ADULT LGBT POPULATION IN THE UNITED STATES

UCLA School of Law Williams Institute

March 2019

Estimated number of LGBT adults in the US and by state

	1	2	3	4	5	6	7	8
	% LGBT	**# LGBT (Total)**	**# LGB (Total)**	# LGB (Cisgender)	# LGB (Trans)	**# Transgender (Total)**	# Transgender (Straight/Other)	# Transgender (LGB)
US	4.5%	11,343,000	10,338,000	9,946,000	392,000	1,397,150	1,005,000	392,000
Alabama	3.1%	117,000	101,000	95,000	6,000	22,500	16,000	6,000
Alaska	3.7%	21,000	19,000	18,000	1,000	2,700	2,000	1,000
Arizona	4.5%	242,000	220,000	212,000	9,000	30,550	22,000	9,000
Arkansas	3.3%	76,000	66,000	62,000	4,000	13,400	10,000	4,000
California	5.3%	1,615,000	1,458,000	1,397,000	61,000	218,400	157,000	61,000
Colorado	4.6%	200,000	185,000	179,000	6,000	20,850	15,000	6,000
Connecticut	3.9%	111,000	102,000	99,000	3,000	12,400	9,000	3,000
Delaware	4.5%	34,000	31,000	30,000	1,000	4,550	3,000	1,000
District of Columbia	9.8%	56,000	45,000	41,000	4,000	14,550	10,000	4,000
Florida	4.6%	772,000	700,000	672,000	28,000	100,300	72,000	28,000
Georgia	4.5%	356,000	316,000	301,000	16,000	55,650	40,000	16,000
Hawaii	4.6%	52,000	46,000	43,000	2,000	8,450	6,000	2,000
Idaho	2.8%	36,000	32,000	31,000	1,000	4,750	3,000	1,000
Illinois	4.3%	426,000	390,000	376,000	14,000	49,750	36,000	14,000
Indiana	4.5%	229,000	209,000	202,000	8,000	27,600	20,000	8,000
Iowa	3.6%	87,000	82,000	79,000	2,000	7,400	5,000	2,000
Kansas	3.3%	73,000	66,000	63,000	3,000	9,300	7,000	3,000
Kentucky	3.4%	117,000	104,000	99,000	5,000	17,700	13,000	5,000
Louisiana	3.9%	139,000	124,000	119,000	6,000	20,900	15,000	6,000
Maine	4.9%	53,000	49,000	48,000	2,000	5,350	4,000	2,000
Maryland	4.2%	198,000	182,000	175,000	6,000	22,300	16,000	6,000
Massachusetts	5.4%	296,000	275,000	267,000	8,000	29,900	22,000	8,000
Michigan	4.0%	311,000	288,000	279,000	9,000	32,900	24,000	9,000
Minnesota	4.1%	175,000	158,000	151,000	7,000	24,250	17,000	7,000
Mississippi	3.5%	79,000	70,000	66,000	4,000	13,650	10,000	4,000
Missouri	3.8%	180,000	162,000	155,000	7,000	25,050	18,000	7,000
Montana	2.9%	24,000	22,000	21,000	1,000	2,700	2,000	1,000

	1	2	3	4	5	6	7	8
	% LGBT	**# LGBT (Total)**	**# LGB (Total)**	# LGB (Cisgender)	# LGB (Trans)	**# Transgender (Total)**	# Transgender (Straight/Other)	# Transgender (LGB)
Nebraska	3.8%	55,000	51,000	49,000	2,000	5,400	4,000	2,000
Nevada	5.5%	127,000	118,000	114,000	4,000	12,700	9,000	4,000
New Hampshire	4.7%	51,000	48,000	46,000	1,000	4,500	3,000	1,000
New Jersey	4.1%	288,000	266,000	258,000	8,000	30,100	22,000	8,000
New Mexico	4.5%	72,000	64,000	60,000	3,000	11,750	8,000	3,000
New York	5.1%	800,000	744,000	722,000	22,000	78,600	57,000	22,000
North Carolina	4.0%	319,000	287,000	274,000	13,000	44,750	32,000	13,000
North Dakota	2.7%	16,000	14,000	14,000	<1,000	1,650	1,000	<1,000
Ohio	4.3%	389,000	361,000	349,000	11,000	39,950	29,000	11,000
Oklahoma	3.8%	113,000	100,000	95,000	5,000	18,350	13,000	5,000
Oregon	5.6%	183,000	169,000	163,000	6,000	19,750	14,000	6,000
Pennsylvania	4.1%	416,000	384,000	372,000	12,000	43,800	32,000	12,000
Rhode Island	4.5%	38,000	35,000	34,000	1,000	4,250	3,000	1,000
South Carolina	3.5%	137,000	122,000	116,000	6,000	21,000	15,000	6,000
South Dakota	3.0%	20,000	18,000	17,000	1,000	2,150	2,000	1,000
Tennessee	3.5%	182,000	160,000	151,000	9,000	31,200	22,000	9,000
Texas	4.1%	858,000	768,000	733,000	35,000	125,350	90,000	35,000
Utah	3.7%	80,000	75,000	73,000	2,000	7,200	5,000	2,000
Vermont	5.2%	26,000	24,000	23,000	1,000	3,000	2,000	1,000
Virginia	3.9%	257,000	233,000	223,000	10,000	34,500	25,000	10,000
Washington	5.2%	300,000	276,000	267,000	9,000	32,850	24,000	9,000
West Virginia	4.0%	58,000	53,000	52,000	2,000	6,100	4,000	2,000
Wisconsin	3.8%	171,000	158,000	152,000	5,000	19,150	14,000	5,000
Wyoming	3.3%	15,000	14,000	13,000	<1,000	1,400	1,000	<1,000

Note: Population estimates accompany the Williams Institute's LGBT Demographic Data Interactive. Due to rounding, estimates for subgroups (i.e., LGB cisgender adults, LGB transgender adults) will not always add up to the total (i.e., all LGB adults). As detailed in the methodological notes below, % LGBT draws upon 2017 data for the US estimate and from 2015-2017 or 2012-2017 aggregated data for state estimates. This means that the sum of all state estimates will not equal the total estimated number of US adults.

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Methodological Notes

% LGBT: The estimated percentages of adults age 18 and older who identify as LGBT is derived from the Gallup Daily Tracking Survey. The Gallup Daily Tracking survey is an annual list-assisted random digit dial (70% cell phone, 30% landline) survey, conducted in English and Spanish, of approximately 350,000 U.S. adults ages 18 and up who reside in the 50 states and the District of Columbia.

LGBT identity is based on response to the question, *"Do you, personally, identify as lesbian, gay, bisexual, or transgender?"* Respondents who answered "*yes*" were classified as LGBT. Respondents who answered "*no*" were classified as non-LGBT. Estimates derived from other measures of sexual orientation and gender identity will yield different results.

National estimates of the percentage of the population that is LGBT-identified use 2017 Gallup data, while state estimates use 2015-2017 data unless otherwise noted. Due to small overall population sizes, 2012-2017 data were aggregated for the following states: Alaska, Delaware, Hawaii, Idaho, Mississippi, Montana, New Hampshire, North Dakota, Rhode Island, South Dakota, Vermont, West Virginia, and Wyoming. All percentages correspond to those reported in the Williams Institute's LGBT Demographic Data Interactive.

 # LGBT (Total): To estimate the number of LGBT adults age 18 and older, nationally and by state, the weighted percentage of LGBT Gallup Daily Tracking respondents was applied to 2017 population estimates produced by the US Census Bureau (based on projections from the 2010 Census) for adults ages 18 and up and rounded to the nearest 1,000. Census estimates were obtained via American FactFinder Table PEPSYASEX, "*Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States, States, and Puerto Rico Commonwealth: April 1, 2010 to July 1, 2017.*"

#LGB (Total): To estimate the number of LGB adults age 18 and older, nationally and by state, the estimated number of transgender adults who do not identify as LGB (column 7) was subtracted from the estimated number of LGBT adults (column 2). Estimates are rounded to the nearest 1,000. This approach avoids double-counting transgender adults who are not LGB-identified in estimates of the total number of LGB-identified adults.

 # LGB (Cisgender): To estimate the number of LGB adults age 18 and older who are cisgender (i.e., do not identify as transgender), the estimated number of transgender adults (column 6) was subtracted from the estimated number of LGBT adults (column 2). Estimates are rounded to the nearest 1,000. This estimate excludes all transgender adults—including those who identify as LGB, as well as those who do not.

 # LGB (Trans): To estimate the number of LGB adults age 18 and older who identify as transgender, the estimated number of transgender adults (column 6) was multiplied by the percentage of transgender adults estimated to identify as LGB.

The percentages of transgender adults who identify as LGB and do not identify as LGB are derived from unpublished analyses of the 2015-2017 Behavioral Risk Factor Surveillance System (BRFSS) data conducted by the Williams Institute. See www.cdc.gov/brfss for more information about the BRFSS and the optional sexual orientation and transgender status ("SOGI") questions included on the BRFSS survey conducted by 34 states and the territory of Guam in 2015 or 2017.

BRFSS respondents who selected *"yes, transgender, male-to-female", "yes, transgender, female-to-male,"* or "*yes, transgender, gender-nonconforming"* as responses to the question "*Do you consider yourself to be transgender?"* were categorized as transgender; those answering "*no"* were categorized as non-transgender

(i.e., cisgender). Respondents who selected "*lesbian or gay*" or "*bisexual*" were categorized as LGB in response to the question "D*o you consider yourself to be..?*" Respondents who selected "*straight*" or who told the interviewer "other" were categorized as straight/other.

In the pooled 2015-2017 BRFSS data, 28.1% of transgender BRFSS respondents, identified as "*lesbian or gay*" (9.9%) *or "bisexual"* (18.1%), *while* 72.0% selected "straight" (64.9%) or said "other" (7.1%) as their sexual orientation. Due to rounding, percentages may not total to 100%.

 # Transgender (Total): The estimated percentage and number (rounded to the nearest 50) of adults ages 18 and older who identify as transgender are reported in: Flores, A. R., Herman, J. L., Gates, G. J., & Brown, T. N. T. (2016). How Many Adults Identify as Transgender in the United States? Los Angeles: Williams Institute.

 # Transgender (Straight/Other): To estimate the number of transgender adults who do not identify as LGB, the estimated number of transgender adults reported in Flores et al. (2016) was multiplied by the estimated percentage of transgender adults who did not identify as LGB (i.e., identified as "*straight*" or "*other*") in unpublished analyses of 2015-2017 BRFSS data (column 5).

 # Transgender (LGB): See # LGB Trans above, which details calculations used to determine the estimated number of adults who identify as both LGB and transgender.

LGBT People in the U.S. Not Protected by State Nondiscrimination Statutes

UCLA School of Law Williams Institute

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At the federal level and in most states, nondiscrimination statutes do not expressly enumerate sexual orientation and gender identity as protected characteristics. Twenty-two states and Washington, D.C. expressly enumerate either or both of these characteristics in their nondiscrimination statutes, although not necessarily in all settings. This research brief estimates the number of LGBT people who are protected by such statutes in the areas of employment, education, public accommodations, housing, and credit—and the number who are not.*

KEY FINDINGS

- An estimated 8.1 million LGBT workers age 16 and older live in the United States. About half of these workers—4.1 million people—live in states without statutory protections against sexual orientation and gender identity discrimination in employment.
- There are over 3.5 million LGBT students age 15 and older in the U.S. About 2.1 million live in states without statutory protections against sexual orientation and gender identity discrimination in education.
- There are an estimated 13 million LGBT people age 13 and older in the U.S. Approximately 6.9 million live in states that do not statutorily prohibit sexual orientation and gender identity discrimination in public accommodations.
- There are an estimated 11 million LGBT adults in the U.S. Over 5.6 million live in states without statutory protections against sexual orientation and gender identity discrimination in housing and 8 million lack such protections in credit.

Our estimates are conservative in that state statutes also protect LGBT children and younger youth; however, due to limited knowledge about the size of these groups in the population, we could not include them in our calculations.

Table 1. LGBT people unprotected by state non-discrimination statutes that include sexual orientation and gender identity

	EMPLOYMENT		EDUCATION		PUBLIC ACCOMMODATIONS		HOUSING		CREDIT	
	Has Statute	LGBT Workers (Age 16+)	Has Statute	LGBT Students (Age 15+)	Has Statute	LGBT People (Age 13+)	Has Statute	LGBT Adults (Age 18+)	Has Statute	LGBT Adults (Age 18+)
Alabama	No	78,000	No	53,000	No	147,000	No	117,000	No	117,000
Alaska	No	15,000	No	7,000	No	25,000	No	21,000	No	21,000
Arizona	No	179,000	No	75,000	No	286,000	No	242,000	No	242,000
Arkansas	No	50,000	No	31,000	No	95,000	No	76,000	No	76,000
California	Yes	1,194,000	Yes	471,000	Yes	1,859,000	Yes	1,615,000	No	1,615,000
Colorado	Yes	156,000	Yes	59,000	Yes	234,000	Yes	200,000	Yes	200,000
Connecticut	Yes	82,000	Yes	43,000	Yes	133,000	Yes	111,000	Yes	111,000
Delaware	Yes	24,000	No	11,000	Yes	40,000	Yes	34,000	No	34,000
Washington DC	Yes	45,000	Yes	9,000	Yes	58,000	Yes	56,000	No	56,000
Florida	No	545,000	No	212,000	No	886,000	No	772,000	No	772,000
Georgia	No	271,000	No	116,000	No	425,000	No	356,000	No	356,000
Hawaii	Yes	34,000	Yes	13,000	Yes	59,000	Yes	52,000	No	52,000
Idaho	No	25,000	No	18,000	No	48,000	No	36,000	No	36,000
Illinois	Yes	326,000	Yes	140,000	Yes	506,000	Yes	426,000	Yes	426,000
Indiana	No	165,000	No	72,000	No	272,000	No	229,000	No	229,000
Iowa	Yes	59,000	Yes	35,000	Yes	106,000	Yes	87,000	Yes	87,000
Kansas	No	56,000	No	33,000	No	92,000	No	73,000	No	73,000
Kentucky	No	82,000	No	45,000	No	144,000	No	117,000	No	117,000
Louisiana	No	94,000	No	49,000	No	169,000	No	139,000	No	139,000
Maine	Yes	35,000	Yes	13,000	Yes	60,000	Yes	53,000	Yes	53,000
Maryland	Yes	151,000	No	67,000	Yes	234,000	Yes	198,000	Yes	198,000
Massachusetts	Yes	224,000	Yes	87,000	Yes	335,000	Yes	296,000	Yes	296,000
Michigan	No	229,000	No	112,000	No	373,000	No	311,000	No	311,000
Minnesota	Yes	135,000	Yes	60,000	Yes	210,000	Yes	175,000	Yes	175,000
Mississippi	No	48,000	No	34,000	No	99,000	No	79,000	No	79,000
Missouri	No	131,000	No	64,000	No	217,000	No	180,000	No	180,000
Montana	No	18,000	No	10,000	No	30,000	No	24,000	No	24,000
Nebraska	No	45,000	No	22,000	No	67,000	No	55,000	No	55,000
Nevada	Yes	92,000	No	27,000	Yes	145,000	Yes	127,000	No	127,000
New Hampshire	Yes	35,000	No	14,000	Yes	59,000	Yes	51,000	No	51,000
New Jersey	Yes	205,000	Yes	97,000	Yes	343,000	Yes	288,000	Yes	288,000
New Mexico	Yes	47,000	No	22,000	Yes	85,000	Yes	72,000	Yes	72,000
New York	Yes	588,000	Yes	221,000	Yes	913,000	Yes	800,000	Yes	800,000
North Carolina	No	238,000	No	111,000	No	382,000	No	319,000	No	319,000
North Dakota	No	12,000	No	8,000	No	20,000	No	16,000	No	16,000

	EMPLOYMENT		EDUCATION		PUBLIC ACCOMMODATIONS		HOUSING		CREDIT	
	Has Statute	LGBT Workers (Age 16+)	Has Statute	LGBT Students (Age 15+)	Has Statute	LGBT People (Age 13+)	Has Statute	LGBT Adults (Age 18+)	Has Statute	LGBT Adults (Age 18+)
Ohio	No	298,000	No	123,000	No	462,000	No	389,000	No	389,000
Oklahoma	No	74,000	No	42,000	No	138,000	No	113,000	No	113,000
Oregon	Yes	129,000	Yes	41,000	Yes	207,000	Yes	183,000	No	183,000
Pennsylvania	No	307,000	No	133,000	No	490,000	No	416,000	No	416,000
Rhode Island	Yes	29,000	No	14,000	Yes	44,000	Yes	38,000	Yes	38,000
South Carolina	No	99,000	No	50,000	No	167,000	No	137,000	No	137,000
South Dakota	No	15,000	No	9,000	No	25,000	No	20,000	No	20,000
Tennessee	No	133,000	No	67,000	No	223,000	No	182,000	No	182,000
Texas	No	647,000	No	316,000	No	1,053,000	No	858,000	No	858,000
Utah	Yes	67,000	No	40,000	No	104,000	Yes	80,000	No	80,000
Vermont	Yes	19,000	Yes	7,000	Yes	30,000	Yes	26,000	Yes	26,000
Virginia	No	197,000	No	96,000	No	308,000	No	257,000	No	257,000
Washington	Yes	226,000	Yes	72,000	Yes	342,000	Yes	300,000	Yes	300,000
West Virginia	No	40,000	No	17,000	No	68,000	No	58,000	No	58,000
Wisconsin**	LGB only	110,000	LGB only	57,000	LGB only	186,000	LGB only	152,000	No	171,000
Wyoming	No	10,000	No	6,000	No	18,000	No	15,000	No	15,000
Total unprotected		4,115,000**		2,132,000**		6,854,000**		5,626,000**		7,976,000
Total protected		4,012,000		1,425,000		6,188,000		5,420,000		3,070,000
Total		8,127,000		3,557,000		13,042,000		11,046,000		11,046,000

*Our estimates do not take into account administrative and judicial decisions that have interpreted sex discrimination laws to cover sexual orientation or gender identity discrimination. Rather, we have limited our analysis to statutes that facially include the words “sexual orientation” or “gender identity.”

**Nondiscrimination statutes in Wisconsin prohibit discrimination based on sexual orientation but not gender identity. An estimated 14,000 transgender people in the state lack employment protections based on gender identity, 6,000 are unprotected in education, 21,000 lack protections in public accommodations and 19,000 lack protections in housing. These numbers were added to the total unprotected in each domain.

EMPLOYMENT

An estimated 3,688,000 LGBT state, local, and private sector workers ages 16 and older in the US lack state statutory protections from discrimination in employment. This includes 148,000 state and 185,000 local government workers and 3,355,000 private sector workers. The table below provides information about LGBT workers in these sectors who lack state statutory protections from employment discrimination. In addition, 160,000 LGBT workers are employed by the federal government. Federal government workers are not covered by state non-discrimination statutes.

Table 2. LGBT workers unprotected by state non-discrimination statutes, by sector

	UNPROTECTED		PROTECTED	
	%	N	%	N
State government workers	56%	148,000	44%	116,000
Local government workers	50%	185,000	50%	183,000
Private sector workers	55%	3,355,000	45%	2,788,000
Total*		**3,688,000**		**3,087,000**

*Table 2 does not include LGBT people in the US workforce ages 16 and older who are self-employed (not working for the government or an employer, but exclusively "working for yourself, freelancing, doing contracting work or working for your own or your family's business") or unemployed (not currently working, but able to work and willing to work). These estimates, therefore, do not total the estimated number of LGBT workers in Table 1.

PUBLIC ACCOMMODATIONS

An estimated 6,854,000 LGBT people 13 and older in the US lack state statutory protections from discrimination in public accommodations. The tables below provide information about the race/ethnicity and sex of LGBT people ages 13 and older.

RACE/ETHNICITY

Table 3. Race/ethnicity of LGBT people age 13 and older unprotected by state non-discrimination statutes in public accommodations

	UNPROTECTED		PROTECTED	
	%	N	%	N
White	57%	3,908,000	57%	3,545,000
Latino/a	19%	1,312,000	24%	1,462,000
Black	15%	1,053,000	10%	619,000
Asian	1%	77,000	3%	169,000
American Indian & Alaska Native	2%	105,000	1%	52,000
Native Hawaiian & other Pacific Islanders	1%	35,000	1%	50,000
More than one race	5%	364,000	5%	291,000
Total		6,854,000		6,188,000

SEX

Table 4. Sex of LGBT people age 13 and older unprotected by state non-discrimination statutes in public accommodations

	UNPROTECTED		PROTECTED	
	%	N	%	N
Male	38%	2,618,000	41%	2,519,000
Female	62%	4,236,000	59%	3,669,000
Total		6,854,000		6,188,000

Suggested Citation: LGBT People in the United States Not Protected by State Nondiscrimination Statutes. (April 2019) The Williams Institute, UCLA, Los Angeles, CA.

METHODOLOGICAL NOTES

LGBT Workers

To estimate the number of LGBT people in the labor force in each state, we relied upon the Gallup Daily Tracking Survey, a population-based survey, for information about the percentage of respondents in the labor force (defined as employed full-time or part-time, or were unemployed, but actively looking for work and able to work) who identified as LGBT. These estimates correspond to information reported in the Williams Institute's LGBT Demographic Data Interactive. We then applied (multiplied) this percentage to estimates provided by the U.S. Census Bureau of the number of people age 16 and older in the labor force in each state (and rounded to the nearest 1,000). The number of people ages 16 and older in the labor force was derived from the 2017 American Community Survey 1-Year Estimates (Table DP03 "*Selected Economic Characteristics*").

The estimated percentages of adults age 18 and older in the labor force who identify as LGBT is derived from the Gallup Daily Tracking Survey. The Gallup Daily Tracking survey is an annual list-assisted random digit dial (70% cell phone, 30% landline) survey, conducted in English and Spanish, of approximately 350,000 U.S. adults ages 18 and older who reside in the 50 states and the District of Columbia. LGBT identity is based on response to the question*, "Do you, personally, identify as lesbian, gay, bisexual, or transgender?"* Estimates derived from other measures of sexual orientation and gender identity will yield different results. Respondents who answered "*yes*" were classified as LGBT. State estimates use 2015-2017 data unless otherwise noted. Due to small overall population sizes, 2012-2017 data were aggregated for the following states: Alaska, Delaware, Hawaii, Idaho, Mississippi, Montana, New Hampshire, North Dakota, Rhode Island, South Dakota, Vermont, West Virginia, and Wyoming.

To determine the number of LGBT people in the labor force protected and not protected under current state statutes, we used information from the Movement Advancement Project on whether a state did or did not have a statute that explicitly prohibits discrimination on the basis of sexual orientation and gender identity, or in the case of Wisconsin, only on the basis of sexual orientation. In total, 21 states, plus Washington DC, have a statute that extends protections to workers on the basis of both sexual orientation and gender identity. We then counted the rounded estimates of LGBT workers in states with and without protective statutes.

For Wisconsin, we counted cisgender LGB workers as protected and transgender workers as unprotected (on the basis of gender identity). To estimate the numbers of cisgender LGB and transgender workers in Wisconsin, we first calculated the percentages of LGBT adults in the state that are cisgender LGB and transgender (of any sexual orientation), 88.8% and 11.2%, respectively, using the data sources described above, and then applied those percentages to the estimated number of LGBT workers in the state.

LGBT Students

To estimate the number of LGBT students enrolled in U.S. schools, we relied upon population-based surveys for information about the percentage of the population that is LGBT and applied it to U.S. Census Bureau estimates of the number of students enrolled in school (public and private) in each state. Given that the Census Bureau's estimates of the number of students enrolled in school was only available by sex and for students in specific age groups, we identified percentage LGBT for corresponding sex and age groups to derive estimates of the number of LGBT students enrolled in each state.

To estimate the percentage of youth age 15-17 that identify as LGBT, separately for males and females:

- To estimate the percentage of males and females age 15-17 who identify as LGB, we averaged the national estimates from the 2015 and 2017 Youth Risk Behavior Surveillance Survey (YRBS), a nationally representative sample of school-enrolled high school students in grades 9-12.
    - Among males age 15-17, we estimated that approximately 4.8% identify as GB, based on an average of 4.4% of males in 2015 who identified as gay or bisexual (2% identified as gay; 2.4% identified as bisexual), and 5.1% of males in 2017 who identified as gay or bisexual (2.3% gay; 2.8% bisexual).
    - Among females age 15-17, we estimated that approximately 13.6% identify as LB, based on an average of 11.8% of females in 2015 who identified as LB (2.0% identified as lesbian; 9.8% identified as bisexual), and 15.4% of females in 2017 who identified as lesbian or bisexual (2.3% lesbian; 13.1% bisexual).

- To estimate the percentage of males and females age 15-17 who are transgender, we used the recent national estimate reported in Age of Individuals who Identify as Transgender in the United States of the percentage of 13 to 17 year old adolescents who are transgender (0.73%). To estimate the percentage of transgender adolescents who were heterosexual/not-LGB (and thus avoid double-counting sexual minority transgender adolescents in our estimate of the total count of LGB+T adolescents) we used data from the 2015-2017 Behavioral Risk Factor Surveillance System (BRFSS). Among BRFSS respondents age 18-24 (the youngest age group for which data were assessed) categorized as transgender by answering *"yes, transgender, male-to-female", "yes, transgender, female-to-male,"* and "*yes, transgender, gender-nonconforming"* to the question *"do you consider yourself to be transgender?"*, 46.3% identified their sexual orientation as "*straight"* or other and were categorized as heterosexual/non-LGB. Applying this 46.3% to the 0.73% of youth who were transgender, we estimated that 0.3% of youth age 13-17 were transgender and not LGB-identified.

- We next added this percentage (0.3%) to the percentage GB (4.8%) among males and LB (13.6%) among females to arrive at an estimate of percentage LGBT for males (5.1%) and females (13.9%).

To estimate the percentage of adults (age 18-64) that identify as LGBT, separately for males and females:

- To estimate the percentage of males and females that identify as LGBT in specific age groupings that correspond to estimated numbers of enrolled students reported by the U.S. Census Bureau, we used data from the 2017 Gallup Daily Tracking Survey described above.

    - Age 18-19: 7.2% of males and 16.2% of females identified as LGBT
    - Age 20-24: 7.3% of males and 15.3% of females identified as LGBT
    - Age 25-34: 5.7% of males and 10.1% of females identified as LGBT
    - Age 35-64: 3.5% of males and 3.4% of females identified as LGBT

To estimate the number of LGBT youth (age 15-17) and adults (age 18-64) enrolled in school:

The numbers of students enrolled in U.S. schools by age, sex, and state were obtained from the 2017 American Community Survey 1-Year Estimates (Table B14003 "*Sex by School Enrollment By Type of School By Age for the Population 3 Years and Over"*).

- To estimate the number of LGBT students age 15-17 by state, we applied (multiplied) the sex-specific percentage LGBT from the YRBS to the ACS reported sex-specific estimates of public and private enrollment for youth aged 15-17 in each state, and summed counts across males and females.

- To estimate the number of LGBT students age 18-64 by state, we applied (multiplied) the age- and sex-specific percentage LGBT from Gallup to each state's ACS reported age- and sex-estimate of public and private school enrollment, and summed counts across sex and age groups.

- To estimate the number of LGBT students 15+ by state, we summed the total estimated number of youth and adult students by state and rounded to the nearest 1,000.

To determine the number of LGBT students protected and not protected under current state statutes, we used information from the Movement Advancement Project on whether a state did or did not have a statute that explicitly protected students "*from discrimination in school, including being unfairly denied access to facilities, sports teams, or clubs"* on the basis of sexual orientation and gender identity, or, in the case of Wisconsin, only on the basis of sexual orientation. In total, 14 states, plus Washington DC, had a statute that extended protections to students (at all levels of schooling, enrolled in public and private schools) on the basis of sexual orientation and gender identity. We then summed up the rounded estimates of LGBT students in states with and without protective statutes.

For Wisconsin, we counted cisgender LGB students as protected and transgender students as unprotected (on the basis of gender identity). To estimate the numbers of cisgender LGB and transgender students in the state, we first calculated the percentages of LGBT youth and adults in the state that are cisgender LGB and transgender (of any sexual orientation), 95.0% and 5.3%, respectively, among youth, and 88.8% and 11.2%, respectively, among adults, using the data sources described above. We then applied those percentages to the estimated numbers of LGBT youth and adult students in the state (and then summed and rounded the cisgender LGB and transgender estimates to the nearest 1,000).

LGBT People

To estimate the number of LGBT people in each state, we relied upon population-based surveys for information about the percentage of the population that is LGBT and applied it to U.S. Census Bureau estimates of the numbers of youth (ages 13-17) and adults (18+) in each state.

- To estimate the number of youth age 13-17 that identify as LGBT, we used information from the Youth Risk Behavior Surveillance Survey (YRBS) and recent estimates from The Williams Institute reported in Age of Individuals who Identify as Transgender in the United States that utilized Behavioral Risk Factor Surveillance Survey (BRFSS) data.

- To estimate the percentage of youth age 13-17 who identify as LGB (9.2%), we averaged the national estimates from the 2015 (8.0%) and 2017 (10.4%) Youth Risk Behavior Surveillance Survey (YRBS), described above.

- Then, to estimate the number of LGB youth, we applied (multiplied) this percentage to 2017 population estimates produced by the U.S. Census Bureau for youth ages 13 to 17 and rounded to the nearest 1,000. Census estimates were obtained via American FactFinder Table PEPSYASEX, "*Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States, States, and Puerto Rico Commonwealth: April 1, 2010 to July 1, 2017.*"

- Next, to estimate the number of transgender youth age 13-17, we used recent estimates from Age of Individuals who Identify as Transgender in the United States with a slight correction to avoid double-counting sexual minority transgender youth (adding a total of 46.3% of the estimated number of transgender youth per state to our estimate of the number of LGB youth to arrive at a total estimate of the number of LGBT youth per state).

- The estimated percentages of adults age 18 and older who identify as LGBT is derived from the Gallup Daily Tracking Survey described above. State estimates of the percentage of the population that is LGBT-identified use 2015-2017 data unless otherwise noted. Due to small overall population sizes, 2012-2017 data were aggregated for the following states: Alaska, Delaware, Hawaii, Idaho, Mississippi, Montana, New Hampshire, North Dakota, Rhode Island, South Dakota, Vermont, West Virginia, and Wyoming. All percentages correspond to those reported in the Williams Institute's LGBT Demographic Data Interactive.

- To estimate the number of LGBT adults age 18 and older by state, the weighted percentage of LGBT Gallup Daily Tracking respondents was applied to 2017 population estimates produced by the U.S. Census Bureau and rounded to the nearest 1,000. Census estimates were obtained via American FactFinder Table PEPSYASEX, "*Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States, States, and Puerto Rico Commonwealth: April 1, 2010 to July 1, 2017.*" The estimated number (rounded to the nearest 50) of adults ages 18 and older who identify as transgender are reported in Age of Individuals who Identify as Transgender in the United States.

To determine the number of LGBT people that are protected and not protected in public accommodations under current state statutes, we used information from the Movement Advancement Project on whether a state did or did not have a statute that explicitly prohibits discrimination on the basis of sexual orientation and gender identity, or, in the case of Wisconsin, only on the basis of sexual orientation. In total, 20 states, plus Washington DC, had a statute that extended protections in public accommodations on the basis of sexual orientation and gender identity. We then counted the numbers of LGBT people in states with and without protective statutes.

For Wisconsin, we counted cisgender LGB people as protected and transgender people as unprotected (on the basis of gender identity). To estimate the numbers of cisgender LGB and transgender people (of any sexual orientation) in Wisconsin, we used estimates of the numbers of transgender youth and adults in the state as reported in Age of Individuals who Identify as Transgender in the United States and subtracted them from our estimates of all LGBT youth and adults in the state. We then rounded all LGB and transgender estimates in to the nearest 1,000.

LGBT Adults (18+)

The methodological notes for our estimates of the number of LGBT adults per state are reported in Adult LGBT Population in the United States.

To determine the number of LGBT people that are protected and not protected in housing under current state statutes, we used information from the Movement Advancement Project on whether a state did or did not have a statute that explicitly prohibits discrimination on the basis of sexual orientation and gender identity, or in the case of Wisconsin, only on the basis of sexual orientation. In total, 21 states plus Washington DC, had a statute that extended protections in housing on the basis of sexual orientation and gender identity. We then counted the numbers of LGBT people in states with and without protective statutes.

For Wisconsin, we counted cisgender LGB people as protected and transgender people as unprotected (on the bases of gender identity). To estimate the numbers of cisgender LGB and transgender people (of any sexual orientation), we used an estimate of the number of transgender adults in the state as reported in Age of Individuals who Identify as Transgender in the United States and then subtracted them from our estimate of all LGBT adults in the state. We then rounded all LGB and transgender estimates in to the nearest 1,000.

To determine the number of LGBT people that are protected and not protected in credit under current state statutes, we used information from the Movement Advancement Project on whether a state did or did not have a statute that explicitly prohibits discrimination on the bases of sexual orientation and gender identity. In total, 14 states had a statute that extended protections in credit on the bases of sexual orientation and gender identity. We then counted the numbers of LGBT people in states with and without protective statutes.

LGBT workers in public and private sector employment

To determine the number of LGBT workers in public and private sector employment, we used several variables in the 2016 Gallup Daily Tracking Survey, the most recent year that government employment was collected, to create mutually non-overlapping employment classes among those in the labor force. We categorized these respondents as follows: working for the federal, state, or local government (answered 'yes' to the question "do you currently work for the Federal, State, or Local government?" and indicated which branch in a follow-up question), and in the private sector (not working for the government, but working full-time or part-time "for an employer"). We estimated the percentage LGBT in each employment class and then applied that to 2017 ACS estimates of the number of LGBT people per employment class in each state. (Table S2408 "*Class of Worker by Sex for the Civilian Employed Population 16 Years and Over*," last accessed January 19, 2019). As described under LGBT Workers above, we used the same policy indicators for state statutory employment protections, and approach, including our treatment of Wisconsin protections, to count the estimated numbers of LGBT workers (by class) in states with and without protective statutes. These state estimates were then summed and the total rounded to the nearest 1,000.

Public accommodations by race/ethnicity and sex

To estimate the number of LGBT people 13 and up by race/ethnicity and sex, we obtained weighted percentages for each demographic characteristic from the 2017 Gallup Daily Tracking Survey data for LGBT-identified adults and from the 2017 Youth Risk Behavior Survey for LGB-identified youth ages 13 to 17, and applied them to our estimates of the number of LGBT youth and adults in states with and without protective statutes, summed them together, and rounded to the nearest 1,000. We then hand-calculated percentages for race/ethnicity and sex among the combined group of LGBT youth and adults.

RACE/ETHNICITY

- Race/ethnicity among adults was defined on the basis of responses to two Gallup Daily Tracking Survey questions -- Hispanic, Latino, or Spanish origin (yes/no) and race (chose all that apply.) Respondents who indicated that they are Hispanic, Latino, or of Spanish origin were classified as Latino/a or Hispanic and all non-Hispanic respondents were classified by race (single race or more than one race.)

- Race/ethnicity among youth was defined on the basis of responses to two YRBS survey questions—

Hispanic or Latino (yes/no) and race (chose all that apply.) Respondents who indicated that they are Hispanic or Latino were classified as Latino/a or Hispanic and all non-Hispanic respondents were classified by race (single race or more than one race.)

SEX

- Adult were classified as male or female, based on their response to the Gallup Daily Tracking Survey question, "I am required to ask, are you male or female?"

- Youth respondents were classified as male or female, based on their response to the YRBS survey question, "What is your sex? (female/male)"

PATHWAYS FORWARD

FOUNDATION FUNDING FOR LGBTQ IMMIGRATION ISSUES

BY DANILO MACHADO AND
BEN FRANCISCO MAULBECK

JULY 2014

FUNDERS FOR LGBTQ ISSUES

PATHWAYS FORWARD

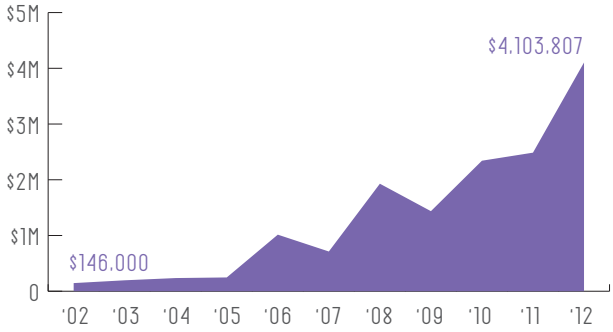
LGBTQ IMMIGRANT RIGHTS ARE MAKING PROGRESS ...

1990
BAN ON LGBT PEOPLE ENTERING THE U.S. IS LIFTED.

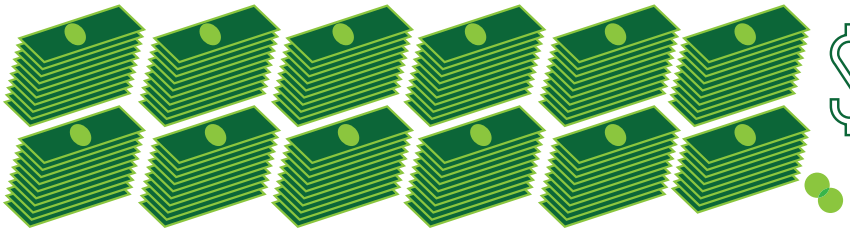
2008
BAN ON HIV-POSITIVE PEOPLE ENTERING THE U.S. IS LIFTED.

2013
THE *UNITED STATES V. WINDSOR* DECISION RESULTS IN LGBTQ CITIZENS BEING ABLE TO SPONSOR IMMIGRANT SPOUSES OF THE SAME SEX FOR A GREEN CARD.

... AND FUNDING FOR LGBTQ IMMIGRATION IS GROWING, HAVING INCREASED MORE THAN 20 FOLD IN THE LAST 10 YEARS ...



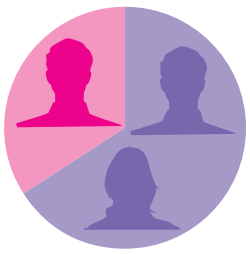
EVEN SO, LESS THAN ONE HALF OF ONE PERCENT OF ALL IMMIGRATION FUNDING SPECIFICALLY TARGETS LGBTQ IMMIGRANTS.



$99.50 VS. 50¢

THERE ARE AN ESTIMATED 904,000 LGBT IMMIGRANTS IN THE UNITED STATES. AT LEAST **ONE IN TEN LGBT ADULTS** IN THE U.S. WAS BORN ABROAD.

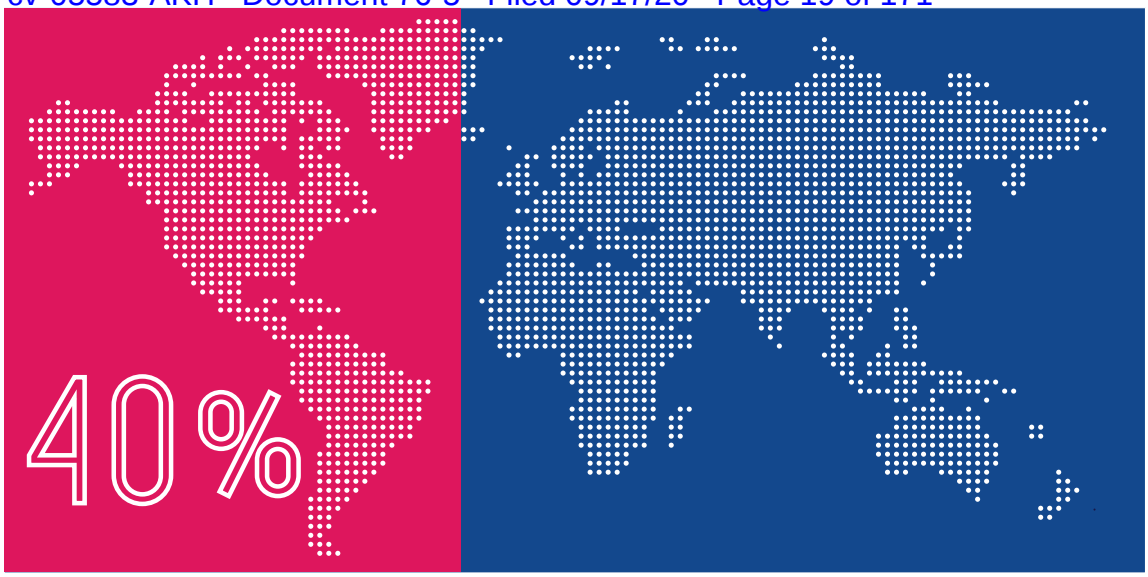
BUT MANY LGBTQ IMMIGRANTS ARE STILL LIVING IN THE SHADOWS. NEARLY A THIRD OF ALL LGBT ADULT IMMIGRANTS IN THE U.S. ARE UNDOCUMENTED.



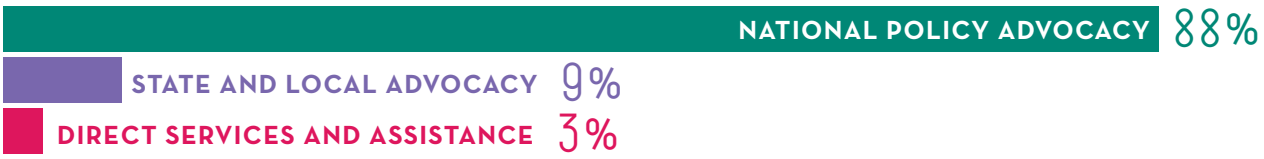
13X

IF DETAINED, LGBTQ IMMIGRANTS FACE ESPECIALLY HARSH CONDITIONS. WHEN INCARCERATED, TRANSGENDER INDIVIDUALS ARE 13 TIMES MORE LIKELY TO BE SEXUALLY ASSAULTED.

APPROXIMATELY 40 PERCENT OF COUNTRIES CRIMINALIZE LGBTQ PEOPLE, LEADING MANY PEOPLE TO FLEE THEIR COUNTRIES OF ORIGIN.



FORTUNATELY, THERE ARE A RANGE OF LGBTQ, IMMIGRANT, AND ALLIED ORGANIZATIONS WORKING TO ADDRESS THE NEEDS OF LGBTQ IMMIGRANTS AND ASYLUM SEEKERS THROUGH BOTH ADVOCACY AND SERVICES. NATIONAL ADVOCACY ORGANIZATIONS RECEIVE THE LARGEST SHARE OF FUNDING:



CURRENTLY, MORE THAN **90 PERCENT** OF LGBTQ IMMIGRATION FUNDING COMES FROM THE TOP TEN FUNDERS.

1. FORD FOUNDATION
2. ANONYMOUS FUNDERS
3. ARCUS FOUNDATION
4. GILL FOUNDATION
5. M.A.C AIDS FUND
6. EVELYN & WALTER HAAS, JR. FUND
7. FOUR FREEDOMS FUND
8. VITAL PROJECTS FUND
9. H. VAN AMERINGEN FOUNDATION
10. DAVID BOHNETT FOUNDATION

FUNDERS CAN HELP IMPROVE THE LIVED EXPERIENCE OF LGBTQ IMMIGRANTS BY:

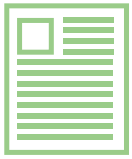
Fund advocacy and coalition-building around LGBTQ/ Immigration issues for the long term.

Support and develop LGBTQ immigrant leaders.

Strengthen state and local LGBTQ immigration advocacy.

Strengthen agencies and networks serving LGBTQ asylum seekers and immigrants.

Increase LGBTQ cultural competence of immigration service systems.



Provide financial assistance for immigration applications.

TABLE OF CONTENTS

INTRODUCTION

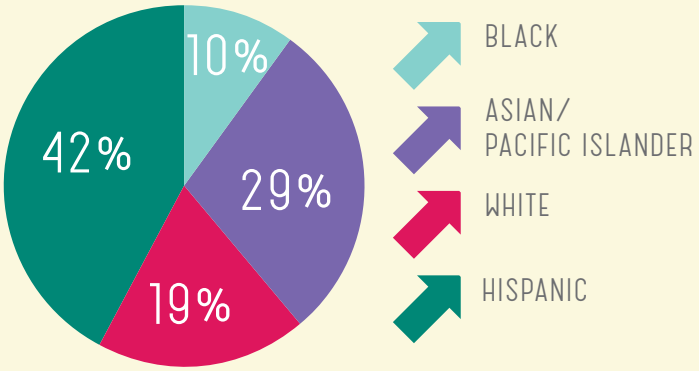
For most of the twentieth century, anyone who openly identified as gay, lesbian, bisexual, or transgender (LGBT) was banned from immigrating to the United States. HIV-positive people were also barred from entry. Until 2013, the immigration system denied recognition of LGBT families: the so-called Defense of Marriage Act (DOMA) prevented gay, lesbian, and bisexual U.S. citizens from sponsoring their same-sex partners for permanent residence.

Slowly, over the past three decades, all of that has changed. The ban on LGBT people was repealed in 1990, and the ban on people living with HIV was lifted in 2008. In 2013, the U.S. Supreme Court's *Windsor* decision overturned part of DOMA, recognizing the legitimacy of binational same-sex couples, ending years of separation and uncertainty for tens of thousands of couples.

But the pathway to equality and basic quality of life is still hard for the vast majority of LGBT immigrants in the U.S., who now number an estimated 904,000.[1] By comparison, New York State is home to roughly 575,000 "out" LGBT adults.[3] In fact, more than a tenth of the nearly nine million "out" LGBT adults in the U.S. are immigrants.[4]

Nearly one-third of LGBTQ immigrants are undocumented. This double minority faces a double closet, a double coming out, and layered challenges. Their identities carry tangible and intangible consequences. From educational opportunity to basic health care, their pathway is one riddled with obstacles and dead ends.

RACE AND ETHNICITY OF LGBT IMMIGRANTS IN THE UNITED STATES[2]



The United States has also become a destination for LGBTQ asylum seekers from around the world, who come here fleeing persecution in their home countries. These LGBTQ asylum seekers also have unique needs often unaddressed by the immigration and asylum system.

LGBTQ undocumented immigrants and asylum seekers would see enormous benefit from comprehensive reform of the U.S. immigration system. Queer undocumented leaders have been among the leading advocates for such policy reforms at both the state and national levels. Alliances between LGBTQ communities and immigrant communities have proved a powerful vehicle for advancing social change in a number of contexts.

It is a period of both progress and uncertainty for LGBTQ and immigrant communities. This report provides a brief snapshot of the unique needs facing LGBTQ immigrants at this crucial moment. It provides an overview of the current state of funding for LGBTQ immigration issues, and of the varied ecology of organizations addressing LGBTQ immigration issues. Finally, it offers recommendations for funders as we look for a pathway forward.

1 Gary J. Gates, "LGBT Adult Immigrants in the United States." The Williams Institute, 2013. http://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBTImmigrants-Gates-Mar-2013.pdf
2 Gates, "LGBT Adult Immigrants."
3 "LGBT Populations." Movement Advancement Project, 2013. www.lgbtmap.org
4 Gates, "LGBT Adult Immigrants."

THE NEED

LGBTQ UNDOCUMENTED IMMIGRANTS

Nearly a third of all LGBT adult immigrants in the U.S. are undocumented. These 267,000 undocumented LGBT immigrants must navigate two separate but similarly complex identities, often living in a double closet and facing unique challenges when their identities intersect.[5] In particular, because of their undocumented status, these LGBTQ immigrants often face significant barriers to attaining education, employment, health care, and other necessities.

RECOMMENDED RESOURCES

Dignity Denied: LGBT Immigrants in U.S. Immigration Detention (2013) *By Sharita Gruberg*
A report from Center for American Progress
Available at http://www.americanprogress.org/issues/immigration/report/2013/11/25/79987/dignity-denied-lgbt-immigrants-in-u-s-immigration-detention/

Living in Dual Shadows: LGBT Undocumented Immigrants (2013)
By Carol Burns, Ann Garcia, and Philip E. Wolgin
A report from Center for American Progress
Available at http://www.americanprogress.org/issues/immigration/report/2013/03/08/55674/living-in-dual-shadows/

EDUCATION: Undocumented students face many barriers in higher education. Financially, they are ineligible for most scholarships and sources of aid. In most states, they are barred from paying the in-state tuition rate, sometimes being classified as "international students." A few states even bar them from attending certain institutions entirely. Furthermore, undocumented students often lack support in the college process, with high school guidance counselors often lacking the cultural competence or knowledge of resources to assist undocumented students.

EMPLOYMENT AND ECONOMIC ISSUES: It is estimated that at least one in five undocumented adults live in poverty compared to one in ten U.S.-born adults. [6] Many LGBTQ immigrants cannot find employment due to their legal status or to discrimination. LGBTQ immigrants who lack familial support sometimes encounter the added burden of living on the streets, and as such are driven to the margins of the formal economy. Undocumented immigrants who are able to find employment make on average 28 percent less than the average American—or, put in other terms, 72 cents on the dollar.[7]

HEALTH CARE: More than half of adult undocumented immigrants lack health care insurance[8], compared to only about 15 percent of the general population. While the Affordable Care Act is rapidly expanding health insurance coverage for much of the U.S. population, the Act explicitly excludes undocumented immigrants. This lack of insurance is especially concerning for LGBTQ immigrants, who must often overcome stigma to attain health care, are often at greater risk for HIV and other diseases, and often face challenges related to mental health and substance abuse.

5 Crosby Burns, Ann Garcia, Philip E. Wolgin, "Living in Dual Shadows: LGBT Undocumented Immigrants." Center for American Progress, 2013.
6 "Portrait of Unauthorized Immigrants." Pew Hispanic Center, 2009.
7 "Portrait of Unauthorized Immigrants." Pew Hispanic Center, 2009.
8 "Portrait of Unauthorized Immigrants."

HIGHLIGHTS OF LGBTQ IMMIGRANT RIGHTS

1917 Immigration Act bars "homosexuals" from entry to U.S., along with "illiterates" and "Asiatics."

1965 Immigration and Nationality Act affirms ban on "sexual deviants."

1990 Immigration Act rescinds language banning LGBT people from entering the country.

1993 Congress bans HIV-positive people from entering the country.

1994 First successful asylum case based on persecution on the basis of sexual orientation.

1996 Defense of Marriage Act passes, assuring that even if same-sex couples attain legal recognition at the state level, the federal government will not recognize their relationship for the purposes of immigration.

2000 First successful asylum case based on persecution on the basis of gender identity.

2001 The DREAM (Development, Relief, and Education for Alien Minors) Act is first introduced in the U.S. Senate. Over the next decade, the "Dreamers" eligible for legalization under the Act—many of them LGBTQ-identified—become some of the most visible activists for immigrant rights. Since its introduction, the DREAM Act has been brought to Congress numerous times without passing, most notably in 2010, when it passed the House of Representatives, but fell five votes short in the Senate.

2008 Ban on HIV-positive people entering the U.S. is repealed.

2013 *United States v. Windsor* strikes down Section 3 of the Defense of Marriage Act, allowing U.S. citizens to sponsor an immigrant spouse of the same sex for the first time.

WHAT'S THE DIFFERENCE BETWEEN A REFUGEE AND AN ASYLUM SEEKER?

Both asylum and refugee status may be granted to people who have been persecuted on account of race, religion, nationality, political opinion, or membership in a particular social group--such as sexual orientation or gender identity. Refugee status may only be sought from outside the United States, while you may apply for asylum from within the U.S. regardless of current immigration status. LGBTQ refugees face challenges in re-settling in the U.S. but by definition already have a legal status; LGBTQ asylum seekers face the additional difficulty of an uncertain legal status as they go through the asylum process.

LGBTQ ASYLUM SEEKERS

Consensual sex between adults of the same sex is still criminalized in over 80 countries as of 2014. While there are a host of reasons an LGBTQ person might choose to immigrate to the United States, in some cases it is simply to escape harsh criminal and social penalties, incarceration, or even death. With increasing persecution of LGBTQ people in countries such as Russia and Uganda, the need for asylum is particularly acute. Immigration Equality has reported an increase of 20 percent in asylum inquiries since mid-2013, including a 143-percent increase in inquiries from Russia and 139-percent increase in inquiries from Uganda.

Under current U.S. law, asylum seekers must file within one year of their last arrival into the U.S., and, according to Immigration Equality, this arbitrary deadline often prevents even the most qualified candidates from filing and, is the number one reason, that prevents them from gaining asylum. The deadline is often particularly challenging for LGBTQ asylum seekers, who come to the U.S. from political contexts where they have been persecuted on the basis of their sexual orientation or gender identity; as such, it may take them some time to understand that those very same identities could provide grounds for attaining asylum.

Since asylum seekers come to the U.S. fleeing persecution, many arrive with few or no financial resources. As newcomers to the country, they often have few connections—and even if they have family or friends in the U.S., they may be isolated from them due to homophobia or transphobia. With such high-levels of isolation and such minimal resources, it is difficult for asylum seekers to attain legal assistance or to navigate the bureaucratic complexities of filing for asylum. Even for those who do manage to file an application, they must wait at least 180 days before they are legally permitted to work. Their legal status makes it difficult not only to attain income but also housing, health care, and other basic necessities. Indeed, asylum seekers are barred from receiving services supported by funds from the federal government and most state governments. In addition, many LGBTQ asylum seekers are recovering from trauma-related illnesses (e.g., post-traumatic stress disorder) and are in need of culturally competent counseling and other health services.

DETENTION

United States immigration officials placed an estimated 429,000 individuals in detention centers in 2011 —which is roughly equivalent to detaining the entire city of Atlanta or Miami.[9] Over the past decade, an estimated 3 million people have spent time in U.S. immigration detention centers. These detention centers often offer especially harsh treatment for LGBTQ detainees:

- HIV-positive people and transgender people are often denied medically necessary health care in detention.

9 John Simanski and Lesley M. Sapp, "Immigration Enforcement Actions 2011." United States Immigration and Customs Enforcement, 2012.

- Transgender detainees are often placed in gender-segregated facilities that do not match their gender identities.

- Incarcerated transgender individuals are 13 times more likely to be sexually assaulted.[10]

- LGBT people are often placed in solitary confinement to protect them from harassment by other detainees, creating another layer of mistreatment.

Unlike in the criminal court system, in the immigration court system there is no legal right to legal representation. Because being in detention makes it more difficult to obtain legal services, LGBTQ asylum seekers in detention are more likely to lack access to the asylum system, and as a result may be sent back to countries where they will be subject to imprisonment, torture, or execution.

BINATIONAL SAME-SEX COUPLES

As a result of the *United States v. Windsor* decision striking down Section 3 of DOMA, many of the 24,700 noncitizens in binational same-sex couples have been able to seek permanent residence for the first time. However, the spirit of that ruling and the letter of the law may at times still be at odds. For example, binational couples living in states without marriage equality may face difficulties getting the marriage license they need in order to begin the path toward legal residence. This is particularly a challenge in border states, where checkpoints are numerous, making it hard for couples to travel to a state that does have marriage equality. Also, couples separated by deportation before *Windsor* are currently still barred from re-entry.

WHAT'S HAPPENING AT THE BORDER?

The past several years have seen a rapid rise in the number of unaccompanied migrant children crossing the Southern border of the U.S. Most of these minors are fleeing pervasive gang violence in El Salvador, Guatemala, Honduras, and Mexico. The United Nations High Commissioner for Refugees estimates that 58 percent of these children were forcibly displaced and warrant international protection. Though less widely reported, there has also been a rise in adults from Central America and Mexico seeking asylum at the border. When violence and exploitation are widespread in societies, vulnerable minorities such as LGBTQ people are often disproportionately affected. While a comprehensive study has yet to be conducted, anecdotal reports from journalists and service providers indicate that a number of the migrants and asylum-seekers at the border are LGBTQ and face unique harms related to homophobia and transphobia.

RECOMMENDED RESOURCES

Rainbow Bridges: A Community Guide to Rebuilding the Lives of LGBTI Refugees and Asylees (2012)
A report from the Organization for Refuge, Asylum and Migration (ORAM) Available at: http://www.oraminternational.org/images/stories/PDFs/oram-rainbow-bridges-2012-web.pdf

The Surge in Arrivals of Unaccompanied Immigrant Children: Recommendations for Philanthropic Response
A report from Grantmakers Concerned with Immigrants and Refugees (GCIR) Available at: https://www.gcir.org/sites/default/files/resources/GCIR%20UAC%20Crisis%20-%20commendations%20for%20Philanthropy%20June%202014%20FINAL.pdf

10 Valerie Jenness, Ph.D., Cheryl Maxson, Ph.D., Kristy N. Matsuda, M.A., & Jennifer Macy Sumner, M.A., "Violence in California Correctional Facilities: An Empirical Examination of Sexual Assault." University of California, Irvine, 2007. http://ucicorrections.seweb.uci.edu/2007/04/14/violence-in-california-correctional-facilities-an-empirical-examination-of-sexual-assault-3/

THE FUNDING

LGBTQ IMMIGRATION FUNDING: OVERVIEW AND CONTEXT

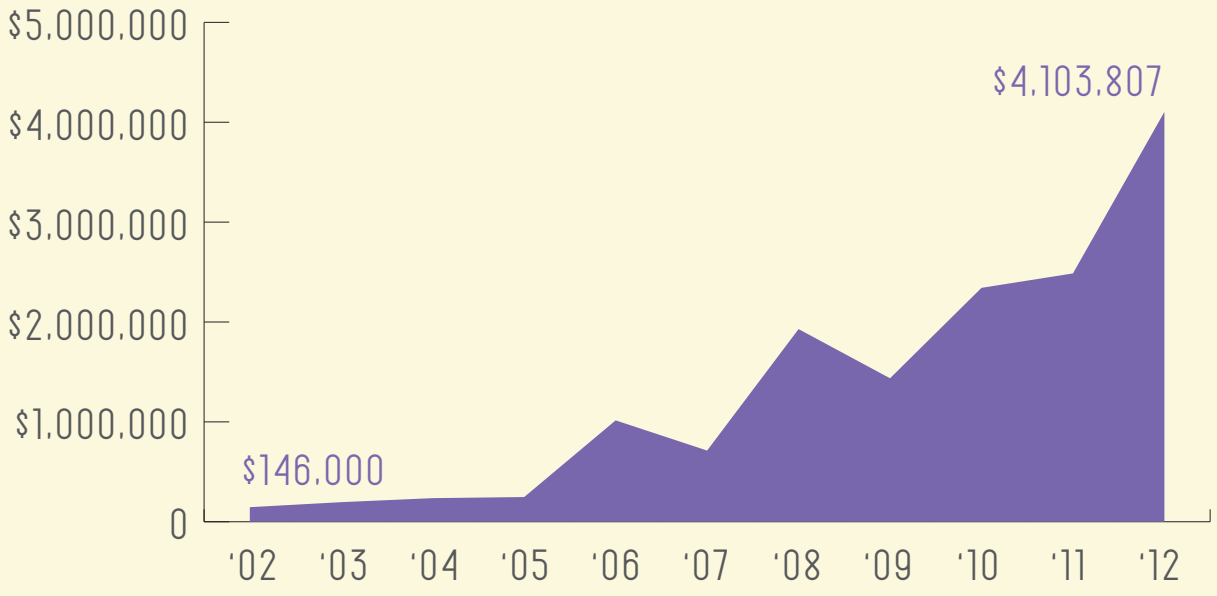
U.S. foundation funding for LGBTQ immigrants, refugees, and asylees around the globe has historically been modest, only recently exceeding $1 million annually. Nevertheless, it has grown rapidly—from barely $150,000 in 2002 to more than $4 million in 2012—an increase of more than 20-fold in just a decade. These figures include funding for LGBTQ immigrants in the U.S. as well as funding for LGBTQ refugees and migrants internationally.

