July 12, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Request for Information Regarding ACA Regulations (CMS-9928-NC)

To Whom It May Concern:

The National Center for Transgender Equality (NCTE) submits the following comments to emphasize the importance of maintaining protections for consumers under the Affordable Care Act (ACA). NCTE is one of the nation's leading social justice organizations working for life-saving change for the over 1.5 million transgender Americans and their families. In recent years, we have seen the positive and often life-saving impact that the ACA and its implementing rules have had on communities around the country, including transgender Americans and their loved ones. Regulations adopted by the Department of Health and Human Services have given many transgender people meaningful health care options where they previously had few or none at all, have helped address the pervasive discrimination transgender people often face in health care and coverage, and have made it possible for many transgender and non-transgender people alike to access essential care.

I. Rolling back consumer protections will not advance the RFI's stated goals, but other affirmative steps will

Undoing the critical progress we have all made in recent years would reduce consumer options, destabilize health care marketplaces, and put affordable care out of reach for millions of Americans. We therefore urge you to preserve the range of life-saving regulations the Department has previously adopted to implement the ACA. These include: **protections against punitive "continuous coverage" requirements** that penalize young adults, **protections from skimpy and misleading plans** that segment the market, **transparency rules** that consumers depend on to make informed choices, and the **common-sense nondiscrimination protections** set forth in 42 U.S.C. § 18116 (Section 1557 of the ACA).[1] The Section 1557 implementing rule helps protect millions of Americans, reflects a correct interpretation of the statute, and ensures covered entities have clear and consistent guidelines to comply with the law. We urge you in the strongest terms to preserve these and other ACA implementing rules and continue to enforce them to protect consumers.

While revisiting existing consumer protections is not an effective way to meet the stated goals of the Department's Request for Information (RFI), there are several affirmative steps that would greatly advance the goals of promoting consumer choice, affordability, market stability, and support for state regulators: (1) **committing to continue cost-sharing reduction (CSR) payments**, (2) **investing in and supporting consumer outreach, education, and marketing** of

[1] 45 C.F.R. § 92 (2016).

Healthcare.gov and consumers' health insurance options, and (3) **committing to enforce the ACA's individual coverage requirement**.

The remainder of these comments outline how *maintaining* consumer protections—and particularly the Section 1557 implementing rule—supports the stated goals of the RFI.

II. The ACA's consumer protections, including Section 1557 and its implementing rule, are critical to empowering patients and promoting consumer choice.

Millions of consumers, including those with employer-sponsored coverage, have benefited from existing HHS rules aimed at enhancing consumer choice and promoting informed decision-making, including the Section 1557 implementing rule. These protections are especially important for women, consumers with disabilities, racial and ethnic minorities, non-English speakers, and lesbian, gay, bisexual, and transgender (LGBT) consumers. Our comments will focused on transgender consumers.

An estimated 0.6% of the U.S. adult population—at least 1.4 million adults—is transgender.[2] The medical and scientific community overwhelmingly recognizes that a person's innate experience of gender is an inherent aspect of the human experience for all people, including transgender people.[3] Gender dysphoria is a serious medical condition affecting some transgender people that is defined in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM 5) as clinically significant distress or impairment related to an incongruence between one's experienced gender and the gender one was thought to be at birth.[4]

Like anyone, transgender people need preventive care to stay healthy and acute care when they become sick. Some may also need medical care to treat gender dysphoria. Under the treatment protocol widely accepted by the medical community, medically necessary treatment for gender dysphoria may require steps to help an individual transition from living as one gender to another. This treatment, sometimes referred to as "transition-related care," may include counseling, hormone therapy, and a variety of possible surgical treatments, depending on the individualized need of each patient.[5] It is the overwhelming consensus among major medical organizations—including the American Medical Association,[6] the American College of Physicians,[7] the American

---

[2] Andrew R. Flores et al., *How Many Adults Identify as Transgender in the United States?* (2016), http://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf. *See also* Jody L. Herman et al., *Age of Individuals who Identify as Transgender in the United States* (2017), https://williamsinstitute.law.ucla.edu/wp-content/uploads/TransAgeReport.pdf (estimating that 0.7% of people in the United States between the ages of 13 and 17, or 150,000 adolescents, are transgender).

[3] *See, e.g.*, World Prof'l Ass'n for Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* 16 (7th ed. 2011).

[4] Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* 452 (5th ed. 2013).

[5] *See* World Prof. Ass'n for Transgender Health, *supra* note 3,**Error! Bookmark not defined.** at 16.

[6] Am. Medical Ass'n, *AMA Policies on GLBT Issues, Patient-Centered Policy H-185.950, Removing Financial Barriers to Care for Transgender Patients* (2008).

