



January 27, 2022

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**Interim President and CEO**  
Wade Henderson

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

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

*Submitted via regulations.gov*

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

Dear Administrator Brooks-LaSure and Director Montz,

On behalf of The Leadership Conference on Civil and Human Rights, a coalition charged by its diverse membership of more than 230 organizations to promote and protect the rights of all persons in the United States, we write to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule, "Patient Protection and Affordable Care Act; Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2023" (the "NBPP 2023 Rule").

**Nondiscrimination on the basis of sexual orientation and gender identity**

We support HHS's proposal to prohibit exchanges, insurers, and agents and brokers from discriminating based on sexual orientation and gender identity. It is well-established that members of the LGBTQ community face discrimination when seeking health care, resulting in poorer health outcomes than their straight and cisgender peers. A 2014 Lambda Legal study found that fifty-six percent of LGBTQ people reported experiencing discrimination from health care providers — including refusals of care, harsh language, or even physical abuse — because of their sexual orientation.<sup>1</sup> Another survey found that 8 percent of LGBTQ people and 29 percent of transgender people had been refused health care because of their identity.<sup>2</sup> Insurers specifically have contributed to this discrimination by employing transgender-specific exclusions to deny coverage for medically necessary treatment,

<sup>1</sup> <https://www.lambdalegal.org/publications/when-health-care-isnt-caring>

<sup>2</sup> <https://www.americanprogress.org/article/discrimination-prevents-lgbtq-people-accessing-health-care/>

including but not limited to gender-affirming treatment.<sup>3</sup> The current rule has and continues to exacerbate these disparities.

The proposed regulatory amendment is within HHS's authority and consistent with the Affordable Care Act's intent to improve access to health coverage and services and to prohibit discrimination in the provision of health care. Provisions of the ACA indicated Congress's intent for the law to prohibit unreasonable barriers to obtaining appropriate medical care and remove limits on the availability of the full scope of health care a person needs.<sup>4</sup> The current rule is contrary to these aims, instead permitting and creating barriers to comprehensive care. In addition, Section 1557 of the ACA clearly indicates that the law intended to prohibit discrimination in health care, and we look forward to the opportunity to provide comments on the implementing regulations of that section later this year. For all of these reasons, HHS should act to prohibit discrimination on the basis of sexual orientation and gender identity in this regulation.

#### **Refine Essential Health Benefits (EHB) nondiscrimination policy for health plan designs**

The proposed rule clarifies insurers' obligation to comply with EHB nondiscrimination requirements and provides a regulatory framework to evaluate plan benefit design and implementation based upon clinical guidelines and evidence. We strongly support this proposal and the examples of presumptively discriminatory benefit design that HHS provides.

Before the ACA, health insurers routinely discriminated against people with preexisting conditions, including persons with disabilities and those with chronic illness. Insurers would charge them exorbitant premiums, exclude coverage for their conditions, or refuse to provide health coverage at all. Although the ACA made these practices unlawful, some insurers still seek to discriminate through benefit design.

Insurance companies have used many features of health plan benefits and delivery to unlawfully deny needed coverage or discourage people with significant health needs from enrolling in their plans. These include exclusions, cost sharing, formularies, visit limits, provider networks, prior authorization and other utilization management that are arbitrary and not clinically based or appropriate.

HHS takes exactly the right approach, establishing that nondiscriminatory benefit design is clinically based and incorporates evidence-based guidelines into coverage and programmatic decisions, and relies on current and relevant peer-reviewed medical journal article(s), practice guidelines, recommendations from reputable governing bodies, or similar sources.

We welcome and strongly support HHS' framework to address and end discriminatory plan benefit design and delivery.

#### **Solicitation of Comments Regarding Health Equity, Climate Health, and Qualified Health Plans**

We strongly support requirements for qualified health plans (QHPs) to collect demographic information on each enrollee. Asking enrollees to provide this information is necessary to illuminate persistent health

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<sup>3</sup> <https://www.americanprogress.org/article/protecting-advancing-health-care-transgender-adult-communities/>

<sup>4</sup> Pub. L. No. 111-148, sec. 18144 (Section 1554 of the ACA)

inequities and to monitor those that are yet unidentified. HHS — for all of its programs and not solely marketplaces — should review expert recommendations and research on demographic data collection and set standards for the language used by QHPs to collect data. Recommendations already exist from the Institute of Medicine<sup>5</sup> and the Williams Institute at UCLA<sup>6</sup> that draw on both studies and stakeholder input. The ultimate purpose of collecting demographic information from enrollees is to advance health equity. As such, HHS should also set expectations for QHPs to engage in systematic review of enrollee data and in taking actions to correct disparities that become apparent through this review.

