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RE: Comment of the Center for Constitutional Rights Opposing the Proposed Rule on Marketplace Integrity and Affordability (CMS-9910-P)

To Whom It May Concern:

The Center for Constitutional Rights (CCR) is a national nonprofit legal and advocacy organization dedicated to advancing and defending civil and human rights through litigation, education, and public advocacy. Since our founding in 1966, we have been committed to confronting policies that infringe upon constitutional rights and disproportionately impact marginalized populations, including lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) individuals.

Today, we write in our capacity as civil rights advocates and leaders to express our grave opposition to the rule proposed by the Department of Health and Human Services ("HHS," or the "Department") and Centers for Medicare & Medicaid Services ("CMS") titled "Patient Protection and Affordable Care Act: Marketplace Integrity and Affordability," 89 Fed. Reg. 19898 (Mar. 19, 2025).

The proposed rule poses a significant threat to the health and safety of transgender people nationwide because, if adopted, it will severely restrict access to medically necessary healthcare for transgender people, particularly care related to gender dysphoria. These barriers are contrary to prevailing medical standards, unsupported by credible evidence, and discriminatory under

established constitutional and statutory protections.

The proposed rule also arbitrarily imposes broad harms on other groups, including low-income individuals and immigrants receiving Deferred Action for Childhood Arrivals (DACA).

We therefore urge the Department to rescind this proposed regulation in its entirety.

I. The Proposed Amendment to Section 156.115(d) Unlawfully Prohibits Coverage for Treatment of Gender Dysphoria Contrary to Evidence-Based Medicine

A. The Proposed Amendment Disregards Accepted Medical Standards and Endangers the Health of Transgender Individuals

The Center for Constitutional Rights objects to the proposed amendment to Section 156.115(d) in the first instance because it contradicts nationally accepted medical standards for gender dysphoria treatment. Gender dysphoria is the psychological distress that results from an incongruence between an individual's gender identity and their assigned sex at birth, and it can lead to significant anxiety, depression, suicidal ideation and other disabling conditions when left untreated.[1]

Gender-affirming care, including hormone therapy, mental health support, and surgical interventions when medically indicated, is the widely accepted standard of care for treating gender dysphoria. The World Professional Association for Transgender Health (WPATH), which sets globally recognized clinical protocols, affirms that gender-affirming medical interventions are evidence-based and improve health outcomes for transgender patients.[2] Similarly, the Endocrine Society has issued Clinical Practice Guidelines affirming the necessity and effectiveness of gender-affirming hormone therapy for individuals diagnosed with gender dysphoria.[3]

The treatment protocols outlined in these guidelines are recognized and accepted by every major medical association in the United States. Further, every major professional medical association, including the American Medical Association (AMA) and American Psychiatric Association, has endorsed gender-affirming care as safe and evidence-based.[4] These endorsements and the continuous support from major medical associations for both the care itself and the clinicians providing these crucial and life-saving services emphasize the positive impact of such

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[1] *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013) (DSM-5).

[2] *See* WORLD PROF'L ASS'N FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSGENDER AND GENDER DIVERSE PEOPLE, VERSION 8 (2022).

[3] *See* Wylie C. Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869, 3870 (2017).

[4] GLAAD, *Medical Association Statements in Support of Health Care for Transgender People and Youth,* GLADD.ORG*,* June 26, 2024, https://glaad.org/medical-association-statements-supporting-trans-youth-healthcare-and-against-discriminatory.

healthcare on transgender individuals' lives.[5]

Peer-reviewed research also strongly supports the safety and efficacy of gender-affirming care. Recent peer-reviewed studies have found that access to gender-affirming healthcare including hormone therapy and surgery significantly reduced rates of depression and suicidal ideation in transgender individuals.[6] Thus, by undermining access to such care, the proposed rule amendment will produce foreseeable harm, including increased rates of anxiety, depression, suicidality, and unsafe attempts at self-treatment.[7]