[7] Am. College of Physicians, *Lesbian, Gay, Bisexual and Transgender Health Disparities: A Policy Position Paper from the American College of Physicians*, 163 ANNALS OF INTERNAL MEDICINE 135, 140 (2015).

Psychological Association,[8] the American Psychiatric Association,[9] the American Academy of Family Physicians,[10] the Endocrine Society,[11] the American College of Obstetricians and Gynecologists,[12] and the World Professional Association for Transgender Health[13]—that transition-related treatments are medically necessary, effective, and safe when clinically indicated to alleviate gender dysphoria. Numerous studies and meta-analyses have demonstrated the significant benefits of transition-related care in the treatment of gender dysphoria.[14]

Despite the medical consensus regarding the necessity of transition-related care, many transgender people have struggled to get access to medically necessary care—including care related to gender dysphoria as well as care for unrelated conditions. Before the Affordable Care Act and key implementing regulations were adopted, insurance companies frequently charged transgender people unaffordable premiums by designating gender dysphoria as a preexisting condition or refused to sell them health insurance entirely.[15] Moreover, until recently, insurance plans routinely included blanket exclusions barring coverage of care related to gender dysphoria regardless of medical necessity.[16] Many insurers also denied coverage for treatments that were entirely unrelated to gender dysphoria, like annual physician check-ups or treatment for a flu, simply because the beneficiary was transgender. These practices contributed to high uninsured rates among transgender people and routine denial of care among those who did have insurance.[17]

---

[8] Am. Psychological Ass'n, *Policy on Transgender, Gender Identity & Gender Expression Non-Discrimination* (2008).
[9] Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender and Gender Variant Individuals* (2012), https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2012-Transgender-Gender-Variant-Discrimination.pdf.
[10] Am. Acad. of Family Physicians, Resolution No. 1004 (2012), http://www.aafp.org/dam/AAFP/documents/about_us/special_constituencies/2012RCAR_Advocacy.pdf.
[11] Wylie C. Hembree et al., *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, 94 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3132 (2009).
[12] Am. College of Obstetricians & Gynecologists, *Committee Opinion No. 512: Health Care for Transgender Individuals*, 118 OBSTETRICS & GYNECOLOGY (2011).
[13] World Prof. Ass'n for Transgender Health, *supra* note 3.
[14] William Byne et al., *Report of the American Psychiatric Association Task Force on Treatment of Gender Identity Disorder*, 41 ARCHIVES OF SEXUAL BEHAVIOR 759 (2012); Marco Colizzi, Rosalia Costa & Orlando Todarello, *Transsexual Patients' Psychiatric Comorbidity and Positive Effect of Cross-Sex Hormonal Treatment on Mental Health: Results from a Longitudinal Study*, 39 PSYCHONEUROENDOCRINOLOGY 65 (2014); Audrey Gorin-Lazard et al., *Hormonal Therapy is Associated with Better Self-Esteem, Mood, and Quality of Life in Transsexuals*, 201 J. Nervous & Mental Disorders 996 (2013); M. Hussan Murad et al., *Hormonal Therapy and Sex Reassignment: A Systematic Review and Meta-Analysis of Quality of Life and Psychosocial Outcomes*, 72 CLINICAL ENDOCRINOLOGY, 214 (2010); Griet De Cuypere et al., *Sexual and Physical Health After Sex Reassignment Surgery*, 34 ARCHIVES OF SEXUAL BEHAVIOR 679 (2005); Giuloio Garaffa, Nim A. Christopher & David J. Ralph, *Total Phallic Reconstruction in Female-to-Male Transsexuals*, 57 EUROPEAN UROLOGY 715 (2010); Caroline Klein & Boris B. Gorzalka, *Sexual Functioning in Transsexuals Following Hormone Therapy and Genital Surgery: A Review*, 6 J. OF SEXUAL MEDICINE 2922 (2009).
[15] Kellan Baker, Laura E. Durso, & Andrew Cray, *LGBT Communities and the Affordable Care Act* (2013), https://cdn.americanprogress.org/wp-content/uploads/2013/10/LGBT-ACAsurvey-brief1.pdf.
[16] *Id.*
[17] Kellan Baker, Laura E. Durso, & Andrew Cray, *Moving the Needle: The Impact of the Affordable Care Act on LGBT Communities* (2014), https://cdn.americanprogress.org/wp-content/uploads/2014/11/LGBTandACA-report.pdf.