Data should be disaggregated in all surveys and data collections. Disaggregation is necessary so that researchers and advocates can see nuances in large trends and the interactions of different factors on marginalized groups. Disaggregation on the basis of characteristics such as race and ethnicity, country of origin, sexual orientation, and gender identity is particularly important both because those are the bases for civil rights enforcement, and also because these aspects of individuals' identities have been the bases for their marginalization. After a long history of policies and practices that excluded people and discriminated against them because of their race, ethnicity, sex (including sexual orientation and gender identity), age, and disability, it is only possible to know if progress is being made by reviewing data that considers those same factors. As a general practice, we urge federal agencies, including HHS, to disaggregate data in all data collections by geographic area, race and ethnicity (including first language), sex (including sexual orientation and gender identity), disability, age, and income, and also in many cases by factors such as parenting, pregnancy, and caregiving status, and social determinants of health.

We also recommend that HHS set an example by improving data collection in its own programs and activities, such as collecting comprehensive demographic data in HealthCare.gov and requiring SBEs to do the same. This will not likely alleviate the need for QHPs to also collect this data, particularly because some individuals will be more confident providing demographic data to a plan or provider (who shares it with a QHP) as opposed to a government agency to enroll in a program, but will demonstrate HHS' own commitment to collecting and utilizing demographic data to address health disparities and improve health equity.

Additionally, HHS requested comment on whether QHPs should be required to obtain the National Committee for Quality Assurance's (NCQA) Health Equity Accreditation (HEA). We support this requirement. HEA's standard for accreditation captures the importance of data collection and affirmative steps that QHPs can take to use health disparity data to improve health equity. However, the HEA lacks specific standards that address people with disabilities. We recommend that HHS work with NCQA and stakeholders to add standards that promote equity for disabled enrollees, including comprehensive data collection. HHS should retain responsibility for oversight of QHP accreditation, and materials provided to NCQA by QHPs, such as scorecards and evaluations, should be publicly available.

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<sup>5</sup> <https://www.ahrq.gov/research/findings/final-reports/iomracereport/reldatasum.html>

<sup>6</sup> <https://williamsinstitute.law.ucla.edu/publications/data-collection-sogi/>;  
<https://williamsinstitute.law.ucla.edu/publications/smart-so-survey/>; <https://williamsinstitute.law.ucla.edu/publications/geniuss-trans-pop-based-survey/>

**Guaranteed availability of coverage: Past due premiums**

In the proposed rule, HHS revises its previous interpretation of the ACA’s guaranteed issue provision which allowed insurers to refuse to cover persons who owe past due premiums until they satisfy arrearages. We strongly support revising this unlawful interpretation of the guaranteed availability provision. The statute is clear — an issuer “must accept every employer and individual in the State that applies for such coverage.”<sup>7</sup> As HHS now acknowledges, denying coverage because of past-due premiums is contrary to the ACA, and disproportionately hurts persons who are low income and others experiencing economic hardship. Especially given the ongoing and devastating impact of the COVID-19 pandemic, no one should lose or be denied health care.

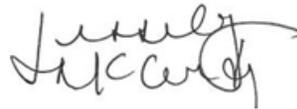
Health insurance companies have other tools available to recoup unpaid premiums without denying enrollment. We strongly support revising HHS’ interpretation of the ACA’s guaranteed issue provision to allow individuals to enroll in coverage even if they have past-due premiums.

Thank you for your consideration of our views. Please reach out to June Zeitlin, senior advisor, at [zeitlin@civilrights.org](mailto:zeitlin@civilrights.org) with any questions.

Sincerely,



Wade Henderson  
Interim President and CEO



Jesselyn McCurdy  
Executive Vice President of Government Affairs

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<sup>7</sup> 42 U.S.C. § 300gg-1(a).