B. The Proposed Amendment Violates Federal Statutory and Constitutional Protections, in Contravention of the APA

CMS's assertion that services related to gender dysphoria are not part of the benefits offered by a "typical employer plan" is unfounded and contradicted by substantial market data. Rather, by facilitating categorical exclusions for gender-affirming care, the proposed rule amendment promotes unequal treatment of transgender individuals in violation of the Constitution's promise of equal protection and federal statutory law. Specifically, the Department's proposal, particularly its efforts to redefine the scope of essential health benefits ("EHB"), violates Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116 ("ACA"). This section prohibits discrimination on the basis of sex in federally funded health programs and activities. The Department and federal courts have repeatedly interpreted this provision to encompass discrimination against transgender persons.

In *Bostock v. Clayton County*, 590 U.S. 644, 665 (2020), the Supreme Court held that discrimination based on transgender status constitutes sex discrimination under Title VII. The reasoning in *Bostock* has since been extended to Title IX and Section 1557 in a growing body of federal case law. *See*, *e.g.*, *Whitman-Walker Clinic, Inc. v. U.S. Dep't of Health & Human Servs.*, 485 F. Supp. 3d 1, 43–44 (D.D.C. 2020).

In addition, the proposed rule amendment likely violates the Equal Protection Clause of the Fourteenth Amendment. Courts have recognized that government actions discriminating against transgender individuals must survive heightened scrutiny. *Grimm v. Gloucester Cnty. Sch.*

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[5] *Id.*

[6] *See, e.g.*, Jeremy A. Wernick et al., *A Systematic Review of the Psychological Benefits of Gender-Affirming Surgery*, 46 UROLOGIC CLINICS OF N. Am. 475, 484 (2019); Nova J. Bradford et al., *Hair Removal and Psychological Well-Being in Transfeminine Adults: Associations with Gender Dysphoria and Gender Euphoria*, 32 J. DERMATOLOGICAL TREATMENT 635, 639–40 (2021); Amy E. Green et al., *Association of Gender-Affirming Hormone Therapy with Depression, Thoughts of Suicide, and Attempted Suicide Among Transgender and Nonbinary Youth*, 70 J. ADOLESCENT HEALTH 643 (2021), https://doi.org/10.1016/j.jadohealth.2021.10.036; Tiffiny A. Ainsworth & Jeffrey H. Spiegel, *Quality of Life of Individuals With and Without Facial Feminization Surgery or Gender Reassignment Surgery*, 19 QUALITY LIFE RES. 1019, 1022–23 (2010); Esther Gomez-Gil et al., *Hormone-Treated Transsexuals Report Less Social Distress, Anxiety and Depression*, 37 PSYCHONEUROENDOCRINOLOGY 662 (2012). Note, while the term transsexual is no longer used to describe transgender people, the research findings remain pertinent.

[7] *See* Wernick et al., *supra* note 6; Bradford et al., *supra* note 6; Green et al., *supra* note 6; Ainsworth & Spiegel, *supra* note 6; Gomez-Gil et al., *supra* note 6 (aggregating related data).

Bd., 972 F.3d 586, 608 (4th Cir. 2020), cert. *denied*, 141 S. Ct. 2878 (2021).

The proposed rule amendment also violates the Americans with Disabilities Act (ADA), 42 U.S.C. §§ 12101 et *seq.*, and Sections 1302(b) and 1557 of the ACA because it purposefully denies healthcare based on disability. *See, e.g.*, *Williams v. Kincaid*, 45 F.4th 759, 766–74 (4th Cir. 2022) (affirming that gender dysphoria is a covered disability for purposes of the ADA), *cert. denied*, 143 S. Ct. 2414 (2023); DOJ Statement of Interest at 7–14, *Doe v. Ga. Dep't of Corr.*, No. 1:23-cv-5578-MLB (N.D. Ga. Jan. 8, 2024) (explaining that Gender Dysphoria is covered by the ADA).