Numerous studies have documented the widespread extent of the discrimination experienced by transgender individuals and their families in the health system. For example, the U.S. Transgender Survey, a 2015 study of nearly 28,000 transgender adults in the United States, found that:

- Just in the year prior to taking the survey, one-third (33%) of respondents who saw a health care provider during that year were turned away because of being transgender, denied treatment, physically or sexually assaulted in a health care setting, or faced another form of mistreatment or discrimination due to being transgender.[18]
- In the year prior to taking the survey, one-quarter (25%) of respondents experienced a problem with their health insurance related to being transgender. This includes being denied coverage for treatments for gender dysphoria as well as being denied coverage for a range of unrelated conditions simply because they are transgender.[19]
- In the year prior to taking the survey, 23% of respondents avoided seeing a doctor when they needed it because of fear of being mistreated, and 33% avoided seeking necessary health care because they could not afford it.[20]

The U.S. Transgender Survey also revealed patterns of marked health disparities affecting respondents. Respondents were approximately five times more likely than the general population to have been diagnosed with HIV, with particularly elevated rates among black transgender women, who were over 60 times more likely to be living with HIV than the general population.[21] Standard questions based on the K-6 Kessler Psychological Distress Scale revealed that transgender respondents were approximately eight times more likely than the general population to have experienced serious psychological distress in the month prior to taking the survey.[22] Further, respondents were nearly twelve times more likely to have attempted suicide in the previous year than the general population.[23]

As the American Psychiatric Association states, "[b]eing transgender or gender variant implies no impairment in judgment, stability, reliability, or general social or vocational capabilities" that would indicate an inherent link between transgender identity and such health disparities.[24] Rather, studies indicate that these disparities result from experiences of discrimination and lack of access to necessary care. For example, studies of transgender youth who affirmed and supported by their families show no such disparities in psychological distress or health.[25] Expert sources such as the

---

[18] Sandy E. James et al., *The Report of the U.S. Transgender Survey* 96–97 (2016), www.ustranssurvey.org/report.
[19] *Id.* at 95. In the year prior to taking the survey, 55% of those who sought coverage for a transition-related surgery in 2015 were denied coverage by their insurance company.
[20] *Id.* at 98.
[21] *Id.* at 122.
[22] *Id.* at 105.
[23] *Id.* at 112.
[24] Am. Psychiatric Ass'n, *Position Statement on Discrimination Against Transgender and Gender Variant Individuals* (2012).
[25] Lily Durwood, Katie A. McLaughlin, & Kristina R. Olson, *Mental Health and Self-Worth in Socially Transitioned Transgender Youth*, J. OF THE AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY 56, 116 (2016); Kristina R. Olson, Lily Durwood, Madeleine DeMeules, & Katie A. McLaughlin, *Mental Health of Transgender Children who are Supported in Their Identities*, PEDIATRICS 137, 3223 (2015).

National Academy of Medicine (formerly Institute of Medicine),[26] and the Joint Commission[27] agree that discrimination and barriers to care contribute to the health disparities affecting transgender Americans, including by increasing transgender people's risk factors for poor physical and mental health,[28] driving high rates of HIV,[29] and obstructing access to preventive care.[30]

The ACA's implementing regulations, including the Section 1557 rule, have been essential in protecting and empowering consumers and increasing the health care and coverage choices available to them. The impact of these protections is reflected in the growth of insurance coverage among transgender people. While the uninsured rate among transgender people remains higher than that in the general population,[31] studies indicate that the uninsured rate among transgender people, as well as gay, lesbian, and bisexual people, has dropped dramatically since 2013.[32] Additionally, after the Section 1557 rule was published, a survey of nearly 900 insurance plans across 16 states found that the vast majority—over 95%—of insurers had removed their exclusions for treatments for gender dysphoria from their 2017 plans, ensuring that a greater number of transgender consumers can have access to medically necessary treatment without discrimination.[33] Despite this progress, transgender people continue to face routine discrimination in health care delivery and coverage. The robust enforcement of nondiscrimination protections under Section 1557, as well as other consumer protections under the law, is critical to ensure that they are able to access affordable, nondiscriminatory care.

---

[26] Inst. of Medicine, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (2011), http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx.

[27] Joint Comm'n, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the LGBT Community: A Field Guide* (2011), http://www.jointcommission.org/assets/1/18/LGBTFieldGuide.pdf.

[28] Ctr. for Disease Control & Prevention, *Lesbian, Gay, Bisexual, and Transgender Health* (July 2014), http://www.cdc.gov/lgbthealth/about.htm. *See also* Brief of Amicus Curiae Am. Acad. of Pediatrics, Am. Psychiatric Ass'n, Am. College of Physicians, and 17 Additional Medical and Mental Health Organizations in Support of Respondent, at 32, *Gloucester Cty Sch. Bd. v. G.G. ex rel. Grimm*, No. 16-273 (S.Ct., *filed* Mar. 2, 2017).

