

Tab 1

Community Toolkit: Opposing the Proposed Rule to Eliminate Gender-Affirming Care under the ACA

🔴 Deadline: 4/11/25 at 11:59 PM EST 🔴

Proposed Rule (Use this link to make your public comment!)

[https://www.federalregister.gov/documents/2025/03/19/2025-04083/patient-protection-and-affordabl
e-care-act-marketplace-integrity-and-affordability](https://www.federalregister.gov/documents/2025/03/19/2025-04083/patient-protection-and-affordabl-e-care-act-marketplace-integrity-and-affordability)

Links to Comment <https://bit.ly/acapubliccomment> | <https://bit.ly/GAProsResources>

ACA Public Comment Flyer that can be shared:

https://www.canva.com/design/DAGieWQ3Mas/ZCbMJW8pf7vGQZB9rB_Low/view?utm_content=DAGieWQ3Mas&utm_campaign=designshare&utm_medium=link2&utm_source=uniqueLinks&utlId=hb2c65f768a

Some Basic Guidelines:

- Use calm, professional language. You can be firm and direct, but be polite.
- Incorporate personal points and experiences that express why this issue is important to you. However, consider how you use specific identifying information about you or your loved ones that you do not want part of the public record.
- If you prefer, you **can** submit anonymously.
- Please **do NOT** simply copy and paste these talking points. Put it in your own words. Multiple identical submissions are simply counted as one submission.
- You can attach files such as articles and reports from media, studies, or any other relevant supporting material you can think of.
- This does not have to be a lengthy letter, substance over length!

Format Idea (Optional, Only If It Helps You)

-Introduction - A few sentences as to why you oppose this and why it is important to you.

-Three separate points incorporating some of the points listed below

-Conclusion reiterating the introduction.

Additional resource with template and format:

[https://medium.com/@magicalweirdochuck/the-fight-for-trans-healthcare-how-a-new-federal-rul
e-could-limit-gender-affirming-care-37e8b0cbe409?fbclid=PAY2xjawJRsbDleHRuA2FibQlxMAA](https://medium.com/@magicalweirdochuck/the-fight-for-trans-healthcare-how-a-new-federal-rule-could-limit-gender-affirming-care-37e8b0cbe409?fbclid=PAY2xjawJRsbDleHRuA2FibQlxMAA)

Breakdown of Proposed ACA Changes in Simple Language

What Is Gender-Affirming Care?

Gender-affirming care refers to healthcare that helps people feel aligned with their gender identity. It is important to note that everyone takes steps to have their gender expression or presentation match with their gender identity. Regardless of whether they are cisgender or transgender.

However, access to gender-affirming care for transgender people, or people whose gender identity doesn't match the sex they were assigned at birth, is the only type of care that is being prohibited through state and federal legislation.

The care that transgender and nonbinary people can need as part of their transition can include:

- - Puberty blockers (GnRH agonists) for young people
- - Hormone therapy (like estrogen or testosterone)
- - Surgery and other procedures
- - Mental health support

Major medical groups say this care is safe, effective, and necessary for the well-being of transgender people — especially trans youth.

For more information about the leading medical groups that recognize the medical necessity of treatments for gender affirming care -

<https://transhealthproject.org/resources/medical-organization-statements/>

What medications are commonly used for gender-affirming care?

- Testosterone Cypionate or testosterone enanthate
 - Injectable, patches, or gel
- Estradiol
 - Injectable, patches, or oral tablets
- Spironolactone
 - Oral tablets
- GnRH agonists
 - Lupron depot
 - 11.25mg, 15mg, 30mg, 45mg
 - Triptodur (triptorelin)
 - 22.5mg
 - Supprelin LA (vantis, histrelin acetate)
 - 50 mg implant

What other conditions/diagnoses are these medications used to treat that are not related to gender affirming care that could be impacted by the changes in coverage to the ACA?

