CONSORTIUM FOR CONSTITUENTS WITH DISABILITIES

April 11, 2025

SUBMITTED ELECTRONICALLY

Secretary Robert F. Kennedy, Jr.
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: RIN 0938-AV61; CMS-9894-P
Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Proposed Rule[1]

Dear Secretary Kennedy:

On behalf of the undersigned members of the Consortium for Constituents with Disabilities (CCD) Health Task Force, we submit these comments on the proposed changes to Marketplace regulations.

CCD is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society free from racism, ableism, sexism, and xenophobia, as well as LGBTQ+ based discrimination and religious intolerance. The Health Task Force works to ensure access to high quality, accessible, affordable health care for people with disabilities and complex conditions of all ages that meets their individual needs and enables them to be healthy, live as independently as possible, and participate in the community.

Marketplace coverage has become a critical option for affordable comprehensive health insurance, with over 24 million individuals enrolling for the 2025 plan year.[2] Improved

[1] U.S. Dep't. Health & Human Srvs., *Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability, Notice of Proposed Rulemaking*, 90 Fed. Reg. 12944 (proposed Mar. 19, 2025), https://www.federalregister.gov/documents/2025/03/19/2025-04083/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability.

[2] CMS, *Press Release*: *Over 24 Million Consumers Selected Affordable Health Coverage in ACA Marketplace for 2025* (Jan. 17, 2025), https://www.cms.gov/newsroom/press-releases/over-24-million-consumers-selected-affordable-health-coverage-aca-marketplace-2025.

affordability protections and streamlined enrollment have made it easier for eligible individuals to enroll. The resulting enrollment gains have helped compensate for significant enrollment declines in Medicaid after redeterminations began again in 2023. This has helped keep the overall uninsurance rate at or near historic lows.[3]

Unfortunately, many of the proposed changes in this new rule would make it harder and more expensive for individuals to remain covered. (HHS estimates that 750,000-2 million will lose coverage.)[4] Rising uninsurance rates would increase uncompensated care and destabilize risk pools in Marketplace insurance plans.

While exact estimates of how many people with disabilities utilize Marketplace health insurance, statistics show that 20-25% of the population has a disability. This would translate to as many as 6 million people with disabilities covered through the ACA marketplace. The proposed changes would create barriers to all individuals getting and using Marketplace coverage by increasing administrative burden, reducing affordability, and restricting eligibility and access to certain services. Often these barriers would be even greater for enrollees and applicants with disabilities. This is especially true for people with disabilities who have unique health care needs and rely on trusted providers, services and a continuity of care to maintain their health and well-being.

We write to urge that CMS not finalize these proposed changes in their present form.

Making Coverage Less Affordable

The proposed rule would make several changes that would result in additional costs to consumers and would inhibit participation in Marketplace health insurance.

Premium Adjustment Percentages – § 156.130(e)

Under the proposed rule, CMS would change the way that it calculates annual increases in the maximum out-of-pocket (MOOP) limits as well as the required individual contributions to premiums. The changes would allow the MOOP to increase faster and, if adopted by the IRS, would increase the portion of premiums that individuals have to pay out of pocket.

The proposal would increase the adjustment percentages by an estimated 4.5% in 2026 over the current methodology.[5] Because this is an annual adjustment, increasing the rate of change even slightly would erode affordability faster with each passing year.

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[3] Jennifer Tolber et al., KFF, *Key Facts about the Uninsured Population* (Dec. 18, 2024), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.
[4] 90 FR 13007.
[5] Sabrina Corlette and Jason Levitis, State Health & Value Strategies, *Recent Federal Marketplace Proposal Imposes New Requirements for States and Consumers* (Mar. 14, 2025),

Increasing premiums for subsidized enrollees and worsening the value of coverage is expected to deter enrollment of healthier enrollees, as described in more detail below. This will worsen the average risk pool and increase premiums, contrary to CMS's purported goal of increasing affordability in promulgating this regulation. We ask that CMS not finalize this proposed change.

Past-Due Premiums and Medical Debt – § 147.104(i)

Under the proposed rules, carriers would be permitted to essentially deny coverage to any enrollee who owes the company for unpaid premiums in prior years. Previously, any requirements to pay unpaid premiums only looked back for the past year, but this rule would extend that look back indefinitely.