Because the proposed rule amendment violates both the United States Constitution and binding federal statutory law—namely, the Equal Protection Clause, ACA, and ADA—it also contravenes the Administrative Procedure Act (APA). Specifically, it runs afoul of Section 706(2)(C), the APA's prohibition on agency action that exceeds statutory authority.

Under the APA, courts must "hold unlawful and set aside agency action" that is "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right." 5 U.S.C. § 706(2)(C). This is commonly referred to as the ultra vires doctrine, which bars federal agencies from acting beyond the powers granted to them by Congress. In promulgating rules, agencies must remain within the bounds of their delegated authority and cannot implement policies that violate governing statutes or constitutional protections.

The proposed rule's exclusion of DACA recipients from health coverage eligibility and its discriminatory treatment of transgender individuals violate the statutory command in Section 1557, which prohibits discrimination on the basis of sex, including gender identity. Likewise, the rule's disparate treatment of similarly situated groups triggers heightened scrutiny under the Equal Protection Clause and lacks any compelling justification.

Because the Department lacks the authority to promulgate a rule that contravenes constitutional mandates or statutory civil rights protections, the proposed rule is ultra vires and must be invalidated under 5 U.S.C. § 706(2)(C). Any attempt to enforce such a rule would exceed the scope of CMS's lawful regulatory authority and fail as a matter of administrative law.

C. The Proposed Rule Amendment is Arbitrary, Capricious, and Unsupported by Evidence

Under the Administrative Procedure Act, agency action must be the product of reasoned decision-making. *See* 5 U.S.C. § 706(2)(A). However, the Department's proposed exclusion lacks both empirical grounding and rational basis, particularly in light of the overwhelming medical consensus and scientific data supporting the care in question.

The Department cites utilization rates of gender-affirming care (0.11%) as a rationale for removing the benefit, ignoring the fact that the low utilization reflects the small proportion of the population that is transgender, not the medical necessity of the services. This reasoning would never be applied to other essential services such as heart transplants, which are infrequent but nevertheless essential and widely covered.

This rule also lacks any meaningful cost-savings that help justify its broad exclusion of

gender-affirming healthcare. Indeed, contrary to any cost-saving rationale, the denial of such care increases long-term medical expenses by exacerbating chronic mental health issues, leading to emergency interventions, and contributing to social and economic instability. Exclusionary policies are therefore not only dangerous but fiscally unsound.

Additionally, the rule's prohibition would create serious logistical and administrative challenges. Many gender-affirming services overlap with care for other conditions—e.g., hormone therapy for menopause or hysterectomy for cancer—raising questions about whether coverage will depend on diagnosis rather than treatment. This raises serious concerns about equitable access and privacy, as plans would need to scrutinize medical records to determine the "reason" for care, complicating claims and creating new pathways for discrimination.

D. The Proposed Rule Amendment has Broader Implications for Public Health and Health Equity

The proposed rule amendment would erode public trust and undermine years of progress in building inclusive healthcare systems. Attempts to stigmatize or delegitimize care for transgender individuals will reduce healthcare access for a group already facing significant disparities. The potential downstream effects include increased healthcare costs due to untreated mental health conditions and avoidable emergency room visits, workplace absenteeism, and adverse health outcomes.

Moreover, the proposal intrudes on the authority of states to design Essential Health Benefit ("EHB") benchmark plans. This represents an unprecedented federal overreach and would reverse years of deference to state autonomy, despite the fact that a majority of states already require coverage for gender-affirming care in their insurance regulations.

Beyond these direct effects, the proposed rule amendment undermines public health policy by allowing political ideology to supersede science and medicine. Policies that restrict or stigmatize medically necessary care for a vulnerable population set a dangerous precedent, eroding trust in the healthcare system and discouraging at-risk individuals from seeking care.