- Testosterone
 - Primary or secondary hypogonadism (low testosterone)
 - Delayed puberty
 - Certain types of cancer in people assigned female (metastatic breast cancer)
 - Osteoporosis
 - Low libido
 - Hypopituitarism
 - 5-alpha reductase deficiency (5 α RD)
 - Vanishing testes syndrome (VTS)
- Estrogen
 - Primary or secondary hypogonadism (low estrogen)
 - Delayed puberty
 - Hormone replacement therapy for menopause
 - Abnormal uterine bleeding
 - Osteoporosis
 - Vaginal dryness and pain
 - Certain types of cancer in people assigned male (prostate)
 - Certain types of breast cancer
 - Contraception/Fertility treatment
 - Hypoestrogenism
 - Hypopituitarism
 - Androgen Insensitivity Syndrome
 - 5-alpha reductase deficiency (5 α RD)
 - Gonadal dysgenesis
- GnRH Agonists (puberty blockers)
 - Endometriosis
 - Fibroids
 - Central precocious puberty (CPP - when puberty starts too early)
 - Abnormal uterine bleeding
 - Prostate cancer
 - Other sex hormone sensitive cancers
- Spironolactone
 - High blood pressure
 - Heart failure
 - Reduce swelling related to heart, kidney, or liver disease

What the Government Is Proposing?

The government wants to label this care as “sex-trait modification” and exclude it from the list of essential health benefits that ACA insurance plans must cover.

They say this care:

- - Isn’t typically covered by employer health plans
- - Doesn’t fit with their new definition of “biological sex”
- - Shouldn’t be paid for with federal money

The government also refers to gender-affirming treatments as “chemical and surgical mutilation” — a term used in recent executive orders signed by President Trump. These orders try to limit or ban gender-affirming care, especially for youth.

What This Rule Would Do

If finalized:

- - ACA health plans would no longer be required to cover gender-affirming care
- - Trans people might lose access to the care they rely on
- - Some states could continue to cover it, but only if they pay for it themselves
- - Young people and low-income individuals would be hit the hardest
- - The proposed rule could weaken protections or access to these services — especially if paired with other legal rollbacks — impacting early HIV detection and prevention efforts.
- - In addition, the proposed rule seeks to exclude DACA recipients (“Dreamers”) from the ACA for **all** healthcare.

What’s Happening in Court

Two federal courts have already blocked parts of the executive orders that push for these restrictions, saying they may be illegal.

But this rule tries to get around those court orders by claiming it's based on different reasons.

Information about previous and ongoing court cases related to gender affirming care:

https://lambdalegal.org/newsroom/us_20240429_victory-fourth-circuit-rules-north-carolina-and-west-virginia-cant-deny-transgender-people-coverage-for-medical-care/

https://lambdalegal.org/newsroom/pflag_us_20250304_federal-judge-grants-pi-against-trumps-anti-trans-healthcare-order/

<https://lambdalegal.org/case/pflag-v-trump/>

<https://www.atg.wa.gov/news/news-releases/wa-judge-temporarily-halts-unconstitutional-trump-order-targeting-gender>

<https://www.acslaw.org/expertforum/courts-are-pumping-the-brakes-on-trumps-anti-trans-crusade/>

Arguments Against the Proposed Rule to Eliminate Gender-Affirming Care from EHB

Legal and Statutory Grounds

- Section 1557 of the ACA prohibits discrimination based on sex, which includes gender identity. Denying coverage for gender-affirming care violates this protection.

- Courts have issued preliminary injunctions against Executive Orders 14168 and 14187. Moving forward with the rule while litigation is pending risks further legal challenges.
- States retain authority under §155.170 to mandate gender-affirming care in benchmark plans; overriding this undercuts federalism and ACA's structure.

Medical Consensus and Scientific Integrity

- The redefinition of gender-affirming care as 'chemical and surgical mutilation' or 'sex-trait modification' is medically inaccurate and contradicts leading health authorities.
- Gender-affirming care is evidence-based, medically necessary, and supported by decades of research and every major medical association.
- The rarity of a treatment does not justify its exclusion. Less than 1% utilization does not mean the service is non-essential.