[29] Office of Nat'l AIDS Policy, "National HIV/AIDS Strategy," (2015), https://www.whitehouse.gov/administration/eop/onap/nhas.

[30] Fenway Institute, *Promoting Cervical Cancer Screening Among Lesbians and Bisexual Women* (2013), http://www.lgbthealtheducation.org/wp-content/uploads/Cahill_PolicyFocus_cervicalcancer_web.pdf.

[31] *See* Kellan Baker, Laura E. Durso, & Andrew Cray, *Moving the Needle: The Impact of the Affordable Care Act on LGBT Communities* 4 (2014), https://cdn.americanprogress.org/wp-content/uploads/2014/11/LGBTandACA-report.pdf; James et al., supra note 18, at 94.

[32] *See, e.g., id.* (finding that 35% of transgender respondents were uninsured in 2014, compared to 59% in 2013); Gary J. Gates, Gallup, *In U.S., LGBT More Likely Than Non-LGBT to Be Uninsured* (2014), http://www.gallup.com/poll/175445/lgbt-likely-non-lgbt-uninsured.aspx (documenting a sharp decline in LGBT uninsured rates since 2013). *See also* Michael Karpman, Laura Skopec, & Stacy Long, *QuickTake: Uninsurance Rate Nearly Halved for Lesbian, Gay, and Bisexual Adults Since Mid-2013*, Health Reform Monitoring Survey (Apr. 2015), http://hrms.urban.org/quicktakes/Uninsurance-Rate-Nearly-Halved-for-Lesbian-Gay-and-Bisexual-Adults-since-Mid-2013.html.

[33] Out2Enroll, *Summary of Findings: 2017 Marketplace Plan Compliance with Section 1557* (2017), https://out2enroll.org/out2enroll/wp-content/uploads/2015/10/Report-on-Trans-Exclusions-in-2017-Marketplace-Plans.pdf.

III. Maintaining critical consumer protections, including Section 1557 and its implementing rule, is necessary for market stability.

Existing consumer protections have provided clarity, certainty, and a level playing field for insurers. Weakening these core consumer protections would be disruptive for insurers who have already taken significant steps to come into compliance with the Section 1557 rule and would create an uneven playing field.

With respect to Section 1557 and its implementing rule, covered entities throughout the health care sector have overwhelmingly and successfully come into compliance with the rule. As noted above, for example, the vast majority—over 95%—of private marketplace plans have eliminated discriminatory exclusions targeting transgender consumers. These findings, though limited to coverage in the individual market, are consistent with significant momentum to offer coverage for transition-related care in the group market: 73% of the employers rated in the 2017 Corporate Equality Index—including 50 percent of fortune 500 businesses—offered transgender-inclusive health coverage, up from only 9% in 2010.[34]

The Section 1557 implementing rule provides a level playing field for insurers, clarity and consistency in the requirements they need to follow, and an incentive for uninsured individuals to obtain coverage by eliminating discriminatory policies across the board. Repealing the rule would create uncertainty for insurers who have already made changes to comply with the law. It would also create uncertainty for consumers, who will no longer have clarity about the extent of coverage they can expect, and would discourage enrollment by transgender consumers and their families, along with many others who depend on the protections of Section 1557.

IV. Consumer protections, including Section 1557 and its implementing rule, enhance affordability.

Repealing consumer protections, such as the 1557 implementing rule, would undermine affordability for consumers when they or their dependents have serious medical needs that are excluded under discriminatory benefit designs, or face other discriminatory treatment. Meanwhile, repealing the rule—and in particular, repealing the nondiscrimination protections for transgender people—would not enhance affordability. Numerous studies have shown, for example, that eliminating transgender exclusions has no significant effect on medical expenditures or premiums and can provide long-term savings. Private and public employers that have covered transition-related care for their employees have found it to be highly cost-effective.

When San Francisco eliminated its exclusion of care for gender dysphoria in 2001, the city responded to concerns about speculated costs by implementing a $1.70 premium surcharge for all employees. Actual cost and utilization data were so much less than expected that the surcharge produced a multi-million dollar surplus and the city eventually eliminated the

---

[34] Human Rights Campaign Found., *Corporate Equality Index 2017: Rating Workplaces on Lesbian, Gay, Bisexual and Transgender Equality* (2016), https://assets.hrc.org//files/assets/resources/CEI-2017-FinalReport.pdf?_ga=2.60591979.798758997.1494410054-188761714.1494410054.

