

**UNITED STATES OF AMERICA
BEFORE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES**

**Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment
Parameters for 2024
Agency Docket No. CMS-9899-P, RIN 0938-AU97**

**Comments of the Federal LGBTQI Health Policy Roundtable and the LGBTQIA+
Primary Care Alliance**

Pursuant to the Department’s December 21, 2022, notice, 87 Fed. Reg. 244, the Federal LGBTQI Health Policy Roundtable and the LGBTQIA+ Primary Care Alliance submit these comments on the Department of Health and Human Services (hereinafter HHS or the Department) and Centers for Medicare & Medicaid Services (CMS) Notice of Benefit and Payment Parameters for 2024 under the Patient Protection and Affordable Care Act (ACA).

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Interest and Expertise of Commenters

The Federal LGBTQI Health Policy Roundtable is a coalition of community health centers and national advocacy organizations that share a focus on laws and policies that affect the health well-being of lesbian, gay, bisexual, transgender and nonbinary, queer, and intersex (LGBTQI) populations. Individually and collectively, our organizations work with agencies and offices within the Department – and with other parts of the Administration – to promote legal reforms and federal policies that advance the health and dignity of sexual and gender diverse people. Our community health center members provide primary health care, gender-affirming care, HIV specialty care, and mental health and substance use treatment services to many tens of thousands of individuals and families, many of whom identify as lesbian, gay, bisexual, transgender, queer, or nonbinary. These centers have years of experience helping patients navigate the complexities of the ACA and the health insurance marketplaces and to enroll in Qualified Health Plans (QHPs). Our membership also includes national advocacy organizations representing LGBTQI communities throughout the country.

The LGBTQIA+ Primary Care Alliance includes Federally Qualified Health Centers (FQHCs), State Primary Care Associations, community health centers, and other health care organizations and providers throughout the nation. Alliance members specialize in best practices for providing culturally responsive and compassionate health care and related services for persons identifying as lesbian, gay, bisexual, transgender and gender diverse, queer, intersex, and/or asexual or on the ace spectrum (LGBTQIA+). The Alliance members joining in these comments collectively serve several hundred thousand individuals and families every year, in the Northeast, Mid-Atlantic, Midwest, South, and West. Our members also advocate for federal, state, and local laws and public policies that advance the health and well-being of sexual and gender diverse people, with particular emphasis on persons of color, immigrants, people with disabilities and chronic illnesses, low-income individuals and families, transgender and gender diverse persons, sex workers, drug users, and other particularly marginalized communities.

Comments

Payment HCC for Gender Dysphoria

We appreciate the opportunity to respond to the request for information on a possible payment Hierarchical Condition Category (HCC) for gender dysphoria. Gender dysphoria is a recognized medical condition that can seriously affect the health and well-being of transgender people. While we share the goal of ensuring that people with gender dysphoria can access coverage for the medically necessary health care services they need—which are robustly supported by the scientific literature and more than five decades of medical practice—we do not believe that an HCC for gender dysphoria is likely to serve that goal under current circumstances in the U.S. health care system. We are also concerned that risk adjustment for gender dysphoria may inappropriately reinforce the perception that transgender identity should inherently be pathologized as a medical

condition, rather than as a natural variation in human identity and experience. We therefore do not support further consideration of such an HCC at this time.

In considering the appropriateness of risk adjustment for gender dysphoria, we referred to the ten principles outlined by CMS in the 2014 Notice of Benefit and Payment Parameters Rule. Below we discuss each of the principles that led us to determine that an HCC for gender dysphoria is not warranted at this time.