Many affected enrollees may not even realize they have unpaid premiums, meaning that individuals could sign up for coverage thinking that they were insured for the coming year without realizing they had an unpaid bill that could potentially prevent that coverage from effectuating.

The proposed rule includes no data to demonstrate why such a proposal would be needed. Denying people coverage for prior debts will only worsen medical debt by exposing individuals to the risk of uninsurance, particularly if they get denied after the enrollment period closes and have no option to enroll until the following year. According to a 2024 report from the Peterson Center on Health Care and the Kaiser Family Foundation, 20 million Americans owe medical debt totaling at least $220 billion.[6] This is equal to 8% of the US adult population. The percentage is even higher for people with disabilities, as 13% of the disabled population has some sort of medical debt. Making it harder for these people to maintain coverage will only compound their problems. The intention of the ACA was to reduce the amount of uncompensated care provided in this country and this rule would undermine that intention and the purpose of the law.

Eliminating Protection from the "Bronze Trap" – § 155.335(j)(4)

One quirk of the structure of Marketplace requires individuals to enroll in a silver plan in order to benefit from the enhanced cost sharing reductions (CSRs) available to low-income enrollees. Because bronze plans are often listed with lower or no premiums, applicants may choose that option, not realizing that selecting the silver plan will be much more affordable due to its far lower cost sharing burden. This is known as the Bronze trap.

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https://www.shvs.org/recent-federal-marketplace-proposal-imposes-new-requirements-for-states-and-consumers/.

[6] Shameek Rakshit et al., Peterson-KFF Health System Tracker (Feb. 12, 2024), https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/.

The proposed rule would remove § 155.335(j)(4), which allows Marketplaces to automatically shift individuals eligible for CSRs who are enrolled in a bronze level plan into a silver plan with CSRs, provided that it is in the same product line, with the same provider network, and has a lower or equivalent premium. The preamble asserts, but provides no evidence, that awareness of the Bronze trap is "substantially less" of a problem recently and would be outweighed by "negative consequences" like "confusion" and "undermining consumer choice."[7]

In this case, the costs of staying in a Bronze plan are potentially huge, as those low-premium plans typically come with extremely high deductibles and out-of-pocket maximums, while CSR-eligible silver plans typically have dramatically lower cost sharing.[8] Given that the current rule does not allow an automatic shift unless the product line and networks are the same, and the premium is equivalent or lower, it is difficult to imagine what the actual negative consequences of an automatic shift might be. Unless CMS can demonstrate an actual harm to this policy, rescinding this provision is an arbitrary and capricious change that will only leave some QHP enrollees worse off in less-affordable coverage.

Unnecessarily Complicating Enrollment and Eligibility

While the new administration has made repeated assertions related to increasing cost-efficiency in government, many of the proposed changes in this rule would have the opposite effect – increasing the complexity of the enrollment process and adding new barriers that would increase administrative burdens and, ultimately, inhibit enrollment of qualified applicants in health insurance.

Verifying Income – § 155.320(c)(3)(iii)

The proposed rules add new requirements for individuals to verify their income to demonstrate their eligibility for financial assistance and require those with $0 premiums to pay $5 per month until they do. The rationale provided claims that this requirement will reduce fraud for the lowest income enrollees (100-150% of the Federal Poverty Level (FPL)). The proposed rule provides no evidence that this issue is widespread, citing only a report that attributes a huge increase in enrollment for those between 100-150% FPL as evidence that people are misreporting their income. This conclusion is unwarranted. In fact, the methodology used by the Paragon Health Institute cited in the

[7] 90 FR 12945.
[8] Center on Budget and Policy Priorities, *Key Facts: Cost-Sharing Reductions* (Oct. 2024), https://www.healthreformbeyondthebasics.org/cost-sharing-charges-in-marketplace-health-insurance-plans-part-2/.

proposed rules has been critiqued for serious methodological flaws that led to a dramatic overestimate of improperly enrolled individuals.[9] Instead, a more plausible explanation is that the enhanced tax subsidies made available through the Inflation Reduction Act made it more affordable for these lower-income individuals to sign-up for a health care plan through the Marketplace and people decided to enroll.

We believe additional income verification is a solution in search of a problem. This requirement will unnecessarily burden low-income individuals, including people with disabilities, who desperately need health insurance coverage. Many will not get the coverage they need. The proposed regulations claim that CMS seeks to prevent people from gaming the system and causing the risk pool to become unbalanced, but these proposed rules will actually worsen the Marketplace risk pool. Making it harder for people to enroll in coverage and get the financial help to which they are entitled will disproportionately discourage enrollment by healthier people, who may not be as motivated to jump over all the administrative hurdles to enroll. Those with more health care needs will be more likely to run the administrative gauntlet to effectuate enrollment.