Looking only at domestic funding for LGBTQ immigrants—the primary focus of this report—foundation funding specifically targeting LGBTQ immigrants in the U.S. totaled $4.6 million in 2011-2012.

This constitutes approximately 2.4 percent of the total $196 million in domestic LGBTQ funding for 2011-2012.

According to the Foundation Center, 2011 foundation funding for immigrants in the U.S. totaled $275 million.[11] That same year, $1.5 million was awarded for LGBTQ immigration issues in the U.S., constituting one half of one percent of the year's immigration funding.

FUNDING FOR LGBTQ IMMIGRANTS, ASYLEES, AND REFUGEES (2002-2012)



11 "Foundation Stats," The Foundation Center, 2013. http://data.foundationcenter.org/

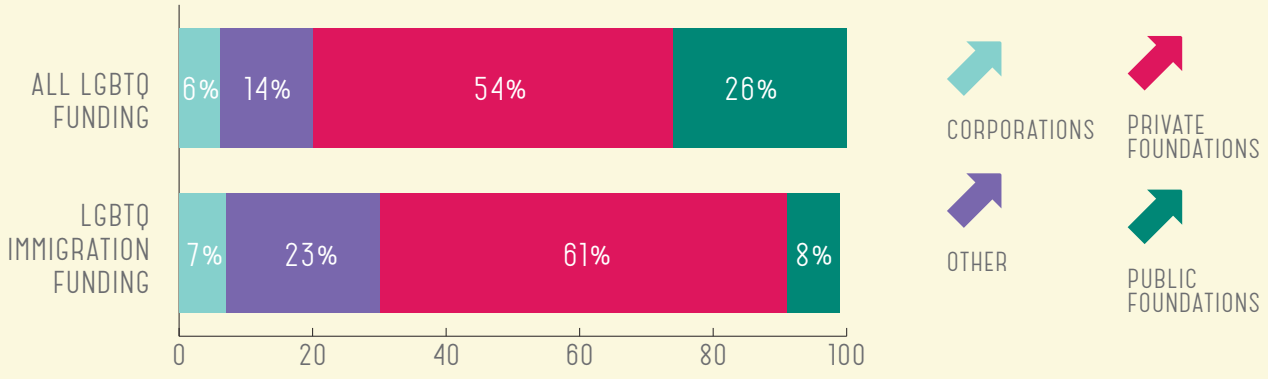
TOP TEN LGBTQ IMMIGRATION FUNDERS (2011-2012)

1. FORD FOUNDATION
   $1,200,000
2. ANONYMOUS FUNDERS
   $1,100,000
3. ARCUS FOUNDATION
   $730,000
4. GILL FOUNDATION
   $395,000
5. M.A.C. AIDS FUND
   $350,000
6. EVELYN & WALTER HAAS, JR. FUND
   $246,000
7. PUBLIC INTEREST PROJECTS - FOUR FREEDOMS FUND
   $215,000
8. VITAL PROJECTS FUND
   $100,000
8. H. VAN AMERINGEN FOUNDATION
   $100,000
10. DAVID BOHNETT FOUNDATION
    $85,000

TOP TEN LGBTQ IMMIGRATION GRANTEES (2011-2012)

1. IMMIGRATION EQUALITY
   $1,282,022
2. POLITICAL RESEARCH ASSOCIATES
   $1,200,000
3. HEARTLAND ALLIANCE FOR HUMAN NEEDS & HUMAN RIGHTS
   $1,140,000
4. NATIONAL CENTER FOR LESBIAN RIGHTS
   $246,000
5. NATIONAL IMMIGRATION LAW CENTER (FOR THE QUEER UNDOCUMENTED IMMIGRANTS PROJECT)
   $125,000
6. COLORADO IMMIGRANT RIGHTS COALITION
   $60,000
6. PROGRESSIVE LEADERSHIP ALLIANCE OF NEVADA
   $60,000
6. ONE COLORADO EDUCATION FUND
   $60,000
9. EQUALITY MARYLAND FOUNDATION
   $50,000
9. LIBERTY HILL FOUNDATION $50,000
9. CAUSA OF OREGON
   $50,000
9. PUBLIC INTEREST PROJECTS
   $50,000

SOURCES OF FUNDING BY FOUNDATION TYPE (2011-2012)



SOURCES OF LGBTQ IMMIGRATION FUNDING

More than 90 percent of LGBTQ immigration funding came from the top ten funders alone. Generally, the top funders of LGBTQ immigration issues—the Arcus Foundation, the Ford Foundation, the Gill Foundation, and The Evelyn & Water Haas, Jr. Fund—are the same foundations that top the list of funders for the LGBTQ movement overall.[12] The most notable exception is the M.A.C. AIDS fund, which is number five on the list of LGBTQ immigration funders but is not among the top ten funders of LGBTQ issues overall.

Private foundations provide 61 percent of all foundation funding for LGBTQ immigration issues. This is an even larger share than the 54 percent of funding that private foundations provide for LGBTQ funding overall. Community foundations and other public foundations provide a smaller share of funding for LGBTQ immigration issues than they do for LGBTQ funding overall, while corporate funders provide a larger share.

RECOMMENDED RESOURCES

Immigration Equality Asylum Manual (2006)
A report from Immigration Equality
Available at: https://immigrationequality.org/issues/law-library/lgbth-asylum-manual/

Immigration Law and the Transgender Client (2008)
by Victoria Neilson and Kristina Wertz
A book commissioned by Immigration Equality and Transgender Law Center
Available at: https://immigrationequality.org/issues/law-library/trans-manual/

12 "2012 Tracking Report: Lesbian, Gay, Bisexual, Transgender & Queer Grantmaking by U.S. Foundations." Funders for LGBTQ Issues, 2013. http://www.lgbtfunders.org/files/2012_Tracking_Report_Lesbian_Gay_Bisexual_Transgender_and_Queer_Grantmaking_by_US_Foundations.pdf

THE ASSETS

THE ECOLOGY OF ORGANIZATIONS ADDRESSING LGBTQ IMMIGRATION ISSUES

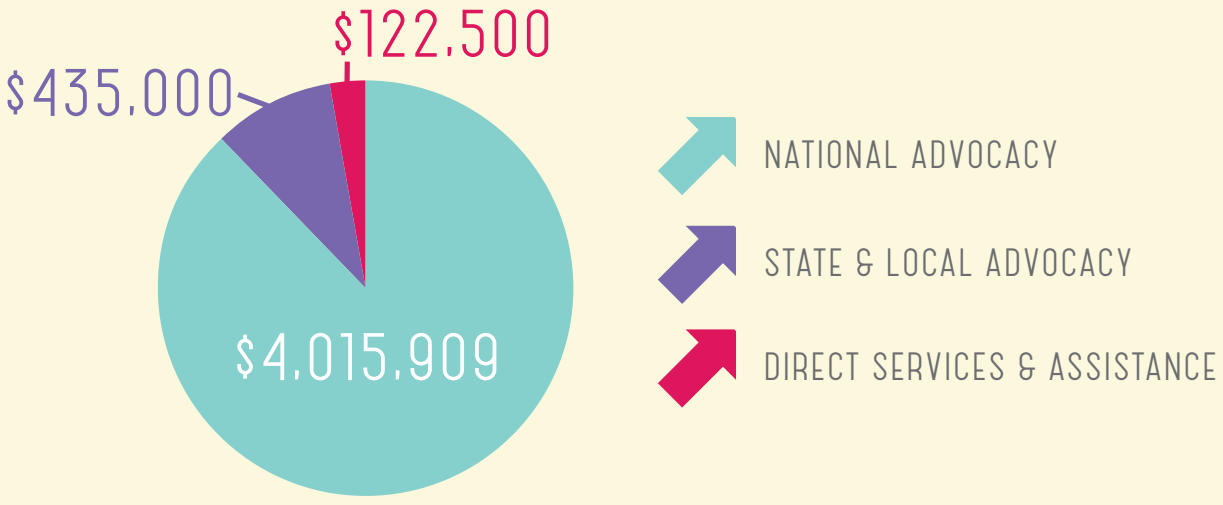
A range of organizations are working to address the needs of LGBTQ immigrants and asylum seekers in the U.S. Organizations working on LGBTQ immigration largely focus on one of three areas: (1) national policy advocacy; (2) state and local advocacy; and (3) direct services and assistance for LGBTQ immigrants.

National advocacy organizations constitute the most well-resourced and developed portion of the LGBTQ immigration civic sector, capturing about $4 million, or more than 80 percent of domestic foundation funding. It should be noted that some of these national organizations, such as Immigration Equality and the National Center for Lesbian Rights, also litigate or offer legal services, but the foundation funding they receive is primarily for their advocacy work.

By comparison, state and local advocacy efforts received $435,000, and service providers captured only $122, 500. These portions of the sector are less well-resourced and have wider gaps, but nevertheless offer significant assets for funders to build upon.

This section provides an overview of the varied "ecology" of organizations working to address LGBTQ immigration issues at all three of these levels.

DOMESTIC LGBTQ IMMIGRATION FUNDING, BY STRATEGY AND GEOGRAPHIC FOCUS (2011-12)



INFRASTRUCTURE FOR NATIONAL ADVOCACY ON LGBTQ/IMMIGRATION ISSUES

ASSETS TO BUILD ON	GAPS AND CHALLENGES
• Small but potent set of organizations specifically focused on advocating for LGBTQ immigrants • Wide range of organizations advocating from both the LGBTQ and immigrant perspectives, particularly through legislative advocacy and litigation • Many LGBTQ undocumented activists who have become visible and effective leaders, spokespeople, and connectors in a range of movements	• Danger of "issue fatigue" from both donors and allied advocates. • Grassroots organizing and awareness-raising efforts are relatively under-resourced.

NATIONAL LGBTQ IMMIGRANT ADVOCACY ORGANIZATIONS: A handful of organizations have a core focus specifically on advancing policies that will improve the lives of LGBTQ immigrants. The largest and most visible of these organizations is Immigration Equality, which was a vocal advocate for immigration reform inclusive of binational couples. Since *Windsor*, Immigration Equality has continued to advocate for immigration legislation and executive action that will address the unique needs of LGBTQ asylum seekers and LGBTQ people in detention.

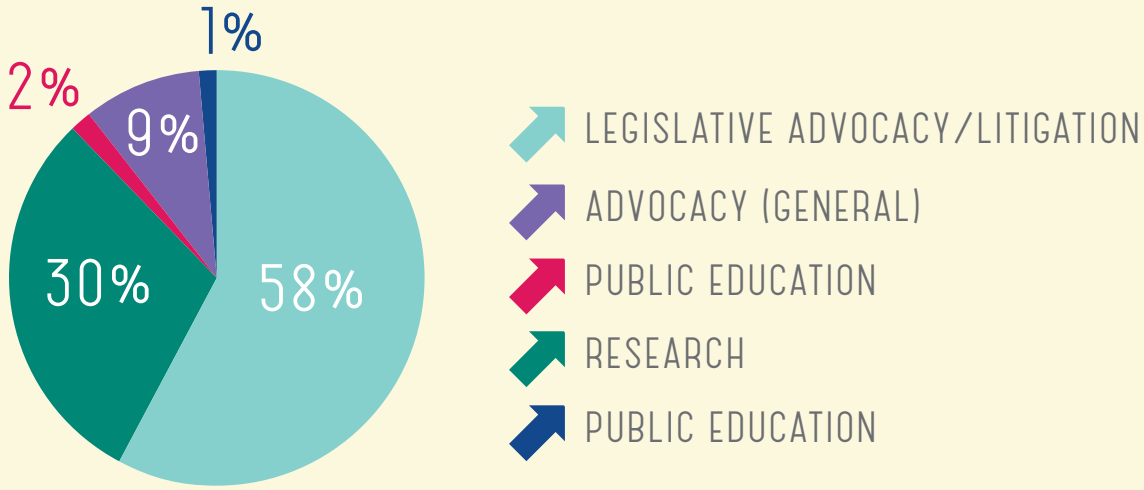
At the international level, the Organization for Refuge, Asylum, & Migration (ORAM), has played a leading role in educating and training non-governmental organizations and governments to be more inclusive and responsive to the needs of LGBTI refugees and asylum seekers. The International Gay & Lesbian Human Rights Commission (IGLHRC) has produced research and documentation of human rights abuses of LGBTI people around the world, providing essential supporting evidence for the claims of asylum seekers in the U.S. and elsewhere.

A number of smaller organizations rooted in LGBTQ immigrant communities in the U.S. have also led significant advocacy campaigns around LGBTQ immigration issues, with notable examples including the National Queer Asian Pacific Islander Alliance (NQAPIA), the Queer Undocumented Immigrant Project (QUIP), and the Trans Latin@ Coalition. Often these groups have local chapters or affiliates, and as such they have been able to play an important role in bridging national advocacy efforts with local groups, leaders, and constituents.

ALLIED ORGANIZATIONS: Several leading national LGBTQ advocacy organizations have integrated immigration issues into their policy agendas. For example, GetEqual has made immigration reform a core priority for its grassroots

movement-building and direct actions. The National Gay and Lesbian Task Force (NGLTF) has been a strong voice for immigration reform, participating in the Coordinating Committee of the Alliance for Citizenship and featuring immigrant rights prominently at its Creating Change conference. The National Center for Lesbian Rights has litigated for LGBTQ people facing immigration challenges and has also helped raise awareness around how immigration affects LGBTQ communities. Other examples include the American Civil Liberties Union (ACLU),

LGBTQ IMMIGRATION FUNDING FOR NATIONAL ADVOCACY, BY STRATEGY FUNDED (2011-2012)



GLAAD, the Gay Straight Alliance (GSA) Network, Lambda Legal, the National Center for Transgender Equality, and Transgender Law Center, all of which have spoken out for immigration reform and immigrant rights.

Similarly, several national immigration, social justice, and human rights advocacy organizations have begun to address LGBTQ issues. Examples include the League of United Latin American Citizens (LULAC), The Mexican American Legal Defense and Education Fund (MALDEF), National Council of La Raza, Center for Community Change, Human Rights First, and the National Immigration Law Center (NILC).

In addition, progressive think tanks such as the Center for American Progress, Political Research Associates, and the Williams Institute have provided invaluable research on LGBTQ immigrants and the policies that affect them.

QUEER UNDOCUMENTED LEADERSHIP: Across a range of organizations, a number of young LGBTQ undocumented activists have emerged as visible and effective leaders. Many of these leaders became active through the undocumented youth or "Dreamers" movement, which initially focused on advocating for the DREAM act, a federal bill that would create a conditional path to citizenship for undocumented immigrants who originally entered the country as minors. Over the past decade, the movement has grown in scale, and undocumented youth have become some of the most visible advocates for immigrant rights. Many of the Dreamers identify as LGBTQ, and have intentionally come out publicly as both queer and undocumented, placing them in a unique position to serve as spokespeople and natural bridge-builders across the LGBTQ and immigrant rights movements. Queer undocu-

WHAT IS DACA?

DACA stands for Deferred Action for Childhood Arrivals, an administrative relief program for undocumented immigrants who came to the U.S. before the age of 16 and meet other requirements. For those who receive it, DACA provides work authorization and defers deportation for two years. As of early 2014, more than 600,000 people have received DACA. Those who applied when the program was first announced in summer 2012 must now re-apply.[13]

mented immigrants are now found in a number of leadership positions—not only in explicitly LGBTQ immigrant programs such as QUIP, but also in LGBTQ organizations such as GetEqual and in immigration advocacy networks such as Immigrant Youth Coalition and United We Dream. Programs such as the Queer Dream Summer National Internship Program and the Pipeline Project for LGBTQ leaders of color offer potential vehicles to further develop queer immigrant leaders.

GAPS AND CHALLENGES: National advocacy for LGBTQ immigrant rights has become more prominent in recent years due to a concerted effort on the part of funders and leading organizations across the LGBTQ and immigrant rights movements. With immigration reform currently stalled in Congress, there is a danger of "issue" fatigue for both funders and allied leaders.

A number of national organizations working on LGBTQ immigration issues have a high capacity for legislative advocacy and litigation. Capacity and resources are less developed for other advocacy strategies, such as grassroots organizing and public education. With media coverage of immigration issues often lopsided, there is a real need to offer counter-narratives and lift up positive stories of LGBTQ immigrants. One model for this work is found in Cuéntame, a project of Brave New Films which has used short videos and other social media to disseminate stories of immigrants, including LGBTQ immigrants.

INFRASTRUCTURE FOR STATE AND LOCAL ADVOCACY ON LGBTQ/IMMIGRATION ISSUES

ASSETS TO BUILD ON	GAPS AND CHALLENGES
• In some states, LGBT equality organizations or immigrant rights organizations have effectively advocated at the intersections of the two issues. • At the local level, grassroots groups rooted in LGBTQ immigrant communities have the potential to serve as bridges and spokespeople on LGBTQ immigrant rights.	• The policy context of many states is fairly conservative, with high resistance to LGBTQ and immigrant rights and, in some cases, active efforts to curtail the civil rights of both communities. • Many states are home to only a handful of advocacy organizations addressing LGBTQ issues or immigrant rights, which are often under-resourced and stretched to capacity.

13 "Number of I-821D, Consideration of Deferred Action for Childhood Arrivals by Fiscal Year, Quarter, Intake, Biometrics and Case Status: 2012-2014." United States Citizenship and Immigration Services, March 2014. http://www.uscis.gov/sites/default/files/USCIS/Resources/Reports%20and%20Studies/Immigration%20Forms%20Data/All%20Form%20Types/DACA/I821d_daca_fy2014qtr2.pdf

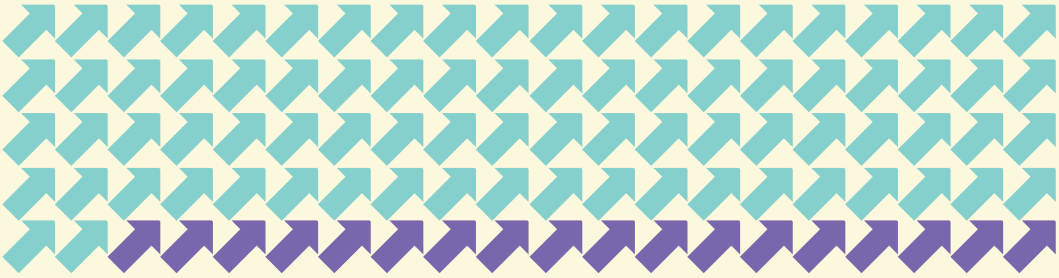
STATE ADVOCACY ORGANIZATIONS AND COALITIONS: In some states, state-level LGBTQ, Latino, or immigrant advocacy organizations have effectively advanced policies that benefit LGBTQ immigrants. In Oregon, Basic Rights Oregon, the state LGBT equality organization; Causa, the state Latino immigrant advocacy organization; and Western States Center, a broad progressive organization, have all worked in coalition to advocate for issues ranging from immigrant rights to marriage equality. Similarly, Colorado has seen effective advocacy for LGBTQ immigrants on the part of both the Colorado Immigrant Rights Coalition and One Colorado. Progressive Leadership Alliance of Nevada has also advocated for both LGBTQ equality and immigrant rights.

INTERSECTIONAL GRASSROOTS GROUPS: At the local level, many grassroots organizations are working to mobilize LGBTQ immigrants around the issues that directly affect them. Many of these groups are rooted in LGBTQ immigrant communities or LGBTQ communities of color, and are inherently intersectional. The Association of Latino Men for Action (ALMA), a grassroots group of gay Latino men, has worked in coalition with other groups for immigrant rights in the Chicago area. Several QUIP chapters and other local immigrant youth groups have organized LGBTQ undocumented immigrants at the local level. At the regional level, Southerners on New Ground (SONG) has worked to mobilize LGBTQ immigrants and people of color in the South around the issues that most affect them.

GAPS AND CHALLENGES: Few states have seen the level of LGBTQ-immigrant coalition-building found in Colorado and Oregon. In many states, particularly outside the Northeast and West Coast, there are simply very few staffed organizations advocating for LGBTQ issues or immigrant rights. What organizations do exist are often strapped for resources, making it difficult to allocate the time and resources required for long-term coalition-building work.

Immigrant and LGBTQ communities also face severe political opposition in many states, particularly in the South and Southwest, where the rights of immigrants, LGBTQ people, and people of color have been under attack in the form of harsh anti-immigrant measures, bills granting religious groups broad license to discriminate, and strict voter identification laws. Unfortunately these are also the states where the infrastructure for state and local LGBTQ and immigrant advocacy is weakest.

LGBTQ IMMIGRATION FUNDING FOR STATE AND LOCAL ADVOCACY, BY STRATEGY FUNDED (2011-2012)



82%
STATE-LEVEL ADVOCACY

18%
LOCAL GRASSROOTS ORGANIZING

Another challenge in many states is the role of the Catholic Church and its affiliates, which have been important champions of immigrant rights but have offered significant opposition to LGBTQ rights. In states such as Colorado, Illinois, and Massachusetts, the Catholic Campaign for Human Development – a Catholic anti-poverty funder that supports many immigrant organizations – threatened to revoke funding from immigrant groups if they continued to work in partnership with LGBTQ communities. For the most part, immigrant advocacy organizations stood by their LGBTQ partners and returned the funds. In some cases, LGBTQ funders and allies were able to give or raise funds to make up for the loss in funding. Nevertheless, the Catholic Church's opposition remains a significant challenge for LGBTQ-immigrant coalitions, especially at the state level.

SERVICES INFRASTRUCTURE FOR LGBTQ IMMIGRANTS

ASSETS TO BUILD ON	GAPS AND CHALLENGES
• Legal service providers offering assistance to LGBTQ asylum seekers and LGBTQ immigrants in detention. • Burgeoning network of faith-based and other volunteer efforts offering support to address housing and other basic needs of asylum seekers	• Legal constraints and other ba rriers make it difficult for LGBTQ undocumented immigrants to access basic needs such as health care, housing, and employment. • Outside of legal services, resources specifically targeting LGBTQ immigrants and asylum-seekers are sparse and severely under-resourced.

LEGAL SERVICE PROVIDERS: Several organizations provide legal services to LGBTQ immigrants, refugees and asylum seekers. The Heartland Alliance's National Immigrant Justice Center in Chicago provides representation for LGBTQ and HIV-positive asylum seekers and LGBTQ immigrants in detention. Immigration Equality, in addition to its advocacy work, provides legal assistance to hundreds of LGBTQ and HIV-positive asylum seekers annually, as well as assistance to LGBTQ immigrants in detention. LGBT legal organizations such as the National Center for Lesbian Rights, also offer legal services for LGBTQ immigrants and asylum seekers.

LGBTQ ASYLUM SUPPORT SERVICES: A small but burgeoning set of organizations have begun to address the needs of LGBTQ refugees and asylum seekers beyond legal services. HIAS, the oldest refugee resettlement organization in the world, has a federal grant that is specifically dedicated to assisting LGBTQ refugees and asylees with their resettlement in the U.S., including basic needs such as housing and medical services. Unfortunately, HIAS and other federally funded programs are able to assist refugees and people who have already been granted asylum, but are prohibited from helping asylum seekers. Far fewer resources exist for asylum seekers: the federal government and most states do not allow their funding to be used for asylum seekers. Organizations such as the LGBT Asylum Support Task Force in Worcester, Massachusetts, and the Center for Integration and Courageous Living in Chicago help LGBTQ asylum seekers secure housing and basic necessities such as food and clothing. Many of these groups are rooted in faith-based

FUNDER COLLABORATION ON LGBTQ IMMIGRATION ISSUES

OVER THE YEARS, FUNDERS HAVE WORKED TOGETHER THROUGH A NUMBER OF COLLABORATIVE INITIATIVES TO ADVANCE THE RIGHTS AND WELL-BEING OF LGBTQ IMMIGRANTS.

EMMA LAZARUS FUND: In the late 1990s, in response to welfare reform cutting benefits for millions of immigrants, the Open Society Foundations launched the $50 million Emma Lazarus Fund. Working through local intermediaries and collaboratives, the initiative provided naturalization services and citizenship classes helping hundreds of thousands of immigrants become citizens, undoubtedly including many LGBTQ immigrants.

FOUR FREEDOMS FUND: This collaborative funding initiative was established in 2003 and is housed at Public Interest Projects. Over the past decade, the Fund has awarded more than $79 million in grants to build the capacity of the immigrant rights field, with a focus on policy advocacy, communications, and collaboration and alliance-building. Several LGBTQ-focused funders, such as the Arcus Foundation and the Gill Foundation, have participated in the Collaborative, which has supported coalition-building between LGBTQ organizations and immigrant rights groups in several states.

LGBT DREAMERS FUND: Launched in 2012 with a challenge grant from the Evelyn & Walter Haas, Jr. Fund, the LGBT Dreamers Fund helped more than 160 young LGBT undocumented immigrants pay the fees required to apply for Deferred Action for Childhood Arrivals (DACA). Housed at the Liberty Hill Foundation, more than 60 LGBTQ organizations and donors contributed to the Fund.

RACIAL JUSTICE FUND: This new fund aims to develop and strengthen a strategic and effective advocacy sector addressing the needs of LGBTQ communities of color. Housed at the Astraea Lesbian Foundation for Justice, and supported by the Ford Foundation, the Arcus Foundation and an anonymous donor, the Fund supports efforts for LGBTQ people of color to influence the issues and policies that most affect them, including LGBTQ immigrant rights.

communities such as the United Church of Christ and Unitarian Universalist Association. Some have small staffs, but they largely operate through networks of unpaid volunteers. Nearly all of their financial support comes from small donations from individuals. The LGBT Faith and Asylum Network (LGBT-FAN) has brought together a diverse coalition of faith and community organizations, service providers, and LGBTQ and immigration policy organizations to increase coordination of their efforts and address the needs of LGBTQ asylum seekers. LGBT-FAN has also established a charitable fund to make grants to support asylum seekers' living expenses.

LGBTQ COMMUNITY CENTERS AND SERVICE PROVIDERS: The Movement Advancement Project's LGBT Community Center Survey Report indicates that 40 percent of LGBT community centers offer services in languages other than English and 15 percent provide programming specifically targeting LGBTQ immigrants.[14] Centers in cities such as Los Angeles, New York, and Washington, DC, offer services such as counseling, legal clinics, referral services, and support groups for LGBTQ immigrants and immigrants living with HIV.

Other LGBT service agencies, including some HIV/AIDS service organizations, also have programs that serve significant numbers of LGBT immigrants. For example, GMHC's Sustainability Living Fund provides rental assistance to eligible residents of New York City with HIV/AIDS, including undocumented immigrants who do not qualify for Federal Aid.

GAPS AND CHALLENGES: Outside of legal services, the service infrastructure specifically targeting the needs of LGBTQ immigrants is weak and severely under-resourced. This is especially concerning, since, as noted above, this population faces unique needs and barriers when it comes to education, health care, and jobs. Moreover, mainstream service providers and institutions often lack the cultural competence to effectively serve immigrants, LGBTQ people, or both.

The larger immigration system itself is perpetually over-burdened and lacks the capacity to effectively manage large influxes. As of June 2014, U.S. immigration courts had a backlog of more than 375,000 pending cases and an average wait time of 587 days.[15] If and when large policy changes such as comprehensive immigration reform are implemented—or even in the case of smaller steps such as administrative relief—the system is likely to be significantly strained.

Finally, many LGBTQ undocumented immigrants do not access what resources are available due to financial barriers or simple lack of awareness. For instance, although more than 1.1 million immigrants are estimated to be eligible for DACA, only about 600,000 have applied for and received the benefits of the program. The remaining 500,000 are either unaware of the program, lack the resources to pay the application fees, or fear that it will not guarantee safety for themselves or their families.

14 "2014 LGBT Community Center Survey Report: Assessing the Capacity and Programs of Lesbian, Gay, Bisexual and Transgender Community Centers." CenterLink and Movement Advancement Project, 2014; "2012 LGBT Community Center Survey Report: Assessing the Capacity and Programs of Lesbian, Gay, Bisexual and Transgender Community Centers." CenterLink and Movement Advancement Project, 2012. http://lgbtmap.org/2014-lgbt-community-center-survey-report

15 "Juvenile Cases Help Push Immigration Court Backlog to New High." Transactional Records Access Clearinghouse, Syracuse University, July 2014.

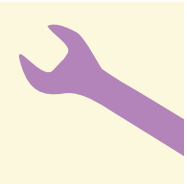
RECOMMENDATIONS

1. FUND ADVOCACY AND COALITION-BUILDING AROUND LGBTQ/IMMIGRATION ISSUES FOR THE LONG TERM.

With major reforms of the immigration system now appearing unlikely over the next two years, it is crucial to sustain and build a strong ecology of organizations to collectively mobilize diverse communities around the rights of LGBTQ immigrants. Over the short term, strong LGBTQ-immigrant coalitions will be crucial for advancing pro-LGBTQ and pro-immigrant policies at the state and local level, and at the national level through administrative relief. Over the longer term, these coalitions will be essential to successfully advancing policies for social change at the national level, ranging from comprehensive immigration reform to nondiscrimination protections based on sexual orientation and gender identity.

2. SUPPORT AND DEVELOP LGBTQ IMMIGRANT LEADERS.

A number of young LGBTQ immigrants from the DREAM movement are now entering positions of leadership not only in the immigrant rights movement, but also in LGBTQ rights movement and other social change movements. Many of these young leaders are natural and effective spokespersons as well as adept and authentic coalition-builders. Funders have an opportunity to support and develop these leaders as a strategy for building stronger and more interconnected social change movements.



3. STRENGTHEN STATE AND LOCAL LGBTQ IMMIGRATION ADVOCACY.

Many key policies around LGBTQ and immigration issues are shaped at the state level, yet funding for organizations working at the state and local levels constitutes less than one-tenth of LGBTQ immigration funding. There is a particularly great need to strengthen state and local infrastructure in the Southeast and Southwest, where policies aimed at curtailing the rights of LGBTQ people and immigrants are being pursued. Funding for local and state-level organizations is an area where community foundations and other place-based funders may play an especially important role, as these local funders often have a deep understanding of the unique regions they serve.

4. STRENGTHEN AGENCIES AND NETWORKS SERVING LGBTQ ASYLUM SEEKERS AND IMMIGRANTS.

Demand for services for LGBTQ asylum seekers and undocumented immi grants far exceeds the current capacity of the handful of organizations working to address this population's needs—which include not only legal services but also housing, health care, and employment opportunities. Funders have an opportunity to build the capacity of the burgeoning set of faith-based groups, community centers, and networks seeking to address the unique needs of this population.

5. INCREASE CULTURAL COMPETENCE OF IMMIGRATION SERVICE SYSTEMS.

Most LGBTQ immigrants, refugees, and asylum seekers are likely to interact with mainstream service systems, including government agencies and mainstream immigrant service providers. Funders have an opportunity to increase the cultural competence of these systems to address the unique needs of LGBTQ people. The LGBTQ cultural competence of mainstream service systems will become especially important if and when comprehensive immigration reform is passed; millions of immigrants will require services and processing in the same period, including hundreds of thousands of LGBTQ immigrants.

6. PROVIDE FINANCIAL ASSISTANCE FOR IMMIGRATION APPLICATIONS.

Initiatives such as the LGBT Dreamers Fund not only covered the direct costs for young LGBTQ immigrants to apply for DACA, it also helped raise awareness of the program. Now, two years after the program was launched, many DACA recipients are due for renewal. It is crucial that qualifying youth, particularly those who identify as LGBTQ, have access to the information and resources to apply for or renew their DACA. As immigration policy evolves, DACA renewal, recognition of binational same-sex couples, expanded administrative relief, and comprehensive immigration reform may provide opportunities for funders to financially assist low-income LGBTQ immigrants in attaining a recognized legal status.

METHODOLOGY

This report combines LGBTQ funding data captured for the 2012 Tracking Report: Lesbian, Gay, Bisexual, Transgender and Queer Grantmaking by U.S. Foundations and Lesbian, Gay, Bisexual, Transgender and Queer Grantmaking by U.S. Foundations – Calendar Year '11. For these reports, requests for grant information were sent to nearly 700 grantmakers. All types of foundations were surveyed - private, public, community, and corporate - as well as nonprofit organizations with grantmaking programs. Information was obtained predominantly through self-reporting by grantmakers, as well as a review of 990s and annual reports.

This report specifically focuses on LGBTQ immigration issues in the United States and captures grants made to support: (1) organizations that specifically focus on LGBTQ immigrant issues; (2) programs and projects that focus specifically on LGBTQ immigrants or LGBTQ immigration issues; and (3) coalition work between LGBTQ and immigrant rights organizations.

The data does not include grants to organizations or projects that are generally inclusive of LGBTQ immigrants unless they explicitly target LGBTQ immigrants or address an LGBTQ immigration issue. For example, a grant awarded to a LGBTQ community center to develop a new mental health initiative, open and welcoming to all LGBTQ individuals, including LGBTQ immigrants, would not have been included in the data. If that same center was funded to provide mental health assistance specifically to LGBTQ immigrants, then the grant would have been included.

Re-granting dollars are included in charts that rank individual grantmakers to accurately show the overall level of LGBTQ funding provided by each grantmaker. As a result, the charts that rank grantmakers "double-count" re-granting when aggregated. However, for all other tabulations and charts, we have not included dollars awarded for the purpose of re-granting, so as to avoid double counting.

ACKNOWLEDGEMENTS

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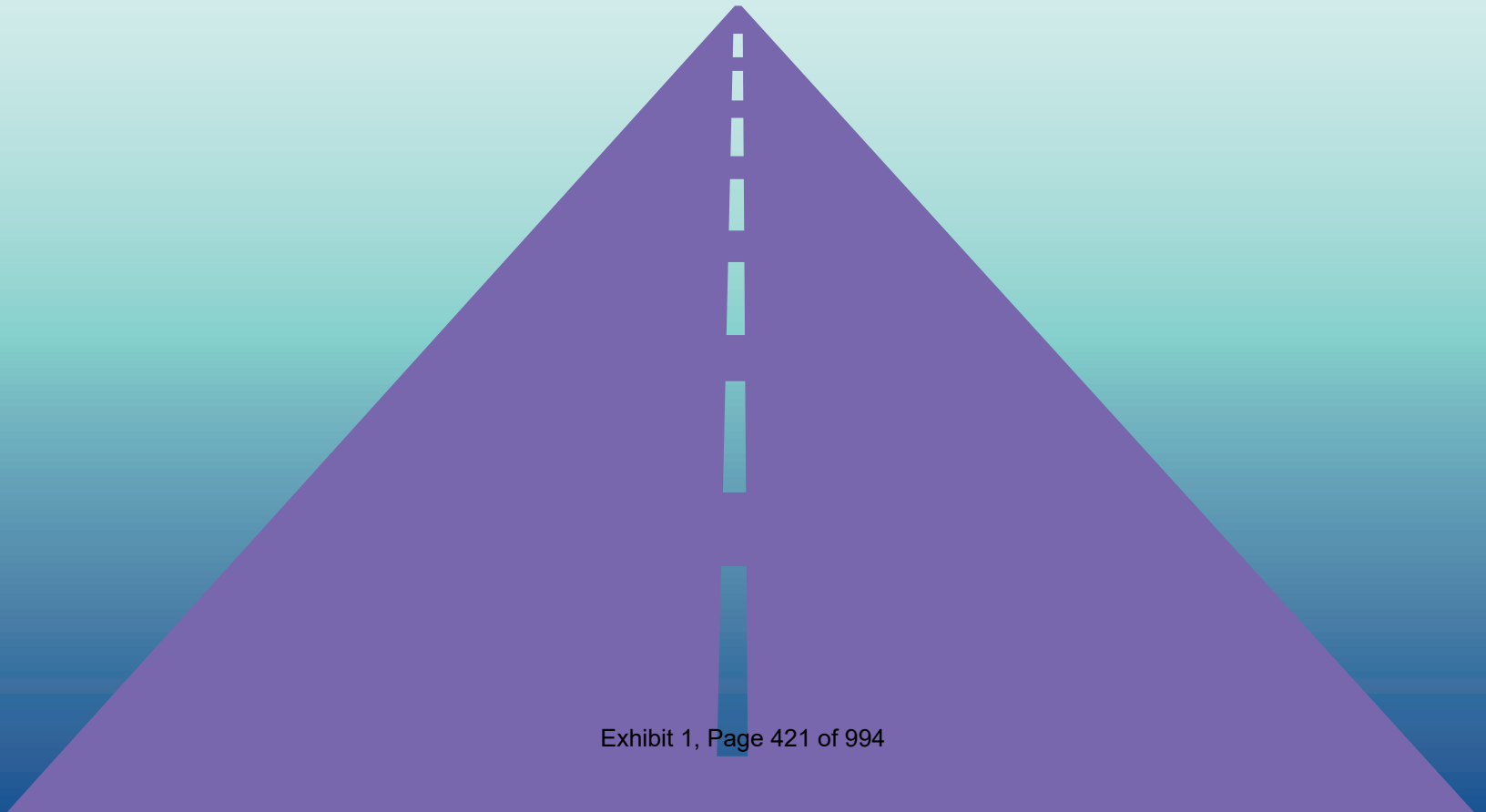

GENDER JUSTICE

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August 13, 2019

To Whom It May Concern:

We appreciate this opportunity to provide comment in response to the Notice of Proposed Rulemaking Regarding Nondiscrimination in Health and Health Education Programs or Activities. Gender Justice is a 501(c)(3) legal and policy advocacy organization based in St. Paul, Minnesota. We work to address the causes and consequences of gender inequality through strategic and impact litigation, policy advocacy, and public education. Our mission is broader than women's rights: we fight any discrimination based on sex, gender, sexual orientation, or gender identity. We work to address discrimination in the workplace, schools, health care, and in public accommodations. We believe in the critical importance of eliminating health disparities and ensuring all people, including lesbian, gay, bisexual, and transgender (LGBT) individuals and their families, do not face discriminatory gender barriers when seeking quality, affordable health coverage and care.

Gender Justice has been at the forefront of Section 1557 litigation, representing clients in both *Rumble v. Fairview Health Services* and *Tovar v. Essentia Health*.[1] We are familiar with the statute and have seen firsthand how it has protected our clients' rights.

Unsurprisingly, we are deeply concerned about the proposed changes to the Section 1557 regulation, and caution the Department and its Office for Civil Rights (OCR) against revising the Final Rule due to the damaging impact such revision would have.

In particular, we strongly urge OCR to reconsider four main points, and instead:

1. Retain the definition of "health program or activity" as applying to insurance;
2. Affirm gender identity as a valid and protected aspect of discrimination "on the basis of sex;"
3. Do not import religious exemptions found in Title IX into Section 1557; and
4. Acknowledge that Section 1557 is a unified statute, not an amendment of four existing and separate statutes.

These recommendations are described in more detail below.

[1] Rumble v. Fairview Health Servs. No. 14-CV-2037 SRN/FLN, 2015 WL 1197415 (D. Minn. Mar. 16,2015); Tovar and Olson v. Essentia Health, et al, 342 F.Supp.3d 947 (D. Minn. 2018).

I. "Health care" Includes Health Insurance.

The Department makes two main arguments for why health care does not encompass health insurance. However, their assumptions are faulty. First, the CRRA definition of program or activity is not applicable. Secondly, the whole term "health programs" has been previously used to refer to insurance. The Department's proposed rule furthers an inconsistent and inaccurate interpretation that would dramatically and harmfully reduce the scope of protection under Section 1557.

a. The CRRA definition of "program or activity" does not apply.

In its commentary to the proposed rule, OCR argues that under the Civil Rights Restoration Act of 1989 (CRRA)[2], it has never defined "program or activity" to include health insurance. The CRRA amended Title VI, Section 504 of the Rehabilitation Act, the Age Act, and Title IX to cover businesses receiving Federal money, as well as those not receiving federal funds when they were "principally engaged" in a public business, including healthcare. The point of the CRRA was to abrogate case law providing an unnecessarily narrow definition of the programs or activities receiving federal funding[3], expanding the reach of the referenced civil rights statutes into other activities engaged in by federal funding recipients.

The definition in the CRRA for "program or activity" is broad, not specific, because the statute amends other statutes that broadly prohibit discrimination in all types of programs receiving federal funding writ large. By contrast, Section 1557 applies the term "program or activity" to a *health* program or activity which specifically receives Federal funding.[4] It is not surprising that CRRA is not as specific about what types of activities are "health" programs or activities since the CRRA applies to all programs, not just health programs, receiving federal funding.

Using the CRRA definition of "program or activity" and applying it to health care, it obviously includes health insurance. Health insurance is "principally engaged" in the provision of health care. Although insurance companies are typically not themselves direct providers of care, insurers serve as a gatekeeper to providers by making decisions about what kind of health care is appropriate and cost effective. In a case deciding whether medical device manufacturers were providing health care, the court found that being engaged in healthcare meant "offer[ing] some form of treatment or direct

[2] 29 U.S.C.A. § 794.
[3] 102 Stat. 28, P.L.100-259, Mar. 22, 1988.
[4] 42 U.S.C.A. § 18116(a).

assistance to individuals."[5] Unlike medical device manufacturers, health insurers do directly serve individuals by deciding what medical procedures are covered.

Other cases interpreting the CRRA have fallen back on dictionary definitions.[6] Black's Law Dictionary defines healthcare as "the services provided…by medical professionals, to maintain and restore health."[7] Merriam-Webster defines health care as "efforts made to maintain or restore physical, mental, or emotional well-being especially by trained and licensed professionals."[8] Although insurance does not include licensed professionals, it is essential to the task of maintaining health. Most people would be incapable of getting healthcare without an insurance plan. Additionally, people working for a health insurance company make judgments about an individual's health and decide what the proper course of treatment for them is under their specific plan. Insurance companies essentially decide whether people can have procedures or not, and are therefore wholly involved in providing services that "maintain and restore health."

b. Where "Health program" has been defined, insurance has been included.

Given that the CRRA is too broad to provide a meaningful definition for "health programs or activities" under Section 1557 and the statute itself does not provide a definition, the agency should look to this phrase in other statutes. Other statutes using the phrase "health care program" define it to include insurance[9], including Medicare and Medicaid.[10] Using this definition, health insurance would be included within Section 1557's definition of health care program or activity.

II. "On the Basis of Sex" Includes Gender Identity.

a. *Price Waterhouse* interprets "on the basis of sex" to include gender stereotyping.

In *Price Waterhouse* the Supreme Court ruled that discrimination "on the basis of sex" included discrimination based on sex stereotyping.[11] In this case, Plaintiff Hopkins was in consideration for partnership, and several partners criticized her for not being

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[5] Drachman v. Bos. Sci. Corp., 258 F. Supp. 3d 207, 212 (D. Mass. 2017).
[6] Doe v. Salvation Army in the U.S., 684, 571 (6th Cir. 2012); Drachman v. Bos. Sci. Corp., 258 F. Supp. 3d 207, 212 (D. Mass. 2017).
[7] Healthcare Definition, *Black's Law Dictionary* (9th ed. 2009), *available from Westlaw*.
[8] "health care" Merriam–Webster Online Dictionary https://www.merriam-webster.com/dictionary/health%20care (last visited July 18, 2019).
[9] 42 U.S.C.A. § 1320a-7b ("for purposes of this section, the term "Federal health care program means…any plan or program that provides health benefits, whether directly, through insurance, or otherwise.").
[10] 42 U.S.C.A. § 1320a-7(a)(1).
[11] Price Waterhouse v. Hopkins, 490 U.S. 228, 250-51 (1989).

feminine enough.[12] One partner suggested she take "a course in charm school."[13] Hopkins was advised to "walk more femininely, talk more femininely, dress more femininely, wear make-up, have her hair styled, and wear jewelry."[14] The Supreme Court determined that sex stereotyping was a type of discrimination on the basis of sex: "an employer who acts on the basis of a belief that a woman cannot be aggressive, or that she must not be, has acted on the basis of gender."[15] Additionally, the court stated that if an employee's flawed interpersonal skills "can be corrected by a soft-hued suit or a new shade of lipstick" it is likely gender and not interpersonal skills behind the remark.

Following *Price Waterhouse*, a number of courts have applied this understanding of sex discrimination including sex stereotyping to Title IX and the Fourteen Amendment.[16] In addition to expanding this understanding of sex stereotyping across various similarly oriented statutes, a large number of courts have also determined that discrimination based on transgender status is necessarily discrimination on the basis of sex.[17] *Schwenk* explains: "under *Price Waterhouse*, "sex" under Title VII encompasses both sex…*and* [socially-constructed] gender [expectations]."[18] Because transgender people do not conform to gender stereotypes, "neither a woman with male genitalia nor a man with stereotypically female anatomy…may be deprived of…employment."[19] Courts around the

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[12] Id., at 235.
[13] Id.
[14] Id.
[15] Id. at 250.
[16] Whitaker by Whitaker v. Kenosha Unifed Sch. Dist. No. 1 Bd. Of Educ., 858 F.3d 1034 (7th Cir. 2017); Glenn v. Brumby, 663 F.3d 1312, 1320 (11th Cir. 2011) (concluding "a government agent violates the Equal Protection Clause…when he or she fires a transgender or transsexual employee because of his or her gender non-conformity.").
[17] Smith v. City of Salem, 378 F.3d 566, 574-75 (6th Cir. 2004) (explaining "discrimination against a plaintiff who is a transsexual…is no different from discrimination directed against [Hopkins] who, in sex-stereotypical terms, did not act like a woman."); Barnes v. City of Cincinnati, 401 F.3d 729 (6th Cir. 2005); Kastl v. Maricopa Cnty. Comm. College Dist., 2004 WL 2008954, at *2-3, 2004 U.S. Dist. LEXIS 29825, at *8-9 (D. Ariz. June 3, 2004); Lopez v. River Oaks Imaging & Diagnostic Group, Inc., 542 F. Supp.2d 653, 659-661 (S.D. Tex. 2008); Mia Macy, EEOC DOC 0120120821, 2012 WL 1435990, at *7 (Apr. 20, 2012) (stating that regardless of whether employer discriminates because of atypical gender expression, "because the employer is uncomfortable with the fact that the person has transitioned…or because the employer simply does not like that the person is identifying as a transgender person" the employer is making a gender-based evaluation in violation of the principle that employers may not take gender into account); Finkle v. Howard County, Md., 12 F. Supp. 3d 780 (D. Md. 2014).
[18] Schwenk v. Hartford, 204 F.3d 1187, 1201 (9th Cir. 2000).
[19] Kastl v. Maricopa Cnty. Comm. College Dist., 2004 WL 2008954, at *2-3, 2004 U.S. Dist. LEXIS 29825, at *8-9 (D. Ariz. June 3, 2004)

country have recognized that transgender people are protected under Title IX[20] and Section 1557[21].

b. The definition of sex is not based solely on genitalia, sex as assigned at birth, chromosomes, or any single factor, binary or otherwise.

Sex has long been an imprecise term subject to various interpretations. Merriam-Webster's current definitions of sex includes "the sum of the structural, function, and sometimes behavioral characteristics of organisms that distinguish males and females" and also "the state of being male or female."[22] Black's Law Dictionary includes "gender" as a definition for sex.[23] Using these definitions, sex discrimination includes discrimination against people because they are transgender.

Additionally, although Title IX uses terms such as "men" and "women" and "one sex" and "other sex," these are not necessarily defined in expressly binary terms.[24] Simply because two categories are mentioned does not mean there are not more categories that go unmentioned.

The commentary to the Department's proposed rule conflates several issues: that sex is binary, that sex excludes protection of transgender people, and that sex is necessarily

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[20] Whitaker by Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. Of Educ., 858 F.3d 1034 (7th Cir. 2017) ("A policy that requires an individual to use a bathroom that does not conform with his or her gender identity punishes that individual for his or her gender non-conformance, which in turn violates Title IX."); Evancho v. Pine-Richland Sch. Dist., 237 F. Supp. 3d 267, 285-86 (W.D. Pa. 2017) (stating school bathroom policy discrimination based on transgender status "is essentially the epitome of discrimination based on gender nonconformity, making differentiation based on transgender status akin to discrimination based on sex for these purposes."); M.A.B. v. Bd. of Educ. of Talbot Cty., 286 F. Supp. 3d 704, 713-15 (D. Md. 2018) ("It is well-settled within the Fourth Circuit, however, that case law interpreting Title VII of the Civil Rights Act…guides courts in evaluating a Title IX claim…allegations of gender stereotyping are cognizable as sex-discrimination claims under Title VII, and consequently, Title IX.").

[21] Rumble v. Fairview Health Servs., No. 14-CV-2037 SRNFLN, 2015 WL 1197415, at *2 (D. Minn. Mar. 16, 2015) (stating that "discrimination based on an individual's transgender status constitutes discrimination based on gender" or sex stereotyping); Prescott v. Rady Children's Hosp.-San Diego, 265 F. Supp. 3d 1090, 1099 (S.D. Cal. 2017) (holding "because Title VII, and by extension Title IX, recognize that discrimination on the basis of transgender identity is discrimination on the basis of sex," the ACA affords the same protection); Tovar v. Essentia Health, 342 F. Supp.3d 947, 952 (D. Minn. 2018) (holding that sex discrimination under Title IX and therefore Section 1557 includes gender identity discrimination).

[22] "sex" Merriam-Webster Online Dictionary, https://www.merriam-webster.com/dictionary/sex (last visited July 18, 2019).

[23] Sex Definition *Black's Law Dictionary* (11th ed. 2019) *available from Westlaw*.

[24] 42 U.S.C. 1681(a)(2).

defined by a person's sex assigned at birth. All of these are false. Even if sex is defined as purely binary, transgender people would still be included as members of their preferred sex, regardless of their gender identity, and would still be protected from sex stereotyping discrimination.

The Department also misuses discussions of "sex" in entirely different contexts in an attempt to bolster its misguided reasoning. The NIH's definition of sex for the purposes of its research is not a sound basis for determining what the meaning of a word in a statute is. Frequently scientific definitions and definitions adopted by courts are wildly different. Consider the classic *Nix v. Hedden*, where tomatoes were classified as vegetables, and not exempt from the tariff as a fruit, despite the scientific definition.[25] While scientific research may need a particular definition, the common understanding may be sensibly different. For example, most people use gender and sex more interchangeably than scientists might. Similarly, the ONC may use a more specific definition of "sex" demonstrated by their use of other data points that include "gender identity" specifically.[26] However, in cases where "sex" has already been acknowledged to encompass a broad variety of discrimination, gender identity could easily be included.

c. Transgender people have an established need for protection against discrimination in health care.

Eliminating gender identity discrimination in health care is essential to further the health and safety of the nation. As a whole group, the LGBT community reports poorer mental health than non-LGBT people, likely in part due to rampant discrimination.[27] Transgender individuals are more likely to need health services than cisgender individuals.[28] Transgender individuals are a particularly vulnerable population. Studies suggest that around 40% adults and perhaps as many as 31% trans youth have attempted suicide.[29]

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[25] Nix v. Hedden, 13 S. Ct. 881 (1893).
[26] 45 C.F.R. § 170.207(n); § 170.207(o).
[27] JUSTUS HEALTH, Voices of Health 2018 Full Report 17 (2018) (75% LGBTQ respondents were experiencing moderate to severe mental distress at time of survey. 87% of transgender or gender nonconforming respondents were experiencing moderate to severe mental distress.)
[28] MINN. DEPAR'T OF HEALTH, Key Indicators of Health and Educational Equity, 2016 (2016) (study of Minnesota High School students showed trans students were more likely to have missed school due to illness, three times more likely to have long-term mental health problems, and twice as likely to have alcohol or drug problems).
[29] Id.; S.E. JAMES ET AL. The Report of the 2015 U.S. Transgender Survey 112 (National Center for Transgender Equality 2016); JAIME M. GRANT ET AL., Injustice at Every Turn: a Report of the National Transgender Discrimination Survey 72 (National Center for Transgender Equality and National Gay and Lesbian Task Force 2011).

Trans individuals face significant barriers to receiving their much-needed care. Providers routinely discriminate against trans individuals in a myriad of ways.[30] Personal anecdotes highlight the gravity of discrimination: "I have been refused emergency room treatment even when delivered to the hospital by ambulance with numerous broken bones and wounds."[31] "Multiple medical professionals have misgendered me, denied to me that I was transgender or tried to persuade me that my trans identity was just a misdiagnosis of something else, have made jokes at my expense in front of me and behind my back, and have made me feel physically unsafe."[32] Frequently trans individuals are denied services related to their transgender status.[33]

In turn, this leads to many trans individuals avoiding care as a direct result of discrimination they have experienced or are afraid of experiencing.[34] This is particularly troubling, because treatment had shown to significantly reduce some of the mental health issues related to being trans.[35] Additionally, trans people who delayed care were

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[30] JAIME M. GRANT ET AL., Injustice at Every Turn: a Report of the National Transgender Discrimination Survey 72-74 (National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011) (19% of respondents were refused care due to being transgender or gender non-conforming; the rate among POC was even higher. 28% were subjected to verbal harassment in a medical setting.); LAMBDA LEGAL, When Health Care isn't Caring 5 (2010) (70% of trans and gender nonconforming respondents reported experiencing at least one instance of discrimination in care: being refused care, professionals refusing to touch them or using excessive protection, using hash or abusive language, being blamed for their health status, or professionals being physically rough or abusive); JUSTUS HEALTH, Voices of Health 2018 Full Report (2018) (3% trans or gender nonconforming respondents reported they had been refused treatment in the past year).

[31] GRANT, *supra* note 27, at 73.

[32] JAMES, *supra* note 26, at 96.

[33] Jae A. Puckett et al. *Barriers to Gender-Affirming Care for Transgender and Gender Nonconforming Individuals*. 15 Sexuality Research & Social Policy 48 (2018).

[34] GRANT, *supra* note 27 at 72 (28% of respondents postponed medical care due to discrimination); JAMES *supra* note 26, at 93 (23% of respondents did not see a doctor for fear of being mistreated); LAMBDA LEGAL, *supra* note 27, at 12 (more than 50% trans and gender nonconforming respondents were concerned about being refused medical services); Makini Chisolm-Straker et al., *Transgender and gender nonconforming in emergency departments: a qualitative report of patient experiences*, 2.1 TRANSGENDER HEALTH 8, 13 (2017) (66% of respondents who did not seek ER care had past negative experiences related to healthcare and their transgender status).

[35] Jaclyn M. White Hughto & Sari L. Reisner, *A systematic review of the effects of hormone therapy on psychological functioning and quality of life in transgender individuals*, 1.1 TRANSGENDER HEALTH 21, 27-28 (2016) (multiple studies show statistically significant reduction in depression and anxiety post hormone therapy); ALI ZAKER-SHAHRAK ET AL. Economic Impact Assessment: Gender Nondiscrimination in Health Insurance (State of California Department of Insurance 2012) (suicide fell from 19% to 0% in trans men, and from 24% to 6% for trans women post medical

more likely to have depression and had almost three times greater odds of being suicidal in the past year.[36]

Youth surveys estimate that the trans population may be as high as 3%.[37] That is far too large a population to ignore outright. The government has a compelling interest in abolishing discrimination, including discrimination based on sex.[38] The government also has an interest in not using federal funds to further discrimination.[39]

III. Title IX Religious Exemptions Should Not be Imported to Section 1557.

The proposed regulation states that religious liberty and "conscience protections" exemptions should be added into Section 1557. However, because Title IX exemptions are specific, narrow, and applicable to education but not health care settings, simply importing these exemptions to Section 1557 is not reasonable. Absent specific statutory guidance from Congress in Section 1557, OCR does not need to add protection beyond what is available under the Constitution and Religious Freedom Restoration Act.

a. Title IX Exemptions are specific and narrow, unlike in other civil rights statutes.

Congress did not mean to import Title IX wholesale, but only the protected class and enforcement mechanisms. Section 1557 explicitly references the enforcement mechanisms and states that the protected class is being imported.[40] It does not address anything else. If all of Title IX was imported, that would presumably include other irrelevant details that don't apply to healthcare, such as exceptions for discrimination in higher education scholarship award "beauty" pageants.[41] Clearly not all parts of Title IX apply in the healthcare context.

Compared to Title VI, Title IX's exemptions are much more context-dependent and specific. Title VI is not limited to education, and therefore its exceptions touch on all

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intervention. 78% of trans people have improved psychological functioning after treatment.).

[36] Kristie L. Seelman et al., *Transgender Noninclusive Healthcare and Delaying Care Because of Fear: Connections to General Health and Mental Health Among Transgender Adults* 2.1 TRANSGENDER HEALTH 17, 17 (2017).