surcharge entirely.[35] This experience has held true in numerous other states and localities that have similarly extended transgender-inclusive health care to employees and dependents. In an Economic Impact Assessment of its 2012 rule eliminating the exclusion state-wide, the California Department of Insurance concluded that "analysis of the potential increase in claim costs from the proposed regulation shows that any such costs are immaterial and insignificant."[36]

Where state Medicaid programs have assessed the cost of covering transition-related care, minimal costs have been observed or expected. In Oregon, for instance, the Oregon Health Authority used utilization and cost data to estimate that the per member per month cost of covering transition-related care—including hormone therapy and surgeries—would be $0.20 to $0.50 for a total cost of $100,000 to $150,000 per year.[37] Overall, the report concluded that the cost of adding hormone therapy "would likely be minimal to the [Medicaid] program" and the cost of adding transition-related surgeries would be "higher than that of cross-sex hormone therapy alone, but still very low."[38] Policymakers also noted the potential for cost savings through reduced suicide attempts.[39]

Private companies have also reported minimal economic impact from providing equal coverage for transgender employees. The Human Rights Campaign's Corporate Equality Index reports that for the 647 employers included in their survey who did so, eliminating exclusions "comes at an overall negligible cost to the employers' overall health insurance plans. This holds true across industries."[40] A survey of employers by the Williams Institute at the UCLA School of Law found that transition-related health care benefits have "zero or very low costs" and low utilization, with utilization rates estimated at 1 per 10,000 to 20,000 employees.[41] The report concludes: "Overall, we find that transition-related health care benefits have very low costs, have low utilization rates by employees, and yet can provide benefits for employers and employees alike."[42] More than fifty leading universities and colleges, including state universities in at least 16 states, have similarly found that it is cost-effective to provide this coverage in their student health plans.[43]

Failing to adequately treat gender dysphoria can result in negative health outcomes that are not only personally adverse, but costly for plans and ultimately for all consumers through their premiums. The California Economic Impact Assessment found that eliminating transgender

---

[35] San Francisco Human Rights Comm'n, *San Francisco City and County Transgender Health Benefit* (2007), http://www.hrc.org/files/assets/resources/San_Francisco_City_and_County_Transgender_Health_Benefit_-_2007-08-10.pdf.

[36] Ca. Dep't of Ins., *Economic Impact Assessment: Gender Nondiscrimination in Health Insurance* (2012), http://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf.

[37] Or. Health Review Comm'n, Value-based Benefits Subcommittee, http://www.oregon.gov/oha/herc/CommitteeMeetingMaterials/VbBS%20Materials%206-12-2014.pdf (June 12, 2014).

[38] *Id.*

[39] *Id.*

[40] Human Rights Campaign, *Corporate Equality Index 2017: Rating American Workplaces on Lesbian, Gay, Bisexual, and Transgender Equality* 26 (2016).

[41] Jody L. Herman, *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefit Plans: Findings from a Survey of Employers* (2013), http://williamsinstitute.law.ucla.edu/wp-content/uploads/Herman-Cost-Benefit-of-Trans-Health-Benefits-Sept-2013.pdf.

[42] Ibid. at 17.

[43] Campus Pride, *Trans Policy Clearinghouse: Colleges and Universities that Cover Transition-Related Medical Expenses under Student Health Insurance* (2017), http://www.campuspride.org/tpc-student-health-insurance.

exclusions could create cost savings, including "lower costs associated with the high cost of suicide and attempts at suicide, overall improvements in mental health and lower rates of substance abuse," and "will not only save insurers from the costs associated with suicide, but prevent significant numbers of transgender insureds from losing their lives."[44]

V. The Section 1557 rule reflects the mandatory requirements of federal law as interpreted by a clear majority of federal courts, and does not impede or interfere with the traditional regulatory authority of states.

We are supportive of the traditional regulatory role of the state in regulating the business of insurance and have worked successfully with many state regulators to adopt state-specific standards and model laws that work best for the consumers they serve. At the same time, consumers need a strong federal and state partnership and minimum federal standards they can rely on no matter what state they live in. Many of these minimum standards are established in federal regulations, which are key to protecting consumers and should not be changed. State regulators already have considerable flexibility under federal and state law when implementing and enforcing these minimum federal standards.