Principle 1—Diagnostic categories should be clinically meaningful. Gender dysphoria is recognized as a serious medical condition in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the International Classification of Diseases (ICD), as well as by every major U.S. medical professional association. The primary means of coding for gender dysphoria in the U.S. is a series of mental health condition codes (F64.x) in the 10th edition of the ICD (ICD-10). A history of discriminatory insurance exclusions for the treatment of gender dysphoria, however, has long discouraged U.S. clinicians from using these codes, and some clinicians have resorted to using non-specific codes such as E34.9 (endocrine disorder, unspecified) to capture a need for gender-affirming care without flagging the patient as transgender. While there are indications that the F64.x series codes are being used more often as blanket exclusions of coverage for gender-affirming care receded over the past decade, the current political landscape in the U.S. is increasingly hostile to transgender people and their health care needs. As such, it is impossible to determine whether coding practices will reliably move in the direction of more consistent and accurate coding for gender dysphoria, or whether these codes will once again be avoided by many clinicians and patients—potentially in differential patterns based on state laws—for fear of triggering a transgender-specific coverage exclusion or disclosing a patient’s transgender identity to state authorities.

Further, in the continuing absence of patient self-reported data on transgender status in most U.S. health care organizations, some clinicians append codes for gender dysphoria to claims for encounters where care is provided to a transgender person for purposes other than gender affirmation. The misapplication of these codes merely to identify a transgender person rather than to indicate the provision of a service to treat gender dysphoria dilutes the clinical relevance of these codes for risk adjustment purposes.

Finally, the existing codes do not differentiate among appropriate treatment courses for gender dysphoria or incongruence and thus do not specify uniform clinical trajectories that would justify risk adjustment. The expert *Standards of Care for the Health of Transgender and Gender Diverse People* (Version 8, 2022)¹ emphasizes that the course of care for gender dysphoria is highly individualized and that determinations of medical necessity should be made by providers in close consultation with individual patients: while some people with gender dysphoria may need mental

¹ World Professional Association for Transgender Health. (2022). *Standards of Care for the Health of Transgender and Gender Diverse People* (8th Version). 23 Int’l J. Trans. Health Supp. 1. <https://doi.org/10.1080/26895269.2022.2100644>

counseling, hormone therapy, and surgeries, others may need only some or none of these services. The course of care for gender dysphoria is also very different not only between individuals but by age: for pre-pubescent children, the only medical intervention that may be indicated is mental health counseling to assist the child and their family in exploring the child's gender through non-medical interventions such as social support. For adolescents, gender affirmation may include mental health support as well as puberty delay medications and eventually exogenous hormone therapy; surgeries are generally not indicated for adolescents and are only performed very rarely and in the presence of severe and debilitating gender dysphoria that is not alleviated by other care alone. For adults, the course of gender-affirming care may include a combination of mental health support, hormone therapy, and surgeries.

In the F64.x code series in the ICD-10, however, while support for children with gender dysphoria is captured in the code F64.2 (gender identity disorder of childhood), care for adolescents versus adults and between patients with differing degrees of clinical severity is not differentiated by the F64.0 (transsexualism), F64.8 (other gender identity disorder), and F64.9 (gender identity disorder, unspecified) codes. The ICD-11 code series maintains this approach with the codes HA60 (gender incongruence of adolescence or adulthood), HA61 (gender incongruence of childhood), and HA6Z (gender incongruence, unspecified). Moreover, the ICD-10 codes currently in use in the U.S. to describe the presence of gender dysphoria or a need for gender-affirming care also include the highly non-specific codes Z87.890 (personal history of sex reassignment) and F64.1 (dual-role transvestism).

For these reasons, we do not believe that coding for gender dysphoria/incongruence as reflected by the DSM-5, ICD-10, or ICD-11 frameworks currently captures discrete clinical trajectories to a degree sufficient to justify risk adjustment under this principle.