[37] Nicole Rider et al. *Health and Care Utilization of Transgender and Gender Nonconforming Youth: a Population-Based Study,* 141 PEDIATRICS MED. J. 3 (2018).

[38] See, e.g., Roberts v. U.S. Jaycees, 468 U.S. 609, 628 (1984).

[39] See, e.g., Richmond v. J.A. Cronson Co., 488 U.S. 469,492 (1989) (plurality opinion).

[40] 42 U.S.C.A. § 18116(a)-(b).

[41] 20 U.S.C.A. § 1681(a)(9).

potential fields.[42] Because of this, Section 1557 does not do the work of expanding Title VI, but merely strengthens it. Title VI does not include a religious exemption. The military is exempt, but only because it has different law governing its procedures.[43] Similarly, Indian programs are exempt.[44]Affirmative action programs are also exempt, because they are actively combating the bias that Title VI seeks to eradicate.[45] By contrast, as the Supreme Court has commented, Title IX's exemptions are specific and narrowed to an education context.[46]

b. Title IX religious exemptions would need to be rewritten to avoid language specific to education.

Another issue with importing Title IX exemptions into Section 1557 is determining how closely to mirror the language, and where modification becomes appropriate. For example, § 1681(a)(3) could be read to only apply to "educational institutions" rather than health institutions.[47] It might be read only to apply to health care institutions that could also be considered educational institutions, so that only religious teaching hospitals would be eligible for exemptions. Since it is the patient, not the student, in question, that makes little sense. Another way of interpreting this exemption might be to translate "education institution" to "healthcare institution" instead. However, "educational institution" is narrowly defined so that certain programs not considered generally to be "schools" might not be exempt. Translating that to healthcare institutions, the exemption would likewise be narrow, and may not include insurance or associations like the CMDA (Christian Medical & Dental Association).

c. Healthcare is fundamentally different from education

Discrimination in healthcare is particularly egregious because of the inherent high stakes. While discrimination in education can have long, enduring, systematic effects, it rarely has the chance to literally cost someone their life. Consider a patient coming in to receive emergency care. They appear normal on the outside, but are suffering from internal bleeding. They have other symptoms that point to a major and life-threatening condition. A doctor comes in, sees that the person is trans, and makes barely any effort

[42] 42 U.S.C.A. § 2000d.
[43] Id. at 3-301.
[44] Id. at 3-304.
[45] Id. at 3-302.
[46] Jackson v. Birmingham Bd. Of Educ., 544 U.S. 167, 175 (2005).
[47] Id. at (a)(3).

to treat them, citing religious beliefs. This scenario is not far-fetched, as many trans patients have been denied treatment,[48] even in the emergency room.[49]

Any religious exemptions must also be carefully considered and calibrated for the health care context, because unlike in education, some patients have no alternative but to seek care at a religious health care provider, and their life may depend on receiving proper care. Currently, 1 in 6 patients are treated in Catholic hospitals.[50] While going to a Catholic high school is entirely optional because the state provides secular schooling for free, hospital care does not work this way. In an emergency, a person is typically taken to the nearest hospital, not to the hospital that most closely matches their spiritual convictions. In many parts of the country, there are no secular or alternative religious providers. Additionally, traveling to a secular health care provider may be extremely difficult or cost prohibitive for someone situated near a religious medical center, even if the situation is not dire.

d. RFRA provides adequate protection for religious interests without importing inappropriate religious exemptions into Section 1557.

The Religious Freedom Restoration Act (RFRA) states that the government may not substantially burden a person's exercise of religion unless it has a compelling interest and uses the least restrictive means. RFRA does not permit "courts to nullify whole regulations just because they have a potential for improper application to a particular faith."[51] Section 1557 does not need any additional religious protection.

Finally, it is fundamentally problematic to apply religious exemptions solely to one protected class, as may be the case if Section 1557 is treated as four different statutes, with religious exemptions only applying to sex discrimination.

IV. Section 1557 Is A Unified Single Statute.

Section 1557 clearly uses its reference statutes to identify protected classes and to create a set of enforcement mechanisms—nothing more. OCR's attempt to subdivide the statute is absurd and should be rejected.

a. Intersectionality requires a single standard.

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[48] GRANT, *supra* note 27, at 72-74 (National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011) (19% of respondents were refused care due to being transgender or gender non-conforming).
[49] Makini, *supra* note 30, at 12 ("The doctors were very rude, barely treated me, and tried to get rid of me as quickly as possible.").
[50] Brendan Pierson & Jan Wolfe. *Trump move on healthcare religious freedom prompts discrimination fears*, REUTERS. January 18, 2018.
[51] Borzych v. Frank, 439 F.3d 388, 391 (7th Cir. 2006).

First, a single standard acknowledges the intersectionality of protected classes. A plaintiff who was discriminated against for multiple reasons (e.g. a black woman being discriminated against because of both sex and race) should not be forced to apply different standards to each protected class. The court in *Rumble* determined that Congress likely wanted a single standard to avoid this type of "patently absurd consequence[]."[52]

For example, under the Rehabilitation Act, a plaintiff must show differential treatment was based solely on disability.[53] Section 1557 allows multiple different bases by collectively listing areas of potential discrimination. This allows a client who has been discriminated against for disability *and* something else, to not have to separate out the strands of what discriminatory act was linked to which protected trait. A plaintiff should not be barred from bringing a claim simply because there were multiple points of discrimination.

b. Consistency requires a single standard.

Additionally, the listed statutes have been interpreted inconsistently from each other over the years. It would be absurd if a woman bringing a claim of discrimination could use a disparate impact theory but a black man bringing the same claim (the only difference being the reason for the discrimination) could not rely on disparate impact, solely because of the different legal doctrinal developments in case law under Title VI and Title IX.

It makes sense to cite to the types of discrimination and their main statutes as a way of grounding the law without importing all of the associated precedent, particularly when the precedent differs from one statute to the next. Citing provides guidance on what possible mechanisms and causes of action are available. Section 1557 specifically states the causes of action are *imported* to it: "[t]he enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply."[54] It does not say its coverage is being exported to each individual statute.

c. Statutory interpretation requires a single standard.

Congress clearly knows how to amend the cited statutes; it did so in the CRRA. If Congress meant to amend, it could easily have done so. Because they used similar language to the CRRA, they were likely looking at it while creating the new statute, and thus is would have been easy for them to do exactly what the CRRA did and amend rather than create something new. They chose not to amend.

Section 1557 also clearly states that it is not a limit on discrimination claims, and that more inclusive state law is still good law: "Nothing in this title…shall be construed to invalidate or limit the rights…available to individuals."[55]

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[52] Rumble, at *12.
[53] 20 U.S.C.A. § 794(a).
[54] 42 U.S.C.A. § 18116(a).
[55] 20 U.S.C.A. § 18116(b).

For the sake of intersectionality, consistency, and following Congress' choices most faithfully, Section 1557 should be read as using a new, unifying standard.

V. Conclusion

Gender Justice, as an advocate for gender equality, finds the agency's proposed rulemaking extremely troubling and urges the OCR to reconsider its revision. As part of the Affordable Care Act, Section 1557 clearly includes health insurance as part of health care. The proposed rule ignores the majority of federal courts in the country that have recognized that sex discrimination includes discrimination because of gender identity, and therefore the regulations should acknowledge this protection under Section 1557. Title IX's religious exemption should not be imported because it is specific to the education context and narrow in its application. Finally, treating Section 1557 as an amendment to the four referenced statutes rather than as a separate unified statute would lead to absurd results.

We urge OCR to:

1. Retain the Final Rule definition of health care program;
2. Retain the Final Rule definition of discrimination on the basis of sex, complete with its definition of gender identity;
3. Refuse to import Title IX religious exemptions into Section 1557; and
4. Acknowledge that Section 1557 is a unified statute.

We are thankful for the opportunity to provide comments on this important civil rights law.

Sincerely,

/s/ Christy L. Hall

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Senior Staff Attorney
Gender Justice

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August 12, 2019

VIA ELECTRONIC SUBMISSION

Secretary Alex Azar
U.S. Department of Health and Human Services
Herbert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

RE: Docket ID HHS-OCR-2019-0007, RIN 0945-AA11, Nondiscrimination in Health and Health Education Programs or Activities

Dear Secretary Azar:

Health Care For All (HCFA) respectfully submits these comments in response to the U.S. Department of Health and Human Services ("HHS") and the Center for Medicare and Medicaid Services ("CMS") Notice of Proposed Rulemaking ("proposed rule," "proposal") to express our concerns with the proposed rule entitled "Nondiscrimination in Health and Health Education Programs or Activities" published in the Federal Register on June 14, 2019. We urge HHS and CMS to withdraw the proposed rule in its entirety.

HCFA is a non-profit consumer health advocacy organization that advocates for health justice in Massachusetts by working to promote health equity and ensure coverage and access for all. HCFA advances its mission through policy, advocacy, outreach, organizing and coalition building, as well as direct service through our multilingual consumer HelpLine. HCFA's HelpLine receives 20,000 calls per year from individuals and families across Massachusetts who need help applying for health coverage and maintaining that coverage over time.

HCFA opposes the proposed rule, which would undermine health care nondiscrimination protections and disproportionately affect the most vulnerable people we serve, including the lesbian, gay, bisexual, transgender and queer ("LGBTQ") community, especially transgender and gender nonconforming people; people who need reproductive health care, including abortion services; people whose first language is not English; women of color; and people living with disabilities and/or chronic conditions – all people who already experience significant barriers to accessing health care. This proposal would exacerbate these barriers and impact those living at the intersections of these identities the most.

The proposed rule would allow discrimination in health coverage and care that would impose additional challenges for people already experiencing barriers to accessing appropriate care. For example, an immigrant woman seeking reproductive health care could face harassment because she is a woman who has limited English proficiency. An individual could experience compounded discrimination based on being transgender and living with HIV. HCFA believes in the critical importance of ensuring that all people can obtain quality, affordable health care without facing discriminatory barriers.

Every day, HCFA's HelpLine hears from consumers across the state who face challenges to accessing affordable, quality health coverage and care. We hear from people for whom English is not their primary language seeking culturally and linguistically competent health care services. We hear from women with heart-wrenching stories who need access to timely and compassionate abortion services. We hear from people of various genders, including transgender people, who already have trouble finding the gender-affirming coverage and care they seek. We hear from people with disabilities who face overwhelming obstacles to finding all the services they need to remain in the community. These are real people who already encounter barriers to accessing the health care services and supports they need.

Narrowing the Scope of Section 1557

The 2016 final rule to implement Section 1557 of the ACA applies to all health programs and activities that receive federal financial assistance from HHS, all HHS-administered health programs and activities, and state-based marketplaces. The 2016 final rule defines health programs and activities to include all operations of an entity receiving federal financial assistance that is principally engaged in the provision or administration of health-related services or health-related insurance coverage.

The proposed rule seeks to reduce the number of health insurance plans that are covered by claiming that if the issuer of a health plan is "not principally engaged in the business of providing health care (as opposed to health insurance), only its Marketplace plans would be covered and any plans it offers outside the marketplace would not be subject to Section 1557."[1] Additionally, the proposed rule improperly attempts to narrow that application of Section 1557's protections to only the portion of a health care program or activity that received federal financial assistance. These changes unlawfully narrow the scope of Section 1557's application. The statute is clear that the law's provisions apply broadly to "any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments)." 42 U.S.C. § 18116(a).

Eliminating the Definition of Sex Discrimination

Sex discrimination disproportionately impacts women of color, LGBTQ people and individuals living at the intersections of multiple identities, resulting in access to less affordable health coverage and lower quality health care, including more frequently receiving improper diagnoses, being provided less effective treatment and sometimes being denied care altogether. As the first broad prohibition against sex discrimination in health care, Section 1557 is crucial to ending gender-based discrimination by health care providers and in health insurers.

Gender Identity

About 5% of Massachusetts residents identify as LGBTQ[2] and it is estimated that nearly 30,000 Massachusetts adults identify as transgender.[3] Transgender people in Massachusetts – and across the nation – already report significant health care access problems due to discrimination by providers and insurers. The 2015 U.S. Transgender Survey found that 28% of Massachusetts-based respondents

[1] MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.
[2] Williams Institute: https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT&area=25#about-the-data.
[3] Williams Institute, How Many People Identify as Transgender in the United States: https://williamsinstitute.law.ucla.edu/wp-content/uploads/How-Many-Adults-Identify-as-Transgender-in-the-United-States.pdf.

experienced insurance problems related to being transgender, such as coverage denials for gender-affirming care or denials of other routine care.[4] Further, 31% of survey respondants reported negative experiences with health care providers in the past year, including refusals of treatment, verbal harassment, physical or sexual assault, or needing to teach the provider about transgender people in order to receive appropriate care.[5] These types of problems caused one-in-five survey respondents to avoid needed care due to fears of being mistreated due to their trans identity, and one third to experience "serious psychological distress" during the month prior to completing the survey.[6]

The proposed regulations would disproportionately impact LGBTQ people, especially transgender, non-binary and gender nonconforming people who already face unique barriers to accessing care, such as higher uninsurance rates and experiences of discrimination and harassment in their everyday lives. The 2016 final rule implementing Section 1557 had clarified that health care providers cannot refuse to treat someone because of their gender identity. By removing gender identity from the interpretation of sex discrimination, the proposed rule essentially sanctions health providers discriminating against or refusing to treat transgender or gender nonconforming people, even in the case of providing care for non-gender related care, such as for a broken bone.

The 2016 final rule also clarified that insurance companies cannot categorically exclude or deny coverage for gender-affirming care. Yet, the proposed rule opens the door to health insurers categorically excluding coverage of gender-affirming care from their plans or denying individuals coverage of procedures needed in conjunction with this care. Moreover, under the proposed rule, transgender, non-binary and gender nonconforming people assigned female at birth whose gender marker is male or non-binary could be denied coverage for necessary care such as a pap smear or mammogram. Similarly, transgender nonbinary, and gender nonconforming people assigned male at birth whose gender marker is female or nonbinary could be denied coverage for necessary care, such as a prostate exam.

In Massachusetts, the state Division of Insurance (DOI) prohibits fully-insured plans from discriminating against people on the basis of gender identity, such as by denying medically necessary treatment of gender dysphoria.[7] The DOI Bulletin relies, in part, on federal authority stemming from current Section 1557 regulations. Since the issuance of the DOI Bulletin and the 2016 final 1557 rule, more health insurance plans, including self-insured plans, are removing exclusions of gender-affirming services, as well as expanding the types of medical services available to treat gender dysphoria. HCFA is concerned that the proposed rule will undermine our state laws and reverse the progress we have made since promulgation of the 2016 Section 1557 rule.

The 2016 final Section 1557 rule was a landmark accomplishment for LGBTQ nondiscrimination protections. The rule has been critical for ensuring nondiscrimination based on gender identity across federally funded health care programs and has also been integral for addressing discriminatory health coverage exclusions for transgender people. The 2016 rule also prohibits some forms of sexual orientation discrimination that take the form of sex stereotyping. By eliminating the regulatory definition of sex discrimination, which currently includes discrimination based on gender identity and sex stereotyping, the proposed rule would unravel the gains made in this area. The proposed rule

[4] 2015 U.S. Transgender Survey, Massachusetts State Report, http://www.transequality.org/sites/default/files/docs/usts/USTSMAStateReport%281017%29.pdf. Nationwide report is available here: https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.
[5] Ibid.
[6] Ibid.
[7] Massachusetts Division of Insurance Bulletin 2014-03**;** M.G.L. c. 151B, Sec. 4.

also runs contrary to numerous rulings by federal courts and the Equal Employment Opportunity Commission that have found that federal prohibitions on sex discrimination prohibit discrimination based on sexual orientation and gender identity.[8]

Pregnancy Status

The 2016 final rule made clear that sex discrimination under Section 1557 includes discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related conditions. The proposed rule would roll back these protections and enable a system where people who are pregnant may not be able to access the care they need. Although HHS acknowledges in the preamble to this proposed rule that Title IX prohibits discrimination based on pregnancy, including termination of pregnancy, it does not state whether HHS would enforce those protections. The proposed rule would have a disproportionate impact on women and other people who are pregnant, especially those living in rural areas and people of color. Women of color already face unique barriers to accessing pregnancy-related and/or abortion care, such as a discrimination, harassment and refusals of care, and experience higher rates of pregnancy-related complications. For example, Black women are three to four times more likely to die from pregnancy related complications than white women.

The proposed incorporation of Title IX's exemptions would cause further harm to LGBTQ people and women of color. For example, the proposed rule seeks to add Title IX's religious exemption to Section 1557's protection against sex discrimination, which could embolden providers to invoke personal beliefs to deny access to a broad range of health care services, including birth control, sterilization, certain fertility treatments, abortion and gender-affirming care. Similarly, the Administration once again attacks abortion access by incorporating the "Danforth Amendment" into the HHS proposed rule, which carves out abortion care and coverage from the ban on discrimination of sex in the education context. Both attempts to incorporate exemptions from other laws would cause significant harm to people seeking reproductive health services and violate the plain language of Section 1557 of the ACA.

Amending Unrelated Regulations to Exclude Sexual Orientation and Gender Identity Protections

Unlike the proposed rule, the 2016 final Section 1557 rule did not attempt to amend other HHS health care regulations. The proposed rule seeks to erase all references to gender identity and sexual orientation in all HHS health care regulations. If implemented, this rule would eliminate express prohibitions on discrimination based on gender identity and sexual orientation from regulations that govern a range of health care programs, including private insurance and education programs. This could result in diminished access to care and poorer health outcomes for communities across the country.

Prior to the passage of the ACA, being transgender could be treated as a pre-existing condition. As a result, transgender people in many states often could not enroll in or afford insurance coverage. Under the proposed rule, states and health insurance marketplaces could discriminate against LGBTQ people in eligibility determinations, enrollment periods, and more. Similarly, enrollment assisters, agents and brokers who assist with enrollment in marketplace plans could discriminate against LGBTQ people.

[8] U.S. Equal Employment Opportunity Commission (updated 2017). Examples of court decisions supporting coverage of LGBT-related discrimination under Title VII. https://www.eeoc.gov/eeoc/newsroom/wysk/lgbt_examples_decisions.cfm.

In addition, under the proposed rule, Programs of All-Inclusive Care for the Elderly ("PACE") organizations, which serve people ages 55+, could discriminate against LGBTQ people.[9] There are more than 3 million LGBTQ people age 55+ in the U.S. That number is expected to double within the next 20 years.[10] Many older LGBTQ adults already feel reluctant to discuss their sexual orientations and gender identities with health providers due to fear of judgment and/or substandard care.[11] The proposed rule would only further discourage older LGBTQ adults from sharing information that may be relevant to the health services they need.

Eliminating Language Access Protections

The proposed rule seeks to weaken protections that provide access to interpretation and translation services for individuals with limited English proficiency ("LEP"). In particular, HHS proposes to repeal Section 1557 provisions on taglines, the use of language access plans, notices of non-discrimination, as well as requirements for remote English-language video interpreting services. Discrimination on the basis of national origin, which encompasses discrimination on the basis of language, creates unequal access to health care. Over 25 million Americans are limited English proficient. An estimated 19 million LEP adults are insured. Language assistance is necessary for LEP persons to access federally funded programs and activities in the health care system.

HCFA knows firsthand the difference linguistically appropriate assistance makes to LEP populations. Our HelpLine provides health insurance enrollment and education services in English, Spanish and Portuguese – the top three languages spoken in Massachusetts. For LEP individuals, language differences often compound existing barriers to accessing appropriate care. LEP often makes it difficult to navigate an already complicated health care system or understand medical or insurance terminology. These challenges are often further compounded by discrimination based on national origin, immigration status, race, ethnicity, sexual orientation and gender or gender identity.

The proposed rule would have a disproportionate impact on people with LEP who are low-income and/or are people of color. In Massachusetts, there are over 224,000 low-income LEP individuals[12]. Nationwide, Latinx people make up 63% of those considered LEP, while Asian Americans and Native Hawaiian and Pacific Islanders make up 22%. LEP individuals are more likely to live in poverty than their English proficient counterparts. The proposed rule could further exacerbate these disparities and will disproportionately burden LEP individuals with health care costs.

We strongly disagree that nondiscrimination notice, taglines and language access plan requirements in the 2016 final rule were not justified by need, were overly burdensome, or created inconsistent requirements. The notice requirement is consistent with the long history of civil rights regulations requiring the posting of notice of rights. The notice is not redundant; OCR created the option of using one consolidated civil rights notice to minimize burden on covered entities. Without the notice, members of the public will have limited means of knowing that language services and auxiliary aids

[9] MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.

[10] Robert Espinoza, Servs. & Advocacy for Gay, Lesbian, Bisexual, & Transgender Elders, Out & Visible: The Experiences and Attitudes of Lesbian, Gay, Bisexual, and Transgender Older Adults, Ages 45-75, 5 (2014), https://www.sageusa.org/wp-content/uploads/2018/05/sageusa-out-visible-lgbt-market-research-full-report.pdf.

[11] Ibid.

[12] Massachusetts Law Reform Institute: https://www.masslegalservices.org/content/maps-low-income-lep-speakers-massachusetts.

and services are available, how to request them, what to do if they face discrimination, and their right to file a complaint.

Taglines are well supported by existing federal and state regulations, guidance and practice. Taglines are a cost-effective approach to ensure that covered entities are not overly burdened. In the absence of fully-translated documents, taglines are necessary to ensure that people are notified of their rights under law. We also oppose removing all references to language access plans. Under the 2016 final rule, these plans are voluntary to begin with and do not pose an undue burden on covered entities. Finally, the regulatory impact analysis fails to provide a tangible analysis of the costs and burdens to protect individuals from removal of the notice and tagline requirements. The costs are not only reduced awareness of language services by LEP persons, but also reduced awareness by the general public about their rights as protected by Section 1557.

Massachusetts is home to a variety of LEP communities, including those whose first language is Spanish, Portuguese, Chinese, French Creole, Vietnamese.[13] While there is a general commitment by Massachusetts health care providers and insurers to serving this population and offering linguistically appropriate services and language assistance, LEP populations continue to face obstacles in this regard. The proposed rule will only exacerbate these barriers.

Allowing Discrimination in Insurance Plan Benefit Design and Marketing

Before passage and implementation of the ACA, people with serious and/or chronic health conditions were often denied health insurance coverage or paid high prices for substandard plans with coverage exclusions, leaving many people unable to afford the health care they needed. Under the ACA, insurers can no longer charge higher premiums or deny coverage for people with pre-existing conditions. These protections have been lifesaving for many people.

Under the 2016 final rule, covered entities are prohibited from designing benefits that discourage enrollment by persons with significant health needs. For example, insurers are prohibited from placing all or most prescription drugs used to treat a specific condition, such as HIV medications, on a plan's most expensive tier[14]. Additionally, covered entities are prohibited from using discriminatory marketing practices, such as those "designed to encourage or discourage particular individuals from enrolling in certain health plans."[15] In addition to the specific gender identity provisions discussed above, the proposed rule also seeks to improperly eliminate the entire regulation that prohibits discrimination in health insurance issuance, coverage, cost-sharing, marketing, and benefit design. Without these provisions, health plans could, for example, cover inpatient treatment for mental health conditions for men but not women or cover certain surgeries for adults except those with developmental disabilities, or place all or most prescription drugs used to treat a certain condition on a health plan's highest cost formulary tier.

[13] See https://www.lep.gov/maps/.
[14] MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.
[15] MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.

In Massachusetts, 11.7% of residents living in the community has a disability[16], including 7.9% of residents under the age of 65[17]. Another estimate shows that 22.5% of adults in Massachusetts has some type of disability[18]. An even larger percentage have one or more chronic health conditions. The proposed rule would disproportionately impact LGBTQ people and people of color with disabilities and/or chronic conditions. Due to systemic barriers to health care and the stress of stigma and discrimination, people of color and LGBTQ people, and especially gay, bisexual, and queer men of color and transgender women of color, are at a higher risk of developing chronic conditions and have a higher prevalence of disabilities. The proposal invites further discrimination for these populations.

Weakening Notice Requirements and Enforcement Remedies

The proposed rule also seeks to limit the enforcement mechanisms available under Section 1557 for patients who have experienced discrimination by eliminating notice and grievance procedure requirements, private rights of action, opportunities for money damages, and by claiming that the remedies and enforcement mechanisms for each protected characteristic (race, color, national origin, age, disability or sex) are different and limited to those available under their referenced statute.

As a result, the proposed rule would create a confusing mix of legal standards and available remedies under a single law, and could limit claims of intersectional discrimination, going against the text and intent of Section 1557. Ultimately, the proposed rule will make it harder for those who are discriminated against to access meaningful health care and to enforce their rights.

Conclusion

This proposed rule could create significant harm, particularly for our most underserved populations who already struggle to access health care. The proposed rule will create additional barriers to care for transgender people and the LGBTQ community; people seeking reproductive health care, including abortion services; individuals with LEP, including immigrants; those living with disabilities or chronic conditions; and people of color. Moreover, this rule would encourage compounding levels of discrimination against those who live at the intersection of these identities and disregards the plain language and intent of Section 1557, specifically, and the ACA broadly. For the reasons detailed above, we urge HHS and CMS to withdraw the proposed rule in its entirety.

Thank you for the opportunity to submit comments on the proposed rule. Please do not hesitate to contact Suzanne Curry, Co-Director of Policy and Government Relations at scurry@hcfama.org to provide further information.

Sincerely,

Amy Rosenthal
Executive Director

[16] Massachusetts Rehabilitation Commission, Massachusetts and U.S. Disability Facts and Statistics: 2017 fact sheet: https://www.mass.gov/files/documents/2018/08/30/MRC-Disability-Fact-Sheet-2017.pdf.
[17] U.S. Census QuickFacts Massachusetts, July 2018: https://www.census.gov/quickfacts/MA.
[18] Center for Disease Control and Prevention, Disability & Health U.S. State Profile Data for Massachusetts (Adults 18+ years of age): https://www.cdc.gov/ncbddd/disabilityandhealth/impacts/massachusetts.html.

Hennepin Healthcare

August 13, 2019

Roger Severino, Director
Office for Civil Rights
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave. SW
Washington, DC 20201

RE: Nondiscrimination in Health and Health Education Programs or Activities

Hennepin Healthcare System appreciates the opportunity to comment on **proposed changes to nondiscrimination protections included in the Affordable Care Act (ACA).**

Hennepin Healthcare is the largest safety-net health system in Minnesota and serves one of the largest Medicaid populations in the nation. Hennepin Healthcare System is dedicated to improving the health of our patients, many of whom are socially and medically complex. Our patients are more likely to live in deep poverty, experience homelessness, and have serious mental illnesses and substance use disorders.

Hennepin Healthcare is an integrated system of care that includes Hennepin County Medical Center, a nationally recognized Level I Adult Trauma Center and Level I Pediatric Trauma Center and acute care hospital, as well as a clinic system with primary care clinics located in Minneapolis and across Hennepin County. The comprehensive healthcare system includes a 473-bed academic medical center, a large outpatient Clinic & Specialty Center, and a network of clinics in downtown Minneapolis and surrounding neighborhoods. The system is operated by Hennepin Healthcare System, Inc., a subsidiary corporation of Hennepin County.

Hennepin Healthcare is a is an innovator and leader in delivery reforms and a statewide resource with medical residency training programs, the state's poison control center and the largest burn center in the state, psychiatric crisis services, addiction medicine, home care and hospice, a research institute and philanthropic foundation.

We write today with concern regarding proposed changes to the nondiscrimination protections in the ACA:

Nondiscrimination based on gender identity
On November 24th of 2015, as enabled by section 1557 of the ACA, the Minnesota Department of Health was able to send administrative Bulletin 2015-5 to all healthcare related companies in the state of Minnesota. The Bulletin informed them that discrimination based on an individual's gender identity was officially prohibited. As a result of this policy change, insurance companies that had exclusions against medically necessary treatments for transgender patients were forced to remove them. The physicians in Hennepin Healthcare's Adult Gender and Sexual Health Clinic saw firsthand many patients gain access to vital, life-saving, transition related care that was withheld from them previously.

By removing anti-discrimination protections for gender identity, these exclusions will certainly recur. Unfortunately, without the federal government's backing, the transgender community will be even more marginalized and will have no recourse against this discrimination. This would not be limited

Hennepin Healthcare

to irresponsible insurance coverage practices. Providers could refuse necessary care for transgender patients without fear for discipline.

In 2015, the National Center for Transgender Equality published their survey of nearly 28,000 transgender respondents that highlighted the discrimination experienced by transgender patients before the ACA non-discrimination positions were implemented. That survey showed that 23% of respondents did not seek care when they needed it based on fear of mistreatment, and that 33% didn't seek care because they couldn't afford it. 33% reported at least 1 negative experience with healthcare in the prior year, and 40% of respondents reported having attempted suicide in their lifetime. Transgender women of color were disproportionately affected by discrimination. Black transgender women reported the highest rate of HIV out of any demographic in the U.S. with 19% of respondents living with HIV.

Since the ACA implementation, there was hope that the next iteration of this survey would show improvement in these tragic statistics. Removing this bare-minimum anti-discrimination protection will make this population more vulnerable and will remove the hope for better lives.

The Adult Gender and Sexual Health Clinic and the rest of Hennepin Healthcare System is proud to care for gender and sexual minority patients. Doing so is much more difficult and costly without support from our regulatory institutions. The proposed change in language which would allow discrimination against patients based on gender identity is unacceptable and would pull the rug out from under our patients and our clinics caring for them.

We respectfully request that this provision not be finalized as it will be greatly detrimental to the health of our patients.

Services for patients with Limited English Proficiency (LEP)

Hennepin Healthcare System serves a very diverse population with 30% of our patients requiring interpreters to receive their care. In order to meet this tremendous demand for language services and comply with requirements around language access, Hennepin Healthcare System provides qualified professional interpreters in various modalities.

Our interpreters are part of one of the largest hospital interpreter programs in the country. They provide professional, culturally competent language interpretation to establish clear communication between the provider and the patient.

Over 120,000 interpreters are available to limited English-speaking, deaf and hard of hearing patients at all Hennepin Healthcare clinics, Emergency Department, inpatient units and services areas. The department staff interprets 21 languages, and contract staff extends that to over 50 languages.

Hennepin Healthcare System respectfully requests that all protections for individuals with LEP in health care settings be upheld. Research shows access to appropriate interpreter services improves patient experience and clinical outcomes, while also decreasing readmission rates and costs. LEP patients are less likely than their English-speaking counterparts to have access to preventive care. It is vital that hospitals and other health care entities continue to provide interpreter services for LEP patients to ensure they have access to high-quality care and to reduce disparities.

Hennepin Healthcare

We respectfully request that proposed changes to the LEP requirements not move forward. The proposed rule alters how the Office of Civil Rights (OCR) will determine whether an entity has met its LEP requirements. As proposed, OCR would eliminate consideration of language access plans when evaluating compliance. An entity's obligation to provide language assistance services would be determined by a four-factor test, additional flexibility is appreciated to provide meaningful access to interpreter services, however, overall these proposed changes will negatively impact patients.

It is important to consider an organizations resources when determining compliance with LEP requirements. Our hospital operates on a slim margin and must use resources efficiently, while still ensuring patients have appropriate access to interpreter services. Even if compliance standards are altered, we will continue to provide necessary services to our patients as these are so critical to care. However, we are concerned that changes to these standards might increase disparities across the health care system at large, resulting in even greater challenges for patients and their families.

HHS should continue to promote the availability of interpreter services through notice and tagline requirements. OCR acknowledges that repealing these notice and tagline requirements will result in lower utilization by LEP individuals who are unaware of available interpreter services. It is vital that LEP individuals are provided with all necessary information to make decisions about their care. We are concerned that removing notice and tagline requirements will reduce utilization by LEP individuals not otherwise informed of their right to interpreter services. Interpreter services are only of use if patients are informed of their availability. **We urge you not to finalize any changes to requirements for LEP patients that will jeopardize access to appropriate interpreter services.**

If you have further questions, please reach out to Susie Emmert, Sr. Director of Advocacy and Public Policy at susie.emmert@hcmed.org or 651-278-5422 c.

Sincerely,

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voice IN OUR OWN
National Black Women's Reproductive Justice Agenda

August 13, 2019

Submitted via www.regulations.gov

Secretary Alex Azar
U.S. Department of Health and Human Services
Herbert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

RE: Docket ID HHS-OCR-2019-0007, RIN 0945-AA11, Nondiscrimination in Health and Health Education Programs or Activities

I. Introduction

On behalf of *In Our Own Voice: National Black Women's Reproductive Justice Agenda*, we appreciate the opportunity to comment on the Department of Health and Human Services' ("HHS", "Department") and the Center for Medicare and Medicaid Services ("CMS") Notice of Proposed Rulemaking ("proposed rule," "NPRM") on the "Nondiscrimination in Health and Health Education Programs or Activities" (hereinafter "proposed rule"). *In Our Own Voice: National Black Women's Reproductive Justice Agenda* writes with strong objection to the proposed rule. The proposed rule is an attempt to eliminate or rollback critical protections guaranteed by Section 1557 of the Affordable Care Act ("ACA") and the 2016 Nondiscrimination in Health Programs or Activities final rule ("2016 final rule"), which would detrimentally impact the health and well-being of communities of color, including women of color; LGBTQ individuals; people with disabilities; people living with chronic conditions; people with Limited English Proficiency ("LEP"), including immigrants; and those living at the intersections of these identities. For this reason and those expanded on below, we urge HHS and CMS to withdraw the proposed rule in its entirety.

In Our Own Voice: National Black Women's Reproductive Justice Agenda is a national-state partnership with eight Black women-led Reproductive Justice organizations: The Afiya Center, Black Women for Wellness, Black Women's Health Imperative, New Voices for Reproductive Justice, SisterLove, Inc., SisterReach, SPARK Reproductive Justice NOW, and Women with a Vision. *In Our Own Voice* is a national Reproductive Justice organization focused on lifting up the voices of Black women leaders on national, regional, and state policies that impact the lives of Black women and girls.

Reproductive justice is a framework rooted in the human right to control our bodies, our sexuality, our gender, and our reproduction. Reproductive justice will be achieved when all people, of all immigration statuses, have the economic, social, and political power and resources to define and make decisions about our bodies, health, sexuality, families, and communities in all areas of our lives with dignity and self-determination. Access to health services free from discrimination is essential to ensuring this right. If finalized, the proposed rule would impose harmful barriers on historically discriminated against

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communities seeking quality, affordable health coverage and care. As such, the proposed rule is antithetical to reproductive justice values and should immediately be rescinded.

II. The proposed changes are contrary to the plain language of the law and pose significant risks to those the law is intended to protect.

Section 1557 protects individuals from discrimination on the basis of race, color, national origin, sex, (including gender identity, sexual orientation, and sex stereotypes; and pregnancy, childbirth, and related medical conditions), age, and disability in certain health programs or activities. Critically, Section 1557 specifically protects against intersectional discrimination, or discrimination based on multiple protected characteristics, by allowing people to file complaints of such discrimination in one place.

Section 1557's current implementing rule, the 2016 final rule, explicitly prohibits discrimination on the basis of sex, which includes discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping and gender identity. The 2016 final rule also protects individuals with Limited English Proficiency ("LEP") and individuals with disabilities and/or chronic conditions from discrimination.

While Section 1557 is still the law, this proposed rule attempts to change the administrative implementation in a way that is contrary to the plain language of the law. The NPRM's proposed changes pose significant risks to those the law is intended to protect, including lesbian, gay, bisexual, transgender, and queer ("LGBTQ") people, people who need reproductive health care, including abortion, women of color, people living with disabilities and/or chronic conditions, and people whose primary language is not English–all people who already experience significant barriers to accessing health care. The proposed changes could create additional barriers and potentially lead to worse health outcomes, disproportionately impacting those living at the intersections of these identities. For example, a provider could discriminate against a Black immigrant woman seeking reproductive healthcare because of her race, gender, and LEP status.

Although Section 1557 is still law, the proposed rule would almost entirely replace the 2016 final rule that made clear what forms of discrimination are prohibited by Section 1557. The proposed rule is not justified and seeks to impermissibly depart from the statutory text of Section 1557 and the 2016 final rule, which was finalized after considerable public comment, including a request for information and one notice of proposed rulemaking. By replacing most of the 2016 final rule with unclear regulations, the proposed rule, if finalized, would create confusion and could open the door to illegal discrimination.

In direct opposition to the text of Section 1557, the proposed rule improperly seeks to exempt many health insurance plans from the anti-discrimination provisions, as well as any health program or activity run by HHS that was not created by Title I of the ACA. It eliminates regulations pertaining to the fundamental requirement that all beneficiaries, enrollees, applicants, and members of the public receive notice of their rights under Section 1557 and removes important regulations that protect individuals with LEP. It improperly tries to incorporate Title IX's religious exemption, which could permit health care entities controlled by a religious organization to discriminate if the entity claims complying with the sex discrimination protections conflicts with its religious beliefs. The rule attempts to overrule decades of federal court precedent by trying to eliminate protections against discrimination on the basis of gender identity, and completely disregards Supreme Court precedent on discrimination based on sex stereotyping.

Although the preamble to the proposed rule acknowledges that Section 1557 prohibits discrimination based on pregnancy, including termination of pregnancy, the Department refuses to state whether it would enforce those protections. Additionally, contrary to the plain language of the law, the proposed rule improperly seeks to incorporate an abortion carveout from Title IX to narrow the protection under Section 1557. This is an attack on all of our civil rights and will harm the very communities and people Section 1557 was intended to protect. In order to reflect the ACA's clear intent and its overriding purpose of eliminating discrimination in health care, the proposed rule should be rescinded.

III. The Proposed Rule Impermissibly Attempts to Dramatically Narrow the Scope of Section 1557

The 2016 final rule made clear that Section 1557 applies to all health programs and activities that receive federal financial assistance from the Department, all health programs and activities administered by the Department, and state-based marketplaces. The 2016 final rule defines health programs and activities to include all operations of an entity receiving federal financial assistance that is principally engaged in the provision or administration of health-related services or health-related insurance coverage.

The proposed rule attempts to reduce the number of health insurance plans that are covered by claiming that if the issuer of a health plan is "not principally engaged in the business of providing health care (as opposed to health insurance), only its Marketplace plans would be covered and any plans it offers outside the marketplace would not be subject to Section 1557."[1] Additionally, the proposed rule improperly attempts to narrow that application of Section 1557's protections to only the portion of a health care program or activity that received federal financial assistance. These changes unlawfully narrow the scope of Section 1557's application. Rather, the statute is clear that the law's provisions apply broadly to "any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments)." 42 U.S.C. § 18116(a).

This change is illegal. If it were nevertheless implemented, it would have significant consequences, particularly for consumers who purchase short-term limited duration insurance ("STDLI"). If implemented, the proposed rule would generally not apply to STDLI plans because insurers are no longer considered health care entities, and these specific plans do not receive federal financial assistance.

Short-term plans are notorious for discriminating against consumers based on gender, age, and disability. If implemented, this proposed rule would be harmful to women, especially women of color, for example. The proposed rule would embolden short-term plans to discriminate against women by refusing to cover reproductive health services, such as maternity, contraceptive care or fertility care and coverage, or deny coverage altogether for other conditions unique to women like breast or cervical cancer. A 2018 study for example, found that not a single short-term plan covered maternity care.[2] Short-term plans also discriminate based on gender identity by excluding coverage for transition-related services, such as surgery. Additionally, short-term health plans could charge women higher premiums than men. For example, according to data submitted to Wisconsin insurance regulators, a National Health Insurance

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[1] MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.

[2] Karen Pollitz et al., *Understanding Short-Term Limited Duration Health Insurance*, Kaiser Family Foundation (Apr. 23, 2018), https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/.

Company short-term plan with a $5,000 deductible would cost $109 per month for a 40-year-old woman, compared to $90 per month for a man of the same age.[3]

IV. The Proposed Rule Impermissibly Attempts to Narrow the Definition of Sex Discrimination

Sex discrimination in health care has a disproportionate impact on women of color, LGBTQ people, and individuals living at the intersections of multiple identities–resulting in them paying more for health care, receiving improper diagnoses at higher rates, being provided less effective treatments, and sometimes being denied care altogether. As the first broad prohibition against sex-based discrimination in health care, Section 1557 is crucial to ending gender-based discrimination in the health care industry. In addition to personal stories, there have been surveys, studies, and reports documenting discrimination in health care against these communities and their families.

a. Sex discrimination based on gender identity

The 2016 final rule clarified that Section 1557's prohibition on sex discrimination includes a prohibition of discrimination on the basis of gender identity, including transgender and/or nonbinary status. The proposed rule illegally attempts to erase all reference to the ACA's protections against discrimination on the basis of gender identity.

If finalized, the proposed rule would have a particularly devastating impact on Black transgender, nonbinary, and gender nonconforming individuals. The 2015 U.S. Transgender Study found that 38% of Black respondents were living in poverty, compared to 24% of Black people in the U.S. population. These individuals are more likely to have difficulty accessing health care services due to barriers related to their race, gender identity, and poverty status, and the proposed changes would further disincentivize them from seeking the care they need.

The 2016 final rule clarified that health care providers cannot refuse to treat someone because of their gender identity. The proposed rule illegally purports to allow a health care provider to refuse to treat someone because of their gender identity. For example, a doctor could refuse to treat a transgender person for a cold or a broken bone, simply because of their gender identity.

Transgender, nonbinary, and gender nonconforming people already experience high rates of discrimination and harassment in health care and often avoid care out of fear of discrimination. According to the 2015 U.S. Transgender Survey, 34% of Black respondents who saw a heath care provider in the past year reported having at least one negative experience related to being transgender, including being refused treatment, being verbally harassed, and being physically or sexually assaulted. Moreover, in the past year, more than a quarter (26%) of Black respondents did not see a doctor when they needed to because of fear of being mistreated as a transgender person. The proposed rule would embolden healthcare providers and institutions to discriminate against individuals who already face significant barriers to accessing care, resulting in a chilling effect for the most vulnerable communities.

The 2016 final rule clarified that insurance companies cannot categorically exclude or deny coverage for gender-affirming care. The proposed rule illegally attempts to again open the door to insurance companies

[3] Sarah Lueck, *Key Flaws of Short-Term Health Plans Pose Risks to Consumers*, Ctr. on Budget & Pol'y Priorities (Sept. 20, 2018), https://www.cbpp.org/research/health/key-flaws-of-short-term-health-plans-pose-risks-to-consumers.

categorically excluding coverage of gender-affirming care from their plans or denying individuals coverage of procedures used for gender affirmation.

Gender-affirming care is medically necessary and often life-saving for transgender, nonbinary, and gender nonconforming people experiencing gender dysphoria.[4] Prior to the 2016 final rule, many insurers did not cover gender-affirming care, making it even more difficult to afford. Transgender, nonbinary, and gender nonconforming people, particularly people of color, are disproportionately living with low incomes. The proposed rule could put gender-affirming care further out of reach.

The 2016 final rule made clear that issuers cannot deny health services or impose additional costs on services that are ordinarily or exclusively available to individuals of one sex or gender based on the fact that the individual's recorded sex in medical or insurance records differs from the one to which such health services are ordinarily or exclusively available. The proposed rule impermissibly tries to permit providers and insurers to refuse to provide and cover certain reproductive health care for transgender, nonbinary, and gender nonconforming people.

Additionally, Section 1557 and the 2016 final rule prohibit covered entities from denying, limiting, or imposing additional cost-sharing for services based on sex or gender. If implemented, the proposed rule would eliminate the regulations that specifically address cost-sharing, adding confusion about whether covered entities may impose additional financial burdens on transgender, nonbinary, and gender nonconforming individuals. For example, health care providers charging higher copayments only for services related to gender-affirming care. Gender-affirming care is already difficult or impossible to access due to cost.[5]

b. Sex discrimination based on sex stereotyping

The 2016 final rule reiterated that sex stereotyping is a prohibited form of discrimination under the 1989 Supreme Court decision, *Price Waterhouse v. Hopkins*[6]. The proposed rule attempts to erase established Supreme Court precedent recognizing that discrimination on the basis of sex includes discrimination on the basis of sex stereotypes. This could result in health providers thinking they could turn a patient away because the patient does not conform with traditional stereotypes about their sex. Federal courts have applied the reasoning of *Price Waterhouse* to both LGBTQ and non-LGBTQ people seeking relief for sex discrimination. If finalized, the proposed rule would disproportionately impact Black LGBTQ individuals, who make up 12% of the LGBTQ population in the U.S.

c. **Sex discrimination based on pregnancy, including termination of pregnancy**

Sex discrimination takes many forms and has the potential to occur at every step in the health care system—from obtaining insurance coverage to receiving proper diagnosis and treatment to harassment by a provider. Such discrimination has serious adverse impacts on the lives of women, causing them to pay more for health care and to risk receiving improper diagnoses and less effective treatments. The effects of

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[4] Nat'l Health Law Program, et al., Medicaid as an LGBTQ Reproductive Justice Issue: A Primer, Gender-affirming Care in Medicaid 1 (2019), https://healthlaw.org/resource/medicaid-as-an-lgbtq-reproductive-justice-issue-a-primer/.

[5] S.E. James, et al., Nat'l Ctr. for Transgender Equality, Report Of The 2015 U.S. Transgender Survey 100 (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[6] 490 U.S. 228 (1989).

sex discrimination for women of color may be compounded by other forms of discrimination they face, including racial discrimination and discrimination based on language proficiency.

The 2016 final rule made clear that sex discrimination under Section 1557 includes discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related conditions. The proposed rule attempts to roll back these protections. Although HHS acknowledges in the preamble to this proposed rule that the prohibition against sex discrimination includes termination of pregnancy, it refuses to state whether the Department would enforce those protections and proposes to delete the 2016 final rule's clarification that the ban on sex discrimination includes all pregnancy related care. In doing so, the Department illegally attempts to eliminate the express protections that apply to someone who has had an abortion or has experienced a miscarriage or ectopic pregnancy and needs care for those conditions. While the scope of protection under Section 1557 is clear, without unambiguous implementing regulations and enforcement, illegal discrimination is likely to flourish.

The proposed rule also seeks to unlawfully incorporate Title IX's "Danforth Amendment", which carves out abortion care and coverage from the ban on discrimination of sex in the education context. Congress did not include the Title IX exceptions, including the Danforth Amendment, either explicitly or by reference, in Section 1557. The proposed rule's unlawful incorporation of the Danforth Amendment is yet another Trump-Pence Administration attack on abortion care. These attacks could embolden illegal discrimination that will fall heaviest on those least able to seek health care elsewhere, including women living in rural areas and women of color, who already face harassment and discrimination by providers during pregnancy, contributing to Black and Native American women's unacceptably high rates of health-related pregnancy complications and death.

In fact, the proposed rule could place Black women further at risk of pregnancy-related complications. Black women are three-to-four times more likely to die from pregnancy related complications than white women. "Pregnancy-related complications" remains within the ten leading causes of death for Black women aged 15-34 years.[7] If finalized, the proposed rule would only exacerbate these disparities.

d. **Religious Exemption**

The 2016 final rule intentionally did not include any religious exemption. The inclusion of a religious exemption, either explicitly or by reference, is contrary to the statutory language in Section 1557, which does not include any exceptions.

The proposed rule attempts to impermissibly apply Title IX's religious exemption to Section 1557's prohibition on sex discrimination. The Department's attempt to incorporate a religious exemption violates the plain language of the statute and is contrary to the express purpose of Section 1557. If implemented, this could allow for religiously-affiliated hospitals and other health care entities to discriminate against patients based on sex, disproportionately harming LGBTQ people, people seeking reproductive health services, including abortion care, and those living at the intersection of these identities.

Allowing a religious exemption to Section 1557's protection against sex discrimination could have far reaching consequences. Incorporating Title IX's religious exemption could create new instances in which

[7] Cynthia Prather, et al., *The Impact of Racism on the Sexual and Reproductive Health of African American Women*, 25(7) J. Women's Health 664, 664-671 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4939479/.

health care providers, including insurance companies, hospitals, doctors, or nurses, can allow their beliefs to determine patient care, opening the door to illegal discrimination. This could impact a broad range of health care services, including birth control, sterilization, certain fertility treatments, abortion, gender-affirming care, and end of life care. Moreover, there is already a proliferation in the types of entities that are now emboldened to use religious beliefs to discriminate against patients and the number of religiously-affiliated entities that provide health care and related services and refuse to provide care based on religious beliefs.[8] The proposed rule could encourage these entities to engage in illegal discrimination.

Providers, hospitals, or clinics that refuse to provide reproductive health services to a woman who is not married or because she does not conform to sex stereotypes force women to seek care elsewhere or forgo it completely. For many women of color and/or immigrant women, access to affordable contraception is often non-existent but is necessary to ensure that they can make the best decisions for them and their families. This proposed rule would only exacerbate the barriers to care that are preventing individuals from accessing the care they need.

Over the past several decades, religious refusals have helped systematically chip away at abortion access across the country. This limiting of abortion care has meant that individuals have been denied the care they need. Being denied an abortion has long-term negative impacts on an individual and reduces financial security and safety for themselves and their families. For example, women denied an abortion had almost 4 times greater odds of a household income below the federal poverty level and 3 times greater odds of being unemployed.[9] Additionally, women who were denied an abortion were more likely to not have enough money to pay for basic family necessities like food, housing and transportation.[10] A recent study found that continuing an unwanted pregnancy and giving birth is associated with more serious health problems than abortion.[11] Critically, lacking access to abortion care can also undermine the safety and security of the individual seeking services. For example, one study found that women who were unable to terminate unwanted pregnancies were more likely to stay in contact with their violent partners, putting them and their children at greater risk than if they had received the abortion.[12]

e. The Proposed Rule Could Embolden Providers to Discriminate Against Individuals in Title X-funded Health Centers

This proposed rule attempts to sow confusion about the critical protections against discrimination to which Title X-funded providers and others must adhere to. Although Section 1557 is still the law of the land, if implemented, the proposed rule could embolden providers to participate in the Title X program and other similar programs even though they intend to allow their personal beliefs to dictate patient care. We believe that providers currently enrolled in the program would continue to act in good faith and would not

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[8] *See*, *e.g.*, Lois Uttley, et al., *Miscarriage of Medicine: the Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, Am. Civil Liberties Union & Merger Watch (2013), https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf.

[9] Bixby Ctr. for Global Reprod. Health, University of Cal. S.F., *Turnaway Study*, https://www.ansirh.org/sites/default/files/publications/files/turnaway_study_brief_web.pdf (last visited Jul. 23, 2019).

[10] Bixby Ctr. for Global Reprod. Health, University of Cal. S.F., *Turnaway Study*, https://www.ansirh.org/sites/default/files/publications/files/turnaway_study_brief_web.pdf (last visited Jul. 23, 2019).

[11] Bixby Ctr. for Global Reprod. Health, University of Cal. S.F., *Turnaway Study*, https://www.ansirh.org/sites/default/files/publications/files/turnaway_study_brief_web.pdf (last visited Jul. 23, 2019).

[12] Bixby Ctr. for Global Reprod. Health, University of Cal. S.F., *Turnaway Study*, https://www.ansirh.org/sites/default/files/publications/files/turnaway_study_brief_web.pdf (last visited Jul. 23, 2019).

discriminate against those obtaining health care. However, the Trump-Pence administration has clearly demonstrated its preference for providers who would use their religious or moral beliefs as a license to discriminate over the needs of patients and this proposed rule would further that goal.

In many states, a Title X-funded provider is one of the few places women of color can access reproductive health care and preventive health care services and it is critical that those providers are not discriminating against the individuals that are able to make it through their doors. Title X-funded health centers are a lifeline for quality health care for underserved communities. Providers administer gynecological exams, contraception, counseling, pap tests, breast exams and screenings for HIV, AIDS and other STIs, and all services are provided confidentially. Their adherence to the protections Section 1557 is critical given their role in these underserved communities. Additionally, Title X health care providers also offer services for foreign-born individuals who are less likely to have coverage (46 percent) than U.S.-born people (75 percent). For those who have limited options for care, these services, which are available at an affordable price at Title X-funded health centers, can mean the difference of a person receiving care or going without care. Given that many individuals who seek care at a Title X clinic live at the intersection of identities protected by Section 1557, the fact that the proposed rule seeks to rollback the protections for those individuals is both contrary to the plain language and spirit of the law.

V. The Proposed Rule Impermissibly Attempts to Amend Unrelated Regulations to Exclude Sexual Orientation and Gender Identity Protections

The 2016 final rule did not touch other HHS health care regulations. The proposed rule attempts to erase all references to gender identity and sexual orientation in all HHS health care regulations. If implemented, this rule would eliminate express prohibitions on discrimination based on gender identity and sexual orientation from regulations that govern a range of health care programs, including private insurance and education programs. This could result in less health care and poorer health outcomes for communities across the country.

Under the proposed rule, Medicaid managed care entities and state Medicaid programs could be emboldened to discriminate against LGBTQ beneficiaries in enrollment. LGBTQ people are more likely to live in poverty than the overall U.S. population.[13] As a result, LGBTQ people are more likely that non-LGBTQ people to use Medicaid.[14] Within LGBTQ communities, LGBTQ people of color (24 percent) are more likely than white LGBTQ people (18.8 percent) to receive Medicaid; transgender people (21.4 percent) are more likely than LGBQ cisgender people (13.4 percent) to receive Medicaid; and LGBTQ people with disabilities (44.4 percent) are more likely than LGBTQ people with no disabilities (11.8 percent) to receive Medicaid.[15] The proposed rule would impermissibly open the door to discrimination against the many LGBTQ people enrolled in Medicaid programs across the country.

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[13] *See*, *e.g.*, Intersecting Injustice: A National Call to Action (Lourdes Ashely Hunter, Ashe McGovern & Carla Sutherland eds., 2018), http://socialjusticesexuality.com/intersecting_injustice/.

[14] Caitlin Rooney, Charlie Whittington & Laura E. Durso, *Protecting Basic Living Standards for LGBTQ People*, Ctr. for Am. Progress (Aug. 13, 2018, 12:01 AM), https://www.americanprogress.org/issues/lgbt/reports/2018/08/13/454592/protecting-basic-living-standards-lgbtq-people/; See also Nat'l Health Law Program, et al., Medicaid as an LGBTQ Reproductive Justice Issue: A Primer, Why Medicaid is an LGBTQ Issue 2 (2019), https://healthlaw.org/resource/medicaid-as-an-lgbtq-reproductive-justice-issue-a-primer/ (citing Kerith J. Conron & Shoshana K. Goldberg, The Williams Inst., *LGBT Adults with Medicaid Insurance* 1 (2018), https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-Medicaid.pdf (last visited May 02, 2019)).

[15] Caitlin Rooney, Charlie Whittington & Laura E. Durso, *Protecting Basic Living Standards for LGBTQ People*, Ctr. for Am. Progress (Aug. 13, 2018, 12:01 AM), https://www.americanprogress.org/issues/lgbt/reports/2018/08/13/454592/protecting-basic-living-standards-lgbtq-people/.

VI. The Proposed Rule Impermissibly Attempts to Eliminate Language Access Protections

Over 21 percent of the U.S. population, or 66 million people, speak a language other than English at home, with 25 million of them speaking English less than "very well" and thus considered LEP.[16] For LEP individuals, language differences often compound existing barriers to access and receiving appropriate care. LEP often makes it difficult for many to navigate an already complicated health care system, especially when it comes to medical or insurance terminology. Moreover, these barriers are often compounded by discrimination based on national origin, immigration status, race, ethnicity, sexual orientation, and gender/gender identity.

Without the regulatory requirements outlined in the current regulations, people with LEP could face additional challenges in access to culturally and linguistically appropriate care, including information about accessing services and health insurance. In particular, discussions about sexual and reproductive care can be sensitive and raise issues of privacy and confidentiality. It is critical that individuals have access to adequate language services, in a private and confidential setting, allowing for information about and access to sexual and reproductive health care to be available in a culturally and linguistically competent manner. Section 1557 provides these protections. The proposed regulations would make their scope less clear, causing confusion and opening the door to illegal discrimination.

Black individuals already face significant barriers to accessing health care. These barriers are exacerbated by additional factors such as LEP and poverty status. Approximately 3 percent of non-Latino Black individuals living in the United States are LEP.[17] Furthermore, LEP individuals are more likely to live in poverty than their English proficient counterparts, and the poverty rate for Black Americans (21.2 percent) is more than double the poverty rate for white Americans (8.7 percent).[18] As a result, a person who is both Black and LEP is more likely to experience discrimination in health care settings based on their intersecting identities. They are also more likely to be unable to afford a variety of health care options due to their poverty status. If the proposed rule is implemented, these gaps in access will only widen, placing critical health care services out of reach for our communities.

a. Remote interpreting services

The 2016 final rule includes standards for video remote interpreting services. The proposed rule attempts to remove video remote interpreting standards and require only audio remote interpreting for spoken language interpretation. The type of interpreting during a medical visit should depend on the type of encounter. Keeping the current standard allows providers to determine which technology is appropriate and that when an entity uses video, it is high quality and without lagging.

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[16] U.S. Census Bureau, *2017 American Community Survey 1-Year Estimates: Table S1603 Characteristics of People by Language Spoken at Home*, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_S1603&prodType=table (last visited Jul. 17, 2019); U.S. Census Bureau, *2017 American Community Survey 1-Year Estimates: Table S1601 Language Spoken at Home*, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_S1601&prodType=table (last visited Jul. 17, 2019).

[17] Jie Zong & Jeanne Batalova, *The Limited English Proficient Populations in the United States,* Migration Pol'y Inst., https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states#Age,%20Race,%20and%20Ethnicity.

[18] Jie Zong & Jeanne Batalova, *The Limited English Proficient Populations in the United States,* Migration Pol'y Inst., https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states#Age,%20Race,%20and%20Ethnicity; U.S. Census Bureau, *Poverty Thresholds for 2017 by Size of Family and Number of Related Children Under 18 Years,* https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html.

b. Taglines

The 2016 final rule requires covered entities to include taglines in the top fifteen languages spoken by individuals with LEP in the state on all significant documents. Taglines, or short statements in various languages informing individuals of their right to language assistance and how to seek such assistance, must be included in significant publications, including notices of nondiscrimination. The proposed rule illegally seeks to eliminate the requirement that entities use in-language taglines. This proposal will cause harm and should not be finalized.