Revisiting consumer-protection rules that implement mandatory statutory requirements, such as prohibition of discrimination under Section 1557, would be particularly unnecessary, inappropriate, and unhelpful to state regulators. The Department based its Section 1557 implementing rule on legal interpretations of the majority of courts that have addressed the relevant issues, as well as the interpretations of other federal agencies over many years and, for some parts of the rule, decades. Many state regulators nationwide have relied on the ACA's protections, as well as their own state laws, to better ensure, for example, that consumers with high-risk conditions such as HIV have access to affordable prescription drugs and eliminate the use of exclusions that discriminate against transgender people.[45]

With respect to transgender Americans, the implementing rule affirms what has already been recognized by the vast majority of federal courts to have considered the issue: discrimination based on the fact that an individual is transgender is necessarily a form of sex discrimination. Over nearly two decades, numerous federal district and appeals courts have repeatedly affirmed that federal sex discrimination laws such as Section 1557 prohibit discrimination based on being transgender.[46] Most courts that have been presented with the question of whether Section 1557's

---

[44] Cal. Dep't of Ins., *Economic Impact Assessment: Gender Nondiscrimination in Health Insurance* (2012), 9, 11.
[45] *See, e.g.*, Kellan E. Baker, *The Future of Transgender Coverage*, N. ENGL. J. MED. 376, 1801 (2017); Ron Hurtibise, *State Tells Insurers to Limit Co-pays for HIV/AIDS Drugs*, FLA. SUN SENTINEL (Jul. 1, 2015); Sally McCarty, *Regulatory Activity in Two States Restricts How Plans Structure Specialty Drug Coverage*, CHIIRBLOG (Jan. 21, 2015); 45 C.F.R. § 92.201 et seq.; Nat'l Health Law Program & AIDS Inst., Discriminatory Pharmacy Benefits Design in Select Qualified Health Plans Offered in Florida, Administrative Complaint to HHS Office for Civil Rights (May 29, 2014).
[46] *See, e.g.*, Whitaker v. Kenosha Unified Sch. Dist., No. 16-3522 (7th Cir. 2017) (Title IX); Glenn v. Brumby, 663 F.3d 1312 (11th Cir. 2011) (sex discrimination under Equal Protection Clause); Barnes v. City of Cincinnati, 401 F.3d 729 (6th Cir. 2005) (Title VII of the 1964 Civil Rights Act); Smith v. City of Salem, 378 F.3d 566 (6th Cir. 2004) (Title VII); Rosa v. Park West Bank & Trust Co., 214 F.3d 213 (1st Cir. 2000) (Equal Credit Opportunity Act); Schwenk v. Hartford, 204 F.3d 1187 (9th Cir. 2000) (Gender Motivated Violence Act); Smith v. Avanti, --- F.Supp.3d ----2017 WL 1284723 (D. Colo. Apr. 5, 2017) (Fair Housing Act)Evancho v. Pine-Richland Sch. Dist., --- F.Supp.3d ---, 2017 WL 770619 (W.D. Pa. Feb. 27, 2017) (Equal Protection Clause); Mickens v. Gen. Elec. Co.,

sex discrimination prohibition specifically covered anti-transgender discrimination have firmly ruled that it does.[47] While a judge presiding over *Franciscan Alliance v. Burwell* issued a preliminary injunction related to certain provisions of Section 1557, this preliminary ruling from a single district court conflicts with the overwhelmingly majority view of the federal courts over many years, and the Department should accordingly be defending this legally sound rule in court.[48]

VI. The Section 1557 implementing rule is the product of a lengthy process of deliberation and public input.

As well as being firmly grounded in a large body of case law, the Section 1557 rule emerged after years of consideration and stakeholder input. The Department developed this rule over the course of six years of study and extensive consultation with a wide range of stakeholders. The Department based its rule on legal interpretations of the majority of courts addressing the relevant issues; the interpretations of other federal agencies over several years; regulatory approaches taken by states[49]; the positions of major medical associations; documented

---

No. 16-603, 2016 WL 7015665 (W.D. Ky. Nov. 29, 2016) (Title VII); Students & Parents for Privacy v. U.S. Dep't of Educ., No. 16-cv-4945, 2016 WL 6134121 (N.D. Ill. Oct. 18, 2016) (Title IX); Bd. of Educ. of Highland Local Sch. Dist. v. U.S. Dep't of Educ., 208 F.Supp.3d 850 (S.D. Ohio 2016), *stay pending appeal denied sub nom.* Dodds v. U.S. Dep't of Educ., 845 F.3d 217 (6th Cir. 2016) (Title IX, Equal Protection Clause); Fabian v. Hosp. of Cent. Conn., 172 F.Supp.3d 509 (D. Conn. 2016) (Title VII); U.S. v. S.E. Okla. State Univ., No. CIV–15–324–C, 2015 WL 4606079 (Title VII); Finkle v. Howard Cty., 12 F.Supp.3d 780 (D. Md. 2014) (Title VII); Schroer v. Billington, 577 F. Supp. 2d 293 (D.D.C. 2008) (Title VII); Lopez v. River Oaks Imaging & Diagnostic Grp., Inc., 542 F.Supp.2d 653 (S.D. Tex. 2008) (Title VII); Mitchell v. Axcan Scandipharm, Inc., No. Civ.A. 05-243, 2006 WL 456173 (W.D. Pa. 2006) (Title VII); Tronetti v. Healthnet Lakeshore Hosp., No. 03–CV–0375E, 2003 WL 22757935 (W.D.N.Y. Sept. 26, 2003) (Title VII). *See also* Hively v. Ivy Tech, 853 F.3d 339 (7th Cir. Apr. 4, 2017) (en banc) (citing gender identity cases favorably and holding that sexual orientation discrimination constitutes sex discrimination); Hunter v. United Parcel Service, 697 F.3d 697, 703 (8th Cir. 2012) (assuming gender identity claims are covered under Title VII); Tovar v. Essentia Health, 857 F.3d 771 (8th Cir. May 24, 2017) (same under Title VII and ACA). *But see* Etsitty v. Utah Transit Auth., 502 F.3d 1215 (10th Cir. 2007) (relying on now-overturned Seventh Circuit precedent to hold that anti-transgender discrimination is not covered per se under Title VII but may be covered as sex stereotyping discrimination).