Principle 2—Diagnostic categories should predict medical expenditures. Putative claims of higher health care costs are routinely used against transgender people to argue that coverage for gender dysphoria is a burden on the health care system and should be restricted or eliminated. The available evidence shows, however, that removing exclusions of coverage for gender dysphoria from insurance plans is cost-neutral or extremely low-cost. The City and County of San Francisco initially raised premiums when they became the first major U.S. employers to remove blanket exclusions for gender-affirming care in 2001. But after five years, “beneficial cost data led Kaiser and Blue Shield to no longer separately rate and price the transgender benefit—in other words, to treat the benefit the same as other medical procedures such as gallbladder removal or heart surgery.”² A 2013 survey of employers providing coverage for gender-affirming care to their employees found that two-thirds of the employers that provided information on the actual costs of utilization of gender dysphoria treatments reported zero costs, and those employers who reported

² City and County of San Francisco Human Rights Commission, *San Francisco City and County Transgender Health Benefit* (Aug. 7, 2007), https://transhealthproject.org/documents/19/SF_transgender_health_benefit.pdf

some costs said that the costs were very low or minimal.³ An analysis of gender-affirming care uptake by transgender people over 6.5 years in one California health plan found a utilization rate of 0.062 per 1,000 covered persons.⁴ Estimates from other states show equally low utilization and related low costs, with North Carolina estimating costs at 0.011% to 0.027% of premiums;⁵ Alaska, 0.03% to 0.05%;⁶ and Wisconsin, “immaterial at 0.1% to 0.2% of the total cost.”⁷ Cost estimates under Wisconsin Medicaid were “actuarially immaterial, as they are equal to approximately 0.008% to 0.03%”⁸ of Wisconsin’s share of its Medicaid budget. Similarly, an analysis in the military context concluded that the financial cost of covering gender-affirming care was “too low to matter”⁹ or, as military leadership noted, “‘budget dust,’ hardly even a rounding error.”¹⁰ This is because only a small percentage of the U.S. population is transgender, and, as noted above, not all transgender people need or use a full scope of services related to the treatment of gender dysphoria.

While we support continuing research to better understand patterns of utilization and expenditures in relation to gender dysphoria, we note that efforts to conduct this research can be susceptible to inherent bias that stems from the fact that, in the absence of self-reported demographic data on transgender status that can be linked to claims data, transgender people can only be identified through encounters with the health care system that result in the generation of claims and related costs. As such, claims data analyses may paint a distorted picture in which transgender people appear to use more health care services and incur higher costs in comparison to people who may have very low or zero utilization and who are presumed to be cisgender due to the absence of codes for gender dysphoria. Any future analyses assessing possible relationships between gender dysphoria and health care costs should rely on self-reported data on transgender status so that transgender and cisgender enrollees can be fairly compared, and they should use long time horizons and incorporate potential cost-savings in long-term mental health and surgical needs that may be realized by timely treatments such as puberty delay medications in adolescence.

³ Herman JL, The Williams Institute, *Costs and Benefits of Providing Transition-Related Health Care Coverage in Employee Health Benefits Plans: Findings From a Survey of Employers* (Sept. 2013), <https://escholarship.org/content/qt5z38157s/qt5z38157s.pdf?t=n2ff2l>.

⁴ State of California Department of Insurance, *Economic Impact Assessment: Gender Nondiscrimination in Health Insurance*, Reg. File No. REG-2011-00023 (Apr. 13, 2012), at 5, <http://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf>

⁵ Segal Consulting memorandum to Mona Moon, Executive Administrator of the North Carolina State Health Plan, re: Transgender Cost Estimate, Nov. 29, 2016, <https://files.nc.gov/ncshp/documents/board-of-trustees/3aii-3-The-Segal-Company-Transgender-Cost-Estimate-Memorandum.pdf>

⁶ Plaintiffs’ Motion for Partial Summary Judgment, *Fletcher v. Alaska*, No. 1:18-cv-00007-HRH (D. Alaska July 1, 2019), https://www.lambdalegal.org/sites/default/files/legal-docs/downloads/fletcher_ak_20190701_plaintiffs-motion-for-partial-summary-judgment.pdf

⁷ *Boyden v. Conlin*, 341 F. Supp. 3d 979, 1000 (W.D. Wis. 2018).

⁸ *Flack v. Wis. Dept of Health Servs.*, 395 F. Supp. 3d 1001, 1008 (W.D. Wis. 2019).