Taglines are useful to ensure that individuals are aware of their protections under the law. Combined with the elimination of the requirement to post notices of nondiscrimination, the proposed rule could leave many people, including LEP individuals, without the knowledge of their own rights and further put legal services out of reach for those who are discriminated against.

c. Language access plans

Protections around language access have long included recommendations around development of language access plans to help covered entities better meet the needs of people with LEP. The 2016 final rule did not require covered entities to develop language access plans but said if an entity has a language access plan, the Office of Civil Rights ("OCR") must consider it when evaluating compliance. The proposed rule attempts to eliminate recommendations that entities develop language access plans and remove the consideration requirement. The development of language access plans should remain an item that supports an entity's compliance with the law.

By eliminating critical protections for LEP individuals seeking care, the administration is discouraging entities from meeting individuals where they are, making health care access inaccessible and often convoluted for marginalized or linguistically isolated communities. Language proficiency should not determine whether or not people have access to care or the quality of a person's care.

VII. The Proposed Rule Impermissibly Attempts to Eliminate Prohibitions on Discrimination in Insurance Plan Benefit Design and Marketing

Over 133 million people in the U.S. live with at least one chronic condition.[19] Over 61 million people in the U.S. live with a disability.[20] Notably, 11% of Black working-age adults in the U.S. live with a disability. Black individuals have disabilities at a rate 2.5 times greater than their white counterparts. Furthermore, 13% of Black people of all ages report that they are living with chronic conditions, such as diabetes, hypertension, heart disease, and asthma. In fact, Black people have higher rates of these conditions than any other group. If finalized, this proposed rule would push critical health insurance coverage and lifesaving services out of reach for our communities.

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[19] *The Growing Crisis of Chronic Disease in the United States*, P'ship to Fight Chronic Disease, https://www.fightchronicdisease.org/sites/default/files/docs/GrowingCrisisofChronicDiseaseintheUSfactsheet_81009.pdf (last visited Jul. 17, 2019).

[20] Press Release, Ctrs. for Disease Control & Prevention, *CDC: 1 in 4 US Adults Live with a Disability* (Aug. 16, 2018, 1:00 PM), https://www.cdc.gov/media/releases/2018/p0816-disability.html.

Before the ACA, people with serious and/or chronic health conditions were often denied health insurance coverage or paid high prices for substandard plans with coverage exclusions, leaving many people unable to afford the health care they needed. Under the ACA, insurers can no longer charge higher premiums or deny coverage for people with pre-existing conditions. These protections have been lifesaving for many people.

Under the 2016 final rule, covered entities are prohibited from designing benefits that discourage enrollment by persons with significant health needs. For example, insurers are prohibited from placing all or most prescription drugs used to treat a specific condition, such as HIV prescriptions, on a plan's most expensive tier.[21] Additionally, covered entities are prohibited from using discriminatory marketing practices, such as those "designed to encourage or discourage particular individuals from enrolling in certain health plans."[22] The proposed rule improperly attempts to eliminate these prohibitions.

Due to systemic barriers to health care, people of color experience higher rates of chronic conditions. For example, "[i]n the case of diabetes, the risk of being diagnosed is 77 percent higher for African Americans… than for whites."[23] Further, in the case of HIV, people of color also are more likely to be living with HIV. For example, in 2017, Black or African American individuals made up 43 percent (16,694) of the 38,739 new HIV diagnoses in the U.S. and dependent areas, even though they account for only 13 percent of the U.S. population.[24]

VIII. The Proposed Rule Impermissibly Attempts to Undermine Notice and Enforcement Requirements and Remedies

a. Nondiscrimination notice and grievance procedure requirements

The 2016 final rule requires covered entities with at least 15 employees to adopt a grievance procedure and designate at least one employee to coordinate its Section 1557 responsibilities.[25] The 2016 final rule also requires covered entities to provide notice of nondiscrimination policies in significant communications, in physical locations where the entity interacts with the public, and on the home page of their website. The notice of nondiscrimination must include information about the characteristics protected from discrimination under Section 1557, the availability of and how to access auxiliary aids and services, the availability of and how to access language assistance services, contact information for the designated employee coordinating the entity's Section 1557 responsibilities, the entity's grievance procedures, and

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[21] MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.

[22] MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.

[23] Kenneth E. Thorpe, et al., *The United States Can Reduce Socioeconomic Disparities by Focusing on Chronic Diseases*, HealthAffairs (Aug. 17, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170817.061561/full/.

[24] *HIV and African Americans*, Ctrs. for Disease Control & Prevention, https://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html (last updated March 19, 2019).

[25] MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.

complaint procedures for OCR. The proposed rule improperly attempts to eliminate these provisions entirely.

Section 1557 is the law of the land. The proposed rule's inconsistency with the statute itself would cause confusion for both health care entities and patients, ultimately increasing confusion about what the law requires and who is protected under it and making it harder for those who are discriminated against to enforce their rights. Further, the proposed rule would discourage people from reporting discrimination, making discrimination harder to track and thus harder to prevent.

Notices of nondiscrimination are particularly critical for women and LGBTQ people. Notices tell individuals that an entity cannot discriminate and what to do if they face discrimination, including how to file a complaint with OCR.

b. Private right of action and compensatory damages

The 2016 final rule, like the statute itself, allows for a private right of action in federal court. The proposed rule attempts to eliminate the regulatory provisions recognizing private right of action in federal court. Additionally, the 2016 final rule allows for money damages for violations of Section 1557 in both administrative and judicial actions brought under the regulation. The proposed rule attempts to eliminate the regulatory provision providing that money damages are available to those who are injured by violations of the statute.

Many people who experience discrimination cannot access the court system due to cost.[26] When people can afford to bring judicial actions, they generally receive little in the form of compensatory relief.[27] This could make it even more expensive for people to enforce their rights, deterring them from filing complaints of discrimination.

c. Enforcement Mechanisms

Section 1557 made it so individuals seeking to enforce their rights would not be limited to only the remedies provided to a particular protected group. Under the plain language of Section 1557, individuals have access to any and all of the remedies under any of the cited statutes, including Title VI, Title IX, Section 504 of the Rehabilitation Act, and the Age Discrimination Act, regardless of the type of discrimination an individual faced. The proposed rule attempts to limit remedies and enforcement mechanisms that are available to those who are discriminated against by claiming that the remedies and enforcement mechanisms for each protected characteristic (race, color, national origin, age, disability or sex) are different and limited to those available under their referenced statute. As a result, the proposed rule would create a confusing mix of legal standards and available remedies under a single law, and could limit claims of intersectional discrimination, going against the text and intent of Section 1557.

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[26] *See* Brittany Kauffman, *Study on Estimating the Cost of Civil Litigation Provides Insight into Court Access*, Inst. for the Advancement of the Am. Legal System (Feb. 26, 2013), https://iaals.du.edu/blog/study-estimating-cost-civil-litigation-provides-insight-court-access; Michelle Chen, *One More Way the Courts Aren't Working for the Poor*, The Nation (May 16, 2016), https://www.thenation.com/article/one-more-way-the- courts-arent-working-for-the-poor.

[27] Maryam Jameel & Joe Yerardi, Workplace discrimination is illegal. But our data shows it's still a huge problem, Vox (Feb. 18, 2019),https://www.vox.com/policy-and-politics/2019/2/28/18241973/workplace-discrimination-cpi-investigation-eeoc.

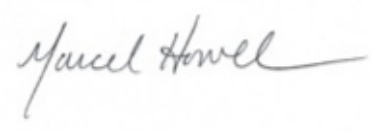
This would have harmful consequences for communities who have historically been discriminated against in health care settings. For example, under the proposed rule, a Black woman who experienced compounded discrimination based on both her race and her sex would have to file two separate claims of discrimination rather than the current structure where she would be able to file one single claim.

IX. Conclusion

For all of the foregoing reasons, HHS and CMS should immediately withdraw this punitive proposed rule. This proposed rule is an attack on people seeking reproductive health care, including abortion; LGBTQ individuals; individuals with LEP, including immigrants; those living with disabilities; and people of color, including women of color. If enacted, this rule would embolden compounding levels of discrimination against those who live at the intersections of these historically discriminated against identities. The proposed rule is dangerous and contravenes the plain language of Section 1557, specifically, and the ACA broadly. It undermines fundamental reproductive justice values and would ultimately push critical health care services out of reach for our communities.

Thank you for the opportunity to submit comments on the proposed rule. For further information, please do not hesitate to contact Jessica Pinckney, Vice President of Government Affairs, at jessica@blackrj.org.

Sincerely,



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August 12, 2019

Mr. Roger Severino
Director, Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave. SW, Washington, DC 20201

Re: Nondiscrimination in Health and Health Education Programs and Activities (Section 1557 NPRM), RIN 0945-AA11

Dear Mr. Severino:

International Community Health Services (ICHS) writes to comment on the notice of proposed rulemaking (NPRM or "proposed rule") on Section 1557 of the Patient Protection and Affordable Care Act (ACA) ("Section 1557"). ICHS is strongly opposed to the proposed changes to Section 1557, which will put needed health care out of reach for our patients and communities. We urge the Office of Civil Rights (OCR) at the Department of Health and Human Services (HHS) to withdraw the proposed rule in its entirety.

Established in 1973, ICHS is a Federally Qualified Health Center (FQHC) that provides comprehensive, culturally and linguistically appropriate health and wellness services throughout King County.

This proposed rule seeks to eliminate or severely limit protections under Section 1557 and 2016 Nondiscrimination in Health Programs and Activities Final Rule (2016 Final Rule), preventing a wide range of individuals to access health care without discrimination.

Changes to "Covered Entities" Will Limit Scope and Impact Care

ICHS opposes the proposed changes that would narrow the scope of application of Section 1557 by removing the definition of "covered entities." The proposed changes run counter to the statutory text and intent of Section 1557 which applies to any health program or activity, any part of which is receiving federal financial assistance or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the ACA. In addition, given that the majority of individuals access health care through insurance plans, the provision of health insurance is a "health program or activity" and thus Section 1557 applies to it.

The proposed rule would exempt from the definition of "covered entities," and therefore from Section 1557's nondiscrimination coverage, many health insurance plans. As a community health center, we regularly connect our patients to health insurance plans that would now be excluded from "covered entities." The nondiscrimination protections enable patients to secure coverage they are legally entitled to, and assures that our community health center can be reimbursed for covered services.

Sex Discrimination Will Harm Patient Care

The 2016 Final Rule defines "on the basis of sex" to include discrimination based on pregnancy, false pregnancy, termination of pregnancy, or recovery from such, childbirth or related medical conditions, sex stereotyping, and gender identity. Section 1557 and the 2016 Final Rule adopted the existing prohibitions against any discrimination on the basis of pregnancy from Title IX regulations.

The proposed rule would entirely eliminate the Section 1557 regulatory definition of sex discrimination, which includes discrimination on the basis of gender identity and sex stereotyping. Current federal caselaw, including a US Supreme Court decision, establish that at a minimum, differential treatment of individuals based on failure to conform to stereotypes about how men or women are supposed to behave constitutes sex-based discrimination.[1] Without the definition in the 2016 Final Rule, sex discrimination protections under Section 1557 will not be able to extend far enough to truly protect all health care patients who need it.

The proposed rule goes beyond the elimination of sex stereotyping. It seeks to remove all references to "sexual orientation" from other HHS regulations, even beyond Section 1557. Proposing to eliminate nondiscrimination language from multiple regulations is not appropriate. Protections enumerated in one regulation cannot be uniformly revoked via a different regulation without offering any legal, policy, or cost-benefit analysis about them and their impact on various programs of their administering entity. The proposal to eliminate sexual orientation and gender identity nondiscrimination protections from Section 1557 will negatively impact health care access; the proposal to eliminate them from separate regulations falls outside entirely OCR's jurisdiction.

Patients Are at Risk of Health Care Discrimination

ICHS opposes changes to Section 1557 which prohibits discrimination on the basis of race, color, national origin, sex, age, and disability as well as they provisions that provide critical protections for Limited English Proficiency (LEP) individuals. Many individuals identify with multiple communities that have experienced discrimination and currently have protection and recourse under Section 1557. Below are examples of patient populations that may suffer if the proposed rule were implemented.

<u>LGBTQ+ Individuals</u>

The proposed rule severely threatens LBGTQ+ patients' access to health care in all forms. If finalized, the rule would create confusion among patients and providers about their rights and obligations, and promote discrimination. The proposed rule would encourage hospitals to deny care to LGBTQ+ people, and enable insurance companies to deny transgender people coverage for essential health care services that they cover for non-transgender people. By proposing to eliminate protections against discrimination based on transgender status and sex stereotyping, the Department of Health and Human Services (HHS) is contradicting over 20 years of federal case law and clear Supreme Court precedent.

Allowing hospitals to deny care and insurance companies to deny coverage to LGBTQ+ individuals will exacerbate the health disparities members of these communities already face. These health disparities include higher rates of depression and suicide attempts, greater risk for HIV/AIDS, higher rates of tobacco and alcohol use, and higher risk of developing breast cancer.[2] 29% of LGBTQ+ individuals

[1] *Price Waterhouse v. Hopkins*, 490 U.S. 228, 250-51 (1989); 81 Fed. Reg. at 31389

[2] 81 FR 31460. https://www.federalregister.gov/documents/2016/05/18/2016-11458/nondiscrimination-in-health-programs-and-activities.

report being refused service by a health care provider because of their actual or perceived gender identity, and almost one-quarter of transgender individuals did not see a provider for needed health care services because of fears of mistreatment or discrimination.[3] The proposed rule would make it even harder for LGBTQ+ individuals to access health care safely.

Limited English Proficiency Individuals

Language has long presented a significant barrier for Limited English Proficiency (LEP) individuals attempting to enroll in health insurance. Once enrolled, many LEP individuals face ongoing difficulties understanding their benefits and coverage – in large part due to the fact that materials are often not in-language. Without the nondiscrimination notice requirement, LEP individuals will have limited ways of knowing what language services and other aids are available to them, how to request them, what to do if they face discrimination, and their right to file a complaint.

The proposed repeal of the in-language taglines threatens the civil rights of LEP individuals. Discrimination on the basis of national origin encompasses discrimination on the basis of language, which threatens to create unequal access to health care. In the absence of fully translated documents, taglines ensure that covered entities provide in-language information on the availability of language assistance to the LEP individuals who need it. Their use is a cost-effective way to do so, and is well-supported by long-standing federal and state regulations, guidance, and practice.[4]

People with Disabilities and Chronic Conditions

Section 1557 and its 2016 Final Rule specifically prohibited health insurance companies from discriminating through marketing practices and benefit design. These protections are essential for individuals with disabilities and chronic conditions. The proposed rule seeks to exempt most health insurance plans from Section 1557's protections and eliminate the regulation prohibiting discriminatory benefit design and marketing. It is unclear what remaining opportunities individuals who experience these discriminatory practices would still have to file complaints.

This could result in health insurers excluding benefits or designing their prescription drug formularies in a way that limits access to medically necessary care for those living with disabilities and other chronic conditions. Health insurers could be allowed to offer coverage of some services for men but not for women, or limit coverage of certain services based on developmental disabilities. Health insurers may be able to require prior authorizations for all medications in drug classes such as anti-HIV protease inhibitors, regardless of medical evidence.[5] Repealing Section 1557's nondiscrimination protections will have very real, negative health consequences in many people's lives.

Older Adults

Health care information is complex and can only be communicated effectively in an individual's primary language. It is therefore critical that affirmative notice about one's rights be readily available in-language throughout the process of accessing health care services. Many Medicare beneficiaries – older

[3] Candace Gibson, Wayne Turner, "Questions and Answers on the Proposed Rollback of Nondiscrimination Protections Under the ACA's Section 1557," National Health Law Program, https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2019/06/1557-Reg-Revision-QA-update-6.6.2019.pdf.

[4] See Title VI Coordination Regulations, 29 C.F.R. § 42.405(d)(1); Marketplace and QHP issuer requirements, 45 C.F.R. § 155.205(c)(2)(iii); Medicaid Managed care plans, 42 C.F.R. § 438.10(d)(3); DOL WOIA Nondiscrimination requirements, 29 C.F.R. § 38.9(g)(3); USDA SNAP Bilingual Requirements, 7 C.F.R. § 272.4(b); and the 2003 HHS LEP Guidance.

[5] 81 FR 31429.

adults and individuals with disabilities – must have robust language access resources and protections from discrimination.

Four million Medicare beneficiaries are Limited English Proficient (LEP). Nearly eight million Medicare beneficiaries are deaf or hard of hearing, and four million have blindness or low vision. Over 1.8 million LEP seniors and people with disabilities are also low-income. They rely on the tagline and notice requirements of the 2016 Final Rule to get the information they need across both Medicare and Medicaid.

Older adults and people with disabilities who are unable to access health care due to language or other barriers are at grave risk. As an example of what could happen if Section 1557 protections were eliminated, if an LEP older adult does not understand a billing statement they receive, and is not notified of their right or informed of how to get help in their primary language, then they may not ask for an interpreter. The LEP older adult may then fail to follow up or pay for a service when Medicare denies coverage because they were not adequately informed of their right to appeal.

Conclusion
ICHS requests that the Department of Health and Human Services withdraw the proposed rule in its entirety. Please contact ICHS Health Policy Coordinator Liz Agi at elizabetha@ichs.com or (2016) 788-3664 with any questions.

Sincerely,

Teresita Batayola
President and Chief Executive Officer
International Community Health Services

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

August 13, 2019

U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Ave. SW, Washington, DC 20201

Submitted via www.regulations.gov

Re: Nondiscrimination in Health and Health Education Programs and Activities (Section 1557 NPRM), RIN 0945-AA11

Justice in Aging writes to comment on the notice of proposed rulemaking (NPRM) on Section 1557 of the Patient Protection and Affordable Care Act (ACA) issued by the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS). Because of the harmful effects of these proposed changes on low-income older adults, we urge HHS to withdraw this NPRM in its entirety.

The Health Care Rights Law (Section 1557 of the ACA) prohibits discrimination in health care on the basis of race, color, national origin, sex, age, and disability.[1] We strongly oppose the NPRM provisions which seek to either eliminate or limit legal protections for Limited English Proficient (LEP) individuals, LGBTQ persons, persons with disabilities and chronic conditions, and persons needing reproductive health services, as well as individuals whose identities intersect across multiple protected classes.

Justice in Aging uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. We have decades of experience with Medicaid and Medicare, with a focus on long-term services and supports and the particular needs of those dually eligible for Medicare and Medicaid coverage. Our advocacy focuses on populations of older adults who have historically faced discrimination, including older women, LGBTQ older adults, seniors of color, and LEP seniors. Therefore, ensuring that programs and services are delivered without discrimination based on race, ethnicity, language ability, disability, gender identity, sexual orientation or age is at the heart of our work. We advocate for culturally competent, person-centered care in programs like Medicare and Medicaid to meet the diverse needs of low-income seniors across the country. Every day, we work with a network of advocates and professionals serving low-income seniors who benefit from the non-discrimination protections of Section 1557, so the implementing regulations for the statute are critically important to us, the advocates we support, and ultimately low-income older adults.

Our comments begin with a discussion of the NPRM's language access provisions and provisions that would eliminate or weaken protections contained in the 2016 Nondiscrimination in Health Programs and Activities Final Rule (2016 Final Rule) as they apply to LEP older adults. We then discuss the NPRM's harmful effects on LGBTQ older adults and older adults with disabilities. We also comment on how the proposed rule would limit and weaken the ability of all older adults to fight discrimination in healthcare. The proposed changes eliminate some of the most important and unique protections underlying Section

[1] 42 U.S.C. 18116.

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1557, which was the first and only federal law to incorporate existing civil rights statutes and apply them directly to health programs and activities receiving federal financial assistance. Again, because of the importance of the 2016 Final Rule's protections and the proposed rule's harms to low-income older adults, we urge HHS to withdraw this NPRM in its entirety and retain the 2016 Final Rule. If HHS does finalize any of the proposed revisions, we strongly oppose the proposed incorporation of any changes into regulations implementing the underlying civil rights laws, such as Title VI, Title IX, and Section 504.

I. The Proposed Rule Would Greatly Harm Older Adults Who Are Limited English Proficient

We strongly oppose the proposal to eliminate Section 1557's nondiscrimination notice, taglines – short statements in multiple languages alerting individuals to the availability of language assistance services – and language access plan provisions. As a threshold matter, we are troubled that HHS largely conflates its discussion of taglines with Section 1557's notice requirement. We believe that while both requirements are critical to LEP older adults and others, they have different purposes. We discuss the tagline requirement and the language access plan provisions in this section and then address the proposed elimination of the notice requirement in section IV(a) below.

The taglines and language access plan provisions are key to ensuring the country's more than 10 million seniors over age 60 and other individuals who are LEP can access care and services, receive important healthcare information in a language they understand, and are informed of their rights and how to enforce them.

(a) Low-Income Older Adults Require Robust Language Access Protections

It is especially critical that older adults have robust language access resources and protections from discrimination. Due to their age, physical limitations, and other factors, it is unrealistic to expect many LEP seniors to attain full English proficiency.

Four million Medicare beneficiaries—older adults and people with disabilities—are limited English proficient, and 12% of Medicare beneficiaries living in the community report that English is not their primary language. Reports from the Office of Minority Health estimate that almost 2 million Medicare beneficiaries speak languages other than English or Spanish, including over 200,000 beneficiaries who speak Chinese, over 150,000 who speak Vietnamese, and over 140,000 who speak Tagalog. [2] They live in every part of the country, including California (where 22% of all Medicare beneficiaries are LEP), Hawaii (19%), New York (16%), Texas (13%), New Jersey (12%), Florida (12%), Massachusetts (11%), and more.[3] In all, 1.8 million LEP seniors and people with disabilities are also low-income and rely on the tagline requirements in the 2016 Final Rule to get the information they need across both Medicaid and Medicare.[4]

[2] CMS Office of Minority Health, Understanding Communication and Language Needs of Medicare Beneficiaries, Apr. 2017, available at https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-Medicare-Beneficiaries.pdf.
[3] *Id*.
[4] Proctor, K., Wilson-Frederick, S. M., & Haffer, S. C., 2018. The Limited English Proficient Population: Describing Medicare, Medicaid, and Dual Beneficiaries. Health Equity, 2(1), 82-89, available at https://www.liebertpub.com/doi/full/10.1089/heq.2017.0036.

In our experience, the language access requirements in Section 1557's implementing rule are critical to LEP older adults getting access to the healthcare they need to stay engaged and healthy, and live with dignity in the community. For an older adult with limited resources, not getting needed care in a language one understands could pose serious and adverse health risks. Most people's health care needs increase and become more complicated as they age, and LEP older adults are no different. Health care information is complex and can only be communicated effectively in an individual's primary language. Furthermore, older adults may be less inclined to ask for language assistance, out of a fear of inconveniencing others, even if the language assistance is necessary for them to truly understand their health care. In this context, affirmative reminders of one's rights through taglines are critical and help to counter the stigma of asking for help. If LEP older adults do not understand a statement they receive and are not told how to get help in their primary language, they may not ask for an interpreter. As a result, they may fail to follow up as necessary or may not appeal a wrongful denial of coverage because they are not adequately informed of their appeal rights. Especially for older adults with limited income and high health care needs, the consequences of an erroneous bill or forgoing care can be catastrophic.

(b) The NPRM Fails to Adequately Account for the Importance of Language Access Protections to LEP Consumers Or to Consider Any Alternatives

In proposing to eliminate the tagline requirements, HHS describes them as not justified by need, overly burdensome, and inconsistent or duplicative with other legal requirements. The agency's reasoning is flawed and not persuasive. The NRPM focuses solely on the burdens that taglines impose on providers and other covered entities and takes, at face value, those entities' accounts of beneficiary need and impact. Congress passed Section 1557, a key civil rights law included within the Affordable Care Act, as a way to protect individuals from discrimination in healthcare. In the NPRM, HHS seems to imply that it must weigh any alleged burdens imposed by taglines against the benefits provided to LEP individuals. First, we note that such a balancing is not required in either Section 1557's statutory language or any other authority. Second, HHS must better consider the benefits provided to affected individuals. HHS rationalizes the elimination by citing data that over three-quarters of the U.S. population 18 years of age and older speak only English at home and concluding that they are not well served by taglines or notices, but in doing so, fails to recognize the fact that a quarter of the U.S. population does not speak English at home is itself a powerful argument for use of taglines. Civil rights laws are meant to protect minorities, and while particular protections may not benefit the majority, their value should not be diminished based on that fact. Though taglines may be directly beneficial primarily for LEP populations, low-income seniors are disproportionately LEP. In 2018, over half of all older adults applying for Supplemental Security Income (SSI) asked to be interviewed in a language other than English.[5] We encourage HHS to not jettison established legal requirements, which have been in place for years helping LEP older adults and others access healthcare, without a searching inquiry into the benefits they provide consumers. HHS's inquiry to date has been inadequate. HHS has not considered the utility of the taglines from any perspective other than covered entities.

The failure to provide adequate language access has a real, well-documented cost to consumers, and policies promoting language access are widely recognized as leading to better care. For example, a study examining individuals receiving palliative care for cancer found that without professional interpreter

[5] Social Security Administration (SSA) Quarterly Data for Spoken Language Preferences, Supplemental Security Income (SSI) Aged Initial Claims, available at https://www.ssa.gov/open/data/LEP-Quarterly-Spoken-Language-SSI-Aged-Applicants.html.

services, individuals did not properly understand their diagnoses and prognoses, experienced more pain and anxiety, and experienced worse quality in their end-of-life care.[6] Another study found poorer health outcomes for LEP Asian American Pacific Islander (AAPI) and Latino older adults and recommended written instructions in native languages as a priority.[7] The proposed changes to eliminate the tagline requirement runs counter to even HHS's own recommendations. The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) through HHS's Office of Minority Health recommends "inform[ing] all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing."[8]

Justifying the proposed elimination of taglines from Section 1557's implementing rule based on the financial burdens on covered entities is misguided because long-term healthcare spending actually decreases when LEP individuals have appropriate language access. For instance, one report found that consistent and convenient access to professional interpreter services in the acute hospital setting was associated with decreased 30-day readmission rates for LEP patients who were 50 years and older.[9] The same report acknowledged the modest costs of professional interpretation but emphasized the estimated hospital expenditure savings due to the decreased readmission rates.

In proposing to eliminate the tagline requirements entirely, the NPRM fails to strike the proper balance and makes a policy decision favoring the interests of covered entities, inadequately considering the interests of those whom the underlying statute was designed to protect. HHS uses reports and evidence provided by those covered entities who arguably are best situated to handle the costs imposed by such requirements – large health insurance companies and provider groups—and does not cite to any reports from smaller covered entities who presumably might have less resources to implement the rule's language access requirements.[10] HHS's proposed changes to the rule go beyond the purported basis for their NPRM. In order to meet the goal of lessening the burdens to covered entities, HHS could propose other reasonable requirements that would better balance the language access interests of beneficiaries and the administrative realities on covered entities. For example, it could have addressed the definition of "significant communications" in response to claims that covered entities did not know what constituted significant communications that triggered the inclusion of taglines, or it could have considered reducing the number of required taglines from 15 to a smaller number. Not only did HHS not propose any alternative to the current tagline requirements, the NPRM does not examine any alternatives or explain why the only option proposed is total elimination.

We also note that in proposing the elimination of the tagline requirements to covered entities, HHS failed to adequately account for the intangible costs of LEP older adults and others of not knowing what their rights are and how to access language assistance services. These costs, while difficult to estimate and enumerate, must be considered because the statute's ultimate aim is to eliminate health disparities and protect against discrimination. The costs of not knowing how to access language assistance services is the cost of eliminating the tagline – and related notice – requirements. We believe such a proposal, if finalized, will only further exacerbate health inequities among LEP older adults.

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[6] https://www.ncbi.nlm.nih.gov/pubmed/26549596

[7] Kim, et. al. Vulnerability of Older Latino and Asian Immigrants with Limited English Proficiency. Journal of the American Geriatrics Society. Vol. 59, No. 7, July 2011.

[8] https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5309198/

[10] 84 Federal Register 27858, 27859.

For these reasons, we believe the NPRM fails to account for the importance of taglines to LEP older adults, and the elimination of the tagline requirement should be withdrawn.

(c) Section 1557's Tagline Requirements Are Not Duplicative of nor in Conflict with Existing Requirements and Guidance

HHS erroneously states that some of the tagline requirements are unnecessary because they are duplicative of existing requirements.[11] The rules governing Medicare Advantage (MA) and Part D (PDP) plans are one example. While it is true that 42 C.F.R. 422.2268 and 423.2268[12] set forth requirements that plans must translate vital materials if a 5% threshold in the plan's service area is met, that requirement pertains only to *translation* and only when the *population threshold* is triggered; it does not include a tagline requirement. In addition to Section 1557, the only Medicare-specific authority requiring taglines existed in the Medicare Marketing and Communications Guidance (MCMG). However, in guidance issued in August 2019 to MA and PDP plans about the MCMG, CMS eliminated the tagline requirement from Appendix 2, described as "Non-English Translations disclaimer," effective for plan year 2020.[13] Simply put, the tagline requirements in the 2016 Final Rule are not duplicative of or in conflict with rules governing MA and PDP documents and communications.

We note that although the MCMG guidance no longer requires taglines beginning plan year 2020, covered entities, including MA and PDP plans, are still subject to the requirements of the 2016 Final Rule and as such must include taglines in all significant communications. This obligation continues until a new NPRM that eliminates the tagline requirements is in effect. In the interim, we encourage HHS to remind MA PDP plans and other covered entities of their obligations under the 2016 Final Rule, including the tagline requirement.

The tagline requirement also is not duplicative or in conflict with rules governing forms for Medicare Savings Programs and Medicaid. Rules governing applications for Medicare Savings Programs like the Qualified Medicare Beneficiary Program and the Specified Low-Income Medicare Beneficiary Program do not include a tagline requirement on those applications, instead only providing a model application that has been translated into ten languages in addition to English. While states must treat a completed model application as a start, it can require additional information from the applicant.[14] HHS correctly notes that Medicaid beneficiaries are required to be notified of the availability of language services through taglines.[15] But again 1557 is not duplicative, but rather adds specificity in how Medicaid beneficiaries are to be notified and in what languages taglines should be made available. Because of these reasons, HHS is incorrect in its assertion that taglines are duplicative of or in conflict with other Medicare or Medicaid rules.

(d) Language Access Plans Can Better Connect Individuals with Language Access Services and Help Covered Entities Fully Comply with Non-Discrimination Mandates

[11] 84 F.R. 27859.
[12] Note that HHS cited dated regulations in the NPRM as 422.2264(e) and 423.2264(e) have been re-codified in 422.2268(a)(7) and 423.2268(a)(7) respectively.
[13] CMS, Changes to Contract Year 2019 Medicare Communications and Marketing Guidelines, Aug. 6, 2019.
[14] 42 U.S.C. 1396(p)(5)(A).
[15] 42 C.F.R. 435.905(b)(3).

Language access plans are documents that spell out how an entity will provide services to individuals who are non-English speaking or LEP. They are tailored to individual entities but may have common components, like needs assessments, notices, training for staff, evaluations, and more. From CMS's own materials, language access plans are described as helping ensure that an organization provides high-quality and appropriate language services and that its staff are aware of what to do when an LEP individual needs assistance.[16] In this way, language access plans are similar to racial impact assessments or statements that have been largely recognized to assist decision makers in crafting policies that explicitly address inequities and help reduce racial disparities.[17]

In proposing to eliminate the language access plan provisions, HHS notes that the HHS LEP Guidance allowed for recipients of federal financial assistance not to develop a plan if they served very few LEP individuals or had limited resources. HHS appears to find an inconsistency between the 2016 Final Rule and others discussed above, but this is a phantom problem. In fact, in issuing the 2016 Final Rule, HHS indicated that a language access plan was not required but could be useful in determining whether a covered entity was in compliance with Section 1557.[18] Language access plans for LEP individuals were a key component of Executive Order 13166, which required all federal agencies, including HHS, to create LEP plans for how they would provide services for LEP persons to ensure meaningful access.[19] HHS arbitrarily eliminates the 2016 Final Rule's provisions for language access plans without addressing how covered entities are different from agencies who are required to have plans in place. The 2016 Final Rule strikes the right balance in recognizing how effective language access plans can be in promoting compliance while allowing covered entities discretion by not requiring them. Such a balance should be retained.

Because of the profound harmful effects on low-income older adults, we oppose the NPRM's elimination of the taglines requirement and the language access plan provisions in the Section 1557 implementing rule.

II. The Proposed Rule Would Greatly Harm LGBTQ Older Adults

We strongly oppose the proposed rule's elimination of the definitions of sex, gender identity, and references to sex stereotyping. The current regulations make clear that the law's prohibition on discrimination on the basis of sex includes discrimination on the basis of gender identity and sex stereotyping.[20] The rules' protections for transgender older adults include requiring covered entities to treat individuals consistent with their gender identity and prohibiting health plans from denying medically necessary care, such as a prostate exam for a trans woman or a hysterectomy for a trans man.[21]

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[16] CMS Office of Minority Health, Guide to Developing a Language Access Plan, https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Language-Access-Plan.pdf.
[17] Mauer, Marc. Racial Impact Statements as a Means of Reducing Unwarranted Sentencing Disparities, 5 Ohio St. J. Crim. L. 19 (2007-2008). Race Forward, Racial Equity Impact Assessment, 2009, available at https://www.raceforward.org/sites/default/files/RacialJusticeImpactAssessment_v5.pdf.
[18] 42 C.F.R. 85.12 and 84.22(f).
[19] E.O. 13166, "Improving Access to Services for Persons with Limited English Proficiency," Aug. 11, 2000.
[20] 45 C.F.R. 92.4.
[21] 45 C.F.R. 92.206.

Because Section 1557 is the first to apply Title IX sex discrimination protections to healthcare, how the rule implements the sex discrimination prohibition is paramount. By proposing to eliminate these definitions and provisions providing explicit protections for transgender older adults and other transgender individuals, HHS not only reverses existing regulations but also runs counter to nearly two decades of caselaw that say federal sex discrimination laws protect transgender people.[22]

There is significant evidence that discrimination in health care contributes to health disparities among LGBTQ older adults. For example, they may be denied care or provided inadequate care. Only 16% of surveyed hospitals report having any LGBTQ comprehensive training for their providers,[23] and in one survey, an overwhelming 78% of LGBTQ older adults living in nursing homes, assisted living facilities, and long-term care facilities said "no" or "not sure" in response to the question of whether they felt comfortable being open about their sexual orientation or gender identity to facility staff.[24] Many older adults report having to go back "in the closet" because of stigma and fear when transitioning to a long-term care facility or other institutional setting.[25] These fears and stigmas contribute to overall feelings of dissatisfaction and health disparities that LGBTQ seniors experience, and the rule's protections are necessary because covered entities like hospitals and other providers routinely fall short of culturally competent care for this population.

In addition to this discrimination, LGBTQ older adults experience disproportionate rates of poverty compared to their cis-gendered, heterosexual peers. For example, 21% of LGBTQ adults living alone reported incomes of less than $12,000 a year, compared to 17% of non-LGBTQ adults.[26] Due to intersectional discrimination, women, people of color, and transgender individuals are particularly hard hit. Lesbian couples over 65 have poverty rates twice that of heterosexual married couples over 65, and Latina lesbian couples have poverty rates three times as high as non-Hispanic lesbian couples.[27] The rollback of the gender identity protections will potentially exacerbate senior poverty among LGBTQ older adults and increase health disparities, contrary to one of statute's desired outcomes.

The practical impact cannot be overstated. The proposed changes would sanction discrimination, such as, health insurance companies denying treatment to a transgender older adult because a service they sought did not match their gender identity. It would also allow staff at a Medicaid adult day health center to mis-gender older adults by using improper pronouns and calling them by another name. By eliminating the protections in the existing rule against sex discrimination, seniors will have little recourse when faced with discrimination based on their LGBTQ identity.

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[22] National Center for Transgender Equality, "Federal Case Law on Transgender People and Discrimination," available at https://transequality.org/federal-case-law-on-transgender-people-and-discrimination.
[23] Justice in Aging, LGBT Older Adults in Long-Term Care Facilities: Stories from the Field, updated June 2015, available at https://www.justiceinaging.org/wp-content/uploads/2015/06/Stories-from-the-Field.pdf.
[24] American Journal of Public Health, (Apr. 16, 2015), available at http://ajph.aphapublications.org/doi/10.2105/AJPH.2014.302448.
[25] Anna Gorman, "LGBTQ seniors face discrimination in long-term care," Kaiser Health News, Oct. 18, 2016, available at https://www.pbs.org/newshour/nation/lgbtq-seniors-face-discrimination-long-term-care.
[26] Center for American Progress, Map, et al, Paying an Unfair Price: The Financial Penalty for Being Gay in America, (Sept. 2014; Updated Nov. 2014), available at http://www.lgbtmap.org/file/paying-an-unfair-price-full-report.pdf.
[27] The Williams Institute, Poverty in the Lesbian, Gay, and Bisexual Community, (Mar. 2009), available at http://williamsinstitute.law. ucla.edu/wp-content/uploads/Albelda-Badgett-Schneebaum-Gates-LGB-Poverty-Report-March-2009.pdf.

The NPRM makes a point of discussing the impact of one federal district court's issuance of a preliminary injunction, enjoining HHS from enforcing the sex and pregnancy-related discrimination protections in the rule.[28] The NPRM does not explain why the *Franciscan Alliance* decision alone is adequate grounds for eliminating the gender identity protections in the current rule. The NPRM mentions attempting to avoid future litigation over HHS's Section 1557 regulations as one rationale, but issuing new regulations that are a dramatic departure from existing rules is likely to confuse covered entities and increase potential litigation.[29] We oppose any proposed changes that would curtail the rights of LGBTQ older adults to obtain protection from discrimination on the basis of their sex or gender identity.

Finally, we oppose HHS's attempt to use this rulemaking process to change other, long-standing rules that prohibit discrimination on the basis of gender identity and sexual orientation.[30] These other rules are outside the scope of this proposed rulemaking and furthermore not promulgated by OCR, so they cannot be properly considered at this time.[31] These other rules are critically important for low-income older adults as they prohibit, for example, the Program of All Inclusive Care for the Elderly (PACE) and Medicaid managed care organizations from denying enrollment to LGBTQ older adults on the basis of their gender identity or sexual orientation. It is inappropriate for HHS (OCR) to change these other, long-standing rules without any discussion. Furthermore, HHS has characterized them as "conforming amendments" without offering any legal, policy, or cost-benefit analysis about them and their impacts on various HHS programs.

III. The Proposed Rule Would Harm Older Adults with Disabilities & Chronic Conditions

We oppose HHS's proposal to eliminate provisions in the 2016 Final Rule that prohibit health insurers from using discriminatory benefit design and marketing. Eliminating these provisions will have a harmful effect on older adults with disabilities and chronic conditions. The 2016 Final Rule prohibits health insurance companies from discriminating through marketing practices and benefit design. These protections are especially important for people with disabilities and chronic conditions. However, as discussed below, the proposed rule seeks to exempt most health insurance plans from Section 1557's nondiscrimination protections and also would eliminate the regulation prohibiting discriminatory benefit design and marketing, a protection that exists in the current rule. Together, these changes could lead to health insurers excluding benefits or designing their prescription drug formularies in a way that limits access to medically necessary care for those living with disabilities and other chronic conditions.

Furthermore, nearly half of adults 65 and older have a disability, and nearly eight million Medicare beneficiaries have hearing impairments or deafness, and four million have visual impairments, blindness, or low-vision. HHS's NPRM has other far-reaching consequences for all these older adults with disabilities. For example, the NPRM's removal of the notice requirement informing individuals with disabilities about their rights to auxiliary aids and interpreter services – discussed in greater detail below in section IV(a) – suffers from the same deficiencies as we discussed above with respect to the removal of the tagline requirement for LEP older adults and others.

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[28] See 84 F.R. 27864, discussing *Franciscan Alliance v. Burwell*, et. al, 227 F. Supp. 3d (N.D. Tex. Aug. 23, 2016).
[29] 84 F.R. 27870.
[30] 84 F.R. 27871.
[31] For example, the PACE regulations in question at 42 C.F.R. 460.98(b)(3), 460.11(a) were not promulgated by OCR, and neither were the Medicaid managed care regulations at 42 C.F.R. 438.3(d)(4), 438.206(c)(2), and 440.262.

The proposed rule also changes the definition of auxiliary aids and services, deleting "acquisition or modification of equipment and devices, and other similar services and actions" from the list of examples. Such a proposed change could stoke confusion because it seems to imply that the list is exhaustive. Furthermore, Justice in Aging is opposed to the NPRM's proposal to exempt covered entities with 15 or fewer employees from the requirement to provide effective communication.[32] We concur with HHS's conclusion in 2016 that a standard requirement, regardless of number of employees, would promote "uniformity and consistent administration of law."[33] Any carve-out for smaller covered entities could potentially result in older adults with disabilities, especially those who live in rural communities or other areas where provider networks are already stretched thin, stranded without a provider who is able to communicate with them.

IV. The Proposed Rule Would Harm Older Adults' Meaningful Access to Care and Nondiscrimination Protections

In addition to eliminating protections for LEP older adults, LGBTQ seniors, and seniors with disabilities, the NPRM significantly reduces the scope of entities covered under Section 1557 and the types of discrimination that the regulations can be used to remedy. Further, the NPRM attempts to eliminate a private right of action under the statute. The combined effect of these proposed changes frustrates the purpose of Section 1557 as the premier federal health care rights law and would make it dramatically more difficult for low-income older adults to challenge discrimination.

(a) The Proposed Rule Would Make It Much More Difficult for Older Adults to Know about Their Non-Discrimination Rights

The proposed rule eliminates the requirement that covered entities provide notice of non-discrimination rights. Above, we noted how the elimination of this notice has a particularly detrimental effect on older adults with disabilities because the notice requires specific information about the way they can access auxiliary aids and related services. We also note that many of our concerns regarding the elimination of taglines on significant communications that we raised in I applies with equal force to the elimination of the notice requirement, and therefore we incorporate them here. HHS argues that as a result of the notice, consumers call OCR about plan issues rather than discrimination, but this suggests that the notice could be edited for clarity, not scrapped altogether.[34] We also note that those calls may also demonstrate the language access needs of LEP individuals and their desire for more direction on how to receive it. Additionally, we emphasize that the notice from the 2016 rule benefits *all individuals*, including low-income seniors who are not LEP or do not have disabilities, because it apprises every one of their right to access health care free from discrimination. Specifically, it includes pertinent information about how individuals can file a grievance with a covered entity and how they can file a complaint with OCR.[35]

Because HHS conflates the elimination of the notice requirement with its discussion of taglines, we note here that any claim that the notice requirement in Section 1557 is duplicative of or in conflict with

[32] 84 F.R. 27866.
[33] 81 F.R. 31407.
[34] 84 F.R. 27859, 27860.
[35] Appendix A, "Sample Notice Informing Individuals About Nondiscrimination and Accessibility Requirements and Sample Nondiscrimination Statement."

existing rules is even more unpersuasive. The notice requirement in the 2016 Final Rule informs all individuals of their legal rights. Without such notice, older adults of all backgrounds and identities will be less likely to know what to do if they experience discrimination, including filing grievances and complaints. Such a specific notice requirement is not currently mandated by any other authority in health programs and activities receiving federal financial assistance.

(b) The Proposed Rule Grossly Narrows the Scope of Entities Covered under Section 1557

In proposed sections 92.1-92.3, HHS narrows the scope of entities that would be required to comply with Section 1557's mandate. Under current rules, Section 1557 applies to all health programs and activities administered by HHS as well as other federal departments and the entirety of those entities, any part of which receives federal financial assistance. The NPRM would limit application of Section 1557 to only federal health programs and activities administered by an agency established under Title I of the ACA and only to the portion of the covered entity receiving federal financial assistance.

HHS engages in a gross misreading of both Section 1557's plain statutory language and the existing rule to achieve a result that applies Section 1557 solely to programs and activities administered under Title I of the ACA.[36] In doing so, it appears that HHS is attempting to carve out federal agencies, including HHS itself, from the statute's non-discrimination requirements. This interpretation would potentially mean that many of the programs and activities that are tasked with delivering care to low-income older adults, like the Centers for Medicare and Medicaid Services (CMS), would no longer have to comply with Section 1557. This approach flies in the face of Section 1557's statutory language, which explicitly states:

"An individual shall not…be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, *or* under any program or activity that is administered by an *Executive Agency* or any entity established under [Title I]."[37] (emphasis added)

By limiting the statute's application to only programs under Title I, the NPRM engages in a contrived exercise of statutory interpretation that is not supported by the statute's plain language. The NPRM provides little rationale on why such an interpretation is either appropriate or necessary. Congress could not have intended to limit the statute to covered entities under Title I when executive agencies are expressly included in the statute's language. Furthermore, HHS fails to provide any justification in the NPRM for why health programs or activities created under the Affordable Care Act should be subject to a different non-discrimination standard than the agency tasked with administering those programs and activities.

The NPRM goes even further, proposing that only those programs or activities of a covered entity receiving federal financial assistance are to be subject to the non-discrimination protections of Section 1557 and not the entire entity itself, and attempts to limit what counts as federal financial assistance.[38] HHS provides no sufficient rationale for this decision, only indicating that the business of providing

[36] 84 F.R. 27862.
[37] 42 U.S.C. 18116(a).
[38] 84 F.R. 27850 ("Therefore, the Department is now proposing to clarify that health insurance programs administered by entities not principally engaged in providing health care will only be covered by the Rule to the extent those programs (as opposed to those entities) received Federal financial assistance from the Department."); 27860 ("'Federal financial assistance' includes credits, subsidies, or contracts of insurance.").

healthcare is substantially different from the business of providing health insurance coverage. The proposed changes could potentially exempt most health insurance companies' plans, products, and operations from meeting the statute's non-discrimination protections. For example, employer-sponsored insurance and short-term limited duration insurance would no longer be subject to Section 1557. In our experience, particularly given the degree to which managed care companies now routinely provide care for individuals dually eligible for Medicare and Medicaid, the distinction between health care and health insurance is increasingly muddied. Consider, for example, a health insurance company that organizes an enrollment fair in the local community to connect individuals with services and explain their different enrollment options, and one of the vendors is offering free health screenings. Also consider care coordinators who offer some guidance and advice with respect to navigating and accessing healthcare benefits but are employed by the health insurance company. Dual eligibles, due to the fractured nature of health care delivery between Medicare and Medicaid, are widely believed to benefit from the assignment of care coordinators, so HHS's potential exemption of health insurance companies is particularly concerning for this population.

The proposal also creates an environment where programs and activities run by the same company could have different non-discrimination requirements, depending, for example, on whether the specific program or activity receives federal financial assistance. When two separate programs are both run by the same entity, it does not make sense to allow one to discriminate while prohibiting the other simply because the latter is the only recipient of federal financial assistance. This type of granular interpretation, which contradicts the NPRM's purported rationale of creating consistency, is simply not administrable and would ultimately harm consumers.

(c) The Proposed Rule Attempts to Eliminate a Private Right of Action for Discrimination Claims

We oppose the proposed changes in proposed section 92.5 that seeks to severely limit the remedies available to individuals under Section 1557. Section 1557 expressly provides individuals access to any and all of the "enforcement mechanisms provided for and available under" the cited civil rights statutes, regardless of the type of discrimination. The current regulations already have clarified that, for example, victims of disparate impact discrimination under Title VI - incorporated into Section 1557 - have a private right of action to challenge that discrimination in federal district court. We strongly oppose the proposed rule's elimination of provisions recognizing a private right of action for disparate impact discrimination claims.

In proposing such changes, the NPRM focuses to a significant extent on one or two federal district courts opinions that have found that Congress's express incorporation of enforcement mechanisms manifests an intent to import those standards and burdens of proof into a Section 1557 claim, depending on the protected class at issue.[39] In the same discussion, the NPRM glaringly omits any significant discussion of *Rumble v. Fairview Health Servs.*, 2015 WL 1197415, in which a federal district court, faced essentially with the same question as in *Gilead*, decides that Section 1557 created a single standard, regardless of a plaintiff's protected class, therefore allowing disparate impact claims to be heard under the statute. The lack of consideration in the NPRM of *Rumble* is concerning as it appears that HHS is cherry-picking legal justifications to support its proposed changes and failing to adequately consider counter-authorities. The *Rumble* court reached a conclusion at odds with the NPRM: if Section 1557 is read as simply reiterating existing civil rights protections in healthcare programs and activities receiving federal

[39] 84 F.R. 27850, citing *Southeastern Pennsylvania v. Gilead*, 102 F. Supp. 3d 725, 738 (N.D. Ill. 2015).

financial assistance, it does not actually effectuate Congress's intent in passing an additional non-discrimination protection in the Affordable Care Act. If federal civil rights laws already applied to covered entities under the incorporated statutes, Section 1557's mandate becomes superfluous.[40] Rather, HHS should read Section 1557 in such a way as to best effectuate a new non-discrimination provision in healthcare.[41] We also note that both *Rumble* and *Gilead* – despite erroneous dates cited in the NPRM – were decided prior to the issuance of the 2016 Final Rule. Thus, the 2016 rule should be fairly interpreted as having ultimately settled the question of whether such claims under Section 1557 are permissible.[42]

The effects of the proposed change are significant in barring access to courts for many of the country's low-income older adults. For example, if LEP older adults or seniors of color experience discrimination on the basis of their race or ability to speak English, they would be foreclosed from bringing their Section 1557 – and Title VI – disparate impact claims to federal court based on the NPRM's interpretation that only the Title VI underlying enforcement mechanisms prevail and that *Alexander v. Sandoval* has essentially barred a private right of action for disparate impact claims.[43] While those older adults could still file an administrative complaint with OCR, the ability of the office to respond is limited by constrained resources, and even fewer older adults would be made aware of their rights should HHS finalize its proposal to eliminate the notice of non-discrimination requirement as discussed in IV(a). This leaves those older adults with very few avenues of relief. For all these reasons, we oppose the proposed changes regarding enforcement and remedies in the NPRM.

(d) The Proposed Rule Silently Eliminates Claims of Intersectional and Associational Discrimination under Section 1557

The 2016 Final Rule and its preamble expressly allow for claims of intersectional discrimination and associational discrimination as cognizable under the statute.[44] Both are critical to the rights of older adults to receive health care services free from discrimination, yet the NPRM is entirely silent on whether associational and intersectional forms of discrimination are still prohibited should the proposed changes take effect. The silent elimination of cognizing intersectional and associational discrimination is particularly problematic because HHS does not provide any justification for the change from the 2016 Final Rule in the NPRM. We oppose any changes, express or implied, that would limit an older adult's ability to seek relief based on claims of either intersectional or associational discrimination.

Intersectional discrimination occurs when individuals experience discrimination that is particular to the intersection of multiple protected classes or identities. For example, a black woman can be

[40] The notable exception is that sex discrimination under Title IX applied only to the education context.
[41] This approach is in line with canons of statutory interpretation, including the rule against surplusage – that courts should give effect to every clause and word of a statute so that it is not rendered superfluous, void, or significant – as well as the rule of purposive construction – to interpret statutes so as best to carry out their statutory purposes. *See Duncan v. Walker*, 533 U.S. 167, 174 (2001); *Young v. UPS*, 135 S. Ct. 1338, 1352 (2015); Antonin Scalia & Bryan A. Garner, Reading Law: The Interpretation of Legal Texts (2012); William N. Eskridge, Jr., Phillip P. Frickey, Elizabeth Garrett, & James J. Brudney, *Cases and Materials on Legislation and Regulation: Statutes and the Creation of Public Policy*, 2014.
[42] 45 C.F.R. 92.301, 81 F.R. 31440 ("We note as well that both the proposed and final rule specify that a private right of action is available under Section 1557").
[43] *Alexander v. Sandoval*, 532 U.S. 275 (2001).
[44] 81 F.R. 31405, 42 C.F.R. 92.209 (non-discrimination on the basis of association).

discriminated against because she is both black and a woman. Intersectional discrimination occurs among low-income older adults, many of whom hold multiple identities and can experience discrimination at those intersections, like age and gender, race, ethnicity, and disability. The results of intersectional discrimination on disparate health outcomes are well-established. For example, one study that compared functional limitations across intersections of race and gender found that all demographic groups exhibited worse functional imitation trajectories than white men, and specifically that Black and Latino women had the highest disability levels.[45] At the intersection of age and race, it is also well-researched that Black older adults have shorter life expectancies, live a greater proportion of their lives with a disability, and have higher rates of many leading causes of death, like cancer and heart disease, compared to white older adults.[46] For Section 1557 to make important differences in curbing health disparities, it must recognize intersectional discrimination claims.

Similarly, protecting someone's right to be free from associational discrimination is important to older adults. Protection from associational discrimination allows older adults to support others who are in a protected class and to seek redress if they are discriminated against in providing support or receiving healthcare themselves. For example, the 2016 rule makes clear that nursing facilities are prohibited from denying admission to a white older adult whose spouse is black, or that managed care companies cannot exclude a doctor from their network who primarily serves LEP individuals. The right, codified in the current rule at 42 C.F.R. 92.209, has been removed in the proposed rule, and the silence of the NPRM on whether Section 1557 protects against associational discrimination is concerning, allowing the inference that it may be foreclosed. We oppose any attempt to remove or otherwise limit 42 C.F.R. 92.209.

Conclusion

Thank you for the opportunity to comment on the nondiscrimination NPRM. The NPRM would result in harm to many populations of older adults, including LEP seniors, LGBTQ older adults, and seniors with disabilities. The NPRM would exacerbate existing health disparities for these communities. It would also frustrate the ability of all older adults to challenge discrimination they face by reducing the scope of remedies offered under the statute. Because of these harms, we strongly urge HHS to withdraw this NPRM in its entirety. Again, should HHS finalize any of the proposed revisions, we strongly oppose incorporating any changes into regulations implementing the underlying civil rights laws, such as Title VI, Title IX, and Section 504. For questions about our comments, please contact Denny Chan at dchan@justiceinaging.org.

Sincerely,

Jennifer Goldberg
Deputy Director

[45] David Warner and Tyson Brown, Understanding How Race/Ethnicity and Gender Define Age-Trajectories of Disability: An Intersectional Approach, Soc Sci Med, Apr. 2012.
[46] Kenneth Ferraro, Blakelee Kemp, and Monica Williams, Diverse Aging and Health Inequality by Race and Ethnicity, Innovation in Aging, Mar. 2017.

Lambda Legal
making the case for equality

August 13, 2019

VIA Electronic Submission

Hon. Alex M. Azar, II, Secretary
U.S. Department of Health and Human Services
Attention: 1557 NPRM, RIN 0945-AA11
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Re: **Agency Notice of Proposed Rulemaking; Public Comment Request; Nondiscrimination in Health and Health Education Programs or Activities RIN 0945-AA11**

To Whom It May Concern:

Lambda Legal Defense & Education Fund, Inc. ("Lambda Legal") submits these comments in response to the U.S. Department of Health and Human Services ("HHS" or "Department") and the Center for Medicaid and Medicaid Services ("CMS") Notice of Proposed Rulemaking ("Proposed Rule" or "NPRM") to express our opposition to the proposed rule entitled "Nondiscrimination in Health and Health Education Programs or Activities," published in the Federal Register on July 14, 2019.

Founded in 1973, Lambda Legal is the oldest and largest national legal organization dedicated to achieving full recognition of the civil rights of lesbian, gay, bisexual, transgender and queer ("LGBTQ") people and everyone living with HIV through impact litigation, education, and policy advocacy. The matters addressed in the Proposed Rule are of great concern to Lambda Legal because LGBTQ people and those living with HIV already face widespread discrimination in health care services, and violations of their personal autonomy regarding reproductive decisions, sexual health, gender expression, transition-related care, HIV care and other matters. Lambda Legal has been a leader in the fight against this discrimination and, accordingly, has submitted a series of comments to HHS providing extensive documentation of this discrimination, its serious health effects, the ways that current federal law must be understood as forbidding this mistreatment, and the ways that additional conscience-based exemptions to health standards and federal would wrongfully endanger LGBTQ people and others.[1] Because Lambda Legal remains committed to protecting the rights of LGBTQ people seeking health care and to ensuring that medical professionals and healthcare facilities understand and respect their responsibility to treat LGBTQ patients fairly, Lambda Legal opposes the Proposed Rule for the reasons explained in these comments.[2]

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[1] *See, e.g.,* Lambda Legal Public Comment in Response to the Proposed Rule, Protecting Statutory Conscience Rights in Health Care, RIN 0945-ZA03 (submitted March 27, 2018) ("Lambda Legal Religious Exemption Comments"), *available at* https://www.lambdalegal.org/in-court/legal-docs/dc_20180327_comments-hhs; *Lambda Legal Comments on Proposed Rule 1557 Re: Nondiscrimination in Health Programs and Activities, 1557 NPRM (RIN 0945-AA02)* (submitted Nov. 9, 2015) ("Lambda Legal 1557 Comments"), *available at* https://www.lambdalegal.org/in-court/legal-docs/hhs_dc_20151117_letter-re-1557; *Lambda Legal Comments on Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities (RIN 0945-AA02 & 0945-ZA01)* (submitted Sept. 30, 2013) ("Lambda Legal Nondiscrimination Comments"), *available at* https://www.lambdalegal.org/in-court/legal-docs/ltr_hhs_20130930_discrimination-in-health-services.