Healthcare access must be grounded in medical necessity, not prejudice. Attempts to discredit or delegitimize gender-affirming care only intensify barriers to health equity. The Department should affirm, not undermine, the ACA's central aim of expanding affordable and equitable health coverage.

II. The Proposed Amendment to Section 155.20 Unjustifiably Eliminates Health Coverage for DACA Recipients

A. The Proposed Rule Amendment Inflicts Significant Harms on DACA Recipients

The proposed rule also seeks to roll back its current policy by amending the definition of "lawfully present" to exclude individuals with DACA status. This alteration would make DACA recipients ineligible for enrollment in Marketplace and Basic Health Program ("BHP") coverage, as well as for receiving premium tax credits and cost-sharing assistance. If finalized, this change would take effect immediately upon the rule's implementation and would result in DACA

recipients currently enrolled losing their eligibility mid-coverage year. The outcome would be widespread disruptions in healthcare access, including treatment delays or cancellations, exposure to overwhelming medical expenses for individuals with limited financial resources, and increased uncompensated care burdens on providers. Many would face losing insurance while undergoing essential medical treatment.

CCR strongly recommends that CMS rescind this proposal and maintain its current policy that recognizes DACA recipients as "lawfully present." Historically, HHS has interpreted this term to cover individuals granted deferred action by the Department of Homeland Security ("DHS"). While DACA recipients were initially excluded from this category in 2012 when the DACA program was introduced, DHS has since codified the program through formal regulation. DHS's final rule reaffirmed that individuals granted deferred action—including those with DACA—are considered "lawfully present" in other federal contexts, such as Social Security eligibility.

CMS revisited its stance on Marketplace and BHP eligibility following DHS's 2022 rule and finalized a regulation in 2024 that extended equal treatment to DACA recipients alongside other deferred action grantees. This move not only promoted fairness but also advanced the ACA's core mission of reducing the uninsured population and expanding access to affordable care.

While CMS cites concerns in this rulemaking about adverse selection in the ACA marketplaces, excluding DACA recipients would remove a relatively healthy group from the insurance risk pool. According to a 2024 federal survey, most individuals likely to be eligible for DACA are employed and rate their health as very good or excellent.

CMS currently projects that 10,000 DACA recipients would lose their Marketplace plans and another 1,000 would be removed from BHP coverage if the proposal moves forward. However, these figures likely understate the real-world impact. In its 2024 rulemaking, CMS had estimated that around 100,000 people with DACA status could benefit from expanded access to Marketplace insurance and subsidies. Because the eligibility change only recently took effect, many DACA recipients may not have had the opportunity or awareness needed to enroll, especially amid ongoing litigation surrounding DACA policies, which may have sown confusion about their eligibility.

Moreover, reversing course now would impose operational challenges on state-based marketplaces and the two BHP-participating states. These programs would be forced to alter their eligibility systems mid-year, terminate existing coverage, and prevent future enrollments for DACA recipients. CMS's current cost and burden estimates for these states appear incomplete, as they fail to consider necessary investments in consumer education, revised training materials for call centers and enrollment assisters, and updates to websites and scripts used for customer service.

B. The DACA-Related Provisions of the Proposed Rule Violate the APA by Failing to Consider Important Aspects of the Problem

In addition to contravening constitutional and statutory protections, the proposed exclusion of DACA recipients from Marketplace and BHP eligibility violates the APA because CMS failed to consider key, relevant factors in its rulemaking process. The APA requires that agency action be set aside if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance

with law." 5 U.S.C. § 706(2)(A). An agency acts arbitrarily and capriciously when it "entirely fail[s] to consider an important aspect of the problem." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

In this case, CMS proposes to terminate health insurance eligibility for a class of individuals without adequately evaluating the foreseeable harm to DACA recipients or the downstream costs to healthcare providers and state systems. The preamble to the proposed rule acknowledges that approximately 11,000 DACA recipients will lose Marketplace or BHP coverage, yet it offers no meaningful assessment of how many of these individuals will subsequently become uninsured or require uncompensated care. It similarly fails to estimate the economic burden such care will impose on hospitals, community clinics, and state and local health systems—especially in emergency settings where providers are legally obligated to offer care regardless of insurance status.