⁹ Belkin A. Caring for our transgender troops – The negligible cost of transition-related care, 2015 *New Eng J Med* 373:1089-1092, at 1092, <https://www.nejm.org/doi/full/10.1056/NEJMp1509230>.

¹⁰ Declaration of Raymond Edwin Mabus, Jr., Former U.S. Secretary of the Navy, in Support of Plaintiff’s Motion for Preliminary Injunction, *Doe v. Trump*, No. 17-cv-1597-CKK (D.D.C.) filed Aug. 31, 2017, at 41), available at <http://files.eqcf.org/wp-content/uploads/2017/09/13-Ps-App-PI.pdf>

Principle 3—Diagnostic categories that will affect payments should have adequate sample sizes to permit accurate and stable estimates of expenditures. Transgender people are estimated to make up less than 1% of the U.S. population.¹¹ In claims data analyses, the prevalence of people presumed to be transgender based on the presence of codes for gender dysphoria is typically a tiny fraction of a percent.¹² When these already small cohorts are broken down by age to more accurately reflect potential differences in expenditures, the sample sizes for predicting costs become even smaller. Widespread and consistent collection of demographic data on transgender status, as recommended by a 2022 report from the National Academies of Sciences, Engineering, and Medicine,¹³ and linkages of these data with information on health care utilization and expenditures are needed to even begin to build sample sizes that would be sufficient to satisfy this principle.

Principle 10—Discretionary diagnostic categories should be excluded from payment models. As discussed in relation to Principle 1, a great deal of variation currently exists in the degree to which clinicians are aware of the appropriate application of codes for gender dysphoria treatment. Moreover, given elements of the current U.S. political environment that increasingly threaten the safety of transgender people and the providers who care for them, coding practices are unlikely to soon stabilize across age groups, states, and insurance programs. Until transgender people are afforded sufficient protection from discrimination in health coverage and care—and until their health care needs are correctly viewed as legitimate and justified on the basis of the scientific literature that has established the medical necessity of this care—gender dysphoria codes will continue to be treated by providers and patients alike as not only discretionary but potentially dangerous.

Finally, we note that there is no inherent relationship between gender dysphoria/incongruence and any other diagnoses, which the ICD-11 further emphasized by moving gender incongruence from the mental and behavioral health chapter to a separate chapter on “conditions related to sexual health,” where the only other entries are sexual dysfunctions and sexual pain disorders. Given the lack of a meaningful clinical relationship between gender dysphoria/incongruence and other conditions in the ICD-10 and ICD-11, these codes should not be combined with other diagnoses to form a broader HCC that is inclusive of gender dysphoria.

¹¹ Herman JL, Flores AR, O’Neill KK. (2022). How Many Adults and Youth Identify as Transgender in the United States. Los Angeles: The Williams Institute. <https://williamsinstitute.law.ucla.edu/publications/trans-adults-united-states/>

¹² See, e.g., Jasuja GK, de Groot A, Quinn EK, et al. Beyond Gender Identity Disorder Diagnoses Codes: An Examination of Additional Methods to Identify Transgender Individuals in Administrative Databases. *Med Care* 2020;58(10):903–11.

¹³ National Academies of Sciences, Engineering, and Medicine. (2022). *Measuring Sex, Gender Identity, and Sexual Orientation*. Washington, DC: National Academies Press. <https://nap.nationalacademies.org/catalog/26424/measuring-sex-gender-identity-and-sexual-orientation>

In sum, as long as transgender people continue to be the targets of state-sanctioned mistreatment and exclusion in health coverage and care, the primary means of ensuring access to gender-affirming care must be robust nondiscrimination protections that apply and are enforced nationwide. A strong bulwark of laws and policies protecting transgender people from discrimination in health care and coverage, as well as clear indications that regulators and carriers in states across the country understand and respect the medical necessity of gender-affirming care, are necessary prerequisites for any further consideration of an HCC for gender dysphoria.