[47] *E.g.*, Rumble v. Fairview Health Servs., No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015); Cruz v. Zucker, 195 F.Supp.3d 554 (S.D.N.Y. 2016).

[48] 2016 WL 7638311 (N.D. Tex. Dec. 31, 2016).

[49] For example, eighteen states and the District of Columbia have taken regulatory action to explicitly prohibit exclusions that discriminate against transgender consumers. 10 Cal. Code Reg. § 2561.2 (2012); Cal. Dep't of Managed Health Care, Letter No. 12-K, *Gender Nondiscrimination Requirements* (2013); Div. of Ins., Colo. Dep't of Regulatory Agencies, Bull. No. B-4.49, *Insurance Unfair Practices Act Prohibitions on Discrimination Based upon Sexual Orientation* (2013); Conn. Ins. Dep't, Bulletin No. IC-37, *Gender Identity Nondiscrimination Requirements* (2013); Ill. Dep't of Ins., Company Bulletin No. 2014-10, *Healthcare for Transgender Individuals* (2014); Mass. Office of Consumer Affairs & Bus. Regulation, Div. of Ins. Bulletin No. 2014-03, *Guidance Regarding Prohibited Discrimination on the Basis of Gender Identity or Gender Dysphoria Including Medically Necessary Transgender Surgery and Related Health Care Services* (2014); Minn. Dep't of Commerce & Dep't of Health, Administrative Bulletin 2015-5 (November 24, 2015); Nev. Div. of Ins., Bulletin No. 15-002 (June 25, 2015); Or. Ins. Div., Bulletin No. INS 2012-1, *Application of Senate Bill 2 (2007 Legislative Session) to Gender Identity Issues in the Transaction & Regulation of Insurance in Oregon* (2012); R.I. Health Ins. Comm'n, Health Bulletin 2015-3 (Nov. 23, 2015); Dep't of Fin. Regulation, Div. of Ins., Bulletin No. 174, *Guidance Regarding Prohibited Discrimination on the Basis of Gender Identity Including Medically Necessary Gender Dysphoria Surgery and Related Health Care* (2013); Wash. Comm'r of Ins., *Letter to Health Insurance Carriers in Washington*

experiences of discrimination from transgender consumers as well as complaints and investigations of discriminatory practices; and medical and cost research. It engaged stakeholders through listening sessions, participation in conferences, and other outreach prior to taking regulatory action. The proposed rule in 2015 was preceded by a 2013 Request for Information with a public comment period. The proposed rule received comments from nearly 25,000 individuals and organizations, which were overwhelmingly supportive. Reopening such a recent rule following years of consideration and study, particularly without a change in the underlying law or facts, would create unnecessary confusion and uncertainty for covered entities, patients, and their families. In these circumstances, such a reversal would also raise serious concerns under the Administrative Procedures Act.

VII. Adding new religious exemptions to Section 1557 is unnecessary, harmful, and outside the scope of the Department's authority.

When considering whether the Section 1557 rule adequately protects religious freedom, it is important to emphasize that the rule already incorporates a range of existing religious exemptions excepting covered entities from requirements that conflict with their religious or moral beliefs in a wide variety of circumstances. Adding additional exemptions, from requirements related either to sex discrimination or to discrimination based on any other ground, is unnecessary, harmful to consumers, and exceeds the Department's authority under the statute.

