient's sex assigned at birth, but it may not be covered under the benchmark plan when it is provided to "align with an identity that differs

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[78] Movement Advancement Project, *Healthcare Laws and Policies* (last accessed Mar. 27, 2025), https://www.mapresearch.org/equality-maps/healthcare_laws_and_policies.

[79] 45 C.F.R. § 156.125(a). The nondiscrimination standards in this section are applied to benchmark plans through 45 C.F.R. § 156.110(d).

[80] Proposed Rule at 12987.

[81] 45 C.F.R. § 156.200(e) (applied to EHB at § 156.125(b)) (prohibiting discrimination based on "sex (which includes discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes)").

[82] Proposed Rule at 12986.

from [an enrollee's] sex," as assigned at birth. This policy discriminates based on sex even if the Department interprets sex discrimination to encompass only discrimination based on "a person's immutable biological classification as either male or female"[83]: Whether a treatment can covered as an EHB still turns on whether that treatment is believed to align with the enrollee's sex assigned at birth.

Finally, in order to comply with nondiscrimination requirements, EHB benefit designs must be "clinically-based."[84] As noted, an arbitrary exclusion of gender-affirming care conflicts with both the widely accepted standards of care and the overwhelming scientific evidence showing its benefits and efficacy. A prohibition on covering gender-affirming care as EHB would force states to adopt benefit designs in their benchmark plans that are contrary to clinical standards and evidence.

d. The Department fails to provide a reasoned justification for prohibiting coverage of gender-affirming care as an EHB.

None of the Department's proffered justifications for this provision are sufficient to prohibit coverage of gender-affirming care as an EHB. The Department initially points to two recent executive orders that attempt to limit the rights of transgender people, E.O. 14168 and E.O. 14187.[85] However, as the Department itself recognizes, these executive orders have been preliminarily enjoined.[86] Even if they had not been enjoined, these executive orders cannot override the existing prohibitions on discrimination in EHB. Thus, they cannot form the basis for the proposed policy.

The Department offers as its primary justification that this coverage "is not typically included in employer-sponsored plans."[87] But it provides no source for this conclusion other than state benchmark selections that were made more than a decade ago.[88] Typical employer plans (TEPs) have substantially evolved since then. Today, 72% of Fortune 500 companies—and 91% of all businesses rated in the 2025 Corporate Equality Index—cover gender-affirming care in their health plans.[89] By contrast, in 2014, the year of the benchmark selections the Department relies on, a mere 28% of the Fortune 500 offered transgender-inclusive benefits.[90] Additionally, a review of 2,138 silver Marketplace plan option across every state and Washington, D.C., found that the overwhelming majority of insurers—93%—covered gender-affirming care.[91]

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[83] *See* Proposed Rule at 12986.
[84] 45 C.F.R. § 156.125(a).
[85] Proposed Rule at 12986.
[86] *E.g., Washington v. Trump*, No. 2:25-CV-00244-LK, 2025 WL 659057 (W.D. Wash. Feb. 28, 2025); *PFLAG, Inc. v. Trump*, No. CV 25–337–BAH, 2025 WL 685124 (D. Md. Mar. 4, 2025).
[87] Proposed Rule at 12986.
[88] Proposed Rule at 12986.
[89] Human Rights Campaign Foundation, *Corporate Equality Index 2025* (Jan. 2025), https://reports.hrc.org/corporate-equality-index-2025.
[90] Human Rights Campaign Foundation, *Corporate Equality Index 2014* 9 (2013), https://assets2.hrc.org/files/assets/resources/CEI_2014_final_draft_7.pdf.
[91] Out2Enroll, *Summary of Findings: 2025 Marketplace Plan Compliance with Section 1557 of the Affordable Care Act* (2024), https://drive.google.com/file/d/1FpSNyaZVfC25o3zXnYBWUVaYRWokwbwg/view.

Additionally, even if TEPs did not widely cover gender-affirming care, the Department would not be compelled to prohibit coverage for this care as an EHB. The ACA's typicality standard should be understood only as setting a guideline for *minimum* benchmark coverage. Reading the typicality standard as setting a hard cap is contrary to the ACA's statutory language and purpose: TEPs have historically excluded coverage for the same services that the EHB provision was intended to expand, and using employer plans as the ceiling for coverage would perpetuate the gaps that persisted prior to the ACA. For example, NWLC research found that plans routinely excluded maternity care prior to the enactment of the ACA[92]; interpreting the typicality provision to allow benchmark plans to go no further than TEPs would undermine states' obligations to comply with the required coverage of these services. Using TEPs as a ceiling for coverage could limit states to matching inadequate coverage of EHBs, undermining the intent of the ACA and compromising access to care.

As an additional justification, the Department notes that "some stakeholders do not believe that sex-trait modification services fit into any of the 10 categories of EHB and, therefore, do not fit within the EHB framework even if some employers cover such services."[93] This is a red herring: Gender-affirming care consists of a range of treatments that fall into several EHB categories, including ambulatory patient services, hospitalization, mental health services, prescription drugs, and preventive services. Indeed, many of the services used for the treatment of gender dysphoria are routinely covered under these EHB categories for other indications.

The Department also suggests that it is "concerned about the scientific integrity of claims made to support" the provision of gender-affirming care.[94] This assertion—which the Department fails to substantiate with any evidence—runs contrary to the overwhelming weight of evidence demonstrating safety and effectiveness of gender-affirming care, the well-established, evidence-based standards supporting it, and the consensus of every major medical organization in the United States regarding the need to ensure access to it.[95]

The Department therefore fails to justify the substantial harms this proposal would have for transgender enrollees.

V. Conclusion

The proposed rule would create unwarranted hardships for consumers, increase barriers to eligibility and enrollment, and target populations that already face disparities in coverage and health outcomes. We urge the Department to withdraw this rule. Instead, it should prioritize implementing and strengthening the ACA, including by pursuing policy improvements that increase access to comprehensive coverage rather than decrease it.

Additionally, we note our concerns with the abbreviated comment period, which allowed only 23 days for comment from the time of publication in the Federal Register. This length of time falls

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[92] National Women's Law Center, *Turning to Fairness: Insurance Discrimination Against Women Today and the Affordable Care Act* 11 (2012), https://nwlc.org/wp-content/uploads/2022/09/Turning-to-Fairness-Report.pdf.
[93] Proposed Rule at 12987.
[94] Proposed Rule at 12987.
[95] *See supra* notes 73–74.

short not only of the standard 60-day comment period that is appropriate for complex rules such as this one, but even the minimum requirement of a 30-day comment period. This comment period is insufficient to allow the public to appropriately assess and respond to the rule.

We request that the supporting documentation we have made available through direct links in our citations be considered as part of the formal administrative record for purposes of the Administrative Procedure Act. If the Department does not intend to consider these materials part of the record as requested, we ask that you notify us and provide us with an opportunity to submit copies of the studies and articles into the record.

For further information, please contact us at the email address below.

Sincerely,

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