Repeal of Prohibitions on Door-to-Door and Other Direct Contacts

We support lifting the prohibition of door-to-door canvassing by Navigators and Assistors. Whitman-Walker Health, (WWH), an LGBTQ+ serving FQHC in the Washington, DC area, has offered navigation services since before the ACA was implemented. We highlight their services as one of the nation’s longest-running navigation providers.

We agree that door to door canvassing should include non-navigator assistance personnel – sending highly trained Assistors/Navigators door to door is not an efficient use of resources but using non-Navigator support personnel help achieve community outreach and education goals and facilitates effective connections to Navigators via “warm hand offs” from educators to Assistors/Navigators. In recognition of their expanded role in assisting patients and clients in accessing social and health care services, these comments also call Navigators and Assistors, “Patient Benefit Insurance Navigators” (PBINs),

We support the view that repealing restrictions on an Exchange's ability to allow Navigators, non-Navigator assistance personnel, and certified application counselors to offer application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact is a positive step that would enable Assistors to reach a broader consumer base in a timely manner—helping to reduce uninsured rates and health disparities by removing underlying barriers to accessing health coverage.

As part of an integrated service model, the PBIN team serves an important role to help ensure access to care by removing or addressing barriers to care from insurance or lack of insurance issues or cost of care issues. Specifically at WWH, the PBIN team helps WWH patients and DC area residents with health insurance eligibility, enrollment, and literacy, connecting people to Medicaid, Medicare, and Qualified Health Plans on the exchange, subsidies, and other insurance options for which they may be eligible. The PBIN team serve as certified DC Health Link Assistors, providing critical consumer outreach and enrollment assistance to uninsured and under-insured DC residents. Given WWH’s patient population and geographic location, the PBIN team also counsels clients from Maryland and Virginia and receives calls from other areas for assistance and advice. The PBIN team works across three sites and manages an Insurance Helpline (where callers get immediately connected to a navigator for assistance). These avenues ensure that the navigators connect promptly and efficiently so that they can screen all patients and area consumers for eligible

insurance coverage, assist them in applying for benefits as applicable, and handle and resolve any eligibility or coverage issues.

Evidence shows that millions of people find the process of applying for and using health insurance overwhelming. Many lack basic health insurance literacy. Navigators can help demystify the complexity of applying for and using health insurance. They can also help reduce health disparities by improving health literacy in rural and underserved communities, including Black, Indigenous, and other communities of color. Questions and problems accessing care are not limited to the eligibility and enrollment issues. And with many people seeking assistance qualifying for Medicaid or subsidies, issues are not limited to open enrollment periods.

WWH's insurance navigation services are year-round services by trained experts who can help consumers break down barriers and promote access and health insurance literacy. Given this, it is vital that funding and the scope of services of Navigators include eligibility and enrollment, counseling and all the post-enrollment and access activities highlighted. We support expanded funding for Navigator services and ask that HHS intentionally recognizes that PBINs are trained experts on complex systems and supporting the professional development of expert navigators through year-long employment improves efficiency and supports innovation. Additionally, professional navigation should be available year-round to support continuous enrollment, special enrollment periods (SEP), and the full life cycle of consumers years as qualifying events occur. Funding only for open enrollment often results in temporary, seasonal jobs. Temporary employment misses the life cycle of qualifying events and fails to take advantage of the expanded access to SEPs proposed within the notice.

The Biden Administration has been supportive of market reforms that facilitate patient access to health insurance marketplaces, but navigator services are still not emphasized in a way that reflects their essential importance to consumer access. PBINs are service delivery and workforce specialists who unlock access to much needed health care services. As described briefly above, they operate year-round on the front-line of our operations, conducting more than just eligibility and enrollment screenings. PBINs also screen clients and patients for other needs, including health-harming legal issues that affect social determinants of health, like housing, employment, and education, and health related social needs like food security, transportation, and income. Given our focus on the LGBTQ community, PBINs also screen for alignment with name and gender marker on identity documents to ensure being asked for your insurance card and identification at a health visit isn't creating a barrier for people.