Finally, to the extent people are being enrolled without their knowledge, the rules to prevent this should focus on the agents and brokers that are committing this fraud. To address this problem by making enrollment verification more cumbersome for individuals, many of whom may have no contact with any brokers, seems to misplace the blame for some brokers' fraudulent behaviors.

Shortening Open Enrollment to 45 Days

Under the previous Administration, open enrollment lasted 76 days (Nov. 1 - Jan. 15). The proposed rules would shorten the open enrollment period to 45 days (Nov. 1 - Dec. 15). A larger window for the open enrollment period allows for an increase in access and fair health outcomes for millions of people, especially people with disabilities. An overall change in the open enrollment period can lead to enrollee confusion that requires additional education and outreach, which might not be as feasible as it was in previous years due to drastic cuts in Marketplace Navigator funding.

This also creates unnecessary constraints for enrollees, as many get automatically re-enrolled and then may want to make changes. An extended open enrollment period allows those automatically re-enrolled individuals time to make changes, if necessary, so that they can be in a plan for the remainder of the year that actually meets their needs. The extra time is even more important when you consider that the bulk of the

[9] Keep Americans Covered, *KAC Response to Paragon Paper: Full Report* (Feb. 27, 2025), https://americanscovered.org/wp-content/uploads/2025/02/Paragon-Response-Report-FINAL.pdf.

open enrollment period overlaps with the holiday season, when people are preoccupied with other priorities.

A longer open enrollment period would improve access for working people, especially those with multiple jobs, caregivers, people who face unstable housing, and other marginalized groups. It would also leave more time to address administrative errors and mistakes that were seen during the Medicaid unwinding,[10] such as online portal issues, automatic coverage termination when redeterminations were not logged into state systems, and incorrect housing information. A focus should be placed on improving these eligibility and administrative systems instead of shortening the critical window that people with disabilities use to maintain and update their healthcare coverage.

Longer open enrollment periods increase enrollment and coverage rates, as evident by the last open enrollment period, when over 24 million people chose a Marketplace plan. From 2016 to 2019, the average number of individuals who chose a Marketplace plan was 11.9 million. From 2020 to 2024, this average increased to 15.1 million.[11] Generally, higher enrollment correlates with better health outcomes for populations with higher than average health care utilization, including people with disabilities. These populations often require longer outreach and education periods and sometimes struggle to obtain necessary information due to accessibility challenges. Finally, longer open enrollment periods decrease the cost of uncompensated and high-cost care, mostly because they increase coverage rates. Generally, reducing uninsurance promotes the utilization of recommended preventive services. Uninsured individuals rely on emergency care as first treatment, which can worsen outcomes as diagnosis and initial treatment occurs in later stages of disease. Such delays often require additional high-cost specialized care.

Finally, if the enhanced Marketplace tax credits expire on January 1, 2026, monthly premium payments for most enrollees will increase significantly. The Marketplace will most likely see a substantial enrollment decline due to higher costs.[12]

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[10] Cassandra LaRose, National Health Law Program, *Unwinding Issues Show Medicaid Eligibility Systems Need Better Oversight to Ensure Coverage* (Oct. 28, 2024), https://healthlaw.org/unwinding-issues-show-medicaid-eligibility-systems-need-better-oversight-to-ensure-coverage/.

[11] KFF, *Marketplace Enrollment, 2014-2024* (Last visited Apr. 11, 2025), https://www.kff.org/affordable-care-act/state-indicator/marketplace-enrollment/.

[12] Jared Ortaliza et al., KFF, *Congressional District Interactive Map: How Much Will ACA Premium Payments Rise if Enhanced Subsidies Expire?* (Feb. 3, 2025), https://www.kff.org/affordable-care-act/issue-brief/congressional-district-interactive-map-how-much-will-aca-premium-payments-rise-if-enhanced-subsidies-expire/.