Public Health and Health Equity Impact

- Gender-affirming care improves mental health outcomes and reduces suicide risk, especially among transgender youth.
- This proposal disproportionately harms vulnerable populations who rely on ACA plans for access, including low-income, rural, and BIPOC communities.
- Removing coverage will have a chilling effect on healthcare access for transgender people more broadly, not just for transition-related care.

Policy and Administrative Concerns

- Variability in EHB benchmark plans reflects the ACA's intended flexibility, not a flaw. Federal standardization based on ideology undermines that framework.
- This sets a dangerous precedent: denying healthcare based on identity opens the door to targeting other marginalized groups.
- Politicizing medical definitions of sex and care erodes trust in HHS and contradicts its public health mission.

Economic and Implementation Arguments

- Short-term cost savings will be offset by long-term harm, including increased emergency and mental health care costs.
- States and insurers will face increased administrative burdens if forced to shift costs for state-mandated care.
- Removing federal subsidy for gender-affirming care makes it inaccessible for many who need it most.

Ethical and Human Rights Considerations

- Denying care based on gender identity is unethical and discriminatory.
- Healthcare decisions must be made by patients and doctors, not politicians.
- Using terms like 'biological truth' or 'chemical mutilation' reflects ideology, not science, and has no place in policy.

Suggested Alternatives and Safeguards

- Maintain state flexibility to define EHB benchmark plans.
- Require objective, peer-reviewed review before excluding services from EHB.
- Guarantee exceptions for all medically necessary uses of related treatments across patient populations.

Access to Preventive HIV Services

- Preventive HIV measures such as pre-exposure prophylaxis (PrEP) reduces HIV risk by up to 99% when taken as prescribed — it is among the most effective public health interventions in modern medicine.
- Routine HIV screening is critical to reducing undiagnosed cases, interrupting transmission, and connecting people to care.
- Blocking or restricting these services ignores overwhelming scientific consensus and undermines evidence-based policy.

Impact on DACA Recipients

- The rule seeks to exclude DACA recipients from **all** ACA coverage.
- This would reduce access to HIV prevention, testing, and treatment for this population.
- Fewer DACA recipients would be able to participate in HIV research, leading to gaps in public health data and less effective care strategies.

Key Policy Concerns about DACA recipient restrictions:

- The Emergency Medical Treatment and Active Labor Act (EMTALA) is a federal law that requires hospitals to treat patients in need of emergency care. This applies to all individuals regardless of their immigration status. However, while EMTALA would help very low income pregnant people with the cost of emergency visits it will not help them with receiving any medical attention after delivery (postpartum care). Restricting DACA recipients from ACA eligibility prevents pregnant DACA recipients from routine prenatal and postpartum care.
- Restrictions to ACA coverage for immigration status treats DACA recipients as “less than”
- These restrictions set a bad precedent for future immigration policies that might treat newly legalized immigrants as a separate class that has fewer rights
- Violates the spirit and compromises the Affordable Care Act, which was intended to expand health care
- Undermines DACA program’s goals of enhancing the well-being of people who came into the country as children.

Source:

<https://www.nilc.org/wp-content/uploads/2022/12/Exclusion-of-DACA-Healthcare-FAQ-2022-PDF.pdf>

Changes to Eligibility, Enrollment, & Cost

“HHS Proposes To Restrict Marketplace Eligibility, Enrollment, and Affordability In First Major Rule Under Trump Administration (Part 1)” Health Affairs Forefront, March 12, 2025. DOI: 10.1377/forefront.20250312.194932

Link to full article:

<https://www.healthaffairs.org/content/forefront/hhs-proposes-restrict-marketplace-eligibility-enrollment-and-affordability-first-major>

Overview of changes to ACA marketplace eligibility, enrollment, and affordability:

- Reserves Biden-era policies that expanded eligibility, enrollment, and affordability
 - Includes extending annual enrollment period (OEP)
 - Create a new special enrollment period (SEP) for qualifying low-income Americans
 - Reduce administrative burdens on consumers
 - Expiration of enhanced premium tax credits that will expire at the end of 2025 if not extended by Congress. (These credits resulted in more than 24 million people enrolling in health insurance for 2025)
- Alters reenrollment process for consumers currently automatically reenrolling to a \$0 premium plan instead of a \$5 premium plan.
- Eliminating the special enrollment period for low-income Americans would require new paperwork requirements. If the proposed change is made, it would mean that consumers would have to apply for insurance mid-2025.
- The proposed changes also include a severability clause, meaning that the rest of the agreement between the ACA marketplace and consumers (the people enrolled in plans) is valid and enforceable even if parts of the changes are deemed illegal, invalid or unenforceable.
- **Up to two million people could lose their coverage in 2026 alone, with coverage losses concentrated in Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Utah.**

Limits on Enrollment Opportunities

- Makes it harder for people to enroll in marketplace coverage by shortening the annual enrollment period
- Eliminates the monthly special enrollment period for low-income people
- Creates difficult verification requirements for low-income people
- Eliminates marketplace and basic health program eligibility to DACA recipients

Limiting the Annual Open Enrollment period

- HHS proposes to limit the open enrollment period to 45 days (Biden administration extended this period to about 75 days)

- The proposed changes suggest that this shorter enrollment period is better for people because it is less confusing. HHS also states that they will continue to inform consumers about the enrollment period but provides no information about how they will engage with public outreach. Especially as they continue to gut funding and departments dedicated to sharing important health information with the public.

Eliminating the monthly SEP for Low-income consumers

- Despite data supporting that the special enrollment period for low-income people was successful, the proposed changes are to eliminate the SEP. The HHS believes that the SEP increases improper enrollments by agents, brokers, and web-brokers. Instead of addressing that concern with agents, brokers, and web-brokers the agency will abruptly end the special enrollment period for consumers.

Special enrollment period verification requirements

- HHS proposes to restart the special enrollment period (SEP) verification requirements for certain types of SEPS.
 - Consumers would have to complete pre-enrollment verification **before** their health coverage starts.
 - HHS acknowledges that the verification requirements will create barriers and deter people, especially young people, from enrolling in coverage. However, the agency still believes that it is best to move forward with the difficult verification process anyways.
 - The cost of this verification is significant.
 - “Although SBEs could ask to use alternative SEP verification methods, this change could also be costly for SBEs: most SBEs would incur one-time costs of about \$12 million while five SBEs would incur one-time costs of about \$60 million. This is in addition to ongoing annual costs to implement and operationalize SEP verification requirements.”

Guaranteed Issue and Repayment of Past Due Premiums

- HHS would allow insurers to deny new coverage for people who have outstanding payments from previous insurance coverage until all debt has been paid. If someone cannot afford to pay for previous past-due premiums they can be refused a new insurance policy.

Requiring Premiums for those Auto Reenrolled

- Current rules for people who have insurance through the marketplace allow them to automatically reenroll in the same plan. If that plan is no longer available, they will be enrolled into a plan that has similar coverage or more coverage if a plan is available at no additional cost. For the new proposed rule, HHS wants to charge people \$5 per

month until they have completed and confirmed their eligibility information. This includes people who have a premium of \$0

- “HHS asks whether the premium penalty should be greater than \$5 and seeks comment on the appropriate dollar amount that fully subsidized consumers should have to pay before being able to access a zero-premium plan. HHS also solicits comment on whether the risk of “program integrity concerns” might outweigh the benefit of automatic reenrollment, suggesting some interest in additional changes to the automatic reenrollment process.”
- The proposed changes include removing automatic enrollment of similar or more coverage plans. The argument from HHS is that automatic enrollment “inappropriately overrides consumer choice”

Reducing Affordability

- HHS proposes to restart Trump-era policies that would raise premiums and out-of-pocket costs for consumers
- HHS proposes to set the premium adjustment percentage 4.5 % higher in 2026
 - This means higher annual limits on out-of-pocket costs
 - Higher premiums for subsidized consumers