Expert navigators are trained to screen for social determinants of health and legal issues in the natural course of conversation when enrolling patients and clients, and to identify upstream issues to improve health. WWH navigation services are available in Spanish, English, and Amharic and are an essential part of a culturally competent practice. Screening for these additional barriers is organic, as the PBINs have much of this information from their screening for health insurance options - income, family size, immigration status, name, gender marker, employment status,

housing status. By using that information to identify potential other needs, the PBINs serve as a "upstream screener" and connector to other services like legal services who can assist to break down other systemic barriers critical to increased patient engagement, empowerment of consumers, and improving overall health care delivery. Conducting insurance navigation helps build health insurance literacy for our diverse patient population, helps give providers more care options when patients are insured, and helps our health center have stronger financial stability and long-term sustainability.

It is our experience that no matter someone's education, age, or computer literacy, people need navigation services. Despite the reforms that we have seen increasing enrollment periods, expanding tax credits for enrollees, protections from renewals and terminations of Medicaid during the COVID-19 public health emergency (PHE), and expansions of insurance coverage, consumer needs for Navigation services remain high and we are as busy as ever helping people navigate the very complicated health care system.

We support the proposal that changes rules to allow sharing information with Navigators of consumers who have been determined ineligible for Medicaid. The NPRM makes clear that consumers may only be approached when ineligible for Medicaid. Unfortunately, this regulation misses the opportunity to leverage PBIN expertise to support re-enrollment. Navigators need to be able to talk eligibility across options and engage by helping consumers to recertify Medicaid or discuss life events – new job/higher income, family size shift, etc – that may change eligibility. Sharing of information should be seen as part of supporting a “no wrong door” policy and a coordinated, robust screening process.

We support the change to allow Assisters and Navigators to offer application assistance door-to-door and through other unsolicited means at this stage of the implementation of the ACA. We agree that now that the Exchanges and their Assister programs have been in operation for almost 10 years, Assisters have more name recognition and consumer trust within the communities the Assisters serve. Accordingly, HHS believes that its previous concerns related to consumers' privacy and security interests and consumers not knowing what to expect when interacting with Assisters have been sufficiently mitigated with the measures HHS has enacted such that a blanket prohibition on unsolicited direct contact of consumers by Assisters for application or enrollment assistance is no longer necessary.

Regarding Providing Correct Information to the FFEs (§ 155.220(j))

We support a statutory requirement to

“...explicitly require agents, brokers, or web-brokers assisting consumers with completing eligibility applications through the FFEs and SBE-FPs to confirm with those consumers the accuracy of the information entered on their applications prior to application submission or document the consumer has reviewed and confirmed the information to be accurate.”

This regulation reasonably incentivizes the agent to take due care when engaging with clients and establishes a duty to confirm the information with the consumer. The rule seems likely to improve the accuracy of the information received in applications by establishing a second level of review and is constructed to support consumer-driven and informed consent of consumers as well.

The requirements on the documentation of consent seem carefully calibrated to balance the need for ease of understanding, storage of the information, and creating incentives for agents and brokers to explore and innovate new best practices for their business and the consumers they serve. The minimum standard of keeping records for 10 years helps establish consumer expectations and uniformity across brokers and agents.

Regarding Documenting Receipt of Consumer Consent (§ 155.220(j))

We are concerned about the security of consumer consent records and want to ensure strong data security and data hygiene standards are applied to any potentially sensitive information, including private health data. For example, is the consumer consent documentation kept, but not the underlying consumer application data? What happens to the consent confirmation? Is it encrypted, or otherwise kept physically and digitally secure? How long do brokers retain consumer application data? Under what conditions is this data kept? Large troves of consumer data retained by agencies and brokers represent a substantial risk to consumer privacy, which can be minimized by leveraging emergent best and promising practices on data retention and storage.

Regarding Failure to File and Reconcile Process (§ 155.305(f))

We agree that the costs of the current policy that ends a consumer's coverage are outweighed by the benefits of encouraging robust enrollment and participation in insurance programs. The proposed rule to not terminate because someone failed to file taxes for two years is an excellent addition. As noted, the IRS records may be inaccurate, and it is important that consumers not be improperly removed from a plan due to error on the part of the government.