This issue, combined with a reduction in funding for the ACA Navigator program from $98 million to $10 million, will create immense challenges for people with disabilities.[13] Without Navigators to adequately conduct outreach and provide enrollment assistance, people with disabilities will need more time to go through healthcare plans on the Marketplace and get their coverage questions answered. They will also need to plan further ahead of time to compensate for higher costs without enhanced premium tax credits that were previously available. Doing this with dramatically reduced consumer assistance resources over a substantially shorter open enrollment period will only mean that many fewer eligible individuals will be able to enroll.

We therefore urge CMS not to finalize this proposal, to maintain the current OEP duration of November 1-January 15, and to continue to provide State-Based Exchanges (SBEs) with flexibility to determine their own OEP dates. Finalizing this proposal will reduce enrollment of eligible individuals, create a less-healthy risk pool, and increase premiums for Marketplace enrollees.

Eligibility Verification for Special Enrollment Periods (SEP) – § 155.420(g)

CMS proposes to impose additional documentation requirements on consumers seeking to enroll in Marketplace coverage through a SEP. CMS has traditionally afforded SBEs flexibility to define SEPs and verification procedures for their state, but this proposed rule would require all Marketplaces, including SBEs, to verify eligibility prior to enrollment for at least 75% of new SEP enrollments.

In proposing this change, CMS argues that requiring consumers to submit documents proving that they have experienced a SEP-triggering event will prevent people from enrolling only after they become sick or need health care services. Contrary to available evidence, CMS asserts that additional documentation burdens will improve, not worsen, the Marketplace risk pools.[14] In fact, CMS's own analysis found that younger, often healthier, consumers submit acceptable documentation to verify their SEP eligibility at much lower rates than older, generally less healthy, individuals.

CMS asserts that providing pre-enrollment documentation does not create "any substantial enrollment barrier" for consumers, and that all consumers have "ready access" to the necessary official documents.[15] But CMS' itself acknowledges that more than 75,500 (14%) of individuals required to submit pre-verification documentation did

[13] CMS, *Press Release: CMS Announcement on Federal Navigator Program Funding* (Feb. 14, 2025), https://www.cms.gov/newsroom/press-releases/cms-announcement-federal-navigator-program-funding.
[14] 90 RF 12945, 12984.
[15] 90 FR 12984.

not get their issue resolved during PY 2019.[16] In fact, a considerable body of research has found that paperwork and other administrative hurdles serve as a strong deterrent to enrollment among people who are otherwise eligible for the coverage.[17] Younger, healthier individuals are most likely to be deterred from enrolling, leading to a less-healthy risk pool. For example, one study found that adding one additional step to the enrollment process prompted a 33 percent decline in enrollment, predominantly among young, healthy, and economically disadvantaged people.[18] Removing paperwork burdens, on the other hand, has been found to significantly increase enrollment and continuity of coverage, especially among healthy, younger individuals.

Additional documentation challenges may also create uniquely significant barriers for people with disabilities applying for Marketplace coverage, because each hurdle often has its own accessibility challenges. The human and economic costs of leaving people with disabilities uninsured are substantial, and will only worsened by the stark 90% reduction in Navigator program funding, which may drive up reliance on brokers and exacerbate any problems due to bad actors wrongfully enrolling individuals.

Because CMS provides no evidence to support either the use of SEPs to commit fraud in the SBEs, nor clear evidence of adverse selection resulting from a lack of pre-verification, there is no rational basis to take away SBEs' traditional flexibility to determine the SEP verification processes that work for their issuers and markets. CMS should not finalize this proposal.

Ending the Low-Income SEP – § 155.420

CMS proposes to repeal the SEP made available to individuals at or below 150 percent of the federal poverty level ("FPL") (or an annual income of $23,475 for an individual, $48,225 for a family of four). The availability of this SEP has helped low-income consumers access affordable health insurance coverage and maintain access to care. However, CMS suggests that this low-income SEP has contributed to improper

[16] 90 FR 12983.

[17] Emmett Ruff & Eliot Fishman, Families USA, *The Return of Churn: State Paperwork Barriers Caused More Than 1.5 Million Low-Income People to Lose Their Medicaid Coverage in 2018* (Apr., 2019), https://familiesusa.org/product/return-churn-state-paperwork-barriers-caused-more-15-million-low-income-people-lose-their; Justin Schweitzer, Emily DiMatteo & Nick Buffie, Center for American Progress, *How Dehumanizing Administrative Burdens Harm Disabled People* (Dec. 5, 2022), https://www.americanprogress.org/article/how-dehumanizing-administrative-burdens-harm-disabled-people/; Phil Galewitz, *Utah Survey Shows Why So Many People Were Dumped from Medicaid*, Washington Post, Jan. 3, 2024, https://www.washingtonpost.com/politics/2024/01/03/utah-survey-shows-why-so-many-people-were-dumped-medicaid/.