The Section 1557 rule explicitly notes that the nondiscrimination provisions in the law are subject to a range of religious exemptions: "Insofar as the application of any requirement under this part would violate applicable Federal statutory protections for religious freedom and conscience, such application shall not be required."[50] These statutory protections include the Religious Freedom Restoration Act[51] and provider conscience laws,[52] as well as provisions in the ACA that specifically permit health providers and facilities to refuse to provide abortion-related care[53] and regulatory exemptions related to preventive services like contraceptive care.[54] These existing laws already exempt numerous providers from provisions in the ACA and Section 1557 in particular, and expanding this range of legal exemptions is wholly unnecessary.

It is also important to underscore the harms to consumers that may result from more expansive religious exemptions. Exemptions broader than those recognized by the existing rule would permit providers to refuse to treat someone—regardless of medical necessity or of the type of treatment being sought—simply because they are transgender or because of other characteristics, like their religion, gender, or HIV status. Such religious exemptions can result in care being denied or delayed for many individuals, putting their health and in some cases their lives in danger. This problem is particularly exacerbated in situations where individuals have a limited choice or opportunity to shop around for a health care provider that will provide them with the care they need, such as in emergencies, in rural areas, or in areas where hospitals are increasingly run by

---

State (June 25, 2014); D.C. Dep't of Ins., Sec., & Banking, Bulletin No. 13-IB-01-30/15 (Revised), *Prohibition of Discrimination in Health Insurance Based on Gender Identity or Expression* (2014).

[50] 45 C.F.R. pt. 92.2(b)(2).

[51] 42 U.S.C. 2000bb–1.

[52] *E.g.,* 42 U.S.C. 300a–7; 42 U.S.C. 238n.

[53] *E.g.,* 42 U.S.C. 18023.

[54] *E.g.,* 45 CFR 147.131.

religiously affiliated institutions. Attempting to add new religious exemptions via regulation could cause great harm to members of the vulnerable populations that Section 1557 is intended to protect.

Further, nothing in Section 1557's statutory language permits HHS to add new religious exemptions beyond those that already exist in the ACA and other federal laws. Doing so would be contrary to the ACA's clear intent and Section 1557's overriding purpose of protecting consumers from discrimination in health care. Reading additional exceptions into a statute where Congress already contemplated and enumerated specific exceptions, contrary to fundamental principles of statutory construction,[55] would exceed HHS' authority in implementing the law as written.

VIII. HHS should revisit portions of the recent Market Stabilization rule that may undermine HHS's stated goals.

HHS should revise, or at least gather information to assess the impact of, provisions of the recent "Market Stabilization" rule that undermine consumer choice and affordability and actually have the potential to create problems for market stability.

First, the Department should reverse its rule permitting states to assess qualified health plans ("QHPs") provider networks. The ACA requires health plans to maintain a network that is sufficient in number and types of providers to assure that all covered services are accessible without unreasonable delay, and ACA requires the Secretary to establish network adequacy requirements for insurers seeking QHP certification.[56] Consumer experiences in accessing providers vary across states, with various states assessing travel time and distance, provider-to-enrollee ratios, appointment wait times, or hours of operation.[57] The Department's decision to allow states to assess their own network adequacy will likely reduce consumer choice. To ensure that Marketplace enrollees across the country have timely access to appropriate, geographically accessible providers who can deliver the health services covered under their plans, the Department should establish and maintain a national network adequacy standard.

Seconds, limitations on special enrollment periods have the potential to deter enrollment by eligible consumers. The Department should collect balanced and actionable information to help determine whether current rules are working or need to be adjusted. It will be particularly important to collect data on the extent to which special enrollment period (SEP) verification deters enrollment of SEP-eligible people, especially those who are healthier. Similarly, the Department should analyze whether shortening the open enrollment period from three months to six weeks in the Market Stabilization rule results in decreased enrollment.

---

[55] *See, e.g.*, U.S. v. Smith, 499 U.S. 160 (1991).

[56] 42 U.S.C. § 18031(c)(1)(B); *see also* § 156.230(a)(2) (requiring all issuers offering Marketplace plans to maintain a network that is sufficient in number and types of providers to assure that all covered services are accessible without unreasonable delay).

[57] Justin Giovanelli, Kevin v. Lucia, & Sabrina Corlette, *Implementing the Affordable Care Act: State Regulation of Marketplace Plan Provider Networks* (2015), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/may/1814_giovannelli_implementing_aca_state_reg_provider_networks_rb_v2.pdf.

Conclusion

We strongly urge you to refrain from reopening, repealing, or modifying rules that ensure that all Americans can enjoy the life-saving benefits of the ACA. Maintaining existing consumer protections best serves the stated goals of the RFI. The Department should take additional actions to advance these goals, including committing to continue CSR payments and enforce the law's individual coverage requirement, and fully funding and supporting consumer outreach, education, and marketing.

Thank you for your consideration.