[2] Lambda Legal also opposes the Proposed Rule for the reasons set forth in the comments submitted by the HIV Health Care Access Working Group – a coalition of over 100 national and community-based HIV service organizations, of which Lambda

TABLE OF CONTENTS

I. Introduction

Lambda Legal vigorously opposes the Proposed Rule. LGBTQ people already experience widespread discrimination in health care settings. Although HHS cannot change the law through the Proposed Rule, the Proposed Rule sends a dangerous message to those who wish to discriminate that they can do so without consequence, which would cause direct harm and literally endanger the lives of LGBTQ people and other marginalized populations. By improperly inviting discrimination contrary to the statute, the Proposed Rule also would cause drastic limitations in access to health care coverage for LGBTQ people, while creating confusion among health care providers about their rights and obligations under the law. The Proposed Rule also would encourage hospitals to deny care to LGBTQ people, and embolden insurance companies to deny transgender people coverage for health care services that they cover for non-transgender people.

It is important to note the context within which the NPRM has been promulgated. HHS issued the Proposed Rule on the heels of two and half years of relentless efforts by this administration to rollback or eliminate equality protections for LGBTQ people in a broad range of contexts. There are too many examples of these efforts to catalogue in this comment, but they are publicly documented.[3] These systematic

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Legal is a member, which represents HIV medical providers, public health professionals, advocates, and people living with HIV who are all committed to ensuring access to critical HIV-related health care and support services.

[3] *E.g.*, Human Rights Campaign, *Trump's Timeline of Hate*, *available at* https://www.hrc.org/timelines/trump; National Center for Transgender Equality, *The Discrimination Administration*, *available at* https://transequality.org/the-discrimination-administration; GLAAD, *Trump Accountability Project*, *available at* https://www.glaad.org/trump.

attempts to facilitate discrimination against LGBTQ people have especially marked out and targeted transgender people. The administration, for example, has sought to eliminate information about transgender elders,[4] to exclude transgender students,[5] to deny transgender workers equal opportunity,[6] to ban transgender service members,[7] to bar transgender immigrants,[8] and to leave transgender prisoners without basic personal needs and subject to sexual and other violence.[9] Now, as the NPRM makes clear, the administration proposes to facilitate denials of medically necessary care to transgender patients.

In an administration that seems to find new ways to target LGBTQ people (and transgender people in particular) on a weekly basis, there is no federal agency that has invited more widespread harm to LGBTQ people than HHS, the agency actually charged by Congress with enhancing the health and well-being of all Americans.[10] Instead of advancing the health and well-being of ***all*** Americans, however, under this administration, HHS is attempting the opposite. For example, HHS recently issued a final rule that invites health care providers to deny LGBTQ people, and most explicitly transgender people, health care based on a health provider's religious or personal beliefs, regardless of the medical standard of care.[11] The Department also has repeatedly attempted to erase information about LGBTQ people. For example, the Department altered its website to remove language referencing protections for LGBTQ people and instructed CDC staff not to even use the word "transgender."[12] HHS also has repeatedly rolled back data collection efforts which are critical for understanding and then attempting to meet the needs of LGBTQ people.[13]

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[4] Health and Human Services Agency, Administration for Community Living Elimination of data collection survey for transgender elders on the National Survey of Older Americans Act, *available at* https://www.federalregister.gov/documents/2018/02/20/2018-03390/agency-information-collection-activities-submission-for-omb-review-comment-request-redesign-of.

[5] John Riley, *Department of Education Issues New Guidance on Transgender Students*, (June 16, 2017); OCR Instructions to the Field re Complaints Involving Transgender Students, *available at* https://www.documentcloud.org/documents/3866816-OCR-Instructions-to-the-Field-Re-Transgender.html.

[6] Office of the Attorney General Memo to U.S. Attorneys regarding the Revised Treatment of Transgender Discrimination Claims under Title VII of the Civil Rights Act of 1964 (Oct. 4, 2017), *available at* https://www.justice.gov/ag/page/file/1006981/download.

[7] Office of the Deputy Secretary of Defense, Directive Memo with regard to Military Service by Transgender Persons (Mar. 12, 2019), *available at* https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dtm/DTM-19-004.pdf.

[8] Ben Kesslen, *Dozens of House Members Demand Better Treatment of Transgender Asylum Seekers in ICE Custody* (Aug. 1, 2019), *available at* https://www.nbcnews.com/politics/immigration/dozens-house-members-demand-better-treatment-transgender-asylum-seekers-ice-n1037471.

[9] U.S. Department of Justice, Federal Bureau of Prisons, Change to the Transgender Offender Manual (May 11, 2018), *available at* https://www.bop.gov/policy/progstat/5200-04-cn-1.pdf.

[10] See HHS Mission Statement, *available at* https://www.hhs.gov/about/strategic-plan/introduction/index.html#mission

[11] Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 84 FR 23170 (May 21, 2019), *available at* https://www.federalregister.gov/documents/2019/05/21/2019-09667/protecting-statutory-conscience-rights-in-health-care-delegations-of-authority (expanding existing conscience protections to include health care treatment for transgender people).

[12] *E.g.*, Lena H. Sun and Juliet Eilperin, *CDC Gets List of Forbidden Words: Fetus, Transgender, Diversity* (Dec. 15, 2017) WASHINGTON POST, *available at* https://www.washingtonpost.com/national/health-science/cdc-gets-list-of-forbidden-words-fetus-transgender-diversity/2017/12/15/f503837a-e1cf-11e7-89e8-edec16379010_story.html?utm_term=.6784cceec03e.

[13] *E.g.*, Department of Health and Human Services, Adoption and Foster Care Analysis and Reporting System NPRM (Apr. 19, 2019), *available at* https://www.federalregister.gov/documents/2019/04/19/2019-07827/adoption-and-foster-care-analysis-and-reporting-system.

Most of the anti-LGBTQ policy changes being attempted by HHS—including the Proposed Rule—arise out of its Office of Civil Rights ("OCR"), headed by its director, Roger Severino. For years Mr. Severino has made no secret of his contempt for LGBTQ people, especially transgender people.[14] For example, before taking the helm of OCR, Mr. Severino was on record that he believes transgender military personnel serving openly "dishonors" the service of other service members.[15] He referred to Gavin Grimm, a male transgender student in a successful Title IX case,[16] as "a gender-dysphoric teen girl."[17] With particular reference to the Proposed Rule, Mr. Severino has referred to the existing health care nondiscrimination protections for transgender people as "special privileges" and propagated the baseless myth that doctors will be forced to enter new fields of medicine against their will.[18]

Consistently with this evident personal antipathy to transgender people as a class, Mr. Severino also has repeatedly disparaged the clinical effectiveness of transition-related health care.[19] Mr. Severino, however, is not a physician and he cites only his opinion and discredited studies that—as with the NPRM—ignore a mountain of both medical and legal authority in order to reach arbitrary, unsupportable and harmful conclusions. Nearly all major medical organizations in the United States have issued position statements confirming based on decades of studies that access to and insurance coverage for transition-related health care is medically necessary for many transgender patients and fully in keeping with contemporary standards of medicine, science, and ethics. For example, the American Medical Association has repeatedly affirmed the propriety of transition-related care in both the civilian and the military context.[20] Likewise, the American Psychiatric Association[21] and the American Psychological Association,[22] as well as a host of other medical organizations, also have issued similar position statements.[23] In fact, no credible major medical organizations have taken a contrary position.

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[14] Charles Ornstein, *Heritage Foundation Alum Critical of Transgender Rights to Lead HHS Civil Rights Office* (Mar. 24, 2017), *available at* https://www.propublica.org/article/heritage-foundation-critical-transgender-rights-HHS-civil-rights-office; GLAAD, Trump Accountability Project, Profile of Roger Severino, Director of Office of Civil Rights (at Dept. of HHS), *available at* https://www.glaad.org/tap/roger-severino.

[15] Roger Severino, *Pentagon's Radical New Transgender Policy Defies Common Sense* (July 1, 2016), CNSNEWS.COM, *available at* https://www.cnsnews.com/commentary/roger-severino/pentagons-radical-new-transgender-policy-defies-common-sense.

[16] *Grimm v. Gloucester Cty. Sch. Bd.*, No. 4:15CV54, 2019 WL 3774118 (E.D. Va. Aug. 9, 2019).

[17] Jim DeMint & Roger Severino, *Commentary: Court Should Reject Obama's Radical Social Experiment* (Dec. 14, 2016), *available at* https://www.heritage.org/gender/commentary/court-should-reject-obamas-radical-social-experiment.

[18] Roger Severino, *Why Obamacare Might Force Doctors to Perform Sex-Reassignment Surgeries* (Jan. 13, 2016), *available at* https://www.dailysignal.com/2016/01/13/why-obamacare-might-force-doctors-to-perform-sex-reassignment-surgeries/.

[19] Ryan Anderson & Roger Severino, *Proposed Obamacare Gender Identity Mandate Threatens Freedom of Conscience and the Independence of Physicians*, Heritage Foundation Backgrounder, No. 3089 (Jan. 8, 2016), *available at* https://www.heritage.org/health-care-reform/report/proposed-obamacare-gender-identity-mandate-threatens-freedom-conscience.

[20] American Medical Association House of Delegates Resolution 122, *available at* http://www.imatyfa.org/assets/ama122.pdf; also see AMA Statement on Pentagon's ban on Transgender in the Military (Apr. 11, 2019), *available at* https://www.ama-assn.org/press-center/ama-statements/ama-statement-pentagons-ban-transgender-military.

[21] *See* Professional Organization Statements Supporting Transgender People in Health Care, Lambda Legal (last visited Aug. 13, 2019), *available at* https://www.lambdalegal.org/sites/default/files/publications/downloads/resource_trans-professional-statements_09-18-2018.pdf.

[22] *Id.*

[23] *Id.*

Accordingly, since before the Affordable Care Act was enacted almost a decade ago and increasingly thereafter, health insurance companies have been eliminating their prior, discriminatory exclusions of coverage for transition-related health care. This trend is accelerating both with plans offered through the exchanges and those offered by employers, and insurers have reported no problems with the provision of coverage for this medically-necessary health care. Indeed many states now prohibit insurers from offering plans that discriminate against transgender people.[24]

While equality and a desire to avoid discrimination should drive decisions about benefit coverage, the case for the provision and coverage of transition-related health care is also economically sound. Over and over again, reputable cost studies have shown that the cost of providing this care is less than one-tenth of one percent of an entity's health budget. For example, a study commissioned by the U.S. military concluded that costs associated with providing health care to transgender service members was considered by a former Secretary of the Navy to be "budget dust, hardly even a rounding error."[25] Likewise, research from the Johns Hopkins Bloomberg School of Public Health calculated that the costs would be fewer than two pennies per month for every person with health insurance coverage in the United States.[26] A cost analysis of the City and County of San Francisco's coverage of transition-related surgeries found that costs in the first five years to both insurers and employers were low, averaging between $0.77 and $0.96 per year per enrollee, and resulted in no surcharge or premium increases.[27] Employers who provide health care coverage for their transgender employees likewise report very low costs, if any, from adding transition-related coverage to their health benefits plans or from actual utilization of the benefit after it has been added – with many employers reporting no costs at all.

Contrary to this information readily available to the public, and the information compiled both by HHS when preparing the 2016 Final Rule and by the Armed Forces when preparing to permit open military service by transgender people, this administration has grossly exaggerated the cost of transition-related health care coverage in order to enshrine discrimination.[28] The discriminatory comments by OCR leadership together with this administration's shockingly overt record of anti-transgender bias make plain that this Proposed Rule is the product of biased ideology, not medical or other evidence. Contrary to the statutory responsibility of HHS to enhance the health and well-being of all Americans, this Proposed Rule illegitimately aims instead to embolden those providers and insurers who wish to withhold medically needed heath care from LGBTQ patients.

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[24] *See States with health insurance bulletins prohibiting discrimination against transgender people*, Transgender Law Center (last updated May 23, 2016), *available at* https://transgenderlawcenter.org/resources/health/bulletins.

[25] See Declaration of Raymond Edwin Mabus, Jr., former Secretary of the Navy, In support of Plaintiff's Motion for Preliminary Injunction, No. 17-cv-1597 (CKK), *Doe v. Trump* (Aug. 28, 2017), *available at* http://www.nclrights.org/wp-content/uploads/2017/08/Mabus-Declaration-1.pdf..

[26] William V. Padula, Shiona Heru, Jonathan D. Campbell, *Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis* (Oct. 19, 2015), *available at* https://link.springer.com/article/10.1007%2Fs11606-015-3529-6.

[27] State of California Department of Insurance Economic Impact Assessment (Apr. 13, 2012), *available at* https://transgenderlawcenter.org/wp-content/uploads/2013/04/Economic-Impact-Assessment-Gender-Nondiscrimination-In-Health-Insurance.pdf.

[28] *See, e.g.,* Asher Stockler, *Legal Experts Say Trump's Latest Freewheeling Interview Could Undermine his Transgender Military Ban Case*, NEWSWEEK (June 6, 2019), *available at* https://www.newsweek.com/donald-trump-interview-transgender-military-ban-1442679.

Against this overwhelmingly discriminatory federal policy backdrop, LGBTQ people, and especially transgender people, already have been experiencing serious and persistent barriers to accessing health care coverage,[29] which would only worsen if the Proposed Rule were to be given effect. For example, one in four transgender people report experiencing discrimination, such as being denied coverage for care related to transition, and one-third report verbal harassment or refusal of treatment.[30] As a result of this discrimination, many transgender and nonbinary people avoid seeking health care altogether. According to the 2015 U.S. Transgender Survey, 23% did not seek care when they needed it from fear of being mistreated.[31] These persistent experiences and delays in preventive treatment can lead many people to avoid seeing a doctor altogether, which inevitably leads to serious negative long-term health care outcomes.[32]

In addition to the statistical evidence showing the glaring disparities, the requests for assistance that Lambda Legal receives via our Legal Help Desk and publicly reported examples of refusals of care[33] demonstrate the extreme harm that LGBTQ people already experience, which unavoidably would be exaggerated were the Proposed Rule to be given effect. Below are only a few examples that show the range of harmful discrimination that LGBTQ people regularly experience regarding health care treatment:

- Tyra Hunter, a transgender woman who was seriously injured in a car accident outside Washington D.C who later died from her wounds was jeered at by ambulance workers who refused to her.[34]

- Robert Eads, a transgender man with ovarian cancer whom 20 separate doctors wouldn't treat; one said the diagnosis should make Eads "deal with the fact that he is not a real man."[35]

- K.S., a transgender woman in Dallas who sought help because she had become suicidal, recounted: On several occasions, I was asked about my genitals as well as other inappropriate questions about my transgender status. When I complained…a nurse told me that I should just "expect to be treated like this." On multiple occasions, they made me sleep on the hallway floor rather than in a room, and when I was finally given a room, it was an isolation room…I was also prevented from using the bathroom for hours at a time…[and]denied use of [my electric shaver] for a week, which caused me to grow a beard. The staff of the facility discussed my transgender status loudly…, and as a result, within the first couple of days of my arrival all of the patients around me knew, which caused me to suffer sexual harassment from two male patients. K.S. Statement. Due to this treatment, K.S. attempted suicide twice while at that facility.[36]

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[29] See extensive material submitted to HHS in Lambda Legal's prior comments, as referenced *supra* in note 1.

[30] James, S.E., Herman, J.L., Rankin, S., Keisling, M., Mottet, L. & Anafi, M. (2016) (p. 92). *The Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality, *available at* http://www.ustranssurvey.org/reports.

[31] *Id.*

[32] See discussions in Lambda Legal's prior comments, referenced *supra* in note 1.

[33] See examples reported in detail in Lambda Legal's prior comments, referenced *supra* in note 1.

[34] *See* Health Provider Discrimination, Lambda Legal (last visited Aug. 13, 2019), *available at* https://www.lambdalegal.org/know-your-rights/article/trans-health-care-discrimination.

[35] *Id.*

[36] *See* Brief of Amici Curiae Lambda Legal Defense and Education Fund, Inc., Family Equality Council, *et al.*, in Support of Respondents (Oct. 30, 2017), *Masterpiece Cakeshop, Ltd. v. Colorado Civil Rights Commission*, 2017 WL 5127317.

- M.H., a gay man in New York City reported: I was treated roughly physically and emotionally and called a faggot on more than one occasion by a health care aide. At one point, I was dragged down the hall roughly in an office chair, because they said they were short on beds, and I fell out of the chair…I was left on the floor, where I went into convulsions and urinated on myself. I was later told I had a seizure and a cyanotic episode…I could hear the nurse running toward me yelling that she was going to lose her job over this. The health aide responded: "This junky faggot isn't going to make you lose your job."[37]

Despite this persistent, appalling reality for transgender people in particular, the Proposed Rule seeks to roll back and limit the existing rule regarding "Nondiscrimination in Health and Health Education Programs or Activities" (hereinafter "2016 Final Rule"), promulgated on May 18, 2016. The 2016 Final Rule represents the culmination of an extensive process. It was developed over the course of six years and took in two notice and comment periods and received over 25,000 comments which overwhelmingly confirmed both the legal foundation and the practical need to include explicit protections against discrimination based on sex stereotyping and gender identity in the regulations. Since its promulgation, the 2016 Final Rule has successfully led to a dramatic decrease in discriminatory policies and practices.[38] A recent study of 37 states in the federal marketplace showed that 95% of plans did not contain blanket exclusions of transition-related care in 2019.[39] If finalized, the Proposed Rule would undermine this progress in eradicating health care discrimination against LGBTQ people in a broad array of health care programs and entities by inviting insurers and providers once again to discriminate against them, while also discouraging LGBTQ people from seeking health care in the first place.

It must be noted that an agency rule that amends an existing rule is subject to review under the Administrative Procedures Act (APA).[40] Proposed rules must examine the relevant information and articulate a satisfactory explanation for the NPRM, including a "reasoned analysis for the change."[41] The APA analysis of whether an agency action was arbitrary and capricious and therefore unlawful includes an examination of whether the agency's explanation runs counter to the evidence before it.[42] Here, as demonstrated above and in further detail below, HHS has failed utterly to provide a reasoned analysis for its proposed changes and the course it has charted, which runs directly counter to the evidence before the agency and to its statutory mandates.

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[37] *Id.*

[38] Sharita Gruberg and Frank J. Bewkes, *The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial*, Center for American Progress (Mar. 7, 2018), *available at* https://www.americanprogress.org/issues/lgbt/reports/2018/03/07/447414/acas-lgbtq-nondiscrimination-regulations-prove-crucial/.

[39] Out2Enroll, Summary of Findings: 2019 Marketplace Plan Compliance with Section 1557, *available at* https://out2enroll.org/out2enroll/wp-content/uploads/2018/11/Report-on-Trans-Exclusions-in-2019-Marketplace-Plans.pdf. This is consistent with summaries from 2017 and 2018, *available at* https://out2enroll.org/out2enroll/wp-content/uploads/2015/10/Report-on-Trans-Exclusions-in-2017-Marketplace-Plans.pdf https://out2enroll.org/out2enroll/wp-content/uploads/2017/11/Overview-of-Trans-Exclusions-in-2018-Marketplace-Plans-1.pdf.

[40] 5 U.S.C. § 706(2)(A); *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29 (1983).

[41] *Id.*

[42] *Id.*

II. The NPRM Fails to Provide a Reasoned Explanation for Repealing the Definition of "On the Basis of Sex."

The 2016 Final Rule explicitly prohibits discrimination on the basis of sex, including discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping and gender identity.[43] While Section 1557 remains the law, the NPRM attempts to significantly alter the ACA's sex discrimination protections by eliminating the 2016 Final Rule's definition of sex discrimination altogether, and does not attempt to provide a different definition.[44]

Instead, the NPRM simply announces that interpreting Title IX to prohibit gender identity discrimination was a "novel theory" when HHS promulgated the 2016 Final Rule.[45] In support of this inaccurate generalization, the NPRM points to non-binding language from a five-page district court decision issued in 2017 (a year after the 2016 Final Rule was issued), which noted the lack of controlling U.S. Supreme Court precedent recognizing gender identity discrimination as prohibited under Section 1557.[46] But the dicta referenced in the NPRM was not cited in that case.[47] Even if it were, simply because the U.S. Supreme Court has not explicitly confirmed a legal interpretation does not mean that interpretation is wrong. Equal weight should be given to the Supreme Court's lack of an explicit holding that discrimination based on gender identity or sexual orientation is *not* a prohibited form of discrimination under Section 1557.

More to the point, the NPRM asserts that the 2016 Final Rule exceeded its legal authority under Section 1557 by adopting an interpretation of civil rights law that was "incorrect."[48] But the Department fails to provide a coherent legal analysis that would explain *why* that interpretation was "incorrect." The 2016 Final Rule grounded its interpretation of "sex" on a detailed survey of the extensive existing case law, which has continued to expand with additional supporting case law since the 2016 Final Rule was issued.[49] The NPRM however, offers only two dismissive paragraphs, which fail to address or even acknowledge the substantial body of well-reasoned contrary authority. Instead, the Department relies almost entirely on one preliminary injunction issued by a lone district court,[50] which similarly ignored extensive, contrary legal authority, and which was not appealed and considered at the Circuit Court level.[51]

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[43] 45 C.F.R. § 92.4.

[44] 84 FR 27857 ("Because of the likelihood that the Supreme Court will be addressing the issue in the near future, the Department declines, at this time, to propose its own, definition of "sex" for purposes of discrimination on the basis of sex in the regulation.").

[45] The Department refers to discrimination against LGBTQ people as a "novel theory" on nine separate occasions, always without addressing the contrary authority.

[46] 84 FR 27853 (*see, e.g., Baker v. Aetna*, 228 F. Supp. 3d 764, 768-69 ("noting no controlling U.S. Supreme Court legal precedent recognizing gender identity as prohibited discrimination under Section 1557.").

[47] *Baker v. Aetna Life Ins. Co.*, 228 F. Supp. 3d 764, 769 (N.D. Tex. 2017) (the decision simply states that "the Fifth Circuit has not extended *Hopkins'* Title VII reasoning to apply to any statute referenced in § 1557").

[48] 84 FR 27849.

[49] *See* 81 FR 31387-31392 (2016).

[50] *Franciscan Alliance, Inc., et al.* v. *Burwell, et al.,* 227 F. Supp. 3d 660 (N.D. Tex. 2016). Judge O'Connor, who recently gained notoriety for issuing a declaratory judgment striking down the entire Affordable Care Act, has issued nationwide injunctions effecting the rights of LGBTQ people on numerous occasions. In addition to the injunction in this case, Judge O'Connor issued a nationwide injunction in 2015 blocking federal rules that would have provided Family and Medical Leave Act (FMLA) to same-sex couples. *Texas v. United States*, 95 F. Supp. 3d 965 (N.D. Tex. 2015). Judge O'Connor also issued a nationwide preliminary

For example, beyond citing the *Franciscan Alliance* injunction, the NPRM fails to discuss the growing number of authorities that have held that the ACA's prohibition against sex discrimination encompasses protections for transgender people.[52] In addition, the NPRM cites Title VII case law to support its position but ignores the extensive, long-standing countervailing Title VII case law concluding that discrimination on the basis of gender identity *is* prohibited by Title VII.[53] This one-sided presentation is inaccurate at best and gives no indication that the Department has grappled with the existing case law as it is statutorily required to do, much less that its analysis is "reasonable."

There is even less excuse for this inaccurate legal presentation because HSS was on explicit notice about the case law, having been informed by advocacy organizations, including Lambda Legal, during their OMB meetings with the Department.[54] Equally concerning is the failure of the Department to address (and in some cases even to cite) the extensive countervailing appellate case law contradicting the Department's position that the 2016 Final Rule was "incorrect."[55] In addition to the Circuit Courts of Appeal that have held that employment discrimination against transgender people is a form of sex discrimination, three other

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injunction enjoining the Title IX student guidance protecting transgender students. *Texas v. United States*, 201 F. Supp. 3d 810 (N.D. Tex. 2016), order clarified, No. 7:16-CV-00054-O, 2016 WL 7852331 (N.D. Tex. Oct. 18, 2016).

[51] 84 FR 27855.

[52] *See*, *e.g.*, *Tovar v. Essentia Health*, 342 F. Supp. 3d 947 (D. Minn. 2018) (D. Minn. Sept. 20, 2018) (holding that a health care plan that excluded health services related to gender dysphoria discriminated against transgender people in violation of the Health Care Rights Law (Section 1557 of the Affordable Care Act), which prohibits discrimination in health care); *Boyden v. Conlin,* 341 F. Supp. 3d 979 (W.D. Wis. 2018) (holding that a state employee health plan refusal to cover transition-related care constitutes sex discrimination in violation of Title VII, Section 1557 of the ACA, and the Equal Protection Clause); *Flack v. Wisconsin Department of Health Services*, 18-cv-309, 2018 WL 3574875 (W.D. Wis. Jul. 25, 2018) (holding that Medicaid exclusion targeting transgender people constitutes sex discrimination under Affordable Care Act and Equal Protection Clause); *Prescott v. Rady Children's Hospital-San Diego*, 265 F. Supp. 3d 1090 (S.D. Cal. Sept. 27, 2017) (holding that discrimination against transgender patients violates the Affordable Care Act); *Cruz v. Zucker*, 195 F. Supp. 3d 554 (S.D.N.Y. 2016) (holding that an exclusion for transition related health care violates the Affordable Care Act); *Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (holding that discrimination against hospital patient based on his transgender status constitutes sex discrimination under Section 1557 of the Affordable Care Act).

[53] Federal District Court decisions holding that Title VII's prohibition against sex discrimination encompasses gender identity discrimination include, inter alia: *Boyden v. Conlin*, 341 F. Supp. 3d 979 (W.D. Wis. 2018); *Equal Employment Opportunity Comm'n v. A & E Tire, Inc.*, 325 F. Supp. 3d 1131 (D. Colo. 2018): *Parker v. Strawser Construction*, 307 F. Supp. 3d 744 (S.D. Ohio Apr. 25, 2018); *E.E.O.C. v. Rent-a-Center East, Inc.*, 264 F. Supp. 3d 952 (C.D. Ill. Sept. 8, 2017); *Mickens v. Gen. Elec. Co.*, No. 3:16CV-00603-JHM, 2016 WL 7015665 (W.D. Ky. Nov. 29, 2016); *Roberts v. Clark Cty. Sch. Dist.*, 215 F. Supp. 3d 1005 (D. Nev. 2016); *Fabian v. Hosp. of Cent. Conn.*, 172 F. Supp. 3d 509 (D. Conn. Mar. 18, 2016); *Doe v. State of Arizona*, No. CV-15-02399-PHX-DGC, 2016 WL 1089743 (D. Ariz. Mar. 21, 2016); *United States v. Se. Oklahoma State Univ.*, No. CIV-15-324-C, 2015 WL 4606079 (W.D. Okla. July 10, 2015); *Finkle v. Howard County.*, 12 F. Supp. 3d 780 (D. Md. 2014); *Schroer v. Billington*, 577 F. Supp. 2d 293 (D.D.C. Sept. 19, 2008); *Lopez v. River Oaks Imaging & Diagnostic Group. Inc.*, 542 F. Supp. 2d 653 (S.D. Tex. 2008); *Mitchell v. Axcan Scandipharm, Inc.*, No. CIV.A. 05-243, 2006 WL 456173 (W.D. Pa. Feb. 17, 2006); *Tronetti v. TLC HealthNet Lakeshore Hosp.*, No. 03-CV-0375E (SC), 2003 WL 22757935 (W.D.N.Y. Sept. 26, 2003).

[54] *See* EO 12866 Meetings for RIN 0945-AA11, *available at* https://www.reginfo.gov/public/do/eom12866SearchResults?pubId=201810&rin=0945-AA11&viewRule=true.

[55] *See, e.g., EEOC v. R.G. & G.R. Harris Funeral Homes, Inc.*, 884 F. 3d 560 (6th Cir. 2018); *Glenn v. Brumby*, 663 F.3d 1312 (11th Cir.2011); *Barnes v. City of Cincinnati*, 401 F.3d 729 (6th Cir. March 25, 2005); *Smith v. City of Salem*, 378 F. 3d 566 (6th Cir. Aug. 5, 2004).

federal circuit courts have held that statutes similar to Title VII prohibiting discrimination based on sex also encompass gender identity discrimination.[56]

Moreover, in addition to the five federal circuit courts of appeals and the dozens of district courts that have held that sex discrimination bans cover gender identity discrimination, all of which the Department unreasonably failed to acknowledge, the Department also failed to acknowledge the multiple E.E.O.C. decisions similarly holding that sex discrimination bans cover gender identity discrimination.[57] In sum, despite this nearly overwhelming body of federal case law concluding that Title VII and other federal statutes forbid gender identity discrimination because it is a form of sex discrimination, the Department rests almost entirely upon the lone *Franciscan Alliance* injunction and one circuit court decision, the reasoning of which has been superseded.[58]

The NPRM also fails entirely to provide any justification for its removal of sex-stereotyping as a form of sex discrimination, which also was included in the 2016 Final Rule.[59] In addition to gender identity discrimination being a form of sex discrimination because it is based on sex-based considerations, much of the case law holding that discrimination against LGBTQ people is a form of sex discrimination is based upon Supreme Court case law interpreting "sex" discrimination to include sex-stereotyping. The Department's proposal simply to eliminate that protection is obviously unreasonable. The 2016 Final Rule extensively surveyed and examined existing law and correctly concluded that gender stereotyping is a prohibited form of discrimination based upon Supreme Court and other case law precedent.[60] The Proposed Rule unreasonably ignores this precedent without discussion. This improper approach likely will invite some health providers to believe, mistakenly, that they are at liberty to turn patients away because they do not conform with traditional sex stereotypes and others' perceptions about their sex.

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[56] *Whitaker By Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ.*, 858 F.3d 1034 (7th Cir. 2017) (holding that Title IX's prohibition against sex discrimination encompasses discrimination against transgender people), *cert. dismissed sub nom. Kenosha Unified Sch. Dist. No. 1 Bd. of Educ. v. Whitaker ex rel. Whitaker*, 138 S. Ct. 1260415 (2018); *Rosa v. Park West Bank & Trust Co.*, 214 F.3d 213 (1st Cir. June 8, 2000) (holding that the Equal Credit Opportunity Act's prohibition against sex discrimination encompasses discrimination based on gender identity); *Schwenk v. Hartford*, 204 F.3d 1187 (9th Cir. Feb. 29, 2000) (holding that the Gender Motivated Violence Act's prohibition against gender discrimination encompasses gender identity discrimination).

[57] *See Lusardi v. Dep't of the Army*, EEOC Appeal No. 0120133395, 2015 WL 1607756 (April 1, 2015); *Complainant v. Dep't of Veterans Affairs*, EEOC Appeal No. 0120133123, 2014 WL 1653484 (Apr. 16, 2014); *Jameson v. U.S. Postal Service*, EEOC Appeal No. 0120130992, 2013 WL 2368729 (May 21, 2013); *Macy v. Dep't of Justice*, EEOC Appeal No. 0120120821, 2012 WL 1435995 (April 20, 2012).

[58] The Department cites *Etsitty v. Utah Transit. Auth.*, 502 F.2d 1215 (10th Cir. Sept. 20, 2007) as a case supporting its view, but *Etsitty* relied upon a Seventh Circuit decision (*Ulane v. Eastern Airlines, Inc.*, 742 F.2d 1081 (7th Cir. 1984) which has been superseded by the reasoning of *Whitaker v. Kensohsa Unified Sch. Dist. No. 1 Bd. Of Educ.*, 858 F.3d 1034, 1047 (7th Cir. 2017) (clarifying that *Ulane*'s reasoning "cannot and does not foreclose Ash and other transgender students from bringing sex-discrimination claims based upon a theory of sex stereotyping as articulated four years later by the Supreme Court…"); *see also*, *Smith v. Avanti*, 249 F. Supp. 3d 1194, 1200 (D. Colo. 2017) (clarifying that a sex discrimination claim based on gender stereotyping brought by a transgender litigant pursuant to the Fair Housing Act is cognizable in the Tenth Circuit under *Price Waterhouse*).

[59] 45 C.F.R. § 92.4.

[60] 81 FR 31387 ("OCR also believes that its inclusion of gender identity is well grounded in the law and disagrees with those commenters who argued to the contrary. As the Supreme Court made clear in *Price Waterhouse v. Hopkins*, in prohibiting sex discrimination, Congress intended to strike at the entire spectrum of discrimination against men and women resulting from sex stereotypes."); *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1989).

While an erasure of transgender people from Section 1557's protections would certainly send a message to health care providers that it is perfectly acceptable to discriminate against transgender patients, the NPRM is similarly dangerous (and incorrect) in proposing to send a message that it is acceptable to turn patients away because they do not conform with traditional gender stereotypes because they are lesbian, gay, or bisexual. As explained at length in Lambda Legal's prior comments,[61] lesbian, gay, bisexual and queer people already experience significant discrimination in health care. For example, seven percent of LGBQ people report having had a provider use abusive language when treating them and seven percent report experiencing unwanted physical contact from a provider, including fondling, sexual assault or rape.[62] In addition to applying sex-stereotyping analysis to the discrimination claims presented by transgender people, federal courts have also confirmed that sex-based considerations and sex-stereotyping protections also apply to sexual orientation discrimination, which similarly must be recognized as a form of unlawful sex discrimination.[63] The EEOC has also definitively interpreted Title VII to cover sexual orientation-related discrimination as sex discrimination prohibited both as an unavoidably sex-based consideration and as necessarily involving illicit sex stereotyping.[64]

Also, without discussion or analysis, the NPRM proposes to eliminate from the 2016 Final Rule the provision that prohibits a covered entity from discriminating against an individual based on those with whom they are known or believed to have a relationship or to be associated.[65] As with the inclusion of gender identity and sex-stereotype protections, this provision was grounded in an examination and understanding of the existing case law. For example, many courts have recognized an actionable race discrimination claim based on the race of an individual with whom the plaintiff is associated.[66] These cases

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[61] *See* note 1, *supra*.

[62] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, CTR. FOR AM. PROGRESS (Jan. 18, 2018), *available at* https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[63] *See Zarda v. Altitude Express, Inc.*, 883 F.3d 100, 123 (2d Cir. 2018), *cert. granted sub nom. Altitude Exp., Inc. v. Zarda*, 139 S. Ct. 1599 (2019); *Hively v. Ivy Tech Cmty. Coll. Of Indiana*, 853 F.3d 339 (7th Cir. 2017). Numerous district court decisions have also concluded that sexual orientation discrimination is forbidden sex discrimination. *See, e.g., Boutillier v. Hartford Pub. Schs.*, 2016 WL 6818348 (D. Conn. Nov. 17, 2016); *EEOC v. Scott Med. Health Ctr., P.C.*, 2016 WL 6569233 (W.D. Pa. Nov. 4, 2016); *Winstead v. Lafayette Cty., Bd. Of Cty. Comm'rs,* 197 F. Supp. 3d 1334 (N.D. Fla. 2016); *Videckis v. Pepperdine Univ.*, 150 F. Supp. 3d 1151 (C.D. Cal. 2015); *Isaacs v. Felder Servs., Inc.*, 143 F. Supp. 3d 1190 (M.D. Ala. 2015); *Hall v. BNSF Ry. Co.*, 2014 WL 4719007 (W.D. Wash. Sept. 22, 2014); *Terveer v. Billington*, 34 F. Supp. 3d 100 (D.D.C. 2014); *Koren v. Ohio Bell Tel Co.* 894 F. Supp. 2d 1032 (N.D. Ohio 2012); *Heller v. Columbia Edgewater Country Club*, 195 F. Supp. 2d 1212 (D. Or. 2002); *Centola v. Potter*, 183 F. Supp. 2d 403 (D. Mass. 2002).

[64] *See, e.g., Baldwin v. Foxx*, 2015 WL 4397641 (E.E.O.C. July 16, 2015); *Complainant v. Cordray*, 2014 WL 7398828 (E.E.O.C. Dec. 18, 2014); *Complainant v. Donahoe*, 2014 WL 6853897 (E.E.O.C. Nov. 18, 2014); *Complainant v. Sec'y, Dep't of Veterans Affairs*, 2014 WL 5511315 (E.E.O.C. Oct. 23, 2014); *Complainant v. Johnson*, 2014 WL 4407457 (E.E.O.C. Aug. 20, 2014); *Couch v. Dep't of Energy*, 2013 WL 4499198 (E.E.O.C. Aug. 13, 2013); *Brooker v. U.S. Postal Serv.*, 2011 WL 3555288 (E.E.O.C. May 20, 2013); *Castello v. U.S. Postal Serv.*, 2011 WL 3560150 (E.E.O.C. Dec. 20, 2011); *Veretto v. U.S. Postal Serv.*, 2011 WL 2663401 (E.E.O.C. July 11, 2011).

[65] 81 FR 31472 § 92.209: "A covered entity shall not exclude from participation in, deny the benefits of, or otherwise discriminate against an individual or entity in its health programs or activities on the basis of the race, color, national origin, sex, age, or disability of an individual with whom the individual or entity is known or believed to have a relationship or association."

[66] *E.g.*, *Floyd v. Amite County School Dist.*, 581 F.3d 244, 249 (5th Cir. 2009); *Holcomb v. Iona Coll.*, 521 F.3d 130, 138 (2d Cir. 2008); *McGinest v. GTE Service Corp.*, 360 F. 3d 1103, 1118 (9th Cir. 2004), cert. denied, 552 U.S. 1180 (2008); *Tetro v. Elliot Popham Pontiac, Oldsmobile, Buick & GMC Trucks Inc.*, 173 F.3d 988, 993–96 (6th Cir. 1999); *Parr v. Woodmen of the World Life Ins.*, 791 F.2d 888, 892 (11th Cir. 1986). A number of District Courts have reached similar conclusions when the discrimination was based on association

have recognized that protections apply to both discrimination based on an individual's protected status and discrimination based on a disfavored association involving protected status. This provision is consistent with existing law and should be retained along with the protections concerning gender identity, sex stereotypes and sexual orientation.

The NPRM also argues that that discrimination "because of sex" under Title IX does not include gender identity or sexual orientation discrimination based on a lack of congressional activity in this area. The NPRM asserts that Congress's inaction indicates a policy preference to preclude interpretations of federal law that would protect LGBTQ people from discrimination. This argument is logically specious. First, as former Justice Scalia clarified in a unanimous 1998 Supreme Court decision, although same-sex sexual harassment was not the issue Congress was concerned with when it enacted Title VII, "statutory prohibitions often go beyond the principal evil [they were enacted to combat] … and it is ultimately the provisions of our laws rather than the principal concerns of our legislators by which we are governed." Thus, the *Oncale* case concludes, Title VII's ban on sex discrimination encompasses same-sex sexual harassment.[67] Accordingly, Congressional inaction is irrelevant to whether anti-LGBTQ bias is covered by statutory protections. There are many reasons why legislation does not advance in Congress.[68] But as Justice Scalia explained, it is the words of the statutes that have been enacted, as they are logically understood, that govern absent congressional action to change those words.[69]

The NPRM notes that the Supreme Court will soon be deciding analogous questions in the context of Title VII to help justify the proposed elimination of protections for LGBTQ people, but the proposed action is premature at best.[70] The Supreme Court might well hold, consistently with the enormous and growing case

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with persons of a different national origin or sex. *E.g.*, *Montes v. Cicero Pub. Sch. Dist. No. 99*, 141 F. Supp. 3d 885,900 (N.D. Ill. 2015) (national origin); *Morales v. NYS Dep't of Labor*, 865 F. Supp. 2d 220, 242-43 (N.D.N.Y. 2012), aff'd summarily, 530 F. App'x 13 (2d Cir. 2013) (race and national origin); *Kauffman v. Maxim Healthcare Servs., Inc.*, No. 04-CV-2869, 2006 U.S. Dist. LEXIS 47514, 2006 WL 1983196, at *4 (E.D.N.Y. July 13, 2006) (sex and race); *Reiter v. Ctr. Consol. Sch. Dist. No. 26-JT*, 618 F. Supp. 1458, 1460 (D. Colo. 1985) (race and national origin). Courts have also recognized claims of associational discrimination under Section 504 of the Rehabilitation Act. *E.g.*, *Loeffler v. Staten Island Univ. Hosp.*, 582 F.3d 268, 277 (2d Cir. 2009); *Falls v. Prince George's Hosp. Ctr.*, No. Civ. A 97–1545, 1999 U.S. Dist. LEXIS 22551, 1999 WL 33485550 at * 11 (D. Md. Mar. 16, 1999).

[67] *Oncale v. Sundowner Offshore Servs.*, 523 U.S. 79-90, 75 (1998). *See also* Brief of Lambda Legal Defense and Education Fund, Inc. as Amicus Curiae in Support of the Employees, *Bostock v. Clayton County, Georgia*, Supreme Court No. 17-1618, and *Altitude Express, Inc. v. Zarda*, Supreme Court Case No. 17-1623, at page 31 (July 3, 2019), *available at* https://www.supremecourt.gov/DocketPDF/17/17-1618/107176/20190703170952032_190704%20for%20E-Filing.pdf.

[68] *See Solid Waste Agency of N. Cook Ct. v. U.S. Army Corps of Eng'rs*, 531 U.S. 159, 170 (2001) ("A bill can be proposed for any number of reasons, and it can be rejected for just as many others."); *Schroer v. Billington*, 577 F. Supp. 2d 293, 308 (D.D.C. 2008) ("However…another reasonable interpretation of that legislative non-history is that some Members of Congress believe that the *Ulane* court and others have interpreted "sex" in an unduly narrow manner, that Title VII means what it says, and that the statute requires, not amendment, but only correct interpretation. As the Supreme Court has explained, [S]ubsequent legislative history is a hazardous basis for inferring the intent of an earlier Congress. It is a particularly dangerous ground on which to rest an interpretation of a prior statute when it concerns, as it does here, a proposal that does not become law. Congressional inaction lacks persuasive significance because several equally tenable inferences may be drawn from such inaction, including the inference that the existing legislation already incorporated the offered change. *Pension Ben. Guar. Corp. v. LTV Corp.*, 496 U.S. 633, 650, 110 S.Ct. 2668, 110 L.Ed.2d 579 (1990) (internal citations and quotation marks omitted)).

[69] *See further discussion in* Brief of Lambda Legal Defense and Education Fund, Inc., *Bostock v. Clayton County, Georgia*; *Altitude Express v. Zarda*, *supra*, note 67.

[70] 84 FR 27874.

law establishing that discrimination based on gender identity or sexual orientation both are prohibited forms of sex discrimination under Title VII.[71] Even if the Department is confident that the Supreme Court will agree with their contrary reasoning with regard to how sex should be understood under Title VII, many courts have disagreed, as discussed above. Therefore, unless and until the Supreme Court agrees with the Department's view, it clearly would be premature for the Department to act in a manner contrary to the overwhelming body of current case law. Accordingly, we urge the Department immediately to rescind this NPRM and to wait until the Supreme Court has issued a decision. If warranted at that time, the Department can open up another notice and comment period. But for now, if the Proposed Rule is permitted to remain extant, it will only invite harmful discrimination against LGBTQ people (and particularly transgender people), place health care providers in legal jeopardy by falsely signaling to them that it is fine to discriminate, and prompt litigation by those who are injured.

In one especially troubling section of the NPRM, the Department asserts that it considered adding gender identity and sexual orientation discrimination to a definition of sex discrimination or discrimination "on the basis of sex" under Title IX, but concluded doing so was inappropriate (again without any legal analysis) and that state and local entities are better equipped to address issues of gender "dysphoria" and sexual orientation.[72] The NPRM then obliquely refers to potential privacy interests involving "young children" and intimate settings. The notion that health care protections for LGBTQ people are at odds with "young children" in some way is deeply offensive and tellingly reveals the animosity the Department harbors towards LGBTQ people.

The NPRM follows this offensive reference with an equally offensive footnote about cases discussing restrooms and other facilities[73] that is untethered to existing law and outside the scope of Section 1557. The cases cited had nothing to do with what facilities should be available to a patient in a health care setting given the patient's gender identity.[74] In addition, the Department fails once more to acknowledge significant countervailing authority holding that there is no cognizable legal claim for having to share a restroom or

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[71] Given the Department's reliance on the Supreme Court's current consideration of TVII's scope of coverage with respect to anti-LGBT discrimination, and the fact that extensive briefing on this issue has been filed very recently with the Supreme Court, the Department's failure to acknowledge the extent of the case law contrary to its interpretation is even more unreasonable, arbitrary and capricious.

[72] 84 FR 27874.

[73] 84 Fed. Reg. 27846, 27874 n.179 ("Policies of covered entities that result in unwelcome exposure to, or by, persons of the opposite biological sex where either party may be in a state of undress – such as in changing rooms, shared living quarters, showers, or other shared intimate facilities – may trigger hostile environment concerns under Title IX. *United States v. Virginia*, 518 U.S. 515, 550 n.19 (1996) ("Admitting women to [an all-male school] would undoubtedly require alterations necessary to afford members of each sex privacy from the other sex in living arrangements"); *Fortner v. Thomas*, 983 F.2d 1024, 1030 (11th Cir. 1993) ("[M]ost people have a special sense of privacy in their genitals, and involuntary exposure of them in the presence of people of the other sex may be especially demeaning or humiliating.").)

[74] The quote from *U.S. v. Virginia* simply noted that Virginia Military Institute would likely need to make accommodations to transition from an all-male school; *Fortner v. Thomas* involved the asserted rights of (presumably cisgender) male inmates not to have their naked bodies and intimate bodily functions intrusively and regularly exposed to (presumably cisgender) female correctional officers.

other single-sex facility with a transgender person.[75] For the Department to suggest otherwise is inconsistent with the rule of law and can hardly be considered a "reasonable" analysis.

We are a nation of laws. Discrimination against transgender people in health care is not only wrong, court after court has held that it is unlawful under the Affordable Care Act. This lawless Proposed Rule invites harm to patients, will spur litigation after that harm is inflicted, and will place health care providers in serious legal jeopardy by falsely signaling to them that it is fine to discriminate against LGBTQ people. We urge the Department immediately to rescind the NPRM.

III. The NPRM Impermissibly Seeks to Eliminate Sexual orientation and Gender Identity Protections in Unrelated Regulations.

The NPRM proposes to allow states and Marketplaces to be able to discriminate against LGBTQ people in all aspects of the Affordable Care Act (nondiscrimination, eligibility determinations, enrollment periods and more). The NPRM purports to allow insurance companies to employ discriminatory benefit designs that could inquire about an applicant's sexual orientation or gender identity and use that information for determining insurability. The NPRM seeks to amend a series of unrelated rules to conform with the NPRM. In other words, the NPRM seeks not only to erase existing protections for LGBTQ people within the 2016 Final Rule, which is consistent with Section 1557 as enacted by Congress, they also seek to eliminate existing protections for LGBTQ people in other regulations—nine of them to be exact.[76] But these rules were not promulgated by OCR and these amendments fall outside OCR's jurisdiction. Rather, they were all advanced by CMS and were promulgated pursuant to the authority granted by several different statutes,[77] including Section 1321(a) and other provisions of the ACA, the Social Security Act and other statutory authority, not Section 1557. As such, OCR lacks the authority to repeal those regulations. It is evident from reliable media reporting that the Department intends to eliminate legal protections for and essentially erase transgender people from federal law, not solely from Section 1557's protections.[78] HHS lacks the authority to do so.

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[75] *E.g., Doe v. Boyertown Area Sch. Dist.*, 897 F.3d 518, 526-36 (3d Cir. 2018), cert. denied, 139 S. Ct. 2636 (2019); *Whitaker v. Kenosha Unified Sch. Dist. No. 1 Bd. Of Educ.*, 858 F.3d 1034, 1052-1053 (7th Cir. 2017); *Parents for Privacy v. Dallas Sch. Dist. No. 2*, 326 F. Supp. 3d 1075 (D. Or. 2018); *Adams v. Sch. Bd. of St. Johns Cnty.*, 318 F. Supp. 3d 1293 (M.D. Fla. 2018).

[76] Statutory authority for C.F.R. 155.120(c)(1)(ii), 45 CFR 155.220(j)(2)(requirements of ACA-created health insurance exclusions) provided under: 42 U.S.C. 18021-18024, 18031-18033, 18041-18042, 18051, 18054, 18071, and 18081-18083; statutory authority for 45 C.F.R. 147.104(e) (guaranteed availability of coverage): 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92, as amended.; Statutory authority for 45 C.F.R.156.200(e) (QHP issuer participation standards): 42 U.S.C. 18021-18024, 18031-18032, 18041-18042, 18044, 18054, 18061, 18063, 18071, 18082, 26 U.S.C. 36B, and 31 U.S.C. 9701); Statutory authority for 42 C.F.R. 460.98(b)(3), 42 C.F.R. 460.112(a) (Programs of All-Inclusive Care for the Elderly): 42 U.S.C. 1302, 1395, 1395eee(f), and 1396u–4(f), 42 U.S.C. 1302, 1395, 1395eee(f), and 1396u–4(f). Part 460; Statutory authority for 42 C.F.R. 438.3(d)(4): 42 U.S.C. 1302; 42 C.F.R. 438.206(c)(2): 42 U.S.C. 1302; Statutory authority for 42 C.F.R. 440.262 (Standard Medicaid state plans and Medicaid contract requirements): Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

[77] The Affordable Care Act provided the statutory authority for CMS's promulgation of 45 C.F.R. 155.120(c)(1)(ii)(non-interference with Federal law and non-discrimination standards); 45 CFR 155.220(j)(2) (ability to States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs); and 45 CFR 156.200(e) (QHP issuer participation standards); 45 CFR 147.104(e) (guaranteed availability of coverage); 42 CFR 438.3(d)(4) (Standard contract requirements); 42 CFR 438.206(c)(2) (Availability of services); and 42 CFR 440.262 (Access and cultural considerations).

[78] Erica L. Green, Katie Benner and Robert Pear, *"Transgender' Could Be Defined Out of Existence Under the Trump Administration* (Oct. 21, 2018), *available at* https://www.nytimes.com/2018/10/21/us/politics/transgender-trump-administration-sex-definition.html

One especially pernicious consequence of proposing to amend these other regulations is that it would allow discrimination against LGBTQ people with regard to marketing or benefit design practices of health issuers under the ACA.[79] Over 133 million people in the U.S. live with at least one chronic condition[80] and over 61 million live with a disability. Before the ACA, people with chronic health conditions were often denied care or paid exorbitant prices for substandard care. The protections against discriminatory benefit design has been lifesaving for many LGBTQ people. The NPRM's proposals, by contrast, would make it more difficult for LGBTQ people to afford health care, contrary to Congress's intentions when enacting the ACA.

For example, the 2016 Final Rule's prohibition on discriminatory plan benefit designs helped LGBTQ people living with HIV get the medications they need. Due to systemic barriers to health care, LGBTQ people have a "higher prevalence and earlier onset of disabilities" and disproportionately experience chronic conditions,[81] including HIV.[82] HIV disproportionately affects gay, bisexual, and queer men of color and transgender women of color.[83] For example, more than 25 percent of Black and Brown transgender women are living with HIV,[84] and 60 percent (10,070) of Black or African American individuals who received an HIV diagnosis in 2017 were gay or bisexual men.[85] Further, 26 percent of gay men, 36 percent of bisexual women, 36 percent of lesbian women, 40 percent of bisexual men experience a form of disability.[86] Additionally, 28 percent of transgender, nonbinary, and gender nonconforming people experience a form of disability.[87] The Proposed Rule unreasonably and unjustifiably would disproportionately impact LGBTQ people, especially LGBTQ people of color living with disabilities and chronic conditions.

The NPRM's proposal to "update" other unrelated regulations to carve out protections for LGBTQ people is not consistent with, and in some cases is unrelated to, the Affordable Care Act and the 2016 Final Rule. The Department has failed provide any explanation or analysis concerning why it proposes to change these unrelated rules or the impact of such an action. There is extensive information to be considered because

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("The department argued in its memo that key government agencies needed to adopt an explicit and uniform definition of gender as determined 'on a biological basis that is clear, grounded in science, objective and administrable.' The agency's proposed definition would define sex as either male or female, unchangeable, and determined by the genitals that a person is born with, according to a draft reviewed by The Times. Any dispute about one's sex would have to be clarified using genetic testing.").

[79] The NPRM proposes to update 45 C.F.R. 147.104(e) as a "conforming amendment" in order to eliminate protections for LGBTQ people.

[80] *The Growing Crisis of Chronic Disease in the United States,* Partnership to Fight Chronic Disease, (last visited Aug. 13, 2019), *available at* https://www.fightchronicdisease.org/sites/default/files/docs/GrowingCrisisofChronicDiseaseintheUSfactsheet_81009.pdf.

[81] Intersecting Injustice: A National Call to Action 63 (Lourdes Ashely Hunter, Ashe McGovern & Carla Sutherland eds., 2018), *available at* http://socialjusticesexuality.com/intersecting_injustice/.

[82] *Id.* at 48.

[83] *Id.* at 64-64.

[84] *Id.*

[85] *HIV and African Americans*, Ctrs. for Disease Control & Prevention, *available at* https://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html (last updated March 19, 2019).

[86] Disabled World, *LGBT and Disability: Information, News and Fact Sheets*, *available at* https://www.disabled-world.com/disability/sexuality/lgbt/ (last updated Feb. 7, 2019).

[87] S.E. James, et al., Nat'l Ctr. for Transgender Equality, *Report Of The 2015 U.S. Transgender Survey* 247 (2016), *available at* https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

some of these regulations have been in place for over a decade. Still, the Department fails even to purport to address the impact these regulations have had or the impact that changing these regulations would have.

Because these proposed changes are outside of the OCR's jurisdiction and are insufficiently related to Section 1557, and because the Department offers no legal, policy or cost-benefit analysis about them and their likely impacts on various CMS programs, it is not appropriate for these rulemakings to be combined.

IV. The NPRM's Inclusion of the Title IX Religious Exemption is Not Appropriate in the Health Care Context and Conflicts with the Statutory Text of the ACA.

The 2016 Final Rule provides that covered entities do not have to comply with Section 1557 if having to do so would violate religious exemption laws, but it does not include a categorical Title IX-based religious exemption. The Department rejected the request to include that exemption in the 2016 Final Rule because existing federal law already protects religious beliefs in an appropriate manner.

In addition, the Department explained that the Title IX exemption would be inappropriate in the health care setting because it is framed for educational institutions, which are vastly different from health care settings and the differences "warrant different approaches."[88] The Title IX exemption allows an *educational institution* controlled by a religious organization not to violate its own tenets.[89] Thus, an exemption such as allowing religious schools to only allow men to become ministers serves an important educational and religious function core to those institutions' purpose, which is very different from the purpose served by institutions and insurers that receive federal funding to provide health care to patients or plan members who are members of the general public.

The 2016 Final Rule explains that the education context also is different from the health care context because, for example, while students or parents select schools as matter of choice, individuals needing health care often have limited or no choice, especially patients who live in rural areas or where religious institutions have taken over hospitals that serve people of diverse faiths and no faith.[90] Religiously affiliated hospitals take up a large and growing portion of the health care market.[91] The 2016 Final Rule also clarifies that, unlike the dynamics in educational settings, a blanket religious exemption could result in denial or delay of care or the discouragement of care with serious "life threatening results." [92]

In addition, the inclusion of a new religious exemption, either explicitly or by reference, is contrary to the statutory language in Section 1557, which does not include any exceptions and which incorporated its

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[88] 81 FR 31379-80

[89] 20 U.S. C. § 1681(a)(3); 34 C.F.R. § 106.12 (emphasis added).

[90] *Id.* at 31380

[91] *See* Michael Hiltzik, *UC's deal with Catholic Hospitals Threatens the Health of Women and LGBTQ Patients*, LA TIMES (Apr. 12, 2019), *available at* https://www.latimes.com/business/hiltzik/la-fi-hiltzik-uc-dignity-health-discrimination-20190412-story.html; Amy Littlefield, *Meet Another Religious Health System Restricting Reproductive Care* (Jan. 30, 2019) REWIRE.NEWS, *available at* https://rewire.news/article/2019/01/30/meet-another-religious-health-system-restricting-reproductive-health-care/.

[92] 81 FR 31380.

enforcement mechanisms without any such additional exemption.[93] Inserting the Title IX exemption by regulation, contrary to the statute's text, also would create an imbalance in enforcement because the other enforcement statutes (Title VI, the Age Discrimination Act, and Section 504 of the Rehabilitation Act) do not have such exemptions.

Moreover, as Lambda Legal has explained in our prior comments, inserting a new, blanket Title IX religious exemption to Section 1557's protection against sex discrimination likely would have far reaching and serious consequences for patients. It would invite new instances in which health care providers, including insurance companies, hospitals, doctors and nurses, wrongfully would allow their personal beliefs to determine patient care, contrary to medical standards and the current nondiscrimination rules. Also as we previously have explained, religious exemptions disproportionately harm LGBTQ people, who too often are refused health care because of their sexual orientation or gender identity. For example, 8 percent of LGBQ people were refused health care because of their sexual orientation.[94] Similarly, 29% of transgender people were denied care because of their gender identity.[95] When LGBTQ people are denied care, it becomes difficult (and impossible for many) to find another provider, especially for those who live in rural areas and for transgender people. According to a 2018 study, 18% of LGBTQ people said it would be impossible to find the same type of service in another hospital.[96] These rates are dramatically higher for people living outside a metropolitan area, where 41% of respondents stated that, if they were denied treatment, it would be very difficult if not impossible to find the same service at a different location.[97]

For example, in 2017 Lambda Legal filed a federal lawsuit against St. Joseph's Healthcare in Paterson, New Jersey, after the hospital refused to allow a surgeon to perform a medically-necessary hysterectomy for Jionni Conforti as part of his medically necessary treatment for gender dysphoria.[98] In addition to New Jersey's Law Against Discrimination, the case includes a claim under Section 1557 because the Affordable Care Act prohibits discrimination against transgender people as a form of sex discrimination, and publicly funded hospitals must not be permitted to interpose religious beliefs between doctor and patient.

The Proposed Rule's misguided plan to create a new religious exemption ignores Congress's text and is likely to encourage health care providers and institutions to believe religious beliefs are a legitimate basis to limit or deny health care in ways that constitute illegal discrimination. The proposed plan would both harm patients and place health care providers at risk of significant liability. It should be withdrawn.

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[93] 42 U.S.C. 18116(a).