[18] Mark Shepard and Myles Wagner, *Do Ordeals Work for Selection Markets? Evidence from Health Insurance Auto-Enrollmen*t, 115 American Economic Review 772 (2025).

enrollments, driven largely by unscrupulous brokers and web-brokers seeking commissions. CMS also suggests, without evidence, that this SEP has increased adverse selection, leading to a less-healthy risk pool.

We urge CMS not to finalize this proposal. The low-income SEP has helped millions of individuals overcome challenges enrolling in health coverage. These challenges are particularly acute for lower-income individuals who may lack access to necessary information, face greater employment and household volatility, or reside in areas without sufficient enrollment assistance. Because people with disabilities have lower average incomes than the general population, they are also more likely to make use of the low-income SEP.[19]

There is zero evidence that the existence of the low-income SEP has caused the increase in fraudulent enrollments experienced by the Federally-funded Exchange (FFE) in 2024. The premium tax credits available to these individuals would mean they would have little incentive to try and "game the system," as the premiums paid by these individuals are usually $0. They gain nothing by waiting to enroll. Instead, the cause of enrollments made without consumer consent can be traced to brokers and agents in the FFE who are taking advantage of systemic vulnerabilities unique to the FFE. Attempting to deter fraudulent enrollments by making it harder for people to enroll in coverage is counterproductive and effectively blaming the victims.

There is zero evidence of any meaningful fraud in the SBE states, all but two of whom have implemented the low-income SEP and have had it available to consumers for multiple years. None of these SBEs have reported problems with fraud. Covered California's comprehensive safeguards to ensure that brokers obtain consumer consent before completing an enrollment.

Access to healthcare is typically linked with income status, and often lower income individuals face more barriers to obtaining coverage. People with disabilities on average are overrepresented among these low-income populations and more likely to be on Medicaid or qualify for Marketplace cost sharing reductions. This SEP makes it easier for people with disabilities to enroll in coverage when they need it. We are concerned

[19] Zachary A. Morris et al., *The Disability Squeeze: The Extra Costs of Living with Blindness or Low Vision in the U.S.* (Sept. 2024), https://www.afb.org/research-and-initiatives/research/partnered-projects/disability-squeeze-the-extra-costs-of-living-with-blindness-or-low-vision; Nanette Goodman et al., National Disability Inst., *The Extra Costs of Living with a Disability in the U.S. – Resetting the Policy Table* (Oct. 2020), https://www.nationaldisabilityinstitute.org/wp-content/uploads/2020/10/extra-costs-living-with-disability-brief.pdf.

that elimination of this SEP will make it that much harder for people with disabilities to get timely coverage.

Redefining Deferred Action for Childhood Arrivals (DACA) – § 155.20

CMS proposes to reverse its policy relating to the over 538,000 young adults who can qualify for Marketplace tax credits as DACA recipients. The specific change would redefine the term "lawfully present" to exclude DACA recipients for the purposes of enrollment in Marketplace and Basic Health Program ("BHP") coverage, premium tax credits, and cost-sharing reductions. These individuals have been at the center of a political maelstrom for over two decades and their families, livelihoods, and futures have been under constant threat. This proposed change in definition would go into effect upon the effective date of the final rule, prompting DACA recipients currently enrolled in Marketplace or BHP coverage to lose eligibility mid-year, causing yet more unnecessary disruptions. Some current Marketplace or BHP enrollees could lose coverage while in the middle of a course of treatment.

Their disenrollment will also significantly increase the uninsurance rate and force more DACA recipients to forgo preventive care and rely on emergency care, face catastrophic medical bills for many members of this financially vulnerable population. In several sections of the preamble to this proposed rule, CMS expresses concerns about adverse selection in the ACA Marketplaces. Yet the proposal to terminate DACA recipients would remove a generally younger, healthier population from the Marketplace risk pool. A 2024 analysis of federal survey data found that the majority of immigrants likely eligible for DACA are working and have self-reported excellent or very good health. CMS estimates that 10,000 DACA recipients will lose their Marketplace coverage and 1,000 will lose BHP coverage if this proposed rule is finalized. However, the final 2024 rule that includes DACA recipients in the definition of lawfully present projected that 100,000 DACA recipients would benefit from access to Marketplace coverage and subsidies. Because the policy is new, and many DACA recipients may not have known about their new coverage options in time to enroll, fewer have taken advantage of this coverage option, but the prior estimate suggests that the full scope of this policy change in terms of lost coverage opportunities has been substantially understated.