Additionally, this change supports consumers who may not properly understand the consequences of failing to file, due perhaps historical expectations that lack of income negates the necessity to file taxes. In our practice, many consumers do not fully understand – even with coaching – the relationship between taxes and health insurance. The connection in many minds is non-obvious, complicated, and questionable. Finally, many people file late, some files years late after realizing they need to. This new language is a good relaxation of the original requirement to enhance consumer protections in support of continuity of coverage, and reduce the resources allocated to needless appeals. The proposed rule extending the grace periods instituted during the COVID-19 PHE will give consumers ample time to adjust to new requirements while Navigators and Assistors implement HHS's new flexibilities to engage in consumer education and the new requirements

that support accurate reporting of consumer data, ensuring the efficient administration of HHS resources.

Rather than provide an extra year of flexibility, we suggest that it may further support HHS's objectives to remove the penalty entirely. This would ensure that eligible consumers retain coverage under all circumstances. HHS should consider the impact of eliminating the penalty on the market and if HHS has a less restrictive means of administering the filing requirement. For example, consumers found to be ineligible for APTC could be charged premiums retroactively.

Regarding Income Inconsistencies (§§ 155.315 and 155.320)

We support the proposed regulation allowing self-attestation of projected income and family size in the absence of data from the IRS or when such data from the IRS fails to reflect a change of circumstance that is relevant to a consumer's eligibility for insurance affordability programs. Self-attestation and alternative documentation procedures support, to the greatest extent practicable, the inclusion of potentially eligible consumers in the insurance programs. This is an excellent use of Department resources as a high value is placed on consumer participation in insurance plans and incentivizes the IRS to provide timely information to the Exchange. The added flexibility supports an approach that meets consumers needs and balances the Department's interest in the judicious use of federal funds.

We support the range of additional flexibilities, especially the mandatory extension for consumers to provide documentation supporting their eligibility for advanced premium tax credits (APTCs) and cost sharing reductions (CSRs). Many patients who benefit most from these programs are working in households with multiple sources of income woven together to support a family. These beneficiaries are well-poised to benefit from these changes, and potentially deeply harmed when incorrectly removed from coverage. The additional flexibilities support consumers with the needed time to understand the requested information and gather it from across their household.

Annual Eligibility Redetermination (§ 155.335)

We support the proposed rule directing re-enrollment into lower or same cost, high generosity plans. This proposal is well calibrated to protect consumers who are most likely to need additional support and could benefit from the updated guided auto enrollment rules. As HHS notes, the proposed change will have a protective effect on consumers, likely lowering out of pocket costs while directing consumers to high-value products on the exchanges when they do not actively re-enroll themselves.

Special Enrollment Periods (§ 155.420)

We support the proposed change to requirements to allow a household to enter a special enrollment period based on a single member of that household having a qualifying event. This change supports

inclusion of households with different family structures and access to affordable insurance options for more consumers, especially those who move from Medicaid plans to marketplace plans. This will be particularly important for consumers facing the end of Medicaid enrollment flexibilities upon the expiration of the COVID-19 PHE, which is expected starting April 1, 2023. The proposed change more accurately reflects the lived experiences of consumers, in which often the changed circumstances of a single person within a household are part of a larger ecosystem of resources, income, and insurance products. For example, a qualifying event, like a birth, marriage, or job loss, may require a household to make changes to make certain other changes, and this expansion of SEP supports the lived experiences of many families.

Plan Display Error Special Enrollment Periods (§ 155.420(d))

We support the proposed changes to ensure that errors in Marketplace plan displays do not adversely affect consumers. We believe this change encourages the efficient operations of Marketplaces and the Exchanges while reducing the burden on consumers to prove an error occurred.