The Department's failure to analyze the impact of increased emergency room utilization, deterioration of untreated chronic conditions, or the rise in preventable health crises reflects a glaring omission of relevant, outcome-related data. DACA recipients tend to be young, employed, and previously uninsured—traits that make them both vulnerable to financial hardship from medical expenses and likely to rely on safety-net providers if coverage is revoked. These consequences are not speculative but well-documented in existing literature and were acknowledged by CMS itself in prior rulemakings.

Moreover, CMS did not address how the sudden disenrollment of DACA recipients mid-year will disrupt ongoing treatment regimens, including for mental health care, reproductive health, and chronic disease management—issues that bear directly on public health and state expenditures. This failure to assess or respond to these foreseeable harms demonstrates a failure to engage in the reasoned decision-making required by the APA.

For these reasons, the DACA-related portions of the proposed rule must be set aside as arbitrary and capricious under the APA. CMS has not offered a rational connection between the facts found and the choices made, nor has it reasonably considered the real-world impact of its policy shift, as required under 5 U.S.C. § 706(2)(A) and the standards articulated in *State Farm*, 463 U.S. at 43.

III. The Proposed Amendment to Sections 155.410 and 155.420 Harms Members of the Public, Particularly Low-Income Individuals, by Reducing Opportunities to Enroll in Health Insurance

A. Curtailing the Enrollment Window Undermines Access, State Flexibility, and Violates the APA (Section 155.410)

CMS proposes to shorten the annual open enrollment period (OEP) for the federally facilitated Marketplace ("FFE") from 76 days to 45 and eliminate the discretion of state-based Marketplaces ("SBEs") to set a longer enrollment period. Under the proposed rule, all Marketplaces would be required to end open enrollment by December 15. CMS justifies this policy change by asserting that a longer OEP leads to adverse selection and consumer confusion, yet offers no data to support these claims.

Available evidence contradicts CMS's reasoning. Numerous state exchanges have demonstrated that extending the OEP beyond December 15 brings in more young, healthy enrollees, strengthening the overall risk pool. Enrollees who sign up later in the OEP are frequently younger and select lower-tier plans, indicating fewer anticipated healthcare needs. CMS has not provided comparable data for the FFE and offers no substantive support for the idea that extended enrollment harms the marketplace.

In addition to being unsubstantiated, the proposed policy would impose significant administrative burdens and financial costs on SBEs. CMS's own estimates suggest that each SBE would need approximately 4,000 labor hours and $7.8 million to reprogram and modify IT systems to comply. However, these projections overlook related expenses such as updating public-facing materials, retraining assisters, revising websites, and managing consumer communications. The omission of these foreseeable impacts constitutes a failure to consider relevant factors in the rulemaking process, rendering the proposal arbitrary and capricious under the Administrative Procedure Act (APA). See 5 U.S.C. § 706(2)(A); *State Farm*, 463 U.S. at 43.

Moreover, many families face financial hardship during the end-of-year holiday season. Maintaining the current January 15 deadline allows individuals time to assess their options after this period, promoting informed enrollment decisions. Abruptly shifting the deadline earlier will increase confusion, particularly in states that have used the same longer OEP window for several years.

CMS acknowledges that many Marketplace enrollees may face premium increases in 2026, especially if enhanced subsidies expire. These consumers may not be aware of those changes until after December 15, effectively denying them the chance to reassess their plans. This timing concern is compounded by CMS's drastic reduction in Navigator funding, limiting the support available to consumers during a shortened enrollment window. Additionally, a compressed OEP will likely strain call centers, prolong wait times, and degrade the customer experience.

Finalizing this policy without weighing the full costs and operational burdens violates the APA's requirement for reasoned decision-making and undermines the statutory objective of promoting access to affordable care.