We urge CMS not to finalize this proposal and to retain its current definition of "lawfully present" to include DACA recipients. HHS has generally interpreted "lawfully present" to include those granted deferred action by the Department of Homeland Security ("DHS"). Although HHS excluded DACA recipients from the definition of lawfully present in 2012—after DHS first announced its DACA policy—since then DHS issued regulations formalizing its DACA policy.

Making Coverage Less Comprehensive

In addition to multiple policies that will make it more expensive and more burdensome to enroll in Marketplace health plans, the proposed rule, if finalized, would prohibit states from including gender-affirming care as an Essential Health Benefit (EHB).

Prohibiting Coverage of Gender-Affirming Care as an EHB – § 156.115(d)

The proposed rule seeks to forbid states from including gender-affirming care as an EHB. Gender-affirming care is best practice medical care that is necessary for many transgender individuals and is provided according to well-established clinical standards. The overwhelming consensus among medical experts, including every major medical organization in the United States, is that gender-affirming care is medically necessary, effective, and safe.[20]

Despite this consensus, transgender people continue to face barriers to accessing this care.[21] These barriers would be further exacerbated by the proposed rule. By denying gender-affirming care the protections of being an EHB, the proposed rule would lead to higher out-of-pocket costs for transgender individuals and discourage states from requiring coverage of this care.

The proposed rule conflicts with numerous nondiscrimination protections applying to EHB. The medical services used to treat gender dysphoria are routinely covered as EHB when used by non-transgender people for a variety of other indications. By seeking to prohibit this care from being covered as an EHB only when it is used to treat gender dysphoria, the proposed rule would engage in explicit discrimination based on a health condition or disability (gender dysphoria) and based on sex. If finalized, therefore, the proposed rule would conflict with laws such as Section 1557 of the ACA, Section 504 of the Rehabilitation Act, and the Americans with Disabilities Act, as well as with prohibitions on discrimination specific to EHB and benchmark plans.[22]

Furthermore, the proposed rule fails to provide a reasoned justification for this provision. As its primary justification, the Department claims that coverage for gender-affirming care is not included in typical employer-sponsored plans, but its support for this assertion relies exclusively on state benchmark selections that were made more than a decade ago. The scope of employer plans has significantly changed in recent years.

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[20] *See, e.g.,* Advocates for Trans Equality, *Medical Organization Statements* (last visited Apr. 7, 2025), https://transhealthproject.org/resources/medical-organization-statements.
[21] *See, e.g.,* Caroline Medina et al., *Protecting and Advancing Health Care for Transgender Adult Communities* (Aug. 18, 2021), https://www.americanprogress.org/article/protecting-advancing-health-care-transgender-adult-communities/#Ca=10.
[22] *See, e.g.,* 45 C.F.R. § 156.125(a); 45 C.F.R. § 156.200(e).

The most recent analysis of Fortune 500 companies, for example, found that 72% covered gender-affirming care in their plans.[23] The proposed rule also makes unsubstantiated claims about the "scientific integrity" of the evidence supporting gender-affirming care, disregarding the overwhelming consensus of medical and scientific experts in the United States.

Conclusion

Thank you for your consideration of our input to help improve access to affordable Marketplace coverage for people with disabilities. If you have any questions, please contact David Machledt (machledt@healthlaw.org).

Sincerely,

Access Ready, Inc.
American Association on Health and Disability
American Association of People with Disabilities
American Music Therapy Association
The Arc of the United States
Autistic Self Advocacy Network
Caring Across Generations
CommunicationFIRST
Disability Rights Education and Defense Fund (DREDF
Epilepsy Foundation of America
Justice in Aging
Muscular Dystrophy Association
National Disability Rights Network (NDRN)
National Health Law Program
The Partnership for Inclusive Disaster Strategies
SPAN Parent Advocacy Network

[23] Human Rights Campaign Foundation, *Corporate Equality Index 2025* (Jan. 2025), https://reports.hrc.org/corporate-equality-index-2025.