Prohibition of Mid-Plan Coverage Termination for Dependent Children Aging Out

We support the proposed prohibition on terminating coverage mid-year for dependent beneficiaries of plans who age out. This proposed change supports the industry standard of enrolling in health plans during the open enrollment periods at the end of each calendar year and creates stability for parents and families during transitions.

We see the coverage gap scenarios that HHS highlights in their NPRM. During the COVID-19 PHE-related SEP, Washington, DC's Marketplace exchange allowed consumers to essentially choose the effective date – not mid-month but retroactive, current, or prospective enrollment. Recognizing that mid-month enrollment is logistically difficult for insurers, an approach that allows for flexibility as to the effective date to meet the needs of consumers is balanced with the need for insurers to efficiently administer their plans.

Limitations on the Number of Non-Standardized Plans

We support the proposed rule to limit the number of non-standardized plans as reasonably designed to produce efficient health exchanges that are understandable and navigable by consumers. This proposed regulation may have a beneficial effect of reducing incentives for insurers to drive consumers from high value products through confusing marketing techniques. Combined with marketplace requirements based on meaningful differences, the proposed change reduces incentives to market a plethora of relatively cheap plans and supports innovation by insurers.

Network Adequacy (§ 156.230) and Essential Community Providers (§ 156.235)

We support the proposed changes to network adequacy and Essential Community Provider (ECP) standards. ECP requirements are a key feature of HHS regulations that ensure vulnerable communities, including low-income communities, LGBTQIA+ people, and communities of color are able to access health care services that are affordable and culturally and linguistically appropriate. Many LGBTQ+ serving health care centers are ECPs, and we support robust requirements that specialized ECPs with specific expertise be included in network adequacy requirements, including the proposed rule to create new standalone classes for ECPs for Substance Use Disorder (SUD) Treatment and Mental Health Facilities. We note that for patient access purposes, it is important that Mental Health Facilities and SUD Treatment centers used to satisfy the proposed requirements include facilities that are secular in nature, as many LGBTQIA+ people and racial and ethnic minority patients report discomfort with religiously affiliated programs.

We support the proposed changes to expand QHP requirements for contracting with Family Planning and FQHC ECPs to a 35% threshold. This ensures that network adequacy requirements result in meaningful coverage for underserved populations.

In the experience of WWH in Washington DC, low-income clients from Virginia and Maryland with exchange plans may find that WWH is excluded from their network because the plan issuer identifies the in-state ECPs, but not those in DC. HHS can provide clarification that a plan's service area and geographic distribution requirements include nearby metropolitan areas. Additionally, we propose a clarification that the threshold requirements do not prohibit adding to the plan's network, just removing providers from a plan's network.

In response to questions about ensuring network adequacy of certified QHPs, we recommend that HHS look to the requirements for Essential Health Benefits (EHBs) sold on state exchanges. The 10 categories of EHBs provide consumers with confidence to understand the quality of the insurance plans they are purchasing and provide market stability for insurers. Consumers would also benefit from plans having up-to-date information on available providers on insurers online network platforms. It may be helpful for consumers to understand whether an ECP is included or covered if the meaningful differences between network robustness is indicated by metal level.

Pricing Adjustment for the Hepatitis C Drugs

The Department's proposed rule to continue a market pricing adjustment specific to Hepatitis C drugs in models for the 2024 benefit year seems reasonably well calibrated to reduce the incentives that issuers will create discriminatory plans to drive away people living with or at risk for Hepatitis C. Virus (HCV). HCV cure therapies represent a breakthrough in HCV treatments as the NPRM notes, the costs are changing rapidly among drug products. A pricing adjustment for HCV drugs encourages formularies with sufficient access to all effective treatments for patients that need them.

Conclusion

The LGBTQI Health Policy Roundtable and the LGBTQIA+ Primary Care Alliance are pleased to participate in this important discussion. We would be happy to provide additional information or to assist CMS or the Department in any other way. For more information regarding any portion of these comments, please contact Benjamin Brooks, Associate Director of Policy and Education at Whitman-Walker Institute via bbrooks@whitman-walker.org.