[94] Shabab Ahmed Mirza and Caitlin Rooney, *Discrimination Prevents LGBTQ People From Accessing Health Care*, Center for American Progress (Jan. 18, 2018), *available at* https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[95] *Id.*

[96] *Id.*

[97] *Id.*

[98] *See* Complaint for Declaratory, Compensatory, and Injunctive Relief, *Conforti v. St. Josephs Healthcare System, Inc.*, Case No. 17-cv-0050 (D.N.J. January 5, 2017), *available at* https://www.lambdalegal.org/sites/default/files/conforti_nj_20170105_complaint.pdf.

V. The NPRM Improperly Limits the Scope of Application of Section 1557.

It is unclear whether the NPRM seeks to narrow the scope Section 1557 to only programs or activities administered by the Department under Title I, but to the extent that the Department so intends, such an interpretation would be inconsistent with the Affordable Care Act's statutory provisions. Such a narrowing of scope would improperly carve out other HHS programs administered by other agencies.[99] Such a dramatic limiting of scope would be contrary to the statutory requirements of Section 1557, which applies broadly to "any health program or activity, any part of which is receiving federal financial assistance," any program or activity that is administered by an executive agency," and "any entity established under this title."[100] A narrowing of scope also cannot be squared with the court decisions that have found that state Medicaid plans, and other health insurance plans, violate Section 1557's sex discrimination when they exclude coverage of medical procedures for transgender persons.[101] Accordingly the current regulatory provisions regarding Section 1557's applicability to health insurance, and to HHS-administered programs outside the scope of ACA Title I, should be left in place. It is evident that the statutory text of Section 1557 extends to health programs or activities receiving federal financial assistance, including programs not funded directly by HHS, but which are administered by and executive agency.

The NPRM also seeks to improperly limit the scope of Section 1557 with regard to health insurance companies. The NPRM achieves this by redefining "health program or activity" to import a requirement that the health program or activity at issue be "principally engaged in the business of providing health care."[102] The Department's novel argument imports this interpretation from the Civil Rights Restoration Act ("CRRA") in order to allow insurance companies to discriminate without fear of liability under Section 1557 because they are not "principally engaged in the business of providing health care."[103] This legally incorrect.

Congress enacted Section 1557 more than two decades after the CRRA was enacted, and it did so with the clear intent to impose nondiscrimination requirements broadly to any "health programs and activities" receiving federal financial assistance.[104] If Congress intended to limit the scope of liability, it could have easily done so. However, it chose not to include this provision. Furthermore, the CRRA did not address the question of whether health insurance is a "health program or activity."

The proposed narrowing of the scope of Section 1557's protections would allow insurance companies that have to comply with Section 1557 for the plans they sell on an exchange to offer a discriminatory plan in other parts of the insurer's business, such as the sale of non-ACA products or when serving as a third party

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[99] *E.g.*, programs administered by the Center for Disease Control and Prevention, the Indian Health Service, and the Substance Abuse and Mental Health Services Administration.

[100] 42 U.S.C. § 18116(a).

[101] *E.g.*, *Flack v. Wisconsin Department of Health Services*, 18-cv-309, 2018 WL 3574875 (W.D. Wis. Jul. 25, 2018) (holding that Medicaid exclusion targeting transgender people constitutes sex discrimination under Affordable Care Act and Equal Protection Clause).

[102] 84 92.3(a)(1), (b)-(c) ("[f]or purposes of this part, and entity principally or otherwise engaged in the business of providing health insurance shall not, by virtue of such provision, be considered to be principally engaged in the business of providing health care.")

[103] 84 FR 27850.

[104] 42 U.S.C. § 18116(a).

beneficiary for group health care plans. Non-ACA-compliant plans often discriminate against patients in various ways prohibited by Section 1557, and giving insurers license to discriminate in this way would defeat the text, context and purpose of Section 1557. The administration has sought to expand the availability of plans that lack consumer protections and the comprehensive design necessary to meet the needs of LGBQ people.[105] Many of these plans discriminate against transgender people and women by simply denying transition-related and reproductive care.[106] This aspect of the Proposed Rule thus is inconsistent with the ACA's text, congressional intent, and the statutory duty of HHS to act in furtherance of the health and well-being of all Americans.

VI. The ACA's Statutory Text Evinces a Clear Intent to Create a Single Legal Standard and Burden of Proof for Any Basis of Prohibited Discrimination Incorporated into Section 1557.

The NPRM repeals the enforcement mechanisms in the 2016 Final Rule and replaces them by limiting the enforcement mechanisms for each protected classification to those of the statute from which it was incorporated, namely those from Title VI, Title IX, the Age Discrimination Act, or Section 504 of the Rehabilitation Act respectively.[107] However, based on Congress's express mandate, Section 92.301 of the 2016 Final Rule clarified that *all* the mechanisms provided for by these statutes apply for purposes of Section 1557 enforcement. For one, Section 1557 creates a private right of action to address claims of discrimination on the basis of race, color, national origin, sex, age, or disability.[108] The ACA's statutory text makes evident that Congress did not intend to import multiple piecemeal legal standards from the multiple statutory contexts into a doctrinal crazy quilt, as the HHS now proposes in the NPRM.

Instead, Congress clearly intended to create a "singular standard, regardless of a plaintiff's protected class status."[109] First, "there is no indication that Congress limited the enforcement mechanisms to apply only to its own protected classes."[110] To the contrary, Congress specified that "[t]he enforcement mechanisms provided for and available under such title VI, title IX, section 504, ***or*** such Age Discrimination Act shall apply for purposes of violations of this subsection."[111] The use of the disjunctive "or" clarifies that the enforcement mechanisms applicable under any of the incorporated statutes are available to every claim of

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[105] Jennifer Kates et al, *Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender (LGBT) Individuals in the U.S.* (May 3, 2018) Kaiser Family Foundation, available at https://www.kff.org/report-section/health-and-access-to-care-and-coverage-lgbt-individuals-in-the-us-impact-of-changes-in-the-legal-and-policy-landscape-on-coverage-and-access-to-care/.

[106] *See* Karen Pollitz et al., *Understanding Short-Term Limited Duration Health Insurance, Kaiser Family Foundation* (Apr. 23, 2018), *available at* https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/.

[107] *See* Section 27850 and 27891.

[108] *See Callum v. CVS Health Corp.*, 137 F. Supp. 3d 817, 848 (D.S.C. 2015); *see also S.E. Pennsylvania Transp. Auth. V. Gilead Scis.*, Inc., 102 F. Supp. 3d 688, 698 (E.D. Pa. 2015); *Rumble v. Fairview Health Servs.*, No. 14-CV-2037, 2015 WL 1197415, at *7 n.3 (D. Minn. Mar. 16, 2015); *East v. Blue Cross & Blue Shield of Louisiana,* No. 3:14-CV-00115-BAJ, 2014 WL 8332136, at 2 (M.D. La. Feb. 24, 2014).

[109] See *Rumble*, 2015 WL 1197415, at *10.

[110] *See* Sarah G. Steege, *Finding A Cure in the Courts: A Private Right of Action for Disparate Impact in Health Care*, 16 Mich. J. Race & L. 439, 462 (2011).

[111] 42 U.S.C. § 18116(a) (emphasis added).

discrimination under Section 1557.[112] This is so regardless of the particular type of discrimination triggering the claim. Applying standard rules of statutory construction, all the enforcement mechanisms provided for and available under each of the generally incorporated statutes in Section 1557 are available to every claim of discrimination under Section 1557.

The creation of a single legal standard and burden of proof is also manifest in Congress's interest in avoiding absurd results. Allowing different mechanisms and standards depending on whether the plaintiff's claim is based on race, sex, age or disability discrimination would lead to absurd inconsistencies and would provide "no guidance about what standard to apply for a Section 1557 plaintiff bringing an intersectional discrimination claim."[113] It would be absurd to interpret Section 1557 to not allow people to file complaints of multiple forms of discrimination in one place. Section 1557 recognizes the reality that discrimination "may occur not solely because of the person's race or not solely because of the person's sexual orientation or gender identity, [disability status, or national origin], but because of the combination."[114] Thus, the law aimed to make it easier for people to file complaints of intersectional discrimination. If adopted as a final rule, the proposed changes would only make it harder for people to file reasonably efficient complaints and seek redress in a sensible manner for the discrimination they experience, as Congress has intended.

In addition, we urge the Department to clarify that it has not invented a notice and deliberate indifference standard for claims brought under Section 1557 for purposes of institutional liability. Doing so is appropriate given the text of the statute, and will encourage health care institutions to create grievance procedures and to take steps to discover, address and eliminate discrimination. Requiring health care consumers to identify and notify the official within a health care institution with the requisite authority to address the alleged discrimination would place an unreasonable burden upon them, contrary to the special vulnerability of patients and the goals of Section 1557. Courts have rejected the imposition of an actual notice and deliberate indifference standard under Title IX in cases involving retaliation claims, equal opportunity in athletic programs, employment discrimination and in the athletic programs context.[115] Given Congress's purposes when enacting the ACA, the same result is proper here.

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[112] "In its elementary sense, the word 'or,' as used in a statute, is a disjunctive particle indicating that the various members of the sentence are to be taken separately." 73 Am. Jur. 2d Statutes § 147; *see also United States v. Woods*, 134 S. Ct. 557, 567 (2013) ("ordinary use [of the word 'or'] is almost always disjunctive"); *In re Espy*, 80 F.3d 501, 505 (D.C. Cir. 1996) (per curiam) ("Canons of construction ordinarily suggest that terms connected by a disjunctive be given separate meanings and a statute written in the disjunctive is generally construed as setting out separate and distinct alternatives.") (internal citations and quotations omitted.

[113] *Rumble*, 2015 WL 1197415, at *11. "No rule of construction necessitates our acceptance of an interpretation resulting in patently absurd consequences." *United States v. Brown*, 333 U.S. 18, 27 (1948)."

[114] Brief for National LGBTQ Task Force as Amici Curiae Supporting Respondents, *Masterpiece Cakeshop v. Col. C.R. Comm'n*, 137 S.Ct. 2290 (2017), http://www.thetaskforce.org/wp-content/uploads/2017/10/16-111-bsac-LGBTQ-Task-Force.pdf.

[115] See *Jackson v. Birmingham Bd. Of Educ.*, 544 U.S. 167 (2005) (Supreme Court holding that no pre-litigation notice required in the retaliation context); *Pederson v. Louisiana State Univ.*, 213 F.3d 858 (5th Cir. 2000) (athletic programs); *Roberts v. Colo. State Bd. Of Agric.*, 998 F.2d 824, 832 (10th Cir. 1993) (courts have expressly held that Title VII, 42 U.S.C. § 2000e et seq., respondent superior standard is "the most appropriate analogue when defining Title IX's substantive standards" in the employment context).

VII. Notices of Nondiscrimination

Notices informing individuals that an entity cannot discriminate and what to do if they face discrimination, including how to file a complaint with OCR, are essential. The 2016 Final Rule requires covered entities with at least 15 employees to adopt a grievance procedure and designate at least one employee to coordinate its Section 1557 responsibilities.[116] The 2016 Final Rule also requires covered entities to provide notice of nondiscrimination policies in significant communications, in physical locations where the entity interacts with the public, and on the home page of their website. The notice of nondiscrimination must include information about the characteristics protected from discrimination under Section 1557, the availability of and how to access auxiliary aids and services, the availability of and how to access language assistance services, contact information for the designated employee coordinating the entity's Section 1557 responsibilities, the entity's grievance procedures, and complaint procedures for OCR. The Proposed Rule improperly attempts to eliminate these provisions entirely.

The NPRM also proposes to make it more difficult for people with Limited English Proficiency (LEP) to understand their health care rights under federal law by eliminating the requirements outlined in the final rule. As explained already, LGBTQ people experience significant health care disparities. These disparities are multiply compounded when a person is LEP, LGBTQ and a refugee or immigrant. Because of the persecution many LGBTQ people experience in their country of origin, many LGBTQ refugees and immigrants have had limited educational opportunities and often have limited English language facility, which in turn means additional, unwarranted barriers to appropriate health care.[117]

Because many individuals do not know about their rights, how to request language services, or how to file a complaint if they face discrimination, the 2016 Final Rule formulated standards to effectuate Congress's nondiscrimination intentions. By eliminating tagline requirements and notice standards, the Proposed Rule instead will undermine access to health care, health insurance, and legal redress for LGBTQ people and other vulnerable communities, contrary to the statute and without the analysis and evidentiary basis to support the proposed changes.

Moreover, without the regulatory requirements established in the 2016 Final Rule, patients are likely to be placed at risk for serious consequences with regard to privacy and confidentiality where access to language services in a confidential setting are essential in order for information about the patient's health status to be exchanged in a medically competent manner. The NPRM's proposed changes would make the requirement's scope significantly less clear and would cause confusion, discrimination and unjustified health consequences.

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[116] MaryBeth Musumeci et al., *HHS's Proposed Changes to Non-discrimination Regulations under ACA Section 1557*, Kaiser Family Foundation (Jul. 1, 2019), *available at* https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.

[117] Sharita Gruberg et al, *Serving LGBTQ Immigrants and Building Welcoming Communities* (Jan. 24, 2018), Center for American Progress, *available at* https://www.americanprogress.org/issues/lgbt/reports/2018/01/24/445308/serving-lgbtq-immigrants-building-welcoming-communities/.

VIII. Private Right of Action

The NPRM asserts that the Department will "no longer assert that a private right of action exists for parties to sue covered entities for any and all alleged violations of the proposed rule … leaving the matter as primarily one for the courts to decide."[118] But this interpretation flouts the will of Congress. When Congress enacted the ACA, including Section 1557, it knowingly and intentionally incorporated the four statutes, each of which provides for both a private right of action as well as compensatory damages. In addition, Congress enacted Section 1557 "against the backdrop of" Supreme Court precedents and regulations making clear that each of the statutes incorporated into Section 1557 provided for a private right of action and compensatory damages.[119] Accordingly, it is beyond clear that Congress intended that there be a private right of action for Section 1557 claims.

IX. Risk Impact Assessment

OCR estimates that 60% (3% of the overall increase) of the originally anticipated increase of 5% of long-term caseload would have been attributable to discrimination claims based on gender identity and sex stereotyping.[120] OCR further estimates that the removal of gender identity and sex stereotyping protection will result in a certain number of covered entities currently at risk of incurring grievance–related costs will no longer face such costs. This analysis is completely unreasonable. First, there is no clarity with regard to the actual number of complaints that have been filed and this cited information thus is highly speculative. Second, because the erasure of gender identity and sex stereotyping protections from the rule is inconsistent with the vast consensus of case law precedent, it will significantly compound the number of grievances and lawsuits as the rule begins to encourage more discrimination and harassment, causing more and more individuals to bring grievances.[121] Lastly, the NPRM fails to account for the human costs associated with LGBTQ people who will be inappropriately denied, discouraged and discriminated against in some cases, with serious health care consequences.

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[118] 84 FR 27883-84.

[119] See *McNely v. Ocala Star-Banner Corp.*, 99 F.3d 1068, 1076 (11th Cir. 1996). See *Callum*, 137 F. Supp. 3d at 847 ("Congress intended to create a private right and private remedy for violations of Section 1557 by expressly incorporating the enforcement provisions of the four federal civil rights statutes."; *SEPTA*, 102 F. Supp. 3d at 698; *Rumble*, 2015 WL 1197415, at *7 n.3; see also *Barnes v. Gorman*, 536 U.S. 181, 185 (2002) (finding that although neither Section 202 of the ADA nor Section 504 of the Rehabilitation Act explicitly provides for a private cause of action, they implicitly create one due to their cross-references to each other ant to Title VI of the Civil Rights Act of 1964).

[120] 84 FR 27883.

[121] *See*, e.g., *Tovar v. Essentia Health*, cv-16-100-DWF-LIB (D. Minn. Sept. 20, 2018) (holding that a health care plan that excluded health services related to gender dysphoria discriminated against transgender people in violation of the Health Care Rights Law (Section 1557 of the Affordable Care Act), which prohibits discrimination in health care); *Boyden v. Conlin*, No. 17-cv-264-WMC, 2018 (W.D. Wis. September 18, 2018) (holding that a state employee health plan refusal to cover transition-related care constitutes sex discrimination in violation of Title VII, Section 1557 of the ACA, and the Equal Protection Clause); *Flack v. Wisconsin Department of Health Services*, 18-cv-309, 2018 WL 3574875 (W.D. Wis. Jul. 25, 2018) (holding that Medicaid exclusion targeting transgender people constitutes sex discrimination under Affordable Care Act and Equal Protection Clause); *Prescott v. Rady Children's Hospital-San Diego*, 265 F. Supp. 3d 1090 (S.D. Cal. Sept. 27, 2017) (holding that discrimination against transgender patients violates the Affordable Care Act); *Rumble v. Fairview Health Servs.*, No. 14–cv–2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015) (holding that discrimination against hospital patient based on his transgender status constitutes sex discrimination under Section 1557 of the Affordable Care Act).

X. Conclusion

Although the NPRM cannot change the law, as interpreted by multiple courts already, it improperly signals to those who wish to discriminate that they are free to do so, promising direct harm to LGBTQ people, and especially transgender people. This lawless Proposed Rule will only spur both mistreatment of patients and resulting lawsuits, placing health care providers in legal jeopardy by falsely signaling to them that it is perfectly fine to discriminate contrary to established federal law. Similarly, all the Proposed Rule will do concerning insurers is to create confusion, foster discrimination against LGBTQ patients, and pointlessly expose insurers to costly lawsuits.

And yet one more serious impact the Proposed Rule will have if left extant for any substantial period – even if not finalized – is to discourage people from seeking the health care they need. Nearly half of the U.S. population already avoids medical appointments when they need them due to cost,[122] and many already avoid care because of fear of discrimination.[123] The combination of these factors, of course, falls hardest on those already marginalized, including people of color, people living with low incomes, and LGBTQ people.

For all the reasons stated above, HHS and CMS should not finalize the NPRM and should instead redirect their efforts to serving the explicit mission of the nation's health care agency by advancing health care access and equity for all. We urge the Department immediately to withdraw the NPRM.

Thank you for the opportunity to submit comments on the Proposed Rule. Please do not hesitate to contact Sasha Buchert at sbuchert@lambdalegal.org if further information would be of assistance.

Most respectfully,

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[122] Bruce Jaspen, *Poll: 44% of Americans Skip Doctor Visits Because of Cost*, Forbes (Mar. 26, 2018), *available at* https://www.forbes.com/sites/brucejapsen/2018/03/26/poll-44-of-americans-skip-doctor-visits-due-to-cost/#5feab6ff6f57.

[123] *See, e.g.,* S.E. James, et al., Nat'l Ctr. for Transgender Equality, Report Of The 2015 U.S. Transgender Survey 96-98 (2016), *available at* https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

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August 13, 2019

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Roger Severino
Director
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U.S. Department of Health and Human Services
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Re: Nondiscrimination in Health and Health Education Programs or Activities (Section 1557 NPRM), HHS-OCR-2019-0007, RIN 0945-AA11

Dear Secretary Azar and Mr. Severino,

On behalf of The Leadership Conference Education Fund, I write in response to the notice of proposed rulemaking (NPRM) on Section 1557 of the Patient Protection and Affordable Care Act (ACA) ("Health Care Rights Law" or "Section 1557") that promotes discrimination in health care. The Leadership Conference Education Fund (Education Fund) is the research and education arm of The Leadership Conference on Civil and Human Rights, a coalition charged by its diverse membership of more than 200 national organizations to promote and protect the civil and human rights of all persons in the United States. The Health Care Rights Law is a major civil rights law and our members have advocated for its full and complete implementation since its enactment in 2010. The Education Fund strongly opposes any rollbacks of civil and human rights and is therefore deeply concerned by the harmful and discriminatory changes suggested by the U.S Department of Health and Human Services (HHS) in this proposed rulemaking.

Health care is a human right. Every person in our nation should be able to safely access health care without fear of discrimination, harassment, or persecution. Since it took effect on March 23, 2010, the Health Care Rights Law has prohibited discrimination on the basis of race, color, national origin (including language access), sex, age, or disability in health programs or activities that receive federal financial assistance or are administered by an executive agency or any entity established under Title I of the ACA.[1] Section 1557 is the key nondiscrimination provision of the ACA, and builds upon existing civil rights laws[2] to ensure that everyone in America has access to quality, affordable health insurance coverage and

[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010); 42 U.S.C. § 18116.

[2] Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.), Title VII of the Civil Rights Act of 1964 (42 U.S.C. § 2000e et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), Section 794 of Title 29, or the Age Discrimination Act of 1975 [42 U.S.C. § 6101 et seq.].

health care. The Health Care Rights Law is also the first federal law to ban sex discrimination in health care. Significantly, Section 1557 recognizes that individuals have complex identities and may be part of multiple protected classes and face discrimination because they belong to one or more of these classes.

During the previous administration, HHS undertook an extensive process to develop thoughtful regulations for the Health Care Rights Law. This included a Request for Information, a proposed rulemaking, as well as a final rule.[3] In addition, the Office of Civil Rights (OCR) at HHS engaged in robust outreach and education efforts with individuals, community organizations, and providers regarding their rights and responsibilities under Section 1557. HHS considered more than 24,875 public comments submitted for the 2016 rule.[4]

On May 29, 2019, OCR announced its proposal to eliminate key provisions of Section 1557 of the ACA. This new proposed rule promulgated by HHS ignores the reasoned process HHS previously undertook. If implemented, this civil rights rollback would harm millions of people in America by allowing health care providers to deny care to marginalized communities and worsen already existing health disparities in our country. The proposed rule would encourage discrimination against and eliminate/limit protections for individuals who are part of the LGBTQ community, people with limited English proficiency, women, and people with disabilities, exacerbating the barriers to coverage and discrimination in health care that these communities already face within our health care system today. Section 1557 addresses not only protections for each protected class covered, but the intersection of those protections. Therefore, an attack on the civil rights of one group in the NPRM is an attack on the civil rights of all.

The Leadership Conference Education Fund strongly recommends that HHS not finalize or implement the NPRM on Section 1557 regulations as well as the other conforming provisions. HHS should instead leave the 2016 final Section 1557 regulations in place in their entirety. Below is feedback on numerous portions of the proposed rulemaking.

I. The Proposed Rulemaking Would Impermissibly Limit the Scope of Applicability of Section 1557, Violating the Intent of the ACA

HHS seeks to significantly narrow the scope and applicability of Section 1557 in its proposed rulemaking, contradicting the plain meaning of the statute. In its 2016 Final Rule, HHS highlighted the purposes of the ACA and how Section 1557's protections are inextricably linked to broader ACA coverage requirements and other protections: "a fundamental purpose of the ACA is to ensure that health services are available broadly on a nondiscriminatory basis to individuals throughout the country."[5] This interpretation is consistent with the Supreme Court's recognition of the broader purpose of the ACA to "expand insurance coverage. . . . [and] ensure that anyone can buy insurance."[6]

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[3] U.S. Department of Health & Human Services, *Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities*, 78 Fed. Reg. 46558 (Aug. 1, 2013); U.S. Department of Health & Human Services, *Nondiscrimination in Health Programs and Activities* (Notice of Proposed Rulemaking), 80 Fed. Reg. 54172 (Sept. 8, 2015); U.S. Department of Health & Human Services, *Nondiscrimination on the Basis of Race, Color, National Origin, Sex, Age, or Disability in Health Programs or Activities Receiving Federal Financial Assistance and Health Programs or Activities Administered by the Department of Health and Human Services or Entities Established under Title I of the Patient Protection and Affordable Care Act*, 45 C.F.R. Part 92, 81 Fed. Reg. 31376 (May 18, 2016) (hereinafter "2016 Final Rule").

[4] 2016 Final Rule.

[5] 2016 Final Rule.

[6] *King v. Burwell*, 135 S. Ct. 2480, 2493 (2015).

The current regulations state that if an entity is principally engaged in providing or administering health services or health insurance coverage, all of its activities are covered by Section 1557 if any part receives federal financial assistance (FFA).[7] Covered entities under the Health Care Rights Law include hospitals, clinics, and health care providers' offices and issuers selling health insurance plans within and outside of the ACA Marketplaces.[8] The proposed rule would limit the scope of entities covered under Section 1557. The NPRM suggests eliminating the current definition of FFA under the Health Care Rights Law and instead would narrowly construe what entities qualify as a recipient of FFA, defying the purpose behind the ACA.

HHS also proposes to exempt itself and other federal programs and agencies from the nondiscrimination requirements of Section 1557. Both the plain language of Section 1557 and the 2016 Final Rule established that any health "program or activity" administered by an Executive agency is subject to the law's provisions.[9] HHS now argues that Congress wanted to limit application of the Health Care Rights Law only to federal health programs or activities created under Title I of the ACA. If implemented, this regulatory scheme would not only lead to more discrimination, it would also lead to the absurd result of recipients of FFA being subject to Section 1557, but the programs themselves, and the agencies administering them, would be exempt.

Finally, the NPRM seeks to exempt a broad array of health insurance companies from the non-discrimination provisions of Section 1557, claiming in the proposed rule that "'Health insurance' is distinct from 'health care.'"[10] The proposed rule contends that health insurance is not a health program or activity within the meaning of the Health Care Rights Law. This is inconsistent with the plain meaning of the statute and would undercut application of the non-discrimination provision of the ACA through regulation.

II. The Proposed Rule Attempts to Limit Enforcement Mechanisms and Remedies under Section 1557

When Congress passed the ACA, it included remedies for discrimination under Section 1557. Every court that has ruled on the question has found that the statutory language of Section 1557 confers a private right of action for monetary damages. The statutory language of Section 1557 explicitly references and incorporates the "enforcement mechanisms" of the four civil rights laws listed, all of which include a private right of action. Congress specified that "[t]he enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection."[11] HHS proposes to remove the regulatory language that makes clear that a private right of action and monetary damages are available to redress violations of the Health Care Rights Law. It would also eliminate the regulation that makes money damages available to those who are harmed when Section 1557 is violated. The civil rights community strongly opposes this proposal.

[7] 45 C.F.R. § 92.4.
[8] 42 U.S.C. § 18116(a); 45 C.F.R. §§ 92.2(a), 92.4.
[9] 42 U.S.C. § 18116 (a); 42 C.F.R. §§ 92.1, 92.2, 92.4.
[10] 84 Fed. Reg. 27846 (Pg. 27862).
[11] 42 U.S.C. § 18116(a).

HHS also proposes to delete in its entirety a rule of interpretation for Section 1557. The current provision makes clear that the four pre-existing civil rights laws referenced by Section 1557 (as noted above) set the floor for protections within Section 1557. This is consistent with Congressional intent that Section 1557 build and expand upon these existing civil rights laws while providing broad protection against discrimination in health care. Deleting the rule of interpretation will cause confusion and this proposal should not be finalized.

Finally, the current regulation states that covered entities with at least 15 employees must adopt a grievance procedure. The proposed rulemaking would eliminate the entirety of the existing Health Care Rights Law nondiscrimination notice and grievance procedure requirements, leading to more discrimination in health care and undermining the goals of the ACA.

III. If Implemented, the Proposed Rule Will Harm LGBTQ Individuals

The proposed rule attempts to eliminate anti-discrimination protections for the LGBTQ community, putting the lives of millions of people in this country at risk. The changes would remove sexual orientation, gender identity, and sex stereotyping as recognized forms of discrimination under the ACA. To be clear, the changes proposed in this rulemaking would not alter the statutory protections of Section 1557—federal courts could continue to apply Section 1557 more broadly. However, the proposed regulations would significantly narrow OCR's enforcement of the Health Care Rights Law, encouraging discrimination against LGBTQ people in the health care system.

Although the law itself has not changed, the proposed rule would increase confusion for a community that already avoids medical treatment for fear of mistreatment. It would remove vital protections against the threats of discrimination that have become a defining aspect for too many members of the LGBTQ community when they engage with the health care system. The rule would discourage people from speaking out if they experience discrimination, eliminating the opportunity for any clear recourse against those who deny people essential care simply due to a patient's gender identity or sexual orientation.

The proposed rule would allow health coverage plans to discriminate against LGBTQ individuals and deny coverage for gender-affirming care for transgender individuals. A 2018 report by Human Rights Watch shows that LGBT individuals are already twice as likely to be uninsured as non-LGBT individuals.[12] According to the U.S. Transgender Survey, the uninsured rate for transgender individuals is higher than the rate for the overall population.[13] Fourteen percent of transgender respondents were uninsured, compared to 11 percent of adults in the U.S. population.[14] Transgender adults are also more likely to be uninsured and socioeconomically disadvantaged compared to cisgender adults.[15]

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[12] Thoreson, Ryan. "'You Don't Want Second Best': Anti-LGBT Discrimination in US Health Care." *Human Rights Watch.* July 2018. Pg. 5. https://www.hrw.org/sites/default/files/report_pdf/us_lgbt0718_web.pdf.

[13] James, Sandy E.; Herman, Jody L.; Rankin, Susan; Keisling, Mara; Mottet, Lisa; and Anafi, Ma'ayan. "The Report of the 2015 U.S. Transgender Survey." *National Center for Transgender Equality.* December 2016. Pg. 94. https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[14] Id.

[15] Gonzales, Gilbert and Henning-Smith, Carrie. "Barriers to Care Among Transgender and Gender Nonconforming Adults." *The Milibank Quarterly: A Multidisciplinary Journal of Population Health and Health Policy.* December 11, 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5723709/.

The Leadership Conference Education Fund

The rule would have particularly harmful effects on the lives of transgender people. According to The Williams Institute, there are 4 million transgender adults and 150,000 transgender teens ages 13 to 17 in the United States who would no longer be protected against gender identity discrimination in health care if this rule is finalized.[16] Transgender individuals face widespread discrimination when seeking coverage for gender-affirming care. Twenty-five percent of respondents experienced a problem with their insurance in the past year related to their being transgender, including being denied coverage for care related to gender transition.[17] Twenty-five percent of those who sought coverage for hormones in the past year were denied, and 55 percent of those who sought coverage for transition-related surgery in the past year were denied coverage.

The proposed rule not only removes gender identity from the definition of sex discrimination, but it also erases sections of the existing regulations that prohibit insurance companies from excluding gender-affirming care as a covered service. According to the American Medical Association, "every major medical association in the United States recognizes the medical necessity of transition-related care for improving the physical and mental health of transgender people and has called for health insurance coverage for treatment of gender dysphoria."[18]

The changes that result from this proposed rule could have devastating consequences for the mental health of transgender individuals. According to a 2016 study published in *Transgender Health*, many transgender people experience psychological distress related to the discrepancy between their birth sex and their gender identity.[19] In some cases, these individuals experience psychological distress at such an extreme level that they experience a clinically significant condition called gender dysphoria. According to the American Psychiatric Association, gender dysphoria is associated with high levels of stigmatization, discrimination, and victimization, which contributes to transgender people's negative self-image and increased rates of other mental disorders.[20] A 2019 study on the psychological benefits of hormones and surgeries that align transgender people's outward appearance with their gender identities showed that gender-affirming medical treatments are associated with improved psychological wellbeing, such as higher life satisfaction and lessened gender dysphoria.[21]

According to a joint study by the American Foundation for Suicide Prevention and The Williams Institute, 41 percent of transgender respondents had attempted suicide at some point in their lifetime.[22]

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[16] "HHS aims to roll back non-discrimination protections for more than 1.5 million transgender people." *The Williams Institute.* April 28, 2019. https://williamsinstitute.law.ucla.edu/press/hhs-rules-conscience-and-1557/.
[17] Id.
[18] "Health insurance coverage for gender-affirming care of transgender patients." *American Medical Association.* 2019. Pg. 1. https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf.
[19] Hughto, Jaclyn M. White and Reisner, Sari L. "A Systematic Review of the Effects of Hormone Therapy on Psychological Functioning and Quality of Life in Transgender Individuals." *Transgender Health.* Jan. 1, 2016. https://www.liebertpub.com/doi/pdf/10.1089/trgh.2015.0008.
[20] "What Is Gender Dysphoria?" *American Psychiatric Association.* https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria.
[21] Cai, Xiang, Hughton, Jaclyn M. W., Reisner, Sari L., Pachankis, John E, and Levy, Becca R. "Benefit of Gender-Affirming Medical Treatment for Transgender Elders: Later-Life Alignment of Mind and Body." *LGBT Health.* January 16, 2019. https://doi.org/10.1089/lgbt.2017.0262.
[22] Haas, Ann P., Rodgers, Philip L., and Herman, Jody L. "Suicide Attempts among Transgender and Gender Non-Conforming Adults: Findings of the National Transgender Discrimination Survey." *American Foundation for Suicide Prevention, the*

The Leadership Conference Education Fund

Sixty percent of those who had attempted suicide had been refused treatment by a doctor or health care provider. Transgender individuals are at a higher risk of victimization and hate crimes than the general public, children with gender dysphoria are at a higher risk of emotional and behavioral problems, and adolescents and adults with gender dysphoria are at an increased risk for suicide.

More than half of all respondents to a 2010 Lambda Legal survey of LGBTQ people and people living with HIV said that they experienced some type of discrimination in health care, whether this involved health care professionals refusing to touch them or using excessive precautions, health care professionals using harsh or abusive language, being blamed for their health status, or health care professionals being physically rough or abusive.[23] According to a 2017 study by the Center for American Progress, eight percent of lesbian, gay, and bisexual respondents reported that a health care provider refused to see them outright because of their sexual orientation or gender identity in the past year.[24] The proposed rule does not recognize these forms of discrimination that many LGB individuals face as sex discrimination.

Without protections from discrimination, many transgender people avoid going to the doctor when they need medical care. According to the National Center for Transgender Equality's 2015 U.S. Transgender Study, 23 percent of respondents did not see a doctor in the past year when they needed to because they believed they would be mistreated.[25] Thirty-three percent of respondents reported having at least one negative experience with a health care provider in the past year based on their gender identity.[26] Twenty-nine percent of transgender respondents reported that a healthcare provider refused to see them in the past year because of their sexual orientation or gender identity.[27]

LGBTQ people of color in particular would face increased barriers to care if this rule were finalized. According to the Lambda Legal survey, LGBTQ respondents of color and low-income respondents in nearly every category surveyed experienced higher rates of discrimination and substandard care compared to white LGBTQ respondents.[28] People of color living with HIV and LGB people of color were also at least twice as likely as white people to report experiencing physically rough or abusive treatment by medical professionals.[29]

Williams Institute. January 2014. https://williamsinstitute.law.ucla.edu/wp-content/uploads/AFSP-Williams-Suicide-Report-Final.pdf.

[23] Tillery, Beverly. "When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV." *Lambda Legal.* 2010. https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf.

[24] Mirza, Shabab Ahmed and Rooney, Caitlin. "Discrimination Prevents LGBTQ People from Accessing Health Care." *Center for American Progress.* 2017. https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[25] James, Sandy E.; Herman, Jody L.; Rankin, Susan; Keisling, Mara; Mottet, Lisa; and Anafi, Ma'ayan. "The Report of the 2015 U.S. Transgender Survey." *National Center for Transgender Equality.* December 2016. https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.

[26] Id.

[27] Mirza, Shabab Ahmed and Rooney, Caitlin. "Discrimination Prevents LGBTQ People from Accessing Health Care." *Center for American Progress.* 2017. https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[28] Tillery, Beverly. "When Health Care Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV." 2010. Pg. 11. https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf.

[29] Id.

LGBTQ individuals already face pervasive discrimination and are refused coverage and care due to their gender identity, sexual orientation, and sex stereotyping. The rule would worsen the inequities that already exist, while giving health care providers and insurance plans a free pass to discriminate.

IV. The Proposed Rule Will Undermine the Rights of Individuals with Limited English Proficiency

Due to language barriers, individuals with limited English proficiency (LEP) can face challenges in accessing health care. LEP individuals often do not understand crucial information about their care and may be unfamiliar with the American health care system. And often, the health care providers serving LEP individuals do not understand the full details of their patients' health care concerns. And the stakes are high—a 2010 study commissioned by the National Health Law Program found that patients lost their lives and suffered irreparable harm due to language barriers and the failure to provide appropriate language services.[30] Protections for language access are also required in order to combat discrimination based upon national origin.

With this background in mind, the current regulations for Section 1557 include specific requirements to ensure that covered entities understand their obligations to ensure meaningful access for LEP individuals and also have clear instructions on how to comply with those obligations. Under the Health Care Rights Law, health care entities must notify individuals that they do not discriminate on the bases prohibited by Section 1557, inform them that appropriate language assistance services are available without charge and in a timely manner, and include information about how to file a complaint should these individuals face discrimination. A covered entity must also include taglines in the top 15 non-English languages in the entity's state. The proposed rule would eliminate these notice and taglines requirements, creating barriers to care for LEP individuals and leaving them without the transparency they need about their health insurance and health care services.

Widespread lack of access to comprehensive and accurate information for LEP individuals leads to worse health outcomes. In 2017, 25.9 million people in the United States identified as LEP.[31] According to an article published in the AMA Journal of Ethics, patients who are LEP experience high rates of medical errors with worse clinical outcomes than English-proficient patients, and they receive lower quality care.[32] Compared to English-speaking patients, LEP patients have longer hospital stays when professional interpreters were not used at admissions and/or discharge.[33] LEP individuals face a greater risk of infections, surgical delays due to difficulty understanding how to prepare for a procedure, and a greater chance of readmission for certain chronic conditions when they are unclear on how to manage their conditions and take medications.[34] A 2009 study in the official journal of the American Academy of

[30] Quan, Kelvin and Lynch, Jessica. "The High Costs of Language Barriers in Medical Malpractice." *University of California, Berkley School of Public Health and National Health Law Program.* https://healthlaw.org/resource/the-high-costs-of-language-barriers-in-medical-malpractice/.
[31] Rodriguez, Carmen Heredia. "Non-English Speakers Face Health Setback If Trump Loosens Language Rules." *Kaiser Health News.* June 24, 2019. https://khn.org/news/foreign-language-health-notices-non-english-speakers-trump-administration-rules/.
[32] Green, Alexander R. and Nze, Chihioke. "Language-Based Inequity in Health Care: Who Is the 'Poor Historian'?" *AMA Journal of Ethics.* March 2017. Pg. 263. https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-05/medu1-1703.pdf.
[33] "Overcoming the challenges of providing care to LEP patients." *The Joint Commission.* May 2015. Pg. 1. https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_13_May_2015_EMBARGOED_5_27_15.pdf.
[34] Id.

Pediatrics showed that Spanish-speaking patients whose families have a language barrier have a significantly increased risk for serious medical error during pediatric hospitalization compared with patients whose families do not have a language barrier.[35]

The lack of adequate care that LEP patients receive is not only the result of insufficient language assistance services and resources. A 2009 article in the Journal of General Internal Medicine found that physicians underuse interpreters despite the evidence of benefits and immediate availability of these services.[36] The proposed rule would misguidedly leave it to the discretion of individual providers to determine whether or not patients receive the language assistance services that allow these individuals to make informed decisions about their own health care.

The proposed rule fails to provide a sound rationale for overturning the 2016 final rule's approach around language access. Instead, HHS now suggests that eliminating these provisions will reduce costs and that the alleged benefit of overturning these provisions would "far outweigh any costs of burdens." This is a misguided approach, because it fails to adequately capture the immeasurable benefits of language access, including increased access and participation from underserved communities, improved health outcomes, and compliance with anti-discrimination laws. The cost-benefit analysis also fails to account for the costs to a consumer (as well as their family) when they are denied or delayed language assistance and their health suffers.

If implemented, the rule would encourage the very discrimination that Section 1557 was designed to prevent. The proposed rule would set a standard in this country that those who do not speak English fluently should not have access to quality health care.

V. The Proposed Rule Attempts to Reduce Access to Reproductive Health Care and Adopt a Blanket Religious Exemption

The administration's proposed rule would dramatically reduce access to reproductive healthcare for millions of women, particularly low-income women and women of color who already face barriers to care. Section 1557 was the first federal statute to bar discrimination on the basis of sex in federally funded health care and health coverage, and its protections have been critical in ensuring equal access to health benefits by both men and women. The law has been used to address, for example, exclusions of maternity coverage from the benefits provided to certain female plan participants. Treating pregnancy differently, such as by excluding pregnancy care from an otherwise comprehensive insurance plan, is sex discrimination under civil rights laws such as Title IX and Title VII, and also sex discrimination under Section 1557.[37]

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[35] A.L. Cohen. "Are language barriers associated with serious medical events in hospitalized pediatric patients?" *Pediatrics.* September 2005. https://www.ncbi.nlm.nih.gov/pubmed/16140695.

[36] Diamond, Lisa C.; Schenker, Yael; Curry, Leslie; Bradley, Elizabeth H.; and Fernandez, Alicia. "Getting By: Underuse of Interpreters by Resident Physicians." *Journal of General Internal Medicine.* Dec. 17, 2008. https://link.springer.com/article/10.1007%2Fs11606-008-0875-7.

[37] See, e.g., "NWLC Section 1557 Complaint: Sex Discrimination Complaints Against Five Institutions." *National Women's Law Center*. http://www.nwlc.org/resource/nwlc-section-1557-complaint-sex-discrimination-complaints-against-five-institutions. (Section 1557 complaints filed against five institutions that exclude pregnancy coverage for plan beneficiaries who are dependent children of employees at institutions).

HHS proposes to eliminate the definition of sex-based discrimination, which includes discrimination on the basis of pregnancy, false pregnancy, or termination of pregnancy. The proposed rule would permit health care providers, pharmacies, and insurance companies to cite personal or religious beliefs as a reason to deny care or coverage to a patient because of their sex or gender, limiting patients' access to reproductive health care. As the Kaiser Family Foundation noted in its analysis of the NPRM, "HHS proposes allowing health care providers and other covered entities to invoke blanket abortion and religious objection exemptions from the regulations' general prohibition on sex discrimination."[38] The rule would explicitly allow providers to refuse to perform an abortion and allow insurance companies to refuse to provide coverage for abortions. HHS suggests inappropriately incorporating abortion and religious exemptions included in Title IX, provider conscience provisions including the Religious Freedom Restoration Act, the Weldon Amendment, the Coats-Snow Amendment, and the Church Amendments, as well as several appropriations riders (including the Hyde and Helms Amendments) into Section 1557 through the NPRM.[39] These statutes and legislative riders were not referenced in the ACA and it is impermissible to add them via regulation.

The rule's proposed religious exemption would also allow health care providers and insurance companies to refuse care and coverage to LGBTQ individuals on religious grounds. This discrimination is not limited to gender-affirming care for transgender individuals – allowing health care entities to use religion as a reason to discriminate will result in LGBTQ individuals being denied necessary and life-saving treatment.

VI. The Rulemaking Seeks Comment on Proposals that Would Harm Access to Health Care for People with Disabilities

The NPRM seeks comment on a number of proposals that if adopted would also negatively impact people with disabilities, weakening standards for accessibility in health care facilities and eliminating provisions regarding benefit design discrimination.

The current rule requires covered entities to provide appropriate auxiliary aids and services to people with impaired sensory, manual, or speaking skills. The proposed rule seeks comment on whether to propose an exemption from the auxiliary aids and services requirement for covered entities with fewer than 15 employees. An exemption for an entity with fewer than 15 employees would roll back the civil rights of people with disabilities. If these requirements were removed, certain health care entities would no longer be required to provide people who are deaf, hard of hearing, blind, or visually impaired with services that are necessary for them to receive the care that they need. Data shows that people with disabilities often obtain their health care from specialists or local providers with few employees—this is particularly true in rural areas. The American Medical Association's Physician Practice Benchmark Survey in the period from 2012-16 found that a majority of physicians continue to work in small practices, with 57.8 percent in practices of 10 or fewer physicians, and 37.9 percent working in practices with fewer than 5 physicians in

[38] Musumeci, MaryBeth; Kates, Jennifer; Dawson, Lindsey; Salganicoff, Alina; Sobel, Laurie; and Artiga, Samantha. "HHS's Proposed Changes to Non-Discrimination Regulations Under ACA Section 1557." *Henry J. Kaiser Family Foundation*. July 1, 2019. Pg. 4. https://www.kff.org/disparities-policy/issue-brief/hhss-proposed-changes-to-non-discrimination-regulations-under-aca-section-1557/.

[39] Keith, Katie. "HHS Proposes To Strip Gender Identity, Language Access Protections From ACA Anti-Discrimination Rule." May 25, 2019. *Health Affairs.* https://www.healthaffairs.org/do/10.1377/hblog20190525.831858/full/.

2016.[40] Creating this exemption would therefore have a wide effect, harming the ability of people with disabilities to access care.

The current rule requires covered entities to make reasonable modifications in policies, practices, and procedures to avoid disability-based discrimination, unless doing so would fundamentally alter the nature of the health program or activity. The proposed rule seeks comment on whether this language should be revised, and whether health care entities can be exempted from abiding by this provision if it would impose undue hardship.

OCR also seeks comments on whether HHS should change certain accessibility standards. The rule asks about removing requirements for building construction and architectural standards. While the current rule adopts the 2010 ADA Standards for Accessible Design for entities that receive federal funding, the proposed rule seeks comment on whether these standards should be applied at all. The removal of these standards could permit health care entities to fail to have elevators, accessible entrances, accessible restrooms, or text telephones (TTYs) —which allow people who are deaf, hard of hearing, or have speech impairment to use the telephone by typing and reading text—among other crucial standards that allow people with disabilities equal access to care.[41]

VII. The Proposed Rule Would Eliminate the Prohibition on Discriminating Based on Association

Under the 2016 Final Rule, discrimination on the basis of association with a protected class is expressly prohibited.[42] The proposed rulemaking seeks to eliminate this provision, offering no explanation for doing so.

The current regulations note that the statute does not limit "the prohibition to discrimination based on the individual's own race, color, national origin, age, disability or sex." Further, we noted that a prohibition on associational discrimination is consistent with longstanding interpretations of existing antidiscrimination laws, whether the basis of discrimination is a characteristic of the harmed individual or an individual who is associated with the harmed individual."[43]

The language contained in the current regulation mirrors the language of Title I and Title III of the Americans with Disabilities Act (ADA), which protect against discrimination based on association or relationship with a person with a disability.[44] Congress intended that the Health Care Rights law provide at least the same protections for patients and provider entities. The current regulation recognizes that this

[40] Cane, Carol K. " Policy Research Perspectives: Updated Data on Physician Practice Arrangements: Physician Ownership Drops Below 50 Percent." *American Medical Association.* 2017. Pgs. 4-5. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/health-policy/PRP-2016-physician-benchmark-survey.pdf. The Benchmark surveys are of practicing physicians who provide a minimum of 20 hours of patient care/week in one of the 50 states or the District of Columbia, and who are not employed by the federal government.
[41] "Guidance on the 2010 ADA Standards for Accessible Design." *Department of Justice.* Sep. 15, 2010. https://www.ada.gov/regs2010/2010ADAStandards/Guidance_2010ADAStandards.pdf.
[42] 45 C.F.R. § 92.209.
[43] 81 Fed. Reg. 31439.
[44] 42 U.S.C. §§ 12112, 12182 (2012).

The Leadership Conference Education Fund

protection extends to providers and caregivers, who are at risk of associational discrimination due to their professional relationships with patients, including those patient classes protected under Section 1557.[45]

Congress intended the Health Care Rights Law to protect against discrimination by association, and these provisions should be retained.

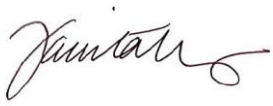
VIII. Conclusion

If implemented in whole, the proposed rulemaking would sow discrimination back into the health care system. The proposals suggested by HHS would result in a system where a health care provider could refuse care to someone because of their sexual orientation or transgender identity, someone who does not speak English could be denied information that is critical to their health and well-being, and a woman could face discrimination in receiving care after a miscarriage or ectopic pregnancy. It is also important to acknowledge that individuals may face discrimination due to multiple factors, and individual experiences often do not fit neatly into the categories outlined above.

The Leadership Conference Education Fund strongly encourages the administration not to finalize this rule. Rather than promoting discrimination in health care, HHS should be working to ensure robust implementation and enforcement of Section 1557 of the ACA throughout the health care system.

Thank you for the opportunity to submit The Education Fund's comments on this proposal. If you have any questions, please contact Emily Chatterjee at chatterjee@civilrights.org.

Sincerely,



Vanita Gupta
President and CEO
The Leadership Conference on Civil and Human Rights

[45] 28 C.F.R. pt. 35, app. B (2015) (interpreting Title I and Title III of the ADA to protect "health care providers, employees of social service agencies, and others who provide professional services to persons with disabilities").

LENOX HILL NEIGHBORHOOD HOUSE

August 13, 2019

U.S. Department of Health and Human Services
Office for Civil Rights
Hubert H. Humphrey Building, Room 509F,
200 Independence Avenue SW,
Washington, DC 20201

Re: HHS Docket No HHS-OCR-2019-0007, RIN 0945-AA11 Comments in Response to Proposed rulemaking: Nondiscrimination in Health and Health Education Programs or Activities

To Whom It May Concern:

We write in opposition to the Department of Health and Human Services ("HHS") proposed rule change regarding section 1557 ("the proposed rule") of the Patient Protection and Affordable Care Act ("PPACA") because it removes critical nondiscrimination protections for gender minorities, people with Limited English Proficiency ("LEP"), older adults, and people with disabilities when they access health care.[i]

Lenox Hill Neighborhood House ("the Neighborhood House") was founded in 1894 as a free kindergarten for immigrant children. We serve 15,000 low-income individuals annually through a wide array of effective and integrated services – social, educational, legal, housing, health, mental health, nutrition, and fitness. The Neighborhood House's clients, who range in age from 3 to 103, represent the full diversity of New York City. Our clients include ten thousand older adults, thousands of working poor individuals and families, and hundreds of homeless and formerly homeless adults living with mental illness. A significant portion of our clients are people with LEP, people with disabilities, women, and people who identify as LGBTQ. Representative of the communities we serve, our staff also represent the full diversity of our city. The entire Neighborhood House community would be adversely impacted by these proposed rules: the clients we enroll as Navigators through the New York State of Health Marketplace; the older adults we counsel on Original Medicare, Medicare Advantage, and Medicare prescription drug plans; the homebound older adults we assist to receive home health care services; the older adults attending our social adult day program for Alzheimer's and dementia; the families of our Head Start program who we help to receive medical care; the adults engaged in our English as a Second Language courses; and our employees who are enrolled in health insurance. On behalf of our clients, our staff, and our community, we oppose the proposed rule in its entirety.

Section 1557

When the PPACA was passed on March 23, 2010, it included section 1557 as an intersectional nondiscrimination framework rooted in longstanding civil rights statutes prohibiting discrimination on the basis of: "race, color, or national origin," under title VI of the Civil Rights Act of 1964;[ii] sex, under title IX of the Education Amendments of 1972;[iii] age, under the Age Discrimination Act of 1975;[iv] and disability, under section 504 of the Rehabilitation Act of 1973.[v] Section 1557 is applicable to "any health program or activity, any part of which is receiving Federal financial assistance," and specifically included insurers and navigators of federal and state-based marketplaces created by the PPACA.[vi] As the proposed rule would apply to Medicaid, student health plans, insurers receiving tax credits, health programs administered by HHS, and marketplace insureds, it would be estimated to cover approximately "900,000 physicians, 133,343 facilities (such as hospitals and nursing homes), 445,657 clinical laboratories; 1,300 community health centers; 40 health professional training programs; Medicaid and public health agencies in each state and the territories; and at least 180 insurers."[vii] Pursuant to PPACA, in May of 2016, HHS finalized regulations to implement section 1557 based on significant public input and comment. We oppose the proposed changes to the current regulations because they would remove critical nondiscrimination, notice and enforcement, and scope of application provisions that were promulgated based on extensive public information and comment.

The Proposed Rule Will Permit Discrimination Based on Sex, National Origin, Disability, Health, and Insurance Coverage

Sex Discrimination

We oppose the proposed changes to the definition of sex and expanding religious protections of providers as they will result in poor health outcomes for millions of women and gender minorities. Specifically, the proposed rule:

- removes the entire existing definition of sex discrimination, which "includes, but is not limited to, discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity;"[viii]
- replaces gender, sexual orientation, or gender identity with sex across Medicaid programs, including Medicaid managed care plans, state Medicaid administration, and PACE plans; group and individual health insurance markets; and Marketplaces, including Marketplace establishment standards, Federal Marketplace standards of conduct, QHP participation standards, and Federal Marketplace enrollment;
- rescinds specific examples of discrimination on the basis of sex from the regulation, including requirements that a covered entity: treat individuals consistent with their gender identity;[ix] cannot deny, cancel, limit, or refuse to issue or renew a health-related plan, policy, coverage, or claim, or impose additional cost sharing or other limitations or restrictions on coverage to transgender people; cannot have categorical exclusions for gender transition-related medical services or deny services otherwise covered for other individuals simply because someone does not identify with their sex assigned at birth; [x]
- expands on the existing protection in the rules to not provide reproductive health care if there is a religious or conscientious objection, to limit any requirement that would "violate, depart from, or contradict definitions, exemptions, affirmative rights, or protections provided by any of the[se] statutes [ ] . . . or any related, successor, or similar Federal laws or regulations, such application shall not be imposed or required;"[xi]

- adds a provision permitting covered entities from being required to pay for an abortion; and
- removes the provision that prohibits discrimination on the basis of sex with regard to rules of appearance (e.g., dress code, uniform, make-up, or grooming).

The proposed changes would permit organizations to deny access to a hysterectomy, breast reconstruction, or access to family planning based on sex, which is clearly discrimination on the basis of sex.[xii] If enacted, these regulations will deny critical access to insurance and care which will result in poor health outcomes[xiii] and higher costs for the health system.[xiv] The proposed rule threatens the health outcomes of the over 74 million women of reproductive age and 1.4 million adults in the United States that identify as transgender.[xv] Beyond the obvious discrimination of permitting the denial of certain medical treatments used by women and people who identify as transgender, the proposed rule will have effects that reach farther than health care costs. This gap in access represents an increased chance of experiencing economic instability, housing instability, lower educational attainment, and lack of family support.[xvi]

The proposed rule permits denials or lack of payment for certain reproductive health procedures or based on gender incongruence, which flies in the face of preexisting condition exclusions made impermissible under the PPACA.[xvii] Moreover, for government to decide, against standard medical practice and significant medical science, who is a woman, who must and cannot be a woman, what it looks like to be a woman, and what can and cannot be done to the body of a woman, is discrimination on the basis of sex. It is also a gross overstep of government in what should be private health care decisions between a competent provider and a patient.

The Neighborhood House serves a large proportion of people who would be adversely affected by this proposed rule. Through the New York State of Health Marketplace, the Neighborhood House has enrolled 781 women from 2017 to present, all these women will have less access to necessary medical care under the proposed rule on the basis of sex. Additionally, the Neighborhood House has enrolled several transgender clients in health insurance who may no longer be able to obtain insurance or necessary medical care under the proposed rule on the basis of sex. For example, Ms. S is a young transgender woman who works in the retail industry and earns the minimum wage. She requested our immediate assistance with applying for health benefits because she was turning 26 and was no longer able to stay on her mother's insurance. Ms. S depends on hormone therapy and with our enrollment assistance, she was able to continue her drug treatment without lapse. The legal protections currently in place against sex discrimination ensure women like Ms. S have access to care and protections against benefit exclusions. Thus, on behalf of Ms. S, the hundreds of women and transgender clients the Neighborhood House has enrolled in health insurance through New York State of Health Marketplace, and 74 million women of reproductive age and 1.4 million adults in the United States that identify as transgender, we oppose the proposed rules regarding changes to sex, reproductive health care, and transgender health care services.

National Origin Discrimination

We oppose the proposed changes to the regulations requiring access to interpretation services, the quality of interpretation services, the notice of language services, and the enforcement of covered entities which will severely diminish individuals with LEP rights and autonomy regarding medical treatment. Specifically, the proposed rule would:

- change the requirement for covered entities from "take reasonable steps to provide meaningful access to each individual with limited English proficiency ("LEP") eligible to be served or likely encountered"[xviii] to take reasonable steps to ensure meaningful access by individuals with LEP;
- alter the criteria of evaluating a covered entity's provision of meaningful access to health services for individuals with LEP from the two-part test, considering the importance of the health activity and the steps taken by the provider, to a four-part test that will consider the number or proportion of individuals with LEP, frequency of individuals with LEP at health program or activity, the nature and importance of the health program or activity, and the resources available to the entity and costs;
- permit the entity to determine whether language assistance services are required rather than require covered entities to use qualified oral interpretation services when that is reasonable step for providing meaningful access and a qualified translator when translating written communications;
- remove video remote interpreting standard and require only audio remote interpreting; and
- rescind the requirement for covered entities to provide nondiscrimination notices and include taglines in the top 15 language spoken by individuals with LEP which include availability of language assistance services.

Through the proposed changes, individuals with LEP will not be able to enroll in health insurance, understand their benefits, accurately describe their symptoms and medical history to providers, understand their treatment options, or provide informed consent for necessary medical care. This will lead to misdiagnoses, improper treatment, and lack of treatment adherence, which will result in increased incidences of morbidity and mortality for individuals with LEP. Individuals with LEP represent a significant portion of the U.S. population. For instance, in 2013, approximately 25.1 million people in the U.S., both born in the U.S. and abroad, were considered Limited English Proficient (LEP).[xix] In addition to harming millions of individuals with LEP across the U.S., many of whom are U.S. citizens, this rule will perpetuate and exacerbate existing disparities in health care caused by discrimination based on language, race, and national origin.[xx]

The Neighborhood House serves a large proportion of individuals with LEP across all of our programs and departments. Based on our experience we are very familiar with how lack of access to appropriate language services can adversely impact health care. For example, Ms. D could not continue working a few weeks ago after being diagnosed with stage 4 thyroid cancer. Ms. D is a native Spanish speaker and had difficulty enrolling in health care on her own because of LEP. If Ms. D was not able to enroll in health insurance through a navigator who speaks Spanish, her cancer would continue to progress while she did not receive treatment while being uninsured. Further, if upon enrollment, Ms. D did not receive insurance information in Spanish, or at minimum a tagline providing information to her in Spanish, she could not understand her benefits. Moreover, if Ms. D was not able to communicate adequately with her providers, she could not provide accurate information or informed consent for her treatments which would result in improper treatment and lack of treatment adherence. A discriminatory exclusion based on LEP would delay Ms. D's treatment and result in increased likelihood of Ms. D's suffering avoidable health complications or preventable death due to lack of adequate interpretation of written and oral materials from her provider and insurance company. Ms. D's daughter could be

an orphan if her mother is locked out of coverage or provided substandard medical care due to insufficient interpretation services. Thus, on behalf of Ms. D, the 575 clients with LEP we have enrolled in health insurance through the New York State Marketplace since 2017, and the 25.1 million people in the U.S. with LEP, we oppose the proposed rule changes that will change interpretation requirements for people with LEP.