B. Repealing the Low-Income SEP Ignores Benefits, Imposes New Costs, and Violates the APA (Section 155.420)

CMS has also proposed eliminating the special enrollment period ("SEP") currently available to individuals with household incomes at or below 150% of the federal poverty level. This SEP has been essential in helping vulnerable individuals gain and maintain health coverage. CMS attributes enrollment fraud and adverse selection to the existence of this SEP, yet fails to offer compelling evidence or data in support.

In practice, this SEP has mitigated access barriers for people with fluctuating incomes, unstable employment, or limited digital connectivity. These challenges are especially acute for low-income individuals who often miss fixed enrollment windows. Eliminating the SEP would thus exacerbate disparities and reduce coverage among those most in need.

CMS attributes improper enrollments to the SEP itself, but the real source of abuse appears

to be the FFE's vulnerability to broker misconduct, rather than the SEP's design. State-based Marketplaces that operate similar SEPs have reported no systemic fraud, due in part to more robust consumer consent verification processes.

Additionally, CMS's adverse selection concerns are speculative and unsubstantiated. Risk assessments from state exchanges consistently show that individuals enrolling through SEPs are younger and healthier than those enrolling during standard OEPs. If CMS had credible FFE data showing the contrary, it could—and should—have presented it. Its failure to do so reflects a disregard for an important aspect of the problem, in violation of the APA. *See State Farm*, 463 U.S. at 43; 5 U.S.C. § 706(2)(A).

Even without enhanced premium tax credits, individuals under 150% FPL often qualify for $0 premium plans, reducing the likelihood that they would delay enrollment based on health status. CMS's rule fails to consider this important mitigating factor.

Moreover, CMS misstates the scope of state implementation. Nearly all SBEs have adopted this SEP, contradicting CMS's assertion to the contrary. Requiring SBEs to terminate this SEP within 60 days of the final rule would impose major system and staffing costs. These include IT changes, public education efforts, assister retraining, and updates to call center infrastructure. CMS's failure to account for these costs renders the proposal arbitrary and capricious under 5 U.S.C. § 706(2)(A).

Finally, CMS claims that it lacks authority to establish or continue the SEP under the ACA. This is incorrect. Section 1311(c)(6)(C) of the ACA allows Marketplaces to provide special enrollment opportunities in cases of "exceptional circumstances," a term not narrowly defined. This authority has been used broadly and repeatedly, including for SEPs following natural disasters, public health emergencies, and systemic enrollment issues. The low-income SEP fits well within this framework. The Medicare Part D program similarly allows ongoing enrollment flexibility for low-income beneficiaries under comparable statutory authority.

Reversing the SEP now would eliminate a proven and equitable access mechanism, create new administrative burdens for states, and undermine health equity goals. CCR urges CMS not to finalize this change. Doing so without a thorough consideration of the economic and operational effects would contravene the APA and represent a departure from reasoned agency decision-making.

IV. Conclusion

CCR strongly opposes the proposed rule in its entirety because, as detailed above, it is both legally indefensible and medically unsound. The proposed rule would severely curtail access to medically necessary gender-affirming care, unjustly strip health coverage from DACA recipients, and impose harmful restrictions on enrollment periods that disproportionately affect low-income individuals. These changes not only undermine public health, but also violate federal statutory and constitutional protections, including Section 1557 of the Affordable Care Act, the Equal Protection Clause, and the Administrative Procedure Act.

Each of these proposed policy changes—whether limiting coverage for transgender people, denying eligibility to DACA recipients, or shortening enrollment access for vulnerable

populations—introduces new costs, risks, and burdens that CMS has not meaningfully evaluated. As such, the rule is arbitrary, capricious, and unlawful.

CCR respectfully urges HHS and CMS to withdraw this proposed rule and instead reaffirm its commitment to equitable, inclusive, and accessible healthcare for all.

Respectfully submitted,

The Center for Constitutional Rights