Disability Discrimination

We oppose the proposed changes to the regulations requiring auxiliary aids and services, compliance with the Americans with Disabilities Act ("ADA"), and reasonable modifications which will severely diminish individuals with disabilities rights and ability to access medical programs and activities. Specifically, the proposed rule seeks comment on the following:

- exempting entities with 15 employees or less from the requirement to provide appropriate auxiliary aids and services to people with impaired sensory, manual or speaking skills, where necessary to afford an equal opportunity to benefit from the health program or activity;
- whether it is appropriate to apply the 2010 ADA standards of public building and or facility to all covered entities, especially regarding multi-story building elevators and TTY standards; and
- changing the requirement from "a covered entity shall make reasonable modifications to policies, practices, or procedures when such modifications are necessary to avoid discrimination on the basis of disability, unless the covered entity can demonstrate that making the modifications would fundamentally alter the nature of the health program or activity"[xxi] to "shall make reasonable accommodations to known physical or mental limitations of otherwise qualified people with disabilities."

Through the proposed changes, individuals with disabilities and older adults will not be able to enroll in health insurance, understand their benefits, accurately describe their symptoms and medical history to providers, understand their treatment options, provide informed consent for necessary medical care, or access medical treatment due to lack of auxiliary aids and structural barriers. This will lead to misdiagnoses, improper treatment, lack of treatment adherence, and treatment avoidance and delays in necessary medical care, which will result in increased incidences of morbidity and mortality for individuals with disabilities and older adults. There are almost 40 million United States residents, almost 13% of the population, who have a disability.[xxii] Moreover, this rule will perpetuate and exacerbate existing disparities in health care caused by discrimination based on disability and age.[xxiii]

The Neighborhood House serves a large portion of individuals with disabilities and older adults and these changes would be very harmful to them in their access of health programs and activities. Since 2017, we have assisted a total of 331 clients on 472 matters who are over aged 65 or with a disability with access to medical care and public benefits. For example, Ms. J is an older adult who is homebound. Ms. J suffered a severe stroke many decades ago and has left side paralysis which impacts her ability to communicate and her mobility. She has no family and very limited social support network. Ms. J also suffers from anxiety and depression. For all her medical conditions, Ms. J requires ongoing treatment from her doctors. It is imperative that she has health insurance and access to proper medical services to manage her health. With the proposed changes, without auxiliary aids, Ms. J would struggle to schedule medical

appointments and communicate with providers about her physical and mental health symptoms. Further, Ms. J would not be able to access providers who do not have an elevator or do not make other reasonable accommodations. The increased difficulty Ms. J would face access medical facilities and services would cause her health to deteriorate. Thus, on behalf of Ms. J, the hundreds of older adults we help with health insurance and the thousands of older adults we serve in our senior centers, geriatric care management, and other programs, and the 40 million people in the U.S. with a disability, we oppose the proposed rule changes regarding people with disabilities and their access to medical care and accommodations.

The Proposed Rule Will Restrict Rights of Notice and Enforcement

We oppose the proposed changes that limit the notice requirements and ability of individuals to enforce discrimination available under section 1557. Specifically, the proposed rule:

- removes the requirement that covered entities with at least 15 people must adopt a grievance procedure;
- eliminates the requirement to provide notice of nondiscrimination policies;
- rescinds the potential for compensatory damages under administrative and judicial actions brought under the regulations; and
- eliminates the right of private individual to sue in federal court for violations of section 1557

The proposed rule will restrict individual rights which are fundamental to Due Process. Without sufficient notice and enforcement provisions, the ability of individuals to understand or enforce their rights is severely diminished. Further, this reduces the financial disincentive on providers who engage in discriminatory practices and will thereby increase the level of discrimination toward individuals. As the Neighborhood House programs have evolved over the past 125 years to serve the full diversity of New York City and its intersectional communities, we were encouraged by PPACA section 1557's acknowledgement that an intersectional framework for nondiscrimination was necessary.

At the Neighborhood House, we frequently represent clients with lack or inadequate notice issues and this change would exacerbate their problems enforcing their rights. For example, Ms. A suddenly lost her health insurance. After numerous calls, we learned that her benefits were discontinued because she was found ineligible based on her age. The notices that she received did not clearly communicate the reason for the discontinuance or Ms. A's rights. We were able to retroactively reinstate Ms. A's benefits because Ms. A remained eligible for coverage and Ms. A's right to adequate notice. Without our assistance, Ms. A would be uninsured and unable to access her medications, which she relies on as a breast cancer survivor because she did not understand she had rights to challenge the decision because of the inadequate notice she received. Under the proposed changes, people will experience more denials and discontinuances similar to Ms. A's discountenance of coverage but will not have proper recourse to challenge the decisions. Thus, on behalf of Ms. A and the millions of Americans whose Due Process rights are threatened by this proposed change, we oppose the restrictions on notice and enforcement as they would diminish Due Process rights and a critical intersectional nondiscrimination framework.

The Proposed Rule Will Change the Scope of Application
We oppose the proposed changes that change the scope of application for who can be subject to discrimination and which entities are covered. Specifically, the proposed rule:

- removes the protection from discrimination based on association
- changes from health programs and activities that receive federal financial assistance to entities principally engaged in the business of providing health care that receive federal financial assistance and would only apply to the extent that those programs receive federal financial assistance

The proposed rule not only seeks to narrow the nondiscrimination protections, it also seeks to expand who can be discriminated against with the proposed changes. Under the proposed changes spouses of people seeking abortions, parents of transgender children, families with LEP family members, and others can be denied based on their association. Further, certain entities will not be required to abide by nondiscrimination in their practices under this proposed rule.

The Neighborhood House has served many clients who could face discrimination by association as a caregiver relative, parent, sibling, child, spouse, etc. For example, a family with a child, who is a U.S. Citizen, that attends school at our Early Childhood Center have another young daughter, who is also a U.S. Citizen, is on a wait list to receive a new kidney. The parents are not proficient in English and rely on the assistance of our social workers and health care advocates to access vital social programs and health insurance for their children. The parents, although not U.S. Citizens, have status through. The child has undergone multiple surgeries and treatments because of organ failure and bone displacement as a result of her condition. The parents of the two little girls would be devastated if their children can no longer have access to care based on their LEP. On behalf of this family, and everyone else who might be subject to discrimination by association with their loved ones, we oppose this proposed rule.

The Proposed Rule is Motivated by Discriminatory Animus
The proposed rule changes are allegedly made on the basis rule clarity, overstep, cost savings, etc. However, they are part of a clear pattern by this administration to attack women and other gender minorities, immigrants, racial minorities, people with disabilities, etc.[xxiv] As we have watched this administration's misogynistic responses to everything from sexual assault and reproductive health care, denial of transgender people's access to spaces, vilification and dehumanization of immigrants, repudiation toward racial minorities, and humiliation of people with disabilities, the premise for these proposed changes are very clear, they are motivated by discriminatory animus. The proposed rule, by virtue of being sexist, racist, transphobic, xenophobic, and ableist, is deeply discriminatory and runs counter to the goal of the PPACA to expand health coverage to more people in the country. While this Administration has unsuccessfully sought to overturn the PPACA several times, this attempt to slowly deconstruct the PPACA by attacking women and other gender minorities, immigrants, racial minorities, and people with disabilities, should not be permitted.

Conclusion
The Neighborhood House, in solidarity with other community-based organizations, opposes the proposed rule. Rather than stripping away the coverage and protections of section 1557, HHS should work to expand health care access and services to vulnerable populations by enforcing section 1557 as intended by Congress and the significant public input on the current regulations.

Sincerely,

Alexandra Brandes

Alexandra Brandes, Esq., MPH
Policy and Advocacy Manager

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[i] "Regulations.Gov - Proposed rule Document," accessed July 9, 2019, https://www.regulations.gov/document?D=HHS-OCR-2019-0007-0001.
[ii] 42 USC 2000d
[iii] 20 USC 1681
[iv] 42 USC 6101
[v] 29 USC 794
[vi] 42 USCS § 18116
[vii] https://www.healthaffairs.org/do/10.1377/hblog20190525.831858/full/
[viii] 42 CFR 92.4
[ix] 45 CFR § 92.206
[x] 45 CFR § 92.207
[xi] https://www.federalregister.gov/documents/2019/06/14/2019-11512/nondiscrimination-in-health-and-health-education-programs-or-activities
[xii] 2014 publicly funded family planning prevented: 2.2M unintended pregnancies, 1.1m unplanned births, 761,000 abortions, 164,000 preterm/low-birth-weight births, 99,000 chlamydia infections, 16,000 gonorrhea infections, 410 HIV infections, 1,130 ectopic pregnancies, 2,210 infertility cases, 3,680 cervical cancer cases, 2,100 cervical cancer deaths. This investment resulted in $13.6 billion in savings, a return of $7.09 for every public dollar spent. $7 billion of this was a direct result of Title X supported centers. - "U.S. Family Planning Effort Improves Women's Health," Guttmacher Institute, October 14, 2014, https://www.guttmacher.org/news-release/2014/us-family-planning-effort-improves-womens-health. A recent Kaiser Family Foundation survey also noted the following as it relates to Women's health care and insurance coverage - "Since the Affordable Care Act (ACA) went into effect, there has been a sharp drop in the uninsured rate among women, along with major increases in Medicaid and private insurance coverage. In 2013, the Kaiser women's health survey found nearly one in five non-elderly women were uninsured. By 2017, this had dropped to one in ten. Just as before the ACA, uninsured rates are higher among subgroups of women, particularly those who are low-income and Latina," "Roughly one in four (26%) women and one in five (19%) men have had to delay or forego care in the past year due to cost," Half (49%) of uninsured women went without or delayed care because of the costs. Almost as many postponed preventive services (47%) and 42% skipped a recommended medical test or treatment. One in three uninsured women did not fill a prescription and/or skipped or cut pills, and roughly one in six (16%) reported they experienced problems obtaining mental health care because of cost." Published: Mar 13 and 2018, "Women's Coverage, Access, and Affordability: Key Findings from the 2017 Kaiser Women's Health Survey," The Henry J. Kaiser Family Foundation (blog), March 13, 2018, https://www.kff.org/womens-health-policy/issue-brief/womens-coverage-access-and-affordability-key-findings-from-the-2017-kaiser-womens-health-survey/.
[xiii] S.E. James et al., "The Report of the 2015 U.S. Transgender Survey" (Washington, DC: National Center for Transgender Equality, December 2016), 3, https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf.
[xiv] William V. Padula, PhD MS MSc, Shiona Heru, JD, and Jonathan D. Campbell, PhD, "Societal Implications of Health Insurance Coverage for Medically Necessary Services in the U.S. Transgender Population: A Cost-Effectiveness Analysis," *Society of General Internal Medicine*, October 19, 2015, https://doi.org/10.1007/s11606-015-3529-6.
[xv] U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, Andrew R. Flores et al., "How Many Adults Identify as Transgender in the United States?" (University of California Los Angeles School of Law: The

Williams Institute, June 2016), 4. In New York City there are currently estimated to be over 2.2 million Women of Reproductive Age. - U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates, and in New York State there are estimated to be 78,600 people who Identify as transgender, with an estimated 50,000 residing in New York City - Andrew R. Flores et al., "How Many Adults Identify as Transgender in the United States?" (University of California Los Angeles School of Law: The Williams Institute, June 2016), 4, "Elmhurst Vigil Remembers Transgender Victims Lost to Violence and Hate," QNS.com, accessed August 6, 2019, https://qns.com/story/2016/11/27/elmhurst-vigil-remembers-transgender-victims-lost-to-violence-and-hate/.

[xvi] James et al., "The Report of the 2015 U.S. Transgender Survey," 125.

[xvii] 45 CFR § 147.108

[xviii] 45 CFR § 92.201

[xix] https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states

[xx] Hyung Chol Yoo, Gilbert C. Gee, and David Takeuchi, "Discrimination and Health among Asian American Immigrants: Disentangling Racial from Language Discrimination," *Social Science & Medicine* 68 (December 18, 2008): 726. . There is a 14% gap in health insurance coverage for those not born in the United States. - Disparities Data Details AHS-1.1 by Country of Birth for 2017 | Healthy People 2020," accessed August 6, 2019, https://www.healthypeople.gov/2020/data/disparities/detail/Chart/3966/8.1/2017 Among insured nonelderly adults, there are appreciable disparities in health-care use by race and Hispanic ethnicity. Ethnic disparities in care are largely explained by differences in English fluency, but racial disparities in care are not explained by commonly used access factors - Kevin Fiscella et al., "Disparities in Health Care by Race, Ethnicity, and Language among the Insured: Findingsfrom a National Sample," *Medical Care* Vol. 40, no. No. 1 (January 2002): 52..

[xxi] 45 CFR § 92.205

[xxii] U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates – According to a geographic breakdown of this data 916,271 or 10.8% of this population resides in New York City.
"Search the Data | Healthy People 2020," accessed August 6, 2019, https://www.healthypeople.gov/2020/data-search/Search-the-Data#objid=4152; - 41.6% of Adults over 18 w/ disability who had barriers to primary care access - "Each year, 3.6 million people in the United States do not obtain medical care due to transportation issues. Transportation issues include lack of vehicle access, inadequate infrastructure, long distances and lengthy times to reach needed services, transportation costs and adverse policies that affect travel. Transportation challenges affect rural and urban communities." "HPOE.Org - Social Determinants of Health Series: Transportation," accessed August 7, 2019, http://www.hpoe.org/resources/ahahret-guides/3078.

[xxiv]According to the leadership Conference on Civil & Human rights the Trump administration, the Executive Office of the President, many Executive Agencies, and the Republican Lead Senate and House have acted to rollback or restrict civil rights 160 times (as of July 25, 2019). This includes almost 50 actions taken against the very groups that would be impacted by the proposed rule. - "Trump Administration Civil and Human Rights Rollbacks," The Leadership Conference on Civil and Human Rights, accessed August 6, 2019, https://civilrights.org/trump-rollbacks/.

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August 13, 2019

U.S. Department of Health & Human Services,
Office for Civil Rights,
Attention: Section 1557 NPRM, RIN 0945–AA11,
Hubert H. Humphrey Building,
Room 509F,
200 Independence Avenue SW,
Washington, DC 20201.

Dear Luben Montoya:

The Family Planning Association of Maine (DBA: "Maine Family Planning"), the statewide Title X grantee for the state of Maine is pleased to submit comment in response to the Notice of Proposed Rule Making published in the Federal Register entitled **"Nondiscrimination in Health and Health Education Programs or Activities" 84 *Federal Register* 115 (June 14, 2019), p.27846 Reference #s 42CFR Parts 438, 440, and 460 [Docket No.: HHS–OCR–2019–0007] RIN 0945–AA11.**

Preamble

The Family Planning Association of Maine (FPA), a private, not-for-profit corporation organized under Section 501©3 of the Internal Revenue Service, has served as the State of Maine's statewide grantee for Title X services for more than 45 years, during which time Maine's teen pregnancy rate went from one of the highest in the nation, to the sixth lowest. As demonstrated by the numerous notices of grant award made by the US Department of Health and Human Services, the Family Planning Association of Maine has maintained the highest medical ethical standards in carrying out the Title X program described below.

To meet its mission, the FPA operates 18 family planning centers and provides funding through subcontracts that support 26 additional sites. Specifically, Maine's family planning network includes:

--18 family planning clinics directly operated by the Family Planning Association of Maine (Augusta, Bangor, Belfast, Calais, Damariscotta, Dexter, Ellsworth, Farmington, Fort Kent, Houlton, Lewiston, Machias, Norway, Presque Isle, Rockland, Rumford, Skowhegan and Waterville);

--4 sites managed by Planned Parenthood of Northern New England (Portland, Sanford, Topsham, Biddeford);

--20 Federally Qualified Health Centers (Albion, Bangor, Belgrade, Bethel, Bingham, Brewer, Coopers Mills, Kingfield, Leeds, Livermore Falls, Madison, Monmouth, Old Town, Portland, Rangeley, Richmond, South Portland, Strong, Turner, Vinalhaven); and

--5 School-based Health Centers (Portland [3], Readfield, and Calais).

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The FPA exponentially expands access to the services it provides through the use of telemedicine in a variety of non-contract settings, including residential drug treatment programs, harm reduction programs for women experiencing substance use disorders, domestic violence shelters and organizations working with survivors of human trafficking.

Altogether, the FPA's 44-site network is geographically comprehensive and meets the clinical and educational reproductive health needs of more than 22,000 Mainers annually. It does so through the network and partnerships described above and by employing staff who have deep roots in the communities they serve whose practice of ethical medical care meets the very highest standards.

This introduction to the FPA's comments would be incomplete without noting that the Family Planning Association of Maine believes that abortion is an integral and constitutionally protected part of the full range of reproductive health care that should be available to any pregnant person seeking such care. Acting on this belief, the FPA has, since 1996, made first trimester abortion care available to Maine residents without using ANY federal resources to support abortion care. This declaration has been repeatedly documented and certified by our US/DHHS partners: No Title X funds have ever been used to support non-Title X activities—including abortion care--either by the FPA or its sub-contract agencies.

Since 2016, Maine Family Planning has also been a critical provider of gender-affirming care for hundreds of adult transgender, non-binary and gender nonconforming Mainers seeking sexual and reproductive health care, including hormone replacement therapy (HRT).

Comments

The proposed rule would impact Mainers significantly and negatively. The combination of poverty rates among women and lesbian/gay/bisexual/transgender/queer (LGBTQ+) populations and rurality makes the hardships this rule would impose detrimental to Maine women, LGBTQ+ people, individuals with disabilities, immigrants and their families.

"…the proposed rule would ensure that the Department's Title IX and corresponding Section 1557 regulations follow the will of Congress with respect to the States by not expanding Title IX's definition of ''sex'' beyond the statutory bounds."

The proposed rule fails to recognize the pervasive problem of discrimination faced by transgender patients within health care settings, and thereby places such patients at greater risk for harm.

The 2015 U.S. Trans Survey Maine State Report found that among Maine's transgender respondents, "43% of those who saw a health care provider in year prior reported having at least one negative experience related to being transgender. This included being refused treatment, verbally harassed, or physically or sexually assaulted, or having to teach the provider about transgender people in order to get appropriate care." Additionally, "12% of [Maine] respondents reported that a professional, such as a psychologist, counselor, or religious advisor, tried to stop them from being transgender." These experiences of discrimination are occurring under the current Section 1557 regulation, which indicates how much worse the situation might be if the definition of sex discrimination

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refused to continue inclusion of gender identity. While legal definitions of sex, biology and gender are taking time to catch up with social conditions, it is clear that a broad definition of sex discrimination, which includes gender identity, provides meaningful protection to a group that already commonly experiences discrimination in health care settings.

It is also clear that discrimination based on gender identity is inextricably tied to sex as assigned at birth. Cultural norms and expectations around gender expression and identity are enforced based on clinicians' identification of an infant's external genitalia at birth as either male or female. The application of a binary understanding of sex persists, despite the commonality of intersex individuals born with reproductive organs, genitalia, and sex chromosomes typically associated with both males and females. Given the deep medical and social ties between assigned sex and gender expectations, it is logical to provide recognition, as well as means for grievance, for gender identity under the Section 1557 definition of sex discrimination.

The U.S. Trans Survey found that 40% of transgender respondents had attempted death by suicide in their lifetime, which is many times more than cisgender Americans (note: cisgender refers to a person whose gender identity aligns with their assigned sex at birth). The high rates of depression, anxiety, self-harm, suicide attempts and suicide death rates among transgender Americans is a reflection of the extreme discrimination such individuals face in every sphere of life, including health care. To remove any protections whatsoever for this population is negligent at best and life-threatening at worst. Maine Family Planning strongly opposes this proposed change to Section 1557.

"The Department believes that its enforcement of Title IX, and its enforcement of Section 1557 (to the extent it incorporates Title IX), must be constrained by the statutory contours of Title IX, which include explicit abortion and religious exemptions and which should be set forth more clearly than in the Final Rule….proposed §92.6 would explicitly identify and incorporate protections from specific religious freedom, conscience, and nondiscrimination statutes—42 U.S.C. 18113 (Section 1553 of the Patient Protection and Affordable Care Act); 42 U.S.C. 2000bb et seq. (the Religious Freedom Restoration Act, which applies to ''all Federal law . . . unless such law explicitly excludes such application''); 42 U.S.C. 238n (the Coats-Snowe Amendment); 42 U.S.C. 300a–7 (the Church Amendments); the Weldon Amendment (e.g., Consolidated Appropriations Act of 2019, Pub. L. 115–245, Div. B, sec. 506(d) (Sept. 28, 2018)); and related conscience provisions in appropriations law (e.g., Consolidated Appropriations Act of 2019, Pub. L. 115–245, Div. B. sec. 506) (Sept. 28, 2018)).
VerDate"

The proposed rule opens the door for refusals of care and discrimination for patients seeking abortions based on religious or personal beliefs.

As an abortion provider, Maine Family Planning opposes any attempts to deny care or proper referral to a patient based on their status as pregnant, seeking an abortion or information about an abortion, and/or past experience of abortion. According to most recent data from the Guttmacher Institute, 1 in 4 women in the United States will have

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at least one abortion by the age of 45. This is a great number of people who would now be open to experiencing discrimination from their health care provider, based on seeking care that is within their constitutional rights, legal, safe and common. One of the findings of the well-researched and respected Turnaway Study indicates, "Restrictions on abortion that prevent women from obtaining wanted abortions may result in reductions in full-time employment, increased incidence of poverty, more women raising children alone, and greater reliance on public assistance. The net result may have serious adverse economic consequences for women and children." Maine Family Planning knows how deeply abortion stigma impacts patients—even deterring them from seeking information related to abortion care. Based on our experience providing sensitive health care services, we strongly recommend striking the above proposed change to Section 1557.

The proposed rule changes related to language access, grievance, compliance and hardship exemptions fail to recognize the reality of limited health care resource options in a largely rural state.

In addition to alarming rates of poverty, Maine was found to be the most rural state in the nation in the 2010 census, which creates additional burdens on patients who might experience discrimination or refusal of care due to (perceived or actual) gender identity, status of pregnancy and/or abortion experiences, and English language proficiency. There are often few providers in a given area, and patients with limited financial resources cannot often afford to seek alternative providers if they cannot get care via a local resource. It is clear that rurality impacts health outcomes. For those who might be denied care and/or are mistreated due to their disability, gender identity, language ability, and/or pregnancy status—the proposed changes present a threat to their civil rights, health, and overall well-being. The proposed rule changes would further limit access to medical providers for care and severely burden a state as rural as Maine, where there are only two population centers dense enough to support comprehensive/diverse health care providers. The Department ought not to assume that 'choice of provider' is a meaningful reality to all patients, especially those living in rural parts of the country.

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The changes proposed by HHS undermine the purpose of Section 1557, which is to protect and provide proper notice and recourse for vulnerable populations who have traditionally experienced the brunt of discrimination within health care settings. It is necessary to continue and expand such protections until health equity is a reality, and regulation and oversight are not greater burdens than the pervasive discrimination they seek to eradicate. The Family Planning Association of Maine urges the HHS Secretary to withdraw the Notice of Proposed Rule Making with the greatest possible speed.

Sincerely,

George A. Hill, President & CEO
Family Planning Association of Maine

August 13, 2019

VIA ELECTRONIC SUBMISSION

U.S. Department of Health and Human Services
Office for Civil Rights
Attention: Section 1557 NPRM, RIN 0945-AA11
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue SW
Washington, DC 20201

Re: Nondiscrimination in Health and Health Education Programs or Activities [RIN 0945-AA11]

Dear Director Severino:

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to comment on the proposed rule, "Nondiscrimination in Health and Health Education Programs or Activities." Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to over three million people with Medicare, family caregivers, and professionals.

The Health Care Rights Law (HCRL) found in section 1557 of the Affordable Care Act (ACA) is the health law's key nondiscrimination provision.[1] It clarifies how important civil rights statutes specifically apply to health care, better protecting older adults, people with disabilities, and marginalized communities from discrimination. The HCRL prohibits discrimination in health programs and activities receiving federal financial assistance, health programs and activities administered by the executive branch, as well as entities created under the ACA, including the Marketplaces and health plans sold through the Marketplaces. Its protections extend to discrimination on the basis of age, disability, race, color, and national origin—including language access—by building on existing civil rights laws. Importantly, it is the first federal law to ban sex discrimination in health care.

The Department of Health and Human Services (HHS), through its Office for Civil Rights (OCR), appropriately implemented these protections in a 2016 final rule. The current HHS and OCR have proposed a revised rule that would undermine the extant rule's interpretation of the HCRL

[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010); 42 U.S.C. § 18116.

and lead to discrimination, fear of accessing care, confusion about civil rights, and increased suffering from lack of confidence in the health system and lack of health care.

Medicare Rights strongly opposes these proposed changes. We are especially concerned that this proposal removes critical protections and access to information and recourse for LGBTQ+ individuals, individuals with disabilities or chronic diseases, and individuals with limited English proficiency (LEP individuals). While the proposal cites alleged cost savings of removing protective regulations,[2] no cost savings should come at the expense of necessary antidiscrimination protections and access to needed medical services. Further, all claims to savings must also account for cost increases caused by less preventive and early-stage care and increased need for high acuity or emergency care—which the proposal fails to do. Consumers, families, and the health care system as a whole are harmed when individuals are afraid, or unable, to access care.

Accordingly, and as outlined in more detail below, we urge HHS and OCR to withdraw the proposed changes and work instead to strengthen the access to care the HCRL guarantees.

General Comments

The proposed rule eliminates key provisions in the 2016 final rule that currently protect people living with chronic illnesses and disabilities. Such populations regularly face discrimination in health care settings, including the refusal of health care, the provision of lower-quality health care, and the approval of insurance plans that place covered nationally-recommended medications on the highest cost-sharing tier.[3] The 2016 rule clearly describes how certain insurer and provider practices are discriminatory and in violation of the HCRL, including: Section 92.206 "Equal program access on the basis of sex"; Section 92.207 "Nondiscrimination in health-related insurance and other health-related coverage"; Section 92.208 "Employer liability for discrimination in employee health benefit programs"; and Section 92.209

[2] 84 Fed. Reg. 27876.

[3] Health advocates have filed multiple complaints with the Office of Civil Rights highlighting discriminatory practices experienced in health programs and settings. *See, e.g.*, Discrimination Complaint (UPMC Health Plan), Center for Health Law and Policy Innovation of Harvard Law School & AIDS Law Project of Pennsylvania (U.S. Dep't of Health and Human Services, Complaint), http://www.chlpi.org/wp-content/uploads/2013/12/PA-UPMC.pdf; Discrimination Complaint (Independence Blue Cross), Center for Health Law and Policy Innovation of Harvard Law School & AIDS Law Project of Pennsylvania (U.S. Dep't of Health and Human Services, Complaint), http://www.chlpi.org/wp-content/uploads/2013/12/PA-IBX.pdf; Discrimination Complaint (Highmark), Center for Health Law and Policy Innovation of Harvard Law School & AIDS Law Project of Pennsylvania (U.S. Dep't of Health and Human Services, Complaint), http://www.chlpi.org/wp-content/uploads/2013/12/PA-Highmark.pdf; Discrimination Complaint, Center for Health Law and Policy Innovation of Harvard Law School & Nashville CARES (U.S. Dep't of Health and Human Services, Complaint), http://www.chlpi.org/wp-content/uploads/2013/12/TN-Cigna.pdf; Discrimination Complaint, Center for Health Law and Policy Innovation of Harvard Law School (U.S. Dep't of Health and Human Services, Complaint), Discrimination Complaint, Center for Health Law and Policy Innovation of Harvard Law School & Nashville CARES (U.S. Dep't of Health and Human Services, Complaint); National Health Law Program & The AIDS Institute, "Re: Discriminatory Pharmacy Benefits Design in Select Qualified Health Plans Offered in Florida, Administrative Complaint filed with the HHS Office for Civil Rights" (May 28, 2014), https://healthlaw.org/resource/nhelp-and-the-aids-institute-complaint-to-hhs-re-hiv-aids-discrimination-by-fl/. These complaints have included instances where insurers have used discriminatory insurance design to sell products on the Marketplace that place most or all of the nationally-recommended front-line medications for HIV on the most expensive cost-sharing tiers (or do not cover them at all).

"Nondiscrimination on the basis of association." These sections describe common forms of discrimination on the basis of race, color, national origin, age, disability, and sex.

While proposing to delete entire sections of regulation, HHS neglects to detail whether the deletion of these particular sections reflects a new position that the actions listed, including providing unequal access to programs or activities on the basis of sex, restricting access to gender-appropriate facilities, excluding categories of care in insurance coverage, or mistreating a person due to their partner's identity, will no longer be considered discrimination under the HCRL. People living with chronic illnesses and disabilities, people of color, and LGBTQ people have historically been subject to such discrimination in health settings.[4] Any change in policy regarding enforcement against these discriminatory practices would significantly impact all protected classes and may embolden those who wish to discriminate against these populations.

Without more explanation as to how the deletions reflect HHS's enforcement policies, we are unable to provide complete comments. The HCRL and 2016 rule have already been instrumental in addressing many discriminatory practices, including inappropriate provider behavior and condition-based categorical exclusions in health insurance, [5] and are vital parts of helping address chronic illness in the United States.[6] Changes to these HHS policies would be monumental and deserve adequate clarity and an opportunity for the public to provide meaningful feedback.

The Importance of Protections for LGBTQ+ Individuals and Current Law

Discrimination hinders a population's ability to thrive. The HCRL, along with its implementing rule, is an important part of HHS's arsenal to protect consumers from discrimination based on age, race, color, national origin, limited English proficiency, disability, or sex—including discrimination on the basis of gender identity or sex stereotypes. The statute and regulation together are vital to addressing health disparities, improving health care access and delivery, and in turn lowering health care costs for both the Medicare and Medicaid programs by

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[4] *See, e.g.* Lourdes Ashely Hunter, Ashe McGovern & Carla Sutherland editors, *Intersecting Injustice: A National Call to Action,* 62-76 (2018), http://socialjusticesexuality.com/intersecting_injustice/; Susan Reif, *et al.*, "The Relationship of HIV-related Stigma and Health Care Outcomes in the U.S. Deep South, AIDS and Behavior" (2019); S.E. James, *et al.*, Nat'l Ctr. for Transgender Equality, "Report of the 2015 U.S. Transgender Survey 247" (2016), https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf; Gina M. Wingood, *et al.*, "HIV Discrimination and the Health of Women living with HIV," 46 Women & Health 99 (2007).

[5] Tovar v. Essentia Health, No. 16-cv-00100-DWF-LIB (D. Minn. September 20, 2018); Boyden v. Conlin, No. 17-cv264-WMC, 2018 (W.D. Wis. September 18, 2018); Flack v. Wis. Dep't of Health Serv., 328 F. Supp. 3d 931 (W.D. Wis. 2018); Prescott v. Rady Children's Hosp.-San Diego, 265 F. Supp. 3d 1090 (S.D. Cal. 2017); Rumble v. Fairview Health Serv., 2015 U.S. Dist. LEXIS 31591 (D. Minn. Mar. 16, 2015); Out2Enroll, "Summary of Findings: 2019 Marketplace Plan Compliance with Section 1557," https://out2enroll.org/out2enroll/wp-content/uploads/2015/10/Report-on-Trans-Exclusions-in-2019-Marketplace-Plans.pdf; Out2Enroll, "Summary of Findings: 2018 Marketplace Plan Compliance with Section 1557," https://out2enroll.org/out2enroll/wp-content/uploads/2015/10/Report-on-Trans-Exclusions-in-2018-Marketplace-Plans.pdf; Out2Enroll, "Summary of Findings: 2017 Marketplace Plan Compliance with Section 1557," https://out2enroll.org/out2enroll/wp-content/uploads/2015/10/Report-on-Trans-Exclusions-in-2017-Marketplace-Plans.pdf; "The Brooklyn Hospital Center Implements Non-Discriminatory Practices to Ensure Equal Care for Transgender Patients," HHS OCR (July 15, 2015), https://www.hhs.gov/sites/default/files/ocr/civilrights/activities/agreements/TBHC/statement.pdf.

[6] Increased access to these medications and nondiscriminatory medical coverage are crucial to efforts to end the HIV epidemic. AIDS United & Act Now "Ending the HIV Epidemic in the United States: A Roadmap for Federal Action," End AIDS 40-62, (2018).

providing protections and information for vulnerable populations that will help them access preventative and early care. While this proposal, if finalized, would not affect the underlying statutory provisions of the HCRL, it would affect its implementation in ways that are likely to increase confusion, reduce access to information, and increase the risk of older adults and people with disabilities losing access to the care they need.

LGBTQ+ older adults face pronounced health disparities and higher poverty rates compared to their heterosexual and cisgender peers due in large part to historical and ongoing discrimination.[7] For example, HIV disproportionately impacts the LGBTQ+ community,[8] and it is affecting an increasing number of older adults.[9] The Aging and Health Report, funded by the National Institutes of Health (NIH) and the National Institute on Aging (NIA), outlines a number of other disparities: lesbian, gay, and bisexual older adults face higher rates of disability and mental health challenges; older bisexual and gay men face higher rates of physical health challenges; bisexual and lesbian older women have higher obesity rates and higher rates of cardiovascular disease; and transgender older adults face greater risk of suicidal ideation, disability, and depression compared to their peers.[10]

There is significant evidence that discrimination in health care contributes to these disparities, causing LGBTQ+ older adults to be denied care or provided inadequate care.[11] According to one survey, 8% of lesbian, gay, and bisexual (LGB) individuals had a recent experience where a doctor or other health care provider refused to see them because of their actual or perceived sexual orientation, while 29% of transgender individuals faced such refusals on the basis of their actual or perceived gender identity.[12] Troublingly, refusal was not even the worst outcome: 7% percent of LGB individuals experienced unwanted physical contact and violence from a health care provider and that number skyrocketed to 29% of transgender people.[13]

In long-term care facilities, transgender adults and their loved ones are especially at risk of discrimination, including verbal and physical harassment, visiting restrictions and isolation, denial of basic care such as showers, or discharge or refused admission.[14] As a result of these discriminatory acts, LGBTQ+ individuals may be afraid to seek care for fear of mistreatment,

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[7] The National Gay and Lesbian Task Force, "No Golden Years at the End of the Rainbow: How a Lifetime of Discrimination Compounds Economic and Health Disparities for LGBT Older Adults" (August 2013), https://nwnetwork.squarespace.com/s/2013-TF-No-Golden-Years.pdf.

[8] Centers for Disease Control and Prevention, "HIV in the United States: At a Glance" (June 2017), www.cdc.gov/hiv/statistics/overview/ataglance.html.

[9] Centers for Disease Control and Prevention, "HIV Among People Aged 50 and Over" (June 2017), www.cdc.gov/hiv/group/age/olderamericans/index.html.

[10] Fredriksen-Goldsen, *et al.*, "The Aging And Health Report: Disparities And Resilience Among Lesbian, Gay, Bisexual, And Transgender Older Adults" (November 2011), www.lgbtagingcenter.org/resources/resource.cfm?r=419.

[11] *Id.*

[12] Shabab Ahmed Mirza & Caitlin Rooney, "Discrimination Prevents LGBTQ People from Accessing Health Care," Ctr. for American Progress, (Jan. 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/?link_id=2&can_id=d90c309ac9b5a0fa50d294d0b1cdf0b2&source=email-rx-for-discrimination&email_referrer=&email_subject=rx-for-discrimination.

[13] *Id.*

[14] Justice in Aging *et al.*, "LGBT Older Adults In Long-Term Care Facilities: Stories from the Field" (updated June 2015), www.justiceinaging.org.customers.tigertech.net/wp-content/uploads/2015/06/Stories-from-theField.pdf.

even when the care is necessary.[15] Even HHS's Healthy People 2020 initiative recognizes that "LGBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights."[16]

This reality makes HCRL's current protections against discrimination on the basis of sex, including sex stereotypes and gender identity a critical bridge to medical care for these historically marginalized populations.[17]

Proposed Changes to LGBTQ+ Protections

The proposed rule would eliminate sex stereotyping from the definitions section of the current regulations[18] and attempts to go even further by purging references to "sexual orientation" that appear in other HHS regulations.[19] Such deletions could set the stage for a refusal to enforce important and well-established nondiscrimination protections. Changing this rule, however, cannot eliminate thirty years of case law finding that sex stereotyping is part of nondiscrimination protections based on sex. It can only lead to confusion, more litigation, and increased suffering.

Further, although nothing in the current rule impacts the applicability of existing religious exemption laws, the proposed rule incorporates additional religious exemption language.[20] The combination of this additional language and the pullback of explicit protections is likely to lead to an increase in care refusal for some of society's most vulnerable members. As discussed above, many LGBTQ+ individuals already have significant challenges finding providers that are able and willing to provide them with culturally competent care,[21] and older LGBTQ+ individuals in particular experience pronounced health disparities compared to their straight counterparts, underscoring the need for enhanced protections and access to care.[22] This pattern leads to exacerbated health disparities.[23]

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[15] National Center for Transgender Equality, "Report from the 2015 U.S. Transgender Survey" (December 2016), http://www.ustranssurvey.org/; Center for American Progress, "Discrimination Prevents LGBTQ People from Accessing Health Care" (January 18, 2018), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.

[16] "Healthy People 2020, Lesbian, Gay, Bisexual, and Transgender Health," U.S. Dept. Health & Human Serv., https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health.

[17] 45 C.F.R. § 92.4.

[18] 84 Fed. Reg. 27855, 27869

[19] Proposal to amend 45 C.F.R. §§ 147.104(e), 155.120(c)(ii), 155.220(j)(2), 156.200(e), 156.1230(b)(3); 42 C.F.R. §§ 438.3(d)(4) 438.206(c)(2), 438.262; 42 C.F.R. §§ 460.98(b)(3), 460.112(a). Note, the EHB nondiscrimination requirements at 45 C.F.R. § 156.125(b) cross reference 45 C.F.R. § 156.200(e).

[20] 84 Fed. Reg. 27864.

[21] Jennifer Kates, *et al.*, "Health and Access to Care and Coverage for Lesbian, Gay, Bisexual, and Transgender (LGBT) Individuals in the U.S.," Henry J. Kaiser Family Foundation, https://www.kff.org/disparities-policy/issue-brief/health-and-access-to-care-and-coverage-for-lesbian-gay-bisexual-and-transgender-individuals-in-the-u-s/.

[22] Karen I. Fredriksen-Goldsen, *et al.,* "Health Disparities Among Lesbian, Gay, and Bisexual Older Adults: Results From a Population-Based Study," 103 Am J Public Health 1802, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3770805/.

[23] *Id.*

Medicare Rights strongly opposes removing or limiting antidiscrimination protections and remedies for LGBTQ+ individuals, as well as others who may not conform to traditional sex stereotypes. While we respect the exercise of religious and conscience rights, these rights must be balanced against the rights of others to receive care that is appropriate, medically necessary, freely chosen, transparent, and person centered.

The Importance of Protecting Rights for Individuals with Limited English Proficiency and Current Law

There are an estimated 25 million people with limited English proficiency (LEP) in the United States.[24] For those individuals, language barriers impede access to quality health care and limit their ability to meaningfully engage in the care they do receive. When individuals are unable to effectively communicate with their health providers, they are more likely to experience adverse health outcomes.[25] LEP individuals may misunderstand important instructions or make medical decisions without fully realizing the implications of that decision.[26] Recent studies have found that patients "suffered death and irreparable harm" due to language barriers and provider failure to ensure access to appropriate language services.[27]

Language access in health care and protections from discrimination based on language are uniquely critical for older adults. U.S. Census data from 2017 estimates that more than 10 million older adults over age 60 speak a language other than English at home and 6 million speak English less than "very well." More specifically, 4 million Medicare beneficiaries—older adults and people with disabilities—are limited English proficient, and 12% of Medicare beneficiaries living in the community report that English is not their primary language.[28] Reports from the Office of Minority Health estimate that almost 2 million Medicare beneficiaries speak languages other than English or Spanish, including over 200,000 beneficiaries who speak Chinese, over 150,000 who speak Vietnamese, and over 140,000 who speak Tagalog.[29]

Communications issues are not solely a result of LEP language barriers. Nearly 8 million Medicare beneficiaries are deaf or hard of hearing and 4 million have blindness or low vision.

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[24] Migration Policy Institute, "The Limited English Proficient Population in the United States" (2015), https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states.

[25] "Individuals whose care is inhibited due to a communication barrier. . .may be at risk for poor outcomes." Wilson-Stronks, Lee, Cordero, Kopp, and Galvez, "One Size Does Not Fit All: Meeting the Needs of Diverse Populations," Oakbrook Terrace, IL: The Joint Commission (2008), https://www.jointcommission.org/assets/1/6/HLCOneSizeFinal.pdf.

[26] Smedley, Stith, and Nelson, editors, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care,* Board on Health Science Policy, Institute of Medicine (2002), at 17, http://www.nationalacademies.org/hmd/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx.

[27] National Health Law Program, The High Costs of Language Barriers in Medical Malpractice, at 3, https://healthlaw.org/resource/the-high-costs-of-language-barriers-in-medical-malpractice/.

[28] CMS, "2017 Medicare Beneficiary Survey Early Look Data Brief" (May 2019), https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/Downloads/2017_MCBS_Early_Look.pdf.

[29] Centers for Medicare & Medicaid Services Office of Minority Health, "Understanding Communication and Language Needs of Medicare Beneficiaries," p 9 (April 2017), www.cms.gov/About-CMS/AgencyInformation/OMH/Downloads/Issue-Briefs-Understanding-Communication-and-Language-Needs-of-MedicareBeneficiaries.pdf.

These consumers may be in need of auxiliary aids and services to help them understand, communicate, and engage with providers. The proposed rule would also threaten access to these supports.

The current HCRL regulations work to correct language access issues by requiring health care insurance companies and providers to provide notice—in English and in other languages—of nondiscrimination and rights to language assistance.[30] These notice and tagline requirements help ensure that covered entities inform beneficiaries, enrollees, applicants, or members of the public of the availability of language services and auxiliary aids and services, and that the entity does not discriminate on the basis of race, color, national origin, sex, age or disability. This aligns with longstanding Supreme Court precedent, which holds that language assistance services are required to ensure that LEP individuals have meaningful access, and that the denial of such access is a form of national origin discrimination.[31]

Over 1.8 million LEP seniors and people with disabilities are also low-income and rely on the tagline and notice requirements in the 2016 implementing regulations to get the information they need across both Medicaid and Medicare.[32] LEP beneficiaries rely on notice requirements that allow them to understand and fully engage in their health care through meaningful communication with providers. Consumers must have the opportunity to fully understand their own care in order to make informed decisions and provide critical information to their providers to avoid negative health outcomes.

These protections are particularly important for older because most people need more health care as they age. Health care information is complex and can only be communicated effectively in an individual's primary language. Furthermore, older adults may be less inclined to ask for language assistance out of a fear of inconveniencing others, even if the language assistance is necessary for them to truly understand their health care. In this context, affirmative reminders of their rights through notices and taglines are critical and help to counter the stigma of asking for help. If LEP older adults do not understand statements they receive but are not told or have no notice of how to get help in their primary language, they may not ask for an interpreter, resulting in failing to follow up as necessary or paying for a service when their insurer denies coverage because they are not adequately informed of their right to appeal. Especially for older adults with limited income or high health care needs, the consequences of an erroneous bill or forgoing care can be catastrophic.

Proposed Changes to Language Access Requirements

HHS proposes to eliminate the requirement for posting HCRL notices and including taglines on documents. This would, in part, compromise and diminish the primacy of the non-

[30] 45 C.F.R. § 92.206; 45 C.F.R. § 92.8.

[31] *See* Lau v. Nichols, 414 U.S. 563, 568 (1974).

[32] Proctor, K., Wilson-Frederick, S. M., & Haffer, S. C., "The Limited English Proficient Population: Describing Medicare, Medicaid, and Dual Beneficiaries," Health Equity, 2(1), pp 82-89 (2018), https://www.liebertpub.com/doi/full/10.1089/heq.2017.0036.

discrimination message of the law and could result in some individuals not knowing their rights or how to exercise them.

HHS has provided no justification for eliminating notice and tagline requirements entirely, instead of making amendments to such requirements. Further, HHS failed to explain why completely eliminating notice requirements is justified given the prior analysis HHS has already undertaken in adopting these requirements just a few short years ago. The elimination of these requirements entirely ignores the challenges faced by LEP individuals in accessing adequate health care.

Medicare Rights strongly supports the existing notice and tagline requirements, which require covered entities to inform beneficiaries, enrollees, applicants, or members of the public of the availability of language services and auxiliary aids and services. These regulations ensure that such entities do not discriminate on the basis of race, color, national origin, sex, age or disability and should not be changed.

We do appreciate that the proposed rule properly makes clear that language assistance services must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency.

Proposed Changes to the Scope of the Proposed Rule

The HCRL, according to the statute and current regulations, applies to health care programs and activities receiving federal financial assistance or funding, programs administered by the federal government, and entities created under Title I of the ACA. Covered entities include hospitals, clinics, and health care provider's offices and issuers selling health insurance plans within and outside of the ACA Marketplaces.[33] If an entity is principally engaged in providing or administering health services or health insurance coverage, and any part receives federal financial assistance, the current regulations state that all of its activities are covered by the HCRL.[34]

However, the proposed rule seeks to limit this scope, by reducing the types of entities and programs that are subject to the HCRL—thereby limiting the ability of the law to provide robust civil rights protections.

For example, the current regulation applies to all entities principally engaged in the provision of health care, where some part of the entity receives federal financial assistance. Under the current regulations, this includes health insurance companies that receive any federal financial assistance. In the proposed rule, HHS posits that providing health care "differs substantially" from providing health insurance coverage.[35] As such, HHS seeks to exempt a broad swath of

[33] 42 U.S.C. § 18116(a); 45 C.F.R. §§ 92.2(a), 92.4.
[34] 45 C.F.R. § 92.4.
[35] 84 Fed. Reg. 27850.

health insurance companies from the application of the HCRL. This would significantly—and inappropriately—reduce the application of the law through regulation.

Importantly, it is also inconsistent the design and intent of the ACA. An insurer does not simply process claims. Insurers design benefits; establish formularies, payment structures, and networks; conduct prior authorization; and evaluate other clinical coverage criteria. Insurers exercise considerable control over the health care of enrollees—deciding what providers a patient may see, what hospitals they may visit, and what treatments or medications they may receive.[36] HHS recognized this in the 2016 Final Rule, emphasizing the application of the HCRL to all the operations of a health insurer, program, or activity, if any part receives federal financial assistance, as being the very purpose of the ACA and its nondiscrimination protections, noting:

> "This interpretation serves the central purposes of the ACA and effectuates Congressional intent, by ensuring that entities principally engaged in health services, health insurance coverage, or other health coverage do not discriminate in any of their programs and activities, thereby enhancing access to services and coverage…"[37]
>
> "One of the central aims of the ACA is to expand access to health care and health coverage for all individuals. Equal access for all individuals without discrimination is essential to achieving this goal. Discrimination in the health care context can often lead to poor and inadequate health care or health insurance or other coverage for individuals and exacerbate existing health disparities in underserved communities. Individuals who have experienced discrimination in the health care context often postpone or do not seek needed health care; individuals who are subject to discrimination are denied opportunities to obtain health care services provided to others, with resulting adverse effects on their health status. Moreover, discrimination in health care can lead to poor and ineffective distribution of health care resources, as needed resources fail to reach many who need them. The result is a marketplace comprised of higher medical costs due to delayed treatment, lost wages, lost productivity, and the misuse of people's talent and energy."[38]

This interpretation is further supported by Congress's repeated expressions that it intends civil rights laws to be broadly interpreted in order to effectuate their remedial purposes, as well as a plain reading of the statute.[39] Section 1557 of the ACA clearly applies to "*any* health program or

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[36] See, *e.g.*, Institute of Medicine, "Controlling Costs and Changing Patient Care? The Role of Utilization Management" (1989); Joseph B. Clamon, "Does My Health Insurance Cover It - Using Evidence-Based Medicine and Binding Arbitrator Techniques to Determine What Therapies Fall under Experimental Exclusion Clauses in Health Insurance Contracts," 54 Drake L. Rev. 473, 508 (2006).

[37] 81 Fed. Reg. 31386.

[38] 81 Fed. Reg. 31444.

[39] *See* Kang v. U. Lim Am., Inc., 296 F.3d 810, 816 (9th Cir. 2002); *see also* H. Rep. No. 102–40(I), at 88, U.S. Code Cong. & Admin. News at 626 (stating that "remedial statutes, such as civil rights law[s], are to be broadly construed").

activity."[40] Thus, at a minimum, the HCRL's applicability to all of the operations of an entity principally engaged in health care—including health insurers—is the only plausible reading.

Medicare Rights strongly encourages HHS to maintain the current scope of the regulations, such that they apply not only to providers, but also to health insurance companies. Limiting the HCRL's applicability would leave many individuals, including older adults and people with disabilities and chronic illness, at heightened risk of discrimination. Additionally, we urge HHS to maintain a broader interpretation of the federal programs that must abide by the HCRL, encompassing federal programs and activities administered by all Executive agencies in order to maintain appropriate protections for consumers.

Effects of Proposed Changes to the Scope of the Proposed Rule

Exempting health insurers from the rule would have significant implications for individuals with disabilities or chronic illness and older adults. For example, the current regulation prohibits discriminatory "marketing practices or benefit design,"[41] which helps protect against insurance practices that lead to "cherry picking" and "lemon dropping", such that individuals with certain health care needs are disadvantaged by a plan's structure and disincentivized to enroll.

The proposed rule would also eliminate these protections for gender and sexual minorities, and effectively eliminate them for thousands of other individuals. If finalized as proposed, there would be a significant adverse impact on individuals with disabilities and chronic illness, including many older adults. Plans would be free to implement business practices that help them avoid taking on high-cost patients, reducing consumer choice and ultimately increasing costs to beneficiaries—changes that could lead to worse health outcomes.

Proposed Changes to Individual Recourse for Discrimination

In addition to the ways the proposed rule would cause confusion or undermine antidiscrimination protections, it explicitly attempts to eliminate the HCRL's private right of action and undermine disparate impact claims.

Currently, the implementing rule clarifies that the HCRL includes a private right of action to allow those who face discrimination to challenge that conduct in federal district court.[42] Unfortunately, many people who experience discrimination cannot access the court system due to cost,[43] and those who can generally receive little in the form of compensatory relief.[44]

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[40] 42 U.S.C. § 18116(a) (emphasis added).

[41] 45 CFR § 92.207(b)(2).

[42] 81 Fed. Reg. at 31439-40.

[43] *See* Brittany Kauffman, "Study on Estimating the Cost of Civil Litigation Provides Insight into Court Access," Inst. for the Advancement of the Am. Legal System (Feb. 26, 2013), https://iaals.du.edu/blog/study-estimating-cost-civil-litigation-provides-insight-court-access; Michelle Chen, "One More Way the Courts Aren't Working for the Poor," The Nation (May 16, 2016), https://www.thenation.com/article/one-more-way-the- courts-arent-working-for-the-poor.

[44] Maryam Jameel & Joe Yerardi, "Workplace discrimination is illegal. But our data shows it's still a huge problem," Vox (Feb. 18, 2019), https://www.vox.com/policy-and-politics/2019/2/28/18241973/workplace-discrimination-cpi-investigation-eeoc.

By undercutting disparate impact claims and the private right of action, this rule could make it even more expensive and difficult for people to enforce their rights, deterring them from filing complaints of discrimination.

Conclusion

The HCRL is the law. The proposed rule's inconsistency with that statute would cause confusion about what the law requires and who is protected under it. Such changes would ultimately make it harder for people to access needed health care free from discrimination and in a way they understand, while also limiting the ways people who experience discrimination could seek legal redress.

The Office for Civil Rights is tasked "to improve the health and well-being of people across the nation" and "to ensure that people have equal access to and the opportunity to participate in and receive services from HHS programs without facing unlawful discrimination." In accord with that mission, we strongly urge you to withdraw the proposed changes to the HCRL. We welcome an opportunity to work together toward a future of equality for all Americans.

Thank you for the opportunity to provide comments. For additional information, please contact Lindsey Copeland, Federal Policy Director, at 202-637-0961 or lcopeland@medicarerights.org or Julie Carter, Senior Federal Policy Associate, at 202-637-0962 or jcarter@medicarerights.org.

Sincerely,

Fred Riccardi

Frederic Riccardi
President
Medicare Rights Center

August 13, 2019

VIA ELECTRONIC SUBMISSION

Secretary Alex Azar
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 509F
200 Independence Avenue, SW
Washington, DC 20201

RE: Docket ID HHS-OCR-2019-0007, RIN 0945-AA11, Nondiscrimination in Health and Health Education Programs or Activities

Dear Secretary Azar:

The National Council of Jewish Women ("NCJW") is pleased to provide comments in response to Nondiscrimination in Health and Health Education Programs or Activities, a proposed rule published by the Department of Health and Human Services ("HHS") in the Federal Register on June 14, 2019 at 84 Fed. Reg. 27,846 ("Proposed Rule").

Founded in 1893, NCJW is the oldest Jewish women's volunteer organization in the United States. Our 90,000 grassroots volunteers and advocates turn progressive ideals into action and make change happen. Inspired by Jewish values, NCJW strives for social justice by improving the quality of life for women, children, and families and by safeguarding individual rights and freedoms. NCJW members carry out the organization's long tradition of progressive action through a powerful combination of community organizing, education, direct service, and advocacy. Through 60 sections and action teams across the country as well as a strong State Policy Advocacy network in 16 states, NCJW works on local, state, and federal issues.

Our organizational principles state that equal rights and equal opportunities for all people must be guaranteed and that all forms of discrimination must be eliminated. NCJW champions the enactment, enforcement, and preservation of laws and regulations that protect civil rights and individual liberties for all — especially for the most marginalized in our society who face structural barriers to exercising their human rights. By encouraging discrimination in health care, HHS takes steps that are directly contrary to these principles.

For the reasons detailed below, we ask HHS to withdraw the Proposed Rule and leave current regulations unchanged. The Proposed Rule, if finalized, would egregiously remove protections and increase the burdens on people of color, women, the LGBTQI community, persons with disabilities, and people of limited English proficiency, violating their civil rights and imposing damage far greater than the monetary effects on the regulated community. In addition, this rulemaking violates the United States Constitution and the Administrative Procedure Act ("APA").

As an organization and community member, NCJW is committed to the belief that every individual has an equal right to access health care.[1] Our Jewish values teach us to respect the dignity and decisions of all people and, as such, we aim to create a world where everyone — regardless of race, class, gender, sexuality, ability, or immigration status — is able to control their body, sexuality, and future. Individuals have the right to follow their own conscience on matters of their own health care, irrespective of their faith or that

[1] *E.g.*, Interfaith Statement Opposing Restrictions on Women's Health Care Options, Jan. 2014; Nat'l Council of Jewish Women, *Vision for America*, https://www.ncjw.org/wp-content/uploads/2018/11/Vision-for-America_ONLINE.pdf (Nov. 2018).

of their providers and the institutions they serve. To that end, NCJW works to ensure that all people have full and equal health coverage consistent with Federal law, including all services and nondiscrimination provisions guaranteed by the Patient Protection and Affordable Care Act ("ACA"). We oppose any regulation that impinges on anyone's ability to access the care best-suited for their own beliefs and conscience.

NCJW believes the Proposed Rule violates the religious freedom and moral autonomy of the individual; jeopardizes the lives and health of people seeking reproductive health care (including abortion), LGBTQ individuals, individuals with LEP (including immigrants), those living with disabilities, and people of color; and would embolden compounding levels of discrimination against those who live at the intersection of these identities.

As such, NCJW strongly believes that HHS should not finalize the Proposed Rule.

I. NCJW, and Communities of Faith in General, Believe that All People Deserve Equal Access to Care.

A common thread running through different faiths is that all strive for social justice and equal rights, including equal access to care. People of faith believe in the dignity of all — and that means *all*. As each of us is made in the image of the divine — *b'tselem Elohim* (Genesis 1:26) — every single person's health is paramount and unassailable. We have an obligation to care for and protect our bodies and to ensure all others can do the same. This means that every human being deserves fair treatment and respect when accessing health care, free from political interference or economic coercion.

As Jews, we value every individual as a moral decision-maker, free to make personal decisions about their lives and care based on their own religious beliefs and consciences without interference from others. Irrespective of their faith or moral opinions, the personal "beliefs" of any provider or institution should never jeopardize patient health and safety or impede the care the patient is able to receive and the services they may access.

Respect for individual conscience must necessarily extend to choices about one's own health care. Individuals have consciences. Non-person entities do not. The proper role of government is to guarantee fair treatment and to protect the freedom of conscience for all patients. By sanctioning discriminatory activity in health care, the government promotes inequality and obstructs patients' decision-making, compromising their moral autonomy and human rights.

As part of our faith-based mission of *tzedek* (justice) for all, NCJW is dedicated to lifting up those disadvantaged economically, those with limited access to services, and those who face structural barriers to exercising their human rights. Our founder Hannah G. Solomon asserted, "We must add our voices to those who cry out that there is a standard below which we will not allow human beings to live, and that standard is not at the freezing or starving point." Since she spoke those words, NCJW has championed policies that improve the lives of marginalized and vulnerable communities including women, children, LGBTQ individuals, individuals with disabilities, and people of color. It is profoundly unjust to even propose reducing health care options for individuals based on their gender identity or any other arbitrary factor.

In sum, health care is a human right, and NCJW overwhelmingly respects the moral autonomy of the individual to make choices about the care they receive.

II. The Impact of the ACA

NCJW was proud to play a role in the enactment of the ACA,[2] landmark legislation that had a transformative impact on all aspects of health care by increasing the scope of benefits and improving access to coverage for millions of Americans. The ACA has reduced health care costs for individuals and employers while at the same time reducing uncompensated care by more than $7.4 billion.[3] In addition, the ACA included critical provisions ensuring full and equitable access to essential services without discrimination.

Indeed, the ACA is a critical source of health care coverage for America's traditionally underserved communities including individuals and families living in poverty, people of color, women, immigrants, LGBTQI individuals, individuals with disabilities, seniors, and individuals with limited English proficiency. Moreover, the ACA reduced the number of individuals without insurance to historic lows, including a reduction of 39 percent of the lowest income individuals.[4] These gains are particularly noteworthy for Latinos, African Americans, and Native Americans. What's more, with the enactment of the ACA, 9.5 million uninsured women gained affordable, comprehensive coverage. Between 2013 and 2015, the first two full years of ACA implementation, the proportion of uninsured women of reproductive age (15-44) declined by 36%. The nation and our communities cannot afford to go back to a time when they did not have access to comprehensive, affordable coverage.

Furthermore, the ACA has been instrumental in covering a wide range of preventive services, ensuring that individuals have access to life-saving cancer screenings and treatment as well as effective contraception and reproductive health care services (well visits, mammograms, lactation counselling and supplies) at no cost to the patient. Similarly, plans are sharply limited in their ability to impose formularies, prior authorization requirements, and other administrative barriers to preventive care services or to benefit designs that may discriminate against persons with specific disease states.

Significantly, absent the financial assistance offered by the ACA, many marginalized groups (including low-income people, people of color, immigrants, young people, and LGBTQ individuals) faced the impossible choice of going without health insurance or straining their resources to pay for services out-of-pocket. By introducing provisions to help low- and moderate-income individuals and families buy health insurance, over 9 million women who would have gone without affordable coverage became eligible for ACA premium tax credits and cost-sharing reductions as of 2014. The ACA also provided states with the option to expand Medicaid, resulting in 3.3 million more women holding Medicaid coverage in 2014 compared to the previous year. Augmented Medicaid coverage promotes women's economic security because those covered by this program are less likely to disregard other bills or to borrow money to pay medical expenses than individuals without health insurance.

Notably, the ACA was the first federal program to prohibit gender discrimination (including gender identity discrimination) in health care. The law specifically bars discriminatory gender-rating, the practice of routinely charging women significantly higher premiums than men (costing American women $1 billion annually prior to the ACA's implementation). ACA Section 1557, in particular, is an essential mechanism to ensure meaningful access to health care by all Americans. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability by any programs or activities that receive Federal financial assistance, such as credits and subsidies (monetary and nonmonetary).

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[2] Pub. L. No. 111-148, 124 Stat. 119–1025 (2010).
[3] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, New Report Details Impact of the Affordable Care Act (Dec. 13, 2016), https://www.hhs.gov/about/news/2016/12/13/new-report-details-impact-affordable-careact.html available at http://wayback.archive-it.org/3926/20170127135924/https://www.hhs.gov/about/ news/2016/12/13/new-report-details-impact-affordable-care-act.html.
[4] Kelsey Avery, Kenneth Finegold and Amelia Whitman, *Affordable Care Act Has Led to Historic, Widespread Increase in Health Insurance Coverage*, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES ASPE ISSUE BRIEF, (Sep. 29, 2016) https://aspe.hhs.gov/system/files/pdf/207946/ACAHistoricIncrease Coverage.pdf.

Section 1557 bars hospitals, doctors, and insurers from discriminating against persons seeking health care services or health care coverage. The Proposed Rule, however, would erode the scope of those protections and, correspondingly, impair access to critical services by communities who most need critical care.

III. Summary of the Proposed Rule

Elimination of Nondiscrimination on the Basis of Gender Identity and Sex Stereotyping — The Proposed Rule would remove the inclusion of gender identity[5] and sex stereotyping[6] from discrimination "on the basis of sex." Currently, health insurers are prohibited from excluding coverage of health care services for persons seeking gender transition or limiting coverage on the basis of a person's gender identity. The Proposed Rule would embolden institutions and providers to discriminate.

Elimination of Nondiscrimination on the Basis of Termination of Pregnancy — The Proposed Rule would not include termination of pregnancy as a prohibited basis of discrimination on the basis of sex. The Proposed Rule also "does not adopt a position" as to whether termination of pregnancy constitutes discrimination on the basis of sex based on miscarriage or medical complications.

Narrowing Scope of Nondiscrimination Protections by Eliminating Definition of "Covered Entity" — The Proposed Rule would abandon the definition of "covered entity" and the corresponding extension of nondiscrimination protections. Instead, the Proposed Rule would narrow Section 1557's application to the following programs or activities:

- Health programs or activities any part of which receive Federal financial assistance from the Department of Health and Human Services ("HHS");
- Any program or activity administered by HHS under Title I of the ACA; and
- Any program or activity administered by an entity established by Title I of the ACA.

Thus, Section 1557's protections would no longer extend to all of a health insurer's operations. Instead, under the Proposed Rule, Section 1557 would apply only to the subset of an insurer's operations that receive Federal financial assistance from HHS such as qualified health plans offered on an exchange.

Elimination of Notice Requirements and Narrowing of Language Access Requirements — The Proposed Rule would eliminate the requirement that a covered entity notify beneficiaries, applicants, and the public that the entity does not discriminate on the bases protected by Section 1557, that timely language assistance and other aid is available without charge upon request, and how to contact OCR to file a complaint. The Proposed Rule also would eliminate the requirement that covered entities include taglines in the top 15 languages spoken by Limited English Proficiency ("LEP") persons in the relevant state.

IV. The Proposed Rule Tramples Individuals' Religious Liberty and Would Harm Patients by Encouraging Providers to Deny Care Based on Their Personal Beliefs.

[5] The current regulation defines "gender identity" as ''an individual's internal sense of gender, which may be male, female, neither, or a combination of male and female, and which may be different from an individual's sex assigned at birth.'' 81 Fed. Reg. 31,375, 31,467 (May 18, 2016) (codified at 45 CFR § 92.4). The current regulation The regulation requires covered entities to treat individuals ''consistent with their gender identity'' except that covered entities ''may not deny or limit health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available.'' 45 C.F.R. §§ 92.206 and 92.207(b)(3).

[6] The Section 1557 Final Rule defines ''sex stereotypes'' as ''stereotypical notions of masculinity or femininity, including expectations of how individuals represent or communicate their gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms, or body characteristics. These stereotypes can include the expectation that individuals will consistently identify with only one gender and that they will act in conformity with the gender-related expressions stereotypically associated with that gender. Sex stereotypes also include gender expectations related to the appropriate roles of a certain sex.'' 81 Fed. Reg. at 31,468 (codified at 45 C.F.R. § 92.4).

True religious liberty, cemented as one of our nation's founding principles in the First Amendment's Establishment Clause, signifies both freedom of and freedom from religion. The Proposed Rule turns that principle on its head, expressly allowing businesses and individuals to impose their disingenuously claimed "beliefs" upon individuals seeking care.

Being forced to live by another person's beliefs — not to mention the disingenuously claimed "beliefs" of a corporate entity — eviscerates religious freedom. Religious refusals of care do not protect conscience; but instead trample individual religious liberty by granting entire institutions the moral decision-making powers that should be left to patients and ignoring the deeply held convictions of those called to provide patients with abortions or transition-related care. The Proposed Rule is an affront to our Jewish values and to the values of all people of faith who seek to eliminate all forms of discrimination, who rightfully view health care as a basic human right, and who respect the moral autonomy of the individual to make their own choices about the care they receive.

The Proposed Rule fails not only as a matter of policy but also under the Constitution. The First Amendment to the Constitution protects each individual's right to exercise their religious beliefs. By enabling institutions and individuals to prevent others from obtaining their chosen health care services using religious- or conscience-based justifications, the Proposed Rule places an unconstitutional thumb on the scales in favor of one set of beliefs over another.

A. More Important Even Than Constitutional Protections, the Proposed Rule Would Violate the Inherent Dignity of Each Individual.

The Section 1557 Final Rule (presently in effect) provides: "Insofar as the application of any requirement of this part would violate applicable Federal statutory provisions for religious freedom and conscience, such application shall not be required." 45 C.F.R. § 92.2. Nothing more is necessary to adequately protect the religious- and conscience-related beliefs as required by current law. By explicitly incorporating federal refusal of care laws, the Proposed Rule places undue emphasis on the exceptions to the rules that could encourage an unwarranted expansion of claims of such beliefs. Combined with the removal of protections against discrimination, not to mention the narrowing of the application of the rule with regard to certain federal health care programs, the incorporation of the refusals provisions have a compounding negative effect on the people most needing civil rights protections.

Our Jewish tradition calls on us to celebrate religious liberty, which honors individuals' rights to both freedom of and freedom from religion. We depend on religious liberty to be a protective shield, not a weapon used to harm others. Those who invoke "religious liberty" to discriminate and block access to health care grossly violate this principle and our nation's Constitution.

Indeed, discrimination or other violations of an individual's civil rights should not be permissible based on religious or conscience exemptions.[7] Yet the Proposed Rule encourages that result by expressly enabling individual providers to impose their beliefs on their patients. Patients are moral agents who have the capacity, right, and responsibility to make their own decisions about their bodies and health care without interference. Regulations that authorize discrimination and thereby limit access to needed health care

[7] *Cf. Miller v. Davis*, 123 F. Supp. 3d 924, 941 (E.D. Ky. 2015) (finding it unlikely that clerk refusing to issue marriage licenses to same-sex couples would succeed in establishing a violation of her constitutional rights if required to do so, and instead that allowing her to refuse to issue such licenses would likely violate others' constitutional rights); *see also Obergefell v. Hodges*, 135 S.Ct. 2584, 2607 (2015); *Masterpiece Cakeshop, Ltd. v. Colo. Civil Rights Comm'n*, 138 S. Ct. 1719,1727 (2018) ("Nevertheless, while those religious and philosophical objections are protected, it is a general rule that such objections do not allow business owners and other actors in the economy and in society to deny protected persons equal access to goods and services under a neutral and generally applicable public accommodations law.").

severely constrain patients' ability to make choices guided by their own consciences, personal circumstances, and moral or faith traditions.

Perversely, the Proposed Rule would also encourage institutions to instruct their providers regarding what care they may or may not provide, ignoring many with deeply held moral convictions that affirmatively motivate them to provide patients with health care, including abortion, transition-related care, and end-of-life care. For instance, Jewish providers believe that the existing life and health of the pregnant individual is paramount at any and all stages of pregnancy. What's more, unlike some faith traditions, Jewish law does not consider abortion to be murder because the fetus is not considered a 'life' or a 'person' with independent rights. These beliefs would motivate Jewish providers to, for instance, provide an abortion to a patient in an acute medical crisis regardless of hospital policy. Allowing an employer to dictate the type of care Jewish providers can or cannot provide directly impedes their religious liberty.

The institution's violation of civil rights is thus two-fold: both on the provider *and* the patient. Moreover, the provider prohibited from providing necessary care could also face negative repercussions if such denials would result in violations of professional and ethical duties separately required of the provider.

Furthermore, the combination of exemptions incorporated in the Proposed Rule and the removal of definitions related to discrimination leaves a gaping hole in protections for individuals' right to equal treatment. For example, one provision of the Church Amendments allows individuals who work for or with entities receiving grants or contracts for biomedical or behavioral research entities to refuse to participate in "any lawful health services or research activity" based on religious beliefs or moral convictions *specifically related to the service or research activity to which they object*.[8] But the Proposed Rule contains no such limitations, implying that the exemptions are broader than existing law allows. This is a real concern because individuals are at serious risk of experiencing discrimination based on who they are, not based on what care they seek.[9]

Finally, in May 2019, HHS promulgated a Denial of Care Rule (described by some as the "Conscience Rule")[10] that broadens the application of at least 25 federal laws related to the application of religious- or conscience-based beliefs to health care. Immediately challenged in court, HHS has agreed to delay implementation of the Denial of Care Rule pending the outcome of these cases.[11] At the core of those legal challenges are issues that are also implicated in the Proposed Rule. At the very least, HHS should delay finalizing any rule, such as this Proposed Rule, that could fall on the same grounds.

Ultimately, the Trump administration's manipulation of religious liberty in the name of "conscience" has one overarching theme: a push to make policy and to interpret the law based on a narrow understanding of evangelical Christianity. This view leaves no room for minority religions or atheists and completely disregards the separation of religion and state. The administration threatens the religious liberty of all people when it enacts policy to align with one interpretation of one religion, and when it allows employers, health care providers, and government officials to use their individual beliefs to thwart our nation's civil rights laws.

B. Regulations Authorizing Religious Refusals of Care, including Those Incorporated in the Proposed Rule, Harm Patients.

[8] The Church Amendments, 42 U.S.C. § 300a-7 (2018).
[9] *See infra* note 38.
[10] U.S. Dep't of Health and Human Servs., "Protecting Statutory Conscience Rights in Health Care; Delegations of Authority," 84 Fed. Reg. 23,170 (May 21, 2019).
[11] Katie Keith, "Provider Conscience Rule Delayed Due to Lawsuits," HealthAffairs (July 2, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190702.497856/full/.

The 2016 final rule intentionally did not include any religious exemption. The inclusion of a religious exemption, either explicitly or by reference, is contrary to the statutory language in Section 1557, which does not include any exceptions.

Allowing a religious exemption to Section 1557's protection against sex discrimination could have far-reaching consequences. This could create new instances in which health care providers, including insurance companies, hospital, doctor, or nurses, can allow their beliefs to determine patient care, opening the door to illegal discrimination. This could impact a broad range of health care services, including birth control, sterilization, certain fertility treatments, abortion, gender-affirming care, and end of life care. Moreover, there is already a proliferation in the types of entities that are now emboldened to use religious beliefs to discriminate against patients and the number of religiously-affiliated entities that provide health care and related services and refuse to provide care based on religious beliefs.[12] The proposed rule could encourage these entities to engage in illegal discrimination.

For instance, refusals of care based on personal beliefs have been invoked in countless ways across the country to deny patients the care they need. One woman experiencing pregnancy complications rushed to the only hospital in her community, a religiously affiliated facility, where she was denied the miscarriage management she needed because the hospital objected to this care.[13] Another woman experiencing pregnancy loss was denied care for ten days at a religiously affiliated hospital outside Chicago, Illinois.[14] In New Jersey, a transgender man was denied gender affirming surgery at a religiously affiliated hospital which refused to provide him a hysterectomy.[15] Another patient in Arkansas endured a number of dangerous pregnancy complications and could not risk becoming pregnant again. She requested a sterilization procedure at the time of her Cesarean delivery, but her Catholic hospital provider refused to give her the procedure.[16] Another woman was sent home by a religiously affiliated hospital with two Tylenol after her water broke at 18 weeks of pregnancy. Although she returned to the hospital twice in the following days, the hospital did not give her full information about her condition and treatment options.[17]

Religious exemptions disproportionately harm LGBTQ people, especially those who are transgender, nonbinary, or gender nonconforming. LGBTQ people are often refused health care services because of their sexual orientation and/or gender identity.[18] For example, 8 percent of LGBQ people were refused health care because of their sexual orientation, and 6 percent were refused care related to their sexual orientation. Similarly, 29 percent of transgender people were refused health care because of their gender identity,[19] and 12 percent were refused gender-affirming health care.[20] The proposed rule purports to allow further illegal refusals of care for LGBTQ people.

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[12] *See, e.g.*, Lois Uttley, et al., *Miscarriage of Medicine: the Growth of Catholic Hospitals and the Threat to Reproductive Health Care*, Am. Civil Liberties Union & Merger Watch (2013), https://www.aclu.org/files/assets/growth-of-catholic-hospitals-2013.pdf.
[13] *See* Kira Shepherd, et al., *Bearing Faith The Limits of Catholic Health Care for Women of Color*, PUB. RIGHTS PRIVATE CONSCIENCE PROJECT 1, 6 (2018), https://www.law.columbia.edu/sites/default/files/microsites/gender-sexuality/PRPCP/bearingfaith.pdf.
[14] *See* Julia Kaye, et al., *Health Care* Denied, AM. CIVIL LIBERTIES UNION 1, 12 (2016), https://www.aclu.org/sites/default/files/field_document/healthcaredenied.pdf.
[15] *See* Shepherd, et al., *supra* note 13.
[16] *See The Patient Should Come First: Refusals to Provide Reproductive Health Care*, NAT'L WOMEN'S L. CTR. (2017), https://nwlc-ciw49tixgw5lbab.stackpathdns.com/wp-content/uploads/2017/05/Refusals-FS.pdf; Sandhya Somashekhar, *A Pregnant Woman Wanted her Tubes Tied. Her Catholic Hospital Said No.*, WASH. POST (Sept. 13, 2015), https://www.washingtonpost.com/national/a-pregnant-woman-wanted-her-tubes-tied-her-catholic-hospital-said-no/2015/09/13/bd2038ca-57ef-11e5-8bb1-b488d231bba2_story.html?utm_term=.8c022b364b75.
[17] *See* Shepherd, et al., *supra* note 13.
[18] Shabab Ahmed Mirza & Caitlin Rooney, *Discrimination Prevents LGBTQ People from Accessing Health Care*, Ctr. for Am. Progress (Jan. 18, 2018, 9:00 AM), https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/.
[19] *Id.*
[20] *Id.*

When LGBTQ people are refused treatment, it becomes difficult or impossible to find another provider, especially for those living in rural areas and for transgender people.[21] According to a 2018 study, 18 percent of LGBTQ people said if they were turned away, it would be very difficult or not possible to find the same type of service at a different hospital, and 17 percent said it would be very difficult or not possible to find the same type of service at a different clinic. Rates are higher for LGBTQ people living outside of a metropolitan area: 41 percent said if they were turned away, it would be very difficult or not possible to find the same type of service at a different hospital, and 31 percent said it would be very difficult or not possible to find the same type of service at a different clinic. Rates are also higher for transgender people: 31 percent said if they were turned away, it would be very difficult or not possible to find the same type of service at a different hospital, and 30 percent said it would be very difficult or not possible to find the same type of service at a different clinic. The proposed rule would make it harder for LGBTQ people to access the health services they need.

Additionally, NCJW works for comprehensive, affordable, accessible, and equitable family planning, reproductive, sexual health, and maternal health services — including abortion; people seeking access to these services are also harmed by religious refusals. Geography is already a barrier for people needing abortion care. If people are refused care because of a provider's religious beliefs, it would make it difficult or impossible to receive the care they need. People often must travel between 10-79 miles to reach their nearest abortion clinic, with 20 percent having to travel 42-54 miles or more.[22] "[T]hose living in rural areas typically have to travel greater distances who live in urban areas."[23] "As of 2014, 90 percent of U.S. counties lacked an abortion clinic. . . . Many states have only one clinic."[24] NCJW opposes all measures, including the Proposed Rule, that restrict access to safe abortion and prevent patients from receiving the services they need.

Religious exemptions have a particularly negative impact on people of color. Women and people of color are disproportionately served by Catholic hospitals. These institutions are "governed by strict guidelines that prohibit health care providers from providing contraceptives, sterilization, some treatments for ectopic pregnancy, abortion, and fertility services regardless of their patients' wishes, the urgency of a patient's medical condition, the provider's own medical judgment, or the standard of care in the medical profession."[25] The Proposed Rule would make it harder for people of color, especially those that are LGBTQ and/or needing reproductive care, to access the health services they need.

Over the past several decades, religious refusals have helped systematically chip away at abortion access across the country. This limiting of abortion care has meant that individuals have been denied the care they need. Being denied an abortion has long-term negative impacts on an individual and reduces financial security and safety for themselves and their families. For example, women denied an abortion had almost 4 times greater odds of a household income below the federal poverty level and 3 times greater odds of being unemployed.[26] Additionally, women who were denied an abortion were more likely to not have enough money to pay for basic family necessities like food, housing and transportation.[27] A recent study found that continuing an unwanted pregnancy and giving birth is associated with more serious health

[21] *Id.*
[22] Jonathan M. Bearak, et al., *Disparities and Change Over Time in Distance Women Would Need to Travel to Have an Abortion in the USA: A Spatial Analysis*, 2 The Lancet e493, e493-e500 (2017), https://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(17)30158-5.pdf.
[23] *Id.*
[24] Anna North, *Abortion is Still Legal in America*, Vox (May 16, 2019, 12:19 PM), https://www.vox.com/2019/5/16/18626744/alabama-abortion-law-legal-50-states-roe.
[25] *Bearing Faith: The Limits of Catholic Health Care for Women of Color*, Columbia Law Sch. (Jan. 19, 2018), https://www.law.columbia.edu/events/bearing-faith-limits-catholic-health-care-women-color.
[26] Bixby Ctr. for Global Reprod. Health, University of Cal. S.F., *Turnaway Study*, https://www.ansirh.org/sites/default/files/publications/files/turnaway_study_brief_web.pdf (last visited Jul. 23, 2019).
[27] *Id.*

problems than abortion.[28] Critically, lacking access to abortion care can also undermine the safety and security of the individual seeking services. For example, one study found that women who were unable to terminate unwanted pregnancies were more likely to stay in contact with their violent partners, putting them and their children at greater risk than if they had received the abortion.[29]

At base, allowing the personal beliefs of health care entities and providers to override patient care jeopardizes public health and lives. For many patients, refusals of care do not merely represent an inconvenience, but can result in delay or outright denial of vital care. These refusals are particularly dangerous in situations where individuals have limited options, such as in emergencies, when needing specialized services, in rural areas, or in areas where religiously-affiliated hospitals are the primary or sole institution serving a community. Based on the Jewish value of *kavod ha bri'ot*, NCJW believes that refusals of care and discrimination simply have no place in health care, where all are entitled to fair treatment and respect.

C. The Proposed Rule Unconstitutionally Prioritizes the Religious Beliefs of the Few over Those of the Many.

The First Amendment to the Constitution reads, "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press . . . ."[30] The Proposed Rule violates the Free Exercise and Establishment of Religion Clauses of the First Amendment because it enables an individual or institution receiving government funds to discriminate against a patient due to the patient's beliefs or very being. Both clauses regulate how government policy interacts with moral and religious belief.

In interpreting these clauses, the Supreme Court has held that both prevent the government from shifting the cost of religious and moral accommodation from those who practice to third parties.[31] The Proposed Rule would do just that by shifting the cost of religious and moral accommodations for health insurers and health care providers onto patients by denying them access to services and forcing them to delay or forgo care, which can come with a cost to both their health and their pocketbook. The government's ability to accommodate the free exercise of religion does not relieve its burden of ensuring that they do not compel others to subsidize religious practices that they do not support.[32]

V. The Proposed Rule Would Have Serious Negative Implications for the Health of Women and LGBTQI Individuals.

One of the main benefits of the ACA is its guarantee of certain basic minimum requirements for health care policies *for everyone*. Although only one step towards truly seamless health care, the ACA nevertheless was supposed to make it easier, not more difficult, for people to live their lives without worrying about what services may or may not be covered.

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[28] *Id.*
[29] *Id.*
[30] US CONST. amend. I.
[31] *See Estate of Thornton v. Caldor, Inc.*, 472 U.S. 703, 710 (1985) (stating, "The First Amendment. . . gives no one the right to insist that in pursuit of their own interest others must conform their conduct to his own religious necessities."); *United States v. Lee*, 455 U.S. 252 (1982) ("When followers of a particular sect enter into commercial activity as a matter of choice, the limits they accept on their own conduct as a matter of conscience and faith are not to be superimposed on the statutory schemes which are binding on others in that activity. Granting an exemption from social security taxes to an employer operates to impose the employer's religious faith on the employees."); *see e.g. Cutter v. Wilkinson*, 544 U.S. 709, 720, 722 (2005) (to comply with the Establishment Clause, courts "must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries" and must ensure that the accommodation is "measured so that it does not override other significant interests") (citing *Estate of Thornton v. Caldor*, 472 U.S. 703, 710 (1985)); *see also Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2781 n.37 (2014); *Holt v. Hobbs*, 135 S. Ct. 853, 867 (2015) (Ginsburg, J., concurring).
[32] *United States v. Lee*, 455 U.S. 252 (1982).

As the first broad prohibition against sex-based discrimination in health care, Section 1557 is crucial to ending gender-based discrimination in the health care industry. Sex discrimination in health care has a disproportionate impact on women of color, LGBTQ people, and individuals living at the intersections of multiple identities. resulting in them paying more for health care, receiving improper diagnoses at higher rates, being provided less effective treatments, and sometimes being denied care altogether. In addition to personal stories, there have been surveys, studies, and reports documenting discrimination in health care against these communities and their families.

This Proposed Rule is a giant step backward in the quest for adequate health care for all. By repealing the definition of "on the basis of sex," the Proposed Rule improperly encourages discrimination against people that lawfully exercise their rights or that present in a way that some may oppose and thereby violates the Constitution. Although the Constitution, through the Fifth and Fourteenth Amendments, guarantees equal protection for all, the Proposed Rule would enable government-subsidized discrimination by allowing denial of care to particular groups of people.

A. Women and LGBTQI Individuals Have Long Endured Discrimination in Health Care, Leading Patients to Delay or Forego Care.

Patients who endure discrimination based on religious or moral beliefs of providers or the disingenuously claimed "beliefs" of hospitals and clinics may suffer devastating health consequences.[33] These consequences extend far beyond those services most associated with reproduction or gender identity that providers may believe they are allowed to deny to individuals under rules such as the Proposed Rule. For example, nearly 60% of women use contraception to help treat several medical conditions specific to women, not necessarily for contraceptive purposes.[34]

Women have long been the subject of discrimination in health care. Despite the historic achievements of the ACA, women are still more likely to forego care because of cost, and women — particularly Black women — are far more likely to be harassed by a provider. These barriers mean women are more likely not to receive routine and preventive care than men. Moreover, when women are able to see a provider, women's pain is routinely undertreated and often dismissed. And due to gender biases and disparities in research, doctors offer women less aggressive treatment, or even no treatment, for conditions such as heart disease.

Women who have exercised their rights to services such as abortion also face a real, harmful stigma that can affect their ability to seek and access care.[35] These effects can extend to not "seeking or receiving social support," or experiencing "economic costs" when women "feel they must conceal their abortions.[36] Additionally, this stigma could result in providers being less likely or able to be trained to provide abortion procedures,[37] leading to even fewer avenues for women to access safe abortion services.

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[33] For documented instances where religious health care providers denied care to patients on the basis of religious beliefs, *see* Compl. 2, *ACLU of Mich. v. Trinity Health Corp*., 2016 U.S. Dist. LEXIS 30690 (E.D. Mich. Mar. 10, 2016); Freedman et al., *When There's a Heartbeat: Miscarriage Management in Catholic-Owned Hospitals*, 98 AM. J. PUBLIC HEALTH 1774 (2008), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2636458/; National Women's Law Center, *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide*, https://nwlc.org/resources/refusals-to-provide-health-care-threaten-the-health-and-lives-of-patients-nationwide/ (last visited Oct. 20, 2017).

[34] Jones, R.K. (2011). Beyond Birth Control: The Overlooked Benefits of Oral Contraceptive Pills. Retrieved from http://www.guttmacher.org/pubs/Beyond-Birth-Control.pdf. Over 99% of sexually-active women using at least one method of contraception at some point during their lifetime. Guttmacher Institute, *Contraceptive Use in the United States*, (September 2016) https://www.guttmacher.org/fact-sheet/contraceptive-use-united-states.

[35] Alison Norris et. al., WOMEN'S HEALTH ISSUES, "Abortion Stigma: A Reconceptualization of Constituents, Causes, and Consequences" (2011), https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/Abortion-Stigma.pdf.

[36] *Id.* at 4.

[37] *Id.* at 8.

Similarly, transgender, nonbinary, and gender nonconforming people already experience high rates of discrimination and harassment in health care. In fact, "the data show that health care providers most often discriminate against transgender people *simply for being who they are* –not based on the care they need."[38] According to the 2015 U.S. Transgender Survey, 33 percent had at least one negative experience in a health care setting relating to their gender identity in the past year. Rates were higher for Native respondents (50 percent), Middle Eastern respondents (40 percent), multiracial respondents (38 percent), and respondents with disabilities (42 percent). Moreover, a 2018 study from the Center for American Progress indicated that 23 percent of transgender, nonbinary, and gender nonconforming patients had a provider intentionally misgender or use the wrong name for them, 21 percent had a provider use harsh or abusive language when treating them, and 29 percent experienced unwanted physical contact, such as fondling, sexual assault, or rape, from a provider. The Proposed Rule could impermissibly open the door to further discrimination.

LGBTQ people, and especially transgender, nonbinary, and gender nonconforming people, also face unique barriers to accessing reproductive health care. Under the proposed rule, those barriers would only increase. For example, transgender, nonbinary, and gender nonconforming people assigned female at birth whose gender marker is male or nonbinary could be denied coverage for necessary care such as a pap smear or mammogram. Likewise, transgender nonbinary, and gender nonconforming people assigned male at birth whose gender marker is female or nonbinary could be denied coverage for necessary care, such as a prostate exam.

Together, systemic barriers to care and fear of discrimination lead transgender, nonbinary, and gender nonconforming people to avoid care. According to the 2015 U.S. Transgender Survey, 23 percent did not seek health care when they needed it due to fear of being disrespected or mistreated as a transgender person. Again, rates were higher for Native American respondents (37 percent) and Middle Eastern respondents (34 percent). By emboldening discrimination, the Proposed Rule would only further discourage people from seeking necessary medical care.

B. The Proposed Rule Would Sow Confusion Regarding Provider Duties Under the Emergency Medical Treatment and Active Labor Act.

The Emergency Medical Treatment and Active Labor Act ("EMTALA") requires all hospitals receiving Medicare funds — including those that are private, public, and religiously affiliated — to provide appropriate medical screening to any patient who presents to an emergency room. If the patient is suffering from a medical emergency, the hospital is required to either stabilize the condition or to transfer the patient to another facility that is more equipped to handle the condition.[39] Repealing the Section 1557 Final Rule's definition of "on the basis of sex" would create confusion in the provision of care because, in conjunction with the Denial of Care rule, the Proposed Rule could be interpreted so as to allow providers to violate EMTALA by refusing to provide care to, for example, transgender men or women with emergency complications that require an abortion.

The question whether EMTALA overrules the Denial of Care Rule and/or the Proposed Rule is particularly concerning considering the number of religiously-affiliated hospitals with emergency departments that are the only available providers for miles in certain rural areas. By one count, "Catholic hospitals hold 1 in 6 hospital beds in the United States."[40] While we anticipate that HHS, based on its response to comments in

[38] Sharita Gruberg & Frank J. Bewkes, CENTER FOR AMERICAN PROGRESS, "The ACA's LGBTQ Nondiscrimination Regulations Prove Crucial" (Mar. 7, 2018), https://cdn.americanprogress.org/content/uploads/2018/03/06122027/ACAnondiscrimination-brief2.pdf (emphasis added).
[39] *See* 42 U.S.C. §1395d(e)(3)(A); 42 U.S.C. §1395dd(b).
[40] Emily London & Maggie Siddiqi, CENTER FOR AMERICAN PROGRESS, "Religious Liberty Should Do No Harm" 9 (Apr. 11, 2019), https://www.americanprogress.org/issues/religion/reports/2019/04/11/468041/religious-liberty-no-harm/.

the preamble to the Denial of Care Rule issued in May 2019, will claim that EMTALA and religious exemption will be applied "harmoniously,"[41] their inevitable conflict could lead to violations of this guarantee for emergency care.

C. Repealing the Section 1557 Final Rule's Definition of "On the Basis of Sex" Will Encourage Unlawful Discrimination Against LGBTQI People and Women in Direct Conflict with Constitutional and Statutory Protections.

The Section 1557 Final Rule defines "on the basis of sex" to "include[], but is not limited to, discrimination on the basis of pregnancy, false pregnancy, termination of pregnancy, or recovery therefrom, childbirth or related medical conditions, sex stereotyping, and gender identity."[42] In the Proposed Rule, HHS would remove this definition from the regulatory text.[43] HHS provides essentially three justifications: (1) one federal district court issued a preliminary injunction against implementation of the definition; (2) HHS should be consistent among definitions within HHS and across federal agencies; and (3) the decision regarding how to implement "on the basis of sex" should be left to the States. None persuades that the Proposed Rule satisfies the Constitution.

The Fifth and Fourteenth Amendments explicitly prohibit the federal government and the states from depriving individuals of their "life, liberty, or property" without due process of law.[44] The Fourteenth Amendment, applicable to the states, expressly extends "equal protection of the laws" to "any person," and although the Fifth Amendment does not contain such a clause, it has been interpreted as embodying principles of equality and anti-discrimination as against the federal government.[45] By rescinding protections from groups courts have already ruled are deserving of them, such as women[46] and gender non-conforming individuals,[47] the Proposed Rule violates the equality principles embodied in the Fifth Amendment, expressly applicable to the federal government, and encourages states to violate the Equal Protection Clause of the Fourteenth Amendment.

The Proposed Rule would allow certain health insurers and health care providers to discriminate against many of the groups that are currently covered by Section 1557, and the opportunity to cut costs would likely encourage them to do so. The Proposed Rule has not set forth an "exceedingly persuasive justification" to allow such disparate treatment, under the "heighted scrutiny" such treatment receives in court.[48] To justify enabling discrimination, HHS asserts that the Section 1557 Final Rule is the only federal regulation defining "sex," and that since other agencies have not supported that definition, rescission is warranted.[49] A purported need for consistency with other definitions is not a remotely, much less "exceedingly" persuasive rationale to allow discrimination. To the contrary, context is important, and any presumption that the phrase "on the basis of sex," and in particular, the term "sex," must mean the same thing regardless of context "readily yields whenever there is such variation in the connection in which the words are used as reasonably to warrant the conclusion that they were employed in different parts of the act with different intent."[50] To

[41] 84 Fed. Reg. 23,170, 23,188 (May 21, 2019).
[42] 81 Fed. Reg. at 31,467/3.
[43] 84 Fed. Reg. at 27,852.
[44] U.S. CONST. amend. V; U.S. CONST. amend. XIV; *see also Frontiero v. Richardson*, 411 U.S. 677 (1973) (applying Fifth Amendment as barring discrimination between men and women in context of military benefits and explaining that "classifications based upon sex, like classifications based upon race, alienage, and national origin, are inherently suspect and must therefore be subjected to close judicial scrutiny"); *United States v. Virginia*, 518 U.S. 515 (1996) (prohibiting state of Virginia from treating women differently in context of military education).
[45] *E.g.*, *Frontiero*, 411 U.S. at 680 n.5.
[46] *Virginia*, 518 U.S. at 531–33.
[47] *E.g.*, *Smith v. City of Salem, Ohio*, 378 F.3d 566, 575 (6th Cir. 2004) (ruling that "[s]ex stereotyping based on a person's gender non-conforming behavior is impermissible discrimination, irrespective of the cause of that behavior").
[48] *Virginia*, 518 U.S. at 531–33.
[49] 84 Fed. Reg. at 27,856.
[50] *Gen. Dynamics Land Sys., Inc. v. Cline*, 540 U.S. 581, 595 (2004) (quoting *Atl. Cleaners & Dyers, Inc. v. United States*, 286 U.S. 427, 433 (1932)) (ruling that "age" means "old age" when coupled with the term "discrimination").

be sure, just as "age" is a word that "has several commonly understood meanings among which a speaker can alternate in the course of an ordinary conversation, without being confused,"[51] so too with "sex." In the context of a statutory provision expressly incorporating protections against discrimination in a range of statutes, giving the term its broadest possible meaning is more important than any claimed consistency rationale.

HHS claims that removing the definition of "on the basis of sex" would "significantly restore the ability of States to establish policies in this area, based on their weighing the competing interests at stake."[52] HHS expresses the concern that retaining the Section 1557 Final Rule's definition of "sex" "may stifle the ability of States, local governments, and covered entities to set their own policies and balance multiple competing interests on questions related to gender dysphoria."[53] HHS nowhere explains what "competing interests on questions related to gender dysphoria" could possibly exist, or what "questions" could lead to such competing interests, much less counsel in favor of allowing discriminating against individuals seeking care.

What this rule really would do is to allow states to decide that some groups are not deserving of civil rights protections. HHS' rationale that states are "heavily reliant on the continued receipt of Federal funds subject to Title IX requirements,"[54] and therefore they cannot be expected to extend civil rights protections, could be used to justify rolling back all progress since states first accepted federal funds. In the case of "on the basis of sex," states cannot reasonably argue that they could not have been "cognizant" of the consequences of their participation. Again, then, HHS has failed to demonstrate that an "exceedingly persuasive justification" exists to enable the discrimination inherent in the Proposed Rule.

In sum, by removing civil rights protections from certain groups of people based on specious and unsupported rationales, HHS would enable the discrimination of those groups, in violation of the Constitution.

VI. The Proposed Rule's Narrow Interpretation of the Scope of Covered Entities under Section 1557 Would Further Disadvantage Individuals Seeking Care in Derogation of the Fundamental Right to Health Care.

The Proposed Rule would significantly narrow the scope of entities impacted by this rule and would increase the likelihood that now-exempted entities could engage in discriminatory practices that will negatively impact health and well-being of communities that are currently protected under the 2016 rule. The proposed changes frustrate the original intent of Congress to prevent discrimination under "any health program or activity, any part of which is receiving Federal financial assistance." Organizations that are already inclined towards discrimination will be all the more emboldened by HHS writing them out of their existing anti-discrimination requirements.

The Proposed Rule draws a distinction between "health insurance" and "health care,"[55] unlike the Section 1557 Final Rule which applied to "all of the operations of an entity principally engaged in providing or administering health services or health insurance coverage."[56] OCR justifies this change in interpretation by citing the Civil Rights Restoration Act of 1987 ("CRRA"): "The CRRA… defined "program or

[51] *Id.* at 596.
[52] 84 Fed. Reg. at 27,857.
[53] 84 Fed. Reg. at 27,857.
[54] *Id.*
[55] *See* 84 Fed. Reg. at 27,862.
[56] *See* 81 Fed. Reg. at 31,385.

activity"…to cover all the operations of entities only when they are 'principally engaged in the business of providing education, *health care*, housing, social services, or parks and recreation.'"[57]

The Proposed Rule argues that an entity principally or otherwise engaged in the business of providing health insurance shall not be considered to be principally engaged in the business of providing health care.[58] This means the proposed rule would not apply to Medicare Part B, self-funded health plans under ERISA, the Federal Employees Health Benefits Program, or STLDI plans because those programs do not receive Federal financial assistance from HHS, and the entities operating them would not be considered to be principally engaged in the business of providing health care.

The text of Section 1557 of the ACA is much more expansive and was interpreted accordingly in the Section 1557 Final Rule. The legislative text states that that this title will apply to "any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title [1] (or amendments)."[59]

In the Section 1557 Final Rule, HHS stated that including issuers of health insurance coverage was appropriate because "[t]his interpretation serves the central purposes of the ACA, and effectuates Congressional intent, by ensuring that entities principally engaged in health services, health insurance coverage, or other health coverage do not discriminate in any of their programs and activities, thereby enhancing access to services and coverage."[60] This rationale is still true today. The Proposed Rule ignores the fact that health insurance programs are vital to the provision of health care in the United States. In controlling how health care is paid for, how benefits are designed and which providers are within their networks, health insurance programs have vast influence over access to and the provision of health care to Americans.

Indeed, HHS even cites a definition of health insurance coverage at 42 U.S.C. § 300gg-91 that includes "benefits consisting of *medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care)* under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer." (emphasis added) This very definition makes it clear that the provision of health insurance coverage is inextricably linked to the provision of health care itself.

Further, Section 1557 applies to "any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or *contracts of insurance*…" (emphasis added). This strongly suggests that Congress intended for the law to apply to entities receiving a contract of insurance from the Federal government, such as a Federal Employees Health Benefits Program plan. Excluding health insurance programs from the scope of Section 1557 would fundamentally frustrate the objective of Congress, which was to avoid discrimination in the provision of health care, including denial of benefits. This change will encourage unlawful discrimination against specific communities, including LGBTQI people and women as discussed above, in direct conflict with existing constitutional and statutory protections.

Differing insurance products determine not only what will be covered but also drive access to care with provider networks designing them to include or exclude persons. As explained above, there is no distinction between health care and health insurance. Insurance companies will use benefit design and coverage decision-making to limit and exclude treatment for patients and discriminate against them. For example,

[57] *See* 84 Fed. Reg. at 27,862.
[58] *See* 84 Fed. Reg. at 27,863.
[59] 42 U.S.C. § 18116.
[60] *See* 81 Fed. Reg. at 31,386.

insurers could put therapies or medications specific to LGBTQI or women's health in the highest cost-sharing tier, while not doing so for other conditions. Insurers could use provider networks to exclude particular providers based on the scope of their practice including women's reproductive health care or health care for LGBTQI individuals.

VII. The Proposed Rule Would Make Access to Care More Difficult for People with Limited English Proficiency.

Section 1557 of the Affordable Care Act , along with other non-discrimination laws that are incorporated into Section 1557, provide necessary protections to ensure every person has access to health care on a non-discriminatory basis. Equal access to health care is a fundamental human right — regardless of one's national origin or language. Central to respecting the dignity of all, a core Jewish value, is ensuring that all people receive information that can affect their rights in a way they can understand. People cannot understand what they cannot read, much less what they hear in a language they do not speak. Indeed, the principle of informed consent underlying modern medical practice cannot possibly be met when individuals do not know what they are being asked to consent to. Nevertheless, the proposed revisions to Section 1557 of the ACA seek to repeal certain provisions that provide individuals with limited English proficiency ("LEP") with necessary language services.

In underserved communities, laws like Section 1557 can make all the difference in patients receiving the care they are entitled to. The proposed revisions would open the door to national origin discrimination in health care, and the existing protections of Section 1557 should remain in place.

Ensuring language access touches the lives of millions of Americans, 25 million of whom are LEP.[61] As discussed more below, research has shown that language barriers negatively impact the quality of care and ability of a person to access care and maintain coverage. Existing protections ensure LEP persons understand their rights and help limit the barriers they have to accessing quality health care. The revisions to Section 1557, on the other hand, would raise language barriers. While OCR claims that this might save money, this justification does not outweigh the pernicious impact the rule change will have on individuals with LEP and does not account for the increased costs the health care system will ultimately bear when LEP individuals are placed at higher risk by reduced access to and impaired understanding of medical care.

Research has proven that health care quality and outcomes improve for LEP patients and families when professional interpreters are used or language-concordant providers are available. Although professional interpretation can present logistical and financial challenges for health care providers, many LEP patients do not have access to quality health care without such services. And given that such institutions are receiving federal funding, they must comply with the federal requirement not to discriminate based on individuals with a different national origin. Part of this obligation is to provide individuals with LEP adequate translation services.[62] Providing such services is particularly essential in the health care sphere as

[61] Migration Policy Institute (MPI) tabulations from the U.S. Census Bureau's 1990 and 2000 Decennial Censuses and 2010 and 2013 American Community Surveys (ACS), available at: https://www.migrationpolicy.org/article/limited-english-proficient-population-united-states.

[62] *See, e.g.*, U.S. Dep't of Health and Human Services Office for Civil Rights, Settlement Agreement with AL Dep't of Human Resources (Oct. 25, 2017) ("OCR's investigation found that the father's LEP was a significant factor in ADHR's failure to provide timely language assistance and other services essential for reunification. Additionally, OCR's investigation found that ADHR consistently failed to take reasonable steps to ensure meaningful access to its programs by Latino persons with LEP. Thus, OCR determined that ADHR administered its programs in a manner that had the effect of delaying or denying access to its programs and services on the basis of national origin in violation of Title VI," *available at* https://www.hhs.gov/sites/default/files/alabama-child-welfare-agreement.pdf; U.S. Dep't of Health and Human Services Office for Civil Rights, Resolution Agreement with MI Dep't of Human Services Division of Family & Children's Services, Transaction Numbers 09-099895/10-109106 (Apr. 15, 2014), ("The compliance review was initiated in response to information received from the U.S. Department of Justice that indicated MDHS-DFCS may be discriminating against persons based on their national origin (Hispanic) in violation of Title VI of the Civil Rights Act of 1964 (Title VI) in the operation of its programs by failing to ensure that limited English proficient (LEP) persons have meaningful access to its

that LEP patients might otherwise avoid or postpone seeking the medical care they require out of fear of discrimination or mistreatment due to their national origin or the language they speak.

HHS should not prioritize lowering costs for providers at the expense of these patients. LEP has been shown as a risk factor for health disparities including access and medical errors that may have disastrous effects on patient safety. Although translation services may lead to a marginal increase in operating costs for health care providers, these costs are far outweighed by the costs associated with "medical errors, greater malpractice risk, poor quality of care, and disparities in morbidity and mortality between English-speaking patients and those with limited English proficiency."[63] Providers have a number of options to minimize costs, including the use of pooled resources and remote translators. In fact, HHS' own breakdown of the costs demonstrates that, per party insured, the costs are minimal. Surely providers have passed along larger costs to their patients and insureds. The minimal cost per patient is the relevant benchmark, not the total.

It is important to note that individuals with limited English proficiency are also more likely to be individuals with difficulty accessing other resources, including transportation, making it even more important for those individuals to know their rights. What's more, these individuals may also fall within a category now allowed to be subject to discrimination by the Proposed Rule, further compromising their access to care.

Disadvantaging an individual on the basis of his or her English proficiency is inextricably linked to discrimination on the basis of national origin. Those who are seeking health care cannot be assumed to be aware of their rights. Making people aware of their rights is integral to the values of justice and dignity for all central to faith communities. Created in the image of the divine, Jews believe that *every person* has the right to be understood and to understand. The different languages we speak are but one manifestation of the wonderful abundance of creation. To respect this creation, OCR should retain the existing requirements of Section 1557 as they pertain to LEP individuals.

VIII. The Proposed Rule Violates the Rulemaking Requirements of the Administrative Procedure Act.

The discussion above demonstrates that the Proposed Rule is unconstitutional and, simply put, bad policy. In addition, the Proposed Rule violates basic principles of law applicable to agency decisionmaking, further demonstrating why it should not be finalized and why the Section 1557 Final Rule should remain in place.

As a rulemaking exercise of an executive branch agency, the Administrative Procedure Act ("APA") applies to the Proposed Rule. The APA imposes important procedural requirements on the actions of executive branch agencies, including when agencies are "formulating, amending or repealing" a rule.[64] The APA requires courts to "hold unlawful and set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law,"[65] "contrary to a constitutional right,"[66] or "in excess of statutory jurisdiction."[67]

Here, the Proposed Rule fails in a number of respects, but two are of particular note: First, the Proposed Rule violates Section 1557 by enabling individuals and institutions to deny care that Section 1557 requires they provide. As such, HHS lacks the statutory authority to promulgate the Proposed Rule. Second, HHS' rationale for the Proposed Rule is arbitrary and capricious. HHS has failed to provide a reasoned explanation

programs and services." As a result, MDHS-DFCS agreed to expand language services to resolve the complaints), *available at* https://www.hhs.gov/sites/default/files/ocr/civilrights/activities/agreements/miss_dhs_vra.pdf; *see also* 42 U.S.C. § 2000d; 45 C.F.R. Part 80.

[63] Elizabeth A. Jacobs, et. al., Shared Networks of Interpreter Services, At Relatively Low Cost, Can Help Providers Serve Patients With Limited English Skills, Health Affairs, Vol. 30, No. 10, (Oct. 2011), *available at* https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0667.

[64] 5 U.S.C. § 551(5).

[65] 5 U.S.C. § 706(2)(A).

[66] 5 U.S.C. § 706(2)(B).

[67] 5 U.S.C. § 706(2)(C).

for why the facts and rationale it relied upon just three years ago when promulgating the Section 1557 Final Rule are no longer persuasive, and why such an opposite result should prevail today. Additionally, HHS has justified the Proposed Rule based on cost considerations, but has analyzed only one side of the equation, completely ignoring costs to patients.

A. Section 1557 Prohibits the Discrimination the Proposed Rule Would Enable.

The APA requires courts to set aside rules that run contrary to the statute they purport to interpret.[68] Section 1557 of the ACA, by its own terms, prohibits sex discrimination in certain health programs and activities.[69] By permitting objecting institutions to deny coverage for contraceptives, transition-related services, and numerous other services; and by improperly narrowing the scope of beneficiary protections to only health care programs and activities and to programs and activities administered by executive agencies, the Proposed Rule enables violations of the statute it intends to interpret and must be set aside on that basis.

The Proposed Rule also arbitrarily fails to recognize the large amount of case law contrary to HHS' view. Instead of examining this case law in determining the ability of HHS to promulgate the Proposed Rule, HHS relies on the preliminary injunction issued in *Franciscan Alliance Inc. v. Burwell* to justify the change in policy. But a preliminary injunction in a district court case does not require a change in HHS policy and, in any event, is contrary to the weight of case law. Over twenty years ago, a court recognized that discrimination based on the fact that a woman had had an abortion was sex discrimination, *i.e.*, discrimination "on the basis of sex."[70] Moreover, being prohibited from discriminating against someone because they had an abortion is in no way related to any requirement to provide abortions. Indeed, Title IX itself expressly does not permit penalties based on a woman's prior termination of pregnancy.[71] Nor does Title IX exclude gender identity from its protections. For example, the court in *Adams v. School Board of St. Johns Cty.* held that "the meaning of 'sex' in Title IX includes 'gender identity' for the purposes of its application to transgender students."[72] The NPRM correctly notes that the Supreme Court has not settled the matter for purposes of Title IX; however, in a related context — Title VII of the Civil Rights Act — the Court stated:

> [W]e are beyond the day when an employer could evaluate employees by assuming or insisting that they matched the stereotype associated with their group, for in forbidding employers to discriminate against individuals because of their sex, Congress intended to strike at the entire spectrum of disparate treatment of men and women resulting from sex stereotypes.[73]

The NPRM ignores entirely that the Sixth Circuit has applied this reasoning to extend Title VII's protections, ruling that "[s]ex stereotyping based on a person's gender non-conforming behavior is impermissible discrimination, irrespective of the cause of that behavior."[74] Although Section 1557 does not expressly incorporate Title VII, it does incorporate Title IX, and this Title VII protection has also been applied in the Title IX context.[75]

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[68] 5 U.S.C. § 706.
[69] 42 U.S.C. § 18116.
[70] *Turic v. Holland Hosp., Inc.*, 85 F.3d 1211, 1214 (6th Cir. 1996) (holding an employer who discriminates against an employee who has exercised right to access abortion violates Title VII prohibition on sex discrimination).
[71] 20 U.S.C. § 1688.
[72] 318 F. Supp. 3d 1293, 1325 (M.D. Fla. July 26, 2018); *see also A.H. v. Minersville Area Sch. Dist.*, 290 F. Supp. 3d 321 (M.D. Pa. Nov. 22, 2017) (holding that plaintiff successfully stated a claim where plaintiff alleged discrimination based on gender identity).
[73] *Price Waterhouse v. Hopkins*, 490 U.S. 228, 251 (1989) (internal quotation marks and citation omitted).
[74] *Smith v. City of Salem, Ohio*, 378 F.3d 566, 575 (6th Cir. 2004).
[75] *Johnston v. Univ. of Pittsburgh of Com. Sys. of Higher Educ.*, 97 F. Supp. 3d 657, 680 (W.D. Pa. 2015), *appeal dismissed*, No. 15-2022 (3d Cir. Mar. 30, 2016) (applying Title VII sex-stereotyping rulings to Title IX claims of transgender individual).

Relying instead on litigation positions in unsettled matters as HHS does here by invoking *Franciscan Alliance* offers no support for HHS' policy change and does not provide a sound basis for a reasoned analysis under the APA.[76] Moreover, HHS' wholesale avoidance of *any* contrary case law in the Proposed Rule demonstrates the one-sided nature of the agency's decisionmaking, yet another reason it violates the APA.

B. HHS Has Failed to Justify Its Abrupt About-Face from the Section 1557 Final Rule, or Otherwise Provide a Reasoned Explanation for the Proposed Rule.

When an agency proposes a change in position, it must "display awareness that it is changing position" and "show that there are good reasons for the new policy."[77] The agency must provide a more detailed justification where, as here, "its new policy rests upon factual findings that contradict those which underlay its prior policy; or when its prior policy has engendered serious reliance interests that must be taken into account."[78] Ultimately, "a reasoned explanation is needed for disregarding facts and circumstances that underlay or were engendered by the prior policy."[79]

Here, HHS proposes to remove important protections offered by the Section 1557 Final Rule.[80] HHS has failed to provide a reasoned analysis for why it decided to change in position, much less the substance of those changes. HHS fails to account for the extensive history of health care discrimination that LGBTQI individuals and individuals seeking reproductive care have suffered as noted above, and it provides no contrary data to counter the original factual findings in the Section 1557 Final Rule. Furthermore, individuals have reasonably placed their reliance upon the federal government to protect their civil rights as explained in the Section 1557 Final Rule. The Proposed Rule fails entirely to address these concerns, and as such is arbitrary and capricious.

In addition to representing an arbitrary shift from the Section 1557 Final Rule, the Proposed Rule fails on its own merits because HHS has not adequately explained its reasoning. For example, HHS has identified cost[81] and regulatory burdens[82] as primary factors in its proposal to rescind the Section 1557 Final Rule. Setting aside the question of whether factors such as cost are even relevant in a rulemaking interpreting civil rights protections, having put these factors at issue, the APA requires HHS to consider all important aspects of those factors, and adequately explain the agency's conclusions.[83]

The Proposed Rule's cost-benefit and regulatory analyses are woefully deficient, analyzing only costs and impacts to providers, not costs and other impacts to individuals needing care. Focusing on the burdens imposed by the notice and tagline requirements,[84] the NPRM offers six reasons why the costs do not justify the need.[85] Each reason focuses on either the ineffectiveness, lack of evidence of benefit, or burden of implementation.[86] Aside from relying on questionable or attenuated data sets, HHS also fails to provide support for its position because it does not balance the considerations against any need. It overstates the

[76] *See* 84 Fed. Reg. at 27,853.
[77] *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009).
[78] *Id.*; *see also Perez v. Mortgage Bankers Ass'n*, 135 S.Ct. 1199 (2015) (reaffirming that an agency must provide "more substantial justification" when its previous policy engendered serious reliance interests or its new policy relies on facts contrary to those relied on for the previous policy).
[79] *F.C.C. v. Fox Television Stations*, 556 U.S. at 516.
[80] 45 C.F.R. pt. 92.
[81] *See* 84 Fed. Reg. at 27,857–60.
[82] *Id.* at 27,872–77.
[83] *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co. ("MVMA")*, 463 U.S. 29, 43 (1983).
[84] The Section 1557 Final Rule requires notices of nondiscrimination and taglines be appended to all "significant" publications and communications (larger than a postcard or brochure) sent by covered entities to beneficiaries, enrollees, applicants, or members of the public. 45 C.F.R. § 92.8(f)(1).
[85] 84 Fed. Reg. at 27,859.
[86] *Id.*

import of these regulatory costs of compliance, which alone do not justify the proposed changes. HHS ignores the costs to individuals — financial, health-related, and otherwise — when services are denied, or when providers are allowed to discriminate against them in the provision of services. HHS does not attempt to quantify, for example, the number of women who will suffer irreparable health effects or death should they be refused services due to complications from an abortion, *or even a miscarriage*.[87] Nor does HHS concern itself with the psychological impacts to LGBTQI individuals, much less the health effects, of being provided inadequate care or being denied care entirely due to gender identity or presentation.

Almost two-thirds of Americans face medical debt.[88] Policies that would remove necessary coverage would only result in additional debt, lifelong health implications, or both, without a compelling justification. The federal government should be focusing its resources expanding coverage, not arbitrarily making it easier for plans to discriminate and take coverage away.

By not accounting for *any* cost or other impacts on patients or providers, HHS has "entirely failed to consider an important aspect of the problem," a hallmark of arbitrary and capricious decisionmaking.[89]

IX. Conclusion

Thank you for the opportunity to provide comments on the Proposed Rule for Nondiscrimination in Health and Health Education Programs or Activities. We trust that these comments, along with the many others we expect the Department will receive, will demonstrate how damaging and unjust the Proposed Rule would be to numerous individuals, whether members of a faith community or not. We hope that HHS will come to understand that this Proposed Rule prioritizes the religious liberty of the few[90] — typically the powerful and wealthy — over the dignity and conscience of the many — often vulnerable and already disadvantaged — and unconstitutionally interferes with the rights of individuals to make decisions regarding their own care based on their own conscience and faith. In discriminating against the religious liberty of the individual, this Proposed Rule upends the protections the Constitution is supposed to provide.

We believe the Department has the duty not to finalize this damaging rule and recognize once more that full access to health care should be available to all.

Please do not hesitate to contact Shannon Russell, Legislative Associate, at srussell@ncjw.org to provide further information.

Respectfully submitted,

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[87] Nancy Northrup, HUFFINGTON POST, "New Bill Would Allow Religious Hospitals to Deny Life-Saving Emergency Care" (Feb. 14, 2011), https://www.huffpost.com/entry/new-bill-would-allow-reli_b_822168.
[88] https://www.commonwealthfund.org/publications/newsletter-article/survey-79-million-americans-have-problems-medical-bills-or-debt
[89] *MVMA*, 463 U.S. at 44.
[90] Gruberg *et al.*, CENTER FOR AMERICAN PROGRESS, "Religious Liberty for a Select Few" 2–3 (explaining effect of these types of policies as "protecting the religious liberty of only [a] small segment of Americans"—"conservative Christians"), *available at* https://cdn.americanprogress.org/content/uploads/2018/04/03074429/ReligiousExemptions-report-5.pdf.